HEALTH EDUCATION INTERVENTIONS AND FEMALE GENITAL MUTILATION/CUTTING (FGM/C) IN BIRMINGHAM, UK: A MIXED METHOD INQUIRY

By

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Abstract

Health education interventions aimed at preventing female genital mutilation/cutting (FGM/C) have been implemented in numerous communities globally; however, the practice continues. This doctoral research aimed to explore health education interventions intended to prevent FGM/C locally and globally, in order to identify factors affecting their effectiveness and guide professionals caring for communities and patients/service users affected by FGM/C. A mixed method research methodology was used, underpinned theoretically by intersectionality.

The research was undertaken in three phases. First, a systematic review examined the effectiveness of health education interventions designed to prevent FGM/C in affected communities globally. Second, a survey investigated the experiences and views of health professionals in Birmingham regarding the discussion of FGM/C with their patients/service users. Third, a generic qualitative study explored the experiences and views of individuals from communities with a history of FGM/C in Birmingham regarding health and wellbeing programmes/sessions (HWPs).

Findings from the three phases uncovered several interrelated factors affecting the effectiveness of FGM/C health education interventions: 1) social structures (including factors relating to inclusivity, privilege checking, gender disparities and generational differences); 2) culture (comprising beliefs, attitudes, cultural competence and active communication); and 3) media contributions (incorporating the platforming of inequalities while also acknowledging disparities within media, such as the use of illustrations and language, e.g. type and utterance).

All of these factors play an important role in determining the effectiveness of FGM/C health education interventions, and a Theory of Change (ToC) approach is used to illustrate the steps of implementing these interventions successfully. A novel ‘Six Aspects of FGM/C Education’ (SAFE) model was developed, informed by the factors identified from this research which affect the effectiveness of health education interventions. The SAFE model offers guidance to the design and implementation of effective FGM/C interventions.

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Contributorship Statement

All the chapters in this thesis are entirely a product of my own work with the guidance of my supervisors Prof Julie Taylor, Dr Lucy Doos and Prof Caroline Bradbury-Jones.

The systematic review (Chapter 3) was undertaken by me with Hapreet Sihre (PhD Student, Institute of Applied Health Research – IAHR) contributing as a secondary reviewer in the selection of studies for inclusion. My supervisors contributed as third person reviewers to confirm or settle review disagreements between Hapreet and I.

The survey study and qualitative study were primarily designed and analysed by myself with guidance from all of my supervisors.

Table of Content

List of Abbreviations

ADHD— Attention Deficit Hyperactive Disorder
FGM/C— Female Genital Mutilation/Cutting
GP— General Practitioner
HICs— High Income Countries
HIV— Human Immunodeficiency Virus
HWPs— Health and Wellbeing Programmes/sessions
ID— Identity
LMICs— Low-Middle Income Countries
MAST— Message, Audience, Strategy, Timing
MASTE— Message, Audience, Sharing information, Timing, Evaluation
SAFE— Six Aspects of FGM/C Education
SAT— Social Action Theory
UK— United Kingdom
UN— United Nations
UNICEF— United Nations Children’s Fund
WHO— World Health Organization

CHAPTER 1

Background and Context Overview

Introduction

This chapter introduces the research starting with a broad background about female genital mutilation/cutting (FGM/C), the rationale for the study and its overall aim. A thesis outline is provided, showing the process and the layout of this thesis, including the components that are presented in each chapter.

1.1 Background

Female Genital mutilation/Cutting (FGM/C)

1.1.1. History and terminology

FGM/C is believed to have originated in ancient Egypt and to have existed for at least 5000 years (DeMeo, 1997). The practice has spread into many different cultural groups including those in Europe and North America. The practice pre-dates all three of the most predominant religions (Judaism, Christianity and Islam). Some people practising these religions have been known to practise FGM/C, although their holy books condemn bodily harm (Ortiz, 1998, HM Government, 2011, El-Damanhoury, 2013).

FGM/C refers to all procedures that involve partial or total removal of the external female genitalia for non-medical purposes. The term ‘female genital mutilation’ was coined after the previously used term ‘female circumcision’ was found to attract comparisons with male circumcision, which resulted in the development of ambiguous ideologies that made it difficult to distinguish the two forms of ‘circumcision’. The term ‘female genital mutilation’ became widely used in the 1970s by organisations and activists spearheading campaigns to end the practice. FGM/C was then categorised as an act that violates human rights, which facilitated the development and promotion of both national and international advocacy for preventing the practice (Trivedi, 2019). In 1991 for instance, members of the United Nations (UN) adopted the term ‘female genital mutilation’ because it was regarded to be less offensive, especially to those who have undergone the practice (Marmot et al., 2008). The term has since been endorsed as the standard term used around the globe. Debates, however, have emerged regarding other terminologies, for instance using the terms ‘circumcision’ or ‘cutting’, especially to lay people who may not understand the term ‘mutilation’ (Rahman et al., 2000). In this thesis, I have used the term ‘female genital mutilation/cutting’ as it takes account of multiple perspectives by including both ‘mutilation’ and ‘cutting’.

1.1.2. Types of FGM/C

The United Nations Population Fund (UNFPA) states that FGM/C is traditionally carried out by a woman, usually of old age, who has no medical training and who undertakes the procedure without anaesthesia or antiseptic treatments (UNFPA, 2019). The tools used for cutting vary, but may include knives, scissors, scalpels, pieces of glass and razorblades. The World Health Organization (WHO) has classified FGM/C into four types, described in Table 1.1 (WHO, 2016b).

Table 1.1: Types of FGM/C

Types of FGM/C	Description
Type I- Clitoridectomy	Partial or total removal of the clitoris
Type II- Excision	Total or partial removal of the clitoris and the labia minora with or without excision of the labia majora

Type III- Infibulation	Narrowing of the vagina opening with a covering seal or repositioning of the inner or outer labia
Type IV- Other Procedures	Piercing, incising, scraping or cauterising of the genital area and elongation (pulling of labia)

1.1.3. Consequences of FGM/C

FGM/C violates the human rights of girls and women and leads to devastating physical and psychological consequences (WHO, 2018). Some of these consequences are immediate or short-term, including pain, shock, bleeding, infections, difficulties in micturition, and damage of nearby organs (Reisel and Creighton, 2015). Long-term consequences include chronic and recurring vaginal and pelvic infections, menstrual complications, persistent urinary infections, kidney damage and possible failure, cysts and abscesses, dyspareunia, infertility, complications during pregnancy and childbirth, and emotional and psychological effects (HM Government, 2011, Reyners, 2004). Death can occur in severe cases, with estimates suggesting that around 10% of girls who undergo FGM/C die shortly afterwards due to complications (Lee, 2007). Men are not an exception to the negative impacts of FGM/C. A study by Berggren et al. (2007) on men's perspectives revealed that some men are affected psychologically, because they continually worry about the suffering endured by their wives and daughters. The study also reported physical challenges to men, including genital wounds as a result of difficulties during sexual intercourse.

1.1.4. Factors that facilitate continuation of FGM/C

Tackling a complex issue such as FGM/C is challenging. Interventions are often prone to accusations of racism and discrimination, thus making it difficult for comprehensive and sustainable intervention and total elimination of the practice (Costello, 2015). However, failure to engage in tackling FGM/C can be perceived as a sign of neglect of those affected (Brown and Hemmings, 2013).

The difficulty of tackling FGM/C is also perpetuated by cultural or traditional factors. These include rituals and beliefs that are passed on for decades from one generation to the next, eventually developing into social norms (WHO, 2011). These norms subject community members to social pressure in adhering to the practice. In Sudan, for instance, a woman risks divorce if it is discovered on the wedding night that she has not undergone FGM/C (Norman et al., 2009). Women, therefore, are forced to undergo FGM/C so that they can be regarded suitable for marriage.

Religious factors, steered by specific religious beliefs, also have the capacity to influence the continuation of FGM/C (WHO, 2011). This is influenced largely by teachings that are usually delivered by religious leaders who misinterpret sacred texts. In Indonesia, for instance, religious leaders have been found to play a significant role in influencing the continuation of FGM/C. This is because leaders obstruct government efforts to ban the practice by protesting in its favour and terming it as ‘important’ (Berg et al., 2010, ORCHID Project, 2016, HM Government, 2011).

Other factors allowing the continuation of FGM/C include misconceptions associated with health and hygiene factors. An example illustrating this is a cross-sectional survey study undertaken in Egypt where 35.2% of medical students (males and females) revealed that they regarded girls with FGM/C as more clean and hygienic when compared to those without FGM/C (Mostafa et al., 2006).

1.1.5. Prevention of FGM/C

a) Conventions and treaties

As a growing global concern, efforts to prevent FGM/C have been adopted in several conventions and treaties worldwide (Table 1.2), with the aim of eliminating the practice.

Table 1.2: Examples of international treaties and consensus documents citing FGM/C as a harmful practice

International treaties	• **Universal Declaration of Human Rights, adopted 10 December 1948. General Assembly Resolution 217. UN Doc. A/810. (https://www.refworld.org/docid/3ae6b3712c.html)** • **Convention on the Rights of the Child, adopted 20 November 1989. General Assembly Resolution 44/25. UN GAOR 44th session, Supp. No. 49. UN Doc. A/44/49 (entry into force, 2 September 1990) (https://ec.europa.eu/anti-trafficking/legislation-and-case-law-international-legislation-united-nations/united-nations-convention-rights_en)**
Regional treaties	• European Convention for the Protection of Human Rights and Fundamental Freedoms, adopted 4 November 1950 (entry into force, 3 September 1953) (https://www.equalityhumanrights.com/en/what-european-convention-human-rights) • African Charter on the Rights and Welfare of the Child, adopted 11 July 1990. Organization of African Unity, Doc. CAB/LEG/24.9/49 (entry into force 29 November 1999) (https://www.refworld.org/docid/3ae6b38c18.html)
Consensus documents	• United Nations General Assembly, Declaration on the Elimination of Violence against Women, UN Doc. A/RES/48/104 (1993) (https://www.refworld.org/docid/3b00f25d2c.html) • Beijing Declaration and Platform for Action of the Fourth World Conference on Women, Beijing, China, 4–15 September 1995. UN Doc. A/CONF.177/20 (https://www.refworld.org/docid/3dde04324.html)

b) FGM/C guidelines/pathways

More detailed guidelines and pathways have also been established globally and locally, in the United Kingdom (UK), to enhance effective prevention and management of the consequences of FGM/C. These guidelines target different populations and stakeholders such as communities affected by FGM/C, local governments, policymakers, health and social care professionals, and charitable organisations (Table 1.3).

Table 1.3: Global and UK guidelines and pathways

Examples of global guidelines and pathways

Guideline/pathway	Target population	Aim
Care of girls and women living with female genital mutilation (WHO, 2018)	This handbook is for healthcare providers, including obstetricians and gynaecologists, surgeons, general medical practitioners, midwives, nurses and other country-specific health professionals. It also includes healthcare professionals providing mental health care, educational and psychosocial support such as psychiatrists, psychologists, social workers and health educators.	To guide the care of girls and women who have been subjected to any form of FGM/C.
WHO guidelines on the management of health complications from female genital mutilation (WHO, 2016)	These guidelines are intended primarily for healthcare professionals but also policymakers, healthcare managers and others.	To guide the planning, development and implementation of national and local healthcare protocols and policies. The information contained in this document is useful for designing job aids and pre- and in-service professional training in the areas of medicine, nursing, midwifery and public health for healthcare providers caring for girls and women living with FGM/C.
Global strategy to stop health-care providers from performing female genital mutilation (WHO, 2010)	These guidelines target both healthcare providers and national authorities.	To suggest various ways the medicalisation of FGM/C can be tackled so as to discourage health professionals from carrying out the procedure.

Examples of United Kingdom (UK) guidelines and pathways

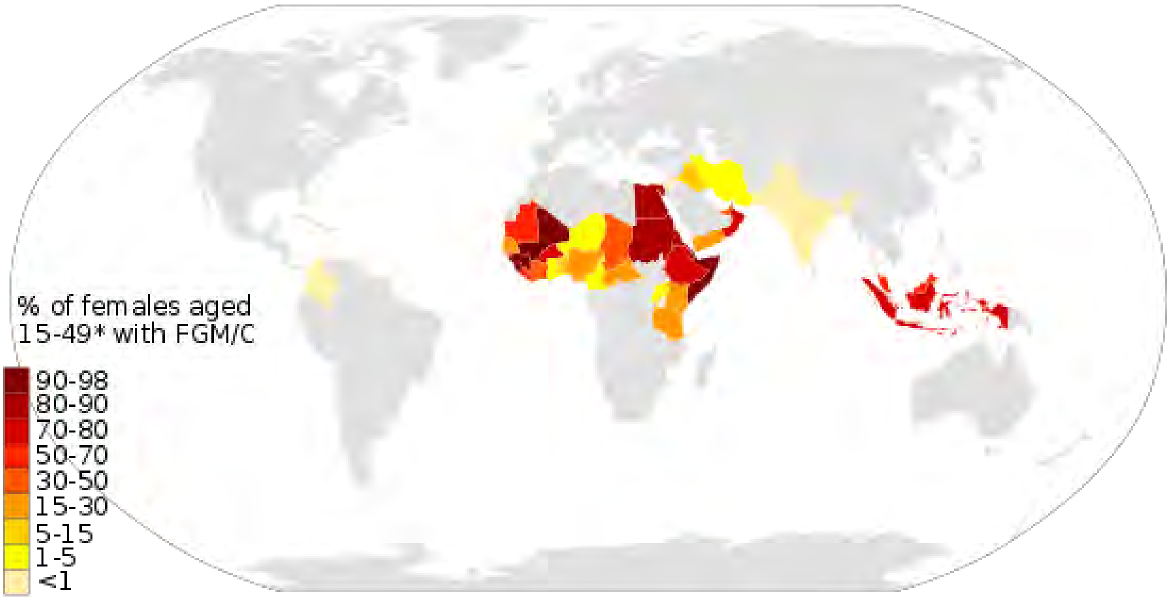
Guideline/pathway	Target population	Aim
FGM: mandatory reporting in healthcare (Department of Health and Social Care, 2015)	This webpage contains different resources targeting healthcare professionals.	To describe the responsibilities of healthcare workers in reporting cases of FGM/C.
FGM enhanced dataset: guidance on NHS staff responsibilities (Department of Health, 2015)	The National Health Service (NHS) staff responsible for recording and reporting FGM/C cases.	To provide guidance and enhance national data collection of both new and previously recorded cases of FGM/C. The goal of this document is to develop accurate national statistics of the prevalence of FGM/C with a view to informing prevention programmes and professionals about the present state of the issue.
FGM safeguarding pathway (Department of Health)	All professionals assisting women and girls affected by or subjected to FGM/C in the UK.	To guide signposting of affected women and girls to the relevant/required services.

Female genital mutilation risk and safeguarding: guidance for professionals (Department of Health, 2016	Healthcare professionals, local safeguarding children board members, named safeguarding leads, designated safeguarding professionals, commissioning professionals, and all other professionals involved in child protection.	To outline professionals' responsibilities and ensure that healthcare services have appropriate safeguarding arrangements for individuals either directly or indirectly affected by FGM/C.

1.1.6. Prevalence of FGM/C

According to the United Nations Children's Fund (UNICEF), although the numbers of new cases of FGM/C have reduced in some communities as a result of interventions, over 200 million girls and women globally are estimated to live with FGM/C (UNICEF, 2016). The practice is predominantly concentrated in some African, Asian and Middle Eastern countries (UNICEF, 2013). In Africa, for instance, where there are some of the highest prevalence rates, about three million girls are estimated to be at risk of undergoing FGM/C every year (Yoder et al., 2004). Prevalence, however, varies across different affected countries (Figure 1.1). For example, Somalia has a prevalence of more than 90%, while Uganda has a prevalence of less than 5%.

Figure 1.1: Estimated global prevalence rates of FGM/C among females aged 15-49 years in 2018 *



*Source: Nederlandse (2018)

In some Western countries, FGM/C is practised among migrants (diaspora communities) who have come from practising regions. Population migration has contributed to an increased geographical distribution of FGM/C around the globe (Ceschia, 2015). It is estimated that about 513,000 girls and women had undergone or were at risk of undergoing FGM/C in the United States of America (USA) in 2012 (Goldberg et al., 2016). In the European Union (EU), including the UK, it has been estimated that around 500,000 women are living with FGM/C and 180,000 girls are at risk of undergoing FGM/C every year (Brown and Hemmings, 2013). There are also occasions where FGM/C is performed on girls or women from non-practising backgrounds; this tends to happen when an individual wishes to be accepted into a family that practises FGM/C. Marriage, for instance, to a partner who is from a practising community might require a woman to undergo FGM/C so as to be accepted by the partner's family (Shell-Duncan and Herniund, 2006).

In the UK, in 2015, Macfarlane and Dorkenoo (2015) estimated that the prevalence of FGM/C among women aged 15-49 in England and Wales was 103,000, representing 7.7 per 1,000 population of all women in England and Wales. Statistics by region showed that London had the highest prevalence with 28.2 per 1,000 population of women. Outside of the greater London region, Manchester, Slough, Bristol, Leicester and Birmingham had high prevalence rates, ranging from 12 to 16 per 1,000 women. These figures illustrate that, in England and Wales, there is at least one woman of childbearing age living with FGM/C in almost every local authority area, and the affected populations are mostly concentrated in large cities, which can be explained by migration patterns to these cities (Birmingham City Council, 2021). The total estimates showed approximately 137,000 women and girls, including 10,000 girls under the age of 14, living with FGM/C in England and Wales (Macfarlane and Dorkenoo, 2015). In Scotland, it was recorded that 363 girls were born to mothers from practising countries in the year 2012 alone, which represented a fivefold increase over the course of a decade. This is significant as being born to a mother from an FGM/C-practising country is considered to be a risk factor for girls in the UK (Baillot et al., 2014). As Birmingham is known to have a high prevalence of FGM/C, it was selected as a suitable setting to conduct empirical research for this thesis. Birmingham the second largest city and metropolitan area in England and the UK, with a highly diverse population that includes many from FGM/C-practising countries (Birmingham City Council, 2021).

1.1.7. Mandatory recording and reporting

In order to present a more accurate estimation of the prevalence of FGM/C in England, the Department of Health England (DoH) launched the 'FGM/C enhanced dataset' in 2015. To support the development of this dataset, health and social care professionals are required to record newly identified cases of FGM/C, as well as *any* attendances where FGM/C is identified (that is, both newly recorded or previously identified). Since April 2015 to March 2020, a total of 24,420 newly identified cases were recorded in England, with the majority originating from the Eastern Africa region (National Health Service Digital, 2019).

In England and Wales, all regulated health and social care professionals, in addition to teachers, now have a mandatory reporting duty for any cases of FGM/C identified among girls under the age of 18. This involves reporting to the police any 'visually' confirmed or confessed cases. The main goals of mandatory recording and reporting are to protect girls and identify perpetrators, while improving the accuracy of prevalence estimations (Department of Health, 2015). However, this initiative has attracted some criticism: for example, Naftalin and Bewley (2020) expressed concern that the mandatory sharing of patient-identifiable information may cause women and girls to feel apprehensive about seeking medical help. Similarly, Plugge et al. (2019) and Dixon et al. (2020) highlighted the potential damage to relationships between patients and health professionals as a result of compromised confidentiality and trust. It had initially been suggested that all women who have had FGM/C should be reported, regardless of their age, but this did not come to fruition. Instead, any diagnosed cases of FGM/C in women over the age of 18 must now be recorded (rather than reported) as part of professionals' mandatory recording duty. Mandatory recording, as proposed by the DoH, includes recording every case of identified FGM/C, the age of the survivor, type of FGM/C, the survivor's country of origin, and the country where FGM/C was carried out (Malik et al., 2018).

Acquiring data through mandatory recording and reporting is important because it provides a more accurate picture of the true prevalence of FGM/C in the UK (Macfarlane and Dorkenoo, 2015). However, if not applied appropriately, the processes of reporting and recording have the potential to cause more harm than good to affected individuals and communities, in addition to causing undue stress to professionals (Naftalin and Bewley, 2020, Malik et al., 2018).

It has been suggested that effective education for professionals is key to ensuring the successful implementation of mandatory recording and reporting. Education programmes should aim to help professionals to sensitively ask about FGM/C, act/react appropriately, and provide relevant information and resources to affected individuals (Amasanti et al., 2016). Although the UK Home Office through Virtual College offers an online education package for professionals, evidence suggests that many professionals remain unaware of the FGM/C educational resources that are available to them (Reig-Alcaraz et al., 2016). Other FGM/C education packages are offered by organisations in Birmingham, including the Birmingham Safeguarding Board, the Clinical Commissioning Groups (CCGs) and Birmingham and Solihull Women's Aid. Specialist midwives also conduct FGM/C training, which includes opportunities to work with women in maternity care settings. Although these training sessions are not mandatory, all health professionals have a legal and professional duty to safeguard survivors and those at risk of FGM/C (Naftalin and Bewley, 2020).

To my knowledge, there is no research exploring health professionals' experiences of discussing FGM/C with their patients/service users in line with their duties in Birmingham (including their duty to provide patient education on the subject). This thesis, therefore, included a survey to explore this matter.

It is also important to explore the views of recipients of FGM/C health education. The third phase of this thesis explored the experiences of communities with a history of FGM/C, living in Birmingham, regarding health and wellbeing programmes (HWPs) that they had attended. Examples of HWPs delivered by charity organisations in the West Midlands, UK, include those provided by Coventry Haven and Birmingham and Solihull Women’s Aid. Statutory organisations include the National Society for the Prevention of Cruelty to Children (NSPCC).

Following the above discussion of FGM/C, together with its impact and the importance of effective professional education, a problem statement was developed, which then led to the formulation of a research question and aims to guide this project.

1.2. Problem statement and research theoretical approach

Although interventions to prevent FGM/C have been widely explored in the literature (Berg and Denison, 2012, Barrett et al., 2020, Berg et al., 2018), this study explored health education interventions specifically, so as to illuminate the factors contributing to the effectiveness of FGM/C interventions among health professionals. Intersectionality was used as a theoretical lens for this thesis. The key features of intersectionality relevant to this thesis include social structures, culture and media. Using intersectionality enabled a pragmatic approach for evaluating the interventions (Collins and Bilge, 2020, Zimmerman, 2017). Intersectionality is especially important in this research because of its ability to unearth complexities and show the interconnectivity of all involved elements relating to FGM/C health education interventions.

1.2.1. Research question

What aspects determine the effectiveness of health education interventions in the prevention of FGM/C?

1.2.2. Research aim

This research aimed to explore FGM/C health education interventions locally and globally, in order to explore which aspects contribute to the effectiveness of these interventions in preventing FGM/C. A better understanding of these aspects will help to inform professionals, such as educators and health professionals, to care for FGM/C affected communities and patients/service users.

1.3. Project outline

The following outline shows the detailed process and content of this thesis, beginning with the next chapter (Chapter 2), also summarised in Diagram 1.1:

Chapter 2: Literature review. This chapter reviews literature relating to FGM/C health education, including theories of health education, the relevance of health education in the prevention of FGM/C, and training materials for health professionals. The chapter also presents an exploration of the theory of intersectionality, including its evolution and the development of FGM/C discourse within the theory. The facets of intersectionality discussed in this chapter are used in the integration of the overall findings of this thesis.

Chapter 3: Phase 1, systematic review. This chapter reports on a systematic review of primary research data, including a write-up of the methods, results, a discussion of findings, and a conclusion. A paper from this phase has been published with the BioMed Central (BMC) Reproductive Health Journal (Waigwa et al., 2018) and is included in the appendices of this thesis. An updated search conducted in August 2020 is included in this chapter.

Chapter 4: Research methodology. This chapter describes the research tools that were used to collect and analyse data in all three phases of this thesis. Each phase was conducted independently and using different research methods. The chapter also includes a summary of the researcher's positionality.

Chapter 5: Phase 2, survey. This chapter presents the results of the survey study exploring health professionals' experiences and views of discussing FGM/C with patients/service users. Alongside the description of the results, this chapter presents a review of two FGM/C training programmes for health professionals, showing the extent of coverage in the training programmes of the gaps identified from the survey.

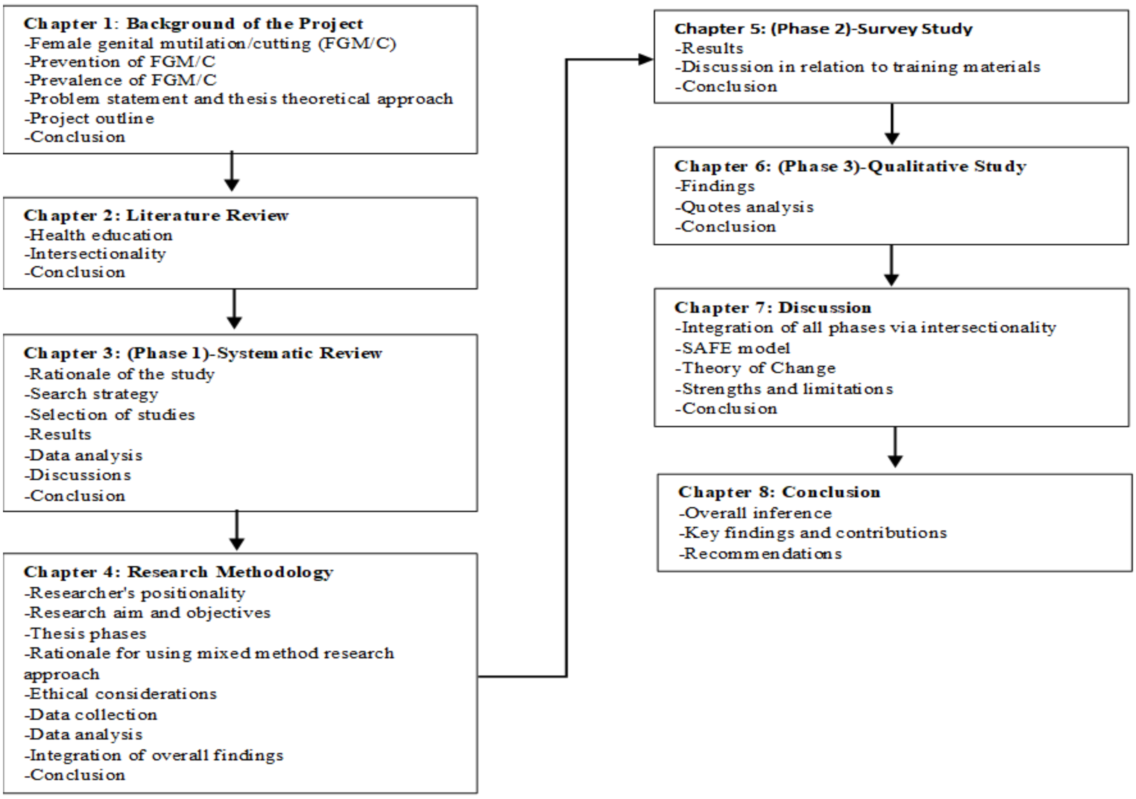
Chapter 6: Phase 3, qualitative study. This chapter presents the findings of the qualitative study exploring the experiences and opinions of members from communities in Birmingham with a history of FGM/C regarding health and wellbeing education programmes. The chapter includes an analysis and utilises participant quotes to support the researcher's claims.

Chapter 7: Discussion. This chapter consolidates the findings from Phases 1, 2 and 3 and presents a discussion using facets of intersectionality. The chapter also includes the development of the SAFE model, a critique of intersectionality, the strengths and limitations of the individual studies, key findings and contributions, and recommendations for education, practice, policy and research.

Chapter 8: Conclusion. This chapter summarises the research project as a whole and discusses its impact and contribution.

The appendices include all additional resources and documents used in different stages of this research project, including the documents used for ethics application, publication, tables, figures and dissemination letters.

Diagram 1.1: Project outline flowchart showing each chapter



1.4. Conclusion

This chapter has presented an introduction to this research project which explores health education interventions in FGM/C. The rationale guiding the development of the research question and aims has also been presented, including an introduction to the theoretical framework used to guide this study. A thesis outline and the components contained within each chapter of the thesis have been summarised. The next chapter (Chapter 2: Literature review) provides an in-depth exploration of the existing literature on FGM/C health education interventions and intersectionality.

CHAPTER 2

Literature Review

Introduction

This chapter explores two of the fundamental concepts underpinning this thesis: (1) health education interventions and (2) intersectionality. First, the chapter explores health education interventions in depth, including definitions, theories, examples of successful health education interventions, and the relevance of these interventions to preventing FGM/C. Secondly, the chapter presents intersectionality, including relevant discourses pertaining to the prevention of FGM/C.

2.1. Health education

2.1.1. Background

Health education refers to a combination of different learning experiences designed to help individuals and communities improve their health, with strategies often focusing on increasing knowledge and influencing attitudes (WHO, 2016a). Effective health education has the potential to improve the health literacy of individuals and communities, thus resulting in a reduced burden of disease, and similarly, reduced support for harmful practices (Nutbeam, 2000, WHO, 2016b). Although this thesis primarily utilises the above WHO definition, health education can encompass a broader range of activities and goals. For example, communication activities which aim to promote positive health, or prevent or reduce ill-health through influencing the beliefs, attitudes and behaviour of those in positions of power within communities (Tannahill, 1990). Health education can also be defined as any combination of theoretically informed learning experiences which provide individuals, groups and communities with the opportunity to acquire the information and skills needed to make better-informed decisions relating to health (Gold and Miner, 2002). Further, Green and Kreuter (2005) added that health education can incorporate learning experiences which reinforce voluntary behaviours that are conducive to good health. Overall, it can be concluded that health education is structured, involves the use of various techniques, and aims to pre-empt and alter harmful behaviours, with a view to encouraging the voluntary adoption of positive health behaviours. This can be attained through one-to-one, group or community-based strategies. It is important to note that there is a difference between health education and health promotion: primarily, the latter does not rely as heavily on personal decision-making, and is generally conducted at a group or community level (Sharma, 2016). Yet health education can form an integral part of health promotion and has even been referred to by some as a form of social policy. This is because, as an intervention, health education contributes to the general wellbeing of populations by providing individuals, groups and communities with essential knowledge and skills to voluntarily adopt healthy behaviours (Simonds, 1974, Doyle et al., 2018).

Health education as a concept is largely underpinned by behavioural science, and therefore behavioural theories contribute significantly to the constructs of health education interventions. Theories are important because they facilitate the development of measurable objectives (Sharma, 2016). In health education, the focus is largely interpersonal and involves influencing individual behaviours, knowledge, attitudes, beliefs and personal traits. It is also intrapersonal, – influencing the processes and groups that provide social identity, support and role definition such as friends, family, and peers – but with less of a focus on environmental influences, which falls within the scope of health promotion (West et al., 2019). Examples of health education theories focusing on interpersonal and/or intrapersonal influences are provided in the next section.

2.1.2. Theories in health education

Theories utilised in health education include the rational model, health belief model, extended parallel process model (EPPM), transtheoretical model of change, theory of planned behaviour, active health education model, social learning theory, social cognitive theory, COM-B and behaviour change wheel. These are described further in Table 2.1.

Table 2.1: Theories in health education

Theory	Description	Strengths	Weaknesses
Rational model	-Involves presentation of unbiased information to individuals or communities. -Assumes that lack of knowledge is the obstacle to acting rationally (Merakou et al., 2002, WHO, 2017).	-Effective in awareness-raising interventions.	-Has been refuted on the basis that people require more than knowledge to change behaviour.
Health belief model	-Helps to explain human health decision-making and subsequent behaviour. -Assesses individuals' perceived susceptibility to illness, perceived severity of consequences, perceived benefits of actions, perceived barriers to correcting behaviours, cues to action, and self-efficacy (Champion and Skinner, 2008).	-Has the potential to predict health-related behaviours. -The provided cues encourage individuals to engage in health promoting behaviours.	-Does not acknowledge interpersonal factors that prevent engagement in health-related behaviours.
Extended parallel process model (EPPM)	-Involves presentation of messages that are biased and emotionally loaded. -Aims to increase fear arousal to make individuals feel more susceptible to specific risks/negative impacts. -Focuses on emphasising the severity of the threat and susceptibility. -Emphasises or illustrates how the threat manifests. -Focuses on efficacy to emphasise that the recommended response will be effective, and	-Clearly guides decisions throughout all stages of intervention planning, implementation and evaluation.	-Focuses on fear as the main emotion influencing behaviour.

Theory	Description	Strengths	Weaknesses
	amplifies performance accomplishments and vicarious experiences (Gore and Bracken, 2005).		
Transtheoretical model of change (TTM)	-Acknowledges that people have specific information needs at each stage of behavioural change, thus requiring specific intervention strategies for each stage. -Comprises five stages: precontemplation (awareness of the need for change), contemplation (acquiring motivation), preparation (setting gradual goals), action (implementing behaviour modifications) and maintenance (working to maintain change) (Prochaska et al., 2015).	-Applying the core constructs of the theory programmatically is highly successful in enhancing health, especially in addictive behaviours such as smoking.	-May require major adaptations when being applied across different cultures.
Theory of planned behaviour	-Posits that intent is central to the adoption of positive behaviours and the abandonment of negative ones. -Intent is influenced by attitude towards the behaviour, motivation to comply, and the degree of perceived control (Ajzen, 2011).	-The hypothesised causal relationships among the components of the model are clearly stated, as well as measurements and computations.	-Does not consider the effects of intervention messages on all model components simultaneously.
Activated health education model	-Contains an experiential phase, where individuals assess their own health, and an awareness phase, where information is presented with a rationale pertaining to the assessed health behaviour, leading to the creation of the target behaviour. -Also includes a responsibility phase where participants engage in change processes with customised plans for behaviour change (Dennison and Golaszewski, 2002).	-Provides measures and identifies observable behaviours for future goals.	-Does not consider that increasing feelings of susceptibility may impact individuals differently and sometimes negatively.

Theory	Description	Strengths	Weaknesses
Social learning theory	-Acknowledges that individuals may both create and be influenced by their surroundings. -Feelings and behaviours are learned through the observation of others, which has a bearing on health. -Interventions should consider strategies that include measures to address all factors influencing health (Akers and Jennings, 2016).	-Acknowledges different ways of learning that influence behaviour.	-Does not account for differences or individual milestones of learning.
Social cognitive theory	-Builds upon the basics of social learning theory, observational learning and vicarious reinforcement. -Holds that an individual's will to change is based on self-efficacy, goals and outcome expectancies (West et al., 2019, Schunk and Usher, 2019).	-Uses a broad range of approaches to modify diverse behaviours that require a broad focus, such as peer modelling.	-May not be as effective as models that focus on specific health behaviours, due to its broad focus and measurement methods.
Capability, Opportunity and Motivation-Behaviour (COM-B)	-Posits that capability, opportunity and motivation are key components leading to behaviour change. -Provides a comprehensive framework for understanding behaviour (Michie et al., 2014).	-The combined model of COM-B and BCW can be used in complex interventions for complex issues.	-Integration of different components of the combined model is complex and may lead to different results as changes occur with time and space.
Behaviour change wheel (BCW)	-Identifies sources of behaviour that inform interventions (Michie et al., 2014).		

A 'cumulative theoretical framework' of these and other theories of behavioural science could therefore be said to encompass beliefs, control and self-efficacy, which determine perceived behavioural control (Hastings et al., 2020). In a quest to provide a more comprehensive model of behaviour, the COM-B (Capability, Opportunity, Motivation, Behaviour) model is often combined with the Behaviour Change Wheel (BCW), which identifies sources of behaviour that inform interventions (such as health education interventions) (Michie et al., 2014). For example, evidence has shown that intense inclusion of communities in developing required intervention has successfully yielded from clearly stated capabilities, opportunities, and motivation of these communities, which result to changed behaviour. These are seen to direct, for example, how training should be conducted, identification of resources and how to include peer group champions to implement actions. Involvement of communities throughout all of these stages is crucial to ensuring success of the interventions and empowerment of communities in relation to FGM/C (Barrett et al., 2015).

In view of the strengths and weaknesses of individual health education theories, some scholars recommend utilising more than one theory to inform interventions, but caution that this requires careful integration of the theories (Prestwich et al., 2015). Although there is a dearth of literature reporting on FGM/C health education interventions which incorporate health education theories, it is likely that these theories would enhance the effectiveness of such interventions. Health education theories can provide a structure upon which to organise programmes, based on the specific needs and preferences of target audiences. For instance, the rational model and the health belief model, which focus primarily on knowledge and beliefs, could be used in FGM/C health education interventions to enhance individuals' knowledge, and thus influence decision-making in relation to FGM/C. Reaching out to individuals is an important first step before striving to influence the rest of the family or community members. This has been evidenced in weight management behaviour among college students (Saghafi-Asl et al., 2020). The transtheoretical model of change (TTM) and extended parallel process model (EPPM) are highly structured to enable step-by-step behavioural change, particularly for deeply ingrained harmful behaviours. Examples of their application include interventions for improving physical activity levels, and behaviours to reduce the risk of skin cancer (Romain et al., 2018, Gerayllo et al., 2021). These models could be helpful in directing FGM/C health education interventions by developing highly structured programmes that facilitate step-by-step behaviour change (with the target behaviour being the abandonment of the practice). The theory of planned behaviour and activated health education model focus on the adoption of new behaviours and the abandonment of old harmful behaviours. These theories could inform FGM/C health education interventions which seek to promote new alternative rites that are not harmful, thus replacing (and abandoning) FGM/C. Such alternative rites have already been introduced within some FGM/C practising communities (Hughes, 2018), and the use of these theories could enhance the success of these interventions, as has been demonstrated in breastfeeding interventions (Zhang et al., 2018). Theories such as social action theory and social cognitive theory, which are wider in scope and recognise the broad range of individuals'/groups' capacity for learning, can guide FGM/C health education interventions by prompting intervention planners to consider the differences in learning capacity among their audiences. For example, utilising such theories has been successful in altering sexual risk behaviours among HIV-positive persons (Sullivan et al., 2017).

Selection of theories for behaviour change should be guided by the target population and setting, as these factors determine what is acceptable and practically feasible. The perceived impact of the problem to individuals or populations would also require the application of certain theories. The specific features captured within each theory will therefore determine the theory's compatibility with the aims of the intervention programmes. However, the focus should not only be on individual capabilities and motivation, but also on the wider context and social factors (Davis et al., 2015, Michie et al., 2018).

These theories can be applied within health education interventions across different settings, ranging from education institutions, communities and also health facilities, as discussed next.

2.1.3. Health education settings

Health education can be carried out in schools, where it is taught as a subject or as a co-ordinated health programme targeting students, staff and parents. In colleges or universities, health educators help to empower students to make healthy choices, while also equipping future health workers with the knowledge and skills they will need to guide their practice. In companies and other work environments, health educators provide employees with occupational health and safety support as well as education. In healthcare settings, health educators teach patients while also providing training to staff on topics such as the cultural and social barriers to health. In communities, health educators assist individuals and groups to identify their needs, problem-solving abilities and resources by way of mobilisation and advocacy (WHO, 2017).

The techniques required to deliver health education interventions differ depending on the setting and purpose of the interventions. One common strategy is to enable communities to engage in an extended education intervention that leads to changes in perception and behaviour, with a focus on learning new concepts and abandoning dysfunctional ones (Kickbusch et al., 2013). This is necessary to increase health literacy, which is the level of knowledge possessed by an individual and their ability to understand information relating to an issue associated with their or their community's health (Batterham et al., 2016).

There are various means by which health education can be delivered to improve the health literacy of different populations, depending on the health issue. Visual, audible and reading materials are widely used: for example, videos/DVDs with an accompanying pamphlet written in plain language and illustrations are very effective methods of delivering patient education

(Ferguson, 2012). To maximise the effectiveness of written materials, such as patient information leaflets (PILs), these resources must be noticeable, readable, understandable, believable and easily remembered by a large majority of the target population (Gal and Prigat, 2004). A study of 17 GP practices across Stoke-on-Trent, England, found that 75% of the distributed PILs were written at too complex a level, with 15% of the English population being unable to understand the content. These PILs were therefore ineffective because they did not meet the needs of a significant proportion of the target population (Protheroe et al., 2015).

There are various dimensions of health, as described by Donatelle and Davis (2011), including physical health, social health, intellectual health, emotional health, environmental health and spiritual health. For prevention of disease or harmful practices affecting any of these dimensions, it is important for populations to have a good degree of health literacy. To achieve this outcome, populations need education that improves health knowledge and understanding. This can include a focus on taking responsibility for one’s own health, while also putting this into the context of family and community health. Other relevant factors, such as socioeconomic factors and cultural values, should be consistently considered when providing health education interventions (Nutbeam, 2008, Kickbusch et al., 2013). If these factors are not considered, the intervention could result in undesirable outcomes such as (re)traumatisation and flashbacks. Misconceptions may also develop if inadequate information is provided: for instance, in the case of FGM/C, this may relate to the consequences and legalities of the practice (Nutbeam, 2000, WHO, 2016b).

2.1.4. Examples of successful health education interventions

Health education interventions have proven to be effective in altering a variety of health behaviours (such as breastfeeding) and risk behaviours (such as smoking and unprotected sexual activity). For instance, in Lucknow, India, an evaluative quantitative study was carried out in 2019 to evaluate the effectiveness of health education regarding the complications of teenage pregnancy. One hundred adolescent girls were involved in the study. A mean of 14.47 pre-test increased to a mean of 32.66 post-test, indicating increased knowledge levels after the education intervention, which coincided with reduced local rates of teenage pregnancy (Sharma and Siddiqui, 2019). Similar results were reported in the USA by Coyle et al. (2016), who found that high school students were 1.76 times more likely to utilise pregnancy prevention methods, such as condoms and birth control pills, after participating in a health education intervention on the subject of teenage pregnancy.

In the Kingdom of Saudi Arabia, a controlled pre- and post-test study explored the effects of health education on the uptake of breastfeeding among a sample of 360 women (Hanafi et al., 2014). Tools such as lectures, pamphlets, leaflets and videos were used to convey information including general knowledge and guidance on breastfeeding to the intervention group. After the intervention, a significant difference in knowledge and attitudes was found between the intervention and control groups, with the intervention group demonstrating improved attitudes, increased knowledge and intentions to breastfeed for a longer period of time.

Health education has also been an important tool in addressing harmful health behaviours such as smoking. In an interventional pre- and post-test study focusing on tertiary institution students in Nigeria, 280 students participated in a health education intervention that explored the health hazards of smoking, the factors influencing smoking, strategies for quitting and ways of controlling the habit (Salaudeen et al., 2011). after the health education intervention there was a reduction from 20.4% to 16.4% in the intervention group. In the control group, there was a reduction of only 0.2 percent. The study endorsed health education interventions and recommended continuous health education programmes on smoking.

2.1.5. Health education and its relevance in prevention of FGM/C

Health education has been used globally since 1982 as a recognised means of intervention against FGM/C. The use of health education as a means of addressing the problem became more widespread when WHO declared the practice as a public health and human rights concern in the 1990s (Easton et al., 2003). Health education was initially widely implemented with the assumption that when populations became aware of the health consequences, the practice would be abandoned. However, it soon became apparent that this was not the case. This was likely due to implementers' failure to recognise the impact of this extremely ingrained practice as a social norm, and failure to acknowledge the need to avoid top-down approaches (Easton et al., 2003, Andarge, 2014). However, a few health education interventions have shown success in preventing FGM/C.

2.1.6. Examples of successful health education interventions in FGM/C

TOSTAN, which means 'breakthrough' in the Wolof language (a language used by the Wolof ethnic group), is an ongoing programme in Senegal that includes health education interventions which aim to eliminate FGM/C. While FGM/C was outlawed in Senegal in 1999, the practice continued 'underground' among communities (Shell-Duncan et al., 2013). The TOSTAN programme, which was introduced in 2000, therefore aimed to create additional health and wellbeing programmes about human rights, basic hygiene and women's health. Post-intervention tests results showed that awareness of FGM/C and its consequences increased significantly among communities. For instance, the percentage of women who could name at least two consequences of FGM/C increased from 7% to 83%; for men, this increased from 11% to 80%. This study found that men had a higher baseline awareness because they had more access to information via radios than women. Attitudes also changed: for example, the percentage of women who thought that the practice was a social necessity reduced from 70%

to 15%. Due to the impact of the intervention, leaders from more than 300 villages supported a public declaration against the practice in the year 2002 (Easton et al., 2003, Diop and Askew, 2009). In 2010, it was recorded that about 4,000 communities in Senegal had participated in the public declaration against FGM/C, which has contributed to the current overall reduction of national prevalence rates (although some regions are yet to show any significant reduction) (Kandala and Shell-Duncan, 2019).

Another study, which explored the impact of health education on attitudes towards FGM/C in a rural Nigerian community, similarly showed that health education had a positive impact on respondents' attitudes. The proportion of men who wanted the practice to stop increased following the intervention, as did the number of respondents who reported having no intention to perform FGM/C on their daughters (Asekun-Olarinmoye and Amusan, 2008).

Overall, health education interventions should aim to be culturally sensitive, non-judgemental and non-stigmatising. Such interventions are likely to be more successful in raising awareness among communities about the harms of FGM/C (Diop and Askew, 2009), in addition to its illegal status and lack of religious affiliations (Abdulah et al., 2019). Moreover, effective FGM/C health education has the potential to reduce social pressure to undertake the practice (Pashaei et al., 2016); encourage alternative rituals (Abreu and Abreu, 2015); improve satisfaction with self-image and sexual functioning (Biglu et al., 2016); and increase willingness to access health and support services (Mbanya et al., 2018), thus lowering the morbidity and mortality rates associated with FGM/C.

In the diaspora, communities with a history of FGM/C who have received health education interventions have shown a willingness to move away from the practice. Johnsdotter et al. (2009), in a qualitative Swedish study involving communities originally from Ethiopia and Eritrea, found that participants considered the practice to be 'redundant'. The authors attributed this in part to health education and anti-FGM/C attitudes which are prominent in Sweden, in addition to the acculturation that resulted from integration within the Swedish population. Similarly, the authors concluded that the participants' determination to abandon the practice suggests that girls born in Sweden to parents from countries where FGM/C is widely practised remain at low risk. However, the study also highlighted that Swedish media often portrayed the practice of FGM/C in an insensitive and sometimes vulgar manner, with implications that non-FGM/C-practising communities are superior. These messages made minority communities feel targeted. Previous research has suggested that a more sensitive approach in Western countries is required in order to effectively challenge the practice, particularly when the goal of interventions is to care for and support FGM/C affected individuals. For example, educating professionals about the practice and how to provide support in a sensitive manner, in addition to the provision of clear guidelines to govern support services and other interventions. Such measures encourage affected individuals to seek help, while also increasing the likelihood that health education interventions seeking to eliminate FGM/C will be more widely accepted (Leye et al., 2006). Although the diaspora communities have the advantage of acculturation and access to information regarding the harms of the practice, it is important that education interventions continue to be developed and implemented. This is particularly important for newly migrated individuals who may have limited knowledge regarding the dangers of FGM/C, as highlighted by Gele et al. (2012) in their study focusing on Somali communities in Oslo.

2.1.7. Awareness raising in health education interventions

Though the phrase 'FGM/C awareness raising' is used frequently, it has become clear that this phrase has different meanings and usages in the literature. For this reason, I turned to dictionaries, thesauruses, subject based literature and organisations' websites which referenced this concept, in part or full, with the goal of exhaustively identifying common usages of the phrase and ultimately writing a standardised definition. The following discussion details the findings of this review of various sources.

International organisations such as WHO and UNICEF have included ‘FGM/C awareness raising’ as one strategy to support eradication of the practice globally. Pragmatic interventions, for instance, are often implemented with the aim of promoting the empowerment of women and girls through awareness raising campaigns (UNICEF, 2005, WHO, 2006). In the UK, disciplines such as education, health and social care have introduced initiatives with ‘FGM/C awareness raising’ for professional groups who work with patients/service users from communities with a history of FGM/C (HM Government, 2016). Although ‘awareness raising’ in itself may not be successful in altering attitudes towards FGM/C, in these contexts it can play an important role when coupled with legislation and comprehensive social support systems (UNICEF, 2005, Zurynski et al., 2015).

Yet, as noted above, the phrase ‘FGM/C awareness raising’ lacks a clear definition. Occasionally, conceptualisation of FGM/C awareness raising focuses on the concept as a result, rather than a strategy with a more far-reaching outcome. The concept is often placed on a par with the acquisition of information, knowledge and behaviour change (Isman et al., 2013b, Brown et al., 2013); but these are empirical referents of FGM/C awareness raising. Other authors argue that FGM/C awareness raising is more than a product or end result (Asekun-Olarinmoye and Amusan, 2008, Diop and Askew, 2009). It is clear then that the concept is complex, and as already illustrated, can have multiple applications and interpretations across organisations and within the literature. These differences and inconsistencies pose a significant challenge that can hinder the success of interventions aiming to prevent FGM/C.

However, after exploring various interpretations of the concept in both the academic literature and in organisational resources (examples of organisations are described in Table 2.2, using the MAST acronym from the UNESCO description of general awareness raising), I identified five core defining attributes that capture the fundamental elements of the concept. Using the MASTE acronym (Message, Audience, Sharing of information, Timing, and Evaluation) as a framework, in which ‘evaluation’ is added because it is recommended in some of the reviewed literature about FGM/C interventions, I produced the following definition:

> *FGM/C awareness raising for communities and professionals is a process of disseminating information about the practice. It includes:*
>
> - *Emphasis on the pragmatic application of the right messages;*
> - *Consideration of the diverse characteristics of the audience;*
> - *Sharing of relevant information with proper timing of successive activities;*
> - *Evaluation of the process.*
>
> *The goal is to increase awareness/literacy about FGM/C, change perceptions and behaviours, and ultimately to prevent and eliminate the practice.*

Proper implementation of the concept, based on this definition, will require consideration of the following: the prevalence of FGM/C, recognition and acknowledgement of the existence of the practice, a goal of preventing the practice, and the presence of trustworthy organisations.

The outcomes of proper implementation of FGM/C awareness raising, as described here, will include increased knowledge about FGM/C, empowerment of women and girls, attitudinal changes, and ultimately prevention of the practice. The overall outcomes should be measured by empirical referents, which in this case are FGM/C literacy and prevention of the practice. To evaluate the effectiveness of these awareness raising/training courses, two major training programmes for professionals will be reviewed against the results from the Survey Chapter (5) of this thesis.

Table 2.2: MAST attributes from FGM/C awareness raising organisations

Elements (MAST) **Organisation/agency**	**Message**	**Audience**	**Strategy**	**Timing**
Virtual College UK	-An overview of FGM/C to help identify and assist girls who are at risk of FGM/C.	A range of professionals, particularly frontline staff in healthcare, police, border force and children's social care.	Training.	Not covered
Daphne Toolkit European Commission	-General information about FGM/C.	General practitioners, midwives, outpatient and gynaecological staff, and other relevant health professionals.	Training and information.	Not covered
Educare UK	-How to spot the signs of FGM/C -Understanding the risks and consequences of FGM/C -Understanding the law and mandatory reporting duty -Roles and responsibilities of professionals -Importance of working together.	Those working with young people.	Training.	Not covered
Police in Northamptonshire, UK	-Children are at a higher risk of being taken abroad for FGM/C.	Somali populations.	Campaign.	To coincide with the run-up to the school holidays.
National Police Freedom charity	-Red Triangle campaign rolled out across the UK to mark the International Day of Zero Tolerance for Female Genital Mutilation. -Encourage people to provide the police with information.	General public and police forces.	Campaign: 13,000 posters promoting the Red Triangle to be displayed inside police buildings and within appropriate community settings.	International Day of Zero Tolerance for Female Genital Mutilation.
Aneeta Prem, a writer and the founder of Freedom	-FGM/C is a crime.	School children.	Novel warning about FGM/C, called Cut Flowers.	Not covered
Baroness Featherstone, a Lib Dem peer (Mark Pack, 2017)	-Make teaching of FGM/C compulsory in all UK schools.	Politicians: Theresa May and Justine Greening.	Video.	1 minute long.
Safeguarding in schools	-General FGM/C information.	Staff in schools.	Training.	Not covered
Northamptonshire Safeguarding children Board	-FGM/C is child abuse -Signs to look out for which may indicate a child is at risk of FGM/C.	Health and social care practitioners and the general public.	Education.	School holidays: 'the cutting season'.
UK Government	-Recognising and preventing FGM/C.	NHS organisations and professionals.	E-learning tool: Training consists of five sessions.	20 minutes per session

Home Office, UK: Resource pack (Values vs Violence)	-Understanding of FGM/C issues.	Primary and secondary schools and communities.	Training: Using 'Cut – some wounds never heal' DVD.	13 minutes long.
Foundation for Women's Health Research and Development (FORWARD)	-FGM/C and child protection issues -FGM/C and how to respond appropriately -Think Again.	Professionals and organisations; schools; students and teachers; general public.	Training: Sessions are tailored to the specific needs, issues and concerns of individuals and organisations and include: -FGM Training Programme, accredited and tailored training for professionals on FGM/C -Sessions for training -Film: https://youtu.be/kzBNTtR7toE	Film is 8 minutes long.
Birmingham and Solihull Women's Aid	-Domestic violence, forced marriage and FGM/C.	Frontline professionals, schools and affected communities.	Training.	Not covered
Manor Gardens Centre	-Understanding both why FGM/C is practised, how it affects women, and the role of professionals in preventing the practice.	Health, social care and education professionals and students training in relevant professions.	Training: Delivered by a specialist FGM/C midwife and a community facilitator from an FGM/C-affected community.	Not covered
BAWSO	-Domestic abuse and other forms of abuse, including FGM/C, forced marriage, human trafficking and prostitution.	People from BME backgrounds; health professionals.	Specialist support service.	Not covered
Metropolitan police: Project Azure	-General FGM/C information	Teachers, students and parents, and outreach workers.	Training packages and DVDs on FGM/C.	Not covered
Home Office (Home office UK, 2018)	-Ending FGM/C.	Communities.	DVD featuring interviews with health professionals, survivors and the NSPCC.	8 minutes long.
United to end FGM (EUFGM)	-To better prevent and address FGM/C -Preventing stigmatisation in the media -The role of the media in preventing FGM -Cultural and gender sensitive reporting.	General public and professionals.	Web-based knowledge platform: -Easily accessible (and culturally appropriate) information and support to professionals; -A module on FGM/C and media reporting.	Not covered
End FGM European Network: Change Plus project	-Gender equality -The role of men and male activism in behaviour change.	Professionals in five EU Member States (Germany, Netherlands, Portugal, Italy and France).	-External and internal newsletter, via website and its social media channels (Facebook and Twitter) -Work with The CHANGE Champions who act as mentors and advocates at local, national and European level.	Not covered
NHS England	-Care and prevention	Patients and professionals.	-Website information -Video resources	Not covered

	-Health and physiological consequences of FGM/C.		-Animated films, telling stories about FGM/C.	

2.2. Intersectionality and FGM/C

2.2.1. Background of intersectionality

Historically, especially in the context of feminism, instances of discrimination were treated as discrete and unrelated to one another. Intersectionality emerged in response to this failure to acknowledge that experiences of discrimination are interrelated and overlapping, with a complexity overlooked by the systems that were supposed to tackle them. Intersectionality generally focuses on how intersecting power dynamics influence social relations across diverse societies, as well as individual experiences in everyday life. The concept has been widely used by professionals in healthcare, social care, education, academia, human rights activism, and by government officials in order investigate the varying dimensions involved in a given social issue (Collins and Bilge, 2020, Atewologun, 2018, Dhamoon and Hankivsky, 2011).

However, there has been debate regarding the dissimilarities between different forms of discrimination. Some argue that race and social classes, for instance, should not be treated in the same way; in other words, it is necessary to consider the distinctiveness of inequalities while simultaneously acknowledging the similar or overlapping ways in which they manifest. It has also been argued that it is impossible to address multiple inequalities at the same time, and that instead, the focus ought to be on the more prevalent forms of discrimination, such as gender-related discrimination. Yet this view has also been criticised, with some critics arguing that such an approach results in inadequate policies and actions (Phoenix and Pattynama, 2006). Kimberlé Crenshaw (1993), who coined the term ‘intersectionality’, highlighted that challenging only certain forms of discrimination (while supporting or perpetuating other existing hierarchies) not only marginalises those who experience multiple inequalities, but also often leads to disagreement in inequality discourses. This has been evident in many activist rallies wherein participants advocate for one inequality while condoning or perpetuating another either consciously or unconsciously (Bilge, 2013, Crenshaw, 1993). To avoid omitting any dimensions that may be involved in health education interventions, this thesis integrates intersectionality theory within discussions about health education interventions for preventing FGM/C, with the aim of developing a deeper understanding of these complex factors.

2.2.4. Elements in intersectionality theory and examples related to FGM/C

Theory is important to advance our understanding of complex phenomena and the evidence-based data from which knowledge derives (Atewologun, 2011). As a way of understanding the concepts of multiple positionality and oppression, intersectionality can be regarded as a critical theory. The theory suggests that none of the social categories is mutually exclusive, and rather, that they build upon each other and work together (Clarke and McCall, 2013, Else-Quest and Hyde, 2016). As an analytical tool, therefore, intersectionality views different social categories including race, class, gender, sexuality, nationality, (dis)ability, ethnicity and age as interrelated and mutually influential. Intersectionality seeks to explain this relationship in order to develop a more nuanced understanding of people’s experiences of discrimination and vulnerability. Rather than grouping people with similar characteristics together (homogeneous grouping), intersectionality seeks to provide a framework to explain how characteristics, and combinations thereof, can determine individuals’ positions in the world: for example, making them vulnerable or privileged (Collins and Bilge, 2020). The following elements are important to consider when discussing inequalities:

i) Social structures

Social structures are generally social arrangements in society, including social institutions such as education, family and religion. It is within the context of these social structures that categories dividing people are defined. The definitions may vary across different societies and in different social structures. Gender inequalities, for instance, may be exacerbated by religious institutions, though not in the absence of sexism resulting from the already-existing gender inequalities (Shields, 2008). For example, with their advantaged social position, men in positions of power are (in many cases) likely to be able to propel equality measures more quickly and with less opposition (Soucie et al., 2018, Chamberlain, 2017). It has been suggested that men should be included in initiatives aiming to tackle FGM/C; however, they are in fact usually excluded from campaigns because of the power that women have with regards to FGM/C matters. Men also often hold influential positions in society, including imams, doctors and politicians, and some authors argue that men's exclusion from important debates surrounding issues which disproportionately affect women is misguided (John, 2017).

The practice of type IV FGM/C is attributed in some cases to the social pressures women face to appear trendy and modern. Genital piercing and tattooing has been portrayed as desirable in some areas of contemporary society, and both practices have the potential to cause harm to women and girls (for example, infection, local reactions) (Saracoglu et al., 2014). Intersectionality includes contemporary discussions regarding the ways in which these axes of discrimination intersect across social structures in order to expose power dynamics and to generate solutions to empower women.

ii) Culture

Culture involves the aspects of life in which human values are enacted. Since this is a channel for the transmission of identities, knowledge, norms, beliefs, values and attitudes (Spencer-Oatey, 2012), it can also serve as a means of compounding discrimination. The politics of power and dominance between cultures is central to this issue, as it leads to 'privilege checking', where individuals or groups in positions of privilege are reminded to reflect on the role of their advantage. These power dynamics are observed within and between social classes, genders and races (Collins and Bilge, 2020). For example, an example of privilege-checking in modern society is illustrated by the personal experience of a UK-based Nigerian-born woman, who was advised by other Nigerians that she ought not to speak out against FGM/C on behalf of less privileged Nigerian women (Peace, 2017). This awareness is an important dimension that allows for the recognition of gatekeepers, such as the presence of older women in FGM/C-affected communities who exploit younger women and girls, and subject them to the practice (Baron and Denmark, 2006). This is the result of generational differences that allocate certain powers to older generations, such that younger generations have fewer opportunities for decision-making and enacting change (Hunter, 2017).

Another facet of the cultural domain is language, which has been observed to enhance inequality. For instance, changes in the use of language have been required in various settings to encourage participation in programmes and to minimise the harms associated with language that has previously been utilised to label, shame or pigeonhole individuals or groups (Munro, 2013, Chamberlain, 2017, Julios, 2018, Penny, 2014). To deal with these challenges, cultural competence has been suggested as a crucial skill to enable understanding and acceptance of diversity. Failure to acknowledge cultural diversity has been said to contribute to a culture in which sexism or other misogynistic behaviours can thrive (Chamberlain, 2017). Such behaviours are known to encourage discrimination, including the infringement of individuals' or groups' rights to participate and openly express views (Barker and Jurasz, 2019). Discrimination thus inhibits the challenging of dominant cultures that perpetuate practices such as FGM/C (Gomaa, 2018). Intersectionality seeks to illuminate these issues, which if tackled appropriately can result in the protection of future generations.

iii) Media

The media (analogue and digital), including the internet, has provided a platform for many contemporary dialogues and campaigns regarding social issues. Digital media, for instance, has provided a new means of organising campaigns and mass mobilisation against issues of inequality (Eudey, 2012). It has the capacity to foster global communities who use social networks to debate/discuss information, share experiences and call for action (Munro, 2013).

However, the media can also provide a platform for exacerbating inequalities. As the media circulates and organises information that is designed by and for particular audiences, other groups can be discretely excluded (Rigoni, 2012). This has led to movements on certain media platforms that aim to challenge discrimination, which has manifested because of the social categorisations of class, race and gender (Leung and Williams, 2019).

The media does not only provide a space for the discussion and sharing of experiences, but also provides access to resources and help for girls who have undergone or who may be at risk of FGM/C. It plays a crucial role in bringing FGM/C into the public consciousness, and helps to initiate dialogue with the goal of helping to safeguard the rights and wellbeing of young girls (Julios, 2018). Major newspapers in the UK, now more than ever before, frequently report on FGM/C and many have FGM/C tags for digital articles on their websites. There is also increasing online media coverage on the practice: for instance, a Google search for ‘FGM blog’ generated 469,000 results in April 2016 (Polygeia, 2016), and in January 2020, after running the same search, I retrieved 4,030,000 results. This shows that there is increasing information and awareness circulating online. The social media platform Twitter has also facilitated media movements such as #EndFGM, which succeeded in bringing the conversation to an audience which may not have previously considered the issue, or equally, to those who are too scared to speak out (Polygeia, 2016). Individuals have also taken advantage of social media platforms in the fight against FGM/C. Ifran Ahmed (2010) in Ireland, for instance, has actively involved the media in launching #MeTooFGM and #AGirlFromMogadishu. These Twitter hashtags have provided a platform for discussion and awareness-raising about FGM/C, and have successfully attracted international audiences (Ahmed, 2010). These efforts to reach out to the public through the media have also included activities such as ‘The international day of zero tolerance for female genital mutilation’, which takes place on the 6th of February each year. The event is coordinated by the UN, which has set a goal to eradicate FGM/C by the year 2030 (United Nations, 2018).

However, there remains a lack of male spokespersons in the media and across other platforms in conversations surrounding FGM/C. As already discussed, this is likely because FGM/C is perceived as a woman-dominated subject, yet this is an issue that continues to spark debate about the gender disparities associated with FGM/C. Evidence demonstrates that many men support the discontinuation of the practice, and involving men in conversations about FGM/C could have a number of benefits (Varol et al., 2015).

Some have called for more discussion of intersectionality across media platforms, with a view to minimising inequality (Christian et al., 2020). Although viewing FGM/C through an intersectionality lens is a complex approach, intersectionality is a key framework in this thesis because it acknowledges social structures, culture and media. This thesis uses intersectionality to identify, analyse and discuss different dimensions and complexities in health education interventions that aim to prevent FGM/C. The goal of this approach is to illuminate the factors and inequalities that affect the success of these interventions, while also displaying their interconnectivity and their influences upon one another. This approach will also help to demonstrate the link between these factors from both structural and individual perspectives. The concept of intersectionality will be displayed within a Theory of Change (ToC) which will be introduced in the following chapter.

2.3. Conclusion

This chapter has discussed in depth two of the main concepts that are central to this thesis: health education, as the intervention being explored by this research, and intersectionality, as the theoretical approach guiding analysis and discussion. The following chapters will detail the methods and results of empirical studies about health education interventions for preventing FGM/C. But first, the next chapter (Chapter 3) presents a systematic review about the effectiveness of health education in preventing FGM/C in communities with a history of the practice.

CHAPTER 3

Effectiveness of Health Education as an Intervention Designed to Prevent Female Genital Mutilation/Cutting (FGM/C): A Systematic Review

Introduction

This chapter presents the methods and results of a systematic review about the effectiveness of health education interventions in preventing FGM/C around the globe. A research paper from this chapter titled 'Effectiveness of health education as an intervention designed to prevent female genital mutilation/cutting (FGM/C): a systematic review' was published in April 2018 in BMC Reproductive Health (Waigwa et al., 2018). To avoid replication, some details such as tables are omitted from this chapter, because they are printed in the published paper, which is attached in Appendix 4. In this chapter, however, I have updated the systematic review so as to be up-to-date in August 2020. First, I will present a brief background to the systematic review, showing the rationale and aim of the study. The methods used in this systematic review will be presented next, highlighting the inclusion and exclusion criteria, the search strategy and quality assessment of the studies. The results obtained from searching databases are then presented, including a brief description of the included studies. Emergent themes, categorised as sociodemographic factors; socioeconomic factors; traditions and beliefs; and programme strategy, structure and delivery, are presented in a descriptive way followed by a discussion and conclusion for this systematic review.

3.1. Background

As discussed in Chapter 2 (Literature review), it is evident that health education interventions are effective in the prevention of different health debilitating conditions and behaviours. Health education interventions in smoking cessation, for instance, have been shown to prevent and reduce smoking habits. However, few studies have reported successful health education interventions in preventing FGM/C globally. There is, therefore, a need for more exploration of interventions aimed at preventing FGM/C, including their effects in different communities (Richard et al., 2017). To explore more about health education interventions, I carried out a systematic review to explore the effectiveness of health education interventions in the prevention of FGM/C in affected communities. To my knowledge, no systematic review had previously synthesised such evidence in order to understand the effectiveness of health education interventions as distinct interventions for FGM/C.

Aim of the systematic review

The main aim of this systematic review was to provide an understanding of health education as an intervention, particularly its effectiveness in preventing FGM/C in different communities affected by the practice around the globe.

3.2. Methods

3.2.1. Search strategy

I searched electronic databases for published work using comprehensive search strategies. Without date restrictions (available data until August 2020), seven main international databases, most likely to contain literature about FGM/C, were systematically searched. The databases were:

-MEDLINE (Medical literature Analysis and Retrieval System Online; indexed and non-indexed)

-EMBASE

-Cochrane library (CDSR, DARE, HTA, CENTRAL)

-Web of Science

-Psych INFO (Database of Psychological literature)

-CINAHL (Cumulative Index to Nursing and Allied Health Literature)

-ASSIA (Applied Social Science Index and Abstracts-ProQuest)

Other databases that are not subject based, for example ChildData, were also searched.

This review used key words, which were derived from prior scoping of various fields dealing with FGM/C. Since this research is health related, the key words used for this search were developed using the PICOS framework (population/problem, intervention, comparator, outcomes and study type) as shown in Table 3.1. PICOS was used because of its ability to highlight the main parts of the research question, which helped in formulation of the search strategy used in this systematic review (Santos et al., 2007). The advantage in using this framework is that the elements may remain relevant and applicable even at a later stage of the review and can be used to conduct and update a similar search (Tacconelli, 2010, Alpi, 2005).

Table 3.1: Key words and their synonyms as developed using PICOS

PICOS	Key Words	Synonyms	Description
Population	Communities affected by FGM/C, globally.	'Female circumcision' 'Female genital surgery' 'Ritual genital surgery' 'Sexual mutilation'	The term 'circumcision' is considered so as to ensure that relevant data that may have used the term before it was replaced with FGM/C are included.
Intervention	Health education intervention.	'Community based education' 'School based education'	This intervention is prioritised based on its relevance in influencing and facilitating noticeable changes in other fields.
Comparator	Any other intervention or none.		This is to aid in accommodating any other interventions that may have been applied.
Outcomes	*Primary*: Prevention *Secondary*: Health literacy, changes in attitude and behaviour towards the practice, change or inauguration of legislations.		These outcomes are prioritised based on the most likely results in health education interventions.

Study type	Any study type		This was considered so as to accommodate all available study types.

The search was extended by including synonyms, abbreviations and spelling differences where applicable. A combination of Medical Subject Headings (MeSH) and free text terms were applied to ensure complete coverage. Boolean operators (and, or, not) to combine MeSH terms and free text results were also used (Appendix 1). Although there is a tendency of over-reliance on 'free text' in searches related to public health due to mismatching of terminologies in the databases, using Boolean operators ensures that only literature containing the relevant terms are retrieved (Tacconelli, 2010). I supplemented the database searches by hand searching relevant international organisations' databases, including:

-World Health Organization (WHO)

-United Nations Children's Fund (UNICEF)

-United Nations Population Fund (UNFPA)

-End FGM Middle East

These databases were considered important for identification of unpublished literature or on-going research or projects related to FGM/C health education interventions.

Hand searching of the reference lists of relevant studies was also undertaken. Additionally, I searched for Grey literature using the Open Grey database, and searched the university research library catalogue. Google (Scholar) was searched for academic and unpublished literature. No consultations were made with FGM/C field experts. Only literature that met the inclusion criteria were considered for inclusion.

Inclusion criteria

i) Population/problem: All studies focusing on communities affected by FGM/C were included. There was no limit to the population by geographical location. Studies included one or a variety of individuals or groups associated with FGM/C.

ii) Intervention: All studies either included or discussed health education as an intervention. They had a goal of disseminating information to individuals or groups of people with an aim of preventing FGM/C.

iii) Comparator: Studies included any other intervention(s) or none. If present, the comparison group(s) had interventions other than health education, or no intervention.

iv) Outcomes: Studies included the primary outcome of preventing FGM/C and/or the secondary outcomes of increasing health literacy, achieving attitudinal and/or behaviour changes, and changes to or introduction of legislation.

v) Study design: Only studies that were relevant to the topic were included. Study designs included:

-Randomised controlled trials

-Quasi-experimental studies

-Observational studies such as cohort studies, case-control studies and case series studies

-Systematic reviews

-Qualitative studies

vi) Time frame: Studies were not restricted by date of publication and the time frame depended on each database, meaning that all relevant studies identified from the inception date of each individual database were considered up until August 2020.

vii) Language: Studies were limited to English language only. The cost anticipated in translations of non-English literature was the main restriction preventing the inclusion of research published in other languages.

Exclusion criteria

i) Population/problem: Studies that did not focus on communities affected by FGM/C and those that focused on medical or cosmetic procedures, such as vulvectomy or labiaplasty, were excluded. This is because of contextual features that are unique to voluntary or medically indicated procedures that differ to prohibited procedures, such as FGM/C. However, perceptions about these types of procedures were considered.

ii) Intervention: Studies whose major focus was on other interventions, with *no* focus on health education, and studies that involved non-female circumcisions/genital cuttings (for instance, male circumcision) were excluded.

iii) Comparator: There was no exclusion on the basis of a study having a comparison group or not.

iv) Outcomes: Studies that did not include FGM/C prevention as an outcome, or that that did not include other outcomes such as health literacy, attitudinal and/or behavioural change, and changes to or introduction of legislation, were excluded.

v) Study design: No limits were applied on the basis of study design.

vi) Time frame: There were no restrictions based on date.

vii) Language: Studies published in languages other than English were excluded.

3.2.2. Selection of studies

I independently screened the titles of all studies retrieved using databases and other additional sources. A second reviewer, Harpreet Sihre (HS), who was a fellow postgraduate researcher, also screened all retrieved titles to make sure no relevant studies were excluded by title. HS and I then scanned abstracts independently, before deciding which full-text sources should be screened. Full-text screening was then undertaken independently both reviewers. However, a second reviewer was not involved in the screening of studies after the paper's publication, because the process of study selection and data extraction had been validated earlier, and because over half (67%) of the total included studies had been peer reviewed.

A predetermined inclusion and exclusion criteria form was used to guide the screening and selection process. A piloting exercise on a sample of studies was carried out beforehand to ensure that the criteria were reliable in the selection of relevant papers for the review. No authors of the selected studies were contacted to clarify any missing data or additional information, as the data extraction process provided sufficient information for this review.

3.2.3. Quality assessment/appraisal

The Mixed Methods Appraisal Tool (MMAT) was deemed the most appropriate tool to appraise the included studies. This quality appraisal tool has been verified and published in the Cochrane and National Collaborating Centre for Methods and Tools (NCCMT). The tool has two stages: stage one is the screening stage, containing two questions common to all study types. Studies are viable for further assessment if they fulfil the criteria of the two screening questions. Stage two contains the individual assessment sections, which contain 19 other questions corresponding to five types of study; that is, qualitative research, randomised control trials, non-randomised studies, quantitative descriptive and mixed method studies. The advantage of using MMAT is that it has all-inclusive guidelines that are simplified and applicable to a range of different study designs. The results generated by the appraisal lead to an overall methodological score, which is presented as a percentage. For the mixed method studies, which contain both qualitative and quantitative components, each component is given a separate score using the corresponding categories/sections. The lowest score of the components defines the overall score of each study (Pluye et al., 2011).

3.2.4. Data extraction

I extracted data from the included studies using a predesigned data extraction form tailored to the review topic (Table 3.2). This form was piloted beforehand so to avoid possible errors and ensure standardisation. All extracted data was recorded on an Excel spreadsheet. HS independently repeated the process and checked three quarters of the data extracted using the same data extraction form to ensure accuracy. A third reviewer (from the supervisory team) clarified any disagreements between HS and me. The following information was extracted from each study:

Table 3.2: Predesigned data extraction form

Category	Particulars
a) General information of the study	-Author -Title -Type/source of publication -Country of study -Country of publication
b) Study characteristics	-Aim/objectives of the study -Design -Inclusion criteria -Exclusion criteria -Recruitment process
c) Characteristics of participants	-Age

	-Gender -Ethnicity -Relationship with FGM/C
d) Description of interventions and control groups (if any)	-Development and methods of intervention -Content offered to the intervention and control groups -Number of sessions -Duration of intervention (and equivalent data for control groups, if present) -Intervention provider or commissioner
e) Setting(s)	-Description of where the interventions were delivered
f) Findings and results	-Reported outcomes: dichotomous, which involve only two values; continuous, which involve measurements on a numerical scale; or thematically described -Measurement tools used -Follow-up including length and intervals
g) Enrolment process of participants	-The number of enrolled participants -Number included in study analysis -Number of withdrawals, exclusions and loss in follow-up
h) Summary	-Results -Outcomes

	-Additional outcomes -Description of measurement tools used
i) Key conclusions	-Authors' major opinions and theory discussions

3.3. Results

3.3.1. Quality assessment/appraisal

HS and I independently assessed the included studies. HS assessed 12 of the included papers, while I assessed all included papers. Discrepancies were addressed through discussions between HS and I, and a third party was involved where a consensus could not be reached. All the studies are categorised using the tick of scoring metrics where (✓) means that one criterion was met and (✓✓✓✓) means that four criteria were met. The number of criteria met, divided by four, was used to estimate the scores of the qualitative and quantitative sections. This means that the highest of the scores is (✓✓✓✓), representing 100%, while the lowest score is (✓), representing 25%. All the studies and their scores are included in Table 3.3.

Table 3.3: Criteria met by each study and scoring percentage

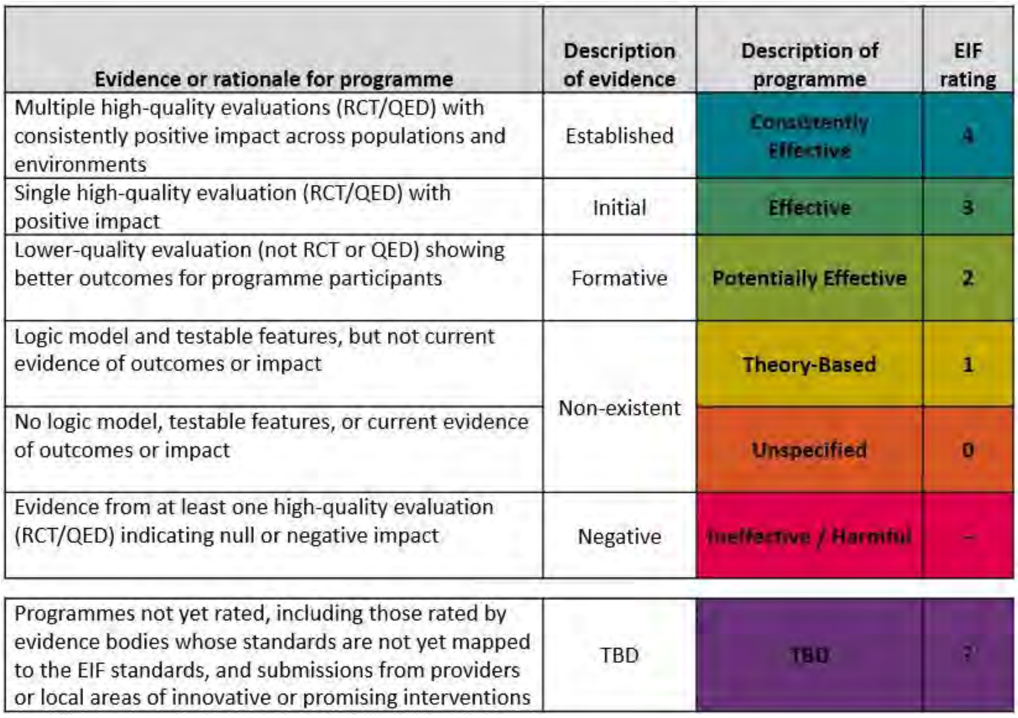
Study	Screening questions		Qualitative				Quantitative (non-randomised)				Descriptive Quantitative				Mixed Methods			Quality score %
	QA	QB	Q1.1	Q1.2	Q1.3	Q1.4	Q3.1	Q3.2	Q3.3	Q3.4	Q4.1	Q4.2	Q4.3	Q4.4	Q5.1	Q5.2	Q5.3	
Awuah (2008)	✓	✓	✓	✓	✓	✗												75
Ajuwon et al (1995)	✓	✓	✓	✓	✓	✗												75
Ruiz et al (2016)	✓	✓	✓	✓	✓	✗												75
Shahawy et al. (2018)	✓	✓	✓	✓	✓	✗												75
Olaitan (2010)	✓	✓					✗	✓	✓	✓								75
Allam et al (2001)	✓	✓					✓	✓	✓	✓								100
Asekun-Olainmoye and Amusan (2008)	✓	✓					✓	✓	✓	✓								100
Babalola et al (2006)	✓	✓					✓	✓	✓	✓								100
Mounir et al (2003)	✓	✓					✓	✓	✓	✗								75
Diop and Askew (2009)	✓	✓					✓	✓	✓	✓								100
Chege et al (2004)	✓	✓					✓	✓	✓	✓								100
Abdulah et al. (2019)	✓	✓					✓	✓	✓	✓								100
Mahgouh et al. (2019)	✓	✓					✓	✓	✓	✓								100
Abdulcadir et al. (2019)	✓	✓					✓	✓	✓	✓								100
Khalil and Orabi (2017)	✓						✓	✓	✓	✓								100
Ofonime and Okon (2017)	✓	✓									✓	✓	✓	✓				100
Nkwam-Uwaoma eta al. (2019)	✓	✓									✓	✓	✓	✓				100
Schliep et al. (2018)	✓	✓									✓	✓	✓	✓				100
Alo & Gbadebo (2011)	✓	✓	✓	✗	✓	✗					✓	✓	✗	✗	✓	✓	✓	50
Jacoby et al (2015)	✓	✓	✓	✓	✓	✗					✓	✓	✓	✓	✓	✓	✗	75

The 20 papers that were included in this review fulfilled most of the criteria in the MMAT for each individual study design. The reviewers decided to include one fairly low quality (✓✓) study because of its contribution in supporting the high-quality studies. This, however, may affect the overall quality of the review. Four studies were appraised against the qualitative category; eleven studies were assessed against the non-randomised quantitative category; three against the descriptive quantitative category, while two studies were appraised against the mixed method criteria. The methodological quality mean score was 88.75%, which was above the desired minimum mean of 50%. The qualitative studies had a mean of 75%. The non-randomised and descriptive quantitative studies scored the highest with 12 studies out of 14 scoring 100%. The mixed method studies had a mean of 62.5%. Although the MMAT is not independently strong in showing specific states of quality, in this review, the included studies show a moderate-low risk of reporting bias.

EIF standard of evidence on health education interventions quality assessment

Due to health education interventions showing effectiveness in preventing other harmful conditions or behaviours, as discussed earlier in this thesis, I decided to appraise health education interventions for FGM/C against the early intervention foundation (EIF) standard of evidence in order to rate effectiveness of the interventions using the results from this review (Early Intervention Foundation, 2016). The EIF provides guidance and advice on implementing early interventions, whereby learning from evidence can be put into practice. A scaled table (Table 3.4) is used to illustrate the evidence or rationale of a programme, description of evidence, and description of programme. EIF ratings range from negative (-) to four (4), indicating the levels of effectiveness of programmes or interventions in tackling the target problem(s) across various populations.

Table 3.4: EIF standard of evidence programme/intervention*



Evidence or rationale for programme	Description of evidence	Description of programme	EIF rating
Multiple high-quality evaluations (RCT/QED) with consistently positive impact across populations and environments	Established	Consistently Effective	4
Single high-quality evaluation (RCT/QED) with positive impact	Initial	Effective	3
Lower-quality evaluation (not RCT or QED) showing better outcomes for programme participants	Formative	Potentially Effective	2
Logic model and testable features, but not current evidence of outcomes or impact	Non-existent	Theory-Based	1
No logic model, testable features, or current evidence of outcomes or impact		Unspecified	0
Evidence from at least one high-quality evaluation (RCT/QED) indicating null or negative impact	Negative	Ineffective / Harmful	–
Programmes not yet rated, including those rated by evidence bodies whose standards are not yet mapped to the EIF standards, and submissions from providers or local areas of innovative or promising interventions	TBD	TBD	?

**RCT (randomised controlled trials), QED (quality evaluation and design), TBD (to be decided).*

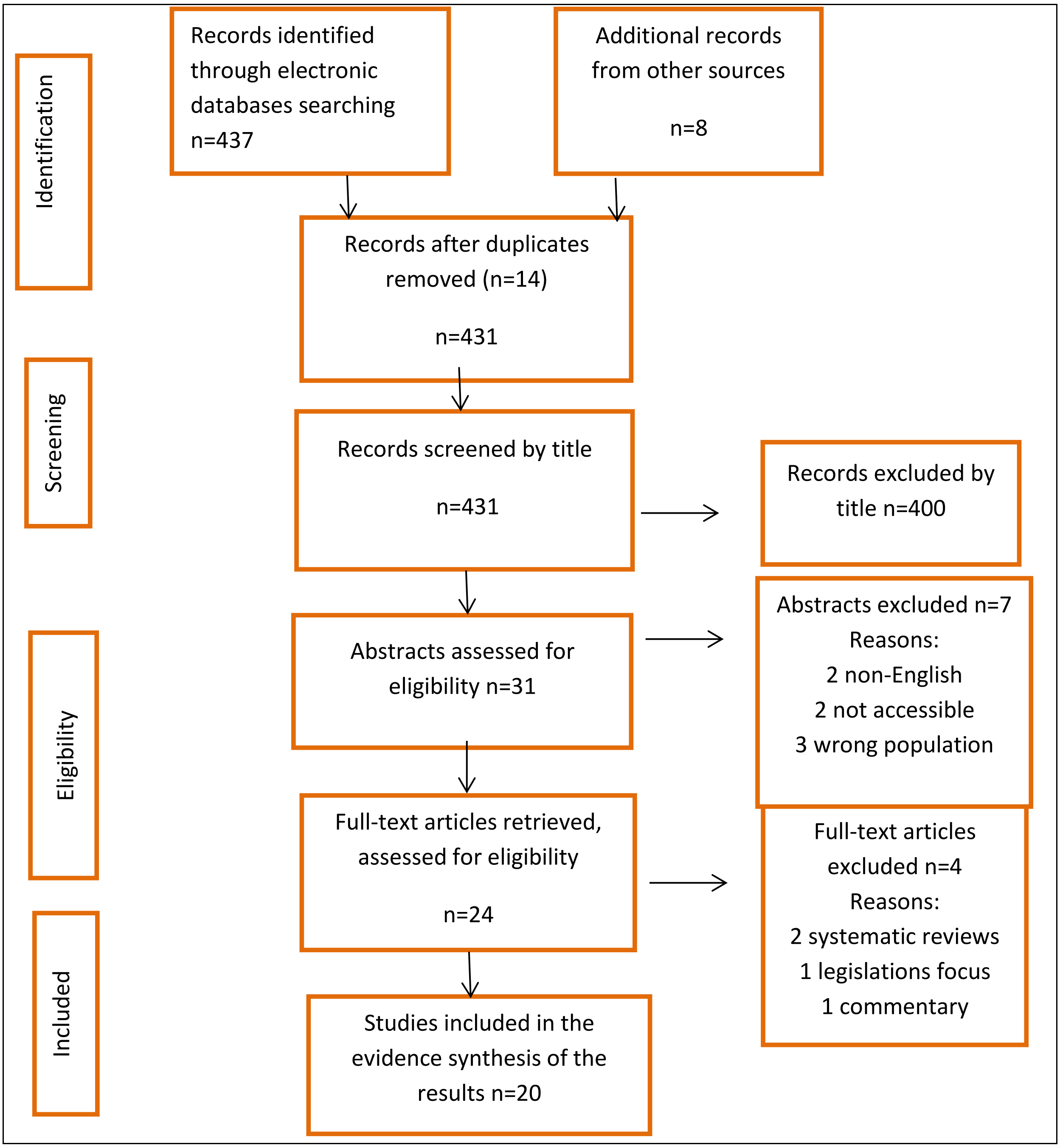
*Source: Early intervention foundation guidebook (Early Intervention Foundation, 2016)

In this review, health education interventions tend to fall between 3 and 4 EIF ratings. This is because there was more than one quasi-experimental study and there was less evidence available to show that the health education interventions are well established. In other words, although the interventions were found to be effective in preventing FGM/C across varying settings and populations, their consistency has not yet been established.

3.3.2. Description of the included studies

The combined searches retrieved 445 individual publications for consideration. Four hundred publications and 14 duplicates were excluded, leaving a total of 31 relevant publications. Two of these were non-English articles, two could not be accessed, and three did not focus on populations within the inclusion criteria. From the remaining 24 papers, two were excluded as they were systematic reviews containing some of the studies included in this review. One further study was excluded as it focused overly on legislation, and another was excluded because it was a commentary paper. A total of 20 papers met our inclusion criteria and were included in the review. A summary of the selection process is shown in the PRISMA flowchart (Figure 3.1).

Figure 3.1: PRISMA Flowchart



Out of the 20 included studies, 19 studies were published in peer-reviewed journals, while one was a report to funding agencies (Chege et al., 2004). The studies employed different designs ranging from quantitative, qualitative and mixed method. A summary of the studies' characteristics can be found in the published paper for this systematic review, as well as

Appendix 2, Table 3.1a. The following is a detailed description of specific characteristics of all of the included studies.

i) Participants

Although not all studies were carried out in the African continent, most of the populations involved were from parts of Africa where FGM/C is prevalent. These include Somalia, Egypt, Nigeria, Mali, Senegal, Ghana, Ethiopia, Kenya, Chad, Djibouti, Eritrea, Sudan and Niger. Some participants came from areas outside of the African continent including the United Arab Emirates, Iraqi Kurdistan and Yemen.

The sample sizes in the all the included studies widely varied, ranging from 21 to 2,240 participants.

Only eight studies used health education interventions targeting single-gender participants: Awuah (2008), Jacoby et al. (2015), Mahgoub et al. (2019), Ofonime and Okon (2017), Nkwam-Uwaoma et al. (2019), Abdulcadir et al. (2016), and Khalil and Orabi (2017) focused on females, while Ruiz et al. (2016) focused only on males. The remaining 12 studies had a mixture of male and female participants.

For studies that indicated the age of participants (n=15/20), the oldest among the participants was 70 years old while the youngest was 8 years old. Most participants were between 15 and 60 years of age. Three studies did not indicate the ages of their participants and two studies mentioned the age of some but not all participants.

ii) Setting

Most studies (n=15/20) were entirely based in the African continent. Five studies were conducted outside of the African continent: two in the USA, one in Iraq, one in Switzerland

and another partly in Spain. Table 3.5 presents a detailed summary of the settings for all 20 studies.

Table 3.5: Setting

Study	**Setting**
Abdulah et al. (2019)	Iraqi Kurdistan
Abdulcadir et al. (2019)	Switzerland
Ajuwon et al (1995)	Yoruba community in Southwest Nigeria
Allam et al (2001)	Different universities in Egypt
Alo & Gbadebo (2011)	Yoruba community in Southwest Nigeria
Asekun-Olainmoye and Amusan (2008)	Shao community in Kwara State, Nigeria
Awuah (2008)	Aboabo No.1 in Ghana
Babalola et al (2006)	Enugu and Ebonyi State in Eastern Nigeria
Chege et al (2004)	Awash-Fantale and Amibara Wareda, Ethiopia and Ifo camp and Hagadera camp for Somali refugees in Kenya
Diop and Askew (2009)	Kolda region, Senegal
Jacoby et al (2015)	Maine, USA
Khalil and Orabi (2017)	Cairo, Egypt
Mahgoub et al. (2019)	Sudan
Mounir et al (2003)	Alexandria University (students), Egypt
Nkwam-Uwaoma eta al. (2019)	Imo State, Nigeria
Ofonime and Okon (2017)	Ayadehe clan in Nigeria
Olaitan (2010)	Three state capitals in Southwest Nigeria
Ruiz et al (2016)	Spain and Morocco

Schliep et al. (2018)	Douentza Cercle, Mali
Shahawy et al. (2019)	Massachusetts, USA

iii) Religion

The religious backgrounds of the participants varied, including Muslims, Christians and traditionalists. This will be discussed in more detail later in this chapter, under factors affecting the effectiveness of health education interventions.

iv) Types of FGM/C and prevalence

Only nine out of the 20 included studies indicated the type of FGM/C practised in the area or by the included populations. Types I and II were the types most commonly practised among the included populations, as documented in six studies. One study, conducted in Kenya and Ethiopia (Chege et al., 2004), specified that its population practised only type III. Only one study from the USA (Jacoby et al., 2015) included a population which practised all four types of FGM/C. Only nine studies discussed the prevalence of FGM/C in their target populations or settings (Table 3.6).

Table 3.6: Types and prevalence of FGM/C

Study	**Type of FGM/C**	**Prevalence of FGM/C in study target populations or setting (mostly women of child-bearing age)**
Abdulah et al. (2019)	Not discussed	44.5%
Abdulcadir et al. (2019)	III	Not discussed

Ajuwon et al (1995)	I	Not discussed
Asekun-Olainmoye and Amusan (2008)	I and II	Between 60-70%
Awuah (2008)	II	Between 75-85%
Babalola et al (2006)	I and II	76%
Chege et al (2004)	III	34% (Kenya) and 76% (Ethiopia)
Diop and Askew (2009)	I and II	94%
Jacoby et al (2015)	I, II, III and IV	Not discussed
Mahgoub et al. (2019)	Not discussed	86.6%
Ofonime and Akon (2017)	II	15.2%
Schliep et al. (2018)	Not discussed	89%

v) ***Intervention***

The intervention being looked at in this review is health education. The WHO definition of health education includes the provision of accurate and truthful information to enhance individuals' knowledge, enabling them to make informed decisions. All of the included studies involved or discussed some form of health education delivered to communities affected by FGM/C. Ten of these studies involved assessments either before and after or only after the intervention (Chege et al., 2004, Asekun-Olarinmoye and Amusan, 2008, Diop and Askew, 2009, Babalola et al., 2006, Jacoby et al., 2015, Mounir et al., 2003, Ofonime and Okon, 2017, Abdulah et al., 2019, Mahgoub et al., 2019, Khalil and Orabi, 2017). Eight of the remaining ten studies assessed the effectiveness of previous health education interventions used by different research teams (Allam et al., 2001, Awuah, 2008, Ruiz et al., 2016, Olaitan, 2010, Shahawy et al., 2019, Abdulcadir et al., 2016, Nkwam-Uwaoma et al., 2019, Schliep et al., 2018). The remaining two studies endorsed the health education interventions as a solution for preventing FGM/C following evidence of health education interventions bringing change in communities affected by FGM/C. The studies used results from previously implemented health education interventions (Alo and Gbadebo, 2011, Ajuwon et al., 1995).

vi) *Results, implications and recommendations of included studies*

Change of behaviour and attitude towards FGM/C

All 20 studies included in this review had diverse results involving health education interventions against FGM/C.

Awuah (2008), in her study in the Aboabo suburb of Kumasi, Ghana, found that 100% of the respondents claimed that FGM/C was practised in Aboabo. The solutions that participants recommended for reducing the practice included the suggestion that health professionals should discuss the issue (43% made this suggestion). Fourteen percent suggested the use of drama and role-plays by health educators; another 14% believed that education for females would help; and 4% thought that the use of mass media to educate the public would help to eradicate the practice.

Ajuwon et al. (1995), in their study on indigenous surgical practices in rural South Western Nigeria, found that indigenous surgical practices were perceived as being integral in rural Nigeria and served perceived needs that were not being met by health services, such as performing FGM/C. However, these practices pose intrinsic health threats and risk disease transmission through blood contact. The authors emphasised that health education aimed at preventing infections related to traditional practices should have the long-term aims of preventing the perceived need for harmful surgeries and improving hygiene during operations. Integration of practical training in primary health care systems was also recommended in conjunction with educational interventions that could reduce these risks.

Ruiz et al. (2016), in their study on key requirements for abolishing FGM/C from the perspective of men, found that awareness raising promotes recognition of the complications and pathologies associated with the practice. Through health education for parents, physical and mental integrity, and protection of the right to life may be promoted and passed on to following generations. The authors also argued that dialogue also promotes knowledge; knowledge promotes critical thinking; and critical thinking promotes abolition. Awareness efforts in rural areas must be significant, due to the isolation of these areas. Ruiz et al. (2016) argued that it is essential that workshops use visual materials such as videos. Globalisation also plays an important role because the process of sensitisation is natured by comparisons between cultures, which eventually weakens arguments about FGM/C. Health education, awareness campaigns and educational interventions help to promote understanding of the risks associated with different forms of FGM/C, thus reinforcing its gradual eradication. In this study, men opposed to the practice supported legislation against it, though they indicated a preference for less aggressive but farther-reaching measures such as health education.

Olaitan (2010), in a study on knowledge of female genital cutting among parents in Southwest Nigeria, found that there were significant differences in knowledge about FGM/C between male and female parents. The authors recommended health education as the best means of providing health information and education to people regardless of their demographic characteristics.

Allam et al. (2001), in their inquiry on factors associated with the condoning of FGM/C among university students, found that 72% of the 1,020 students who were interviewed supported abolition of the practice. Forty nine percent of those who supported abolition were medical students and 51% were non-medical students. Participants indicated that their main sources of information were medical literature, radio, television and friends. They largely considered discussions in the media to be important in promoting the banning of FGM/C. They acknowledged that education plays an important role in shaping beliefs about FGM/C. The authors concluded that in general, the less knowledgeable people are about FGM/C, the more likely they are to support its practice. They also concluded that even in an educated population, a considerable amount of ignorance concerning FGM/C existed. Correct information, therefore, must be distributed to the population as a whole in order to raise awareness.

Asekun-Olarinmoye and Amusan (2008), in a study on the impact of health education on attitudes towards FGM/C in rural Nigeria, found that respondents' likelihood to have their daughters cut was statistically associated with education status, age and gender. Twelve weeks after the educational intervention, results from interviews showed that participants' intention to excise daughters in the future decreased from 83.3% to 50.0% among traditionalists; from 65.2% to 20.6% among Muslims; and from 49.4% to 16.7% among Christians. The proportion of men among the respondents who were not against FGM/C decreased from 53.5% to 25.4%. Twenty seven percent of respondents thought that educating men was important to eradicating FGM/C, and 25.3% believed that education and/or providing alternative vocations for excisors were important means of reducing the practice. A positive impact of the health education intervention was seen in the changed attitudes of respondents regarding FGM/C and their reduced intentions to have their daughters mutilated.

Babalola et al. (2006), in their study on the impact of a communication programme about FGM/C in Eastern Nigeria, indicated that 63.4% of the respondents in Enugu (the intervention arm) were exposed to at least one programme material or activity. The major source of exposure was radio, but 26.2% participated in community events, such as drama and dancing from which they learnt about FGM/C. About 67.0% of men and 61.4% of women were exposed to at least one component of the programme. There was a significant decline in Enugu in the number of participants who agreed with the statement that ‘there are benefits to FGM/C among men and women’, while there was no change in Ebonyi (the comparison arm). There was a significant increase in perceived self-efficacy to refuse pressure to perform FGM/C among men and women in Enugu State, while there was no change in Ebonyi. Correspondingly, the intention *not* to perform FGM/C was more widespread in Enugu than Ebonyi in the follow-up data. It was concluded that programme exposure was associated with increased self-efficacy to resist pressure to perform FGM/C, decreased personal approval of FGM/C, increased perceived social support for abandonment of the practice, and increased personal advocacy. The study concluded that a multimedia communication programme with anti-FGM/C messages can effectively change FGM/C attitudes, eventually reducing widespread intention to perform the practice.

Mounir et al. (2003) researched the impact of health education programmes about reproductive health, including the knowledge and attitudes of female students from Alexandria University in Egypt. They found that almost 54.0% of the respondents knew that FGM/C is harmful to girls, but only 4% provided complete answers to a query about the side effects of FGM/C. About 41.7% disagreed or were not sure that FGM/C side effects are serious. Students from practical colleges expressed more knowledge than those from theoretical ones. After the health education programmes, more than half of students recognised the side effects of FGM/C. There was a significant increase, by 46%, in knowledge of FGM/C which related to tradition as the main reason for the practice. Overall, the authors concluded that there was a significant improvement in knowledge and attitude scores between pre- and post-tests.

Diop and Askew (2009), in their evaluation of the effectiveness of a community-based education programme (TOSTAN) about eradicating FGM/C in Senegal, found that there was a significant increase in knowledge among women across both the intervention and comparison groups as a result of discussions in the weekly market and in national media. Results were presented from the participating group, comparison group, which did not receive the TOSTAN program, and non-participating group, which involved individuals not involved in the participating or control group. Eighty-seven percent of participating women said that the TOSTAN programme (a programme initiated to raise awareness about health and wellbeing in communities) was their main source of information, as did one in four non-participating women. Thirty-six percent of participating men and 19% of non-participating men reported the TOSTAN programme was their main source of information. Female participants who reported sharing information at endline (the end of intervention) increased to 92%. Awareness of at least two consequences of FGM/C increased from 11% to 80% among men and from 7% to 83% among women. Approximately 47% of non-participating women and 45% of non-participating men could list at least two consequences after the intervention, indicating that information diffusion had been fairly successful. Those who viewed FGM/C as a social necessity reduced from 70% to 15% among participants and from 88% to 61% in the comparison group. Eighty-five percent of participating women indicated that their attitudes changed as a result of participating in the programme, while 64% of women indirectly exposed to the programme similarly attributed attitudinal change to the programme. Among all the male participants, the intentions to cut their daughters in the future significantly dropped, but this was greatest among men in the participating group (from 66% to 13%). Men in the comparison group were more likely (63%) to express a preference for a woman who had been cut compared with the participating group (20%). The proportion of all daughters of women in the participating group who reported having been cut was significantly reduced from 66% to 59%; there was no significant change in the comparison group (71% to 70%). Significant attitudinal and behaviour changes were documented within the villages where the programme was evaluated. It was this change, within these and 70 other intervention villages, that encouraged leaders from 300 other villages to make a public declaration against the practice.

Chege et al. (2004) conducted an inquiry that tested the effectiveness of integrating community-based approaches to encourage the abandonment of FGM/C into CARE's (Cooperative for Assistance and Relief Everywhere) reproductive health programmes in Ethiopia and Kenya. Each of these sites had an intervention group and control group. They found that the percentage of people exposed to anti-FGM/C messages in Ethiopia among the intervention group increased by 50%, while the control group saw an increase of 11%. In Kenya, the intervention group saw an increase of 19%, while in the comparison group there was a reduction of 2%. Regarding changes in knowledge of the harmful effects of FGM/C, within the Ethiopian intervention group, the number of participants *without* knowledge reduced by 53%, while in the control group this reduced by 35%. In the Kenyan intervention group, this number reduced by 34%, while in the comparison group it reduced by 18%. Similarly, in the Ethiopian intervention group, the percentage of participants who could *not* name any negative health effects of FGM/C reduced by 24%, while the control group also saw a reduction of 24%. In the Kenyan intervention group, this number reduced by 29%, while the comparison group saw a reduction of 15%. Regarding the number of participants who supported FGM/C prevention in Ethiopia, among the intervention group this number increased by 32%, while the control group saw an increase of 10%. In Kenya, within the intervention group the percentage remained at 23%, while the comparison group saw an increase of 8%. The percentage of participants who did not intend to cut their daughters in the Ethiopian intervention group increased by 26%, while the control group saw a reduction of 1%. In the Kenyan intervention group, this number increased by 3%, while in the comparison group, it increased by 8%. Marital status was not significantly associated with support for FGM/C at both sites, but education, age and exposure to anti-FGM/C messages were significantly associated with support for the practice in Ethiopia, although not in Kenya. The magnitude of changes in knowledge of the harmful effects between baseline and endline surveys was significantly higher in the intervention compared to control/comparison groups, although in Kenyan the results were affected by a community backlash on forced anti-FGM/C laws. Overall, the authors concluded that the intervention led to an increase in the proportion of respondents who viewed FGM/C as a human rights issue.

Alo and Gbadebo (2011) conducted research about intergenerational attitude differences regarding FGM/C among the Yoruba ethnic group of Southwest Nigeria. The results indicated that the average prevalence rate of FGM/C among the sample was 71% for daughters and 75% for mothers, thus showing a 4% intergenerational difference. Respondents with post-secondary education were less likely to have their daughters cut: 48% of participants with post-secondary education had no daughters with FGM/C, compared with 20% of respondents who had no formal education. The authors therefore concluded that women with higher education levels were less likely to cut their daughters. Fifty-two percent of women were aware of the health hazards of FGM/C. Overall, the authors advocated for education about the health and psychological consequences of FGM/C for policy makers, the general public, health workers and those who carry out the practice. Involvement of political leaders, professionals, development workers, local community leaders, women and community groups/organisations, and traditional rulers was also highlighted as being crucial. Campaigns against the practice were recommended, starting from primary school; the authors also argued that teaching on FGM/C should be made mandatory within sex education. Lastly, the authors noted the importance of free schooling in Nigeria and suggested that rapid urbanisation (which includes the development of rural areas) would be important to reducing the prevalence of FGM/C.

Jacoby et al. (2015), in their mixed method study of immigrant Somali women's health literacy and experiences in Maine, USA, found that of the 19 participants, 84% had less than a high school education. After administering a health literacy questionnaire, the authors found that none of the participants had adequate health literacy. In the qualitative phase, findings showed that a majority of the participants preferred their daughters not to undergo FGM/C. They also indicated a preference for female health care providers, though many suggested that a male would also be acceptable to them. This was attributed to their time spent living in the USA. The participants unanimously approved of the use of historietas (comic-book style health education brochures), which would be used to aid in teaching why emergency caesareans might be necessary (including in the case of FGM/C) and in educating about the somatic symptoms of post-partum depression. The authors concluded that the use of historietas increased perinatal knowledge. Lastly, they recommended that health care providers should address barriers in culturally competent ways, including use of validated historietas.

Shahawy et al. (2019), in their study in Boston, USA, evaluated the perspectives on FGM/C among immigrant women and men. Through qualitative interviews with 20 women and 22 men, who were from FGM/C-practising communities in Somalia, Eritrea, Ethiopia, Sudan, Ghana, Nigeria, Mali, Egypt and the Arab Gulf, the study found that many participants recognised that FGM/C has no advantages, and that FGM/C was unrelated to religion. The notable changes in prevalence, compared to home communities, among the sample were attributed largely to education, immigration processes, advocacy and the media that were against FGM/C in the host county.

Abdulah et al. (2019) conducted a study in Iraqi Kurdistan investigating the impact of health education on the attitudes of parents and religious leaders towards FGM/C. In total, 192 religious leaders, 212 traditional leaders and 523 parents in rural areas were invited to participate in a Health Belief Model-informed short-term educational intervention. The attitudes of the participants changed substantially from supporting the practice to advocating its abandonment, as well as increased intentions not to cut their daughters in the future. Overall, the authors endorsed short-term educational interventions about FGM/C.

Ofonime and Okon (2017) conducted a study investigating the perceptions and practice of FGM/C in a rural community in Nigeria, and included women over the age of 18 from the Ayadehe clan. Two hundred and eighteen women were randomly selected to participate in interviews. Of this number, 5.6% reported receiving information through the media; 6% reported knowing about FGM/C through health workers; and a large majority (73.02%) reported receiving information from family members. There was a significant association between age and perceptions of FGM/C. For example, 75.61% of participants under the age of 20 regarded FGM/C as bad tradition, while 52.9% of those aged over 40 described it as a good tradition. Education levels were also associated with perceptions about FGM/C; the perception that FGM/C is a bad practice was more prevalent among participants with higher education levels. The authors concluded that women's education is essential in the prevention of FGM/C.

Mahgoub et al. (2019) conducted a quasi-experimental study exploring the effects of school-based health education on the attitudes of female students towards FGM/C in Sudan. The study included 154 participants in its pre-intervention phase and 150 participants in its post-intervention phase; the intervention involved an 80-minute health education session which focused on FGM/C and its complications. Post-intervention, students' knowledge about the types of FGM/C increased by 52.1% for type I, 58.3% for type II, 40.9% for type III and 40.5%

for type IV. The percentage of students who knew that FGM/C could result in psychological problems, fertility and sexual problems increased by 23.7%, 16% and 18.3% (respectively) post-intervention. A majority of the students also indicated negative attitudes towards FGM/C post-intervention. For instance, this included 89% who indicated that they would not subject their daughters to FGM/C. The authors concluded that school-based health education has a positive impact on both the knowledge and attitudes of female students towards FGM/C.

Khalil and Orabi (2017) conducted a quasi-experimental study in Egypt to explore the impact of an educational programme in changing knowledge, attitudes and practices of FGM/C. Using a sample of 30 female primary school teachers, the study found that the respondents' knowledge about FGM/C showed a statistically significant increase at post-test. The respondents' attitudes towards FGM/C revealed that at pre-test, some participants believed that FGM/C reduces promiscuity (66.7%), that it should be encouraged for religious reasons (53.3%), and that it protects against sexual deviation (53.3%). However, at post-test, none of the participants reported endorsing these beliefs. While 53.3% of the respondents supported the practice at pre-test, only 6.7% demonstrated continuing support at post-test. At pre-test, reported reasons for supporting FGM/C included to decease sexual desire (62.5%), to prevent promiscuity and sexual deviation (68.8%), and to ensure chastity and marital settlement (68.8%). However, at post-test, the only reported reason for supporting FGM/C was to treat female genital enlargement (10.00%). The authors concluded that the respondents' knowledge and attitudes improved after the implementation of the programme from a fair level to good, and from a neutral attitude (towards FGM/C) to a negative one; thus, they concluded that the educational programme was effective.

Schliep et al. (2018) assessed a radio-based education programme about FGM/C and health and human rights issues in Douentza, Mali. The assessment aimed to capture knowledge about

FGM/C, malaria, HIV/AIDS, girls' education, breastfeeding and sanitation, which had been sensitised through previously broadcasted songs containing these topics. A rural radio station, Daande Duwansa, produced an album in collaboration with the Near East Foundation (NEF) NGO, which has been active in Mali since 1984, and North West Access to Health Project (NAHP). A play about FGM/C was also performed in five communities. In October 2015, 149 interviewees were included in the study's survey/structured interviews, with 98% of respondents reporting that they had heard the album songs. Participants demonstrated both positive and negative attitudes towards FGM/C, with 50% of respondents stating that the practice is a custom, and 9% stating that it is a 'very good' practice. However, only 6% indicated that they would want their daughter to undergo FGM/C. This result was attributed to the education intervention, which included exposure to information via radio. The authors concluded that with over 90% of the community listening daily to the radio, this platform should be considered an important vehicle for further work in human development education, especially in order to reach individuals with lower education and literacy levels.

Nkwam-Uwaoma et al. (2019) included 394 participants in their survey study about the awareness, knowledge and perceptions of an FGM/C radio campaign and the practices among women in Imo State, Nigeria. The study's results indicated that 98.7% of respondents were aware of the anti-FGM/C messages on the radio. When measuring awareness levels, the survey results illustrated that 9.9% of respondents had a high awareness of FGM/C, 49.6% had a moderate awareness, and 30.5% had very low awareness levels. This suggested a discrepancy between the number of participants who reported hearing anti-FGM/C messages via radio and overall awareness levels. The authors concluded that although using the media (including radio) as a platform for communication can easily and widely to disseminate anti-FGM/C messages, the influence of peers, family and wider societal attitudes will likely remain barriers to the eradication of the practice.

Abdulcadir et al. (2017), in a retrospective study in Switzerland, evaluated the health education and clinical care of immigrant women with FGM/C who requested postpartum reinfibulation. Medical files from Geneva University Hospitals (HUG) between April 1, 2010 and January 8, 2014 were reviewed. Of the 196 files of women with FGM/C, only eight requested postpartum reinfibulation. From the records, the women had been followed-up for one year after delivery and were provided specific health education and counselling on female anatomy, physiology, FGM/C, deinfibulation and reinfibulation. They also received nine sessions of pelvic floor training, and received information promoting sexual health, cervical screening and discussions about contraception. Following the care provided, the authors reported that no woman was willing to undergo reinfibulation, nor had travelled abroad to undergo the procedure. The paper suggested that long-term follow-up should start before delivery, when discussing deinfibulation. The authors concluded that counselling, provision of information, education and health promotion among women with FGM/C and their partners can improve acceptability of deinfibulation without reinfibulation.

3.3.3. Factors affecting the effectiveness of health education interventions

On the subject of factors affecting the effectiveness of health education interventions, four themes were identified: sociodemographic factors; socioeconomic factors; traditions and beliefs; and intervention strategy, structure and delivery. These are described further in this section. All of the included studies contributed to at least two themes, and findings from each contributed to this analysis of the effectiveness of health education interventions in FGM/C (Appendix 3, Table 3.2a).

i) Sociodemographic factors

Six sociodemographic elements were described in the studies. They include age, ethnicity, language, gender, marital status and residential status.

a) Age

Age of the participants was one factor that had a significant impact on the effectiveness of FGM/C health education interventions across the studies. In most cases, health education offered to younger populations was referred to as a long-term approach. For example, five of the 20 included studies highlighted that the age of those participating in health education interventions influenced the interventions' effectiveness. In the study by Olaitan (2010), whose sample included parents in Nigeria, the knowledge of older parents was found to be significantly different to that of younger parents; the authors suggested that this was because younger parents were less likely to have experiences of FGM/C. In a similar vein, Alo and Gbadebo (2011) concluded that among populations who supported the practice, the prevalence of FGM/C was higher among older respondents. The authors suggested that this was because younger respondents were more likely to be educated, which increased their chances of engaging with FGM/C health education that encouraged abandonment of the practice. Ofonime and Okon (2017) recognised that the age of participants affected perceptions about the practice, with older participants (>40 years) generally considering the practice to be a good tradition, while younger participants (<20 years) were more likely to regard it as a bad tradition. Mahgoub et al. (2019) concluded that age differences also correlate with different levels of knowledge about the sexual and fertility complications of FGM/C. Lastly, Shahawy et al. (2019) noted that generational differences were linked to differences in education, which consequently affected levels of knowledge about FGM/C.

b) Ethnicity

As observed within some of the included studies, to ensure the efficiency and reliability of interventions, interviewers generally needed to be from the same ethnic groups as participants, or at least had to have familiarised themselves with the communities beforehand. For instance, three studies reported that ethnic differences between facilitators and communities sometimes negatively influenced the effectiveness of health education interventions, due to backlash from communities. It was concluded in these studies that facilitators and interviewers needed to belong to the same ethnic groups as participants. Collaborating with communities prevented interventions top-down approach (which includes involving communities in planning and implementation of interventions rather than authorities imposing interventions on communities). This enhanced the effectiveness of the interventions (Diop and Askew, 2009, Babalola et al., 2006, Chege et al., 2004). To avoid backlash, the studies indicated that if facilitators and interviewers were from a different ethnic background, they would be required to familiarise themselves with the cultural and structural customs of participants by integrating with the communities ahead of time (Diop and Askew, 2009, Babalola et al., 2006).

Mahgoub et al. (2019) acknowledged that the attributes of the study participants belonging to the Jaalia tribe contributed to the sample's knowledge about FGM/C, because women in this tribe are more likely to have undergone FGM/C, thus resulting in higher knowledge scores at baseline when compared with other tribes. Shahawy et al. (2019) noted that the influence of relatives and extended families may positively impact the outcomes of health education interventions if family members are willing to share accurate information. They could, however, also impact negatively on outcomes if they instil a fear of sharing knowledge about and against FGM/C, because of their ethnic beliefs.

c) Language

Communication was a problem in several interventions where facilitators could not deliver messages efficiently because they were not proficient in languages used by participants. For instance, three studies highlighted that language barriers reduced the effectiveness of health education interventions by hindering active communication between the facilitators and the audience (Jacoby et al., 2015, Awuah, 2008, Abdulcadir et al., 2016). Facilitators struggled to effectively deliver messages and participants also found it hard to understand the information being shared, particularly if it was not in their local language. Jacoby et al. (2015) found that the use of a ‘cultural broker’ (a translator) helped in mitigating some of these challenges by translating for both the facilitators and participants into languages they could easily understand. Similarly, Nkwam-Uwaoma et al. (2019) noted that the complex language used in some education materials may have not been entirely understood, thus meaning further explanation was required for the audience to receive the benefits of the intervention.

d) Gender

Some studies suggested that enhancing females’ health literacy would reduce the practice of FGM/C. However, it was noted that men must also be included in the programmes, especially because they are usually the key decision makers within their families. Abdulcadir et al. (2016), for instance, argued that the presence of men in education sessions reassured women that they had support from their husbands/partners. Two studies reported that the gender of participants affected the levels of participation in health education interventions (Babalola et al., 2006, Diop and Askew, 2009). For example, in the study by Babalola et al. (2006), where radio was the major source of information, the authors found that 67.1% of men were exposed to at least one component of the education programme, compared with 61.4% of women. Diop and Askew (2009), in their study evaluating the effectiveness of education offered by the TOSTAN programme in Senegal, found gender differences in participants' awareness of at least two consequences of FGM/C. Among men, awareness increased from 11% to 80% and among women, from 7% to 83%. This slight difference between the genders was attributed to women's personal experiences of undergoing FGM/C, which facilitated a better understanding of the subject.

Gender differences also affected the level of voluntary participation and acceptance of health education interventions. Women, for instance, participated in lower numbers because: their husbands did not allow them; they were sick from their pregnancies; and/or they disliked the crowded classrooms. On the other hand, men were less likely to attend due to lack of incentive. However, those men who did participate gained awareness about FGM/C and were less likely to prefer uncut women as wives or sexual partners (Diop and Askew, 2009).

e) Marital status

Three studies reported that some married participants, both male and female, did not benefit from the health education interventions. This was attributed to the belief among these participants that FGM/C is a means of controlling promiscuity in girls and women, which is considered an important virtue in these communities (Diop and Askew, 2009, Awuah, 2008, Ajuwon et al., 1995, Khalil and Orabi, 2017). However, although FGM/C traditionally was believed to be a prerequisite for marriage, some studies reported that most unmarried participants in their samples did not think it to be important, and that they appreciated the health education interventions. This reflected a natural decline in the practice due to generational differences (Chege et al., 2004, Mounir et al., 2003). However, Chege et al. (2004) did not find a significant association between marital status and support for, or opposition to, FGM/C.

f) Residential status

The residential status of participants also influenced the effectiveness of health education interventions, particularly for participants who were immigrants (Shahawy et al., 2019). Jacoby et al. (2015) indicated that refugees in the USA shared common problematic characteristics with regard to health care matters. These included poor general health literacy levels and knowledge of the health implications of FGM/C. Additionally, Chege et al. (2004) reported that interventions were more likely to be resisted by immigrants due to law enforcement measures against FGM/C in the host countries.

ii) Socio-economic factors

a) Education

Participants' levels of education often determined the degree of acceptability and absorption of information from FGM/C health education interventions. This, however, was not universally the case as some doctors and midwives approved of the practice. The following studies reflected on the extent to which levels of basic education influenced access to and acceptability of FGM/C health education programmes.

Asekun-Olarinmoye and Amusan (2008) reported that participants' education levels determined the acceptability and effectiveness of health education. Demonstrating this, participants with no formal education were more likely to encourage or endorse FGM/C. Olaitan (2010) similarly reported that knowledge about FGM/C varied significantly among participants with different levels of education. Those with more years of education were more likely to be influenced by the health education interventions. Alo and Gbadebo (2011) also highlighted that parents with post-secondary education were less likely to have their daughters undergo FGM/C, because they were more likely to have been exposed to health education interventions about the practice. Mounir et al. (2003) reported that students from higher income families demonstrated a more significant improvement in knowledge about FGM/C, likely because their family background (educated) supported the acquisition of such knowledge. Slightly contradictorily, Allam et al. (2001) found a considerable amount of ignorance concerning FGM/C among the educated population in Egypt, including some doctors and midwives. Similarly, Ofonime and Okon (2017) noted that fewer participants with no formal education perceived FGM/C to be a bad practice when compared with those who had a secondary/tertiary education. Abdulah et al. (2019) stated that the college education of the parents included in their study contributed to their high knowledge of FGM/C. Khalil and Orabi (2017) indicated that regardless of level of education, respondents' knowledge of FGM/C was still affected by deep rooted cultural and social beliefs. Schliep et al. (2018) highlighted that individuals with higher levels of education were more likely to perceive FGM/C as a choice.

The degree and type of prior education was also found to influence the effectiveness of health education interventions. For instance, according to Mounir et al. (2003), participants within the practical college had higher levels of knowledge about FGM/C when compared with their counterparts within the theoretical college. This was attributed to the nature of their study, with participants in the practical college being able to access more information about the subject.

b) Occupation/roles in communities

When influential professionals such as health professionals oppose anti-FGM/C messages, this has the potential to derail the effectiveness of health education interventions. The studies by Asekun-Olarinmoye and Amusan (2008) and Alo and Gbadebo (2011) highlighted that traditional excisors, health professionals, community leaders and religious leaders were not only recipients of health education interventions, but also implementers and change agents for better outcomes of the interventions. When such influential individuals refrain from supporting anti-FGM/C messages, it can negatively affect the success of health education interventions, because their powerful positions are likely to influence communities towards pro-FGM/C attitudes (Chege et al., 2004).

iii) Traditions and beliefs

a) Religion

One study concluded that religious belief was not associated with support for the continuation of FGM/C and, therefore, was not a hindrance to effective health education intervention (Asekun-Olarinmoye and Amusan, 2008). However, Allam et al. (2001) in Egypt and Chege et al. (2004) in Ethiopia reported that religious affiliations of either the participants or the facilitators of health education interventions were likely to affect the effectiveness of interventions. They added that distrust predominantly arose when programme facilitators affiliated themselves with a different religion from that of the participants. They also found that involving religious leaders in health education programmes either positively influenced communities through their teachings about FGM/C, which encouraged abandonment of the practice, or negatively promoted the practice by for instance, referring to it as a religious requirement. Allam et al. (2001) emphasised that it was even harder to educate participants who believed FGM/C is a religious requirement for any faith, because they are more likely to resist change and continue to undertake the practice. Mahgoub et al. (2019) in Sudan also noted that beliefs affect personal attitudes which in turn shape an individual's behaviour and willingness to change.

b) Prevalence of FGM/C in communities

Prevalence rates were also shown to have an effect on health education interventions. For example, in the study from Ghana by Awuah (2008), 100% (n=70) of the respondents claimed that FGM/C was practised, and about 43% did not regret undergoing the procedure. Asekun-Olarinmoye and Amusan (2008) similarly found that 88% (n=211) of female respondents reported to have had FGM/C, of whom 85% had no regrets. Alo and Gbadebo (2011) reported on the differences in prevalence of FGM/C between generations, observing that the nonsignificant 4% intergenerational difference indicated minimal changes in attitudes. Having no regret about the practice, because of misconceptions such as marriageability, religious obligations and health benefits, was seen a barrier to effective health education interventions against FGM/C.

c) Locality

Six studies illustrated the impact that locality has on the effectiveness of interventions. Chege et al. (2004) found that the percentage of people exposed to anti-FGM/C messages in Ethiopia, among the intervention group, increased from 21% to 71%, while in Kenya there was a less significant increase, from 40% to 59%. This difference was attributed to disparities in societal structures. For example, laws against FGM/C are harsher in Kenya, and their enforcement made it harder for interventions to gain the trust of FGM/C-affected communities. Alo and Gbadebo (2011) found that females living in rural settings were more likely to support FGM/C compared to those living in urbanised communities. They concluded that health education interventions in rural areas require more intense planning and implementation than in urban areas. Ruiz et al. (2016) similarly reported that awareness raising efforts in rural areas need to be more intense in comparison to urban areas, due to the inherent isolation in rural areas and lower levels of education. Khalil and Orabi (2017), however, noted that despite their study participants residing in an urban area, attitudes were still deeply ingrained due to cultural and social beliefs, thus affecting the effectiveness of interventions. Mahgoub et al. (2019) similarly acknowledged that differences exist between rural and urban populations. Moreover, they noted that in Sudan, it is socially unacceptable to discuss sexual issues with young people, which subsequently impacts on their knowledge and perceptions about FGM/C. Shahawy et al.

(2019) emphasised that immigration was a contributing factor to the changes within the Boston community in their study, because individuals had learnt through integration and acculturation within the host community, and thus had learnt about FGM/C away from their countries of origin.

iv) Programme strategy, structure and delivery

a) Programme approach

The methods and approaches that health education interventions used were associated with the effectiveness of the interventions. Chege et al. (2004), Mounir et al. (2003) and Allam et al. (2001) reported that it was necessary for health education facilitators to approach communities with caution; otherwise, they could face rejection. In studies that included interviewing as part of delivering health education, interventions were more effective when males interviewed males and females interviewed females (Allam et al., 2001). Diop and Askew (2009) noted that researchers needed to integrate with community interviewers, who belonged to the target communities, prior to implementation so as to increase the reliability of reports from respondents.

Seven studies showed that the levels of programme exposure influenced the effectiveness of the health education interventions (Diop and Askew, 2009, Babalola et al., 2006, Chege et al., 2004, Allam et al., 2001, Abdulcadir et al., 2016, Nkwam-Uwaoma et al., 2019, Schliep et al., 2018). Lower levels of exposure translated to smaller improvements in attitudes and behaviours (Chege et al., 2004), while higher levels of exposure created a more powerful and effective means of facilitating rapid changes within communities (Diop and Askew, 2009).

b) Counselling

Counselling was one of the means of disseminating health information. Jacoby et al. (2015) and Abdulcadir et al. (2016), for instance, showed that counselling during the early antepartum period was more effective than late counselling. This was also preferred by participants on the basis that early intervention provides ample time for thinking and discussing health concerns with spouses. Counselling therefore needs to be carried out in a timely manner for effective results.

c) Media

The use of multiple credible communication channels by FGM/C programmes helped to generate dialogue within communities. This dialogue extended to most members of the communities, including local leaders, men and women, and local radio personalities. Media proved to be a vital tool for delivering some FGM/C health education interventions (Nkwam-Uwaoma et al., 2019, Schliep et al., 2018). Radio appeared to be an effective means to reach men in most communities and was mostly favoured among young people (Diop and Askew, 2009, Babalola et al., 2006, Allam et al., 2001). However, in the study by Chege et al. (2004), the media was at times disadvantageous because its messages did not always support the abandonment of FGM/C, but rather, discouraged listeners from participating in education interventions by inciting rejection of the programmes. This in turn limited the effectiveness of the interventions. Mahgoub et al. (2019) found that the use of television and local radio can facilitate the delivery of messages to a larger proportion of the population. Shahawy et al. (2019) similarly indicated that television (campaigns, documentaries and news about FGM/C) affected participants' views on the effects of the practice, which encouraged discussions within communities.

d) Visual/graphics/artistic

The use of graphics or visual resources to disseminate information was found to be an effective method within health education interventions. Jacoby et al. (2015), in their study about immigrant Somali women's health literacy and perinatal experiences, found that participants approved of the use of historietas (graphical booklets) because the content was accessible and easily understandable. In other studies, practical training, which is more visual, was preferred by many participants and was endorsed as a means of effective communication of anti-FGM/C information, including for traditional excisors (Ruiz et al., 2016, Ajuwon et al., 1995). Lastly, Mahgoub et al. (2019) argued that the lack of variety of educational materials including visual materials about FGM/C contributed to discrepancies in participants' knowledge of FGM/C.

e) Campaign

Campaign efforts to promote human values, rights and gender equality play an important role in enhancing the effectiveness of FGM/C education in communities. This was evident in two studies that showed that well-structured campaigns can lead to wider community denunciation of the practice (Diop and Askew, 2009, Ruiz et al., 2016). Mahgoub et al. (2019) revealed that campaigns using traditional languages and local art contributed greatly to increasing individuals' understanding of messages about FGM/C.

3.4. Discussion

3.4.1. Existing literature

Health education is an important intervention that has the capacity to bring about real change, with the goal of positively impacting the health behaviours of individuals and communities (Coalition of National Health Education Organizations, 2016). This has been evidenced in various fields in health: for instance, the reduction of teenage pregnancy in Hawaii and increase of breastfeeding rates in Saudi Arabia have been attributed to the positive impacts of health education interventions (Hanafi et al., 2014, Paperny and Starn, 1989).

This systematic review aimed to assess the effectiveness of health education interventions in preventing FGM/C in various countries and communities. Health education among other interventions has previously been evaluated and reviewed in various studies, including systematic reviews. These evaluations have regarded the intervention as an important contributor to raising awareness about FGM/C, leading to changes in attitudes and behaviours in numerous communities (Berg and Denison, 2013a, Berg and Denison, 2012, Salam et al., 2016). However, the present review challenged the approach adopted within previous reviews, which investigated the intervention among other interventions. I endeavoured to explore health education as an individual intervention.

3.4.2. Findings from this systematic review

Twenty studies, published prior to August 2020, showed that the effectiveness of health education interventions depended on various factors, which this review captures within four themes: (1) sociodemographic, (2) socioeconomic, (3) traditions and beliefs, and (4) intervention strategy, structure and delivery. The most pronounced finding from this review was that these factors impact and sometimes interrupt the implementation, processes and successes of health education interventions. It is therefore important to ensure that interventions include information, communication and education tailored to each target population. This requires prior understanding of individuals' capacity and existing knowledge, including the ages and levels of education of the target population(s) (Nutbeam, 2000).

Perceptions can influence and drive behaviour changes. Equally, understanding individuals' perceptions can aid in behaviour prediction. Although it can be argued that behaviour is dependent on individual capabilities and environmental constraints, perception has the capacity to influence intentions to change behaviour (Yzer, 2012). Among the included studies, Diop and Askew (2009) found that there was a reduction in the number of daughters who were cut after their mothers participated in the health education programme. Alo and Gbadebo (2011), however, argued that it may not be entirely about women's decisions, because their husbands may in fact control decision-making (Abdulcadir et al., 2016). This argument would imply that though women may be aware of the health consequences, FGM/C might still be practised, with the decision being out of women's control. Michie et al. (2011) similarly suggested that although behaviour change is dependent on psychological capabilities, which in turn affect perceptions, social opportunities such as cultural norms are likely to influence behaviour regardless of individuals' perceptions.

The importance of community-based approaches for health education interventions about FGM/C cannot be underestimated. The value of this approach is demonstrated by Chege et al. (2004) and Abdulah et al. (2019), who reported on how religious leaders and other key leaders in communities were used for advocacy against FGM/C. Community leaders are valued individuals and their inclusion in interventions has been noted to enhance the interventions' effectiveness, particularly where messages relate to sensitive health issues such as HIV (Li et al., 2016). There are a number of strategies to support this approach: for example, Mounir et al. (2003) described how intervention facilitators in their study dressed in a similar style of clothing to that of their participants in an attempt to encourage a sense of shared identity, and at the same time break down any perceived barriers.

While individual attitude and behaviour changes are essential, sharing acquired information is equally important for supporting a collective prevention of FGM/C (Chege et al., 2004). The willingness to share information, however, is dependent on factors such as commitment, desire to help others, reputation, and organisational rewards (Tan and Ramayah, 2014). Diop and Askew (2009), for example, indicated that women who participated in the FGM/C programme were encouraged to 'adopt' a friend/relative and share information regarding their learning during classes. This strategy proved to be effective. The programme also encouraged sharing of information by establishing community management committees to strengthen village ownership of the programme. However, group strategies may not always be an effective means of encouraging FGM/C prevention; this approach runs the risk of inadvertently spreading pro-FGM/C messages if there is significant support for the practice among communities. On the other hand, when accurate information is communicated and shared effectively, this will eventually lead to collective knowledge and awareness that in turn d communal change. This can culminate in more widespread results for public campaigns which denounce FGM/C (Chege et al., 2004).

Acculturation is an important factor in this review because it has the capacity to influence the attitudes and views of immigrant communities. This may depend on the economic status and legislative changes within the home or host countries (Jass and Massey, 2004). Four studies included in this review, conducted in Switzerland, Spain and the USA, focused on communities with a history of FGM/C living in these high-income countries (HICs) (Jacoby et al., 2015, Ruiz et al., 2016, Shahawy et al., 2019, Abdulcadir et al., 2016). These studies found that the views and opinions of participants were likely impacted by acculturation. In addition, the impact of acculturation may not be much different when the host country is a low- or middle-income country (LMIC) (Chege et al., 2004).

According to the WHO, health education presents opportunities for learning that are based on sound theories to offer health information (WHO, 2016a). From some perspectives, FGM/C interventions can be perceived as taking a top-down approach, with communities being the recipients. It is for this reason that Babalola et al. (2006) emphasises the importance of integration with communities prior to the implementation of interventions. The authors reasoned that this increases community acceptance of an intervention, leading to a greater likelihood of its success.

Findings from this review suggest that health education is a promising intervention in preventing FGM/C. Health education interventions are often favoured over other interventions, such as legislation, because they are less repressive (Ruiz et al., 2016). Although the law reduces the rate of FGM/C, it has also been found to drive the practice underground (Shell-Duncan et al., 2013). Reports have shown that parents resort to subjecting girls to FGM/C at a younger age in an attempt to avoid the legal consequences, as detection is more likely if a child is old enough to report the incident. There is also an association between law enforcement and increased medicalisation, which refers to FGM/C being performed by medical professionals. Thus, the law also may lead to reduced reporting of FGM/C cases, in turn leading to reduced identification of new cases (Ruiz et al., 2016, Boyle and Corl, 2010, Yoder et al., 2004, Easton et al., 2003, Jackson et al., 2003, Ahlberg et al., 2004, Yount and Carrera, 2006). Although tackling FGM/C may require intensive long-time interventions, Abdulah et al. (2019) suggest that even brief interventions can be effective, although ideally they should be implemented alongside comprehensive strategies.

Contextualising health education interventions is only possible when there is sufficient consideration of the characteristics of target populations. Contextualising involves the inclusion of communities in programme planning: for instance, involving settled residents who belong to target communities as facilitators or research assistants (Asekun-Olarinmoye and Amusan, 2008). Religious and other key leaders can also help to promote the interventions (Chege et al., 2004, Abdulah et al., 2019). Community members can be involved in the dissemination of information to relatives and friends, thus encouraging public awareness and resistance to FGM/C (Diop and Askew, 2009, Nkwam-Uwaoma et al., 2019). However, as

Mahgoub et al. (2019) indicate, family and societal values can also hinder the effective sharing of information.

The evidence from this review suggests that consideration of these various and interrelated factors is crucial to increasing the acceptability of health education programmes (both at individual and group level), and equally, to accelerating the dissemination of accurate information among communities. Although there are numerous similarities, it should be noted that there are some differences between factors that affect the effectiveness of health education interventions in the diaspora setting and community settings in countries where FGM/C is practised. One of the differences is that diaspora communities may have high levels of acculturation and less pressure from their families, resulting in a lower prevalence of FGM/C among these populations (McNeely and Jong Floor, 2016). Despite this, it may be that diaspora communities hold on to the culture of the practice in order to preserve their identity, which may not be the case with communities in their country of origin (Shahawy et al., 2019). Immigration and integration difficulties experienced by diaspora communities may also present a threat to education interventions, as it may be more challenging to encourage participation among these groups when compared with the cohesive communities in their countries of origin (Chege et al., 2004). Communities in the diaspora may also struggle with communication, including language (Jacoby et al., 2015, Abdulcadir et al., 2016), which would require access to resources in different languages; again, this challenge would be heightened for those living in a host country which speaks a different language. It is differences such as these that make the generalisation of interventions, especially international interventions, challenging. It is thus crucial that these unique community factors are considered when designing, implementing and evaluating health education interventions.

The need for consideration of the differences that exist between and among communities who receive FGM/C health education interventions has not been widely covered within literature, or indeed emphasised in the interventions themselves. For that reason, many interventions tend to operate under various assumptions, resulting in their failure to consider numerous factors: for example, the preferences of their audiences with regards to the involved facilitators and venues. This systematic review has therefore demonstrated the need to scrutinise and analyse different factors, which otherwise would impede the effectiveness of FGM/C health education interventions. The systematic review also inspired further aims to explore the experiences of the providers of health education interventions and the recipients of these interventions, which I will present in Chapters 5 and 6 of this thesis.

3.4.4. Strengths and limitations

A strength of this systematic review was its international scope, resulting in the inclusion of a wide range of studies. However, one limitation was that some studies did not indicate the duration of the interventions. For this reason, though some studies indicated that interventions of longer duration were more effective, it is impossible to say how true this was across all studies contributing to this review.

This review also considered only studies reported in English. Inclusion of studies published in other languages could have provided a different set of results, particularly if these included studies from non-English-speaking and/or high-income countries. The review also only considered studies that focused on affected communities and excluded studies from non-practising communities, which future research should consider including.

3.5. Conclusion

Health education interventions are one example of many interventions that have been implemented in an attempt to prevent FGM/C. Evidence shows that they have been successful in preventing other public health problems such as teenage pregnancy and smoking.

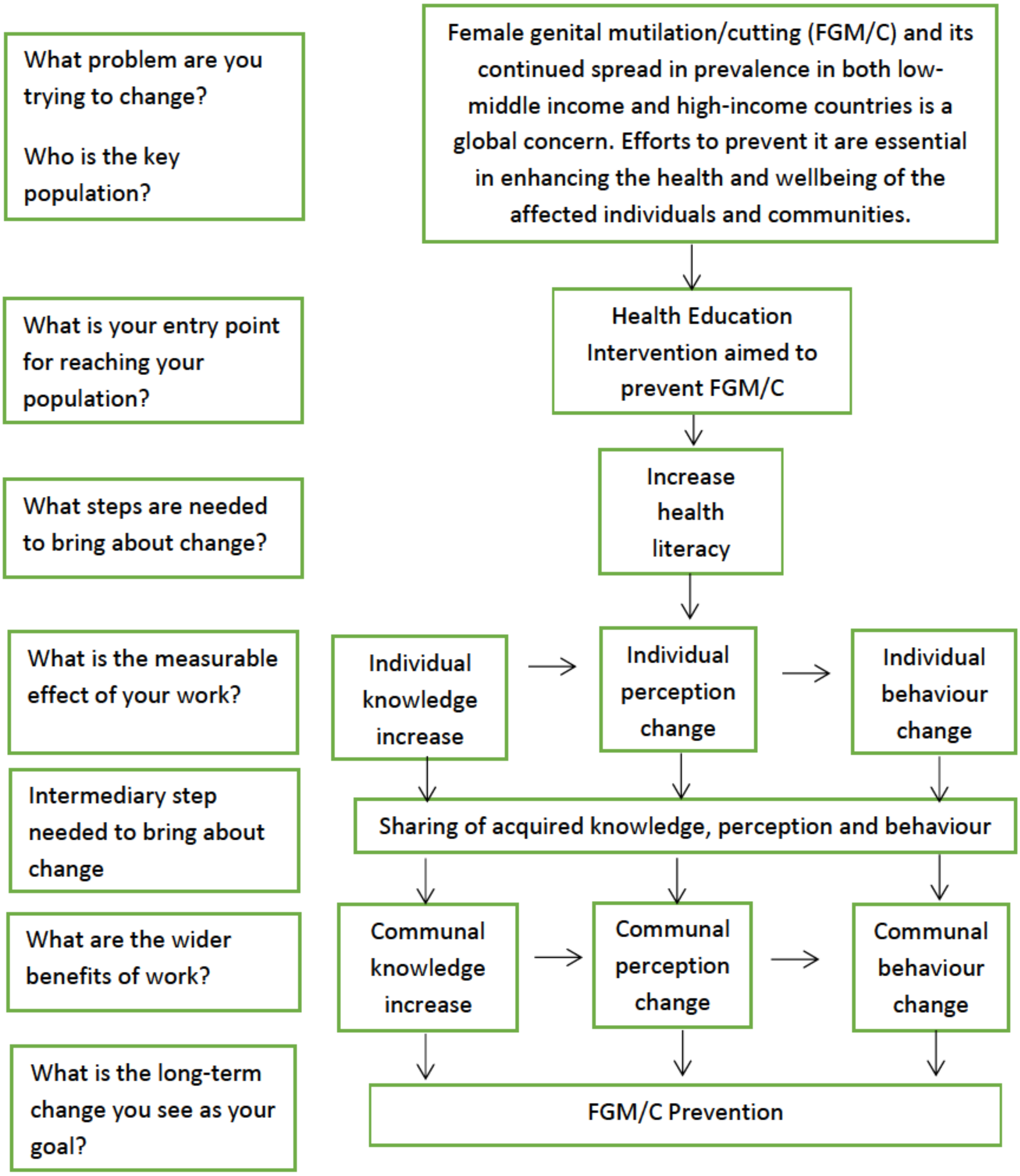
This systematic review evaluated the effectiveness of health education interventions in isolation from other interventions, which has not been observed in previous reviews. Studies included in this review recommended health education as an effective intervention tool to prevent FGM/C in communities affected by the practice, either at home or in a host country. The findings from this review emphasise the importance of tailoring health education interventions to the structure and needs of the target population. The success of health education interventions is dependent on sociodemographic factors, socioeconomic factors, traditions and beliefs, and programmatic approach. Evidence from this review suggests that these factors are vital and require careful consideration at every stage of the intervention. This, in turn, increases the possibility of initiating communal changes in behaviours and attitudes, and leading to a sustained reduction in the prevalence of FGM/C.

While exploring the studies included in this systematic review, a pattern of implementing successful FGM/C health education interventions that can lead to prevention was identified. To demonstrate this process, a Theory of Change (ToC) was therefore developed based on the identified pattern of change through the FGM/C health education interventions. This is shown in a ToC diagram (Diagram 3.1) which presents each step required in the implementation of the interventions.

The findings in this systematic review inspired further investigations to explore the experiences of facilitators of health education interventions, which was done via a survey with health professionals, and the experiences of recipients of the interventions, which was explored in a generic qualitative study with individuals from communities affected by FGM/C. These will be addressed in the empirical chapters of this thesis.

The factors identified in this systematic review, alongside those in the included empirical studies, are expounded in the Discussion Chapter. But first, the Methodology Chapter is presented to show details of the methods used in each study and the integrated findings.

Diagram 3.1: Implicit theory of change in preventing FGM/C through health education interventions



CHAPTER 4

Methodology

Introduction

This chapter discusses, in detail, how a mixed method research was employed in this thesis. Ethical considerations for each of the phases are discussed, followed by data collection and data analysis methods. But first, researcher positionality is discussed, which describes the stance of the researcher regarding the topic, including how I came to conduct this study.

4.1. Researcher positionality

My research interests developed from personal experiences of living with women and girls, from different practising communities in Africa, who have undergone FGM/C. The numerous detrimental consequences that affect and disable these women and girls led me to seek a better understanding of this complex issue. Since there have been several interventions attempting to prevent FGM/C, I was interested in exploring health education interventions in order to understand their effects in preventing the practice. At the same time, I wanted to understand the barriers and facilitators of effective implementation of the interventions. I explored literature from different parts of the globe where the practice is performed and have conducted empirical research in the UK, which may have portrayed a slightly different view from diaspora communities regarding services/interventions, contrary to my initial experiences in practising countries. In view of this, I have pragmatically combined the results from this research using intersectionality, which facilitated a nuanced understanding of relevant factors impacting the reception of FGM/C health education interventions. In turn, I anticipate that my research will lead not only to better understanding, but also to the development of more effective interventions that can help to eradicate the practice across different communities globally. The following sections expound on the methods used to conduct this research.

4.2. Research aim and objectives

4.2.1. Research aim:

This research aimed to explore FGM/C health education interventions locally and globally, in order to explore which aspects contribute to the effectiveness of these interventions in preventing FGM/C. A better understanding of these aspects will help to inform professionals, such as educators and health professionals, to care for FGM/C affected communities and patients/service users.

4.2.2. Research objectives:

1. To explore the existing evidence of the effectiveness of health education interventions in preventing FGM/C locally and globally.
2. To explore the experiences and views of midwives, health visitors and general practitioners regarding discussions about FGM/C with their patients or clients in Birmingham, UK.
3. To explore the experiences and opinions of members of communities in Birmingham with a history of practising FGM/C, regarding health and wellbeing programmes.
4. To compile comprehensively evidence-based information that informs health education interventions in the prevention of FGM/C.

Objectives one to three were developed and explored as three phases for this research. Objective four was developed as an integration chapter, compiling the findings from all of the phases.

4.3. Rationale for using mixed method research

This research used a mixed method research. As described by Creswell et al. (2011), this approach employs rigorous qualitative research to explore the meaning and understanding of constructs, and rigorous quantitative research to assess the magnitude and frequency of constructs. Both qualitative and quantitative data are intentionally collected and integrated, which maximises the strengths and minimises the weaknesses of each type of data. Mixed method research allows investigations to be framed within various philosophical and theoretical positions. A variety of theoretical perspectives can be included, which is an approach employed by my research. Although mixed method research is known to be resource intensive, including requiring multidisciplinary teamwork, this approach is important because it allows for the inclusion of multiple perspectives, which would be impossible when applying a single research method. Also, merging qualitative and quantitative data allows for a more comprehensive understanding of a problem (Mukherjee and Kamarulzaman, 2016, Morse, 2016). A breakdown of how mixed method research was applied in this thesis is presented next.

There are three phases in this thesis: (1) systematic review, (2) survey, and (3) qualitative research. They were each conducted and completed separately. The rationale for including each method is as follows:

> Systematic reviews involve searching for and reviewing available primary research data, providing information about the effects of some phenomenon across a wide range of settings and empirical methods (Kitchenham, 2004). Findings from the systematic review facilitated the formulation of research questions, which would be explored in the empirical stages of this doctoral research. To explore the experiences of the providers of health education interventions, a second phase (survey) was carried out.

A survey is a quantitative method of gathering information from individuals who are scientifically sampled to provide information that reflects a composite profile of the population (Scheuren, 2004). This study employed a descriptive format that intended to describe the nature of the collected data through basic statistical analysis. Since the survey in this research was administered to providers of health education interventions, it was also necessary to find out the experiences and opinions of the recipients of the interventions. Therefore, a third phase (qualitative study) was included.

A qualitative research approach was utilised in order to gain a deep understanding of the perspectives of participants, which contributes to empirical knowledge. The study employed a 'generic' qualitative design, meaning that it does not claim to be aligned to one of the dominant qualitative approaches such as phenomenology or grounded theory (Bradbury-Jones et al., 2017). The generic design provided space to question and explore approaches that do not neatly fit into established methodological boundaries, therefore providing an opportunity for the development of new methodologies (Kahlke, 2014).

4.4. Ethical considerations

Ethical considerations in research are important because they provide guidance for conducting the research. They ensure adherence to codes of conduct such as confidentiality and consent. This is essential for the safety of both participants and researchers (Shirmohammadi et al., 2018). The systematic review in this thesis did not require ethical approval because the study involved only the reviewing of published documents, without contact with those studies' participants.

The research and development departments of relevant organisations approved this study, enabling the research to be carried out with NHS staff. Participants needed to provide their consent to participate in the study. Details of the consent form are provided in Appendix 8. Study participants and their places of work are kept anonymous across this thesis; only characteristics that were not specific to the participants or their affiliations are included in the main findings.

The qualitative study obtained ethical approval from the University of Birmingham Ethics Committee on the 19th of June 2018 and HRA approval on 23rd of May 2018, a full year after the initial application (ERN:R 17-235, IRAS ID:236727). The study required no other ethical approvals because it involved only the public and did not require personal data. Participants were asked to complete a consent form including their written consent for interview recording (Appendices 21 and 22). This is essential for transparency and partnership in research (Wolf et al., 2018). Upon completion of the research, all data including the recorded discussions and their transcripts will be securely stored in the University of Birmingham archives for ten years, after which time they will be destroyed in accordance with the university's research data management policy (University of Birmingham, 2017). Participants were given identifier numbers, so that their real names were not used in the reporting of findings. The report write-up will only include characteristics that were not specific to the participants or the programmes to which they referred. For instance, 'a source/facilitator of health and well-being education programmes in the health sector/third sector…'. This is important in protecting participants from being traced when the data from this study are published (O'Reilly and Kiyimba, 2015).

All data from the survey and qualitative studies were securely stored in the university's research data storage systems, to which only the research team had access.

4.5. Data collection

In the systematic review, electronic databases were searched to identify studies published prior to August 2020. PICOS criteria (population/problem, intervention, comparator, outcomes and study type) were developed and used in the search process. Medical Subject Headings (MeSH), free text and Boolean logic were used to ensure thoroughness in the search. Inclusion and exclusion criteria were formulated to facilitate the screening of retrieved search results, such that only studies that met the inclusion criteria were included for analysis. Two reviewers (HS, a fellow postgraduate researcher, and me) were involved in selection of the studies, followed by data extraction using a pre-designed form. Details for the processes of study selection and data extraction for the systematic review are discussed in Chapter 3 of this thesis.

In the survey, the study population consisted of health professionals who were likely to encounter FGM/C in Birmingham, UK. The target groups among health professionals, who were more likely to encounter FGM/C cases, included midwives, health visitors and general practitioners. Purposive sampling was used, which involves selecting participants based on their capacity to contribute to the study (Etikan et al., 2016). Participants had to be working in Birmingham at the time of the study. The study did not include participants who were unable to participate due to absence from work during the duration of the study, or who had difficulties in accessing electronic devices or the internet. Four key contact persons from the three groups of health professionals acted as gatekeepers for distributing the questionnaire to the health professionals in their contact lists. Approximately 500 midwives, 240 health visitors and 168 general practitioners were invited to the study. This sample was large enough for significant representation of a range of characteristics likely to exist in the wider workforce. In total, 67 health professionals including 46 midwives, 11 GPs, and 10 health visitors responded to the survey (Table 4.1). The key contact persons continued to be the main informants and advisors regarding the appropriate methods to involve the health professionals in this study. Such key contact persons are important because they help the researcher(s) to identify and contact potential participants; in this case, as I did not have legal access to the professionals' personal information, the key contacts enabled me to make contact with potential participants (Harriss et al., 2017). The key contacts agreed to inform their teams about the study and distribute the research pack that contained the participants' invitation letter (Appendix 6), participants' information sheet (Appendix 5), consent form and the study questionnaire (Appendix 9). A reminder letter, which is useful for encouraging participation (Houston et al., 2010), was sent through the key contacts in each group after 10 working days (Appendix 7). Data were collected from participants within the wider Birmingham area; however, the main centres of reference for midwives were two large NHS trusts in the West Midlands. General practitioners were from various settings in Birmingham. The data collection period was between August and November 2018. Survey Monkey software was used; this is an online survey development software that includes various functions, including data collection and data analysis (Survey Monkey found at https://www.surveymonkey.co.uk/). The self-administered electronic questionnaire contained both open and closed questions. Such questionnaires are useful in gathering information from a large population. Also, this platform does not require the researcher to administer the questionnaire, which has been found to encourage genuine responses, especially in sensitive topics (Gnambs and Kaspar, 2015). The questionnaire was specifically designed and tailored to the topic, enquiring about levels of knowledge and confidence about FGM/C. It also sought information about barriers and facilitators to discussing FGM/C with patients/service users.

Table 4.1: Number and percentages of the midwives, GPs and health visitors in gender categories

Profession	Midwives*	GPs	Health visitors
Male	0	3	0
Female	45	8	10

*One midwife did not indicate their gender

In the qualitative study, data were collected from across Birmingham with no specific restrictions on the location, because willing participants resided in different areas. Participants needed to be members of communities with a history of practising FGM/C. Although participants were likely to come from areas in Birmingham with higher populations from FGM/C-practising countries, this study aimed to include all willing and eligible participants regardless of their residence. Birmingham was a suitable location because it accommodates a highly diverse population; various different ethnic, religious and social groups were recorded in the latest published population census of 2011 (Birmingham City Council, 2011). Data were collected between August 2018 and March 2019. The study collected data via a mixture of one-to-one interviews and focus group interviews. One-to-one interviews lasted between 20 to 50 minutes, while focus group meetings lasted about 80 minutes. All interviews were audio recorded, with the written consent of participants, which helps the researcher to capture all that was discussed during the interviews (FitzPatrick, 2018). I facilitated the interviews and took notes to ensure accuracy in capturing the expected and unanticipated responses. For one focus group interview, one of my supervisors (LD) acted as an assistant moderator, supporting the planning and flow of the process. To be eligible for this study, participants had to be residing in Birmingham at the time of the study. They must also have previously participated in an FGM/C health and wellbeing education programme(s) that they could recall. Individuals who could not communicate in the English language were excluded from the study. Participants were selected through co-ordinators (gatekeepers), who are crucial in recruitment for community-level research (Harriss et al., 2017). These co-ordinators were identified through networking in events about FGM/C and violence, held in Birmingham. The co-ordinators agreed to contact individuals using the invitation letter (Appendices 19 and 20) and also organised meetings by selecting potential participants from pre-existing lists recorded by their organisations. The co-ordinators and I organised a preferred suitable time and venue to hold each meeting. Co-ordinators did not participate in the focus group meetings, but were given the option to participate in one-to-one interviews. A reminder letter or message was sent to potential participants to encourage participation of those who had not responded to the first invitation. This study initially aimed to involve a minimum of three separate focus groups of 60-90 minutes, including participants with various demographic characteristics, such as country of birth, age and gender. However, due to the sensitive nature of the subject, the study managed to conduct only two focus group meetings containing, in total, nine female participants. The rest of the interviews (n=12) were on a one-to-one basis, resulting in an overall sample size of 21 participants. The types of FGM/C practised in participants' regions of origin varied. Types I and II were the most commonly practised, while Type IV was the least common (Table 4.2). Prevalence rates also varied: in the girls under 14 years of age, the Western African region average is 25%; Eastern Africa is 10% (Kandala et al., 2018); Southern Africa is below 5%; and the Middle East is 5%. However, there is a lack of consistency in reporting and research in the latter two regions (Reisel et al., 2016, UNICEF, 2013).

Table 4.2: Participants' demographic characteristics

Participant number	Gender	Age (where provided)	Region of origin	Type of FGM/C commonly practised in the region of origin	Occupation
P001	Female	40	Eastern Africa	Type III	College student
P002	Female	28	Middle East	Types I and II	FGM/C worker/trainer
P003	Female	25	Eastern Africa	Types II and III	Community FGM/C trainer
P004	Male	Not provided	Eastern Africa	Type III	Community leader
P005	Female	32	Western Africa	Type II	Postgraduate student and qualified nurse and midwife
P006	Female	25	Western Africa	Type II	Postgraduate student and qualified social worker
P007	Male	Not provided	Western Africa	Types I and II	Postgraduate student
P008	Female	Not provided	Eastern Africa	Type III	Student
P009	Female	Not provided	Western Africa	Types I and II	Care coordinator
P010	Female	21	Eastern Africa	Type III	Nursing student
P011	Male	51	Eastern Africa	Type III	Qualified social worker and translator
P012	Female	Not provided	Eastern Africa	Type III	FGM/C worker/trainer
P013	Female	Not provided	Western Africa	Types I and II	Retired nurse
P014	Female	Not provided	Western Africa	Types I and II	University teacher
P015	Female	Not provided	Western Africa	Types I and II	Doctor
P016	Female	Not provided	Southern Africa	Type IV	Qualified social worker
P017	Female	Not provided	Eastern Africa	Type III	Customer care
P018	Female	Not provided	Eastern Africa	Type III	Housewife, former teacher
P019	Female	Not provided	Middle East	Type I	Sports instructor and translator
P020	Female	Not provided	Eastern Africa	Type III	Postgraduate student
P021	Female	Not provided	Western Africa	Types I and II	Support worker

A sampling matrix (Table 4.3) was utilised to ascertain that the desired variety of demographic characteristics, especially in region of origin and gender, was sampled.

Table 4.3: Sampling matrix: Qualitative

Region of origin	Gender	
	Male	**Female**
Middle East	0	2
Eastern Africa	2	7
Western Africa	1	8
Southern Africa	0	1
Total	3	18

An information sheet (Appendices 17 and 18) was provided to participants and written consent (Appendices 21 and 22) was obtained before participating in the interview. An interview schedule guide was used, which contains structured instructions to assist a researcher in conducting interview sessions without deviating from the topic, and helps to ensure interviews remain within the allocated/predetermined timeframe (Taylor et al., 2015). This guide contained key prompt questions which explored the participants' experiences and opinions about the health and wellbeing education programmes they had previously attended. Though containing the same questions, the study utilised two interview guides: one for the focus group interviews and another for the one-to-one interviews (Appendices 24 and 24). The interview schedule contained open-ended questions, with probing questions for each of the main questions. Due to the sensitivity of the subject, piloting this study was not practical because there were so few willing participants. However, I reviewed the interview schedules with my supervisors.

4.6. Data analysis

In the systematic review, a Mixed Methods Appraisal Tool (MMAT) was used to appraise all of the included studies. This tool was utilised because it provides a means for researchers to conduct quality appraisal of qualitative, quantitative, and mixed method studies (Pace et al., 2012). The quality of each of the 20 studies included in the systematic review was described based on their contribution to answering the research question. Common themes that emerged regarding factors affecting the effectiveness of FGM/C health education interventions were presented and discussed in detail. A paper has been published to disseminate the findings (Waigwa et al., 2018).

In the survey study, 67 health professionals responded to the online survey (Table 4.1). They included 46 midwives, 11 GPs, and 10 health visitors. All midwives (apart from one whose gender was unstated) and health visitors indicated that they were female. There were three male and eight female GPs. Responses from all participants were reviewed and organised into categories and frequency statistics were used to describe and compare the data. Statistical analysis was carried out using SPSS for Windows, version 24. Bivariate correlations using Spearman's test, which is used to determine if there is an association between two nonparametric variables (Akoglu, 2018), were used to test the association between confidence levels and knowledge levels of the same activities/procedures. Two major training programmes (*NHS FGM/C e-learning to improve awareness and understanding of FGM/C*, and *Home Office and Virtual College FGM/C: recognising and preventing FGM/C*) were reviewed against the results of this study. The two were chosen for analysis in this survey because they are provided by UK national institutions (Home Office and NHS) and are freely available to health professionals. The content of the training programmes was evaluated and compared with the needs and gaps identified by the respondents. Gaps that need to be addressed, and content that needs to be introduced to training programmes were identified. A summary of the results is available for participants and interested individuals (Appendix 16).

In the qualitative study, I transcribed the recorded interview discussions verbatim, which facilitates researcher immersion in qualitative data (Neal et al., 2015). Transcripts, containing details of discussions from the recorded interviews, were developed in Microsoft Word. These were then transferred to NVivo 11 software, which was used to organise and manage the collected data including coding (a process of categorising data with similar meaning) (Stuckey, 2015). I coded the transcripts line-by-line to ensure I holistically captured subtle meaning. From the developed codes I utilised framework analysis – where data is sifted, charted and sorted in accordance with key issues (Srivastava and Thomson, 2009) – to organise the codes alongside their corresponding quotes from the transcripts. I used NVivo 11 software to formulate an analytical framework matrix to display the codes and quotes on a spreadsheet. Examples of sections of the matrix showing codes and corresponding quotes from the participants can be found in Appendix 28. Having obtained codes and corresponding data from the transcripts charted in the matrix, I utilised thematic analysis – a method for identifying, analysing and reporting patterns of themes within data (Castleberry and Nolen, 2018, Braun and Clarke, 2006) – to generate themes by categorising the codes based on patterns, relations or similarities (Table 4.4). These themes broadly represented the codes and data within those codes. The themes were used as subtopics in the presentation of the findings. Combining framework and thematic analysis enabled a thorough cross-examination of the interview transcripts, with the framework matrix facilitating the location of recurring themes.

Table 4.4: Codes and themes of qualitative findings

	Themes						
	Demographics	Programme Approach	Social Structures	Attitudes and Beliefs	FGM/C Knowledge	Communication (means and responsibilities)	Better future
Codes	Age Gender Country of Origin Place of residence in Birmingham Occupation	Audience Facilitator Topics -Postnatal depression -Domestic violence Resources /Handouts Venue and place of programme venue	Gender issues Generational differences Ethnic differences Marriage Cultural awareness Specialised services and service collaboration	Reasons for attendance Sex education Feelings towards the programme Religion Personal disclosure of undergoing FGM/C Feelings towards the practice	Lack of knowledge Doubts of own knowledge Reasons of FGM/C Consequences of FGM/C When FGM/C is carried out FGM/C legalities FGM/C prevalence	Sharing Knowledge Media Professional duties Use of pictures Language Disagreement with delivered message	Next generation safeguarding Best practice

Discussions capturing the similarities and differences in content were then developed and presented, thus providing a comprehensive storyline of the study (Vaismoradi et al., 2016). A summary of the findings is available for participants and interested individuals (Appendix 25).

4.7. Integration of overall findings

The purpose of utilising a mixed method approach in this thesis was to integrate the findings from the studies. I used a theoretical lens of intersectionality to deductively integrate the discussions that culminated in a comprehensive conclusion responding to the project objectives (Chapter 7). As stated in Chapter 2, intersectionality is a practical theory that has sparked changes in relation to the conceptualisation of discrimination; it was for this reason that the theory was selected as a lens for this thesis.

During the development of this thesis, an implicit Theory of Change (ToC) in preventing FGM/C through health education interventions emerged. A pattern was deduced showing the stages of change and factors that impact on each stage. A ToC diagram is presented at the end of Chapters 3, 5 and 6, based on the individual chapter contributions to the theory.

4.8. Conclusion

This chapter has described researcher positionality within this research, the rationale for using a mixed method approach, ethical considerations, and the data collection methods. Data analysis processes, integration and dissemination of research findings were also discussed in detail. The following chapters include a description of the findings for each of the empirical phases described in this chapter, after which an integration of the findings will be presented.

CHAPTER 5

Survey Results

Introduction

This chapter reports the results of an online survey of health professionals who worked in Birmingham, UK. The survey explored their experiences and opinions about discussing FGM/C with their patients/service users. The questions captured participants' demographic characteristics; patients/service users' demographic characteristics as provided by the study participants; confidence levels and knowledge levels; and participants' views on the barriers and facilitators of effective discussions about FGM/C.

The survey included questions about the following: identifying FGM/C affected patients/service users; starting a conversation about FGM/C with patients/service users; discussing the health implications of FGM/C with patients/service users; discussing FGM/C illegalities with patients/service users; recording newly identified cases and attendance as per the FGM/C enhanced dataset standards; reporting known cases of girls under the age of 18; and sharing information with relevant professionals (such as school nurses or GPs) to safeguard children and vulnerable adults (Appendix 10, Table 5.1a).

This chapter reviews two online training programmes against the results of this study. From among the training programmes listed in Table 2.2 in Chapter 2 (Literature review), the *NHS FGM/C e-learning to improve awareness and understanding of FGM/C*, and the *Home Office and Virtual College FGM/C: recognising and preventing FGM/*C, were selected for this evaluation because they were established by UK national institutions (the NHS and the Home Office) and they are free to access. Elements that were covered substantially in the training programmes, those that were scarcely mentioned, and those that would need to be included in the programmes are presented in Table 5.1.

The main contributions of this chapter to intersectionality and the ToC for this thesis are highlighted at the end of the chapter.

Results of the online survey of health professionals

5.1. Patients' demographics as provided by the study participants

Among the 63 health professionals who responded to the question of place of residence, 63.5% (n=40) indicated that all of the patients/service users who they had cared for with regards to FGM/C were residents of Birmingham, UK (Appendix 13, Table 5.4a). More than half (56.5%) of the 62 health professionals who responded to the question about the ethnic backgrounds of their patients/service users indicated that *all* of their patients/service users identified as being from an ethnic minority group. The remaining 43.5% of these 62 health professionals (apart from three midwives who indicated 'I don't know') reported that *some* of their patients/service users were from an ethnic minority background. Approximately 82.1% (n=55) of health professionals provided valid responses to the question about the religion of their patients/service users. Twenty-six percent of these participants reported that all of their patients/service users identified their religion as Islam. The remainder of the respondents indicated that either they did not know or that their patients/service users practised different religions.

5.2. Levels of confidence in discussion of FGM/C with patients/service users

Health professionals self-evaluated their confidence levels against statements that involve discussing FGM/C with their patients/service users (Appendix 11, Table 5.2a). Health visitors in general were the most confident group across the three professional groups, with a total of 100% indicating that they were either 'sometimes confident' or 'always confident' in all of the statements, except 'recording newly identified cases and attendance' (80% selected one of the aforementioned confidence statements). Midwives were more confident than GPs, as there was at least one GP in every measure who indicated that they did not know the process.

Interestingly, more midwives indicated that they ‘don’t know the process’ and are ‘never confident’ in ‘discussing health implications’ (8.7%) than in ‘discussing illegalities of FGM/C’ (6.5%). The same trend was noted among the GPs, with 27.3% selecting one of these statements for ‘discussing health implications’ and 9.1% for ‘discussing illegalities of FGM/C’. Across all professional groups, a combined percentage (28.36%) indicated that they were unaware of the process or never confident in ‘recording newly identified cases and attendance’, while about 21% indicated the same for ‘reporting known cases of girls under 18’.

5.3. Levels of knowledge in discussion of FGM/C with patients/service users

When asking about health professionals’ perceived knowledge levels regarding measures that involve discussing FGM/C with their patients/service users, health visitors were generally more knowledgeable than midwives, who in turn were more knowledgeable than GPs (Appendix 12, Table 5.3a). At least one GP indicated that they had ‘no knowledge’ in each measure, which explains their low ranking among the three groups in levels of knowledge. Overall, 30% of all the health professionals reported having ‘no knowledge’ or ‘little knowledge’ in ‘recording newly identified cases and attendance’. Combined results for ‘no and little knowledge’ showed health visitors reporting the highest percentage (40.0%). Notably, 21% of all the health professionals reported ‘no knowledge’ or ‘little knowledge’ in ‘reporting known cases of girls under 18’. Combined results for ‘no and little knowledge’ showed midwives had the highest percentage (23.9%) followed by GPs (18.2%) then health visitors (10%).

5.4. Relationship between confidence and knowledge in discussing FGM/C with patients/service users among different health professionals

To explore the relationship between confidence and knowledge levels of the health professionals in this study, we applied Spearman’s test, used for non-parametric/asymmetric data. The results showed that there were statistically significant, strong-positive correlations between confidence and knowledge variables among all the health professionals in all the measures (r_s=>0.5 and p=<0.01) (Appendix 14, Table 5.5a); the higher the level of knowledge that the health professionals possess, regarding individual measures, the more confident they are in implementing the measures with patients/service users. The largest correlation (r_s=0.776, p=0.0001) was between knowledge and confidence levels of 'sharing information with relevant professionals', inferring that confidence in the implementation of this measure is highly dependent on their knowledge of the same measure. The lowest correlation, but still significant (r_s=0.542, p=0.0001) was between knowledge and confidence levels of 'discussing illegalities with patients/service users', suggesting that confidence in implementing this measure is dependent on their knowledge about the same measure.

5.5. Facilitators of effective discussions of FGM/C

From among the list of facilitators provided to the health professionals in this survey, overall, 'well-structured safeguarding and referral pathways' was the most common facilitator selected by 85.1% of health professionals (Figure 5.1). 'Knowledge about FGM/C matters' was the second most popular facilitator, ranking second among midwives (87.0%) and health visitors (80.0%) and third among GPs (63.6%). 'Availability and accessibility of FGM/C leads' was also favoured across the three groups, ranking second for GPs (72.7%) and third for both midwives (80.4%) and health visitors (80.0%).

The 'availability and accessibility of online learning materials' was the least common facilitator among the GPs (45.5%), while it ranked as the third-to-last facilitator among the midwives (65.2%) and the health visitors (70.0%). The 'presence of third sector services that support FGM/C affected communities' was the least selected facilitator among the midwives (52.2%) and health visitors (50.0%).

Additional facilitators that were highlighted by respondents but not listed in our survey questionnaire included shared information about mothers with FGM/C (health visitors), and the availability of highly trained non-judgemental interpreters (GPs).

Figure 5.1: Facilitators of effective discussion of FGM/C and percentage of health professionals

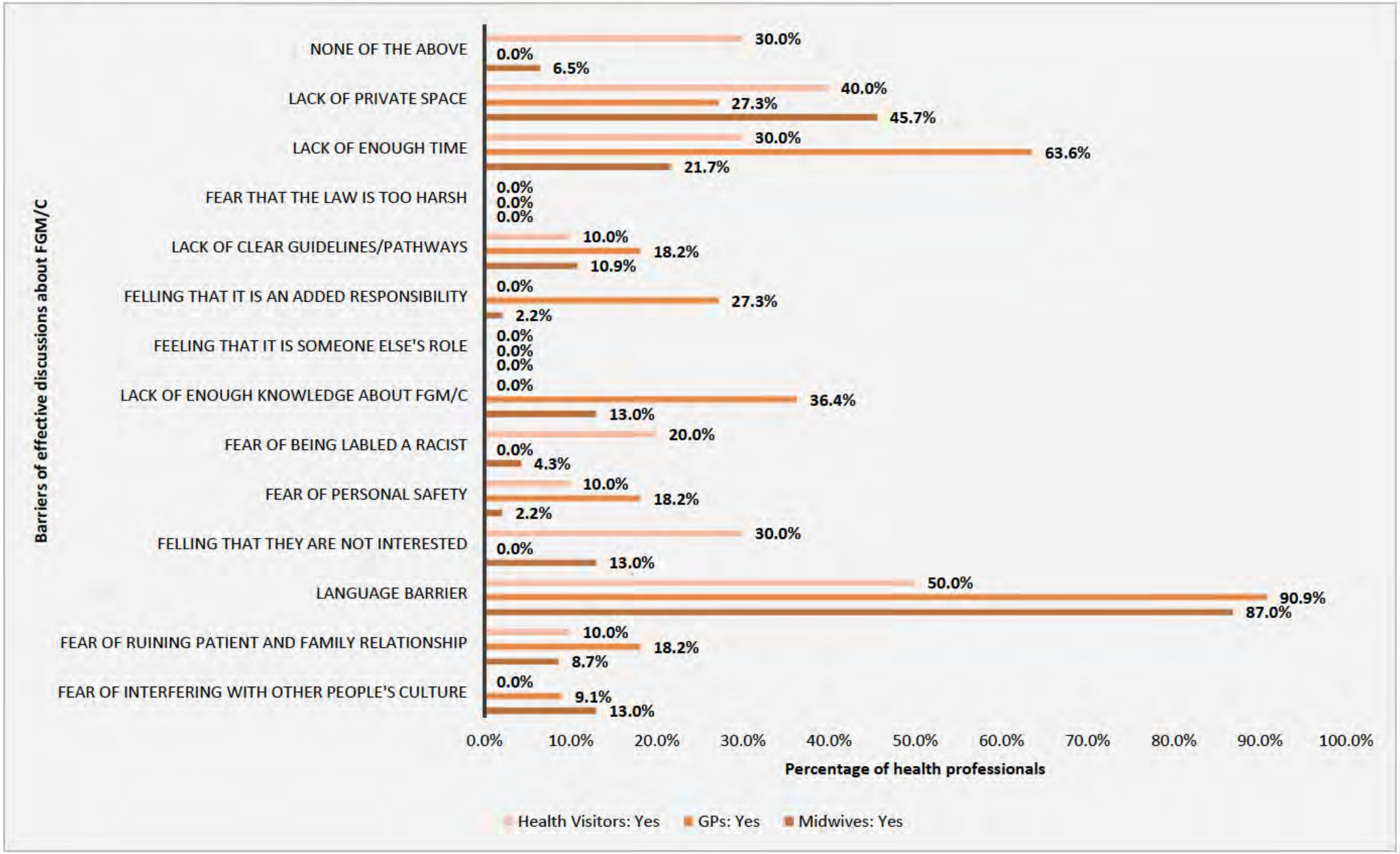
5.6. Barriers to discussing FGM/C with patients/service users

With regards to barriers that make it challenging for health professionals to discuss FGM/C with their patients/service users, ‘language barrier’ was the most commonly selected barrier, selected by three quarters (n=55) of all participants (Figure 5.2). ‘Lack of time’ was selected by many respondents across the three groups, ranking second among the GPs (63.6%) and third among both midwives (21.7%) and health visitors (30.0%). ‘Lack of space’ was also a common barrier identified across the three groups, ranking second among midwives (45.7%) and health visitors (40.0%) and fourth among GPs (27.3%).

Conversely, ‘feeling that it is someone else’s role’ and ‘fear that the law is too harsh’ were not selected as barriers by any of the three groups. In addition, ‘feeling that they are not interested’ and ‘fear of being labelled a racist’ were not highlighted as barriers by the GPs, but were selected by 13% (n=6) and 4.3% (n=2) of midwives respectively, and 30% (n=3) and 20.0% (n=2) of health visitors respectively. ‘Lack of enough knowledge about FGM/C’ and ‘feeling that it is an added responsibility’ were not identified as barriers by the health visitors. Three midwives and three health visitors indicated that none of the factors from the provided list was a barrier. Further inquiry showed that these three midwives agreed that all of the stated facilitators were helpful in enabling effective discussions. However, for the three health visitors, the only commonly selected facilitator was ‘availability and accessibility of FGM/C leads’.

Some respondents mentioned additional barriers that were not provided in the options of the survey. They included: difficulty knowing how/when to bring up the conversation (GPs); the presence of other family members during the consultation, which can hinder creating a good enough rapport (health visitors); fear of causing offence or resurfacing old trauma; not viewing FGM/C through the same eyes as the patient/service user; being perceived to be criticising the patient/service user’s lifestyle; sensitivity of the matter; not discussing FGM/C very often in clinical consultations; and feeling worried that the chosen terminology may offend women (midwives).

Figure 5.2: Barriers of discussing FGM/C and percentage among health professionals



5.7. Review of online FGM/C training resources against the needs highlighted in this survey

To evaluate the extent to which the gaps and needs highlighted by the health professionals in this survey study are covered in training programmes, this section compares the survey's findings against the content of the two identified training programmes.

Various training programmes have been developed that contain materials about and/or related to FGM/C (Table 2.2 in Literature review Chapter 2). From among the stated training programmes, two online training programmes (*NHS FGM/C e-learning to improve awareness and understanding of FGM/C* and *Home Office and Virtual College FGM/C: recognising and preventing FGM/C*) were selected for this evaluation because they were established by UK national institutions (the NHS and Home Office), they are free to access, and they target a range of professionals including health and social care professionals, immigration and border professionals, police, and teachers. The rationale for this review, as indicated in the Chapter 4 (Methodology) (section 4.6), is to evaluate the content contained in these two training programmes against the results of the survey, in order to identify gaps in the training programmes and provide recommendations for future training.

Each of these two online training programmes takes around two hours to complete. Although some professions have suggested compulsory FGM/C training for their cohorts, the training is generally not mandatory. Largely, the content of the two programmes under review in this study included: a definition of FGM/C; history of the practice; types of FGM/C; consequences of FGM/C; myths and misconception; global and local statistics; laws surrounding FGM/C; professional duties with regards to identifying, discussing, recording, reporting and caring for FGM/C survivors or those at risk; case studies/scenarios; and assessments. Details of the content included in each section of the two programmes are summarised in Table 5.6a (Appendix 15).

A previous review on the NHS training programme recommended frequent updating of the content in the modules: for instance, inclusion of prosecution cases, diverse terminologies, and regions where FGM/C is currently being recorded (Barrett, 2016). This content seems to be acknowledged and implemented in the current versions of the training programmes. However, when evaluating the materials in the two training programmes against the results presented in this survey study, I identified some elements that corresponded with the content of the training programmes, elements that were scarcely mentioned and would need to be emphasised more, and elements that were never mentioned and would need to be included, as summarised in Table 5.1.

Table 5.1: Review summary of the NHS and Home Office online training programmes against the survey study results

Element	Reference to the survey	Reference to the training programmes
Agreed with the content within the training programmes		
Referral pathways	• 80.0% of health visitors, 81.8% of GPs and 87.0% of midwives indicated that well-structured referral pathways are important in encouraging effectiveness of discussing FGM/C.	• The training programmes clearly display the pathways with descriptions of each stage and actions included in the pathways.
The law versus health complications	• Professionals participating in this study had more knowledge about the laws of FGM/C and also had more confidence in discussing the law than the health complications of FGM/C.	• There was in-depth coverage of the laws relating to FGM/C but only some explanations about a few health complications that arise from FGM/C in the NHS training programme. Neither programme provides

Element	Reference to the survey	Reference to the training programmes
		comprehensive details on the health complications of FGM/C.
Gaps that need to be addressed		
Knowledge about FGM/C	• 36.4% of GPs in this study and 13.0% of midwives indicated that 'limited knowledge about FGM/C' is a barrier to effective discussions. • 21% of professionals in the survey indicated that they had 'no knowledge' or 'little knowledge' in 'reporting known cases of girls under 18', thus affecting their confidence in carrying out that duty.	• Conflictingly, the training programmes are available for free. • The two training programmes cover mandatory reporting and recording; however, there are no detailed explanations of the step-by-step process to carry out these duties.
Presence of community organisations	• Half of health visitors (50.0%) and midwives (52.2%) thought the third sector presence could facilitate discussions of FGM/C.	• Although the Home Office programme contains the duties of various health and social care professionals, including teachers, the third sector is scarcely mentioned. Third sector duties and contributions have not been clearly highlighted in either of the programmes.
Availability/accessibility of online materials	• 30.0% of health visitors, 55.5% of GPs and 44.8% of midwives indicated that the materials available to them are not helpful in facilitating discussions about FGM/C.	• As the programmes are available online for free, a question is raised about whether the professional groups were aware of these programmes, or had accessed them at any time. The survey did not ask this question, so it

Element	Reference to the survey	Reference to the training programmes
		is impossible to say whether or not the professionals would have rated these two programmes favourably if they had accessed them.
Availability and accessibility of FGM/C leads	• From this study, 80.0% of health visitors, 72.7% of GPs and 80.4% of midwives stressed that FGM/C leads are helpful in facilitating discussions about FGM/C.	• Contrastingly, in the reviewed training programmes, FGM/C leads are mentioned only in the safeguarding pathways as consultants who are designated to guide any professional working on an FGM/C case.
Working environment	• Lack of private space was highlighted by the professionals in this study as a barrier to effective discussions of FGM/C (40.0% health visitors, 27.3% GPs and 45.7% midwives).	• From the two training programmes, very limited considerations were given regarding the working environment in the illustration videos where conducive environment for discussing FGM/C with patients/service users were described. The training programmes did not include suggestions of what to do if such environments are unavailable.
Fear of being labelled racist	• 20.0% health visitors feared this, thus interfering with effective discussions about the practice with their patients/service users.	• Professionals have been encouraged in both training programmes to tackle FGM/C without fear of being labelled racist or interfering with other people's culture.

Element	Reference to the survey	Reference to the training programmes
Feeling that the patients/service user is not interested	- 30.0% of health visitors and 13.0% of midwives thought that patients/service users are not interested in discussing FGM/C.	- The two training programmes have provided some case scenarios with examples of how to initiate conversations about FGM/C if a professional suspect that the patient/service user may be affected or at risk.
Language barrier	- 50% of health visitors, 90.9% of GPs and 87% of midwives in this study indicated that language is a significant barrier to effective discussion of FGM/C.	- The two training programmes have signposted to the use of interpreters but with no details on how to use them.
Never mentioned and would need to be included in training programmes		
Experience of caring for affected individuals	- Health professionals in this study (60.0% of health visitors, 72.7% of GPs and 78.3% of midwives) indicated that having experience of working with FGM/C-affected individuals enhanced the effectiveness of their discussions with patients/service users.	- Although the two training programmes in this review have outlines professionals' duties, there are no suggestions or discussions about the real-life practical application of this information.
Seminars and forums	- Seminars and forums about FGM/C were mentioned as considerable facilitators of discussions about FGM/C by 70.0% of health visitors, 54.5% of GPs and 60.9% of midwives.	- There was no mention or signposting to seminars or forums in the reviewed training programmes.

Element	Reference to the survey	Reference to the training programmes
Consultation time	• GPs in this study were most likely (63.6%) to indicate that time is a barrier to effective discussions about FGM/C. Only 30.0% of health visitors and 21.7% of midwives identified time as a barrier	• The two training programmes did not cover time management with regards to managing consultation time with FGM/C-affected patients/service users.
Personal safety	• 10.0% of health visitors and 18.2% of GPs indicated that they feared for their personal safety when it comes to discussing FGM/C with patients/service users.	• The two training programmes do not mention anything regarding the safety of health professionals, nor is there provision of a reporting or support pathway.
Fear of ruining patient and family relationship	• 10.0% of health visitors and 18.2% of GPs reported to be sensitive to the relationships of a patient/service user with other people, especially family.	• The two training programmes did not provide pathways that clearly suggest how to support patients/service users where family/community relationships are in jeopardy.

Although the results of this review reveal important concepts and principles that need to be included in the two training programmes, these results cannot be generalised to all other training materials. However, the results show the need for standardisation of content that should be present in all FGM/C training programmes.

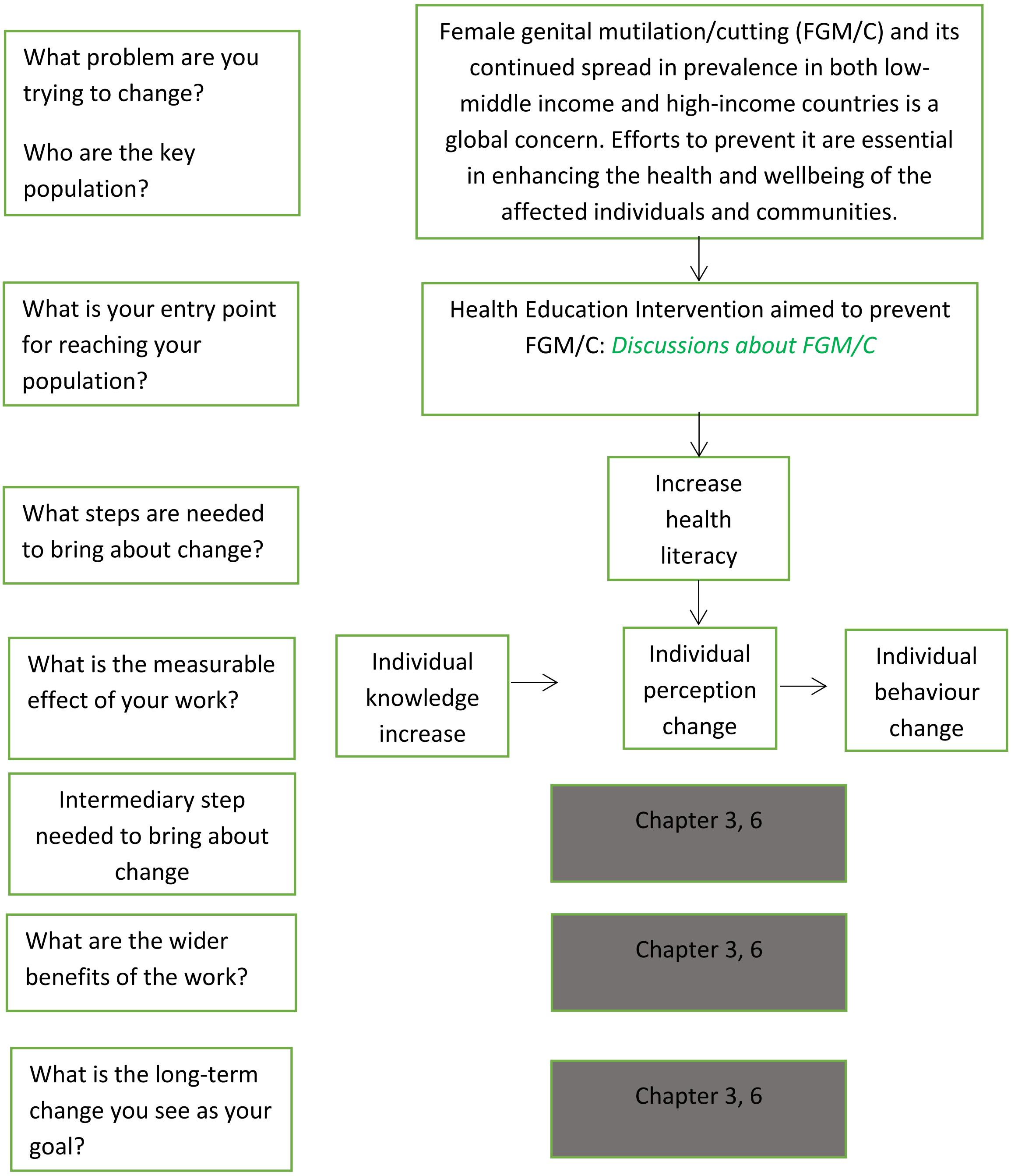
5.8. Conclusion

Health professional participants reported their experiences and opinions across seven measures captured within a survey. Sixty-seven health professionals responded to the survey, of which only three were males. The vast majority of the patients who were cared for by the health professional participants in this study were from ethnic minority groups. Health visitors in this survey were generally the most confident and knowledgeable group, with regards to the self-report measures in the survey, followed by the midwives, while GPs were the least confident and knowledgeable. There was a positive relationship between knowledge and confidence levels in all of the measures across all the health professional groups. ‘Well-structured safeguarding and referral pathways’ was the most selected facilitator among all the health professionals for discussing FGM/C. Language was the most common barrier, selected by over three quarters of participants.

The fact that only three male health professionals participated in this survey is an issue for exploration within a contemporary lens of intersectionality, which advocates for inclusion. Further, the different interconnected aspects mentioned in this study will be explored in Chapter 7 (Discussion) of this thesis.

This survey study has contributed to the development of the ToC (Diagram 5.1) for this thesis from a perspective of health education providers: in this case, health professionals. Health professionals are required by duty to discuss FGM/C with their patients/service users in order to educate, as well as investigate whether patients/service users are affected by the practice, and whether they require care and/or safeguarding. When health professionals discuss the practice with patients/service users, they are prompting change by increasing health literacy with regards to FGM/C. Health professionals in this study showed that personal knowledge and a conducive working environment would enhance discussions about the practice. This, in turn, would not only lead to an increase in individual knowledge about FGM/C, but also prompt changes in perception and behaviours among their patents/service users. However, as observed from the review of the two online professional training programmes against the results from this survey study, there are important gaps that need to be addressed in these programmes in order to facilitate effective conversations about FGM/C.

Diagram 5.1: Implicit theory of change in preventing FGM/C through health education interventions



After considering the experiences and opinions of health education providers, the following Qualitative Chapter (6) explores the experiences and opinions of recipients of health education interventions, who are from communities with a history of FGM/C.

CHAPTER 6

Qualitative Findings

Introduction

The main aim of this qualitative study was to explore the experiences and opinions of communities with a history of FGM/C regarding health and wellbeing programmes (HWPs) in which they have engaged. This chapter presents the findings (themes and codes under each theme as summarised in Table 4.4) that were retrieved from two focus group interviews (9 participants in total) and 12 individual interviews.

As explained in the Methodology Chapter (4) (section 4.6), framework analysis was used to extract codes. These codes were presented alongside their corresponding quotes from the transcripts in a framework matrix developed using NVivo 11. Thematic analysis was then used to group the identified codes and illustrate recurring themes. Six themes were developed and will be used as sub-topics in this chapter while discussing all the codes under each theme. After a brief presentation of demographics, the six themes will be discussed in the following order:

1. Programme approach, which involves components that relate to the organisation and running of HWPs.
2. Active communication, which involves the means by which information and messages are communicated. This also involves discussions about the responsibilities attached to communicating these messages.
3. Attitudes and beliefs that the participants expressed.
4. Social structures, which constitute the hierarchical organisation of societies in association with their impact on social differences.
5. Knowledge about FGM/C as discussed by the participants.

6. The future as described by the participants.

This study included 21 participants (18 women and three men). The average age of the seven participants who provided information about their age was 30 years. All the participants in this study lived in Birmingham, UK, and their countries of origin were from African and Middle Eastern regions. Their occupations ranged widely and included health and social care professions, education, business and charity work. Some reported to be unemployed, stay-at-home parents or students. While discussing the prevalence of FGM/C, participants shared their knowledge of some of the areas where FGM/C is practised, including Ethiopia, Ghana, Iran, Kenya, Mali, the Netherlands, Nigeria, Oman, Somalia, Sudan, Uganda, the UK, the USA, Yemen and Zimbabwe.

With regard to FGM/C health education, some participants spoke of their experiences in attending HWPs that specifically educated about FGM/C. Others, however, mentioned that they had never attended a programme that specifically concentrated on FGM/C, and that the subject was instead embedded within programmes covering topics such as domestic violence. Those who had never been to a specific FGM/C programme spoke of obtaining their knowledge from further reading and discussions with family or colleagues, as well as using the media and internet to research the practice.

The following sections in this chapter present participants' experiences and opinions of attending or engaging in these HWPs. Illustrative quotes are provided to support the themes. These quotes were selected among others on the basis of how well they represented the issue under discussion. The quotes cannot be said to entirely represent the experiences or opinions of the communities/region/social groups which the individuals come from or are currently associated with. This is because experiences and opinions are dependent on various sociodemographic factors such as education level, occupation and age, which would influence individuals' views of the HWPs (Woolley et al 2020, Waigwa et al 2018). Nevertheless, these quotes provide empirical evidence that is likely to resonate with individuals in similar social groups. Pseudonyms are used for each of the study participants to ensure anonymity. Participants' occupation, gender, region of origin and age (where given) are also provided wherever they do not compromise anonymity.

6.1. Programme approach

This involves components that relate to the organisation and running of HWPs. The subthemes under this main theme include the audience, facilitators, resources and handouts, venues, the number of HWPs attended by the participants and the topics covered in those sessions.

6.1.1. Audience

Chapter 3 (Systematic Review) concluded that for every awareness raising event there is a need for conscious consideration of the target audience, including their demographics and preferences regarding FGM/C HWPs. Failure to acknowledge these needs and differences in the audience can lead to poor realisation of the programmes' aims of raising awareness about the practice, and may result in backlash within some communities. Supporting the findings of the review, interviews in this study also revealed the importance of acknowledging the differences that exist in different audiences, which present diverse characteristics and needs. This was related to enhancing better relations with the audience and tailoring interventions to the correct and appropriate group of audiences, without generalisation of needs. The following quote by P007 illustrates the often-made mistake of failing to consider the audience, which may lead to inappropriate generalisation, thus affecting the effectiveness of the HWPs:

> *Who constitutes the audience and who does not? You know, so, there is that kind of struggle for what the state might think is good for everybody may not be right for a group who may be practising it.*

(Postgraduate Student, West Africa, Male, ID: P007)

A majority of the participants valued person-centred HWPs about FGM/C and the acknowledgement that individuals have different capacities to learn and understand. A few participants talked of varying audience capacities in terms of age differences. A young audience was thought to be more adventurous and would be more likely explore the subject in-depth than an older audience. However, participants advised that the content used to explain the subject matter should be age appropriate, because what adult audiences can understand will perhaps require further elaboration for younger audiences to comprehend. Participant P009 clearly illustrates this by recommending the individualisation of HWPs, such that they accommodate and benefit different people, without which the effectiveness of the programmes may be jeopardised:

> *If I am teaching my daughter, I don't expect to speak as I am talking to you, you really have to go to the level of the individual and you have to make sure it's individual based. If you group people there and you are just talking, obviously some will not follow what you are saying and it's a waste of time.*

(Care Coordinator, West Africa, Female, ID: P009)

Some of the participants explained the range of capacities on the basis of occupation, noting that if the audience consisted of educated professionals, the subject could perhaps be explained in a more detailed and professional manner, compared to an audience consisting of less educated individuals. This was also associated with professional duties and their roles regarding the subject; for example, some professionals may require more detailed information if their role requires them to attend to FGM/C affected individuals. The following quote by P002, an FGM/C worker/trainer, emphasises the importance of identifying professional categorisation in terms of knowledge and roles regarding FGM/C:

> *…so, when we go to GPs, we do stand-up when teaching them and it is only because we feel like the GPs don't have enough knowledge so we have to use that approach. So, when we go out to GPs we have a presentation, we make it very formal and we talk at them and we try to give them as much information as possible.*
>
> (FGM/C Worker/Trainer, Middle East, Female, Age: 28, ID: P002)

Some participants expressed the opposite, noting that since practising professionals should already be aware of the subject, then they should require only basic information, while less educated individuals or professionals who are less aware of FGM/C would require more details. Speaking from experience, P015 in the following quote suggests that the more clinically uninvolved the professionals are, the more information they should be provided with if HWPs are to be effective:

> *So, if I am talking to radiologists then I know we are not going to be talking about basic stuff. If I am talking to registrars or trainees or sonographers or radiographers then I know I have to explain a bit more like… so you need to tailor who speaks and what they say to who you are speaking to.*
>
> (Doctor, West Africa, Female, ID: P015)

As regards location, many participants agreed on the importance of reaching out to people where they are located, because only then will they accept the programme. Some participants related this to familiarity with the environment, which makes the audience feel safe and gives them a sense of belonging. This need of belonging also includes other people who attend the HWPs. The comfortable environment was linked to better audience participation in the programmes, as well as greater acceptance and support for the HWPs. Participant P009 highlights this point:

> *But if I come to you in your house, come down to your level and know you a little bit better, start from where we can communicate, then the person will grasp something.*
>
> (Care Coordinator, West Africa, Female, ID: P009)

Similarly, some participants highlighted that when giving feedback, the audience would appreciate polite responses that do not undermine their efforts to answer or ask questions. For example, participant P012 emphasised the importance of using polite language when providing feedback to audience members:

> *…even when people get the question wrong, it depends on who I am speaking to. But even if it's a professional that gets one of the questions wrong… I always direct back to giving them the impression that you know why they said it. But this is actually, right answer.*
>
> (FGM/C Worker/Trainer, East Africa, Female, Age: 28, ID: P012)

Participants spoke about the need to realise that not everyone in the audience would be interested in the subject, or what the programme is offering. There will be individuals who do not care about the subject and who may only be attending because it is compulsory, as a requirement for a course or profession, or who may be in the company of friends or even only present for the provided incentives. These individuals may be a hindrance for successfully delivering the message to others who may be more interested. It was also highlighted that although families/communities may have undergone FGM/C, they may not necessarily want any support or intervention with regards to FGM/C. This is partly because they may never have experienced FGM/C-related difficulties in their lives, or they may have more immediate needs that surpass FGM/C issues such as housing, domestic violence, finances, migration status or work problems. Having worked with communities affected by FGM/C, participant P002 explains the need to respect women/communities if they show no desire for support at that moment. Otherwise, forcing HWPs on them will not be effective:

> *But some of the women that we come across, they have had FGM, but they don't need help with FGM. FGM is the last thing that they have on their mind. They have a whole lot of other things like domestic violence or housing or finances. And you just have to respect that. Women are suffering with FGM, some women are not and some women want to do something about it, but some women don't and that's okay.*
>
> (FGM/C Worker/Trainer, Middle East, Female, Age: 28, ID: P002)

Some individuals in the audience may find it difficult to believe that their community would do anything to harm them. This may affect acceptance of the message, as described by participant P020, who argues that HWP providers should acknowledge the dilemma that information against FGM/C might prompt, which may in turn affect the effectiveness of the programmes:

> *…who wants to believe that their parents don't want what's best for them or the community doesn't want what's best for them. So, even with the education is that, there is that battle within yourselves where you are like "no one wishes me harm, no one does this to harm me".*
>
> (Postgraduate Student, East Africa, Female, ID: P020)

Some participants acknowledged that there may be individuals in the audience who have superficial knowledge about the subject. For instance, women may be aware of FGM/C, but they may not know any details with regards to the different types or the legal matters associated with the practice. Participant P002 is quoted below stressing that it is crucial not to assume the knowledge of audiences, even if they have undergone FGM/C:

> *So, when we sit down with the women, sometimes the women know of FGM, but they don't actually know what the different types look like…*
>
> (FGM/C Worker/Trainer, Middle East, Female, Age: 28, ID: P002)

With regards to the gender of the audience, some participants highlighted that there should be a mixture of men and women. On the other hand, others disagreed with this, expressing the view that because FGM/C is an issue that affects women and girls, the presence of men would hinder open discussion. It was also noted by some participants that although women may relate better to female facilitators, this should not result in the total exclusion of males in the audience. This issue is described by the following participant, P012, who speaks from an FGM/C trainer perspective; she notes that the effectiveness of HWPs would be compromised if the gender composition of the audience does not correspond with the audience's preferences:

> *It's a difficult thing, you know, a woman relates to another woman. And fortunately, I am not saying me delivering training should be all woman delegates; that needs to be mixed.*
>
> (FGM/C Worker/Trainer, East Africa, Female, Age: 28, ID: P012)

Some participants suggested that there is a general public assumption that peer influence is effective when it comes to tackling and discussing sensitive subjects such as FGM/C. They highlighted the difficulty of approaching their peers as well as getting them engaged in the discussions. Participant P020 describes explicitly in the following quote her struggles in trying to reach out to her peers, which affected the effectiveness of the intervention:

> *I tried it, I got my friend who is also a community champion (name of the person). And her friends and my friends we got them all together and me and (name of the person) were standing there actually saying that "so you guys what do you think?" everyone looked at each other…*

(Postgraduate Student, East Africa, Female, Age: 28, ID: P020)

On the other hand, some participants stated that an audience of individuals who were facing the same issues would understand each other better, thus encouraging them to discuss sensitive subjects such as FGM/C. Participant P002 points out that such groups can develop supportive relationships since they can relate to each other more easily, thus facilitating the effectiveness of HWPs:

> *...it is an opportunity for them to create relationships and to create friendships. Yeah, and because they have all gone through the same issue, I think it's easier for them to discuss it between themselves.*

(FGM/C Worker/Trainer, Middle East, Female, Age: 28, ID: P002)

Some participants noted that the country or area from which the audience originates should be considered, because some areas are more exposed to the message of FGM/C awareness than others. The differences between the rural and urban areas is expressed by P005 in the following quote, remarking that communities in rural areas may require more intensive interventions than urban ones:

> *People in the civilised country maybe in the urban setting, but in the rural setting, they still do it...so I think they need awareness in the grassroots.*

(Postgraduate Student, West Africa, Female, Age: 32, ID: P005)

6.1.2. Facilitator

The attitude of the facilitator was highlighted by the majority of participants as an important aspect that could risk backlash from the audience if perceived to be unpleasant or inconsiderate. The facilitator needs to approach the sessions with a non-judgemental attitude that recognises that other persons in the room hold their own views, while allowing the audience to share their perspectives and experiences. The following quote from participant P016 stresses that audiences may fail to fully benefit from the HWPs if the facilitators are patronising:

> *And in terms of facilitators…I think there is need to be very careful about it…And if you go there as if you are the know it all and you are superior and you are patronising and you want to liberate these women from this practice, they will not take it…*
>
> (Social Worker, South Africa, Female, ID: P016)

Compassion, sensitivity and patience were highlighted as desirable characteristics that facilitators should possess. Most participants noted that the presence of these attributes would encourage better relationships with the audience, which would in turn enable better communication, leading to successful education. It was noted that a facilitator needs to be someone who can be trusted by the communities, because they look up to them for information. This was associated with the communities accepting and respecting the facilitator, as explained by participant P010 in the following quote, who emphasises the importance of facilitators' consistency and patience:

> *…if you want them to gain knowledge about something, you should be very consistent and very patient. And the reason why is because they can see that you are passionate about it and then eventually with time they will actually try to, they will try maybe to understand it…*
>
> (Student, East Africa, Female, Age: 21, ID: P010)

Most participants agreed that facilitators who share their experiences of living with FGM/C are better at delivering the education because they talk from experience and not just from theoretical study. These participants noted that lived testimonials are best for expressing the pain and consequences of the practice, as the following quote from participant P004 indicates:

> *... If European people give these lessons, probably the theory they do it. But some people have this practice happen, I would prefer those people to give the course to train them because they know what they... they remember, they will say, "oh I was seven years old, I don't like remember that, I was crying, I was dizzy" ...*
>
> (Community leader, East Africa, Male, ID: P004)

However, some participants were sceptical about the feasibility of FGM/C survivors sharing their lived experience. This is because the facilitators might risk being labelled as incomplete, or as putting a face to FGM/C: for instance, if the facilitator is African, then FGM/C may be construed as an African problem, instead of the global issue that it is. Participant P011 in the following quote highlights one of the problems that facilitators who are FGM/C survivors might face, which may affect the effectiveness of HWPs:

> *...if she says "I am circumcised, it is not good to have it, stop it". People may think "you are unhealthy yourself" (laugh).*
>
> (Social Worker and translator, East Africa, Male, Age: 51, ID: P011)

Some participants suggested that having a facilitator without lived experience of FGM/C would not be a problem. They argued that one can acquire enough knowledge to be an expert in the subject, which gives them credibility. Participant P014 highlights in the following quote the importance of facilitator education on the subject:

> *...so sometimes, the person who would not have had experience, but because of education, the person like your doctor know a lot…because of education…*
>
> (University teacher, West Africa, Female, ID: P014)

The majority of participants noted that the gender of facilitators is a vital factor that needs to be considered when delivering education about FGM/C. Although preferences may vary depending on the gender composition, cultural/traditional beliefs and religious beliefs of the audience, participants indicated that a female facilitator would be most suitable for an all-female audience. When it comes to male audiences, it was suggested by some that the facilitator may be either female or male. Participant P012 explains this from her experience as a trainer, noting that since the practice is a gendered issue, then it would be inappropriate to have a male facilitator delivering the training:

> *I think it would be easier for the people attending the training to listen to a woman talking about the types of it, you know, especially if you think about the motivations that this is done for men, to control their sexuality. If a man is saying that it's a bit of a slap on the face to people.*
>
> (FGM/C Worker/Trainer, East Africa, Female, Age: 28, ID: P012)

The age of the facilitator was also noted as an important factor because, being a sensitive topic, there are some cultures that do not allow younger individuals to speak about such issues as FGM/C to older generations. The following quote by participant P010 explicitly demonstrates the struggles that a young person would face if they attempted to deliver any educative intervention about FGM/C to older generations:

> *To approach older people, I think someone from amongst them should speak to them, cos let's say I go to someone who is older than me and practices FGM, they will not listen to me cos they will think "oh that girl doesn't have any experience in life…"*
>
> (Student, East Africa, Female, Age: 21, ID: P010)

Regarding the area of origin, most participants indicated that facilitators are best coming from the same communities where HWPs are delivered. This is based on the belief that people find it easier to accept 'one of their own' since they believe that the person would understand the issues of the communities better than an outsider. Participant P019 comments on communities' preferences for HWP providers from a similar background to the audience, rather than from outside their communities, which would likely affect programme effectiveness:

> *That's where you guys (referring to researchers), because it's there in those communities, you go there and you need to-they will rely on you instead of someone coming from out like you said.*

(Sports instructor and translator, Middle East, Female, ID: P019)

However, some participants pointed out that when facilitators belong to the community, but have had some education from other communities, they may face backlash from their own community. This is because communities may believe that the facilitators have been 'brainwashed' and have been trained to extinguish cultures in their own communities. Participant P020 in the following quote shows the challenge of obtaining knowledge from foreign settings and returning to one's own community to share that knowledge. She suggests that the facilitator will not always be welcome because they may be regarded by community members as promoting foreign ideologies:

> *It's like the western ideology promotion that she is no longer part of the country…so she's left and now she's come back with an ideology…*

(Postgraduate Student, East Africa, Female, Age: 28, ID: P020)

In communities where the programme uses a language other than the local language to deliver education, the presence of translators was pointed out to be helpful. This is because most people may not benefit from the programme if the materials and discussions are not translated. In instances where translators are unavailable, it was suggested that the facilitator can translate the talks and the materials for the audience into an understandable language. This was associated with avoiding the risk of disengaging people who are unable to understand the content. This is described by participant P005 in the following quote:

> *...we just try to break it down for them in the language they understand. We speak our local languages there because most of them don't understand English. So, we come down to their level to explain things to them so that they can understand...*
>
> (Postgraduate Student, West Africa, Female, Age: 32, ID: P005)

Participants noted that it is important that facilitators are knowledgeable in the subject of FGM/C so that the audience can have confidence and accept what is being said. It would also help in breaking the stigma associated with the subject. Participant P020 in the following quote demonstrates the challenges that facilitators may face from audiences who require proof of their conversance with the subject (and if hesitant, this may affect acceptance of the HWPs):

> *...so now you are telling the "you know what, this is harmful. This is not something that you should do". The first thing that I would say if I was in that position is "then prove it". And even if you prove it that then depends on how well educated you are on the subject...*
>
> (Postgraduate Student, East Africa, Female, Age: 28, ID: P020)

Some participants highlighted the importance of including other topics in the subject about FGM/C, such that facilitators engage the audience without making them feel targeted. It was suggested that this would minimise the negative impact that such sensitive topics can have on individuals. This strategy was also noted to be effective in encouraging attendance and participation of the audience, as explained by participant P002 in the following quote. She suggests that the audience will remain more engaged and less targeted when presented with other interesting topics:

> *...she actually got a nutritionist too in and have like a little talk about diet and you know, nutrition and stuff like that. Something that's completely different, it has nothing to do with violence, just so that they don't feel like they've been targeted, do you get it?*

> *Like when you are just speaking about violence all the time, which can be a bit depressing.*
>
> (FGM/C Worker/Trainer, Middle East, Female, Age: 28, ID: P002)

Some participants spoke about the duty of facilitators to ensure that the audience is in a comfortable environment in which they can express themselves and share their experiences. This also includes the posture and body language of facilitators during the session. Some participants observed that it is better for facilitators to be at eye level, perhaps sitting among the audience. This was said to improve the experience both for the facilitator and the audience, as explained by both participant P002, as a facilitator, and participant P006, as an audience member, in the following quotes:

> *…so, we don't try and stand up in a presentation. So, we would sit down with them on the same levels and just talk about it as a discussion…*
>
> (FGM/C Worker/Trainer, Middle East, Female, Age: 28, ID: P002)

> *They were interacting well, they were standing and they engaged well with the audience and they used good body language.*
>
> (Postgraduate Student, West Africa, Female, Age: 25, ID: P006)

Some participants expressed the need for facilitators to be approachable during and after the session. This included making themselves available through emails to offer contact opportunities for audience members who require further assistance or information. Participant P006 in the following quote highlights the frustration of having facilitators who do not provide contact details, thus hindering further enquiries that would have perhaps led to improved outcomes from the intervention:

> *…if I had a question for that specific speaker, there is no way I would be able to reach or contact her. So, if she had like even a contact card that "this is my email if you want to reach us". So, that would have been nice in case we had more questions for them…*

(Postgraduate Student, West Africa, Female, Age: 25, ID: P006)

6.1.3. Resources and Handouts

Some participants suggested that their understanding of FGM/C was (or would be) enhanced by accompanying handouts which contained either the information that was delivered during the sessions, or more information that signposted the audience to other resources. Some participants argued that the choice of handouts should depend on the type of audience; that is, whether they are health professionals or the general public. Handouts should also be in the preferred language of the audience. Some participants mentioned that some of the handouts provided in their HWP were printed in English, which they preferred to their mother tongue because it made it easier to avoid some sensitive words that they felt embarrassed to use in their mother language. However, as noted earlier, participants felt that the handouts should be printed in other languages in order to accommodate other people who do not understand English. A number of participants shared their experiences of using handouts, expressing that they benefited from the resources and acquired more knowledge as a result. The handouts were also sometimes kept for individuals' personal records, containing notes from the education sessions and also contact details for available services. Participant P002 in the following quote acknowledges that care needs to be taken in distinguishing the needs of audiences and providing the materials that would serve them best:

> *…with the materials, we also have different materials that are handed out for different-depending on where I am going. So, with the GPs, the CCGs [clinical commissioning*

> *groups] have a set pathway, they have printouts for the communities and for the health professionals and they also have leaflets.*
>
> (FGM/C Worker/Trainer, Middle East, Female, Age: 28, ID: P002)

Other forms of handouts such as wrist bangles that contain messages about FGM/C were endorsed by some participants. These were favourable as they reminded them about the subject and also helped them to share the information with others. The benefits of such handouts are expressed in the following quote by participant P009:

> *...she used to wear lots of bangles and things like that. I even got one, she got- I love wearing things like that so I got one yes but not like a leaflet read or something…it was written on it, I remember it was green and with "help eradicate FGM" or something like that for creating awareness…I like displaying things, so probably someone sees it and is like "oh what is this?" I say "it's about FGM and what it is about blah blah blah" it might lead to a chat...I don't know where it is now.*
>
> (Care Coordinator, West Africa, Female, ID: P009)

Not all participants supported the idea of handouts, however, with some arguing that many people do not end up reading the materials and/or they lose them, as the above quote by P009 illustrates. Other participants admitted that they disliked having a lot of reading materials. Some, however, suggested that online content can be circulated because it is not easily misplaced and can be accessed any time after the sessions.

With regards to where handouts about FGM/C should be made available, some participants suggested public places where people congregate most, such as community organisations and libraries. It was noted that although handouts about FGM/C were often available in workplaces, this was not the case in communities. Participant P001 offers suggestions as to where FGM/C leaflets should be provided:

> *To give more like leaflets, information to give the people where they come mostly like here and the community for (name of community organisation) and where most people- they coming- and maybe in the library also. Some leaflets, maybe they can read and understand it.*
>
> (College Student, East Africa, Female, ID: P001)

Some participants stated that handouts such as flyers could be a suitable tool to help in sharing information, even to communities outside of the UK where FGM/C is practised. Others suggested that sometimes individuals will require more information than that contained within handouts. In the following quote, participant P008 suggests that when flyers are available, they will be shared in other countries where FGM/C is prevalent:

> *Give some flyers. Basically, hold events to talk about this and give them some flyers so they can tell families in Africa.*
>
> (Student, East Africa, Female, ID: P008)

6.1.4. Place and Venue of the HWPs

Most of the participants indicated that their HWPs were held in Birmingham, UK. Others noted that they have attended other programmes in different cities in the UK and other countries from around the globe. As to the specific organisations that hosted the HWPs or sessions, participants mentioned hospitals, churches, universities, colleges, schools, council halls, and charity organisations. However, there were some participants who indicated that they had not attended any HWP about FGM/C in Birmingham.

Participants provided opinions with regards to what they thought were the most suitable places to host HWPs, particularly in relation to FGM/C. Some had no preference and recommended that sessions should be held anywhere. Others added that venues should be accessible and should be able to accommodate different people, including those with disabilities and those with young children. Speaking from the experience of attending and organising several HWPs, participant P012 stresses the importance of venue proximity and accessibility:

> *I think venue wise I think somewhere where it's not far away from people would be good…Maybe have things available for different people with accessibility needs, like a lift should be there. And I think if possible, childcare provided, maybe some places like at the children centre.*

(FGM/C Worker/Trainer, East Africa, Female, Age: 28, ID: P012)

Some participants were particular about the number of people in a room, advising that the smaller the number, the better. This was regarded as helpful in encouraging people to discuss effectively. The venue should also be comfortable and safe, allowing the audiences to interact and discuss without feeling threatened by intruders or people passing nearby. Participant P012 explains this notion in the following quote, noting that privacy facilitates safety for the audience:

> *No, it should be a private room. You can do the training more appropriately. Because also, you know, like you've seen sometimes women feel safe to disclose their own experience and I think it's very inappropriate if another teacher just walks in and out in the middle of a woman talking about her experience, you know.*

(FGM/C Worker/Trainer, East Africa, Female, Age: 28, ID: P012)

6.1.5. Number of health and wellbeing programmes/sessions that individual participants have attended and topics covered

Participants spoke about the number of HWPs that they had attended, which ranged from two to many, such that they could not quantify. These programmes involved a range of health and wellbeing topics including FGM/C, child abuse, HIV, domestic violence, kidney diseases, parenting, mental health, marital rape, child marriage, social problems and youth, drug abuse/misuse, wound dressing, healthy eating and postnatal depression. With FGM/C, some participants specified that the topics included in the sessions were: the types of FGM/C, the consequences of FGM/C and/or health implications, legal issues of FGM/C such as human rights violation, statistics about FGM/C such as prevalence rates, availability of services, reporting FGM/C, recording FGM/C by health professionals, and ways to raise awareness. For domestic violence, participants indicated that the sessions had covered: identifying domestic violence, different types of domestic violence, health implications, reporting domestic violence, causes of domestic violence (such as culture, attention deficit hyperactivity disorder [ADHD] and alcohol addiction), availability of services, emergency contact details, and safety measures. Participant P014 explains the topics that were included in the HWPs that she had attended:

> *Mine was about parenting as well and I remember I attended one about mental health…the other one was more medical so it's about kidneys.*
>
> (University teacher, West Africa, Female, ID: P014)

6.2. Active communication (means and responsibilities)

This involves the means by which information and messages are communicated. It also includes discussions about the responsibilities attached to communicating these messages. The subthemes under this are: sharing knowledge that has been acquired from the HWPs, use of illustrations, language, disagreement with acquired knowledge, the media and professional duties.

6.2.1. Sharing Knowledge

Sharing of knowledge that one has acquired about FGM/C, regardless of the means of acquisition, was often discussed by participants in this study. Participants expressed their willingness to talk about their knowledge, either formally or informally, by sharing and spreading it to family members, friends, their communities and colleagues at work. Some participants also spoke of their willingness to share information with strangers. However, there were concerns about the strategies used to approach a potential audience. Some participants suggested that approaching communities through their leaders and using facilitators from their own communities would make it easier to engage the targeted audience. This is expressed by participant P004 in the following quote, where he highlights the importance of identifying and engaging key people in communities so as to reach target audiences with ease:

> *If you start calling people and say, "come this time, I will give you this". No, it's not going to work. It's not going to work…Yes. Key people. There are some people that have connections, followers… And then in that area you go from that way, that I think you can help the community.*
>
> (Community leader, East Africa, Male, ID: P004)

Signposting was mentioned by some participants as a solution in cases where the audience may require more information about the subject – for example, if facilitators did not possess this knowledge at the time. The importance of sharing accurate information was also emphasised. This was associated with the need to address widely held misconceptions that have contributed to the persistence of FGM/C. Some participants acknowledged that it may be an uncomfortable discussion, but in order to address misconceptions, the details of the practice and its consequences need to be shared. Participant P016 expresses in the following quote how misconceptions and inaccurate messages about FGM/C can be curbed:

> *…if I am not so sure, then maybe identifying other people who are more knowledgeable and linking, yeah making sign posting…*
>
> (Social Worker, South Africa, Female, ID: P016)

In cases of a defensive audience (that is, audiences who are protective of their culture and traditions), participants suggested that it would be appropriate to share the information anyway, citing that the information would not be harmful to the audience. However, most participants indicated that they had never encountered anyone who supported the practice. Some participants explained that people may want to preserve their heritage, and therefore refuse to engage, while others suggested that these individuals could be involved as facilitators, such that they would learn while engaging in the programmes. Participant P005 in the following quote explains why some people may become defensive, and highlights the importance of being consistent with the messages used to educate such people:

> *So, most things we encounter is that they are so rigid and they don't want to change. They feel that "my parent did it for me so why can't I do it for my child? At least I gave birth to this child and I don't have any difficulty. So, if I do it for her how will she have difficulty?" ... So, but they try to explain those things to them that if you are not affected that doesn't mean that your child cannot be affected.*
>
> (Postgraduate Student, West Africa, Female, Age: 32, ID: P005)

The taboo status of FGM/C as a subject has for generations made it difficult for people to share information. Some participants indicated that the subject was not discussed with their parents or grandparents, because of its sensitivity. Other participants shared their experiences of trying to talk with people who avoided engaging in conversations regarding FGM/C, and who had even left the premises if the subject was being discussed. Normalising the conversation, and emphasising that FGM/C should *not* be normal, was suggested as a way of breaking the taboo. The following quote by participant P019 illustrates the challenges imposed by the taboo, which makes it hard for people to share information about FGM/C:

> *I think it's a cultural matter, why? Because this is a very sensitive topic and not everyone would go and approach people saying it… I am very close to my mum. We go shopping, we do this, we do that, but this is sensitive, you don't talk about this stuff.*
>
> (Sports instructor and translator, Middle East, Female, ID: P019)

However, other participants stated that the topic was more sensitive an issue among some groups than others. For instance, some participants were more comfortable discussing FGM/C with their parents than with their peers, as illustrated by the following quote by participant P008:

> *It's not a kind of topic that you talk with your friends. I don't mind talking about it with my mum.*
>
> (Student, East Africa, Female, ID: P008)

Intergenerational information sharing was emphasised by participants as a vital step towards the elimination of FGM/C. However, some participants were sceptical about what information to share with children, especially if they were not confident that they had enough and/or the correct information themselves. Some participants indicated that sharing information about FGM/C with younger generations was important because, if their children were to marry into a practising community, they would be aware of the harms of FGM/C and could prevent it from happening to their own children. Some participants expressed the need for a good relationship between generations because only then would it become easier to discuss FGM/C. Participant P013 shares her experience in the following quote about attempting to educate her children about the practice:

> *What is… it's not been that easy, but I am all for it now. I will tell my children, I think it's important that they know because going back to where, if you marry somebody and*

> *they say, "well we need to go home you know with our daughters, if we go home you know oh this is performed and…"*
>
> (Retired Nurse, West Africa, Female, ID: P013)

The workplace was cited by some of the participants as an opportune place for sharing information regarding FGM/C with colleagues and service users. Some participants, especially those working (or who had previously worked) in health and social care environments, mentioned that they discussed FGM/C informally with their audience (usually colleagues), while others did it in line with their duties as professionals. Some participants recalled having discussed FGM/C with healthcare professionals who had cared for them as patients/service users. Others stressed that colleagues had a duty to inform fellow colleagues about the subject, using various means such as emails and social media. This is seen in the following quote by participant P015, who explains how her work colleagues are required to share information about FGM/C:

> *And one of the things that we do certainly, in my department, is that anybody that goes on a course or anything, has to come back and share it…The department is paying for you to go so you have to bring back that learning and share it. And what we try and encourage people to do is if there is any handouts or leaflets or anything, it's posted on the department… so that people can look into it and see it. And we always WhatsApp…*
>
> (Doctor, West Africa, Female, ID: P015)

Some participants felt that information about FGM/C could be shared everywhere; either in a public place or in a private space, either formally or informally. However, some participants felt that because of the sensitivity of the subject, sharing information about FGM/C should be in a comfortable place where the audience would not feel embarrassed or uncomfortable.

Participant P009 in the following quote expresses her views that information sharing on the subject of FGM/C should be possible everywhere:

> *Everywhere really. To me everywhere, everywhere, as long as it is open under discussion... This is where education starts really. So, everywhere in the bus, formal setting, informal setting, classrooms, everywhere that we can get… So, everywhere even at the toilet…*
>
> (Care Coordinator, West Africa, Female, ID: P009)

Some participants expressed the importance of including people from all genders, cultures and races. However, others felt that FGM/C information would be irrelevant to individuals from communities that do not practise FGM/C. It was also noted that when sharing information, there is a need to consider that males and females may perceive the programme and the practice differently, especially because it is an issue that mostly affects women. This may explain why men in some communities avoid engaging in discussions about FGM/C. Participant P009 in the following quote explains the importance of including all races in discussions about FGM/C:

> *Both whites and black, I am going to use that here, both white and black cos you never know when a black person might get in touch with this person so he might understand the story behind that person's cultural backgrounds.*
>
> (Care Coordinator, West Africa, Female, ID: P009)

Most participants noted that it can be difficult to find opportune moments to discuss FGM/C. Further, they noted the difficulty of finding the right audience as well as the right time to start a conversation about FGM/C. However, most participants expressed their willingness to discuss the subject should the opportunity arise. Others indicated that learning about FGM/C gave them the courage to initiate conversations with family members and friends, as participant P019 illustrates in the following quote:

> *... I feel I am more open. I am more stronger after the session that we received the information, I could discuss it with my husband, with my friends.*
>
> (Sports Instructor and Translator, Middle East, Female, ID: P019)

Participants' views of what would make information sharing more effective included consistency in engaging the audience. Many also suggested that facilitators should allow the audience to express their views, acknowledging that audiences may have information that an outsider may not have. Some participants noted the importance of facilitators' knowledge of the subject, in order for them to pass on the correct information. Other participants made suggestions for how to start conversations in a manner that would not offend the audience. Early education in schools was also suggested as an approach that would make the sharing of information about FGM/C easier. Lastly, the consistent sharing of information in community settings was recommended, particularly when this information is shared by facilitators. Participant P018 in the following quote recommends the incorporation of FGM/C into studies for young people:

> *If FGM can be incorporated in sex education and be taught at an appropriate age. Then that would help.*
>
> (Housewife former teacher, East Africa, Female, ID: P018)

Feigned compliance was mentioned by some participants as a barrier to sharing information effectively. Some noted that the fact that audiences listen to a facilitator does not always mean that they accept the message. In other words, it can be difficult to ascertain whether audiences are truly accepting the message against FGM/C, or whether they have only attended the programme for other reasons – for example, as a mandatory duty in the case of work-related programmes, or even out of fear of accusations of noncompliance. The following quote by participant P007 describes this notion of feigned compliance:

> *…it is difficult to know people's intentions, you know. So, from the point of view of what people are against or what they say would be different from what they actually do.*
>
> (Postgraduate Student, West Africa, Male, ID: P007)

6.2.2. Use of illustrations

The use of illustrations elicited varying views from participants. While some felt the use of illustrations would be appropriate, others disagreed. Healthcare professionals, for instance, need to know the details of the practice and what the operation looks like, including the complications that can arise from the procedure. Some participants argued that the use of illustrations to any audience would be a necessary tool that would encourage learning, especially in terms of recognising and differentiating the types of FGM/C. Instead of graphic illustrations that depict female genitalia, some participants supported the use of diagrams. Some participants acknowledged that though the use of illustrations may be embarrassing and shocking, it is necessary to make sure that the audience understands the subject, thus making the education more effective. Participant P010 in the following quote shares her experience of benefiting from illustrations used in one of the HWPs that she had attended (which she felt had been more useful than a commentary she had watched with no illustrations):

> *I had watched the commentaries, but they've never actually showed the types. I never knew there were different types. So, when she showed me the images I was quite interested cos I didn't know that…they were graphic, graphic yeah. And I think they need that shock…Yeah, they need… cos people just think that it's been so sensitive about everything, they just need a good shock…so that they can go home and they think "oh man that was actually… that was, that looked perpetually painful" that's what they should think.*
>
> (Student, East Africa, Female, Age: 21, ID: P010)

However, some participants felt that the use of illustrations, especially among audiences consisting of the general public, is unnecessary. Some referred to it as a disgusting gesture that can be off-putting and that detracts from the intentions of the programmes. Others explained that the use of illustrations would not be acceptable for community-centred approaches. These participants explained that it is hard to look at the illustrations, especially for individuals who may have undergone FGM/C, and that there is a risk of re-traumatising the audience. Participant P002 gives examples of illustrations that they have found inappropriate:

> *And because we are very community centred, we have decided not to have any blades on the leaflets or knives. Nothing like that…that is not acceptable to have such kind of things because it can bring back trauma.*
>
> (FGM/C Worker/Trainer, Middle East, Female, Age: 28, ID: P002)

The use of artificial models to show the different types of FGM/C was discussed by some participants as useful for helping those audiences who may have no understanding of how their genitals look, or how they should look. By using models, audiences would be able to recognise the different types of FGM/C as well as their consequences. Participant P002 explains in the following quote how models have been helpful in engaging audiences in HWPs:

> *So, we have a model, we actually got it from Africa, from an organisation in Africa, they sent us two models. We put the different types on and we ask the women, "Do you know what this type is?" Before we even talk to them about the different types. And you will be surprised because sometimes women would get it wrong...*
>
> (FGM/C Worker/Trainer, Middle East, Female, Age: 28, ID: P002)

6.2.3. Language application

The language in which discussions about FGM/C are delivered was a contentious issue among the participants. Some disliked the talks being delivered in their native language, because it made them feel uncomfortable and made it difficult to freely engage in the discussions. This was linked to taboos in their cultures. For these participants, using English made them feel more comfortable to discuss the subject as it allowed them to avoid the use of some words from their mother tongue that would be considered vulgar or rude to pronounce. They also noted that there are some words in the English language that cannot be translated into other languages without altering the meaning or becoming offensive. Participant P016 shares her experience of attending a HWP that covered FGM/C in her native language, which she indicates was uncomfortable compared to another HWP of the same subject delivered in English:

> *…and in this case just to explain a bit, even the delivery of that topic was in our language…The language where you don't say…but it's within our language, it's a no-go area…the work-related training, oh, that one was simple, it was English delivered.*
>
> (Social Worker, South Africa, Female, ID: P016)

However, some participants reported that they learn more when education sessions are delivered in their native language. They also noted that in order to reach more people, especially in a metropolitan area, the sessions should be delivered in a variety of languages. Failure to do so was associated with the risk of disengaging the audience, particularly if the language being used in the programme included medical jargon that would need to be explained. The following quote by participant P012 explains how using various languages eliminates the risk of disengaging and excluding people whose English is not proficient:

> *We use community's appropriate language. So, for example, I am from Somali community, so I would never say to them, "we will talk about FGM today", for example. I would speak to them the language they understand and also just make it simplified… because I don't want to risk disengaging and people feeling like you are just judging them or talking at them. Things like that, I might explain that "you know, medically,*

> *this is the term for it, but it basically means this and here is where you can access that service".*
>
> (FGM/C Worker/Trainer, East Africa, Female, Age: 28, ID: P012)

Showing compassion when delivering HWPs was noted to be vital to ensuring the acceptability of the messages being delivered. Quite simply, the politer the language, the more it is accepted. This was linked to the importance of acknowledging the differences that exist between communities, including social cues, sayings and words which may act as a barriers or facilitators. The following quote by participant P021 illustrates the importance of using polite language and being sensitive to what is acceptable in the communities:

> *Use simple understandable and polite language, as that's when they will listen to you. This is because it is a sensitive topic and you need to understand that you cannot just go in to the point.*
>
> (Support Worker, West Africa, Female, ID: P021)

The facilitator's body language was also reported by some participants to be important, because it may have an emotional impact on the audience. Appropriate body language from health professionals was also cited as being important: for example, a patient/service user may become upset if a health professional displays shock after recognising a case of FGM/C. Participants expounded that facilitators of HWPs should acknowledge that there may be persons in the audience who are affected by FGM/C, and therefore, they should always be cautious about their body language. The following quote illustrates an example of a woman who witnessed inappropriate body language from a professional, which subsequently affected her as a survivor of FGM/C:

> *The nurse was shocked because obviously she showed that she hadn't had the training and she expressed it with her body language. And what's worse is that she called in*

> *three other people to come in and have a look at it. So, the woman sitting there really confused with four faces just staring at her and really shocked. She doesn't speak much English…Yeah, being really cautious, your body language, your voice, I mean, if you hesitate when talking about FGM I mean, it's not the same as just comfortably talking about it. Just treating it like any other form of violence because it is.*
>
> (FGM/C Worker/Trainer, Middle East, Female, Age: 28, ID: P002)

6.2.4. Disagreement with acquired knowledge

Some participants expressed their disagreement with the messages that were delivered to them in HWPs. For instance, some Muslim participants disagreed with facilitators who associated FGM/C with religion, particularly Islam. They cited that religion does not support the practice and that it is a misconception that FGM/C is linked with religious teachings. Others disliked the terminology of 'female genital mutilation', noting that it is judgemental and stereotypical. They preferred 'female genital cutting or circumcision' because it is more inclusive and is used in many practising communities. Several participants found it difficult to accept the statistical figures about the prevalence of the practice in their own countries of origin. This was related to their lack of awareness of the extent of the practice among their immediate families or communities, which in turn was reflected in their doubts about its prevalence throughout the rest of the country. Some participants expressed disagreement with intervention procedures, such as the recording of new identified cases and attendees. This was associated with accusation and victim/survivor blaming that could result in fear, therefore hindering disclosures as well as discourses. Partial education of the practice (that is, where certain information is intentionally omitted) was referred to as prejudicial and misleading. Some participants shared their experiences of engaging in education programmes where only type III FGM/C was discussed, without any mention of the other types. Similarly, there were some disagreements with the assumption or implication that FGM/C only takes place in certain communities/countries; participants argued that this was unacceptable, highlighting that FGM/C is a global issue and can happen anywhere. The following quotes illustrate some of the above points, as discussed by participant P008 (regarding religion) and participant P006 (regarding partial coverage of issues):

> *They said that it is connected to Islam but I would stick, I disagreed with them like "it wasn't connected".*
>
> (Student, East Africa, Female, ID: P008)

> *I went to two other events about it cos we were trying to raise awareness. I still did not know that I was- cos when we were at the event they were only talking about the third level. They did not break it down…*
>
> (Postgraduate Student, West Africa, Female, Age: 25, ID: P006)

6.2.5. Media

With the growing use of media as a platform to communicate information, some participants expressed their experiences of using the media to acquire information about FGM/C, which they referred to as helpful. The availability of YouTube videos, as well as television programmes in the UK and abroad, was mentioned by several participants who reported using these resources to acquire more information about FGM/C. Videos depicting campaigns against the practice, individuals sharing their lived experiences of FGM/C, and commentaries and documentaries were mentioned by many participants. However, some participants were concerned that the information from these sources may be misleading, as illustrated by participant P010 in the following quote, which highlights that some commentaries omit information:

> *I had watched the commentaries, but they've never actually showed the types. I never knew there were different types.*

(Student, East Africa, Female, Age: 21, ID: P010)

Although participants were not against the use of media, some thought that the media is only appropriate for teaching a wider community. To effect change, individual-level interventions were recommended. Similar to the use of illustrations, some participants disliked the use of the media (especially videos) to showcase the practice, questioning the integrity of filming inhumane acts. Others preferred the use of videos to showcase lived experiences and consequences of the practice. Some participants felt that the media was helpful for attracting attention on a wider scale. Participants endorsed the use of the radio and other news mediums, including magazines and newsletters, to inform the public about current affairs such as court cases and proceedings, available training opportunities, and legal and political developments regarding the practice. However, due to public safety, some participants considered media documentaries to be limited, as certain details would not be possible to broadcast. Participant P007 mentions the challenges of using the media to discuss the topic of FGM/C, as some approaches can be ethically ambiguous:

> *So, on one hand there is appeal for you to be part of the fight against the practice and on the other hand you also see the moral aspect of it, whether it's right to even film such a thing, you know.*

(Postgraduate Student, West Africa, Male, ID: P007)

Social media was noted to be popular among younger generations as they use it to acquire information and advocate for issues they care about. It was also emphasised by some participants that older generations may not be as technologically literate as their younger counterparts, and equally, not everybody has access to certain technology (such as computers).

6.2.6. Professional duties

Professional duties in relation to FGM/C were discussed by a number of participants. Over and above discussing FGM/C, social workers, for instance, were noted to have a duty of safeguarding children. Some participants shared their experiences where they or their colleagues attended cases that involved investigations and actions against FGM/C. These included cases where families had been banned from travelling, because the social workers considered it risky for young girls. Counsellors were cited as playing an important role in counselling FGM/C survivors, especially in relation to trauma and social withdrawal. Health professionals, including general practitioners, nurses, midwives and gynaecologists, were mentioned due to their clinical roles: for example, deinfibulation, childbirth by women who have FGM/C, recording and reporting of cases. Professionals who work with issues that pertain to FGM/C were regarded as good resources of information about the practice. As a social worker, participant P016 shares an example of social workers' duties with regards to communicating information about FGM/C:

> *…when a mother goes to give birth and they pick up that she was– it has been done to her, then they need to alert us, social services so that we know…*
>
> (Social Worker, South Africa, Female, ID: P016)

In addition, educators were commended for incorporating FGM/C discussions into other topics. Politicians and community leaders were regarded as pivotal in the implementation of interventions in communities, because they are responsible policy-making and decision-making. Teachers were also mentioned due to their involvement in safeguarding, especially where there are suspicions of school girls travelling to an FGM/C-practising country with their families. The police were mentioned due to their involvement in investigations and safeguarding cases about incidences or suspected cases of FGM/C. Translators were also noted to be helpful in facilitating communication, especially for individuals who are not fluent in English. The roles of religious leaders were also emphasised, which included educating their congregations about and against the practice, especially where there are misconceptions regarding the association of FGM/C with religion. Participant P020 in her quote below highlights the role of police in enforcing the law in communities:

> *…the police is on to us and if you don't know the law, it's the biggest thing that could be used against you as a weapon because you don't know where you stand.*
>
> (Postgraduate Student, East Africa, Female, Age: 28, ID: P020)

6.2.7. Specialised services and collaborations

Participants mentioned the importance of collaborative working between professionals such that there are sufficient services that persons affected by FGM/C can access, and without getting misdirected or inappropriately referred. However, it was mentioned that although the services may be available, the majority of people are unaware of their existence, and therefore make less use of these services. Participant P012 explains from experience in the following quote how women miss out on accessing specialised services:

> *…a lot of women want further help that they didn't know they were able to access even after they've had several children. For the first time maybe going to a specialised service. "So, actually maybe I can get some help for these symptoms"*
>
> (FGM/C Worker/Trainer, East Africa, Female, Age: 28, ID: P012)

6.3. Attitudes and beliefs

This section involves attitudes and beliefs that participants in this study expressed in relation to the following subthemes: reasons for attending HWPs; sex education; feelings towards the programme; feelings towards the practice; disclosures of undergoing FGM/C; and religion.

6.3.1. Reasons for attendance

Participants talked about their motivation to attend HWPs relating to FGM/C and other health topics. Some of the participants attended because it was suggested by another person who highlighted the importance of the subject. Others engaged in informal discussions with colleagues, family members or friends that inspired them to want to learn more. The following quote is an example of a participant who attended because someone else raised the subject:

> *Someone wanted us to know about FGM…it was mainly Zimbabwean women and it was to increase our awareness because we don't know much about FGM.*
>
> (Social Worker, Southern Africa, Female, ID: P016)

For some participants, their attendance was part of their professional duties. This was mainly to enhance their skills to deal with FGM/C or other similar issues encountered at work. Some mentioned that they required personal development to become trainers, while also learning from other people attending the HWPs. Some participants indicated that they had personal interests that inspired them to attend HWPs. Advertisements about the education sessions were also mentioned to have encouraged attendance to HWPs. Participant P004 in the following quote demonstrates that he attended HWPs about FGM/C due to his duties as a community leader, as he was often required to coordinate community events that involve subjects such as FGM/C:

> *Even my organisation, we have done one time in schools and there is also… there is this lady in girls' schools who called me and said she want we do this session together as an organisation…me and my other colleagues who are helping people, we have been trained in safeguarding, like see the certificates of the training. So, it's very important for me to have the training.*
>
> (Community leader, East Africa, Male, ID: P004)

6.3.2. Sex education

Sex education was discussed by participants in relation to its similarities with education about FGM/C. Some participants highlighted the importance of using the right materials to enable the audience to acquire accurate information. Lack of proper consideration of the materials used for educating about sex was highlighted as a reason for parents to remove their children from sex education in schools. Deciding on the appropriate age of education was also pointed out, because taboos in some communities have resulted in conversations about sex being banned, especially when young children are involved. This has spilled over into schools where there are disagreements about whether it is appropriate to educate children about sex and related subjects such as FGM/C. The following quote by participant P011 illustrates the dilemma that leads to heated conversations about sex education:

> *…there is a discussion going on here in this country, teaching the sexual education in schools. Some people are saying no, we are learning, we are teaching how to do it indirectly. But some people are saying "no, we are stopping spreading the disease and the consequences of being pregnant". So, it's always come up with arguments.*
>
> (Social Worker and translator, East Africa, Male, Age: 51, ID: P011)

Participants talked about challenges encountered when sex education is delivered. Some recounted their experiences from when their parents tried to educate them, including uncomfortable feelings because of the taboos in their communities. Some also expressed difficulties when attempting to educate their own children about sex. For example, lack of simplified terminologies that their children can understand. Participant P019 in the following quote describes the difficulties she experienced when her parents tried to educate her about sex, and also the difficulty she has in educating her own children:

> *…But, when I got married, (laugh) my mum never came, she tried several times, but I pushed her away. I had no idea what, I am 19 years old when I got married, I had no idea what I was going into… I had no idea what's going on. So, he (husband to be) said to my mum, "does she know, you know?" and my mum said "no I haven't had this discussion". So he tried and I was in tears, I was crying. I really was crying. I didn't know, it was really shocking, I didn't understand anything.…when my son was old and we need to educate… you know, just informing, I said to my husband "Alhamdulillah, thank god, he is a boy, it's your duty, I will not do this" ...It's- even if I had a girl, I wouldn't do it.*

(Sports Instructor and Translator, Middle East, Female, ID: P019)

Due to the lack of proper and timely sex education, participants highlighted the challenges they faced when discovering the body changes during puberty, as expressed by P018 in the following quote, which shows her shock and confusion:

> *I got married without knowing anything, even when I got my first period you know, it was a bit shocking and you know everything…exactly, so, I don't want my daughter to be in that position, like me not knowing anything...so, I have start talking about things with her in simple ways, explaining, so.*

(Housewife, Former Teacher, East Africa, Female, ID: P018)

6.3.3. Participants' feelings towards the education programme

Participants expressed their attitudes towards HWPs about FGM/C, ranging from the venue setup, the composition of delegates, the topics delivered as well as the means of delivery, including the facilitators. Some participants highlighted that the topic may cause audiences to feel embarrassed. Some of the participants disliked the subject and did not like engaging in discussions regarding FGM/C, while other participants expressed a lack of interest about the subject. Some participants felt that it was unnecessary to keep talking about FGM/C, especially with family members. Participant P008 expressed her dislike for the mode of presentation, the facilitator and the subject in the following quote:

> *…they put PowerPoint in it and that's it. It was not a teacher especially from our school. But I don't remember I forgot what it was all about...The subject that's it, I don't like the subject.*
>
> (Student, East Africa, Female, ID: P008)

There were participants who mentioned that it was not useful for FGM/C survivors to use their stories in HWPs, because the attention tends to move away from the subject to the person, as P012 explains in the following quote:

> *So, I think with FGM sometimes people forget that actually, if you are the trainer, it's not useful to talk about your experience. If you do, people may feel like all of a sudden you are all the same and then you know, it becomes less about the training session and more about people's stories.*
>
> (FGM/C Worker/Trainer, East Africa, Female, Age: 28, ID: P012)

Engaging discussions were metioned by a majority of participants to be beneficial. This is because the audience is provided with the opportunity to share their views and experiences. Some participants also explained how the use of quizzes helped the audience to be more engaged. The following quote by P006 shows the benefits associated with using quizzes to challege the misconceptions of the audience:

> *…they asked more stereotypic questions trying to figure out what we would answer and yeah, I found it very interesting. ...but it made it seem real when we see the statistics of how many people and also when people learn, cos we only learn- someone can stand*

> *and give information but when you have a quiz, it kind of gives you an opportunity to pick an answer that you think is right and then when they tell you that "this is the right answer", then it seems more clear to you because it challenges what you think you know. So, I found the quiz probably the best part of it. Yeah.*

(Postgraduate Student, West Africa, Female, Age: 25, ID: P006)

It was noted that some individuals may begin discussions that can be inappropriate for the occasion or type of audience. Participant P003 gives an example in the following quote about the dangers of not considering and filtering questions/discussions in relation to the audience:

> *I can tell you about the conference that I attended yesterday, and there was women that had made some very challenging… some challenging I would say, enquiries, in the conference and I think as a listener, as a fellow person who was there, the reception or the way I received that was like this is not the time and place. I think sometimes, certain comments can, you know, can be addressed later on and not sort of in a crowd…challenging school that these children are from I don't think that was very appropriate.*

(FGM/C Worker/Trainer, East Africa, Female, Age: 25, ID: P003)

The more detailed the HWPs, as reported by participants, the more satisfied they were with the information they acquired. This is expressed by participant P019 in the following quote, where she compares two HWPs and considers the more detailed of the two to be the more satisfying:

> *…that was interesting. But then it wasn't too proper, and it was just roughly like different kinds of types but you don't know exactly. But the one at (name of organisation) was very good. I got a lot of information…I was- until today, the different types is still in my mind.*

(Sports Instructor and Translator, Middle East. Female, ID: P019)

6.3.4. Feelings and attitudes towards the practice

Although the participants in this study are from FGM/C-practising communities, all of them expressed a negative attitude towards the practice. They proposed a need to globally abolish the practice, terming it as sad, bad, sensitive, fragile, scary, not a good thing, not nice, having no benefits, not good for health, and harmful to mankind, especially women. Some participants were against the idea of practising less harmful FGM/C types, noting that there is no better way of doing it, other than to stop. It is difficult to know people's intentions, because of feigned compliance, which some of the participants expressed as a challenge for interventions. The evidence that in most practising communities, women are the core drivers of the practice was found to be unacceptable by some participants. Some of the participants shared their experiences about their first encounter with information about FGM/C, and highlighted that their initial reaction was shock, especially when they learnt that the practice is prevalent in many other different countries across the globe and not just in Africa. Also, finding out that FGM/C is practised in their country of origin as well as the diaspora was 'appalling' to some. Knowing that the practice is falsely associated with religion, but it is still practised by people on the basis of religion was considered 'depressing'. Some participants were surprised that there is more than one type of FGM/C. Because of the impact of the subject, some participants suggested that FGM/C should be discussed together with other subjects such as domestic violence, because it is depressing to talk about in isolation.

Participants expressed that they or people they know have lost interest in finding out more about FGM/C because they think that they know enough, or that it is not a big deal since they come from communities that practise it, and because it is related to culture. The following quotes are examples of the views provided by participants P009 and P004 with regards to their feelings about the practice:

> *…it's a barbaric practice that will need to be addressed, if not, stopped or try to address or find a better way. What better way can we find really? There isn't a better way. Full stop, stop it.*
>
> (Care Coordinator, West Africa, Female, ID: P009)

> *…it's not good things. Am opposite with this. I don't like people doing this. So that's why I'd love people to help to prevent.*
>
> (Community Leader, East Africa, Male, ID: P004)

6.3.5. Disclosures of undergoing FGM/C

Four participants (P001, P006, P015 and P021) disclosed that they had undergone FGM/C. Two of these women expressed that they have had problems during sexual intercourse and the delivery of their children, while the other two said that they have never experienced any major negative consequences. However, they declared that the reason for this could have been because they were not enlightened enough about the practice and therefore could not have attributed some consequences to FGM/C. One of the latter two mentioned that she did not know that she had FGM/C until her husband told her. All four participants spoke about their determination to enlighten others and safeguard their children against the practice. Two other participants (P004 and P012) talked about family members who had undergone FGM/C and how they have seen them struggling with its consequences. They also mentioned that they have educated them about the practice and told them about available support, but they expressed that it is challenging to keep speaking to family members about the practice, because of the taboo. Another participant indicated that there had been instances when, after sharing information about FGM/C, the audience decided to disclose that they had undergone FGM/C, despite not being prompted to do so. This was discussed in relation to providing people with a safe environment where they feel comfortable to disclose. It also becomes an opportunity to offer services or further education, including correcting misconceptions which the audience may hold regarding FGM/C. The following quotes are examples from the participants who disclosed their FGM/C and its effects:

> *…even in my mind, I said "no" because I have experienced it…And I don't, I haven't seen any problem about myself, but maybe I don't understand. I had to go though and see and then slowly, slowly I understand it's like more disadvantages than advantages…*
>
> (Support Worker, West Africa, Female, ID: P021)

> *So, and I have three girls, but I never do that, because I know what is happen when they get married and think, my life, it has also affect me.*
>
> (College Student, East Africa, Female, ID: P001)

6.3.6. Religion

Some participants related FGM/C to Islam while some did not agree with the relationship of the practice to any religion. Some participants shared their experiences of living with the misconception that the practice only happens within Muslim communities. For example, the following quotes from participants P014 and P006 illustrate their misconceptions that the practice is related to Islam:

> *…most of these Muslims, it is a must that it should be done.*
>
> (University Teacher, West Africa, Female, ID: P014)

> *My parents, my mum never spoke about it and I thought that it was a Muslim thing. Which is why I said, we need to break that religious assumption cos I thought it was a Muslim thing and I was like "no my parents never do that or anything" … it was a rite*

> *of passage and it was to do with my culture, cos I am Catholic, so it's not even anything religious.*
>
> (Postgraduate Student, West Africa, Female, Age: 25, ID: P006)

6.4. Social structures

This theme considers the hierarchical organisation of societies and their relationship with social differences. The subthemes included under this theme are gender issues, generational differences, ethnic differences, marriage, and cultural awareness.

6.4.1. Gender issues

Gender was discussed by some of the participants who spoke of the inequality and discrimination that females often face in communities that practise FGM/C. Some participants suggested that the main reason for FGM/C is to benefit males. Participants highlighted that females were not as important as males in some communities; therefore, everything was done to benefit males, including marriage and the acquisition of basic education, in which girls are not a priority. The following quote provides an example of the perspective of females in some communities in which girls often miss out on education opportunities:

> *...girl child education wasn't a big thing for some Muslims, not all Muslims, but for some Muslims. You know, because the argument then was that no matter how much we invested in a girl child education, she will be married off... you know, girls matter, but they don't matter much... but then if you educated a boy, he came back, he comes back to the family, to support and to build the family.*
>
> (Postgraduate Student, West Africa, Male, ID: P007)

Another issue that was raised involved male facilitators, where some participants saw this as unacceptable, because FGM/C is done to females and therefore male facilitators may not be suitable to deliver a talk about the practice. Participant P015 provides some examples of when a female professional may be preferred to male, because of the issues at hand that seem to be better understood by women than men:

> *…it's a bit like in the world people who have not finished school, you know… (laugh), having period problems and things and they'll go and will see a male gynaecologist and the gynaecologist goes "well periods…"- they know nothing about periods…I think it would be difficult to have a man talking about it…*
>
> (Doctor, West Africa, Female, ID: P015)

Decision-making, usually undertaken by males in the communities that practise FGM/C, was discussed by some participants as a vital factor that determines what families will and will not do. Some participants therefore saw no logic in empowering females in such communities, because their decisions are often overlooked. Some participants also noted that in some communities, older women have more power to make decisions. In some cases, it was these older women who presented their daughters for FGM/C, rather than the girls' fathers. However, some participants also noted that there are instances where men may discourage women from pursuing FGM/C. Yet, as explained by participant P021 in the following quote, women generally hold more power than men when it comes to FGM/C matters, and men rarely want to be involved:

> *And here, we don't have, I don't know any men who can push you to do it because back home you can have your mother-in-law, all the family they pushing you. To put pressure on you…In my country, women have even a high position about the FGM because with the research we understand something because the men there don't want to talking about FGM because… it is intimate. For them it's intimate…*
>
> (Support Worker, West Africa, Female, ID: P021)

Some of the participants shared their views of circumcision/cutting, in general, as an act for distinguishing between males and females. Other participants noted that FGM/C should not be discussed among females only, but also males, because it affects both genders, either directly or indirectly, in the present or in the future. Participant P009 provides an example of how she views FGM/C with regards to gender differentiation:

> *…it's like it's a must, a girl has to pierce ears, that's the distinction between a girl and a boy. So, I believe then FGM- maybe the decision between a girl and a boy is FGM.*
>
> (Care Coordinator, West Africa, Female, ID: P009)

6.4.2. Generational differences

Generational differences were expressed as a concern when it comes to discussions about FGM/C and other topics that are linked to taboos, including sex education. Some participants did not endorse younger individuals delivering education about FGM/C. In most of the communities that practise FGM/C, elderly people are respected more. Some participants therefore suggested encouraging older women in the communities, who are against the practice, to educate others in the communities. Sharing her experience of educating older audiences, participant P012 gives an example of the reaction she receives in such instances and how she handles such situations:

> *So, the response is always positive and maybe surprising as well. They see me so quiet, probably think that I am a lot younger than I am, I get that a lot…they were looking at me like their little daughter, you know, so that they- but I was giving them, saying, and I kept- and they respected it: "... So, let's not- today what we are going to talk about, don't look at it as I am old, you are young..." I just put- I mean you see the looks, and sometimes they will call you auntie and things like that, but you just have to tell them "look, I am here to deliver the training…"*

(FGM/C Worker/Trainer, East Africa, Female, Age: 28, ID: P012)

The superior status that elders (who are usually older members in the communities) possess, makes it difficult for the younger generations to initiate changes in these communities. They are also denied power in decision-making. The following quote by P019 shows a scenario where the older generations have power over the younger generations:

> *So, they said that "well in that case, you could go to Sudan and you have those two daughters, they are at their grandma and they could do that and you don't have a word there, right?" He (father of the daughters) said "oh, no now I am more, I now understand, I know what it is". Cos she- mum has had it done and they, the grandma took their older daughter, but the two younger ones hasn't. And they didn't allow him to travel back to his country during summer.*

(Sports Instructor and Translator, Middle East, Female, ID: P019)

The younger generations were described by some of the participants as being more amenable to change than the older generations, who choose to be more conservative to their traditions and beliefs. Younger generations are also able to understand more quickly the information provided about a subject than their older counterparts, which some participants suggested highlights the need to educate the older generations more than the younger ones. Some participants described how, in their experience, there is very little conversation about sensitive subjects such as FGM/C between generations. However, some of them said that they are willing to start conversations with their children. The following quote reflects these differences between the younger and older generations:

> *…if you are talking to a group of young children or school-aged children who have grown up in this country and they know how to talk about…than talking to older women who would mostly still be willing to be conservative…*

(Doctor, West Africa, Female, ID: P015)

With regards to experiences and knowledge about FGM/C, some participants noted that older generations are expected to know more about FGM/C and its consequences through personal or community experience. However, some of participants acknowledged that, although the practice is reported to be prevalent in some communities, even the older generations seem to have no knowledge about FGM/C, because it never happened in their immediate families. For some families, only the older generations experienced FGM/C while the younger ones have not had FGM/C. However, some participants indicated that the younger generations, especially those who have not had FGM/C, have little knowledge and are unwilling to engage in education about FGM/C. Another explanation was that the subject is discussed less among younger generations because sensitive topics such as FGM/C are simply not openly discussed. Participant P020 indicated that younger generations are often unconvinced that FGM/C can happen in their generation or the next:

> *…yeah, we are not concerned that it's going to happen to our kids because it- because the practice skipped a generation for us, it skipped a generation. But because the generation gap is us, we don't think it's a big deal because for us to see it, we are millennials (quoting her friends).*

(Postgraduate Student, East Africa, Female, Age: 28, ID: P020)

6.4.3. Ethnic differences

Those who have experienced FGM/C seemed to have differing perceptions with regard to other people, especially between races and ethnic identities. Participants indicated that an individual may feel judged by people who are not from a practising community. The patriarchal social structures of some ethnic groups were suggested to be a driving force of the practice, because women and girls are often discriminated against or not prioritised in terms of acquiring basic education and making decisions with regards to marriage. However, in some ethnic communities, the older women dominate in decision-making about marriage and practices such as FGM/C.

Several participants indicated an absence of FGM/C among some ethnic groups in countries/regions that are known to have a high prevalence of the practice. With regards to community willingness to accept and engage in intervention activities, some participants expressed a difference between ethnic groups, citing that some groups prefer not to take risks and therefore would easily accept change. In contrast, other ethnic groups are fearful of that influences from other cultures might cause them to lose their identity; therefore, they resist change. This was linked to conflicting ideologies where some ethnic communities would not accept Western ideologies. This extended to resistance against facilitators from their own communities who are believed to be promoting Western ideologies by 'brainwashing'. Participant P018 suggests that her community readily accepts and engages with interventions, unlike other communities:

> *We as a community, as in, we don't take risks… (laugh)Yeah, we are kind of yeah, we are not like Somalian. Somalian people are a bit tough…we said "it's not legal", stopped immediately. So, it's different with our community.*
>
> (Housewife former teacher, East Africa, Female, ID: P018)

Participants indicated there is a need to recognise that enablement strategies would require more effort, funds and expertise in some ethnic communities than others. Based on evidence that FGM/C is practised differently and for different reasons in different ethnic groups, some participants pointed out that there is a risk of linking FGM/C with specific ethnic groups, which can result in missed opportunities to reach out to other ethnic groups that are not associated with FGM/C. This was linked to failure of recognising the potential presence of FGM/C in non-practising communities, who could be experiencing practices that are known by other names and done for different reasons, but which still fall under FGM/C categories. For instance, they gave examples about plastic surgery of female genitals that apparently cannot be performed on 'brown' people. The stigma that results from these plastic surgery procedures discourages the 'brown' women from seeking support, out of fear of rejection.

Some participants mentioned that practising communities might be unaware of other practising communities among diaspora, including in the UK. However, they were concerned that these ethnic communities could influence the way FGM/C is practised, thus adopting other ways of practising FGM/C. Some participants associated the ethnic differences (in relation to FGM/C) to socioeconomic and sociodemographic differences. They pointed out that to some extent, education levels, occupation of parent(s) and locality (urban, rural, diaspora/integration) of the ethnic groups affected their knowledge about the practice, and thus influenced the rate of its occurrence. Participant P020 explains this by questioning whether communities have found a way of practising FGM/C together, or whether they have influenced each other in the way it is practised, despite the previously known differences between them:

> *I think that is where the globalisation aspect of it comes from, but it- different people have been to different places…and they are practising here, the question would be, does Iraqi know there is a Somali, where are they getting it from?*

(Postgraduate Student, East Africa, Female, Age: 28, ID: P020)

6.4.4. Marriage

The discourse of marriage often focused on patriarchal dominance in the practice of FGM/C. Participants noted that males are often the beneficiaries; that is, the modifications of FGM/C are for men's pleasure, while females experience the negative consequences. For that reason, having a male facilitator who is married to one of the women in the audience was seen as inconsiderate, and for him to facilitate education about FGM/C was unacceptable, because he would not be speaking from an empathetic perspective. FGM/C was reported to be largely carried out on girls in order to reduce infidelity in marriages, because sex would be painful for the female partner. Participants pointed out the trauma that women experience during the first phases of marriage, as they experience horrific pain, with some having to get deinfibulation afterwards. This is because most cultures do not allow deinfibulation before marriage, which is disappointing to the newlyweds. The following quote by P001 explains that due to FGM/C, there are many problems in marriage:

> *...there is lots of problems when they marriage. They get the problem the first time.*
>
> (College Student, East Africa, Female, ID: P001)

The view of marriage as losing a girl to another family has led to less attention being paid to the needs of girls in some communities. This has resulted in less investment on girls than boys, including healthcare and enrolment into basic education. The consequences include diverting attention to grooming girls for marriage, which includes practices such as FGM/C, and culminating in social problems such as child marriage. Cross-cultural marriages were mentioned by some participants as a growing trend between practising communities and non-practising communities. They spoke of the importance of extending health education regarding FGM/C to non-practising communities, such that they may be aware of the practices in other cultures, and so that they may be able to safeguard themselves and their children. Some participants expressed that there should be no alarm or concerns for individuals who want to marry someone from a practising community. They shared their experiences with their partners who are from practising communities, and yet they are against the practice. Those married to partners from non-practising communities who are educated about FGM/C referred to them as educative, protective and understanding. However, the in-laws could pressurise the married couple, though participants stressed about the need to educate everyone so as to empower them for such instances of family pressurisation. Participant P017 shares the view of her sister who is keen to educate her children about FGM/C in case they marry someone from a practising community:

> *… (in educating children) my sister was saying that it's for instance if our children that are born here are to marry somebody who comes from Africa or wherever and they try…take your child back home to do this thing…*
>
> (Customer Care, East Africa, Female, ID: P017)

Some participants suggested that parents should educate their children before they leave to get married, noting that if they do not get the right information from their parents, they will find it from other sources that may not be accurate. Communities and intervening organisations were proposed to educate parents and support them in early education about FGM/C for their children.

6.4.5. Cultural awareness

FGM/C was discussed by most of the participants as a cultural practice that is mostly upheld by embedded cultural beliefs. In some cultures, it was described as a means to distinguish males and females along with other practices such as the piercing of ears. Because cultural beliefs are deeply ingrained in communities and are a form of identity, some participants referred to this as a barrier to change with regard to FGM/C. This was related to the challenges associated with changing people's perceptions about the practice, especially when it has been a part of their culture for generations. It was suggested that education of cultural diversities should be extended to the public, such that people are aware of what happens in other cultures. This was emphasised by participants, especially with regards to intercultural marriages that may require partners to engage with new cultural beliefs and practices.

The cultural environment within which individuals reside may or may not facilitate the practice. Some participants mentioned that the urbanised cultures are less likely to encourage FGM/C because of acculturation, the availability of state institutions such as children's services, other services such as charity organisations for women, and facilities that facilitate reporting and action against the practice such as the police. However, the rural cultural space can uphold the belief that there is a rationale for the practice, especially due to cultural pressures. Being culturally sensitive when intervening in issues that are culturally determined such as FGM/C was suggested by participants. Without cultural sensitivity, interventions face the risk of backlash from the target communities.

Pragmatically, some participants observed that FGM/C is a cross-cultural practice and that there is no one culture with which it can be singularly associated. This was discussed on the basis of different types of FGM/C, such as genital piercing (Type IV), which is potentially reported to happen even in previously non-practising communities. Overemphasising the cultural sensitivity of FGM/C was stated to risk alienation of discussions about the practice, because it ceases to be linked with other types of abuse, and may therefore be avoided. The following quotes are representative of the discussions among the participants on the above issues related to the cultural aspect of FGM/C. Participant P004 demonstrates how culture can be a hindrance to accepting change, and participant P012 emphasises the importance of cultural awareness:

> *…there is time I remember in Holland that somewhere has been advised to operations before they marry but sometimes culture does not allow it.*
>
> (Community leader, East Africa, Male, ID: P004)
>
> *It's very important to be aware of each other's cultures, traditional practices, without judging each other.*

(FGM/C Worker/Trainer, East Africa, Female, Age: 28, ID: P012)

6.5. FGM/C knowledge

This theme is about the knowledge of FGM/C as discussed by participants in this study. The subthemes included: lack of knowledge, doubts of own knowledge, reasons for FGM/C, prevalence of FGM/C, consequences of FGM/C, when FGM/C is carried out, and FGM/C legalities.

6.5.1. Lack of knowledge about FGM/C

Some participants did not have knowledge regarding some of the ‘benefits’ of FGM/C as described by various communities. Others mentioned lack of knowledge about FGM/C among the general public and about the negative impact of the practice, which enables the practice to continue. For example, the following quote by participant P015 shows her belief that there are no ‘benefits’ associated with FGM/C to a man:

> *I really don’t know how it would benefit any man initially.*

(Doctor, West Africa, Female, ID: P015)

A few participants discussed that most women have no knowledge of their bodies and especially the reproductive system, as illustrated in the following quote by participant P017 who described two FGM/C survivors who did not know what their genitalia looked like:

> *I watched embarrassing bodies and there were two girls there, took a photo of them and they molested one of them and then they said which one do you think she was, and you know they both got it wrong, they didn’t know what they looked like…They said “actually, that’s yours” but who sits in a mirror and look at…*

(Customer Care, East Africa, Female, ID: P017)

Some participants expressed their experiences of professionals' illiteracy with regards to FGM/C. They noted that it is traumatising to the patient, who expects the professional to be aware of the condition and be conversant with the procedures to assist the patient. Participant P012 gives an example from experience in the following quote, demonstrating the struggle faced by a health professional while caring for an FGM/C survivor:

> *I mean, even student nurses are not trained on it at university... I was supporting the FGM clinic and there was a student shadowing in the clinic…she had to insert a catheter and she couldn't because the woman had type III FGM and she did not know what it was. She just couldn't insert it and she didn't understand so she called the doctor. Imagine the woman waiting not knowing…*
>
> (FGM/C Worker/Trainer, East Africa, Female, Age: 28, ID: P012)

6.5.2. Doubts of own knowledge

Interestingly, most participants showed a great deal of concern about the level of knowledge that they personally possessed, indicating that they were not confident enough. They doubted that the knowledge they possessed was correct or sufficient to share with other persons. This was highlighted as a barrier to initiating conversations about FGM/C because they felt that one has to be completely sure of what they are sharing to avoid misconceptions. Although they possessed some knowledge about FGM/C, some of the participants indicated that their doubts about their knowledge was a result of not having attended a HWP that specifically educated the audience about FGM/C. Other participants mentioned that they could hardly remember anything from the sessions that they had previously attended. Participant P013 shares her lack of confidence in the knowledge that she has about FGM/C which affects her sharing of information with others:

> *I wouldn't feel uncomfortable passing it on people, but you've got to just be very clear on the information you are passing on and and…that's it really, I think.*
>
> (Retired Nurse, West Africa, Female, ID: P013)

Some other participants questioned their abilities to share their knowledge, indicating their uncertainties as to whether they can communicate in an understandable manner or if they are qualified to educate others. Some participants indicated that they were willing to share their acquired knowledge, and for the information that they may not know, they were willing to signpost their audience to the right resource. The following quote, from participant P003 (who is a trainer), is an example of participants feeling inadequate to share information about FGM/C:

> *…but it's my personality, but I don't like talking at people. It can make people feel intimidated and you know I am not a teacher, I am just someone who just wants to educate people rather than…*
>
> (FGM/C Worker/Trainer, East Africa, Female, Age: 25, ID: P003)

Participants largely expressed their doubts about their knowledge with regards to the prevalence of FGM/C. Some questioned evidence of the practice continuing in the 21st century. Other participants were unsure that the practice happened in other communities, as explained by participant P011 in the following quote showing his unawareness about the prevalence of FGM/C in his region of origin:

> *…is tricky, yes. But, nowadays, Somali community, I think it's nearly eradicated in Somalia, nearly in Somalia. But, I am no sure Somali people living Ethiopia or Kenya did the same…? The government tried to do to eradicate this practice and it was really successful. But after that, the religious people take over campaign but what I am not sure is, as I tell you, there is always Somali people living in Kenya, Somali people living*

in Ethiopia…Somali living even in Djibouti, Somali in Tanzania, but I am not sure if that is eradicated.

(Social Worker and translator, East Africa, Male, Age: 51, ID: P011)

6.5.3. Reasons for FGM/C

FGM/C is practised for different reasons in different communities. Participants shared their knowledge regarding the reasons that FGM/C is practised. Some of them recognised that the practice is done to reduce pleasure for girls so that they are not promiscuous. It is also carried out as rite of passage. It was also associated with providing more pleasure to men during intercourse. Some participants spoke of the practice as an expectation by men in the family, especially the father, and because women often do not have power to oppose men's decisions. Also, it was reported that it is done to fulfil traditions/cultural obligations, and to protect family pride. As a taboo subject, FGM/C is not discussed within communities. Having few prosecutions in relation to carrying out the practice was linked to the continuation of FGM/C. However, inconsiderate and harsh laws were said to be a risk of forcing the practice to operate underground. In such situations, nobody would be willing to discuss it because of the consequences attached to the practice. However, other participants said that a lack of strict laws that ban the practice is encouraging its continuation. The following quotes show some of the reasons for FGM/C, in relation to it being a rite of passage (P016) and lack of enforcement of the laws (P015):

…the women are involved because culturally it's a passage, they believe it has to be done.

(Social Worker, South Africa, Female, ID: P016)

They get away with it (laugh). Nobody, I don't think anybody has ever been prosecuted for it. Nobody's talked about…

(Doctor, West Africa, Female, ID: P015)

Some of the participants mentioned that it is performed because of religious demands, but others disregarded the notion that the practice is linked to any religion. Some participants said that it is because of lack of education that the practice continues, but others suggested that even educated individuals who are not fully against FGM/C continue to practise it. Pressure from the extended family was mentioned, where the decision-making power lies beyond the parents of the young girls. Participant P013 describes religion as part of the reason why FGM/C continues:

> *...it was just done as a religious kind of culture and they didn't realise what the outcome would be.*

(Retired Nurse, West Africa, Female, ID: P013)

Rebellion against Westernisation was highlighted to be common, such that any intervention linked to the West will not be easily accepted, resulting in rejection of anti-FGM/C messages. In the same vein, some participants observed that some people are just not interested in anti-FGM/C information, therefore making it difficult to effect change, which then leads to continued practice. Lack of alternative sustainable income-generating activities for cutters was noted to be a reason for them to resort to the practice. Participant P021 in the following quote explains the attitudes that communities may have against Westernisation, where they reject even those from their own communities who are promoting a foreign idea:

> *"The West come to tell us what we do". You know it's getting difficult for people with good education, they say "no, just West give money to the government and the government want us to leave our intact identity".*

(Support Worker, West Africa, Female, ID: P021)

Lack of information and education because of inadequate coverage by interventions, especially in areas predominantly occupied by practising communities, was highlighted as a risk allowing the continuation of the practice. Missed opportunities by professionals who fail to perform their duties with regards to FGM/C (such as asking every pregnant woman about FGM/C, especially those from FGM/C practising communities) was also said to potentially encourage the practice. The locality within which a community resides may also make them unreachable, such that interventions and laws against the practice may not effectively benefit them. The lack of inter-generational conversations was also considered to lead to misinformation between generations, again resulting in the continuation of the practice.

6.5.4. Consequences of FGM/C

All participants were aware of at least one of the consequences of FGM/C for women and girls. Some participants stated that some women do not experience any of the consequences. However, all participants acknowledged that the practice has no health benefits and that the operation itself is risky to undertake, thus causing short-term and long-term consequences that are physical, psychological and social. Participants discussed the consequences based on the knowledge they had acquired from HWPs, further research that they had individually engaged in, and from personal experiences of having FGM/C, or the experiences of immediate family/community members (Table 6.1). Some participants insisted that the complications are more recognisable when the operation is not performed properly.

Table 6.1: Consequences of FGM/C as discussed by participants

Physical consequences	Psychological consequences	Social consequences
Difficulties while walking	Trauma	Withdrawal

Difficulties with sexual intercourse	Emotional baggage	Ostracization (linked with fistula)
Infections (including internal organs)	Post-traumatic stress disorder	Problems in marriage
Fistula	Flashbacks	Imprisonment
Difficulties in childbirth	Depression	Outcast
Pain	Fear	Negative impact on relationships
Numbness		Stigma
Bleeding		
Death		
Difficulties with menstruation		
Difficulties with urination		
Disability		

The following quotes explain some of the above-mentioned consequences, with participant P007 explaining physical consequences and participant P019 explaining psychological consequences:

> *…some of the instruments that are used for the practice you know may not be sterilised enough. So, chances are that it may lead to infections…there was the issue of fistula, you know, especially if the wounds fail to heal properly…*
>
> (Postgraduate Student, West Africa, Male, ID: P007)

> *…even if it is something mild, it's trauma, it's traumatic stress disorder. It could be flashbacks, it could be in the future…it gets into depression. So, we are talking, not physically, but mentally, how this could affect. It's traumatic. So, you will have this for the rest of your life.*
>
> (Sports instructor and translator, Middle East, Female, ID: P019)

6.5.5. When FGM/C is carried out

Participants shared their knowledge about when FGM/C is typically carried out. Their discourse involved ages that ranged from young to teenage girls. Some of them mentioned that it is a rite of passage, when young girls are approaching adolescence, they are subjected to FGM/C. Girls in some communities have FGM/C before the onset of their first periods. Other participants specified that FGM/C can happen when girls are eight-to-ten years old at the latest. The following quotes by participants P016 and P015 show the participants' explanations of the practice happening as a rite of passage for a woman, and before the time a girl gets her first period:

> *…the women are involved because culturally it's a passage, they believe it has to be done. If it's not done to you, then you are not a full woman.*
>
> (Social Worker, South Africa, Female, ID: P016)

> *…certain parts of the culture that believed that it was the right thing to do when girls, usually done by the time she has her first period, soon after that they do it.*
>
> (Doctor, West Africa, Female, ID: P015)

6.5.6. FGM/C legalities

All participants expressed that they are aware of the illegal status of FGM/C in the UK and that it is regarded as a global human rights issue and child abuse. They indicated their awareness that the laws against FGM/C are not very old, but they did not know the specifics of the times that the laws were enacted. Some participants were unsure whether the practice is illegal in all the practising countries. However, it was mentioned that even in places where the practice has been banned legally, the laws do not stop communities from practising FGM/C. The reason given was that the enforcement of laws is almost inexistent in most countries, and there are few prosecutions, as expressed by participant P015 in the following quote:

> *...And even though it was illegal, it was still very widely practised…even though it was illegal...it is still illegal... But they still do it (Nigeria).*
>
> (Doctor, West Africa, Female, ID: P015)

Although most were not sure how many years of sentencing are issued under UK laws, some participants suggested that the jail term and punishments attached to prosecution of FGM/C perpetrators should be long and harsh enough so that they can act as a lesson for other potential perpetrators. For instance, some suggested taking children away from the family would act as an effective punishment and lesson, because no parent/family would prefer to have their children taken away from them. However, education was preferred to prosecution, with some referring the latter to be the least effective intervention to eradicate the practice. This was linked to fears that criminalisation of the practice would encourage FGM/C to continue underground. Although there has only been one prosecution in the UK that led to a sentence, in March 2019

(Dyer, 2019), some participants acknowledged that the complexity of the issue makes it difficult for perpetrators to be convicted. Some participants also mentioned that it is illegal to perform FGM/C abroad and return to the UK. Some shared their experiences of dealing, in their work duties, with cases that involved families that were banned from travelling abroad to countries where FGM/C is prevalent, because professionals anticipated that the girls were at risk of mutilation if they travelled. Knowing about the law was regarded by some participants to be helpful for families who may face pressure from their communities, and this knowledge could be used as a tool to protect individuals from being forced to perform FGM/C on their daughters. Many participants argued that education about the law is important, especially to new migrants, because most people may not be aware of the illegal status of the practice, and they may perform it without knowing.

6.6. Better future

This theme is about the future as described by the participants in the following subthemes: best practice, and safeguarding the next generation.

6.6.1. Best practice

In addition to previously reported suggestions, participants' ideas of best practice of HWPs regarding FGM/C covered a range of aspects that should be considered for any programme to be successful in delivering the intended message to a target audience. Providing an alternative to the practice, for instance, is recommended as a way to help end FGM/C. The substitute should be functional and effective enough to replace the perceived purpose of the practice. It is important to ensure that the alternatives provided to communities are sustainable, even after the programme has been withdrawn from the community. This is well explained in the following quote by participant P021:

> *As FGM is done for identity, the cutters earn a lot of money from the procedure and if the organisations should stop giving alternatives that are short live for only two or so years because then the cutters will go back to cutting when the alternative source of money runs out.*
>
> (Support Worker, West Africa, Female, ID: P021)

Empowering women was discussed by some participants to be vital in the fight against the practice. This is because women directly suffer the consequences of FGM/C, but they are also known to encourage and perform the practice on girls. Participant P005 in the following quote explains the importance of empowering women with education, which she claims would reduce the prevalence of FGM/C:

> *…empowering our mothers, because if they empower them, I don't think they would want to do this practice. If they empower them and if they take care of the female children and they see that because they are occupied doing something, they don't have time for boys as their parents will put that they are doing it to prevent them from getting pregnant early so that they won't enjoy sex, so that any man will not penetrate. So, I think if these girls can be occupied doing things, maybe there is school education.*
>
> (Postgraduate Student, West Africa, Female, Age: 32, ID: P005)

Safety of the audience and those who participate in the programmes was mentioned as a measure that requires attention, especially when providing handouts. This is because some of the audience may come from families and communities that could become hostile if they found out that the individual has been engaging in programmes or organisations that are against the communities' cultural practices. Safety was also discussed in relation to having a comfortable environment where the audience can freely discuss their experiences without fearing being heard outside the room. Participant P012 explains the importance of being cautious when providing handouts to audiences, as the information may put them in danger from their families or communities:

> *For some women having that information that says domestic abuse is this, that and the other, if they are in that situation it is dangerous to keep that…We try and keep it as private as possible for her safety.*
>
> (FGM/C Worker/Trainer, East Africa, Female, Age: 28, ID: P012)

Setting professional boundaries within the HWPs is vital because when working with communities, there is a risk of over-familiarisation between the audience and the facilitators, which can sometimes be a hindrance to effective delivery of the programme. The following quote gives examples of how professional boundaries could be breached:

> *…professional boundaries and confidentiality because those lines could get blurred in the community. People, you know start to familiarise themselves with the person, so all of a sudden, they might want to take your personal number. They might want you to drop them off somewhere, maybe borrow money. These things professionally are not possible and I think that once people know that, they will be like "oh that's fine" …Yeah, you just set the boundaries and that's all there is.*
>
> (FGM/C Worker/Trainer, East Africa, Female, Age: 28, ID: P012)

Understanding human anatomy, especially of the reproductive system, was regarded as a vital topic that requires covering in HWPs about FGM/C. This is because of the impression that women do not have enough knowledge about their own bodies, which then has been a shock to some individuals who have undergone FGM/C when they find out that their anatomy differs from the norm. Participant P002 explains in the following quote why women are unaware of their genital anatomy:

> *I think women don't know their anatomy and they don't know how they are supposed to look obviously. Coz they've looked this way their entire lives.*
>
> (FGM/C Worker/Trainer, Middle East, Female, Age: 28, ID: P002)

The availability of support services was mentioned by some participants who spoke of the importance of providing information to the audience about the various support services that are accessible within their area, or by providing them with contact details, including emergency phone numbers for use in cases where advice or intervention is needed. Participant P003 suggests in the following quote that people should be provided with information about the support services available to them:

> *...and I think specifically in terms of FGM and I also think it would be good if people were more aware about the support services that already existing.*
>
> (FGM/C Worker/Trainer, East Africa, Female, Age: 25, ID: P003)

6.6.2. Safeguarding the next generation

Participants discussed their concerns regarding safeguarding the next generation against the harmful practice. Most of the participants expressed the urgency of developing ways to ensure that the practice does not continue. They suggested that it is an alarming situation when a woman from a practising community delivers daughters, because they may decide to continue with their cultural practices. Some of the participants told of their experiences of the existing safeguarding strategies, such as health professionals at the pre- and postnatal clinics, who are required to enquire and educate appropriately about FGM/C. The use of referral pathways should be clear as professionals will then be able to enquire and educate aptly about FGM/C.

Others spoke of the roles of parents in educating their children regarding FGM/C, but they expressed a lack of confidence and doubted their knowledge about the practice. For this reason, some participants suggested the need to train specialists who can educate children and young people regarding the practice. However, there was a suggested prerequisite of informing and briefing the parents before their children were taught, such that they are aware of what their children would learn about. Professionals have a role of ensuring protection of the next generation of girls against FGM/C. Normalising discussions about FGM/C were recommended, so that the taboo can be broken and more people get to know about the practice, thus safeguarding the next generation. Involving men in the processes of educating about FGM/C was also regarded as important because they play a role in safeguarding their daughters since they are, in most cases, the decision makers in their home. Some participants also mentioned the role that the law plays in banning the practice which, when effectively enforced, would safeguard generations from experiencing the practice. Participant P015 in the following quote shows the need for awareness raising when a woman from a practising community delivers a baby girl:

> *She may have a girl and they take up their culture…and that's why they need to be aware.*

(Doctor, West Africa, Female, ID: P015)

Participant P006 in the following quote notes the importance of educating men, who in the future would safeguard girls and women at risk of FGM/C:

> *…if educate more men…they can play their role as parents in the future or as fathers whereas that does not-they don't put pressure on their wives or if their wives have cultural pressures to do this coz of the system, they can be like "no, not my daughter, it ends with you, don't pass on to my daughter*

(Postgraduate Student, West Africa, Female, Age: 25, ID: P006)

To ensure that all communities are reached by support services, participants noted that there is a need for more funding for support services – both government and non-governmental organisations. This would encourage the establishment of more support services and workers, meaning that extensive awareness raising and care of those affected or at risk of FGM/C could be implemented. Participant P003 explains the shortage of workers in the following quote:

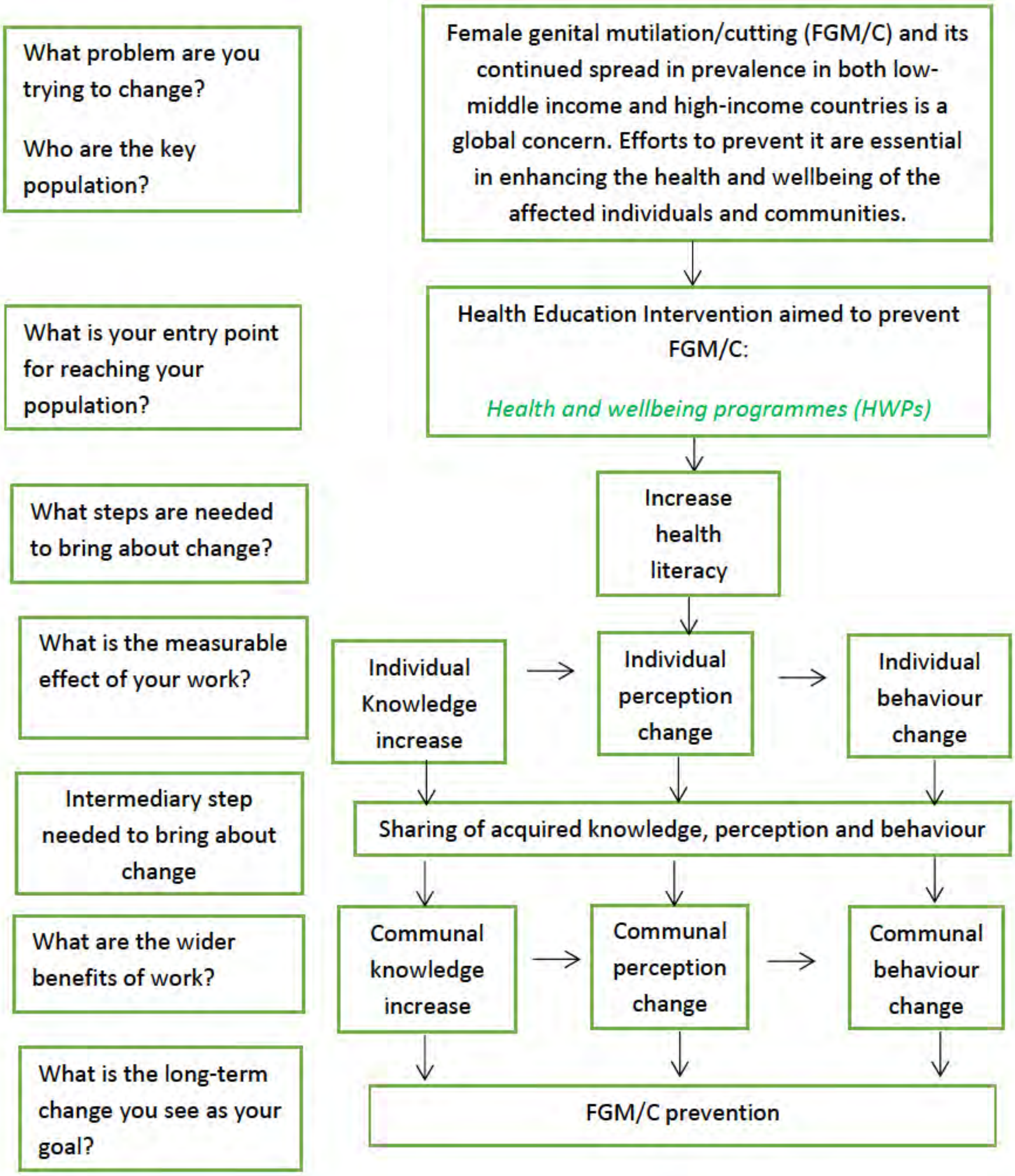
> *I think perhaps more funding can go into doing FGM work. To have FGM specialists who can go out and do community engagement work coz I think that at the moment there isn't many of us. There is quite a shortage and I think that although the notion of FGM is attracting more attention now, I don't think that there is necessarily much help out there.*
>
> (FGM/C Worker/Trainer, East Africa, Female, Age: 25, ID: P003)

6.7. Conclusion

This chapter has presented the qualitative findings as discussed by participants regarding HWPs. Their experiences and opinions have been extensively discussed under six themes: programme approach, active communication, attitudes and beliefs, social structures, knowledge about FGM/C, and the future. These themes have several sub-themes expounding in detail the participants' views. The themes are further explored in the next chapter (Discussion, Chapter 7) which integrates themes derived from the studies in this thesis under the elements of intersectionality. This qualitative chapter in particular has highlighted issues that intersectionality explores including: social structures that influence gender issues and generational differences, which seem to weaken the cohesion of communities when dealing with issues such as FGM/C; culture, including cultural competence, which is advocated for the purpose of reducing discrimination; and media, including platforming of FGM/C issues which aim to reach many populations, thus reducing inequalities. These aspects and more will be explored in the next chapter.

The qualitative findings in this chapter also contribute to the Theory of Change (ToC) for health education interventions from a recipients' perspective. Having attended one or more HWPs, the participants in this study shared their experiences and opinions about the programmes, which are part of health education about FGM/C, aiming to prevent the practice. The process of preventing FGM/C is reflected in the ToC, Diagram 6.1. This shows the required steps to bring about change in communities. It begins with increasing health literacy about the practice through HWPs. Participants in this study suggested a few strategies to encourage individual participation in programmes, such as embedding FGM/C talks in other subjects, and being conscious about the composition of audiences and the characteristics of the facilitators. These are crucial for increasing individual knowledge, and encouraging change in their perceptions and behaviours. Sharing of information was found to be difficult by most participants, for instance, because of doubting their own knowledge about FGM/C. However, it was highlighted as a compulsory step for reaching other community members, thus increasing communal knowledge and encouraging communal perception and behaviour change, which will eventually lead to prevention. There was also an emphasis on proper timing of HWPs, especially with early intervention in schools, and through parents for when children are still young.

Diagram 6.1: Implicit theory of change in preventing FGM/C through health education interventions



*Proper timing of each action

*Evaluation of every step

CHAPTER 7

Discussion: Integration of Findings from all Phases

Introduction

This chapter synthesises the findings presented throughout this thesis in an important ‘integration’ phase that draws on intersectionality theory. The main aim of my research, as stated in Chapter 1, was to explore health education interventions locally and globally, in order to illuminate the aspects that affect the effectiveness of health education interventions that are intended to prevent FGM/C. This was explored through three phases. Phase one was a systematic review of the literature about the effectiveness of health education in the prevention of FGM/C; phase two was a survey about health professionals’ experiences in discussing FGM/C with their patients/service users; and phase three was a qualitative study about the experiences and opinions of communities with a history of FGM/C regarding health and wellbeing programmes/sessions.

As an overlapping concept has been observed throughout the previous chapters, the following discussion and critique integrates the most prominent themes using intersectionality as a framework. The ability of the theory to consolidate different aspects of a phenomenon and effect a holistic investigation and evaluation are characteristics that influenced its use in this thesis. I have developed an integration matrix displaying how the main themes derived from the three phases of this thesis have been grouped and discussed (Appendix 26, Table 7.1a). The matrix contains all the contributions of each phase. These are grouped under intersectionality subheadings: social structures, culture and media contributions.

7.1. Social structures

Social structures, as discussed in the Literature Review Chapter (2), are generally social arrangements in society including social institutions such as education, economy, family and religion. Evaluating social structures with an intersectionality lens involves exposure of power relations that lead to formulation of comprehensive solutions that can empower women. The following discussion includes inclusivity and privilege checking, social generational differences and gender awareness, which are elements within social structures highlighted in the three phases of this study.

7.1.1. Inclusivity and privilege checking

Intersectionality emphasises on the importance of acknowledging diversity and inclusion that consist of creating multiplicity of voices without creating hierarchies of experience (Cochrane, 2013). However, there are extended struggles around inclusion of all races and trans-women, which may pose a threat to successful transcultural campaigning, as discussed by Chamberlain (2017). In my qualitative study (Chapter 6), findings highlighted similar intersectional perspectives with regards to inclusion and exclusion of the audience. Participants expressed the importance of acknowledging the differences of demographic characteristics of different groups even within the same community, which influence their participation in HWPs. This supports the findings of Joy and Kolb (2009) who showed that the existence of differing absorptive and learning capacities of the audience was influenced by education levels, occupation, age and culture. One way to overcome the problem of exclusivity, as suggested by participants in my qualitative study, is to have accessible venues that accommodate everyone, including disabled people and those with young children, by providing the necessary facilities such as lifts and childcare. The layout of venues was highlighted as important and needing consideration. Depending on the size of the audience, venues should be organised in such a way that the audience can engage in small groups that would facilitate discussions and engagement. It is also important that these groups foster a safe environment, as safe spaces in education sessions encourage free engagement and participation (Arao and Clemens, 2013, Khalifa and Brown, 2016). Safe spaces, however, are not always available, as observed in my survey study where midwives and health visitors reported that ‘lack of space’ is a challenge. This may be explained by lack of private spaces in hospital settings for midwives, while for health visitors it is the presence of other family members in the house/room during visits. Such a state of lack of privacy exposes a risk to breaching confidentiality codes and may promote disengagement or exclusion, especially with discussions of sensitive topics such as FGM/C (Smith et al., 2017). Professionals may therefore require more training on how to avoid disengaging and excluding patients or service users and reminding them of their codes of conduct with regards to confidentiality and privacy.

Key findings from my systematic review showed that while engagement in health education programmes encourages change in individuals’ attitude and behaviour as a result of increased knowledge, the subsequent sharing of that acquired information and behaviour change is as important, to allow for collective prevention (Chege et al., 2004). In the same vein participants in my qualitative study emphasised the importance of sharing of learnt/acquired information regarding FGM/C as a crucial action in ensuring active communication of messages about FGM/C. This should aim toward reaching beyond the target audience of HWPs. My findings, however, showed that the majority of participants found it difficult to share knowledge about FGM/C. This could be explained by the challenge of establishing effective strategies to approach, discuss and include family members, community members, friends and colleagues at workplaces. My survey study showed the difficulty that health professionals may have in sharing information about FGM/C, because they perceived that their patients or service users are not interested. This, as well as the qualitative finding, contribute to exclusivity of some individuals, which intersectionality advocates against (Chamberlain, 2017). Clarifications to providers of education about the importance and various methods of starting a conversation about FGM/C is necessary in training sessions. Following training, as observed in my systematic review, participants should be encouraged to share information, which would require them to be equipped with various materials and methods to ensure inclusivity (Diop and Askew, 2009).

When information has been shared, the next step should be providing contact details and information of available support services that can be accessed by all individuals, as highlighted in my qualitative study. This was linked to enabling those who are affected, and those who may be at risk, to find support when they need advice or other interventions (Baxter and Glendinning, 2011). However, when it comes to the provision of services, my survey study showed that language barriers presented a real challenge that risked the exclusion of some individuals whose language differs from that of the service providers. This is also highlighted by primary care health professionals in multiple studies about immigrants, showing that there are missed opportunities within healthcare because of discrimination, prejudice and racism due to language barriers (Lindenmeyer et al., 2016, Samkange-Zeeb et al., 2020). As a result, it limits service users from fully benefiting from services due to interference with effective care and communications between health professionals and their patients/service users (Schyve, 2007, van Rosse et al., 2016). One way of tackling this challenge, as indicated in my systematic review, is by tailoring information to fit the needs of the target populations, focusing on the most effective strategies, which may differ between communities. This is crucial because it enhances communication and increases acceptance of the programme, as well as influencing quicker dissemination of information among communities (Waigwa et al., 2018). Health education providers may benefit from training that not only signposts to language translating organisations, but also provides step-by-step demonstrations or practical engagement opportunities regarding how to use translators, both virtually and in-person. This will help to avoid the exclusion of any individual, and allows for a wide range of learning styles to be catered for.

Educative handouts and resources, in my systematic review and qualitative study, were emphasised to enhance the attainment of knowledge about FGM/C, in addition to providing a valuable means by which information can be shared both locally and abroad. This result supports findings from previous research (Robinson and Graham, 2010, Pomerantz et al., 2010). My studies indicated that depending on the differences among the audiences, the handouts should be tailored to fit the demands of the audience. This is to encourage the inclusion of all individuals regardless of their language needs or preferences about types of handout. Interestingly, as was demonstrated by my survey study, a sizable number of health professionals may find internet-based materials unhelpful for gaining knowledge about FGM/C. Various alternatives should be made available.

Privilege checking, which refers to instances where certain issues can only be discussed or represented by some individuals, can be positively applied to encourage acceptance of the programmes. However, it is sometimes used as a tactic to demonstrate the differences in feminism by reminding someone that they cannot and should not speak for others (Munro, 2013). Health education providers need to be well informed, trained and prepared for their tasks, and this preparation should also include any eventualities such as backlash towards what is being taught, which is possible in culturally sensitive topics such as FGM/C. As a result, providers should be culturally aware of the target groups and communities with whom they work. My systematic review showed that facilitators' affiliations with a community, language, religion, school of thought, and ethnicity should be carefully presented as these characteristics have a capacity to disrupt the awareness raising process (Waigwa et al., 2018). These considerations should be in line with the audience characteristics, which have been found to influence their reactions and acceptance of interventions. The whole programme, therefore, has to adjust in accordance with the characteristics of the audience, which could range from community gatekeepers, health and social care professionals, students, men, women, cutters and religious leaders (Varol et al., 2014, Isman et al., 2013, Vissandjée et al., 2014). Messages about FGM/C can be made to standout and become more immediate by incorporating case studies, personal stories and testimonials from various people, which is recommended for awareness raising projects (Sayers, 2006).

The use of personal experiences in FGM/C campaigns, as expressed by individual activists such as Nimco Ali and Leyla Hussein, has becomes vital to successfully reach out and attract public interest (Chamberlain, 2017). Using lived experiences is central to intersectionality. However, the experiences of backlash that these individuals encounter, including from their own communities, expose the issue of privilege checking yet further. From my qualitative research, facilitators with lived experiences about FGM/C were favourable, which is also observed by García-Moreno et al. (2015). However, this was reported to pose a risk of labelling for survivors, which could act as a barrier discouraging such facilitators. It was recommended that facilitators should possess some affiliation with the target communities, so that they would be better able to understand cultural cues, echoing findings by Minkler and Wallerstein (2011). My systematic review suggests that one solution to this challenge is for facilitators to dress in a similar style of clothing to participants in an attempt to encourage shared identity and break down barriers (Mounir et al., 2003). As indicated in my qualitative study, 'brainwashed' facilitators risk backlash from their communities, which intersectionality would term as 'no-platforming' (O'Keefe, 2016).

It was observed in my systematic review that behaviour change is dependent on psychological capabilities such as strength and skill. These factors could affect individual perception and social opportunities, which include cultural norms that influence behaviour, regardless of individual perception (Michie et al., 2011). Social Action Theory (SAT) also posits that physical and social environments foster and sustain debilitating habits. Further, SAT also suggests that interventions are needed that either improve or increase objective assets by redesigning the setting or by improving access to benefits and services (DiClemente et al., 2009). Austerity, for instance, has been recognised as a huge contributor to increased risk of women facing violence due to their increased vulnerability linked to deprivation and dependency. It is also responsible for excluding and incapacitating women specific services, thus making reduction of violence increasingly difficult (DiClemente et al., 2009). Such challenges that prompt refusal and no-platforming have acted as a fuel for intersectionality activists in conjunction with positive effects (O'Keefe, 2016). Negative effects such as anger typically facilitate dialogue, response and resistance (Chamberlain, 2017, Cochrane, 2013). My qualitative study showed that a lack of funding limits the extent to which organisations can reach various communities, thus excluding some individuals/communities. This supports previous claims that lack of government funding (either due to cuts, or poor funding initially) is contributing to the closure of female-specific services, thus increasing women's exposure to violence (Cochrane, 2013). My survey study also showed that lack of advocacy for community services in training about FGM/C has led to some professionals disregarding their presence and contribution to the prevention of the practice.

As discussed above, the relevance of intersectionality clearly relates to the findings from my studies. This suggests continued consideration of various factors within FGM/C health education programmes including venues, language differences, handout preferences or facilitator partialities. This is done by employing an intersectional perspective that involves considerations of all aspects that could affect the possibilities of ensuring inclusion of all parties, thus affecting the effectiveness of health education interventions. Acknowledging the existence of such excluding factors and addressing them to bridge the difference has the potential to facilitate communal prevention of FGM/C.

7.1.2. Social generation differences

Social generational awareness refers to consciousness of different cohorts born in the same date range, as defined by social structures, technology, innovations and those who share similar cultural experiences, but clearly distinguished from the young and the old (Woodman and Wyn, 2015). Generations may also be characterised by other attributes such as migration phases or socioeconomic shifts over time: for instance, literate generations versus illiterate generations (Bekker and Lhajoui, 2004). Intersectionality emphasises the acknowledgement of the differences that are present between generations, which impose certain power dynamics leading to some generations being especially discriminated or privileged (Gkiouleka and Huijts, 2020, Gross et al., 2016).

These kinds of struggles with social and generational differences were highlighted within my studies. Findings from my qualitative study, for instance, showed difficulties within the execution of sex education, which participants related to discussions about FGM/C. Due to their taboo nature, these topics are not commonly discussed between different generations. This finding suggested that in sex education, just as in health education about FGM/C, the lack of acceptable education materials may trigger resentment from the audiences. Recent politics in the UK regarding this records some parents deciding to opt their children out of sex education sessions in schools because of what they refer to as non-age appropriate learning materials (Long, 2018, Bialystok and Wright, 2019). Participants also disclosed that it is even more difficult to discuss issues about sex, as well as FGM/C, with families. Both young and older parents struggled with discussing these with their children, although younger parents seemed determined to discuss with their children when they become of an understanding age, something which is recommended when educating on sensitive topics (Pariera and Brody, 2018). One of the disadvantages of lack of timely sex education, is that children grow to puberty unaware of the likely body changes as they become young adults. Participants in my qualitative study shared their experiences of this, characterising them as confusing and embarrassing. The perceived indecency of sex and FGM/C discussions causes delayed or denied education, which, as observed in other research, renders an individual vulnerable to performing a variety of risky behaviours (Amini et al., 2016).

Another finding about generational differences emerged in my qualitative study, indicating that older generations do not prefer younger individuals to facilitate discussions about FGM/C with them. This could be explained by linking it to social structures that give a heightened power status to elder members of the communities (Hunter, 2017). Older generations in my qualitative study found it difficult to start conversations with the younger generations, which reflected in younger generations also struggling to discuss FGM/C with their young children. However, younger people were found to be more amenable to change than the older generations who were generally more conservative. This aligns with findings from Kuerbis et al. (2017) who found that older individuals tend to lag behind in their attitudes to change. Nearly 80% of health professionals in my survey study indicated that they have never attended to a case where they reported girls under 18 years. There is therefore a possibility that there are no existing cases of young people in most of the areas covered by the respondents in this study. This could be an indication of generational change with regards to the practice and it should be acknowledged in health education interventions because it will inform intervening strategies. However, this could be a sign of the failure of the health professionals to identify, start a conversation, record or report girls under 18 who are affected by FGM/C, because of lack adequate training with regards to these basics.

Sharing information about FGM/C between groups, such as between different generations and genders, was found to be challenging in my qualitative study due to the differences that exist between such groups. This was also observed in my systematic review where individual characteristics including age and level of education were found to influence the effectiveness of health education messages about FGM/C (Waigwa et al., 2018). To address this challenge, some participants in my qualitative study shared information with individuals whom they felt comfortable with, such as friends rather than families. The value placed on age differences in the communities could explain why sensitive discourses may favour peer discussions. Interventions that encourage sharing of information within and between communities should recognise such values to successfully facilitate information sharing. The age of educators has been found to affect the impact of education. Previous research recommended that the facilitator's age should be of the same age category as the audience or even older (Rees et al., 2009). Kim (2009) suggested that communities' value of age and respect are inseparable because younger individuals are expected to respect older individuals and not vice-vasa.

As mentioned in the previous section of intersectionality, tailoring information to fit the audiences, especially with language differences, is paramount. However, it is important to note the challenges that may arise in tailoring information because with language adoption, for instance, it may be acceptable to some generations, but not others. Also, preference of the mode of dissemination – i.e. electronic or paper – may differ between generations, as observed in my qualitative study. Paper dissemination, for example, was dismissed as an option by some participants because of its tendency to be misplaced, while the electronic mode was endorsed as a quick way to acquire information (Gaglio et al., 2012). A constant supply of handouts such as leaflets, which was highlighted as an effective intervention, was suggested by many participants, especially in public places such as libraries and community organisations (Zionts et al., 2010). However, when handling sensitive issues in such a manner, there is a possibility of conflicts and may lead to imprisonment (Cochrane, 2013). Although such negative resistance is perceived as fuel within activism (DiClemente et al., 2009), interventions should evaluate the social generation differences aiming at informing strategies to encourage sustainable and effective implementation.

It is clearly important to acknowledge the social and generational differences that exist within communities, by acknowledging that these differences may act as either barriers or facilitators of successful health education interventions. Assumptions and 'blanket' categorisation of groups of people, even from the same community, could result in under or over estimation of the needs of the target communities. Conflicts between generations have been a huge issue acknowledged within intersectionality and failure to recognise the existence of these differences and finding suitable solutions only leads to ununified activism, thus derailed elimination of problems such as FGM/C (Householder, 2015), as discussed in the studies of this thesis.

7.1.3. Gender awareness

Gender involves socially constructed characteristics of women and men such as norms, roles and relationships. It is important to note that some individuals may prefer to be recognised as non-binary, because they do not identify with the traditional binary definition of either male or female (Ellemers, 2018). Different types of genders may vary between societies and are often communicated by one generation to the next as appropriate norms and behaviours. However, gender norms, roles and relations may influence some practices that expose individuals to unhealthy conditions and diseases, which may be different between women and men (WHO, 2019). For instance, my qualitative study showed that although one of the main reasons for practising FGM/C is to benefit men, it is also considered as a means of distinguishing between males and females. This clearly depicts gender discrimination and inequality for women.

Although intersectionality emphases multiple inequalities, gender remains a major social identity that is central to various forms of discrimination arising from unequal power dynamics (Shields, 2008). A theory of gender and power by Connell (2013) illustrates this by positing that power relationships between genders arise from the global dominance of men over women. Connell argued that women burdened by the unequal sexual division of labour power are susceptible to poorer health outcomes. My qualitative study supported this theory, demonstrating that it was largely the male figures in families or communities who have the power of decision-making. However, the study findings indicated that with regards to FGM/C, the older women in some communities have higher decision making power than men, which may be illustrated by evidence that men prefer not to discuss and engage with the practice (Norman et al., 2009). Even so, men were mentioned as important in safeguarding their daughters with regards to FGM/C due to their position as decision makers in the families and communities, as similarly observed by UNICEF (2013). Edström et al. (2016) also argues that cross-gender alliances have been identified as a feature in intersectionality, which potentially can have more impact than single-gender campaigns. It is, therefore, crucial for interventions to acknowledge the role of gender in FGM/C matters, as similarly observed by Eldin (2009).

The gender of facilitators was discussed by most of the participants in my qualitative study, suggesting that beyond being compassionate and patient, facilitators must be of the same gender as the audience. This supports other research showing that in instances of health issues regarding female body parts, women audience prefer females to address them (Javanparast et al., 2011, Alli et al., 2013). Most of the participants preferred single-gender audiences with an explanation that this would enhance open discussions of sensitive issues such as FGM/C. However, those who supported mixed audiences insisted on a female facilitator. The differences were also reflected in my survey, which only received three responses from male health professionals. This finding may be explained by the evidence that males health professionals are less likely to deal with female patients, especially with issues specific to women (Bertakis, 2009). It could also be because of the male-female ratios in health professions that are evident to generally favour females (Hall et al., 2015). It is, therefore, crucial that interventions evaluate the audiences' preference of the gender of facilitators for effective implementation. Equally important, the duty of both male and female health professionals to safeguard children and care for adults who are affected or are at risk of FGM/C, should be emphasised by training, something which was observed in my survey study. This will minimise the loss of opportunities to identify cases or provide the required care.

Interventions should take note of the audiences' willingness and preferred initiatives to tackle gender inequality within the target community, while also considering the sustainability of those solutions. From my qualitative study, for instance, the need to safeguard the next generation of girls through the implementation of interventions was something that requires urgent attention. Participants recommended the need to enhance the process by preparing and involving parents, health professionals and educators, so that children (both males and females) are provided with the necessary information at an early age, which denotes a wider general public focus.

Generally, there exists a tension of power in decision-making between males and females with regards to carrying out FGM/C on girls or women. Health education intervention planners should seek to find out the power dimensions and preferences of the target communities, which sometimes may be different at family level or may be influenced by national level policies. Identifying and recognising the presence of gender differences, power imbalances between the genders, and preferences of the communities in tackling gendered issues, would facilitate effective planning and implementation of health education interventions, and thus eventually facilitate the empowerment of women.

7.2. Culture

Culture involves aspects of life in which human values are enacted and as discussed in the Literature Review Chapter (2), intersectionality illuminates the resulting discord caused by power dynamics within and between cultures and seeks to consolidate aspects to illuminate inequalities, which would protect future generations. Lack of acknowledgement of cultural diversity is attributed to creating a culture in which sexism or misogynistic behaviours can thrive, as this rhetoric does not challenge the dominant culture (Chamberlain, 2017). Cultural competence refers to a set of congruent behaviours, attitudes and policies that come together in a system or among professionals, which in turn enable effective work to be done in cross-cultural situations (Luquis, 2013). However, negative working/organisational environments may be a barrier to accommodating cultural competence efforts that enable effective service delivery and safe conditions for marginalised groups (Bradbury-Jones et al., 2019). In my qualitative study the workplace (educational, health and social care) was depicted as one of the environments where discourses about FGM/C occurred more frequently and freely, compared to most home environment or public spaces. Interventions should consider promoting cultural awareness in workplaces within the target communities to enable successful discussions. The study also showed the importance of acknowledging that not everybody would be interested in the subject of FGM/C. The reasons for this may include dislike of the subject; not being convinced about the negative consequences of the practice, especially having personally not experienced FGM/C; or denial that the practice is prevalent.

Active communication is essential, but it can be hindered by language barriers, literacy levels and cultural beliefs (Mira et al., 2014). In my qualitative study for instance, facilitators being knowledgeable about the subject was evidence of their credibility. In addition, facilitators should be able to communicate clearly and include translators where necessary. It is important to be aware of the cultural differences that may stand as a barrier between individuals using the same language (Samkange-Zeeb et al., 2020). Facilitators should be approachable and not blatant about the subject, instead, they should dilute it with other topics or activities (Alli et al., 2013, Gilchrist, 2009).

It was acknowledged in my qualitative study that facing challenges such as taboos, disguised compliance, and defensive audience is inevitable. Using simple language, consistency and normalising the discourses is important in breaking these barriers as also discussed by McCarry and Lombard (2016). However, it should be noted that normalising could negatively influence acceptance of the problem. Study participants in my qualitative study also emphasised that the intensity of the intervention may vary depending on the locality where the audience reside. This was linked to accessibility of information, which would be less available in some geographical areas such as rural areas compared to urban areas (Eng et al., 1998, Diop and Askew, 2009). Evaluation of the environmental roles, assets and challenges relating to FGM/C should be considered by interventions. One way of addressing this is by using reinforcement techniques such as offering meals on the day (especially traditional meals, which were favoured by participants in my qualitative study), to encourage attendance and participation of the audience. This is also mentioned in a study by Community Engagement Key Functions Committee (2009), which established that meals are a good practice in interventions as participants were more engaged in the project. Other suggestions of tackling cultural barriers include creating an open climate where people can speak up and share experiences (Fried et al., 2013, Berg and Denison, 2013b), empowering women, (Afifi, 2009) increasing knowledge (Zurynski et al., 2015), encouraging change of perception (Berg and Denison, 2013a), all of which could lead to change of behaviour (Berg and Denison, 2012). These measures should be applied cautiously as they could determine the success or failure in influencing cultures that support FGM/C.

Limited cultural awareness may cause lack of confidence in discussing FGM/C matters. For example, confidence levels of the participants in my qualitative study with regards to the knowledge they possess about FGM/C turned out to be inconsistent, as they reported to be more confident in discussions with some audiences and not with others. They doubted their knowledge, which acted as a barrier to sharing information. Others questioned their abilities to communicate clearly, thus opting to signpost. This has been shown in other research, indicating that lack of knowledge may influence reluctance in discussing about FGM/C (Forsetlund et al., 2009). In addition, lack of knowledge about FGM/C that was observed from discussions with my qualitative study participants showed that some were uncertain or in denial of prevalence rates stated in the UNICEF world map of FGM/C (UNICEF, 2018), especially for their home countries. This could be because they come from communities in their countries of origin that do not practice FGM/C; therefore, they lack the knowledge of its existence and its magnitude in the practising communities. Participants also showed a lack of knowledge with regards to the reasons ('benefits') of FGM/C as described by the practising communities. Lack of knowledge can be explained by poverty that causes low literacy levels and disempowerment of women in these communities (Finke, 2006). Turning to my survey study, the health visitors were the most confident in discussing FGM/C followed by the midwives and lastly the GPs. Interestingly, the midwives and the GPs demonstrated to be more confident in discussing illegalities of FGM/C than in discussing health implications. This finding is contrary to previous studies that indicate that health professionals are generally more confident about health implications/conditions than they are with the legal matters of the same condition because they are less conversant with the later (Stobo et al., 2002). However, the reason for this is not clear, but may have something to do with the complexity and abundance of health implications associated with FGM/C, compared to the clearly stated illegal status of the practice. Contrary to previous claims by Saner (2008), my survey study did not appear to support the idea that GPs fear being labelled as racists when dealing with FGM/C issues. In my survey, the GPs referred to the 'lack of time' as one of the major barriers and this could be a result of the NHS systemic structures that restrict them to an average of 10 minute consultations with their patients/service users (Rimmer, 2015). This poses a challenge to initiate and conclude discussions on sensitive issues ingrained in cultural beliefs such as FGM/C, which often require more time to unravel. For such reasons, my systematic review stressed the importance of community-based approaches which actively engage community members in health education interventions (Chege et al., 2004).

Intersectionality acknowledges the relevance of cultural competence (Brown, 2009). In issues such as FGM/C, it is recommended that multiculturalism should be addressed in a way that it is neither culturally deterministic nor racist. This leads to the need to counter cultural assumptions alongside the systemic reluctance to address FGM/C (Chamberlain, 2017). Weiss and Brueske (2018), for instance, raised a concern about the fear of interfering with other people's cultures, a concern that has also been discussed in my survey study confirming that it may act as a barrier to interventions. Accordingly, some participants in my qualitative study suggested the use of community leaders to better approach their communities. Some retreated from sharing knowledge due to fear of passing on wrong messages. Instead, they suggested signposting to individuals or services with accredited knowledge about FGM/C. Interventions should be aware of such fears causing community and systemic reluctance to engage in wider conversations about FGM/C.

One of the significant findings in my qualitative study is that participants reported women's limited knowledge with regards to their body anatomy, especially the reproductive system, thus supporting the findings of Harmanli et al. (2014) that most females are underinformed about female reproductive organs. Empowering women, especially with information about their bodies, was stressed as a sustainable strategy that can enhance change with regards to FGM/C, because women are core contributors to the continuation of the practice (Sakeah et al., 2019), and in turn could teach their children. However, as discussed in intersectionality, the present imagery of female bodies portrayed as objects, especially the media, prompts questioning of the definition of women's empowerment and autonomy (Cole, 2009).

Some participants in my qualitative study associated FGM/C with the Islamic religion. My survey study reflected similar results, indicating that a majority of patients the health professionals cared for were Muslims. This is also reflected in previous studies (Rouzi et al., 2013, Kirmani and Phillips, 2011, Gemignani and Wodon, 2015), showing that Islam inherently retained its mythical association with FGM/C. Interventions should seek to clarify such misconceptions and assumptions.

One of the ways that intersectionality challenges cultural incompetence in line with challenging inequalities is by the use of humour (Hearn, 2014). For instance, as mentioned by Chamberlain (2017), 'Slut Walk' was launched to encourage reflection of how it was initially used by critiquing and changing the use of the word against marginalised communities. Similarly, 'queer' community encouraged criticism of previously derogative use of the word, utilised to hurt. Perhaps, 'female genital mutilation' could be reconsidered to a language that is non-labelling and not 'othering'. In my qualitative study, discussions about the best language to use in interventions led to divided conclusions. The use of their mother tongue was preferred by some participants because it was the language that they understood best. However, this was not met with agreement from all participants. Some indicated a preference for English, because in their mother tongue/culture, there are some terms that are taboo, but acceptable in English. Some words also have no translation from English to their mother tongue and the attempt to translate them usually results in change of meaning or taboo words. The level of proficiency of the English language could be an explanation of these preferences, inferring that the lower the proficiency, the less choice individuals may have, resulting to the use of their language even when it is uncomfortable. The mode and tone of utterance about the subject was also suggested to be vital. Leniency and less harsh utterance were favoured. This supports the findings of Quichocho (2018), which also connected language preference to language proficiency and awareness including cues and sayings used in a community. These are important in enhancing effective/active communication in interventions. Body language should also be sensitive, using calm gestures that do not express shock and incompetence, especially from health professionals and educators. This is consistent with other research indicating that body language can act as a tool to either enable or inhibit effective communication (Brunero and Lamont, 2020, Jureddi and Brahmaiah, 2016). When correct information is communicated and shared effectively, it eventually results in collective knowledge and awareness that in turn influences communal change (Chege et al., 2004).

It is risky to use humour to discuss human/women's rights as the speaker and words may be misunderstood or misconstrued (Chamberlain, 2017). It is important therefore to make sure that any reframing is used differently, so that the audience is able to understand the transformation especially in line with cultural preferences (Hemmings et al., 2011). Some messages may not be adaptable to other languages, cultures and community identities, which limits effective reach of these messages to a wider population (Sayers, 2006). It is for such reasons the subject of FGM/C in HWPs discussed in my qualitative study were unsurprisingly embarrassing. This intensifies when the facilitators were of the opposite gender and/or younger than the age of the audience, if the language was mother tongue (in some communities), and/or they used graphic illustrations. A solution to this challenge is to use the lived experiences of facilitators, to be well-organised, and to engage the audience, possibly by including quizzes. Evidence suggests that the use of quizzes enhances learning, encourages audience participation, and often leads on to detailed discussions (Gray et al., 2017). Also, the use of different forms of handouts such as wrist bands/bangles encrypted with messages about FGM/C can be utilised and were endorsed as effective measures for triggering conversations. The effectiveness of using such handouts is known as social marketing in health interventions (Jones et al., 2017, Sewak and Singh, 2012). However, this risks a biased attraction of naturally selected audiences, who most likely would be close family, friends and strangers who are extroverts. In such cases of using humour or reframing, as shown in my systematic review, it would be necessary to review the factor of acculturation as it has a capacity to influence the attitudes and views of communities (Jass and Massey, 2004). This is especially important for interventions targeting newly migrated populations who require timely interventions that can help them to avoid familiar but harmful practices, and to reduce the risk of them adopting those that they may find in their new environment (Kreps, 2006, Kreps and Sparks, 2008). Obtaining timely reliable information regarding FGM/C is key to the elimination of the practice (Wamae, 2015).

Cultural competence is a core contributor to prevention of FGM/C. It enables considerate discussions about the practice in appropriate and safe environments, using acceptable educative materials and language. FGM/C health educators, including health professionals, should have cultural competence, which enables them to understand other cultures as well evaluate their own biases based influenced by their cultures. This would enable easier accommodation and acknowledgement of diversity that would lead to sensitive handling of FGM/C cases/issues in education as well as consultations. Communities should also be encouraged to be fully aware of their own cultures as well as other cultures of communities that practice FGM/C and those that do not practice FGM/C. This would similarly enable easier accommodation of diversity and enlargement of the scope of their knowledge with regards to the practice. Another main element of intersectionality is the media. Its contribution to FGM/C issues, as discussed in the studies in this thesis, is discussed next. Acknowledging the power dynamics present within and between cultures is crucial and addressing them will lead to safeguarding of future generations, consequently, effective FGM/C health education interventions.

7.3. Media contributions

Media contributions in my study refer to the responsibilities and means in the media for disseminating information. Platforming of intersectionality in the media has been essential as discussed in the Literature Review Chapter (2). This is due to the media contribution in escalating and exposing the issues (Rigoni, 2012). Weiss and Brueske (2018) argue that the internet, as one of the mediums of transmitting information, has become central to human life to the extent that they are considered inseparable. Personal issues can quickly be escalated within the internet as it has enabled globalisation of issues including those that were previously place-specific (Chamberlain, 2017). However, it seems that this may not be the case for some GPs in my survey, who surprisingly selected ‘availability and accessibility of online learning materials’ as the least popular facilitator for effective discussion of FGM/C, which could be explained to result from their lack of time. Eberhart-Phillips et al. (2000) notes that the age of the GPs could also be a factor affecting their preference of utilising the internet.

Although the global community is now linked by the so-called information superhighway, there is a need to acknowledge the lives of those who are still bound by local contexts. This is because the internet does not always equate to actual change and the gap between the internet and the reality of women’s experience may be widening (Chamberlain, 2017). A similar view could be used to explain that new online processes within the service systems are the reason why a large number of midwives and GPs in my survey reported to have cared for ‘none’ patients/service users in ‘recording newly identified and attendance cases’ and ‘reporting known cases of girls under 18’, which may not reflect the reality. This concurs with Winter et al. (2010) who suggested that the absorption of new systems may take longer to completely be effective, allowing all the health professionals to comfortably apply them successfully.

Lack of equitable internet access for poor and rural populations is another barrier that is hindering equitable access and sharing of information (Chou et al., 2013). As reported in my qualitative study, the rural areas may be deprived of information due to poor media frequencies and lack of media facilities compared to the urban settings, which affect the number of messages about FGM/C that reach them. Evaluation of awareness of FGM/C is therefore required and success should not be assumed until measurements of change indicators show the occurrence of the preferred changes (Sayers, 2006). It is important for an evaluation team to be included in all the stages of intervention programmes to provide guidance and expertise in measurements, data collection, and analytic strategies from the beginning of program implementation through to the termination stage (Fry et al., 2018).

It is recognised that the response gained from dissemination and participation may not last, but that does not negate that incidences are successfully recognised, documented and answered. Such speed leads to new forms of collective feelings and modes of operation that culminates in uproars and participation in or against issues (Chamberlain, 2017). In my qualitative study, there are varying motivators expressed by the participants with regards to their reasons of attending HWPs. Some attended because it was recommended by individuals who insisted of the importance of acquiring knowledge about FGM/C. Others engaged out of personal interests to gain more knowledge and become effective while handling and discussing about FGM/C. Advertisements and social media were mentioned as a motivator to participate in programmes/sessions. This supports the evidence from previous observations indicating that publicising programmes or actions influence curiosity and attract audience (Read-Hamilton and Marsh, 2016). It is important to use messages that are usable again in different communication strategies and approaches such as posters, brochures, newspapers, advertisements and the media to effectively win the audience attention (Sayers, 2006), and be easily shared as suggested by some of the participants in my qualitative study.

It is crucial that communication of any information is undertaken in a non-harmful way. Accountability for challenging offensive content has been central to intersectionality (Felmlee et al., 2018). However, due to the conflicts which arise from surges that challenge inequality, backlashes are inevitable as the internet has allowed a culture of non-culpability in which people create more difficulty than they would in the real world (Faludi, 1993, Chamberlain, 2017). Such conflicting stances were realised in my qualitative research where the use of illustrations was a contentious debate depicting much divided views from the participants. It was suggested that, depending on the type of audience, the use of graphic illustrations should be cautiously applied. Health professionals, for instance, were mentioned to be accustomed to illustrations of mutilated body parts, especially from their study materials, but the general public would likely be disgusted and embarrassed (Laan et al., 2017). In consideration, using animated illustrations was suggested to avoid excluding or disengaging individuals who learn better with the aid of pictorials. This is also linked to avoiding re-traumatising survivors of FGM/C. The use of moulded models was also suggested to enable understanding of types and consequences of FGM/C, similarly argued in using manikins/models for education to enhance learning (Chung and Puri, 2018).

Generally, media contributions, as discussed above and in the three main studies of this thesis, are central in FGM/C issues, just as in intersectionality. Media, both analogue and digital, is crucial in facilitating active communication against the practice; however, its use should be solely guided by the preferences of the audience. Population media literacy and the availability of media, including diverse facilities such as the internet and gadgets (for example radios and phones), should be evaluated before planning an intervention. This will enable the implementation of interventions with considerations of the accessibility and availability of media. Because of the differences that arise with media inequalities, success of interventions should not be assumed without tangible evidence of the outcomes. Considering power dynamics within Media and tackling them, including utilising the media appropriately, will enhance challenging of inequalities within FGM/C health education interventions.

In this chapter, I have brought together the findings from the three studies of this thesis and explored them in relation to intersectionality. It can be observed from this discussion that no one aspect is solely independent, and that each of the aspects intersect to build on each other, and work together. Social structures (including education levels, venues, gender, and generations) are influenced, to some extent, by factors relating to culture. Lack of cultural competence with regards to different definitions of gender roles between communities may lead to an educator working with incorrect assumptions. Culture aspects (including language, community/religious leaders) are influenced by media contributions because of the platform that the media has that enables reaching numerous populations and can change cultural views. Failure to acknowledge the impact of the media on culture may result in interventions that operate on incorrect assumptions. The media aspects (including media knowledge, accessibility and materials) are also susceptible to the influences of social structures such as privilege checking, which can create backlash for interventions that, for example, fail to consider the preferences of their audiences.

It is from this intersecting principle observed here and throughout this thesis that I have developed a ‘Six Aspects of FGM/C Education’ (SAFE) model for FGM/C health education interventions as explored in the following section. This SAFE model makes an important contribution to knowledge arising from my thesis.

7.4. Towards a new model for FGM/C health education interventions

Models in health and social care are important because they ensure consistency in informing, ordering and describing programmes or interventions (Madoc-Jones 2008). Because of the complex nature of FGM/C, having models for FGM/C health education interventions is crucial. Drawing on empirical aspects of the PhD and intersectionality, I have developed a preliminary model for FGM/C health education interventions. The SAFE model will be suitable for health education interventions provided by any educator who is targeting affected communities (Diagram 7.1).

The model has ‘Six Aspects of FGM/C Education’ (SAFE). Under each aspect I have proposed essential factors, all of which have been discussed in depth in this thesis and presented in Diagram 7.2. The ‘Six Aspects of FGM/C Education’ (SAFE) are as follows:

- The *programme approach:* includes factors relating to organisations that provide health education interventions and their strategies to implement the programmes or sessions.
- *Active communication:* includes the means by which information and messages are communicated among and between facilitators and audiences, and also among and between communities (practising and non-practising communities) both locally and abroad.
- *Attitudes and beliefs:* include how individuals and communities view and perceive issues relating to FGM/C.
- *Social structures:* refer to the hierarchical organisation of societies that influence social differences.
- *FGM/C knowledge:* considers what and how much knowledge individuals and communities possess regarding various aspects of FGM/C.
- *The future:* considers the best practice applicable to future intervention and safeguarding of future generations against FGM/C.

As discussed in Chapter 2 (literature review) health professionals working with patients/service users affected by or at risk of FGM/C play an important role as educators. Although the original SAFE model is appropriate for use to guide discussions, an adopted SAFE model chart for health professionals has been grafted from the original model to accommodate the healthcare setting and narrow focus on individual patient/service user (Appendix 7, Diagram 7.1a).

It is envisaged that the SAFE model can be used by planners and facilitators of health education interventions for FGM/C and related behaviours, conditions or practices. Using

Intersectionality allows a broad and inclusive pragmatic evaluation and analysis of the problem. When educating patients or service users, for instance, health and social care professionals can be guided by the SAFE model to evaluate their knowledge and devise appropriate approaches to the problem by understanding their audiences and other factors that determine the effectiveness of interventions. Students from health and social care courses can also use the SAFE model to develop analysis of behaviours, conditions or practices such as FGM/C, that affect communities, leading to development of knowledge and increased understanding of the problems and how to tackle them.

Diagram 7.1: 'Six Aspects of FGM/C Education' (SAFE) Model: Preliminary model for FGM/C health education interventions

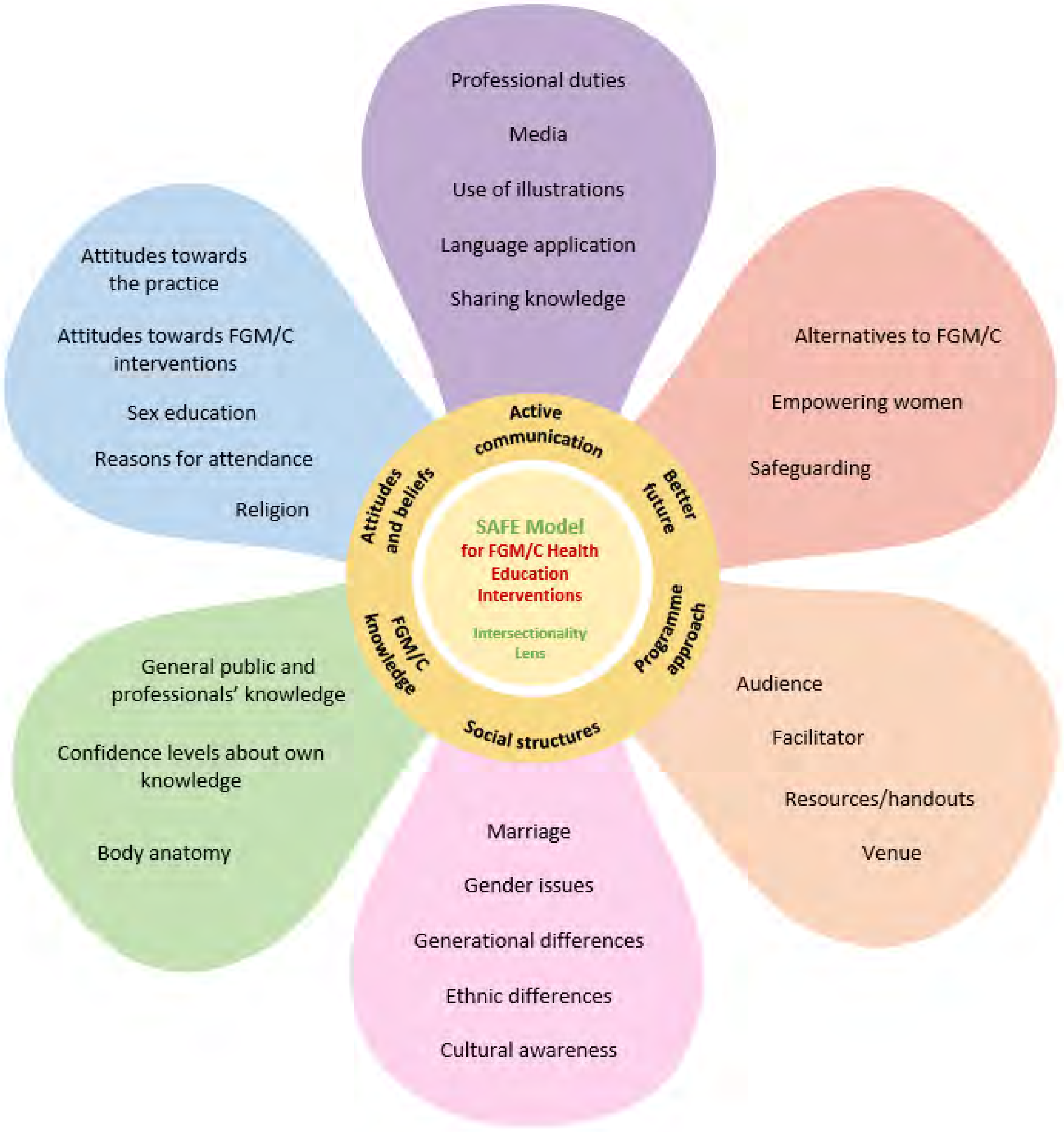
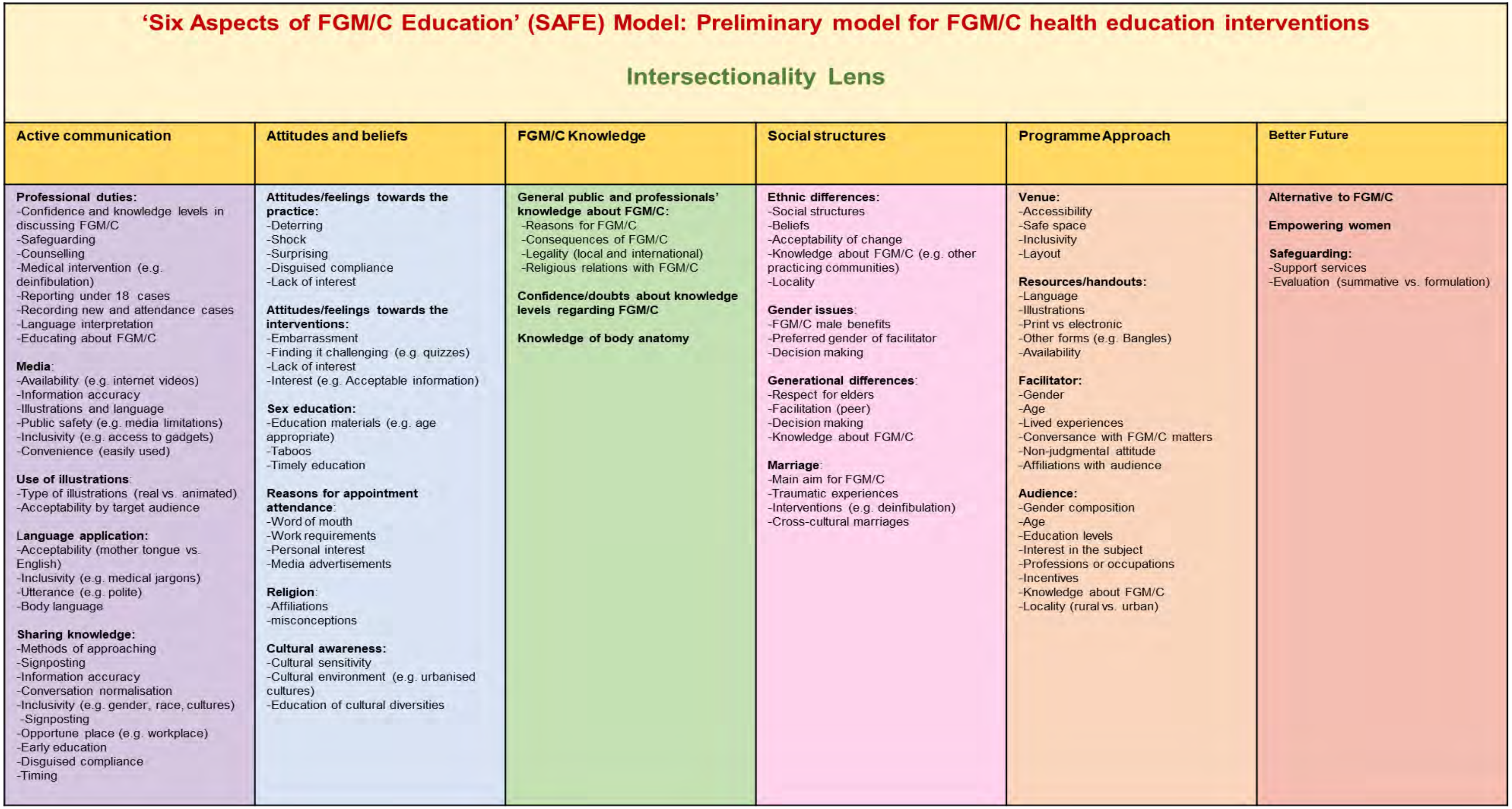


Diagram 7.2: Descriptive chart for the 'Six Aspects of FGM/C Education' (SAFE) Model: Preliminary model for FGM/C health education interventions



'Six Aspects of FGM/C Education' (SAFE) Model: Preliminary model for FGM/C health education interventions

Intersectionality Lens

Active communication	Attitudes and beliefs	FGM/C Knowledge	Social structures	Programme Approach	Better Future
Professional duties: -Confidence and knowledge levels in discussing FGM/C -Safeguarding -Counselling -Medical intervention (e.g. deinfibulation) -Reporting under 18 cases -Recording new and attendance cases -Language interpretation -Educating about FGM/C **Media**: -Availability (e.g. internet videos) -Information accuracy -Illustrations and language -Public safety (e.g. media limitations) -Inclusivity (e.g. access to gadgets) -Convenience (easily used) **Use of illustrations**: -Type of illustrations (real vs. animated) -Acceptability by target audience **Language application:** -Acceptability (mother tongue vs. English) -Inclusivity (e.g. medical jargons) -Utterance (e.g. polite) -Body language **Sharing knowledge:** -Methods of approaching -Signposting -Information accuracy -Conversation normalisation -Inclusivity (e.g. gender, race, cultures) -Signposting -Opportune place (e.g. workplace) -Early education -Disguised compliance -Timing	**Attitudes/feelings towards the practice:** -Deterring -Shock -Surprising -Disguised compliance -Lack of interest **Attitudes/feelings towards the interventions:** -Embarrassment -Finding it challenging (e.g. quizzes) -Lack of interest -Interest (e.g. Acceptable information) **Sex education:** -Education materials (e.g. age appropriate) -Taboos -Timely education **Reasons for appointment attendance**: -Word of mouth -Work requirements -Personal interest -Media advertisements **Religion**: -Affiliations -misconceptions **Cultural awareness:** -Cultural sensitivity -Cultural environment (e.g. urbanised cultures) -Education of cultural diversities	**General public and professionals' knowledge about FGM/C:** -Reasons for FGM/C -Consequences of FGM/C -Legality (local and international) -Religious relations with FGM/C **Confidence/doubts about knowledge levels regarding FGM/C** **Knowledge of body anatomy**	**Ethnic differences:** -Social structures -Beliefs -Acceptability of change -Knowledge about FGM/C (e.g. other practicing communities) -Locality **Gender issues**: -FGM/C male benefits -Preferred gender of facilitator -Decision making **Generational differences**: -Respect for elders -Facilitation (peer) -Decision making -Knowledge about FGM/C **Marriage**: -Main aim for FGM/C -Traumatic experiences -Interventions (e.g. deinfibulation) -Cross-cultural marriages	**Venue:** -Accessibility -Safe space -Inclusivity -Layout **Resources/handouts:** -Language -Illustrations -Print vs electronic -Other forms (e.g. Bangles) -Availability **Facilitator:** -Gender -Age -Lived experiences -Conversance with FGM/C matters -Non-judgmental attitude -Affiliations with audience **Audience:** -Gender composition -Age -Education levels -Interest in the subject -Professions or occupations -Incentives -Knowledge about FGM/C -Locality (rural vs. urban)	**Alternative to FGM/C** **Empowering women** **Safeguarding:** -Support services -Evaluation (summative vs. formulation)

7.5. Criticism of intersectionality

I utilised intersectionality in this thesis because of its stance in advocating the recognition of power dynamics and intersections that exist between and within social categorisations, that enable different forms of privileges and discriminations. Acknowledging the presence of these power dynamics and intersections requires a combined effort of tackling not just one form of discrimination (Collins and Bilge, 2020). As discussed in the literature review Chapter (2), social categories including race, class, gender, sexuality, nationality, ability, ethnicity and age, which often turn to discriminations when power is excised inappropriately, are perpetuated by social structures, cultural domain and media. This approach of tackling social issues is criticised because it is likely to be suitable for societal level rather than individual level interventions (Warner et al., 2020, Nash, 2008). This thesis has intertwined various factors that are involved in health education interventions leading to the development of the SAFE model. The model has community and individual levels, while indirectly considering the ecological influences for the individual.

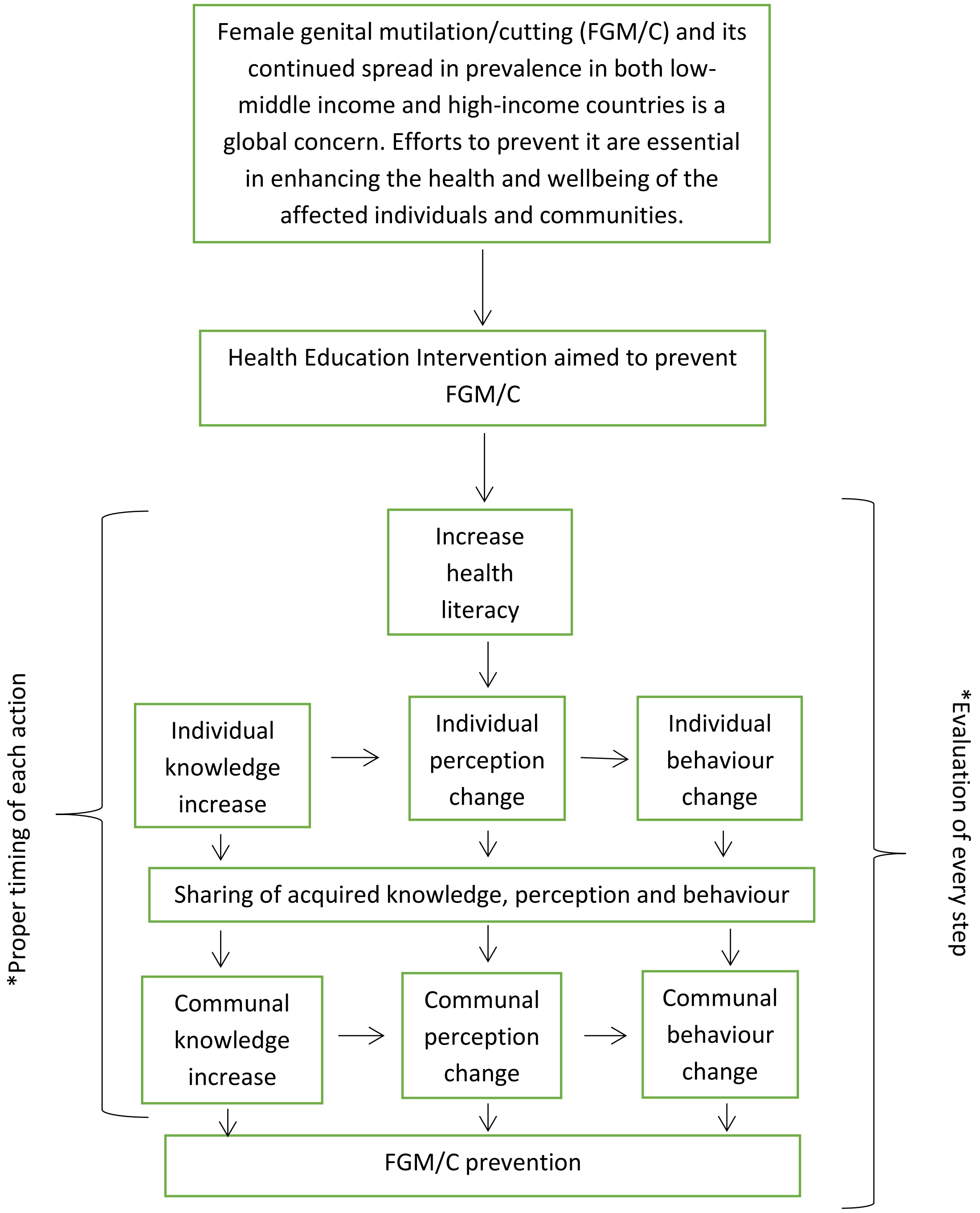
Intersectionality has also been criticised for its essentialisation of social categorisations with emphasis on identity of minority groups and exclusion of other categories, which the theory meant to eliminate. For example, it has been regarded to overemphasis and centralise black women as the main intersectional subject rather than portraying all social positions (Nash, 2008, Warner et al., 2020). Although acknowledging the limitations of intersectionality, this thesis has endeavoured to explore issues affecting all women by widely incorporating experiences and views regarding health education intervention.

7.6. Developments of the Theory of Change

The Theory of Change (ToC) for FGM/C was developed from each study in this thesis. The survey study for instance provided strong contributions for the ToC leading to improving individual's in knowledge about FGM/C and individual change in perception and behaviour towards the practice. Both the systematic review and the qualitative studies provided contributions that were reflected in all stages of the ToC, that is, to the prevention of the practice through collective increase of knowledge of FGM/C and communal change in behaviour and perception. This communal change was shown to be affected by individuals sharing of information they have received about FGM/C and their perception and behaviour change affected by an increase in health literacy through health education interventions. These developments of the ToC for FGM/C show that for the prevention of the practice to occur, the preceding steps must be present in any intervention. However, as I have shown from the survey study, some interventions may fail to prevent the practice (communally). But they can highly impact individuals who in turn may share information and affect their community, if they are encouraged and equipped, as seen in the systematic review and the qualitative study. Intersectionality contributes to this ToC by influencing careful considerations of the various factors that require attention for whole process of implementing FGM/C health education interventions to be successful, leading to prevention of the practice.

In combination of all the research studies in this thesis, I present a complete ToC for FGM/C (Diagram 7.3). As this ToC shows the link between activities of the intervention and the achievement of the long-term goal, it makes the process more explicit. This is anticipated to help in better planning, timing and evaluation because it is possible to measure progress towards the achievement of the long-term goal. Although ToC has been criticised of being too linear, it has been found to present meaningful, plausible, doable and testable ways of influencing change (Serrat, 2017). In FGM/C health education interventions however, combining the use of ToC with SAFE model may be more effective as determining factors for each stage would be accounted for in detail.

Diagram 7.3: Implicit Theory of Change in preventing FGM/C through health education interventions



7.7. Strengths and limitations of this research

Including a systematic review in this research allowed rigorous reviewing of available primary research data that provided information about FGM/C health education interventions across a wide range of settings and empirical methods. This wide exploration informed the formulation of narrowed research questions for the survey and qualitative research for this thesis. The mixed method research allowed, in the survey, assessing of the frequency and magnitude of the experiences and opinions of providers of FGM/C health education interventions and exploring of experiences and opinions of recipients of the interventions in a rigorous quantitative research. This provided multiple perspectives, thus, enriching the data, which would be impossible if only a single research method was applied. Merging qualitative and quantitative data allows a more comprehensive understanding of a problem, which in this case culminated in the development of the SAFE model.

However, there were limitations that could have affected the achievements of each study, which future research should consider:

The systematic review, as earlier indicated in Chapter 3, focused on wider global scope and obtained a wide range of studies. However, some studies did not indicate the duration of the interventions. In addition, only studies reported in English were included. Studies that focused on affected communities were also included but studies from non-practising communities were excluded, which future research should consider including.

Receiving responses from respondents with considerably diverse demographics was a strength in the survey study. Self-reports to assess knowledge, however, may have led to inflated results. For example, some respondents indicated to have high knowledge in all the provided measures. Missing data in some questions of the survey was also a limitation that resulted to different responses rated within the instrument. Question seven was especially compromised based on ambiguity that led the participants to respond in relation to FGM/C affected patients/service users, instead of general demographics of all the patients/service users that they have looked after. For this reason, concrete conclusions can only be cautiously applied with regards to this question. Future research should make it clear with regards to such questions, because only then would the proportions of population diversity be analysed. The response rate for this study could probably be higher considering that not all health professionals could have had access to the survey within the time frame it was distributed. There is difficulty in finding out the actual number of professionals who received the survey, thus hampering calculation of the actual response rate.

In the qualitative study, the use of self-reports to assess knowledge may have led to deflated reports in the qualitative interviews. For example, some participants indicated to doubt their knowledge about FGM/C even after receiving information about the practice on several occasions. Although the representation of different regions that have a history of FGM/C is a strength for this study, this research lacked the capacity to compare the experiences and views between and among the regions or countries due to lack of multiple representatives from each country or region.

Despite the limitations, this research has presented a solid evidence that can inform FGM/C health education interventions, thus improving on their effectiveness.

7.8. Conclusion

This chapter has presented a discussion of the findings from the three studies included in this research using intersectionality. A model of health education that was developed from the research has also been presented. The ToC as developed through the thesis was summarised.

The following chapter (8) will conclude the whole thesis with the key findings and present the study recommendations.

CHAPTER 8

Conclusion

Health education interventions have proven to be successful in facilitating or contributing to the prevention of different public health disorders, habits and practices including smoking and teenage pregnancies. Such interventions have also been implemented in various communities to prevent FGM/C. This doctoral research sought to explore FGM/C health education interventions with an aim of illuminating the aspects that affect the effectiveness of the interventions. Using mixed method research, three phases were included in this research: 1) A systematic review investigating the effectiveness of FGM/C health education interventions. 2) A survey study, investigating the experiences and opinions of health professionals in the UK in discussing FGM/C with their patients/service users. 3) A qualitative study exploring the experiences and opinions of communities with a history of FGM/C, with regards to health and wellbeing programmes/sessions that they have attended relating to FGM/C.

8.1. Key findings and contribution of the thesis

Intersectionality was used in this thesis to integrate findings from the three phases, elaborating issues based on a contemporary view and highlighting the factors and power dynamics leading to inequalities/ineffectiveness in FGM/C health education interventions. These were categorised in relation to: 1) Social structures, including factors relating to inclusivity, privilege checking, gender disparities and generational differences. 2) Culture, comprising of beliefs, attitudes, cultural competence and active communication. 3) Media contributions, incorporating platforming of inequalities while also acknowledging disparities within media such as the use of illustrations and language (type and utterance).

Since health education for FGM/C had not been explored previously in such depth using mixed method research, these PhD findings provide a unique contribution to the field of FGM/C interventions. The findings have particularly illuminated the aspects of health education interventions and presented them on the ‘Six Aspects of FGM/C Education’ (SAFE) model. These are imperative in every health education intervention about FGM/C. The SAFE model has the benefit of showing the elements that either facilitate or hinder effective health education interventions.

An adopted SAFE model for health professionals working with patients/service users affected or at risk of FGM/C provide the health professionals, in a nutshell, with what needs to be considered and not to be assumed. This should create an understanding between the parties to enhance good communication, thus facilitating effective health education interventions (Sørensen et al., 2012). It is important to note that the SAFE model is not limited to health educators in communities or health settings. It can also be utilised by intervention planners as well as evaluators to assess the needs and achievements of the programmes and the participants of the programmes. Students hoping to develop or assess an intervention for course reports can also use the SAFE model to direct them to what is imperative factors in every health education intervention.

Due to the overlapping concept of the identified factors that affect the effectiveness of FGM/C health education interventions, using intersectionality fits best in exploring and evaluating the interventions. In the same vein, a Theory of Change (ToC) for FGM/C health education interventions has been developed from this thesis providing a general interconnected process of all the intervention stages required for prevention of FGM/C. The steps elaborate in simple language what would have been a far more complex process to describe. The ToC has been used to simplify complex issues, especially those requiring participatory interventions (Douthwaite and Hoffecker, 2017).

As the primary studies in this thesis included participants in diaspora within Western countries, the findings therefore contribute to the scarce data available about FGM/C health education interventions delivered to diaspora within Western countries (Waigwa et al., 2018). These findings are important because they contribute to the SAFE model factors such as language barrier and culture unawareness that extensively affect the effectiveness of health education interventions provided in the diaspora/Western settings.

8.2. Recommendations

Following some of the gaps highlighted in this thesis, the recommendations for education, practice, policy and research are now laid out.

My research shows that health professionals need to be more knowledgeable about FGM/C so that they can confidently implement their duties, especially with regards to discussing the practice with their patients/service users. Particular measures that were notably wanting were 'Recording newly identified cases and attendance on enhanced data-set information standard' and 'Reporting known cases of girls under 18'. These are crucial for acquiring national statistics that will enable proper planning of interventions as well as allocation of resources.

As observed from the review of the two online professionals training programmes against the results from the survey study, there are important aspects that need to be stressed, such as how to use language interpreters, and other elements that need to be included in the training programmes that were previously excluded, such as how to manage consultation time when working with patients/service users affected or at risk of FGM/C. It is crucial to include seminars in trainings to inform health professionals about the available and accessible programmes. This will encourage seeking for more knowledge about the subject. Including personal safety in trainings is required so as to prepare health professionals with skills to safeguard themselves in cases where their personal safety is at risk or threatened. This will enable health professionals to understand their professional duties and effectively discuss FGM/C matters as stipulated in the SAFE models.

My research showed that individuals from communities with a history of FGM/C lack general knowledge of human body anatomy. I therefore recommend that emphasis on the topography and functionality of the female body parts require to be reintroduced in educative interventions as well as in the basic education systems. This will illuminate the ambiguities pertaining to sexuality, as well as illegal and legalised operations on female bodies, common in today's era (Goodman et al., 2016). Extending education to non-practising communities is recommended, because intermarriages continue to occur (Green, 2018), which is a crucial factor highlighted under social structures in the SAFE model.

Communicating FGM/C may be difficult for health professionals. Sensitive use of language and media in the discussions of FGM/C is provided to be essential. This can be developed by becoming culturally sensitive, which includes first, recognising one's own culture and biases, then understanding other people's cultures. This enables health educators, including health professionals, to develop free non-judgmental conversations (Brooks et al., 2019). In addition, health professionals should share learned information with their colleagues to enhance the spread of knowledge among professionals (Radaelli et al., 2014). They should also encourage their patients/service users to share knowledge beyond the clinical setting interventions to stimulate communal prevention of the practice (Diop and Askew, 2009), as indicated in the preliminary model under active communication.

Individuals need to be informed of the available supportive services and how they can be accessed. An understandable and preferable language should be used by all educators including health professionals to encourage information uptake, sharing as well as willingness to seek support services by their audiences. Educators should have enough knowledge of these services and the messages should be clearly applied in presentations and conversations as well as in handouts, such as leaflets (Castro et al., 2018). The preliminary models can be used to evaluate needs, such as language and knowledge levels of the audience, which will guide in the development of understandable messages.

There is a need for non-generalising approaches in formulating policies. Policies and approaches that encourage granulated analysis and consideration of communities should be implemented. Such approaches ensure comprehensive accommodation of all diversities without generalisation, thus giving flexibility (Brathwaite, 2020). The SAFE model can be useful in informing non-generalising approaches for interventions as it breaks down factors that need consideration for effective interventions.

Better integration and access to support services need to be established. This can be accomplished by providing a pathway that include various support service providers, which enable effective follow-up after interventions and evaluation of interventions. These are needed to inform further actions in on-going and future interventions (Comoretto, 2018). This is an important factor for better future highlighted in the SAFE model.

Since the SAFE model has been developed from views, opinions and observations of various communities from African, Middle East and Western Countries, with regards to FGM/C health education interventions, it is important that the model be accessible in various languages such as Arabic, English, French and Swahili. This will increase and encourage use of the SAFE model to inform FGM/C health education interventions leading to prevention of the practice.

In-depth investigation is required with health and social care professionals to determine their experiences and opinions with regards to health education interventions, because they play a crucial role to prevent FGM/C. Separate accounts between health and social care professionals from communities with a history of FGM/C and those from communities without a history of

FGM/C, should be considered. This would illuminate the possibly diverse challenges that the two groups may face, when caring for FGM/C affected patients/service users, such as knowledge and experience about the practice, which are highlighted in the SAFE model.

Although this research could have benefited with more participants' representation from communities with a history of FGM/C, the evidence compiled from the three studies has presented a solid conclusion that FGM/C health education interventions contribute greatly to the effective prevention of the practice. It is therefore important that the SAFE model is considered, because intervention programmes are then most likely to succeed.

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APPENDICIES

Appendix 1: Search strategy: Systematic review

Cochrane Library search strategy: Wiley.com

#1 female genital mutilation

#2 female adj5 ((genital mutilation) or circumcis* or (genital Cutting))

#3 health education

#4 health adj5 (educat* adj3 (communit*))

#5 health literacy

#6 MeSH descriptor: [Health Literacy] explode all trees

#7 MeSH descriptor: [Health Education] explode all trees

#8 MeSH descriptor: [Circumcision, Female] explode all trees

#9 prevent* or aboli* or abandon* or eliminat* or stop*

#10 #1or #2 or #8

#11 #4 or #5 or #6

#12 #3 or #7

#13 #11 or #12#

14 #9and #10 and #13

Web of science search strategy: Webofknowledge.com

#1 (female genital mutilation)

#2 (female near5 'genital mutilation' or circumcis* or 'genital cutting')

#3 (health education)

#4 ((health near5 'educat* or communit*'))

#5 (health literacy)

#6 (prevent* or aboli* or abandon* or eliminat* or stop*)

#7 #2 OR #1

#8 #5 OR #4 OR #3

#9 #8 AND #7 AND #6

MEDLINE search strategy database: Ovid MEDLINE

1. Circumcision, Female/

2. ((Female adj5 ('genital mutilation' or circumcis* or 'genital cutting')) or FGM* or FGC).mp.

3. Health Education/

4. (health adj5 (educat* adj3 communit*)) mp.

5. health literacy.mp. or Health Literacy/

6. (communit* adj5 (practic* or affect*)) mp.

7. (prevent* or aboli* or abandon* or eliminat* or stop*).mp.

8. 1 or 2

9. 4 or 5

10. 3 or 9

11. 6 and 7 and 8 and 10

Appendix 2: Table 3.1a: Summary of included papers: Systematic review

Author and year	Setting and prevalence	Population	Sample type and recruitment strategy	Study design and comparison group	Method and quality	Information/activities intervention offered/evaluated	Outcome/results
Abdulah et al. (2019)	Iraqi Kurdistan	Parents and leaders	Parents, religious leaders, and traditional leaders in rural areas	Survey	Questionnaire 100%	Short-term education intervention about FGM/C	Attitudes of participants changed from supporting the practice to abandoning and not cutting.
Abdulcadir et al. (2019)	Switzerland	Women	Women Migrants living in Switzerland who had requested reinfibulation	Retrospective	Medical records review 100%	Health education and counselling on female anatomy, physiology, FGM/C, deinfibulation and reinfibulation, cervical screening, sexual health and contraception.	Participant knowledge about FGM/C, deifibulation and reinfibulation had increased. No woman wanted to undergo reinfibulation after the health education sessions.
Ajuwon J. Ademola, Brieger R. W., Oladepo O., Deniyi D.J. (1995)	South West Nigeria Type I	Male practitioners Males and females community leaders Males and females in focus groups Nigeria, Yoruba community	Male and female community leaders Married and unmarried men and women Practitioners/ circumcisers Leaders in community Community members Practitioners age 45 and 70 years Community leaders and focus groups, not specified	Qualitative	Interviews 75%	General knowledge about FGM/C	Health education is important in preventing the need of some indigenous surgeries
Allam M.F., Irala-Esteves D.J., Navajas F.C.R., Castillo	Universities in Cairo, Egypt	Males and females Egypt	University students	Cross-sectional No comparison group	Face-to-face interviews 32-item questionnaire 100%	General information about FGM	High proportion considered discussions in the media to play an

Author and year	Setting and prevalence	Population	Sample type and recruitment strategy	Study design and comparison group	Method and quality	Information/activities intervention offered/evaluated	Outcome/results
D.S.A., Hoashi J.S., Pankovich M.B., Liceaga R.J. (2001)			mean age of 20.97 years of medical and 20.73 years from non-medical Belong to a community that practice FGM				important role in banning of FGM/C People are aware of the dangers involved, are more likely to be against the practice
Alo & Gbadebo, (2011)	Southwest Nigeria	Women Southwest Nigeria	Women who have at least one living daughter Belong to a community affected by FGM/C 15-49 years	Survey	Interviews 50%	General knowledge about FGM/C	Respondents with post-secondary education were at least likely to have their daughters cut. Only 52% of the women were aware of the health hazards associated with FGC Participants from high socio-economic status are least likely to have their daughters cut
Asekun-Olarinmoye E.O., Amusan O.A. (2008)	Shao community is in Kwara State Nigeria Between 60-70% Type I and II	Males and females Yoruba, Nigeria	Residents of Shao town above 10 years Belong to a community that practice FGM/C Modal age of 30-39 and 20-29 in pre-intervention and post intervention respectively	survey	Questionnaires 100%	Health talks in vernacular on female genital anatomy, nature and types of FGM/C, complications, beliefs that encourage it Pictures were utilised to illustrate female genitalia, different types of mutilation Questions and answer sessions utilised for further discussions	No statistical significance difference between the composition and socio-demographic characteristics Education status, age and gender were found to be statistically significant in association to those who had their daughters excised Positive impact of the health education intervention on the attitude of the

Author and year	Setting and prevalence	Population	Sample type and recruitment strategy	Study design and comparison group	Method and quality	Information/activities intervention offered/evaluated	Outcome/results
							respondents to FGM/C and intentions to subject their daughters
Awuah J.B. **(2008)**	Aboabo No.1 - Suburb of Kumasi 75-85% prevalence (24.5% of women) Type II	Females African-Ghana	Those whose address contacts could be traced to their homes Belong to a community that practice FGM No indicated age	Exploratory research	Face to face interviews 75%	Background knowledge and experiences of being circumcised and facing birth complications participant Suggestions of ways to prevent FGM/C from the participants	43% suggested health professionals should use health talks 14% suggested use of dramas and role plays by health educators 14% believe that education of females would help 4% thought use of mass media to educate the public would help
Babalola S., Brasington A., Agbasimalo A., Helland A., Nwanguma E., Onah N. **(2006)**	Enugu state: 3 local government areas; i. Uzo-Uwani,ii. Isi-Uzo and iii. Enugu South FGC prevalence of Enugu -59% Ebonyi -78% Usually type I and II of FGC are performed	Males and females Africa-Enugu and Ebonyi states, Nigeria	Belong to communities affected by FGC a. Enugu state for intervention b. Ebonyi state for comparison c. age 18 to 59 d. men and women	Cross-sectional survey Ebonyi state for comparison	Interviews 100%	Examination of knowledge, attitudes and practices surrounding women's reproductive health Support and training in development of action plan Discussions on social and health complications of FGC	Increased knowledge leading to widespread intentions not to practice Increased self-efficacy to refuse pressure to perform Extremely religious people are less likely to abandon FGC Large number of children was associated with intentions not to practice
Chege J., Askew I., Igras S, Mutesh J.K. **(2004)**	Semi-arid rural in Ethiopia and Kenya Ethiopia-Awash Woredea.	Males and females African-Ethiopians and Somali in Kenya	Have experienced or lived with people who have experienced FGM Ethiopia-8 to 60 years	Quasi-experimental Ethiopia-six villages in Amibara Woreda.	Interviews 75%	Community level education outreach activities using behaviour-communication-change	Percentage of those who support abandonment in Ethiopia intervention group increased by 32%-control group

Author and year	Setting and prevalence	Population	Sample type and recruitment strategy	Study design and comparison group	Method and quality	Information/activities intervention offered/evaluated	Outcome/results
	Kenya-Ifo in Dadaab 76% (Ethiopia) 34% (Kenya) Specific community: 91% (Ethiopia) 100% (Kenya) Type III		Kenya-15 to 60 years Belong to communities affected by FGC	Kenya-Hagadera camp		Community level advocacy Training dispensary service providers in treating complications and counselling clients on FGC related areas	increased by 10%-Kenya-intervention group remained at 23%-comparison group increased by 8% Percentage of those who do not intend to cut – Ethiopia intervention group increased by 26%-control reduced by 1%-Kenya intervention group increased by 3%-comparison increased by 8% Lower levels of exposure to FGC information translates to lower increases in positive attitudes and intent behaviours.
Diop N.J., Askew I. (2009	Kolda Region in Southern Senegal 94% prevalence Type I and II	Men and women Senegal	Males and females from villages where TOSTAN programme had been implemented Older than 15 years	Survey Quasi-experimental, pre-and post-intervention longitudinal design Comparison- villages where the programme had not reached	Interviews 100%	Modules about: Human rights Problem-solving process, Basic hygiene and Women's health	Statistically significant differences in the proportion of girls reported to have been cut in intervention group Significant attitudinal and behavioural changes leading to mass declaration against FGM/C Education, facilitated rapid change in traditional behaviours

Author and year	Setting and prevalence	Population	Sample type and recruitment strategy	Study design and comparison group	Method and quality	Information/activities intervention offered/evaluated	Outcome/results
Jacoby S.D., Lucarelli M, Musse F., Krishnamurthy A., Salyers V. (2015)	Lewiston, Maine United States. Type I – IV	Somali Women, who have experienced perinatal health care	Somali women living in Lewiston, Maine From country where FGM/C is practised 12 to 60 years	Mixed Method	Interviews 75%	General information about women's health including FGM/C	No participant had adequate health literacy Historietas were unanimously approved As appropriate health education tools
Khalil and Orabi (2017)	Cairo, Egypt	Females	Female primary school teachers	Quasi experimental	Questionnaire 100%	General knowledge about FGM/C	General knowledge of the participants increased, showing statistically significant post-test results. Attitudes of the participants changed reducing the number of those who supported the practice from 53.3% to 6.7% at post-test.
Mahgoub et al. (2019)	Sudan	Females	Female students	Quasi experimental	Questionnaire 100%	School-based health education on general information about FGM/C	There was an increase in the knowledge of students with regards to the types of FGM/C and the consequences of the practice. Attitudes changed with 89% indicating they would not subject their daughters to FGM/C.
Mounir G., Nehad HM, Ibtsam M.F. (2003)	Alexandria University, Egypt	Female students Egypt-Middle East	Students from Alexandria University second grade Belong to community affected by FGM Mean-19.35	Quasi-experiment El-Shatby hostel was the control group that did not receive the program	Questionnaire 75%	Training on Importance of premarital counselling, family planning, breastfeeding, sexually transmitted diseases Alternative methods of family planning, weaning and	Statistically significant improvement in each domain of knowledge measured in intervention group and no absolute change was detected in the control group 33 3% gain scores was detected for knowledge

Author and year	Setting and prevalence	Population	Sample type and recruitment strategy	Study design and comparison group	Method and quality	Information/activities intervention offered/evaluated	Outcome/results
						importance of breastfeeding, importance of antenatal care, methods of prevention of STDs Experience and precautions against FGM and early marriage, social pressure on early marriage and FGM	about the term RH and FGM In regards to effects of intervention program, those of high social class had a higher post-test score The program resulted to significant improvement in most of knowledge items and a shift towards a positive attitude
Nkwam-Uwaoma eta al. (2019)	Imo state, Nigeria	Women	Women Living in Imo State, Nigeria	Survey	Questionnaire 100%	General knowledge about FGM/C	98.7% of the respondents were aware of the radio campaigns about FGM/C. Differences in exposure was attributed to inconsistencies with media coverage.
Ofonime and Okon (2017)	Ayadehe clan in Nigeria	Women	Women Over 18 From rural community in Nigeria affected by FGM/C	Qualitative	Interviews 100%	General knowledge about FGM/C	Information was received by participants from various sources including the media, health workers and family members. There was significant association between age and perception of FGM/C. The higher the education level, the higher the perception that FGM/C is a bad practice.

Author and year	Setting and prevalence	Population	Sample type and recruitment strategy	Study design and comparison group	Method and quality	Information/activities intervention offered/evaluated	Outcome/results
Olaitan L.O. (2010)	3 State Capitals in South west Nigeria	Males and females African-Nigeria (Yoruba, Fulani, Hausa and Nupe)	Parents Belong to communities affected by FGC 15 to 65 and above	Survey No comparison group	Questionnaire 75%	General knowledge about FGM	No significance difference existed on gender differences There was significant difference based on age There was significant difference based on educational status Community health education is the best means of providing health information and education to people at every level.
Ruiz JI, Martinez A.P., Bravo P.M.D.M. (2015)	Spain-Murcia and Eastern Morocco	Males African-Living in Spain and Morocco	Male, living in Spain and Morocco originally from countries where FGM is performed Have lived at least 18 years in their countries of origin and have personally being in contact with women with FGM Comprehend Spanish or French Between 20 and 53 years	Qualitative	Semi-structured interview 75%	First-hand knowledge of the practice and its foundations-from various sensitisation and personal experience	Sensitised men can change viewpoints regarding the practice Important to use visual and communication media in health education programmes Development of health education programmes are important
Schliep et al. (2018)	Douentza Cercle, Mali	Males and females	Males and females residing at Douentza Cercle, Mali	Survey	Structured interviews 100%	Radio-based education about FGM/C and health and human rights	There were positive and negative responses about FGM/c with 9% saying it is a 'very good' practice.

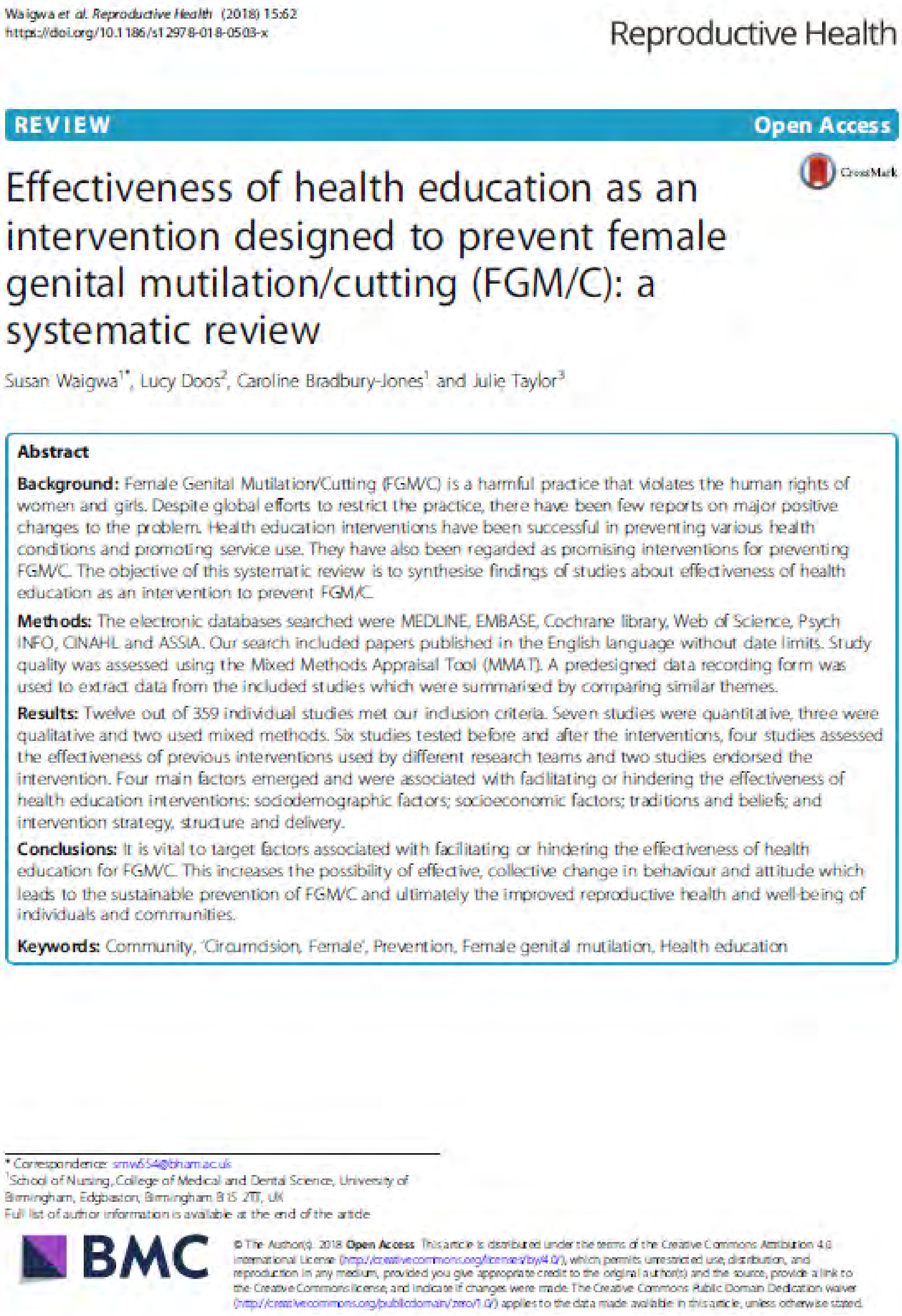
Author and year	**Setting and prevalence**	**Population**	**Sample type and recruitment strategy**	**Study design and comparison group**	**Method and quality**	**Information/activities intervention offered/evaluated**	**Outcome/results**
							There was 90% listening of radio and it should be regarded as a vehicle in FGM/C education.
Shahawy et al. (2019)	Boston, USA	Males and females African and Middle East	Male and female immigrants living in Boston, USA Originally from FGM/C practising communities	Qualitative	Interviews 75%	General knowledge about FGM/C	Participants recognised that FGM/ has no advantages FGM/C was not related to any religion

Appendix 3: Table 3.2a: Summary of themes in each study: Systematic review

Articles\themes	**Programme approach**	**Sociodemographic**							**Socioeconomic**				**Intervention structure and delivery**				
		Age	Ethnicity	Language	Gender	Marital status	Residential status	Religion	Education	Occupation/Role in community	Prevalence rate	location	Attendance	Media	Graphics/artistic	Campaigns	Counseling
Abdulah et al. (2019)								×	×								
Abdulcadir et al. (2019)	×			×	×												×
Ajuwan et al (1995)						×									×		
Allam et al (2001)	×							×	×					×			
Alo & Gbadebo (2011)		×							×	×	×	×					
Asekun-Olainmoye & Amusan (2008)								×	×	×	×						
Awuah (2008)				×		×					×						
Babalola et al (2006)	×		×		×								×	×			
Chege et al (2004)	×		×			×	×	×				×		×			
Diop and Askew (2009)	×		×		×	×							×	×		×	

Articles\themes	Programme approach	Sociodemographic							Socioeconomic				Intervention structure and delivery				
		Age	Ethnicity	Language	Gender	Marital status	Residential status	Religion	Education	Occupation/Role in community	Prevalence rate	location	Attendance	Media	Graphics/artistic	Campaigns	Counseling
Jacoby et al (2015)				×			×								×		×
Mahgoub et al. (2019)		×	×					×				×		×	×	×	
Mounir et al (2003)	×					×			×								
Nkwam-Uwaoma eta al. (2019)	×			×										×			
Ofonime and Okon (2017)		×							×								
Olaitano (2010)		×							×								
Ruiz et al (2015)												×			×	×	
Schliep et al. (2018)	×								×					×			
Shahawy et al. (2019)		×	×				×					×		×			

Appendix 4: Published paper: Systematic review



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Reproductive Health

REVIEW

Open Access

Effectiveness of health education as an intervention designed to prevent female genital mutilation/cutting (FGM/C): a systematic review

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Abstract

Background: Female Genital Mutilation/Cutting (FGM/C) is a harmful practice that violates the human rights of women and girls. Despite global efforts to restrict the practice, there have been few reports on major positive changes to the problem. Health education interventions have been successful in preventing various health conditions and promoting service use. They have also been regarded as promising interventions for preventing FGM/C. The objective of this systematic review is to synthesise findings of studies about effectiveness of health education as an intervention to prevent FGM/C.

Methods: The electronic databases searched were MEDLINE, EMBASE, Cochrane library, Web of Science, Psych INFO, CINAHL and ASSIA. Our search included papers published in the English language without date limits. Study quality was assessed using the Mixed Methods Appraisal Tool (MMAT). A predesigned data recording form was used to extract data from the included studies which were summarised by comparing similar themes.

Results: Twelve out of 359 individual studies met our inclusion criteria. Seven studies were quantitative, three were qualitative and two used mixed methods. Six studies tested before and after the interventions, four studies assessed the effectiveness of previous interventions used by different research teams and two studies endorsed the intervention. Four main factors emerged and were associated with facilitating or hindering the effectiveness of health education interventions: sociodemographic factors; socioeconomic factors; traditions and beliefs; and intervention strategy, structure and delivery.

Conclusions: It is vital to target factors associated with facilitating or hindering the effectiveness of health education for FGM/C. This increases the possibility of effective, collective change in behaviour and attitude which leads to the sustainable prevention of FGM/C and ultimately the improved reproductive health and well-being of individuals and communities.

Keywords: Community, 'Circumcision, Female', Prevention, Female genital mutilation, Health education

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Plain English summary

Female genital mutilation (FGM/C) is a harmful practice that involves total or partial removal of female genitalia without medical purpose. It is mainly practised in some countries in Africa, Asia, the Middle East and some communities in South America. Migration, however, has been associated with the wide spread of FGM/C around the globe. It is performed on young girls and causes short-term and life–long consequences for women as well as extended consequences for families and the community at large. These consequences increase burden to the health systems. Health education interventions are among the prominent forms of interventions that can prevent the practice of FGM/C. However, its impact is dependent on factors that facilitate or hinder effectiveness. Our review revealed that these factors include sociodemographic factors; socioeconomic factors; traditions and beliefs; and intervention strategy, structure and delivery. To ensure the effectiveness of health education interventions, these factors should be considered.

In conclusion, health education interventions have the potential to prevent FGM/C. They can produce a sustainable impact on the reproductive health and well-being of individuals as well as communities. The findings from this study imply that, with caution, health education interventions that focus on FGM/C can be effectively implemented in different populations.

Background

Female genital mutilation/cutting (FGM/C) is a violation against the human rights of women and children such as the right to freedom from discrimination, torture and violence; the right to health; and the right to education. FGM/C involves the total or partial removal of female genitalia without medical purpose. The global prevalence of FGM/C among girls and women is estimated to be over 200 million. It is concentrated particularly in some African, Asian and Middle Eastern countries [1–3]. However, migration has been associated with the wide spread of FGM/C around the globe [4]. Records from 2012 estimate that about 513,000 girls and women had either undergone or were at risk of FGM/C in the United States of America (USA) [5, 6]. In 2015, England and Wales, in the United Kingdom (UK), recorded 137,000 girls and women subjected to FGM/C and 60,000 girls at risk [7].

The World Health Organization (WHO) classifies FGM/C into four types; Type I- Clitoridectomy; Type II- Excision; Type III- Infibulation; and Type IV- Other procedures, including piercing and incising. The practice has been associated with adverse short-term health consequences such as heavy bleeding and tetanus infections; and long-term consequences such as recurring vaginal and pelvic infections, menstrual complications, difficulties during pregnancy and childbirth; and psychological problems such as Post-Traumatic Stress Disorder (PTSD), anxiety and depression [8–11].

FGM/C, which is usually performed on young girls between the age of infancy and 15 years [12], has no medical benefits and medical professionals around the globe are prohibited from carrying out the practice [4, 13]. Whilst the Universal Declaration of Human Rights as well as other global conventions and declarations emphatically oppose the practice [14]. There are a number of factors that allow FGM/C to continue. These include cultural/traditional factors, which are tied up with rituals and complex belief systems [15], religious factors, which are enforced by specific religious beliefs and teachings [16], and health/hygiene factors, which include myths associated with perceived health benefits [17].

The attempts to deal with the negative consequences of FGM/C have unfortunately developed into the medicalisation of the procedure, whereby guarantees of safety are erroneously proffered as a reason for FGM/C to be carried out by health professionals. However, the engagement of health professionals in such procedures inevitably cause harm and constitutes a violation of medical conduct [4, 13, 18]. Consequently, greater effort has been made to deter health professionals from engaging in FGM/C by legal consequences of the practice. However, despite the global efforts to curb FGM/C, there has been few reports on major positive changes of the problem [1].

Health education is the main intervention of interest in this review. It involves different learning experiences designed to help individuals and communities improve their health by increasing their knowledge or influencing their attitude [19]. This goes beyond sharing or disseminating information about a health issue to address motivation, skills, confidence, and communication of information. Differences in economic, social and environmental conditions; individual risk factors and behaviours; and use of health systems are also considered [20].

It is vital for health education interventions to aim at long-term changes to the health behaviour and the norms that are attributed to a health problem. However, evaluation of the effectiveness of interventions depend on documenting the outcomes, effects, formation, process, cost-effectiveness and benefits of the interventions [20].

Health education programmes have been effective in addressing various health related issues such as smoking uptake and cessation, healthy pregnancy and improved newborn outcomes [21–23]. Health education has also succeded in promoting the use of services such as family planning, particularly in communities that are reluctant to access such services [24]. It has also been considered to be a potential intervention for preventing FGM/C.

There are some studies which have reported successful health education interventions in preventing FGM/C globally, but there is need for more exploration of the interventions including their effects in different communities [25]. To our knowledge, there is no systematic review that has synthesised the evidence and ensured understanding of the effectiveness of health education interventions as discrete interventions for FGM/C. The purpose of this review therefore, was to explore the effectiveness of health education as an intervention to prevent FGM/C in the affected communities.

Methods

We searched electronic databases for published work using comprehensive search strategies. Seven main international databases were systematically searched. These included; MEDLINE, EMBASE, Cochrane library, Web of Science, Psych INFO, CINAH and ASSIA. These databases were selected to best represent source material in health, applied health, and human science. Grey literature was also searched and the reference lists from included studies and systematic reviews about FGM/C interventions were hand searched. Search terms were structured carefully to include the problem, intervention comparator and expected outcomes (using a PICO formulation). The terms included female genital mutilation OR female circumcis* OR female genital cutting, affected communit*, health educat* AND/OR health literacy, prevent* OR abandon* OR eliminat* OR stop*(see Additional file 1). English articles with no date restriction were searched. The search was completed in June 2016. Endnote ×7 was utilised as the main reference manager.

The first author (SW) screened titles independently and a second reviewer (HS) independently repeated the process to ensure no relevant studies were excluded. The same reviewers independently decided on the full texts to be included by scrutinising the abstracts. Predetermined inclusion and exclusion criteria were used to guide the screening and selection process.

We included studies focusing on communities affected by FGM/C. There was no limit to the population by geographical location. The included studies either used or discussed health education as an intervention. They had a purpose of disseminating information to individuals or groups of people with an aim of preventing FGM/C as the primary outcome. We considered all study designs with no defined publication timeframe. We excluded studies that did not focus on communities affected by FGM/C and those that focused on medical or cosmetic procedures like vulvectomy or labiaplasty. Studies with a focus on other interventions and studies involving circumcision/genital cutting other than female genital cutting, for instance male circumcision were also excluded.

Data from included studies were extracted using a predesigned data recording form, including general details of the study, intervention description, study outcomes and conclusions. Data were recorded on Microsoft Excel software, which the team used to crosscheck extraction details and ensure accuracy. Discrepancies were discussed and agreed upon within the review team.

Study quality was assessed using the Mixed Methods Appraisal Tool (MMAT) Version 2011 [26]. This was chosen because of its ability to review mixed method studies alongside qualitative and quantitative studies in a single combined tool.

The included papers did not have data that were suitable for meta-analysis, similar to Yang et al. [27], due to heterogeneity. We therefore carried out a thematic analysis focusing on the main themes that were evident in the included studies. Both manifest and latent themes were explored and described as understood by the authors.

Results

The search elicited 359 publications from which 12 full text articles met our inclusion criteria, as shown in the PRISMA flow chart (Figure 1).

The populations involved in the 12 included studies were from Africa and the Middle East, where FGM/C is prevalent. Half of the studies (six) tested knowledge about FGM/C before and after intervention [28, 29, 30, 31, 32, 33]. Four different studies assessed the effectiveness of previous interventions used by different research teams [34, 35, 36, 37]. The remaining two studies endorsed the intervention as a solution for preventing FGM/C following evidence of the relevance of health education interventions to communities affected by FGM/C [38, 39].

From the 12 included studies, seven were quantitative, three qualitative and two used mixed methods. The quality mean-score, of all included studies was 83.33%, which was above the predetermined cut-off mark of 50%, as measured with the Mixed Method Assessment Tool (MMAT). All of the included studies scored above 50% in each of their respective categories and therefore qualified for inclusion. Table 1 presents a detailed summary of each of the 12 included studies.

Factors affecting the effectiveness of health education

Four major themes were identified: sociodemographic factors; socioeconomic factors; traditions and beliefs; and intervention strategy, structure and delivery. These are described further in this section in a nonlinear process. All the studies highlighted at least two themes and discussed their contribution in either enabling or hindering the effectiveness of health education intervention. A summary of the themes is presented in Table 2.

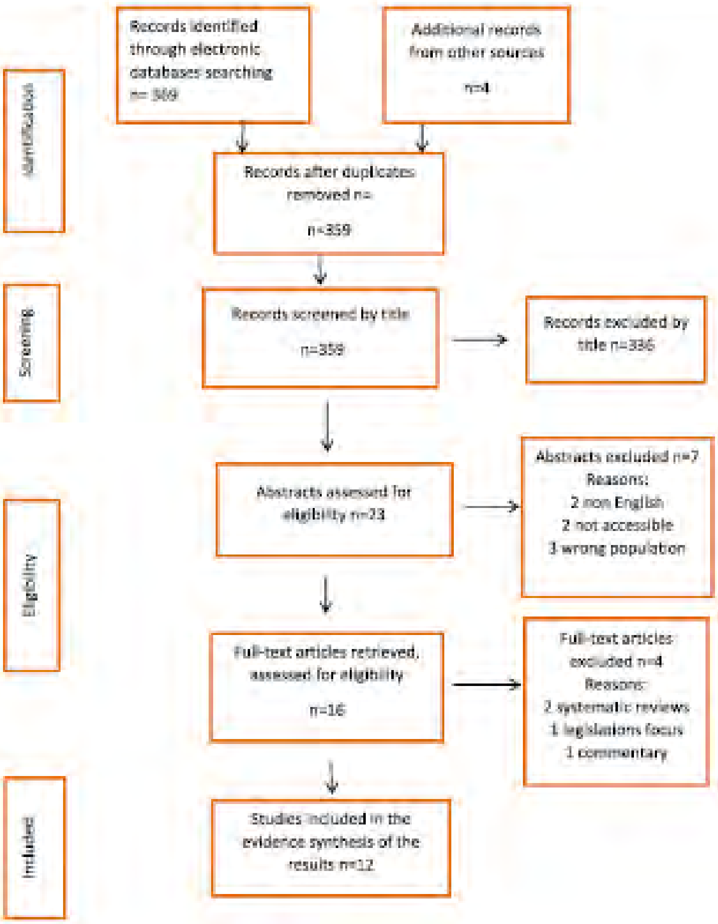

Fig. 1 PRISMA Flow chart

Sociodemographic factors

Six sociodemographic elements were described in the included studies. They include age, ethnicity, language, gender, marital status and residential status.

Age

Two of the twelve studies reported that the age of the populations involved in health education interventions influenced the effectiveness of the interventions. In general, younger populations were more amenable to the interventions. In a study by Olaitan [36] with parents in Nigeria, knowledge of older parents was found to be significantly different from that of younger parents. In the same vein, Alo and Gbadebo [39] concluded that among populations that approved the practice, the levels of FGM/C prevalence were higher among older respondents. They suggested this was because younger respondents were more likely to be school educated, which increased their chances of engaging with FGM/C health education that encouraged abandonment of the practice.

Ethnicity

Three studies reported that ethnic differences between facilitators and communities sometimes influenced the effectiveness of health education interventions due to backlash. It was concluded that facilitators and interviewers needed to belong to the same ethnic groups as participants. Partnering with communities prevented a top-down approach that enhanced the effectiveness of the interventions [28, 30, 31]. If facilitators and interviewers were of different ethnicity from that of the participants, they were required to familiarise themselves with the cultural and structural customs by integrating with the communities beforehand [28, 31].

Language

Two studies highlighted the potential of language barriers reducing the effectiveness of health education interventions [32, 35]. Facilitators struggled with delivering messages and participants also found it hard to understand the messages which were not in their local

Table 1 Summary of included papers

Effectiveness of health education as an intervention designed to prevent female genital mutilation/cutting (FGM/C): A systematic review.

Author and year	Setting and prevalence	Population	Sample type and recruitment strategy	Study design and comparison group	Method and quality of studies	Information/activities intervention offered/ evaluated	Outcome/results
Ajuwon J Ademola, Brieger R William, Oladepo Oladimeji, deniyi D Joshua (1995)	South West Nigeria FGM/C Type I	Male practitioners Males and females community leaders Males and females in focus groups Nigeria, Yoruba community	Male and female community leaders Married and unmarried men and women Practitioners/ circumcisers Leaders in community Community members Practitioners age 45 and 70 years Community leaders and focus groups, not specified	Qualitative	Interviews 75%	General knowledge about FGM/C	There was high need for health education interventions especially for indigenous surgeries
Allam MF, Irala-Esteves DJ, Navajas FCR, Castillo DSA, Hoashi JS, Pankovich MB, Liceaga RJ. (2001)	Universities in Cairo, Egypt	Males and females Egypt	University students mean age of 20.97 years of medical and 20.73 years from non-medical Belong to a community that practice FGM	Cross-sectional No comparison group	Face-to-face interviews 32-item questionnaire 100%	General information about FGM	High proportion considered discussions in the media to play an important role in banning of FGM/C People are aware of the dangers involved, are more likely to be against the practice
Alo & Gbadebo, (2011)	Southwest Nigeria	Women Southwest Nigeria	Women who have at least one living daughter Belong to a community affected by FGM/C 15–49 years	Survey	Interviews 50%	General knowledge about FGM/C	Respondents with post-secondary education were at least likely to have their daughters cut. Only 52% of the women were aware of the health hazards associated with FGC Participants from high socio-economic status are least likely to have their daughters cut
Asekun-Olarinmoye EO,Amusan OA (2008)	Shao community is in Kwara State Nigeria Between 60 and 70% FGM/C Type I and II	Males and females Yoruba, Nigeria	Residents of Shao town above 10 years Participants belonged to a community that practice FGM/C Modal age of 30–39 and 20–29 in pre-intervention and post intervention respectively	survey	Questionnaires 100%	Health talks in vernacular on female genital anatomy, nature and types of FGM/C,complications, beliefs that encourage it Pictures were utilised to illustrate female genitalia, different types of mutilation Questions and answer sessions utilised for further discussions	No statistical significance difference between the composition and socio-demographic characteristics Education status, age and gender were found to be statistically significant in association to those who had their daughters excised Positive impact of the health education intervention on the attitude of the respondents to FGM/C and intentions to subject their daughters

Table 1 Summary of included papers *(Continued)*

Effectiveness of health education as an intervention designed to prevent female genital mutilation/cutting (FGM/C): A systematic review.

Awuah JB (2008)	Ababo No.1 - Suburb of Kumasi 75–85% prevalence (24.5% of women) FGM/C Type II	Females African-Ghana	Those whose address contacts could be traced to their homes Participants belong to a community that practice FGM No indicated age	Exploratory research	Face to face interviews 75%	Background, knowledge and experiences of being circumcised and facing birth complications participant Suggestions of ways to prevent FGM/C from the participants	43% suggested health professionals should use health talks 14% suggested use of dramas and role plays by health educators 14% believe that education of females would help 4% thought use of mass media to educate the public would help
Babalola S,Brasington A, Agbasimalo A, Helland A, Nwanguma E, Onah N. (2006)	Enugu state: 3 local government areas; i. Uzo-Uwani,ii. Isi-Uzo and iii. Enugu South FGC prevalence of Enugu –59% Ebonyi –78% Usually type I and II of FGC are performed	Males and females Africa-Enugu and Ebonyi states, Nigeria	Participants belong to communities affected by FGC a. Enugu state for intervention b.Ebonyi state for comparison c. age 18 to 59 d. men and women	cross-sectional survey Ebonyi state for comparison	Interviews 100%	Examination of knowledge, attitudes and practices surrounding women's reproductive health Support and training in development of action plan Discussions on social and health complications of FGC	Increased knowledge leading to widespread intentions not to practice Increased self-efficacy to refuse pressure to perform Extremely religious people are less likely to abandon FGC Large number of children was associated with intentions not to practice
Chege J, Askew I, Igras S, Mutesh JK. (2004)	Semi-arid rural in Ethiopia and Kenya Ethiopia-Awash Woredea. Kenya-Ifo in Dadaab 76% (Ethiopia) 34% (Kenya) Specific community: 91% (Ethiopia) 100% (Kenya) FGM/C Type III	Males and females African-Ethiopians and Somali in Kenya	Participants must have experienced or lived with people who have experienced FGM Ethiopia-8 to 60 years Kenya-15 to 60 years Participants belong to communities affected by FGC	Quasi-experimental Ethiopia-six villages in Amibara Woreda. Kenya-Hagadera camp	Interviews 75%	Community level education outreach activities using behaviour-communication-change Community level advocacy Training dispensary service providers in treating complications and counselling clients on FGC related areas	Percentage of those who support abandonment in Ethiopia intervention group increased by 32%-control group increased by 10%-Kenya-intervention group remained at 23%-comparison group increased by 8% Percentage of those who do not intend to cut – Ethiopia intervention group increased by 26%-control reduced by 1%-Kenya intervention group increased by 3%-comparison increased by 8% Lower levels of exposure to FGC information translates to lower increases in positive attitudes and intent behaviours
Diop NJ, Askew I (2009	Kolda Region in Southern Senegal 94% prevalence FGM/C Type I and II	Men and women Senegal	Males and females from villages where TOSTAN programme had been implemented and in Older than 15 years	Survey Quasi-experimental, pre-and post-intervention longitudinal design Comparison-villages where the programme had not reached	Interviews 100%	Modules about: Human rights, Problem-solving process, Basic hygiene and Women's health	Statistically significant differences in the proportion of girls reported to have been cut in intervention group Significant attitudinal and behavioural changes leading to mass declaration against FGM/C Education, facilitated rapid change in traditional behaviours

Table 1 Summary of included papers *(Continued)*

Effectiveness of health education as an intervention designed to prevent female genital mutilation/cutting (FGM/C): A systematic review.

Jacoby SD, Lucarelli M, Musse F, Krishnamurthy A, Salyers V (2015)	Lewiston, Maine United States. FGM/C Type I – IV	Somali Women, Individuals who had experienced perinatal health care	Somali women Living in Lewiston, Maine Participants were from countries where FGM/C is practiced 12 to 60 years	Mixed-methods	Interviews 75%	General information about women's health including FGM/C	No participant had adequate health literacy Historietas were unanimously approved As appropriate health education tools
Mounir G, Nehad HM, Ibtsam MF. (2003)	Alexandria University, Egypt	Female students Egypt-Middle East	Students from Alexandria University second grade Participants belong to community affected by FGM Mean-19.35	Quasi-experiment El-Shatby hostel was the control group that did not receive the program	Questionnaire 75%	Training on importance of premarital counselling, family planning, breastfeeding, sexually transmitted diseases Alternative methods of family planning, weaning and importance of breastfeeding, importance of antenatal care, methods of prevention of STDs Experience and precautions against FGM and early marriage, social pressure on early marriage and FGM	Statistically significant improvement in each domain of knowledge measured in intervention group and no absolute change was detected in the control group 33.3% gain scores was detected for knowledge about the term RH and FGM In regards to effects of intervention program, those of high social class had a higher post-test score The program resulted to significant improvement in most of knowledge items and a shift towards a positive attitude
Olaitan LO (2010)	3 State Capitals in South west Nigeria	Males and females African-Nigeria (Yoruba, Fulani, Hausa and Nupe)	Parents Participants belong to communities affected by FGC 15 to 65 and above	Survey No comparison group	Questionnaire 75%	General knowledge about FGM	No significance difference existed between males and females in the knowledge about FGM/C There was significant difference based on age in knowledge about FGM/C There was significant difference based on educational status Community health education is the best means of providing health information and education to people at every level.
Ruiz JI, Martinez AP, Bravo PMDM. (2015)	Spain-Murcia and Eastern Morocco	Males African-Living in Spain and	Male, living in Spain and Morocco originally from countries where FGM is performed Participants lived at least 18 years in their countries of origin and have personally being in contact with women with FGM Participants Comprehend Spanish or French Between 20 and 53 years	Qualitative	Semi-structured interview 75%	First-hand knowledge of the practice and its foundations-from various sensitisation and personal experience	Sensitised men can change viewpoints regarding the practice Important to use visual and communication media in health education programmes There is need for new development of health education programmes.

language. Jacoby et al. found that the use of a 'cultural broker', who is a translator, helped in mitigating some of the language challenges by translating for both the facilitators and participants in languages they could understand [32].

Gender

Two studies reported that gender differences of the recipients affected levels of participating in health education interventions [28, 31]. For example, in the study by Babalola et al. [28], the measure of programme exposure where the radio was the major source revealed that 67.1% of men were exposed to at least one component of the programme, from which they learnt more about FGM/C, compared to 61.4% of women. Diop and Askew [31] in their report on evaluating the effectiveness of education offered by the 'Tostan programme' in Senegal, revealed that there were gender differences in awareness of at least two consequences of FGM/C. Among men, awareness increased from 11% to 80% and among women, from 7% to 83%. The slight difference between the genders was attributed to women's personal experiences of undergoing FGM/C which facilitated a better understanding of the topics.

Marital status

Three studies reported that some married participants, both males and females, did not benefit from health education interventions. This is because they held on to their belief that FGM/C is a means of controlling promiscuity of girls and women which was a virtue in these communities [31, 35, 38]. However, although FGM/C traditionally was believed to be a prerequisite for marriage, some studies reported that most unmarried participants did not think it was important and they appreciated the health education interventions. The authors concluded that this reflected a natural decline in the practice due to generational differences [30, 33]. Chege et al. [30] on a different note, did not find significant association between marital status and support for or opposition of FGM/C and therefore concluded that being married did not act as a barrier to effective health education interventions.

Residential status

The residential status of intervention groups influenced the effectiveness of health education interventions, especially for participants who were immigrants. Jacoby et al. [32] indicated that refugees in the USA shared common concerns in health care matters. These included general health literacy levels and knowledge of the health implications of FGM/C. Additionally, Chege et al. [30] reported that there were higher chances of encountering more resistance to the intervention from immigrants due to forced law enforcement against FGM/C in the host country.

Socioeconomic factors

Two socioeconomic factors emerged from the included studies; education and occupation/roles in communities.

Education

Five studies reflected on the extent to which levels of basic education impacted on access to and acceptability of FGM/C health education programmes. Asekun-Olarinmoye and Amusan [29] reported that education levels of the participants determined the acceptability and effectiveness of health education. This manifested in the attitudes expressed by those with no formal education who were more likely to encourage FGM/C. Olaitan [36] similarly reported that there was a significant difference in knowledge about FGM/C based on educational status. Those with more years of education had greater knowledge influenced by health education interventions. Alo and Gbadebo [39] also highlighted that parents with post-secondary education were less inclined to have their daughters undergo FGM/C because they were more likely to be exposed to health education interventions about the practice. They reported that 48% of those with post-secondary education had none of their daughters cut, compared to 20% of respondents with no formal education. Mounir et al. [33] reported that, students from higher income families had better improvement in knowledge about FGM/C because their family educational background supported acquisition of such knowledge. Slightly contradictorily, Allam et al. [34] found a considerable amount of ignorance concerning FGM/C existed among the educated population in Egypt, including some doctors and midwives.

Occupation/roles in communities

The studies by Asekun-Olarinmoye and Amusan [29] and Alo and Gbadebo [39] highlighted that traditional excisors, health professionals, community leaders and religious leaders were not only recipients of health education interventions, but also implementers and change agents for better outcomes of interventions. When such influential individuals refrain from supporting anti-FGM/C messages, it can negatively affect the success of health education interventions[30].

Traditions and beliefs

Religion

One study concluded that religious belief was not associated with encouraging the continuation of FGM/C and therefore, not a hindrance to effective health education intervention [29]. However, Allam et al. [34] and Chege et

Table 2 Summary of themes in each study

Articles\themes	Sociodemographic						Socioeconomic		Traditions and beliefs			Intervention strategy, structure and delivery					
	Age	Ethnicity	Language	Gender	Marital status	Residential status	Education	Occupation/ Role in community	Religion	Prevalence rate of community	location	Programme approach	Workshops	Counseling	Media	Graphics/ artistic	Campaigns
Ajuwan et al. (1995)					✗											✗	
Allam et al. (2001)							✗		✗			✗			✗		
Alo & Gbadebo (2011)	✗						✗	✗		✗	✗						
Asekun-Olarinmoye & Amusan (2008)							✗	✗	✗	✗							
Awuah (2008)			✗		✗					✗							
Babalola et al. (2006)		✗		✗								✗	✗		✗		
Chege et al. (2004)		✗			✗	✗		✗	✗		✗	✗			✗		
Diop and Askew (2009)		✗		✗	✗							✗	✗		✗		✗
Jacoby et al. (2015)			✗			✗								✗		✗	
Mounir et al. (2003)					✗		✗					✗					
Olaitano (2010)	✗						✗										
Ruiz et al. (2015)											✗					✗	✗

al. [30] reported that religious affiliations of either the participants or the facilitators of health education interventions were likely to affect the effectiveness of the intervention. Distrust predominantly arose when programme facilitators affiliated themselves with a different religion from that of the participants. They also found that involving religious leaders in the health education programmes either positively influenced communities through their teachings about FGM/C, which encouraged abandonment of the practice, or negatively promoted the practice by for instance, referring to it as a religious requirement. Allam et al. [34] emphasised that it was more difficult to educate participants who believed FGM/C is a religious requirement for any faith, because they were more likely to condone the practice.

Prevalence of FGM/C in communities

Prevalence rates were presented to have an effect on health education interventions. For example, in the study from Ghana by Awuah [35], 100% ($n = 70$) of the respondents claimed that FGM/C was practiced, an exercise of which about 43% did not regret. Asekun-Olainmoye and Amusan [29] similarly indicated that 88% ($n = 211$) of female respondents reported to have had FGM/C, of whom 85% had no regrets. Alo and Gbadebo [39] reported on differences in prevalence of FGM/C between generations. They observed that attitude and prevalence more often than not go together. This was reflected in the insignificant 4% intergenerational difference that indicated minimal changes in attitudes following health education interventions that did not justify the efforts made to prevent the practice.

Locality

Three studies demonstrated the impact that locality has on the effectiveness of the intervention [30, 39]. Chege et al. [30], found that the percentage exposed to anti-FGM/C messages in Ethiopia, among the intervention group, increased from 21% to 71% while in Kenya, it increased from 40% to 59%. The difference was attributed to disparities in societal structures. For example, laws against FGM/C were harsher in Kenya, and their enforcement made it harder for interventions to win trust from FGM/C affected communities. Alo and Gbadebo [39] emphasised that, females in a rural setting were more likely to support FGM/C compared to those living in urbanised communities. They concluded that health education interventions in the rural areas require more intense planning and implementation than the urban areas. Ruiz et al. [37] in the same vein reported that awareness efforts in rural areas needed to be more intense in comparison with urban areas because the inherent isolation in rural areas propagated FGM/C.

Programme strategy, structure and delivery

Programme approach

Methods that health education programmes used to approach the intervention groups were associated with the effectiveness of the interventions. Chege et al. [30], Mounir et al. [33] and Allam et al. [34] reported that it was necessary for health education facilitators to approach communities with caution; otherwise, they would face rejection. In studies that included interviewing as a process of health education, interventions were more effective when males interviewed males and females interviewed females [34]. Diop and Askew noted that researchers needed to integrate with community interviewers, who belonged to the target communities, prior to implementation so as to increase reliability of respondents reports [31].

Four studies showed that the levels of programme exposure impacted on the effectiveness of the health education intervention [28, 30, 31, 34]. Lower levels of exposure translated to a smaller increase in positive attitude and intended behaviour [30], while higher levels of exposure translated to powerful, effective means for facilitating rapid communal changes [31].

Workshops

The studies by Babalola et al. [28] and Diop and Askew [31] reported that there was inconsistency in lectures and workshops attendance. This influenced the effectiveness of the health education interventions as it translated to sub-optimal outcomes because they yielded insignificant results.

Counselling

Jacoby et al. [32] showed that counselling early in the antepartum period was more effective than late counselling. This was preferable to the participants on the basis that early intervention gives ample time for thinking and discussing health concerns with spouses.

Media

Media seemed to be a vital tool for delivering FGM/C health education interventions. Radio appeared to be an effective means to reach the men in most populations and was mostly favourable among young people [28, 31, 34]. However, in the study by Chege et al. [30], media was disadvantageous because some messages were not always in support of FGM/C prevention. This in turn limited the effectiveness of the health education intervention.

Graphics/artistic

The use of graphics or artistic modes of dissemination mostly enhanced the effectiveness of health education interventions. Jacoby et al. [32] in their study about immigrant Somali women's health literacy and perinatal experiences found that Historietas (graphical booklets) were endorsed by participants because they understood the contents better [32]. Practical training was reported by participants as a preference and was endorsed as a means of effective communication of anti-FGM/C including to traditional excisors [37, 38].

Discussion

This review aimed to assess the effectiveness of health education interventions in preventing FGM/C in the affected communities. We managed to unveil factors that facilitate or hinder effectiveness of health education interventions. Various studies, including systematic reviews, have evaluated different interventions as well as their benefits and effectiveness in preventing FGM/C. Health education, among other interventions, has been regarded as important in contributing to raising awareness about FGM/C, leading to changed attitudes and behaviours in various communities [40, 41].

Our study challenges the approach applied by previous reviews about the effectiveness of FGM/C interventions in general. We ventured to explore health education as an individual intervention, while focusing on the issues that are specific to this particular intervention. Our results show that the effectiveness of FGM/C health education interventions depended on factors linked to sociodemographic factors; socioeconomic factors; traditions and beliefs; and intervention strategy, structure and delivery. The most pronounced finding was that these factors are guaranteed to disturb the process of implementing change through health education interventions. It is therefore, important to ensure that health education interventions have tailored information, communication and education to fit the target population based on their needs. This requires prior understanding of individual capacity and existing knowledge including individual ages and levels of education [29, 30, 33, 35, 36, 37, 38, 39]. The importance of community-based approaches for FGM/C health education interventions cannot be underestimated. The value of this approach is demonstrated by Chege et al. [30] who reported how religious leaders and other key leaders in the communities were used for advocacy against FGM/C. Community leaders are valued individuals and their inclusion in interventions has been recognised to enhance effectiveness particularly where messages relate to sensitive health problems such as HIV [42]. There are a number of strategies to support the process. For example, Mounir et al. [33] described how intervention facilitators in their study dressed in a similar style of clothing to participants in an attempt to encourage shared identity and break down barriers.

It is important to acknowledge that the studies included in this review focused on different communities who may have varying reasons for performing FGM/C, even when they come from the same country. This supports the importance of tailoring interventions to the target population and minimising generalisation.

Personal beliefs and views have been highlighted in a number of contexts to affect attempts to induce change of negative social behaviours because they are highly influenced by prior knowledge, experience and psychological state [43, 44]. An understanding of individual viewpoints and attitude can predict behaviour change [45]. This review has shown that educational background, rate of prevalence of FGM/C, religion and media all influence the effectiveness of health education interventions [28, 29, 30, 31, 34, 35, 39]. Diop and Askew [31], for example contended that there was a reduction in the number of daughters who were cut after their mothers participated in a programme aimed at changing perceptions of FGM/C. Alo [39], however, reported that women's decisions did not matter as their husbands had control over decision-making, influencing their behaviour. This indicated that though the women were aware of the health issues, FGM/C would still be practised. Michie et al. [46] similarly suggested that behaviour change is dependent on psychological capabilities such as strength and skill that could affect individual perception and social opportunities such as cultural norms that could influence behaviour, regardless of individual perception.

While changed attitude and behaviour by individuals is essential, sharing acquired information and change is as important for better results of collective prevention of FGM/C [30]. The willingness to share information however, is dependent on factors such as commitment, enjoyment of helping others, reputation and organisational reward [47]. Diop and Askew [31] for example, indicated that women who participated in an FGM/C programme were encouraged to "adopt" a friend/relative and share information regarding their learning during classes and this proved effective. The programme encouraged sharing of information by establishing community management committees to strengthen village ownership of the programme. However, it is not always a guarantee that group prevention is attained, especially if pro-FGM/C messages are shared instead of messages against FGM/C. When correct information is communicated and shared effectively, it eventually results in collective knowledge and awareness that in turn influences communal change. This can culminate in wider results for public campaigns and denouncement of the practice [30].

This review acknowledges the factor of acculturation, which has the capacity to influence the attitude and views of immigrant communities, depending on the economic status and legislative changes of the home or host countries [48]. Two studies that were conducted in Spain and USA focused on communities with a history of FGM/C living in these high income countries. They found that participants' views and opinions may not be entirely free from acculturation [32, 37]. In addition, the impact of acculturation may not be reflected differently when the host country is a low-middle income country [30] .

According to the WHO, health education presents to communities a package comprising opportunities for learning that are based on sound theories to offer health information. From some perspectives, the FGM/C interventions can be perceived as a top-down approach, with communities being the recipients[19]. With this in mind, Babalola et al. (28) emphasises the importance of integration with communities prior to implementation of interventions. They argued that this increases community acceptance of an intervention, leading to its success.

Findings from this review highlight health education as a promising intervention in preventing FGM/C. The intervention is favoured over other interventions such as legislation, because it is less repressive. Although the law reduces the rate of FGM/C, it has also been found to drive the practice underground. In other instances, the law has led to parents subjecting girls to FGM/C at a younger age before they are susceptible to anti-FGM/C messages. There is also an association between law enforcement and increased medicalisation as well as reduced reporting of FGM/C cases [37, 49–54].

Contextualising health education interventions is only possible when there is sufficient consideration of the characteristics of target populations. Contextualising involves inclusion of the communities in planning the programmes, for instance, involving permanent residents who belong to the target communities as facilitators or research assistants [29]. Religious and other key leaders can also help to promote the interventions [30]. Community members can be involved in dissemination of information to relatives and friends, therefore, encouraging public awareness and resistance to FGM/C [31]. It is evident from this review that tailoring information to fit the needs of the target populations is crucial because it increases the acceptability of the programme and influences quicker dissemination of information among communities.

Despite the strengths, this review was limited because some studies did not indicate the duration of the interventions. It is therefore important to note that based on the nature of the intervention, shorter durations may have offered less chance for programmes to attain desired goals, especially in sharing of information. This review also considered only studies reported in English. Other languages could have reported the issue differently for instance, studies from non-English speaking high-income countries. The review considered only studies that focused on affected communities and excluded studies from non-practicing communities which future research should consider to include.

There is ample room to improve women and girls' safety from FGM/C. Rational approaches through health education interventions should be carefully planned. As Abdulcadir et al. [55] points out, there is a dearth of research focusing on interventions to prevent FGM/C. This includes health education offered by health professionals who work with communities affected by FGM/C. Further research is needed to establish the effectiveness of health education interventions offered to different populations living in high-income countries. Cultural competency especially in the healthcare system can help improve health outcomes and quality of care [56]. Further research therefore is needed to increase the understanding of how best to involve different demographic groups including non-practicing communities, in health education interventions, in order to maximise effective prevention of FGM/C.

Conclusion

Health education is an important intervention which has the capacity to change deeply engraved beliefs and attitudes attributed to certain health problems such as FGM/C. When the intervention is comprehensively planned, implemented and evaluated, it can be successful in preventing FGM/C in any target group. This study contributes to the understanding of the facilitators and barriers of effective health education interventions in preventing FGM/C. Our findings suggest that health education interventions have the potential to influence communal change, which eventually leads to sustainable prevention of FGM/C. The success of health education interventions is dependent on sociodemographic elements, socioeconomic factors, traditions and beliefs and programme approach. Evidence suggests that these factors are vital and require intensive consideration at every stage of the intervention. This ensures increased possibility of influencing communal change in behaviour and attitude, leading to sustainable prevention of FGM/C, thus, improved reproductive health and wellbeing of individuals and communities.

Additional file

Additional file 1: Search strategies. (DOCX 12 kb)

Abbreviations

CBJ: Caroline Bradbury-Jones; FGM/C: Female genital mutilation/cutting; HS: Harpreet Sihre; JT: Julie Taylor; LD: Lucy Doos; SW: Susan Waigwa; UK: United Kingdom; USA: United States of America; WHO: World Health Organization

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Availability of data and materials
Interested parties can obtain all available data by contacting the corresponding author.

Authors' contributions
SW undertook the systematic review, carried out the thematic synthesis and wrote the manuscript. LD, CBJ and JT participated in the design of the systematic review, advised in the thematic synthesis and revised the manuscript. All authors agreed the final version of the manuscript.

Ethical approval and consent to participate
Not applicable.

Competing interests
The authors declare that they have no competing interests.

Publisher's Note

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Appendix 5: Information sheet: Survey

College of Medical and Dental Science

University of Birmingham

B15 2TT

Research study: Discussions about female genital mutilation/cutting (FGM/C): A survey of experiences and views of health professionals in Birmingham.

My name is Susan Waigwa and I am a student from the University of Birmingham. I am undertaking a PhD in which I am investigating the prevention of female genital mutilation/cutting (FGM/C) in Birmingham. You have been invited to participate in our project because you work or have worked with communities affected by FGM/C. Your contribution and views will be valuable for us to clearly understand issues that affect discussions about FGM/C in Birmingham. It is therefore important for you to understand what the research involves and why it is being done. Before you start, please read this information sheet carefully. You may wish to discuss it with other colleagues who can help you understand this information sheet. If you would want more information, feel free to contact the researcher using the contact details below.

Why are we doing this research?

The purpose of this research is to explore the experiences and views of midwives, health visitors and general practitioners on discussions about FGM/C. The Multi-agency statutory guidance on female genital mutilation (2016) emphasises on the importance of professionals talking about FGM/C with their patients, which is part of health education intervention to increase knowledge. It recognises that the topic can arise in various setups including general practice surgeries as part of consultation and in the home environment with the health visitors' post-natal visit. The professionals may also often need to share that information with other relevant professionals to facilitate safeguarding of children and vulnerable adults. There are about 137,000 women and girls who in England and Wales who live with FGM/C consequences. In addition, there are about 60,000 girls who are at risk of undergoing the procedure. This study aims to compile a report showing enablers and barriers of effective discussions about FGM/C. We would appreciate your participation in sharing your experiences and views that will help in improving the effectiveness of discussions about FGM/C to promote prevention.

Why have I been approached?

You have been invited because you are a health professional who works with or has worked with persons from communities affected by FGM/C in Birmingham. We believe that you are ideally placed to help us understand issues on discussions about FGM/C through sharing your experiences and views.

Do I have to participate?

No, your participation is voluntary and decision is all yours, to participate or not. If you choose to participate, you are at liberty to stop at any point during this research without any questions or fear of reprisal.

What do I do if I am interested in taking part in the study?

This study involves a survey questionnaire which you will access through a link sent to you by email. If you agree to participate, you will be required to provide your consent form before completing the questionnaire. You will then submit the complete questionnaire back to us via the same link provided. If you do not tick the box to consent, you will not be allowed to complete the questionnaire. The questionnaire will not take more than 30 minutes to complete.

It will ask you about your demographic characteristics, experiences and views concerning the topic.

What will happen next with the results?

The questionnaire returned to us will be handled with confidentiality. Each participant will be given a unique number for identifying the data such that no names or address are traceable. The data will only be used for this study and will be stored in the university data archives for ten years, after which that data will be destroyed. The compiled report will be published in relevant open access journals through the university repository.

How do I benefit?

We cannot guarantee direct benefit from this study directly but your responses together with other participants will help in compiling a comprehensive report that will inform the best way for discussing about FGM/C with patients and individuals affected by FGM/C to promote prevention. However, you will benefit from a range of information which you may obtain from the final results and analysis that will be made available to you through your leads. This may contribute to your confidence and professional gratification when dealing with FGM/C issues.

Are there possible disadvantages/risks of taking part?

The questions from this study are seeking your experiences and views on discussions about FGM/C aimed at preventing the practice. It does not involve any clinical interventions or professional practice or service evaluation. Should you feel uncomfortable answering any of the questions, you are at liberty to leave the question unanswered or return to answer later. We anticipate that there should be no disadvantages in taking part, apart from sparing some of your valuable time for us.

Can I withdraw from the study?

As a participant, you are at liberty to abandon the questionnaire at any stage, should you be uncomfortable to continue. After submitting your responses, you will not be able to withdraw from the study as the data provided will be anonymous therefore the researcher may not be able to identify particular information that you wish to be withdrawn. Partial completion of the questionnaire will be recognised as incomplete but, all the important information that has been submitted will be incorporated to the findings as the questions have been set as standalone questions. The researcher's contact details will be made available throughout the study, should you encounter any problems completing the questionnaire.

What do I do if there is a problem?

If you encounter any problem during the study, you should ask to speak to the researcher who will do her best to answer your questions (contacts are at the end of this information sheet). If you are still unsatisfied, you can contact your lead who is working with the research team and he/she will take the matter administratively in liaison with the research team to making sure that your queries are addressed.

How will confidentiality be sustained?

The collected data will be managed and securely stored in the university facilities where only authorised persons in the research team can access. After the analysis, the data will be safely secured in the university archives for ten years, after which it will be destroyed according to the university's data protection policy on safety of collected data. None of the participants or the facilities they work at will be named in the findings. This is to avoid having data that may lead to recognition of the participants or the facilities they work in.

Who is funding the study?

This study has no funding from any funding body but it is running via the sponsorship and support of the University of Birmingham.

Ethical Approval

The project will operate under ethical approval from the University of Birmingham ethics committee and the Health Research Authority (HRA).

Who are the research team?

The main research team is comprised of four individuals, myself; Susan Waigwa. I am a PhD researcher of this project and a registered social worker with overseas practice experience. Professor Julie Taylor, who is a nurse scientist and has expertise in child protection research, Doctor Lucy Doos, who is a medical doctor and has expertise in public health research and Doctor Caroline Bradbury-Jones, who is a registered nurse, midwife and health visitor and has expertise in family violence and child abuse and neglect research.

For further information and contact details:

Susan Waigwa Doctoral researcher Tell:	Prof Julie Taylor Lead supervisor	Dr Lucy Doos Co-supervisor	Dr Caroline Bradbury-Jones Co-supervisor

Write:

Susan Waigwa

c/o Professor Julie Taylor

Medical School

University of Birmingham

B15 2TT

For more information about the project or the research team, please contact Dr Alistair Hewison, Department of Nursing, College of Medical and Dental Sciences, University of Birmingham at or

Thank you for taking time to read this information sheet.

Appendix 6: Invitation letter and Newsletter Briefing: Survey

Invitation letter

College of Medical and Dental Science

University of Birmingham

B15 2TT

Date: 20th Sep 2018

Research study: Discussions about female genital mutilation/cutting (FGM/C): A survey of experiences and views of health professionals in Birmingham.

Dear participant,

We would like to invite you to participate in our study because you may work or are working with individuals who come from communities affected by FGM/C. Before you decide whether you would be interested in taking part, please read the provided information sheet (attached to the survey link). This will provide you with detailed information about the study and what is required of you.

This study will unveil the enablers and barriers of effective discussions about FGM/C in Birmingham. Our aim is to explore the experiences and views of midwives, health visitors and general practitioners on discussions about FGM/C which help compile a comprehensive informative report that will aid to improve discussions about FGM/C that promote prevention.

The study is being supported by the University of Birmingham and it has no affiliation with any funding body.

If you are interested in taking part we would like you to:

☐ Read the Participant Information Sheet so that you understand fully the details of the study.

☐ Consent to take part.

☐ Complete a questionnaire that should not take more than ten minutes.

☐ Submit the completed questionnaire via the link to the researcher.

To take part in the survey, please click on this link:

You can contact the researcher for any clarifications needed about the study.

We hope that you agree to participate

Yours sincerely,

Susan Waigwa

Doctorate researcher

Email:

Newsletter Briefing

Female genital mutilation/cutting (FGM/C) survey

Discussions about FGM/C by health professionals with their patients and clients are very important in the process of raising awareness and have a great effect in preventing the practice. We would like to invite you to participate in this survey by sharing your experiences and views about discussing FGM/C with your patients/clients. Your participation will help us understand the barriers and facilitators to effective discussions about FGM/C, which in turn will inform healthcare and social care professionals in their practice. The University of Birmingham is sponsoring this survey as part of a bigger project about 'Health education and FGM/C'. Please use the link provided for more details about the project and your participation, which are included in the attached information sheet. The survey will not take more than 10 minutes. If you have any questions or problems accessing the survey, you can contact the researcher, Susan Waigwa, via Thank you for taking time to participate in this survey.

Link:

Appendix 7: Reminder invitation letters and newsletter briefings: Survey

Reminder invitation letter

College of Medical and Dental Science

University of Birmingham

B15 2TT

Date: 28th Sep 2018

Research study: Discussions about female genital mutilation/cutting (FGM/C) in Birmingham

Dear Participant,

A few weeks ago you received a survey asking for your experiences and views on discussions about FGM/C. If you have already completed and submitted the survey, thank you for your valuable time and contribution. If not, please complete the survey through the link provided below and submit your responses. The survey itself should take no more than 10 minutes to complete. An information sheet, which will provide you with detailed information about the study and what is required of you, and consent form can be found in the link below.

Link:

Your responses are vital in helping us explore more about discussions of FGM/C by health professionals to promote prevention. This will lead to better understanding of the enablers and barriers of effective discussions that can facilitate better support for health professionals in dealing with FGM/C.

If you have any questions, please contact the researcher via the contacts provided below.

Thank you for your time.

Yours sincerely,

Susan Waigwa

PhD researcher

Email:

Telephone: +44 (0) 7404122064

Supervisory team: Prof Julie Taylor

Reminder Newsletter Briefing

Female genital mutilation/cutting (FGM/C) survey

Discussions about FGM/C by health professionals with their patients and clients are very important in the process of raising awareness and have a great effect in preventing the practice. If you have not yet participated, we would like to invite you to take part this survey by sharing your experiences and views about discussing FGM/C with your patients/clients. Your participation will help us understand the barriers and facilitators to effective discussions about FGM/C, which in turn will inform healthcare and social care professionals in their practice. The University of Birmingham is sponsoring this survey as part of a bigger project about 'Health education and FGM/C'. Please use the link provided for more details about the project and your participation, which are included in the attached information sheet. The survey will not take more than 10 minutes. If you have any questions or problems accessing the survey, you can contact the researcher, Susan Waigwa, via

Thank you for taking time to participate in this survey.

Appendix 8: Consent Form: Survey

College of Medical and Dental Science

University of Birmingham

B15 2TT

Research study: Discussions about female genital mutilation/cutting (FGM/C): A survey of experiences and views of health professionals in Birmingham.

Name of the researcher: Susan Waigwa

Supervisory team: Prof Julie Tailor, Dr Lucy Doos and Dr Caroline Bradbury-Jones

Please confirm the following to continue with the survey:

1) I confirm that I have read and understood the information sheet version 6, dated 19th December 2017 for the above study.

2) I understand that I am participating voluntarily and I am free to withdraw at any time without feeling compelled to give reasons or my rights being affected.

3) I agree to fill in the questionnaire and I understand that it will be stored in a secure place bearing no personal information that can trace me.

4) I understand the Survey Monkey privacy policy indicated at https://www.surveymonkey.com/mp/policy/privacy-policy/

5) I understand that the information I have given may be included in reports and publications from this study and will maintain anonymity, such that I will not be identified.

By clicking yes, you consent you are willing to answer the questions in this survey.

Yes ☐

No ☐

Appendix 9: Questionnaire: Survey

Discussions about female genital mutilation/cutting (FGM/C): A survey of experiences and views of health professionals in Birmingham.

The research is being undertaken at University of Birmingham.

Research team: Susan Waigwa, Prof Julie Taylor, Dr Lucy Doos, Dr Caroline Bradbury-Jones)

1. **By clicking yes, you consent that you are willing to answer the questions in this survey. If you do not tick 'yes', you will not be allowed to continue with this study.**

Yes ☐

No ☐

2. **FGM/C is child abuse and violence against women, discussing it can be difficult and upsetting, but good communication is essential. In the list of activities/processes provided below, please indicate how confident are you in:**

	Always confident	Sometimes confident	Never confident	I don't know the process
Identifying FGM/C affected patient/clients				
Starting a conversation about FGM/C with patients/clients				
Discussing health implications of FGM/C with patients/clients				
Discussing FGM/C illegalities with patients/clients				

Recording newly identified FGM/C cases and attendances on enhanced data-set information standard				
Reporting known cases of girls under 18				
Sharing information with relevant professionals (such as school nurse, GP etc.) to safeguard children and vulnerable adults				

3. As a registered health professional, please rate your knowledge in relation to your duty on the following;

	Strong knowledge (need no help, usually help others to implement)	**Moderate knowledge** (occasionally need help to implement)	**Little knowledge** (need help most of the times to implement)	**No knowledge**
Requirements and procedures of identifying FGM/C affected individuals				
Procedure and prompts of starting a conversation about FGM/C with patients/clients				
Health implications of FGM/C				
Illegalities of FGM/C				
Requirements and procedures of recording newly identified cases of FGM/C and attendances on the enhanced data-set information standard				

Requirements and procedures of reporting known cases of girls under 18				
Requirements and procedures of sharing information with relevant professionals to safeguard children and vulnerable adults				

4. **It is important that health professionals take time to think about their own concerns, feelings and values, so they can discuss FGM/C sensitively with clarity and confidence. In your view, which of the following has hindered you from discussing FGM/C with patients/clients? (**Please tick as many as may apply).

Fear of interfering with other people's culture ☐

Fear of ruining patient and family relationships ☐

Language barrier ☐

Feeling that they are not interested ☐

Fear of personal safety ☐

Fear of being labelled as a racist ☐

Lack of enough knowledge about FGM/C ☐

Feeling that it is someone else's role ☐

Feeling that it is an added responsibility ☐

Lack of clear guidelines/pathways ☐

Fear that the law is too harsh ☐

Lack of enough time ☐

Lack of private space ☐

None of the above ☐

Other (please specify) ☐ ______

5. **Given the hidden nature of FGM/C, it can be deeply embedded and therefore discussions should be undertaken with appropriate care. From your experience, which of the following would you consider to be helpful for you to effectively discuss about FGM/C? (**Please tick as many as may apply).

Good working environment ☐

Well-structured safeguarding and referral pathways ☐

Availability and accessibility of FGM/C leads ☐

Knowledge about FGM/C matters ☐

Seminars and Forums about FGM/C ☐

Availability and accessibility of online learning materials ☐

Experience in caring for individuals from FGM/C affected communities ☐

Presence of third sector services that support FGM/C affected communities ☐

Other (please specify) ☐ ______

6. **It is likely that some individuals affected with FGM/C are living in every local authority area. About how many patients/clients have you cared for in your entire career where you;** (please tick appropriate box or go to question 8 if **none** is appropriate)

	None	1-5	6-10	More than 10
Identified FGM/C affected patient				
Started a conversation about FGM/C with patients				
Discussed about health implications of FGM/C with patients				

Discussed about FGM/C illegalities with patients				
Recorded newly identified cases and attendances on enhanced data-set information standard				
Reported known cases of girls under 18				
Shared information with relevant professionals to safeguard children and vulnerable adults				

7. **In general, about how many of the patients/clients you have cared for during your entire career?**

   (please tick one box only for each)

	All of them	Some of them	None	Don't know
Resident in Birmingham				
Ethnic minority				
Christian				
Buddhist				
Hindu				
Jewish				
Muslim				
Sikh				
Have no religion				
Religion isn't known				

8. **How long have you worked in your profession including previous posts?**

Less than 1 year ☐

1 -5 years ☐

6-10 years ☐

11-15 years ☐

16-20 years ☐

21 and above years ☐

9. In the following text boxes, please indicate;

a. Your profession

b. Area(s) that your organisation serves

c. Your gender

a.
b.
c.

10. Please feel free to add any other comments or concerns on discussions about FGM/C in the space provided.

Thank you for taking your time to complete this survey. If you are comfortable with your answers, please submit and exit the page.

Appendix 10: Table 5.1a: Number of patients cared after by different health professional groups relevant to the measures involving discussion of FGM/C with patients/service users: Survey

	Midwives (n=46)				**General Practitioners (n=11)**				**Health visitors (n=10)**			
Number of patients or service users **Activities/ Measures**	**None** **(%)**	**1-5**	**6-10**	**More than 10**	**None**	**1-5**	**6-10**	**More than 10**	**None**	**1-5**	**6-10**	**More than 10**
Identified FGM/C affected patient	**2** (4.3)	**15** (32.6)	**4** (8.7)	**25** (54.4)	**4** (36.4)	**2** (18.2)	**0** (0.0)	**5** (45.5)	**0** (0.0)	**5** (50.0)	**3** (30.0)	**2** (20.0)
Started a conversation about FGM/C with patients	**0** (0.0)	**9** (19.6)	**7** (15.2)	**30** (65.2)	**2** (18.2)	**4** (36.4)	**0** (0.0)	**5** (45.5)	**0** (0.0)	**4** (40.0)	**1** (10.0)	**5** (50.0)
Discussed about health implications of FGM/C with patients **2 (4.3%) missing- midwives**	**5** (10.9%	**11** (23.9)	**5** (10.9)	**23** (50.0)	**3** (27.3)	**4** (36.4)	**0** (0.0)	**4** (36.4)	**0** (0.0)	**2** (20.0)	**2** (20.0)	**6** (60.0)
Discussed about FGM/C illegalities with patients	**3** (6.5)	**14** (30.4)	**3** (6.5)	**26** (56.5)	**2** (18.2)	**5** (45.5)	**0** (0.0)	**4** (36.4)	**0** (0.0)	**2** (20.0)	**1** (10.0)	**7** (70.0)
Recorded newly identified cases and attendances on enhanced data-set information standard **2 (4.3%) missing -midwives**	**21** (45.7)	**12** (26.1)	**1** (2.2)	**10** (21.7)	**6** (54.5)	**0** (0.0)	**0** (0.0)	**5** (45.5)	**3** (30.0)	**5** (50.0)	**0** (0.0)	**2** (20.0)
Reported known cases of girls under 18	**36** 78.3%	**6** (13.0)	**2** (4.3)	**2** (4.3)	**10** (90.9)	**0** (0.0)	**0** (0.0)	**1** (9.1)	**7** (70.0)	**3** (30.0)	**0** (0.0)	**0** (0.0)

Shared information with relevant professionals to safeguard children and vulnerable adults	**6** (13.0)	**12** (26.1)	**3** (6.5)	**25** (54.3)	**8** (72.7)	**2** (18.2)	**0** (0.0)	**1** (9.1)	**1** (10.0)	**4** (40.0)	**2** (20.0)	**3** (30.0)

Appendix 11: Table 5.2a: Level of confidence across health professionals in measures involving discussion of FGM/C with patients/service users

	Midwives (n=46)				General Practitioners (n=11)				Health visitors (n=10)			
Confidence scale (%) **Activities/ Measures**	**I don't know the process**	**Never confident**	**Sometimes confident**	**Always Confident**	**I don't know the process**	**Never confident**	**Sometimes confident**	**Always Confident**	**I don't know the process (interesting zeros)**	**Never confident**	**Sometimes confident**	**Always Confident**
Identifying FGM/C affected patients/service users	0 (0.0)	3 (6.5)	28 (60.9)	15 (32.6)	1 (9.1)	1 (9.1)	6 (54 5)	3 (27.3)	0 (0.0)	0 (0.0)	8 (80.0)	2 (20.0)
Starting a conversation about FGM/C with patients/service users	0 (0.0)	2 (4.3)	23 (50.0)	21 (45.7)	1 (9.1)	1 (9.1)	5 (45 5)	4 (36.4)	0 (0.0)	0 (0.0)	4 (40.0)	6 (60.0)

Discussing health implications of FGM/C with patients/service users	1 (2.2)	3 (6.5)	23 (50.0)	19 (41.3)	1 (9.1)	2 (18.2)	3 (27 3)	5 (45.5)	0 (0.0)	0 (0.0)	2 (20.0)	8 (80.0)
Discussing FGM/C illegalities with patients/service users	1 (2.2)	2 (4.3)	24 (52.2)	19 (41.3)	1 (9.1)	0 (0.0)	5 (45 5)	5 (45.5)	0 (0.0)	0 (0.0)	3 (30.0)	7 (70.0)
Recording newly identified cases and attendance on enhanced data-set information standard	10 (21.7)	5 (10.9)	20 (43.5)	10 (21.7)	2 (18.2)	0 (0.0)	6 (54 5)	3 (27.3)	2 (20.0)	0 (0.0)	3 (30.0)	5 (50.0)
Reporting known cases of girls under 18	5 (10.9)	6 (13.0)	23 (50.0)	12 (26.1)	2 (18.2)	0 (0.0)	3 (27 3)	6 (54.5)	0 (0.0)	1 (10.0)	4 (40.0)	5 (50.0)
Sharing information with relevant professionals (such as school nurse, GP) to safeguard children and vulnerable adults	2 (4.3)	6 (13.0)	16 (34.8)	22 (47.8)	2 (18.2)	0 (0.0)	3 (27 3)	6 (54.5)	0 (0.0)	0 (0.0)	2 (20.0)	8 (80.0)

Appendix 12: Table 5.3a: Level of knowledge across health professionals in measures involving discussion of FGM/C with patients/service users

	Midwives (n=46)				General practitioners (n=11)				Health visitors (n=10)			
Knowledge scale **Activities/ Measures**	**No knowledge** **(%)**	**Little Knowledge**	**Moderate knowledge**	**Strong knowledge**	**No knowledge**	**Little Knowledge**	**Moderate knowledge**	**Strong knowledge**	**No knowledge**	**Little Knowledge**	**Moderate knowledge**	**Strong knowledge**
Identifying FGM/C affected patients/service users	0 (0.0)	5 (10.9)	28 (60.9)	13 (28.3)	1 (9.1)	1 (9.1)	4 (36.4)	5 (45.5)	0 (0.0)	1 (10.0)	3 (30.0)	6 (60.0)
Starting a conversation about FGM/C with patients/service users	0 (0.0)	3 (6.5)	26 (56.5)	17 (37.0)	2 (18.2)	2 (18.2)	1 (9.1)	6 (54.5)	0 (0.0)	0 (0.0)	2 (20.0)	8 (80.0)
Discussing health implications of FGM/C with patients/service users	0 (0.0)	2 (4.3)	25 (54.3)	19 (41.3)	1 (9.1)	2 (18.2)	2 (18.2)	6 (54.5)	0 (0.0)	0 (0.0)	2 (20.0)	8 (80.0)
Discussing FGM/C illegalities with patients/service users	0 (0.0)	2 (4.3)	22 (47.8)	22 (47.8)	1 (9.1)	0 (0.0)	1 (9.1)	9 (81.8)	0 (0.0)	0 (0.0)	2 (20.0)	8 (80.0)
Recording newly identified cases and attendance on enhanced data-set information standard	2 (4.3)	12 (26.1)	24 (52.2)	8 (17.4)	1 (9.1)	1 (9.1)	5 (45.5)	4 (36.4)	2 (20.0)	2 (20.0)	1 (10.0)	5 (50.0)

Reporting known cases of girls under 18	1 (2.2)	10 (21.7)	25 (54.3)	10 (21.7)	1 (9.1)	1 (9.1)	4 (36.4)	5 (45.5)	1 (10.0)	0 (0.0)	2 (20.0)	7 (70.0)
Sharing information with relevant professionals (such as school nurse, GP) to safeguard children and vulnerable adults	0 (0.0)	8 (17.4)	23 (50.0)	15 (32.6)	1 (9.1)	1 (9.1)	3 (27.3)	6 (54.5)	0 (0.0)	0 (0.0)	1 (10.0)	9 (90.0)

Appendix 13: Table 5.3a: Number and percentages of health professionals indicating the residence, ethnicity and religion of FGM/C affected patients/service users they have cared for: Survey

	How many resident in Birmingham		How many ethnic minority		How many Christians		How many Buddhist		How many Hindu		How many Jewish		How many Muslim		How many Sikh		How many have no religion		How many religion isn't known	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Valid responses	63		62		44		43		44		42		55		44		41		46	
I don't know	1	1.6	3	4.8	13	29.6	21	48.8	18	40.9	19	45.2	10	18.2	18	40.9	24	58.5	18	39.1
None	0	0	0	0	7	15.9	13	30.2	10	22.7	13	31	0	0	9	20.5	4	9.8	4	8.7
Some of them	22	34.9	24	38.7	24	54.6	9	20.9	16	36.4	10	23.8	31	56.4	17	38.6	13	31.7	24	52.2
All of them	40	63.5	35	56.5	0	0	0	0	0	0	0	0	14	25.5	0	0	0	0	0	0

Appendix 14: Table 5.5a: Relationship between levels of confidence and knowledge among health professionals in measures involving discussion of FGM/C with patients/service users: Survey

Activities/Measures	Health professionals (n=67)
Identifying FGM/C affected patients/service users	r_s =0.556 (p=0.0001)
Starting a conversation about FGM/C with patients/service users	r_s =0.565 (p=0.0001)
Discussing health implications of FGM/C with patients/service users	r_s =0.677 (p=0.0001)
Discussing FGM/C illegalities with patients/service users	r_s =0.542 (p=0.0001)
Recording newly identified cases and attendance on enhanced data-set information standard	r_s =0.774 (p=0.0001)
Reporting known cases of girls under 18	r_s =0.765 (P=0.0001)
Sharing information with relevant professionals (such as school nurse, GP) to safeguard children and vulnerable adults	r_s =0.776 (p=0.0001)
Note: all the items are significant at P=0.01	

Appendix 15: Table 5.6a. FGM/C training material matrix

Female Genital Mutilation: Recognising and Preventing FGM/C	**A free online safeguarding training course developed for the Home Office by Virtual College** **https://www.virtual-college.co.uk/resources/free-courses/recognising-and-preventing-fgm**
Content	**Details**
Aim	To provide an overview of FGM/C and professionals' safeguarding responsibilities.
Outcomes	-Definition and types. -Health risks and consequences. -Legal position in UK. -How and when FGM/C is carried out. -Identify who is at risk and describe indicators. -Common justifications of FGM/C. -Role in preventing and support survivors.
Module organisers and material producers	Rasa-the UK fund for women and girls, Virtual college, co-funded by PROGRESS programme of the European Union, FORWARD, College of policing and Department of education.
Module certification	CPD
Copy right	Crown copyright 2016.
Introduction	-FGM/C in the news-its popularity. -Used hope and daughter Sara-animated photos. -Acknowledged multi-agency participation in identification of those at risk and support of those affected (Education, social care, family, police, voluntary services, healthcare, community, border force/UKVI, church/religious organisations). -Health consequences-Fracture or dislocation during constraint, low self-esteem, depression, death, painful intercourse, difficulties with child birth, urinary and other infections, blood loss, haemorrhaging, infection, hepatitis, HIV infection, post-traumatic stress disorder, infertility, severe pain and shock, menstrual obstruction. Physical, emotional and psychological, examples provided as above. -it's a form of child abuse and violence against women and girls and should be dealt with as part of existing child and adult protection procedures. -Its complex, involving different factors. Families may not see it as an active abuse-cultural sensitivity should not get in the way.

What is FGM/C?	Definition-WHO (2014). -Alternative terms-FGM/C, Female Circumcision (discouraged as it compares to male Circumcision because Female Circumcision is much more severe), FGC (Use cutting, to reduce stigmatisation of using mutilation) or ask for the term used in the communities)-link provided with a list compiled by FORWARD showing different names from 11 countries all of which are African countries. -Preconceptions-Same as male circumcision, a religious practice, carried out by men to control women. -Prevalence-UNICEF 2016 (Mainly Africa, Middle East, Indonesia (Asia). -England and Wales prevalence (Macfarlane 2015) 60,000 girls born to mothers with FGM/C, 103,000 women between 15-49 and 24,000 women over 50 live with consequences. 10,000 girls likely to have undergone FGM/C. They live in both urban and rural areas. All local authorities not likely to be entirely free from FGM/C. Dispersed migrant populations in white areas likely to support FGM/C more as they are isolated. -Legal aspect-Illegal in the UK. England and Wales, 2003 criminal and civil legislation, 2015 Serious Crime Act. 2005 Scotland. England and Wales Offence of carrying out FGM/C or assisting=14yrs max imprisonment, a fine or both. Failure to protect girls under 16=7yrs max imprisonment, a fine or both for ‘those over 18 with parental responsibilities’. FGMPOs and mandatory reporting insisted in 2015 amendments. -Genital piercing and cosmetic surgeries, up to the court to decide if it falls on FGM/C categories. -If a procedure is consented and not undertaken for physical or mental health or childbirth purposes it is an offence. -Regulated health and social care professionals and teachers have a duty for mandatory reporting of known cases of under 18s to the police. Not those at risk, suspected or over 18. Call area police where the girl resides, number 101, police will initiate multi-agency response. -Prosecutions-few because: professionals lack of awareness, cultural sensitivity, hidden practice, difficulty for children to testify against parents. -International legal framework-UN convention on the Rights of the child and UN convention on elimination of all forms of discrimination.
Why it is carried out	-Traditions, rite of passage, genitals ugly and dirty, bring evil, bad lack and death to family, promotes virginity, chastity, cleanliness and purity, will not be accepted, not marry, not wanted, clitoris will harm the baby during delivery. -Reasons: status and respect, marriage, acceptance religious chastity, honour, custom, being a woman, purity, clean, rite of passage, desirable, sense of belonging. -Key role-control and desexualise women. -Myths/facts challenge.
Types of FGM/C	-WHO categorisation and definition of each with a normal labelled pic and a type of FGM/C pictures. -Age when FGM/C occurs-from birth to marriage and beyond. -Carried out by women-aunt, grandmother, cutter, without anaesthetic or sterilisation, child often held down.

	-Believed that it happens to British girls in the UK and overseas thought to be taken during summer holidays for sufficient time to heal.
Health risks and consequences	-Immediate/short-term, long-term (depending on the procedure), psychological and mental health (lifetime trauma).
Who is at risk	-Hidden crime: one off, not seen by people outside family, girls unlikely to disclose. -Risk factors/indicators if two or more, should trigger alarm: Level of integration (more unlikely to know it's illegal), family history, sister undergone FGM/C, school activity (withdrawn from personal, social and health education the parent may be keeping her from becoming informed about her body/rights). -Signs FGM/C is about to take place: Older visitor, reference to FGM/C, child confides, girl asking for help, parents/relative statement for prolonged stay of child out of the country, holidays abroad. -Clues/indication that FGM/C has happened: Difficulty walking, sitting, standing; spending longer than normal in toilet, lengthy absence from class with bladder or menstrual problems; frequent urinary or menstrual problems, prolonged absence from school; behaviour change-depression; reluctant for medical examinations; asking for help without exploiting the problem. -Actions where FGM/C has taken place: Offered help to deal with the consequences; enquiries about other female members who may need safeguarding; criminal investigations into the perpetrators.
Taking action-role of safeguarding	-Safeguarding definition. -Local safeguarding children boards: establish local referral schemes; understanding stats and trends; scrutinising handling of FGM/C referrals; setting local policies and procedures. -Life-cycle and involvement agencies: maternity. -Duty to safeguarding: where an illegal act is being performed regardless of age, need to safeguard those at risk, where relatives have undergone, girls removed from country to undergo FGM/C. Report to police is concerned. -Working with families may be enough. But it's a professional's duty to protect girls and women at risk. -Asking the right questions: A female professional should be available, if preferred; make no assumptions; give the individual time to talk and listen; create an opportunity for the individual to disclose-privacy; being sensitive to the intimate nature; the individual may be royal to their parents; non-judgemental; get accurate information of the urgency of the situation; take detailed notes; use simple language straight forward message. Use understandable terminology; avoid offensive language; give the message that the individual can come back to you; explain that FGM/C is illegal and the law can help them. Referrals: two-way information sharing between professionals and local agencies is important for effective identification, assessment and service provision. -Assessment of child under the Children Act 1989: Risk assessment will determine if a child need support or support under section 17 or 47; strategy meeting-share available information, decides whether Section 47 enquiry (child protection enquiry) or child and family assessment should be initiated (or continue), Allocate tasks, decide if any immediate protective action is required, by whom and when, assist in the coordination of the criminal investigation.
Professional roles	-Culture awareness-Don't assume everyone from culture are the same.

	-Skills require: Questioning skills, not making assumption, listening skills, recognition of responsibilities, avoiding preconception, observational skill, working with other professionals. -Guidelines: All professionals working with children and adults-NSPCC FGM/C helpline for advice; police, healthcare, social care, education, border force, UK visa and immigration.
Case studies	Showcasing Hope's life journey and professionals who missed to protect her from FGM/C happening, after it happened, professionals who failed to support her and after she got pregnant professionals who have an opportunity to protect the young girl.
Summary and resources	-Helpline; NSPCC email, website, multiagency statutory guidance, Home Office resource pack
Participants' selection/inclusion criteria	Target population is professionals in England and Wales and those with a responsibility in safeguarding children Healthcare, police, education, border force and UK visas and immigration, children's social services.
Training duration	1-2 hours.
Course assessment	Online assessment consisting 15 questions-randomly selected from a database-pass mark of 1%.
Cost of training	Free
Awards	Certificate-after completing activities, passed the online assessment and relevant evaluation.

FGM/C	**NHS/Health Education England- free e-learning to improve awareness and understanding of FGM/C among health professionals** **https://www.e-lfh.org.uk/programmes/female-genital-mutilation/**
Content	**Details**
Registration	Username and password
Terms and conditions	-GDPR EU -Disclaimer Updated 2018
Security questions	
Login wizard	
Technical check	
Introduction to FGM	-Roles of health professionals: -to provide support and prevention for those at risk. To be aware of FGM/C and health implications (Pic of Black woman). -Definition of FGM/C, different procedures, unknown where FGM/C originated, no health benefits, not related to any religion (Pic of Muslim hijab wearing woman).

	-FGM/C and human rights-quiz: declaration on children rights. -FGM/C worldwide: -Statistics global, Africa-age of FGM/C procedure depending on countries and cultural background. Notice it's not only in Africa it is also in the middle east and South and Southeast Asia and their communities worldwide. (prevalence map of Africa provided-not colour coded). -FGM/C in the UK: -Macfarlane and Dorkenoo (2014) data: 70,000 girls (0-14) have had or are at risk. -Case study- (pic of black woman-London community development worker activist of FGM/C) Not asked about her FGM/C by professionals or whether she intends to do it to her children. -Types of FGM/C-WHO categories (Pic of a black woman holding a black girl. Types pics (black) with map (Africa) showing the prevalence countries for each type. -Complications of FGM/C: Seven immediate/short-term and seven long-term consequences listed. -FGM/C and UK law: Quiz-Law in 1985, 2003 and 14-years jail term for offenders. -Key aspects of care-Provision of sensitive services to women, mostly identified in maternity, all pregnant women should be asked about FGM/C. May present throughout NHS. Respond to the complex medical needs and refer appropriately. -Get help and referral pathways: If over 18 refer to FGM/C services for support and assessment, perform risk assessment if pregnant and consider social services, document FGM/C, contact safeguarding lead if uncertain. If under 18, mandatory reporting by professional who initially identifies. -Mandatory reporting: (pic of a black woman nurse)-introduced in October 2015 for health and social care regulated professionals and teachers in England and Wales. Only for known cases-Call 101 police number, provide girls name, DOB and address, your contact details, safeguarding lead contact details. DOH guidance link provided. -Self-assessment. -Session key points. -Session summary: further reading and resources.
Communication skills for FGM/C consultations	-Introduction-good communication skills. Be aware of specific circumstances, when a discussion needs to take place, best interests of patient, be non-judgemental. Should include verbal and non-verbal techniques (clinical communication). (pic of black woman-back of white male). -Patients affected by FGM/C-may not be clear that FGM is the origin of the problem(s) (Pic of four girls-one black girl). Examples of who may be affected-from a practising community, going for holidays, a special ceremony, a mother with FGM/C and has daughters or younger females in the family, avoiding or missing classes e.g., PE. -Consultation examples-videos showing bad and good communication (to be applied in any clinical setting). Observations from the videos-trust, eye contact, rapport, providing choices, empathetic… (video of black woman from Kenya, white woman consultant). -Why is FGM/C practised: Professionals may be affected emotionally by the stories. Reasons- Social convention, raising girls, reduce libido, femininity, religion, leaders, culture, tradition. Interview with Executive Director of FORWARD. Origin and why its practised.

	-Point of note-no health benefits, no cultural justification, contrary to human rights, child abuse. Health professionals have a duty to intervene and care and report under 18 (Face of Asian girl). -Consultation video 3-Black woman form Nigeria, Male doctor. Offered female doctor to examine. Decision making, appropriate history, appropriate language, sensitive, empathetic. -Clinical communication-interruptions, rapport, mirroring, questioning, remaining professional, non-verbal communication Language use in FGM/C consultations-Culturally sensitive language, be aware there are different terms. Initiating conversations example. Talking to a woman with a daughter at risk examples. -Consultation 4-clinician and supervisor-answering question, formal statements, plan for clinician to follow up, use of language, sensitive to clinicians needs (a male and a female white). -Values and beliefs-practitioner's own feelings and values. Lack of awareness may cause distress for practitioners thus not relate to patient. Care of people as first concern, work with others, provide high standard practice/care, be open and honest (nurses and midwives). Not a racial issue. Carried out by loving family members who believe it is for good. Acknowledge emotions and lean the reasons, demographics and consequences and don't show distress to communities/families/patients. seek supervision support. FGM/C cases can present anywhere in the UK. Not religious. Care, compassion, courage, commitment, communication and competence to be applied by all professionals working with FGM/C patients. -Self assessment. -Session key points. -Session summary-further reading, resources.
Legal and safeguarding issues regarding FGM/C in the UK	-Introduction-It is a crime. Health professionals need to be able to advise patients of the legal status of FGM/C. Its child abuse, thus safeguarding need to be addressed alongside any criminal investigation. HP be aware of local safeguarding and legal processes. (Pic of two black girls) -FGM/C and international perspective of human rights-international treaties and agreements examples. -FGM/C is a crime 1985 and 2003 law Act and 2005 in Scotland explained. (map of UK) -FGM/C is child abuse-WHO definition. -Safeguarding—Based on the children act 1989-principles are child welfare, preserve child's home and family link, parents have responsibilities. Act amended to children Act 2004. Principles did not change. (Pic of two Asian girls with hijab) -Being alert of FGM/C-Quiz-all health professionals should be alert. -Making referrals-safeguarding risk assessment-Consider children under 18 and women over 18 categories. Safeguarding guidance document provided in resource section. Child at immediate risk indicators provided. Child already undergone FGM/C indicators provided-mandatory reporting. Pregnant women indicators of child at risk, other females at risk including her. Non-pregnant women indicators provided- females in her family at risk or herself. -Making referral-pathway (nothing on that page). -Responsibilities of health professionals-knowledge: practising countries, families know about FGM/C, factors which place them at risk, mandatory reporting, when to refer, local safeguarding children board (LSCB) policy on FGM/C, how to access and use translators. Skills: Aware of possibilities of FGM/C, able to assess needs, how to communicate effectively. Information: provide

	FGM/C passport statement, how to access local community groups for support, promote availability of information. Getting help: know LSCB policy to access support, ask for help from designated leads. -Mandatory reporting- (pic of a white nurse) Explained as known cases where girl informs professional or professional observes signs. The relevant age is the girl's age at the time identification/disclosure. Personal duty of the person who identifies. To be reported by the end of the next working day. Ring 101 update local safeguarding lead and record all your decisions. Mandatory reporting guide provided in the resource section. -FGM/C risk indication system-FGM/C RIS-safeguarding girls up to 18-years at risk of FGM/C. Allows healthcare professionals to confidentially share information by adding indicators in the electronic healthcare records used by acute trusts, GP surgeries and community services. professionals with appropriate passcode to update. To activate indicators, consent from guardians or patients is required. Link to health and social care information centre (HSCIC) provided. -Case studies-(Pic of two black girls, hijab wearing woman with baby)-15-year-old was cut at 2years: mandatory reporting to police, referral to children social services, strategic discussions, child examination by paediatrician. Consider siblings (CSC will investigate)-process and duties explained. 7-year-old going to Sudan for summer to see grandmother. Mother had FGM/C. Urgent referral to CSC who will contact police/ investigation team will urgently visit parents. If child is at risk and parents don't cooperate police can remove child from parents for 72 hrs 'police protection'. FGMPO can be provided. An emergency protection order (EPO) for 8 days can be applied by CSC. Care order and supervision order can be applied after EPO. Woman with FGM/C from Iran has new-born baby girl and a 5yr old girl. Midwife assess risk of girls. Refer woman to local FGM/C services for support. Future monitoring of the daughters. Proper notes in the FGM/C RIS and infant red book. -Self assessment. -Key points. -Session summary-Resources/further reading.
Issues, presentation and management in children and young women	-Introduction-For health professionals working in the communities with children, young people and families. -Health consequences-physical, psychological and sexual health. Examples of immediate and long-term consequences. Emotional and psychological immediate and long-term consequences. -Common assessment framework (CAF): Development of the child/young person, parents and carers, Family environment. -Health assessment and FGM/C-Family origin, Age of girl. -Taking history-Case study video and discussion points of the video provided and examples of phrasing enquiries and information. -Making a referral-referral pathway provided. -Public health model-Community: promote understanding of health and wellbeing, child protection, support community projects, offer access to health advice, signpost and refer to organisations. Universal services: Education settings, school nurses, GP practices. Universal plus, Universal partnership plus. -FGM/C risk indication system (FGM/C RIS). -Scenarios-1) Nurse notices abnormal genitals of 1-year-old, example of question phrasing, speak to parent, contact social care, contact police, doctor to examine child. 2) Girl tell cousin about a holiday in Somalia-school nurse speak to child, speak to parents

	if well known, contact social care, social care will contact police, paediatrician might be needed to examine child before and after holiday. 3) Mother from Malaysia with 4-year-old with FGM/C-not necessary to speak to child, speak to parent-inform of illegal status, contact social care, contact police-mandatory reporting, paediatrician to examine child for proper diagnosis. -Self assessment. -Session key points. -Session summary-resources and further reading.
Issues, presentations and management in women and around pregnancy	-Introduction-Healthcare workers should be familiar with FGM/C complications. -Types of FGM/C (Diagrams provided). -Complications: Short-term, long term, and psychosocial examples with detailed description. Childbirth-infibulation complications provided. -Maternity booking history-Consider FGM/C even in previous vaginal births, early identification crucial. At booking ask about FGM/C. Records should be at the hand-held notes and electronic records, under 18-mandatory reporting, safeguarding risk assessment, after delivery assess if child is at risk, discuss appropriate pathway, provide information, inform GP and health visitor. -Discussing FGM/C with patients-Consider language difficulties, psychological vulnerability and cultural differences (professional female interpreter preferable). Provide verbal and written information (leaflets). Offer counselling to those with FGM/C. -Husbands/partners should also be offered counselling (done by lead clinician or trained midwife). -Framework of discussions-general discussions, confidential nature, question about cutting, acknowledge knowledge of the practice in patient's community, explain complications, use sensitive and direct questions. -Caring for patients-Antenatal: refer to lead clinician, specialist midwife/doc to diagnose type of FGM/C and record, offer deinfibulation in type III, follow-up appointment after 2 weeks. During labour: women will have a detailed plan for birth, those identified on admission in labour to be referred to trained midwife for review, those with type III require deinfibulation, any repair after birth should prevent spontaneous reinfibulation. Postnatal: community midwife, health visitor and GP to be informed, documentation to include type of FGM/C, current FGM/C status, any child protection concerns, detail of any discussion and information given about legality and complications. Neonate: female babies should be recorded to have 'normal intact genitals', if child is at risk, document in FGM/C RIS with consent from parents, on discharge inform community midwife/health visitor and GP, handover should be done appropriately. -Deinfibulation-explained with video to show the procedure. Antenatal: performed between 20-32weeks gestation period, local anaesthetic should be provided, women preferring the procedure during labour should be respected. Intrapartum: consider emotional implications such as flashbacks, qualified midwife not student to reduce trauma. Postnatal: reinfibulation is against the law, discuss with woman and family about female child and legal consequences, safeguarding risk assessment for female child should be done, information leaflets should be provided. Aftercare: advice to care for the area. -Documenting the assessment and treatment of FGM/C-Example provided, full form provided in resource section. -Non-pregnant women-can present in various settings, consider FGM/C in all consultations especially if from FGM/C practising community-refer to FGM/C clinic, make clear confidentiality, provide clear accurate documentation in patients record,

	deinfibulation should be offered to type III, safeguarding risk assessment be done if has other siblings at risk, adult safeguarding for vulnerable women, consider PTSD and others for counselling. -Self assessment. -Session key points. -Session summary-resources and further reading.
The psychological impact of FGM/C	-Introduction-empathise and offer support without overreaching professional competencies. Scarce guidance for psychological practitioners. -Current research-not known how many FGM/C survivors have psychological consequences. Peer-reviewed evidence required. Don't make assumptions discuss overall wellbeing and explore the distress. -Case studies- Withdrawal, anxiety, depression, eating disorder. -Psychological effects of FGM/C-Quiz-clinical presentations: depression, fear and anxiety, shame and embarrassment, flashbacks, anger, loss of trust, panic attacks, sleep disturbance, sexual difficulties, being withdrawn, traumatic stress, generalised body pain. -Risk factors: domestic violence, sexual violence, trafficking, breast ironing, forced marriage, being removed from their country of origin, lack of language, history of other trauma, fleeing conflict, forced migration. -Talking to patients-being sensitive, using appropriate terms, good communication skills. -Exploring psychological distress related to FGM/C-examples of phrasing questions. -Indicators for signposting to psychological services-felling low/hopeless, anxious, worried, loss of interest in activities, avoidance of people and situations, avoidance of routine medical procedures, sleet problems/nightmares, unexplained physical symptoms, poor self-care, social isolation, lack of support. -Psychological care-Adapting services: so as to fit community needs, provide interpreters. Psychological support: respect a woman's decision to opt out of family or community support although it is the best, counselling should be provided by a formally trained counsellor, ensure high quality counselling input. Psychological treatment: consider triage the woman to specialised services for couples, psychiatrist (IAPT)where counselling is failing to improve the complex psychological problems. -Additional skills-safeguarding procedures. -Psychological treatment providers-be registered, attend regular supervision, CPDs, know your limitations and triage as appropriate, recognise mental health risks and know what to do, up to date with relevant treatment, up to date with mandatory training in FGM/C and safeguarding, up to date on UK guidance and policies for FGM/C. -Self assessment. -Session key points. -Session summary-resources, further reading.
Training duration	20-minutes each section
Cost of training	Free
Awards	None

Appendix 16: Update of findings to participants: Survey study

College of Medical and Dental Science

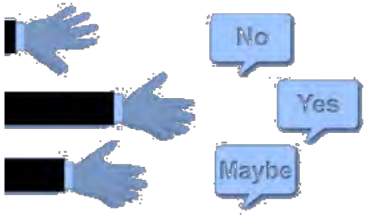
University of Birmingham

B15 2TT

Date ……….

Discussions about female genital mutilation/cutting (FGM/C): A survey of experiences and views of health professionals in Birmingham

We are writing to update you on the results from a research you took part in in 2018-2019. The study sent an online questionnaire to over 900 health professionals (midwives, general practitioner (GPs) and health visitors) in Birmingham and collected information about their experiences and opinions in discussing FGM/C with patients/ service users. Seven measures *(Identifying FGM/C affected patients/service users , Starting a conversation about FGM/C with patients/service users, Discussing health implications of FGM/C with patients/service users, Discussing FGM/C illegalities with patients/service users, Recording newly identified cases and attendance on enhanced data-set information standard, Reporting known cases of girls under 18, Sharing information with relevant professionals(such as school nurse, GP) to safeguard children and vulnerable adults)* were presented to assist in gauging the discussions about FGM/C. The study received 67 responses with 46 midwives, 11 GPs and 10 health visitors. A summary of what we found out from your responses is provided below:



Confidence and knowledge

- Overall, the health visitors were found to have more confidence in implementing the provided measures and more knowledgeable about the same measures than the midwives who were more confident and more knowledgeable than the GPs.
- There was a relation between the confidence levels and knowledge levels. This means that the higher the knowledge about the provided measures, the higher the confidence of implementing the same measures.
- Interestingly, more health professionals had confidence in discussing FGM/C illegalities was discussing health implications about FGM/C. this could be because of the complex health consequences that arise from undergoing the practice, therefore more education about these is required.

Facilitators of effective discussion about FGM/C

- It was indicated that the presence of well-structured guidelines and pathways is most essential in ensuring effective discussion about FGM/C by health professionals with their patients/service users. Trainings should consider providing safety pathways for health professionals who may be at risk of harm or backlash.
- Surprisingly, availability of online materials was listed the least favourable facilitator of effective discussions about FGM/C by health professionals. This could be explained by the limited time they afford to browse through the internet while under systemic pressure of attending to patients/service users. Workshops and forums were preferable; however, trainings should consider signposting.

Barriers of effective discussion about FGM/C

- A majority of the respondents highlighted language barrier as the major barrier of effectively discussing FGM/C with patients/service users. This could be explained by the demographic composition of those affected or from a community with a history of FGM/C, which is mainly ethnic minority who do not often have English as their first language.
- Lack of time and space to discuss with the patients/service users were the other barriers that were pointed and these are as a result of the systemic structures that for instance recommend a maximum amount of time a health professional can spend with a patient/service user.
- Positively, the respondents did not feel that it is someone else's role to discuss FGM/C with patients/service users. They also did not fear that the law is too harsh and although a few feared being labelled as racists, the majority did not. This could be an indicator of overall confidence in discussing about FGM/C.

What next?

The study findings are currently being written up for publication and it is hoped that interventions planners and professionals dealing with FGM/C especially health education interventions can use them to provide their audience such as patients/service users and communities with appropriate, acceptable and sustainable education that lead to prevention of FGM/C.

We would like to thank you for taking the
time to contribute to this research study.

THANK YOU!

Appendix 17: Focus Group interviews information sheet: Qualitative

College of Medical and Dental Science

University of Birmingham

B15 2TT

Date: 16th September 2018

Dear participant

Research study: The experiences and opinions of members from communities in Birmingham with a history of FGM/C regarding health and well-being programmes: A qualitative study

My name is Susan Waigwa and I am a PhD research student from the University of Birmingham. My research is about health education as a prevention measure for female genital mutilation/cutting (FGM/C) in Birmingham and is supervised by three highly experienced researchers from the University of Birmingham. You have been invited to take part in the project because you may have participated in a health and well-being programme and you belong to a community with a history of practising FGM/C. Your contribution will be valuable for us to clearly understand the strengths and weaknesses of health and well-being programmes in Birmingham. It is therefore important that you understand what this research involves and why it is being carried out. Please read this information sheet carefully. You may discuss it with someone who can help you understand better.

Why are we doing this research?

The purpose for this research is to find out the experiences and opinions of communities that have a history of FGM/C regarding health and well-being programmes. Health and well-being education in this study refers to education that raise awareness about the physical, social, intellectual and emotional factors that affect health and well-being such as domestic violence and FGM/C. Health and well-being education programmes can be delivered by health and social care professionals, community organisations or other sectors such as religious organisations or educational institutions. For this reason, there is need for a combined evaluation of different experiences of different participants of health education programmes offered by different organisations or individuals. This study therefore aims to find out the strengths and weaknesses of health and well-being education programmes that include FGM/C as one of the topics. We would appreciate your participation in sharing your experiences and opinions that will help in informing future health education programmes as well as policy makers.

Why have I been approached?

You have been invited because you may have participated in health and well-being education programmes that involved FGM/C as a topic and you belong to a community that has a history of FGM/C. We believe that you are knowledgeable enough and capable to help us understand the strengths and weaknesses of health and well-being education programmes through sharing your experiences and opinions.

Do I have to participate?

No, your participation is totally voluntary and the decision is all yours, to participate or not. If you choose to participate, you have an option of stopping at any stage of the research without having to give reasons or fear of punishment. If you stop at a certain stage of the study, your consent will be required for your data to be used in the study.

What do I need to do if I am interested in participating?

This study involves participation in focus group interviews which you are invited to join if you are interested in participating. The group will be organised by a coordinator, who will have informed you about the study, and there may be participants known to you or complete strangers. The groups will have about six same-sex participants, that is, either all females or all males. Discussions within the group will be guided by an interview schedule that the researcher will use to ask questions. The questions will ask about you, your experiences and opinions concerning the topic. The meeting will take between 60 to 90 minutes.

What will happen next with the results?

The responses that will be recorded or noted during the discussions and will be handled with confidentiality. Each participant will be given a unique name/number such that no real name or address will be traceable. The collected data will only be used for this study. The study aims to compile an all-inclusive report which will be published in relevant journals and presented in various conferences. To maintain anonymity, there will be no real name or address used in the publications or presentations.

How do I benefit?

Your responses will help draw a report that will inform the health and well-being education programmes in Birmingham and beyond. This will ensure that more successful health and well-being education programmes will be implemented in your communities and beyond. You will personally benefit from a range of information that will be provided to you during and after the interview including leaflets, study results and summary sheets. These will be made available to you through the coordinators or the researcher. Due to financial constraints of this study, we may not be able to compensate for your efforts and expenses but we will provide refreshments throughout the meeting.

Are there possible disadvantages/risks of taking part?

The questions from this study will be seeking your experiences and opinions about health and well-being education programmes. It does not involve any clinical procedure or service evaluation. Should you feel uncomfortable to answer or continue to participate, you are at liberty to pass that particular question. We expect no disadvantages in taking part, apart from sparing some of your valuable time for us.

All information that is collected about you during the course of the research will be kept strictly confidential. However, if anything is raised during the discussion group that indicates that either you or someone else is at risk of harm then these concerns may need to be taken further. If there is an indication that you or someone else is at risk of significant harm then it is the duty of the researcher to share this information with the police and local safeguarding teams. Equally, if FGM/C has occurred in the UK it is the duty of the researcher to inform the police and your local safeguarding teams.

Can I withdraw from the study?

You are at liberty to leave the meeting at any stage for any reason. You can return if you feel comfortable to continue to participate. After the data have been collected, you will be at liberty to withdraw from the study within 15 days by notifying the co-ordinator or the researcher. After the 15 days, you will not be able to withdraw. Partial participation will be acknowledged as incomplete, but the provided information may be used in the analysis unless you decide to completely terminate your contribution. Your consent will be required for your information already collected to be used in the study. The researcher’s contacts will be made available throughout the study should you want to withdraw or need more help concerning the study.

What do I do if there is a problem?

If you encounter a problem during the study that affects you or your participation in the study, you should ask to speak to the researcher who will do her best to answer your queries (contacts are at the end of this information sheet). If you are still unsatisfied, you can contact your coordinator who is in connection with the research team and he/she will take the matter administratively.

How will confidentiality be sustained?

The collected data will be cautiously managed and securely stored where only authorised persons in the research team can access. After field work, the data will be safely secured in the university archives for ten years, after which it will be destroyed according to the university research data management policy. None of the participants or the organisations/agents mentioned in the discussions will be named in the findings, unless it is a good example that the participant consents to be revealed. This is to avoid having data that may lead to recognition of the participants or the organisations/programmes which may be referred.

Who is funding the study?

This study has no funding from any funding body but it is running via the sponsorship and support of the University of Birmingham.

Ethical Approval

The project will operate under ethical approval from the University of Birmingham ethics committee.

Who are the research team?

The main research team is comprised of four individuals, myself; Susan Waigwa. I am a PhD research student and a registered social worker. Professor Julie Taylor, who is a nurse scientist and has expertise in child protection research, Doctor Lucy Doos, who is a medical doctor and has expertise in public health research and Doctor Caroline Bradbury-Jones, who is a registered nurse, midwife and health visitor and has expertise in family violence and child abuse and neglect research.

For further information and contact details:

Susan Waigwa Doctoral researcher	Prof Julie Taylor Lead supervisor	Dr Lucy Doos Co-supervisor	Dr Caroline Bradbury-Jones Co-supervisor

Write:

Susan Waigwa

c/o Professor Julie Taylor

Medical School

University of Birmingham

B15 2TT

For more information about the project or the research team, please contact Dr Alistair Hewison, Department of Nursing, College of Medical and Dental Sciences, University of Birmingham at or

Thank you for taking time to read this information sheet.

Appendix 18: One-one interviews information sheet: Qualitative

College of Medical and Dental Science

University of Birmingham

B15 2TT

Date 22nd Nov 2018

Dear participant

Research study: The experiences and opinions of members from communities in Birmingham with a history of FGM/C regarding health and well-being programmes: A qualitative study

My name is Susan Waigwa and I am a PhD research student from the University of Birmingham. My research is about health education as a prevention measure for female genital mutilation/cutting (FGM/C) in Birmingham and is supervised by three highly experienced researchers from the University of Birmingham. You have been invited to take part in the project because you may have participated in a health and well-being programme and you belong to a community with a history of practising FGM/C. Your contribution will be valuable for us to clearly understand the strengths and weaknesses of health and well-being programmes in Birmingham. It is therefore important that you understand what this research involves and why it is being carried out. Please read this information sheet carefully. You may discuss it with someone who can help you understand better.

Why are we doing this research?

The purpose for this research is to find out the experiences and opinions of communities that have a history of FGM/C regarding health and well-being programmes. Health and well-being education in this study refers to education that raise awareness about the physical, social, intellectual and emotional factors that affect health and well-being such as domestic violence and FGM/C. Health and well-being education programmes can be delivered by health and social care professionals, community organisations or other sectors such as religious organisations or educational institutions. For this reason, there is need for a combined evaluation of different experiences of different participants of health education programmes offered by different organisations or individuals. This study therefore aims to find out the strengths and weaknesses of health and well-being education programmes that include FGM/C as one of the topics. We would appreciate your participation in sharing your experiences and opinions that will help in informing future health education programmes as well as policy makers.

Why have I been approached?

You have been invited because you may have participated in health and well-being education programmes that involved FGM/C as a topic and you belong to a community that has a history of FGM/C. We believe that you are knowledgeable enough and capable to help us understand the strengths and weaknesses of health and well-being education programmes through sharing your experiences and opinions.

Do I have to participate?

No, your participation is totally voluntary and the decision is all yours, to participate or not. If you choose to participate, you have an option of stopping at any stage of the research without having to give reasons or fear of punishment. If you stop at a certain stage of the study, your consent will be required for your data to be used in the study.

What do I need to do if I am interested in participating?

This study involves participation in one-to-one interviews which you are invited to participate if you are interested. The meeting, which will have only you and the researcher, will be organised by a coordinator, who will have informed you about the study. Discussions during the meeting will be guided by an interview schedule that the researcher will use to ask questions. The questions will ask about you, your experiences and opinions concerning the topic. The meetings will take between 60 to 90 minutes.

What will happen next with the results?

The responses that will be recorded or noted during the discussions and will be handled with confidentiality. You will be given a unique name/number such that no real name or address will be traceable. The collected data will only be used for this study. The study aims to compile an all-inclusive report which will be published in relevant journals and presented in various conferences. To maintain anonymity, there will be no real name or address used in the publications or presentations.

How do I benefit?

Your responses will help draw a report that will inform the health and well-being education programmes in Birmingham and beyond. This will ensure that more successful health and well-being education programmes will be implemented in your communities and beyond. You will personally benefit from a range of information that will be provided to you during and after the interview including leaflets, study results and summary sheets. These will be made available to you through the coordinators or the researcher. Due to financial constraints of this study, we may not be able to compensate for your efforts and expenses but we will provide refreshments throughout the meeting.

Are there possible disadvantages/risks of taking part?

The questions from this study will be seeking your experiences and opinions about health and well-being education programmes. It does not involve any clinical procedure or service evaluation. Should you feel uncomfortable to answer or continue to participate, you are at liberty to pass that particular question. We expect no disadvantages in taking part, apart from sparing some of your valuable time for us.

All information that is collected about you during the course of the research will be kept strictly confidential. However, if anything is raised during the interview that indicates that either you or someone else is at risk of harm then these concerns may need to be taken further. If there is an indication that you or someone else is at risk of significant harm then it is the duty of the researcher to share this information with the police and local safeguarding teams. Equally, if FGM/C has occurred in the UK it is the duty of the researcher to inform the police and your local safeguarding teams.

Can I withdraw from the study?

You are at liberty to leave the meeting at any stage for any reason. You can return if you feel comfortable to continue to participate. After the data have been collected, you will be at liberty to withdraw from the study within 15 days by notifying the co-ordinator or the researcher. After the 15 days, you will not be able to withdraw. Partial participation will be acknowledged as incomplete, but the provided information may be used in the analysis unless you decide to completely terminate your contribution. Your consent will be required for your information already collected to be used in the study. The researcher's contacts will be made available throughout the study should you want to withdraw or need more help concerning the study.

What do I do if there is a problem?

If you encounter a problem during the study that affects you or your participation in the study, you should ask to speak to the researcher who will do her best to answer your queries (contacts are at the end of this information sheet). If you are still unsatisfied, you can contact your coordinator who is in connection with the research team and he/she will take the matter administratively.

How will confidentiality be sustained?

The collected data will be cautiously managed and securely stored where only authorised persons in the research team can access. After field work, the data will be safely secured in the university archives for ten years, after which it will be destroyed according to the university research data management policy. None of the participants or the organisations/agents mentioned in the discussions will be named in the findings, unless it is a good example that the participant consents to be revealed. This is to avoid having data that may lead to recognition of the participants or the organisations/programmes which may be referred.

Who is funding the study?

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Who are the research team?

The main research team is comprised of four individuals, myself; Susan Waigwa. I am a PhD research student and a registered social worker. Professor Julie Taylor, who is a nurse scientist and has expertise in child protection research, Doctor Lucy Doos, who is a medical doctor and has expertise in public health research and Doctor Caroline Bradbury-Jones, who is a registered nurse, midwife and health visitor and has expertise in family violence and child abuse and neglect research.

For further information and contact details:

Susan Waigwa	Prof Julie Taylor	Dr Lucy Doos	Dr Caroline Bradbury-Jones
Doctoral researcher	Lead supervisor	Co-supervisor	Co-supervisor

Write:

Susan Waigwa

c/o Professor Julie Taylor

Medical School

University of Birmingham

B15 2TT

For more information about the project or the research team, please contact Dr Alistair Hewison, Department of Nursing, College of Medical and Dental Sciences, University of Birmingham at or

Thank you for taking time to read this information sheet.

Appendix 19: Focus Group interviews invitation letter: Qualitative

College of Medical and Dental Science

University of Birmingham

B15 2TT

Date 24th Jun 2018

Research study: The experiences and opinions of members from communities in Birmingham with a history of FGM/C regarding health and well-being programmes: A qualitative study

Dear participant,

We would like to invite you to take part in our study because you have participated in a health and well-being programmes and you belong to a community with a history of practising female genital mutilation (FGM/C). Before you decide whether you would be interested in taking part, please consider reading the provided information sheet (attached to this letter). This will provide you with detailed information about the study and what is required of you and how you will benefit from participating.

This study aims to identify the strengths and weaknesses of health and well-being education programmes by exploring the experiences and opinions of members from communities in Birmingham with a history of practising FGM/C. Our intention is to compile an all-inclusive report that will be informative to future health and well-being programmes and aid in policy making.

The study is sponsored by the University of Birmingham and it has no affiliation with any funding body or organisation.

If you are interested in taking part, we would like you to:

- Read the accompanied participant information sheet so that you understand fully the details of the study.

- Consent to take part.
- Participate in a focus group, which should take between 60 to 90 minutes.

To take part in this study please respond to this letter/email and inform the coordinator (who informed you about this study) or the researcher. Both of their contacts are provided below.

Please contact the researcher or the coordinator if you need more information or clarification about the study.

Yours Sincerely,

Susan Waigwa

PhD researcher

Email:

Telephone: +44 (0) 7404122064

Supervisory team: Prof Julie Taylor

Dr Lucy Doos

Dr Caroline Bradbury-Jones

Coordinator: Name: Pastor Emmanuel Sule

Telephone:

Appendix 20: One-to-one interviews invitation letter: Qualitative

College of Medical and Dental Science

University of Birmingham

B15 2TT

Date 22nd Nov 2018

Research study: The experiences and opinions of members from communities in Birmingham with a history of FGM/C regarding health and well-being programmes: A qualitative study

Dear participant,

We would like to invite you to take part in our study because you have participated in a health and well-being programmes and you belong to a community with a history of practising female genital mutilation (FGM/C). Before you decide whether you would be interested in taking part, please consider reading the provided information sheet (attached to this letter). This will provide you with detailed information about the study and what is required of you and how you will benefit from participating.

This study aims to identify the strengths and weaknesses of health and well-being education programmes by exploring the experiences and opinions of members from communities in Birmingham with a history of practising FGM/C. Our intention is to compile an all-inclusive report that will be informative to future health and well-being programmes and aid in policy making.

The study is sponsored by the University of Birmingham and it has no affiliation with any funding body or organisation.

If you are interested in taking part, we would like you to:

- Read the accompanied participant information sheet so that you understand fully the details of the study.
- Consent to take part.
- Participate in one-to-one interview, which should take between 60 to 90 minutes.

To take part in this study please respond to this letter/email and inform the coordinator (who informed you about this study) or the researcher. Both of their contacts are provided below.

Please contact the researcher or the coordinator if you need more information or clarification about the study.

Yours Sincerely,

Susan Waigwa

PhD researcher

Email:

Telephone: +44 (0) 7404122064

Supervisory team: Prof Julie Taylor

Dr Lucy Doos

Dr Caroline Bradbury-Jones (

Coordinator: Name:

Telephone:

Appendix 21: Focus group interviews consent form: Qualitative

College of Medical and Dental Science

University of Birmingham

B15 2TT

Research study: Exploring the experiences and opinions of members from communities in Birmingham with a history of FGM/C regarding health and well-being education programmes: A qualitative study

Name of the researcher: Susan Waigwa

Supervisory team: Prof Julie Tailor, Dr Lucy Doos and Dr Caroline Bradbury-Jones

Participant given name/number: …………………………

To continue with participating in this study, please confirm the following by writing your initials in the check box

1. I have read and understood the information sheet version 6, dated 13th Jun 2018 for the above study. ☐
2. I understand that I am participating voluntarily and I have up to 15 days, should I want to withdraw my data. ☐
3. I agree to participate in the study and my contribution to be recorded. ☐
4. I agree that my recorded contribution will be stored in a secure place bearing no personal information that can trace me. ☐

5. I understand that the information I will give may be included in reports and publications from this study and will maintain anonymity, such that I will not be identified nor will any organisation that I have discussed about. ☐

Sign ----------------------------------Participant

……………………………...Date

Sign ----------------------------------Researcher

……………………………..Date

Appendix 22: One-to-one interviews consent form: Qualitative

College of Medical and Dental Science

University of Birmingham

B15 2TT

Research study: Exploring the experiences and opinions of members from communities in Birmingham with a history of FGM/C regarding health and well-being education programmes: A qualitative study

Name of the researcher: Susan Waigwa

Supervisory team: Prof Julie Tailor, Dr Lucy Doos and Dr Caroline Bradbury-Jones

Participant given name/number: ……………………………

To continue with participating in this study, please confirm the following by writing your initials in the check box

1. I have read and understood the information sheet version 6, dated 13th Jun 2018 for the above study. ☐
2. I understand that I am participating voluntarily and I have up to 15 days, should I want to withdraw my data. ☐
3. I agree to participate in the study and my contribution to be recorded. ☐
4. I agree that my recorded contribution will be stored in a secure place bearing no personal information that can trace me. ☐

5. I understand that the information I will give may be included in reports and publications from this study and will maintain anonymity, such that I will not be identified nor will any organisation that I have discussed about. ☐

Sign -----------------------------------Participant

……………………………...Date

Sign -----------------------------------Researcher

……………………………..Date

Appendix 23: Focus Group interviews-interview schedule: Qualitative

College of Medical and Dental Science
University of Birmingham
B15 2TT

Research study: The experiences and opinions of members from communities in Birmingham with a history of FGM/C regarding health and well-being education programmes: A qualitative study

General information and housekeeping

Opening

Introduction and welcoming

Good morning/afternoon. My name is Susan Waigwa. I am a PhD research student at the University of Birmingham. I welcome you to this meeting and we are grateful for giving us your time and agreeing to participate in this research.

Refreshments and restrooms

We have prepared some refreshments for you. Please feel free to help yourself as often as you require throughout the meeting. Feel free to leave and come back to the meeting quietly so as to minimise disruptions.

Purpose and outcome of the meeting

The meetings will take between 60 to 90 minutes. The purpose of this meeting is to have a discussion about health and well-being education programmes. We are interested to find out your experiences and opinions about health and well-being education programmes where FGM/C was among the topics discussed in the session. The outcomes will reveal the strengths and weaknesses of the programme and will inform future programmes and policy makers.

Recording and consent

We will record the discussions throughout this meeting using audio recorders. There are two recorders and they are located on the table. The recorders are to assist the researcher to analyse exactly what is said without forgetting some important points.

Before starting, you will be required to consent that you agree to participate voluntarily and that you agree that the discussions be recorded. When speaking you will need to wait for the researcher to call out your given name/number, then proceed with your contribution. This is to help the researcher identify who is talking and what they said to avoid mixing of points during transcription of recorded data. There will be publications of some of your comments and discussions, but confidentiality will be maintained throughout, such that no real names will be published.

Why you are chosen

You have been invited to participate in this research because you belong to a community with a history of FGM/C and you have also previously participated in health and well-being education programmes that involved FGM/C as a topic. We therefore deem you capable of sharing your experiences and opinions about this topic.

Ground rules

This is a voluntary meeting and you are free to pass answering any question.

You are expected to respect other participants' opinions even if you disagree with them.

It would be helpful if one person speaks at a time so that everyone gets a chance to speak and hear each other. The facilitator and the recorder will not express their opinions.

Everything is confidential in this meeting and it would be important to use ‘I’ when expressing an opinion rather than speaking for ‘we’ or about ‘they’.

Interview questions

1. I would like to know a little bit about everyone here. So, please can you introduce yourselves in terms of what you do for a living, what area of Birmingham you come from and your country of origin? Please do not mention your real name.
2. As we are here to talk about health and well-being education, which basically means education that raises awareness about the physical, social, intellectual and emotional factors that affect health and well-being such as domestic violence and FGM/C. Can each of you please tell me how many programmes/sessions of this kind you have attended?
   a. How did you find out about the programme(s)/session(s)?
   b. Where were the sessions held? And what organisation was it offered by?
3. What were the discussion topics in the session(s)?
   a. What did you learn about domestic violence?
   b. What did you learn about FGM/C?
      i. What do you remember about health implications of FGM/C?
      ii. What do you remember about culture/religion and FGM/C?
      iii. What do you remember about the legislations of FGM/C in the UK?
4. I would like to know more about the session(s), could each one of you please share your experiences and opinion about;
   a. The topics and teaching methods
   b. Materials/handouts offered during or after the session(s)
   c. Facilitator(s)/teacher(s)
   d. Venue

    e. What did you like most about the session(s)?

5. Has any of you wanted to comment on the programme(s)?
    a. Has anyone ever contacted someone to comment on the health and well-being programmes? What was this like?
6. Can anyone tell me about their experiences in sharing knowledge from health and well-being programmes with other people?
    a. What do you think should be done to make sharing knowledge with families or communities more effective?
7. In your opinion, what other ways do you think would help in tackling domestic violence and FGM/C that are culturally sensitive and acceptable?
8. Is there anything we have missed that anyone would like to add or talk about?

Closing

Finally, I would like to thank you all for honestly and willingly sharing your experiences and opinions. Your contribution will be used to present the realistic condition of health and well-being programmes that include FGM/C as one of the topics. This will promote better effective health and well-being programmes in the future.

Would it be all right for me to contact any one of you if I have further questions or clarification?

Thank you again for your time and fruitful discussion and I look forward to sharing more information with you.

Appendix 24: One-to-one interviews-interview schedule: Qualitative

College of Medical and Dental Science

University of Birmingham

B15 2TT

Research study: The experiences and opinions of members from communities in Birmingham with a history of FGM/C regarding health and well-being education programmes: A qualitative study

General information and housekeeping

Opening

Introduction and welcoming

Good morning/afternoon. My name is Susan Waigwa. I am a PhD research student from the University of Birmingham. I welcome you to this meeting and we are grateful for giving us your time and agreeing to participate in this research.

Refreshments and restrooms

We have prepared some refreshments for you. Please feel free to help yourself as often as you require throughout the meeting.

Purpose and outcome of the meeting

The meetings will take between 60 to 90 minutes. The purpose of this meeting is to have a discussion about health and well-being education programmes. We are interested to find out your experiences and opinions about health and well-being education programmes where FGM/C was among the topics discussed in the session. The outcomes will reveal the strengths and weaknesses of the programme, and will inform future programmes and policy makers.

Recording and consent

We will record the discussions throughout this meeting using audio recorders. There are two recorders and they are located on the table. The recorders are to assist the researcher to analyse exactly what is said without forgetting some important points. There will be publications of some of your comments and discussions but confidentiality will be maintained throughout, such that no real names will be published.

Before starting, you will be required to consent that you agree to participate voluntarily and that you agree that the discussions be recorded.

Why you are chosen

You have been invited to participate in this research because you belong to a community with a history of FGM/C and you have also previously participated in health and well-being education programmes. We therefore deem you capable of sharing your experiences and opinions about this topic.

Ground rules

This is a voluntary meeting and you are free to pass answering any question.

The facilitator and the recorder will not express their opinions.

Everything is confidential in this meeting and it would be important to use ‘I’ when expressing an opinion rather than speaking for ‘we’ or about ‘they’.

Interview questions

1. Can you introduce yourself in terms of your age, gender, occupation/work, what area of Birmingham you are from and your country of origin? Please do not mention your real name.
2. As we are here to talk about health and well-being education, which basically means education that raises awareness about the physical, social, intellectual and emotional factors that affect health and well-being such as domestic violence and FGM/C. Can you please tell me how many programmes/sessions of this kind you have attended?
    a. How did you find out about the programme(s)/session(s)?
    b. Where was/were the session(s) held? And what organisation was it offered by?
3. What were the discussion topics in the session(s)?
    a. What did you learn about domestic violence?
    b. What did you learn about FGM/C?
        i. What do you remember about health implications of FGM/C?
        ii. What do you remember about culture/religion and FGM/C?
        iii. What do you remember about the legislations of FGM/C?
4. Could you please tell me more about the session(s)? What is your experience and opinion about;
    a. The topics and teaching methods
    b. Materials/handouts offered during or after the session(s)
    c. Facilitator(s)/teacher(s)
    d. Venue

    e. What did you like most about the session(s)?

5. Did you ever want to comment on the programme?
    a. Have you contacted anyone to comment on the health and well-being programmes? What was this like?
6. Tell me about your experience in sharing knowledge from health and well-being programmes with other people.
    a. What do you think should be done to make sharing knowledge with families or communities more effective?
7. In your opinion, what other ways do you think would help in tackling domestic violence and FGM/C that are culturally sensitive and acceptable?
8. Is there anything we have missed that you would like to add or talk about?

Closing

From our discussion, we have covered a lot of things, some personal and others reflecting general issues. Would you concur with me if I summarise from this discussion that health and well-being education programmes are …………………………………..? But …………….. should be done/considered for future programmes to be more effective?

If for any reason you want a part or the whole of your data not to be used for this research, you are free to withdraw by informing your coordinator or the researcher within 15 days. After this duration, you will not be able to withdraw your contribution.

Finally, I would like to thank you for honestly and willingly sharing your experiences and opinions. Your contribution will be used to present the realistic condition of health and well-being programmes that include FGM/C as one of the topics. This will promote better effective health and well-being programmes in the future.

Would it be all right for me to contact you if I have any further questions or clarification?

Thank you again for your time and fruitful contribution and I look forward to sharing more information with you.

Appendix 25: Update of findings to participants: Qualitative Study

College of Medical and Dental Science

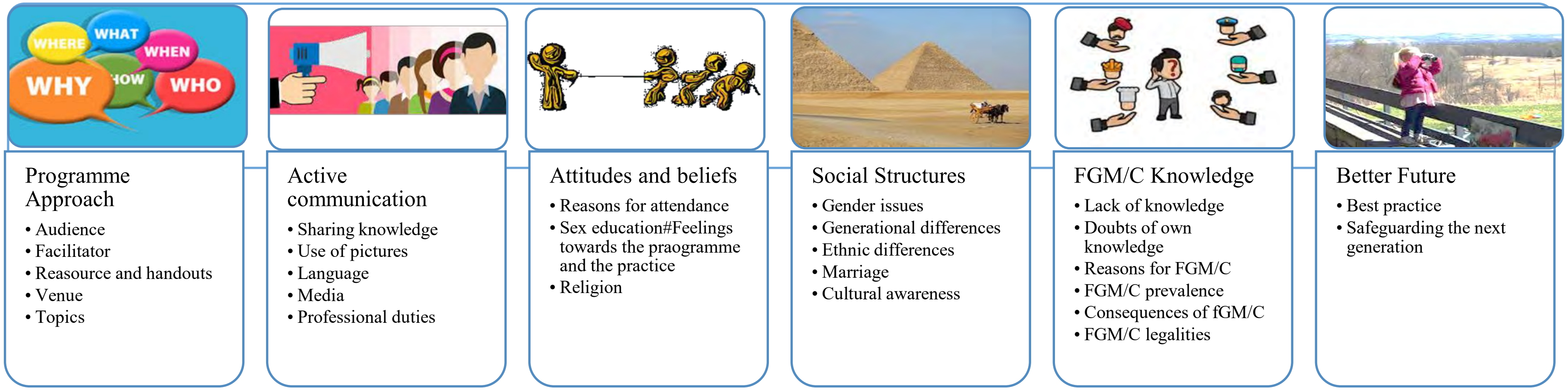
University of Birmingham

B15 2TT

Date ……….

The experiences and opinions of members from communities in Birmingham with a history of FGM/C regarding health and well-being programmes: A qualitative study

We are writing to update you on the findings from a research study you took part in 2018-2019. The study invited you because you come from a community with a history of FGM/C and you lived in Birmingham, United Kingdom, at the time of the study. The study collected information about your experiences and opinions regarding health and wellbeing programmes (HWPs), in relation to FGM/C. Twenty-one of you (participants) contributed to the study either using one-to-one interviews or focus group interviews. A summary of what we found out from you regarding factors that need to be considered in HWBs is provided below:



Programme Approach
- Audience
- Facilitator
- Reasource and handouts
- Venue
- Topics

Active communication
- Sharing knowledge
- Use of pictures
- Language
- Media
- Professional duties

Attitudes and beliefs
- Reasons for attendance
- Sex education#Feelings towards the praogramme and the practice
- Religion

Social Structures
- Gender issues
- Generational differences
- Ethnic differences
- Marriage
- Cultural awareness

FGM/C Knowledge
- Lack of knowledge
- Doubts of own knowledge
- Reasons for FGM/C
- FGM/C prevalence
- Consequences of fGM/C
- FGM/C legalities

Better Future
- Best practice
- Safeguarding the next generation

- Success and acceptability of HWPs was linked to careful consideration of the above factors within the programme. The audience was suggested to best be comprised of the same gender as the facilitators. A mixture of other topics with FGM/C topic was preferred to thin the bluntness of the subject.
- Sharing of information was found by many to be difficult, especially, with family members. For this reason, the use of media and professionals trained in communicating FGM/C issues was suggested alongside use of appropriate pictures and language that is not offensive, and yet communicate the issue.
- Attitudes and beliefs that were pro-FGM/C were mentioned to stand as barriers in interventions such as HWPs for raising awareness. Religion and taboos about sex education in communities were connected to people's feelings towards the practice as well as the programme thus affecting their attendance and engagement in HWPs.
- Gender disparities that exist between females and males regarding FGM/C matters were found to prevail with each gender blaming the other for continued practice. Although generational differences were profound, they did not seem to positively project engagement in HWPs. Cultural awareness was insisted as a major feature in generating a consensus understanding of the practice that could lead to collective prevention.
- The knowledge about FGM/C matters was inconsistent with participants doubting their own knowledge, thus lacking confidence to share. Lack of knowledge manifested a major barrier to engaging in HWPs and although some information about consequences and reasons for practising FGM/C were known, the prevalence rates were often underestimated.

- For better future, there was a unanimous agreement about safeguarding the future generation and enacting best practice in delivering HWPs by providing alternative for the practice, empowering women and funding support services.

What next?

The study findings are currently being written up for publication and it is hoped that interventions planners and professionals dealing with FGM/C, especially, health education interventions can use them to provide their audience and communities with appropriate acceptable and sustainable education that lead to prevention of FGM/C.

We would like to thank you for taking the time to contribute to this research study.

THANK YOU!

Appendix 26: Table 7.1a: Thesis integration matrix using intersectionality

Integration Matrix					
Thesis Phases	**Intersectionality subheading**				
	Social structures			**Culture**	**Media contributions**
	Inclusivity and Privilege checking	**Social generation differences**	**Gender awareness**		
Phase 1: Systematic review	-Collective prevention by sharing. - Tailoring information. -Educative handouts. -Facilitators affiliations with the communities. - Individual perception influencing behaviour.	-Individual characteristics influencing the effectiveness of interventions.		-Acculturation influencing attitudes.	

Integration Matrix					
Thesis Phases	Intersectionality subheading				
	Social structures			Culture	Media contributions
	Inclusivity and Privilege checking	Social generation differences	Gender awareness		
Phase 2: Survey	- Lack of space and language barrier is a challenge that risks exclusion of some individuals.	- Never attended to a case where they reported girls under 18 years could indicate generational changes.	- Only three responses from male health professionals.	- Fear of being labelled as racists. - More confident in discussing illegalities of FGM/C than it is in discussing health implications. -Lack of time is a hindrance to unravel ingrained cultural beliefs.	-Availability of online materials as the least popular facilitator for effective discussions. -New systems take time to successfully be used by health professionals.

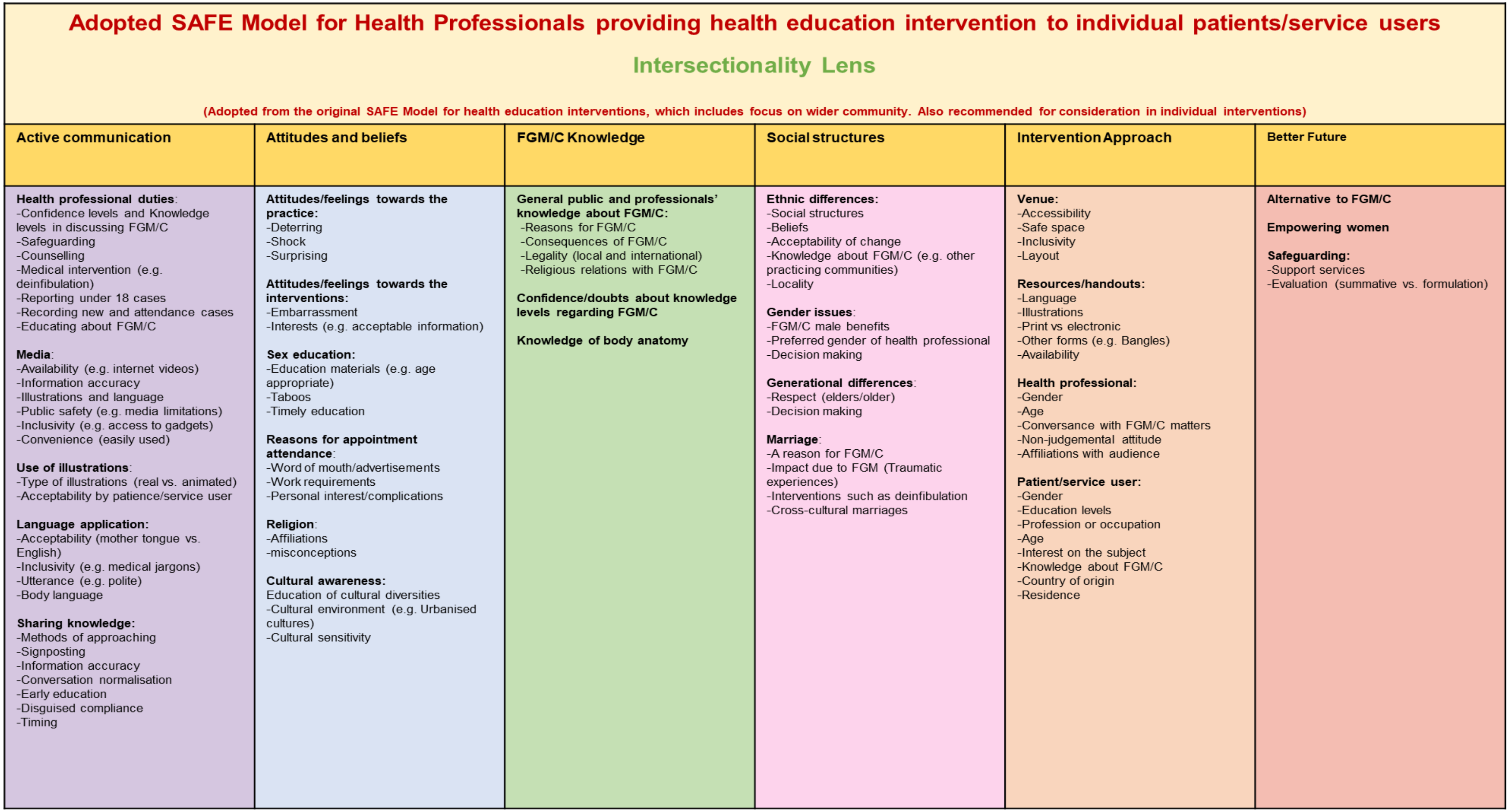
Integration Matrix					
Thesis Phases	**Intersectionality subheading**				
	Social structures			**Culture**	**Media contributions**
	Inclusivity and Privilege checking	**Social generation differences**	**Gender awareness**		
				- Interfering with other people's cultures as a barrier to discussions. -Islamic religion and its mythical association with FGM/C.	
Phase 3: Qualitative	- Acknowledging the differences of demographic characteristics.	- Lack of acceptable education materials	- The primary reason for FGM/C is to benefit men.	-Cultural awareness in workplace.	-Advertisements and social media as motivators to

Integration Matrix					
Thesis Phases	**Intersectionality subheading**				
	Social structures			**Culture**	**Media contributions**
	Inclusivity and Privilege checking	**Social generation differences**	**Gender awareness**		
	- Accessible venues. -Venues organised to enhance discussion. -Active communication of messages enhanced by sharing learnt/acquired information. - Provision of contact details and information of available support services.	may trigger resentment. - Both young and older parents struggled with discussing these with their children. - Older generations do not prefer younger individuals to facilitate.	- Male figures have the power of decision-making. - Older women, in some communities, have higher decision-making power than men. - Men are important in safeguarding their daughters.	-Conversance and not blatant about the subject. - Incentives such as traditional meals. - Lack of knowledge regarding FGM/C thus lack of confidence to discuss/share - Women possess limited knowledge	participate in the programmes/sessions. -Use of graphic illustrations should be cautiously applied.

Integration Matrix

Thesis Phases	Intersectionality subheading				
	Social structures			Culture	Media contributions
	Inclusivity and Privilege checking	Social generation differences	Gender awareness		
	-Educative handouts important. - Facilitators affiliation with the target communities. - Lack of funding as a limit.	-Sharing information between generational groups as challenging. - Facilitator should be of the same age as the audience or older. -The mode of dissemination may differ between generations	- Facilitators must be of the same gender as the audience. - Mixed audiences insisted on a female facilitator.	about their body anatomy. - Mother tongue preferred by some participants. - Taboo status of the subject make it embarrassing to discuss.	

Appendix 27: Diagram 7.1a: Adopted Preliminary SAFE Model for health professionals providing health education interventions to individual patients/service users



Adopted SAFE Model for Health Professionals providing health education intervention to individual patients/service users

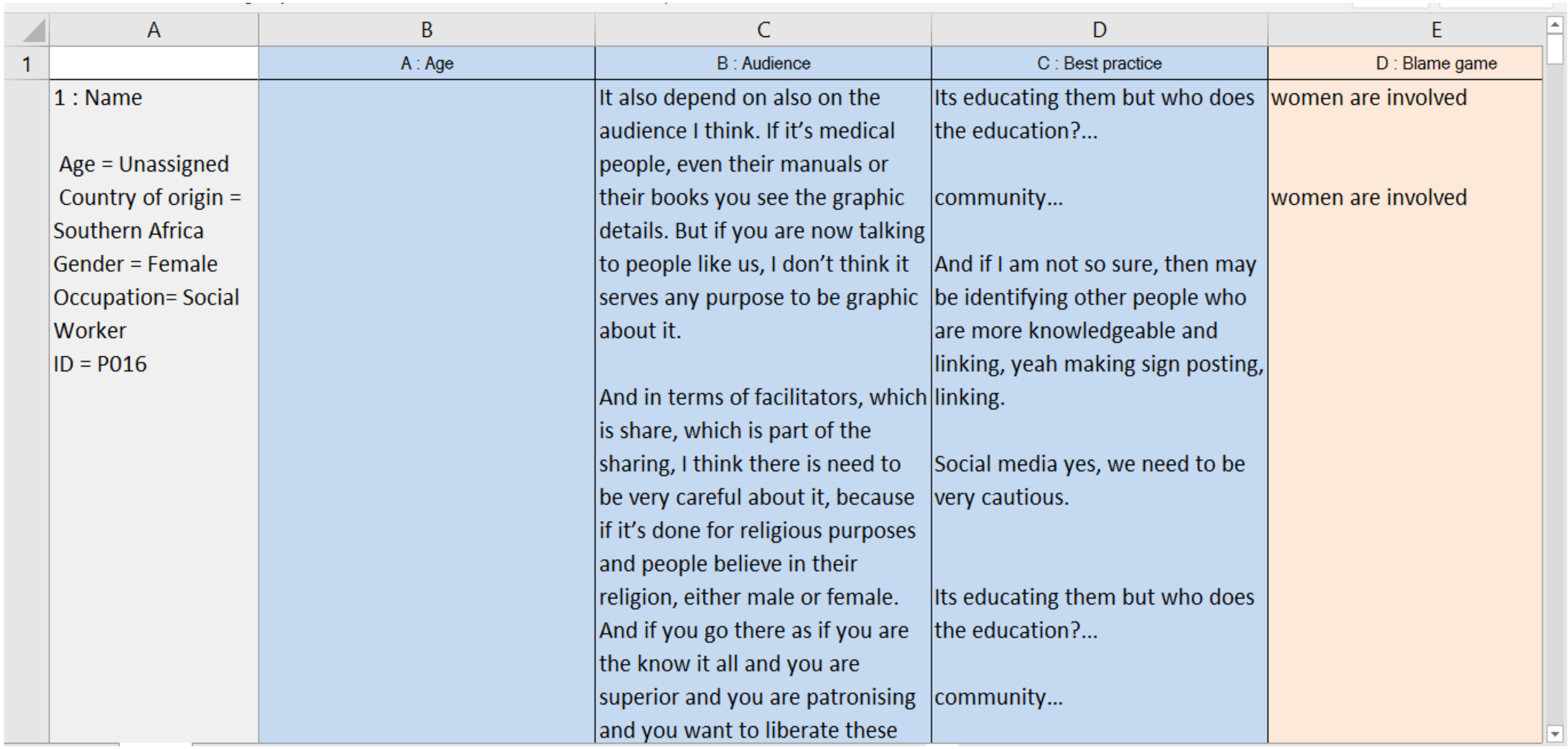
Intersectionality Lens

(Adopted from the original SAFE Model for health education interventions, which includes focus on wider community. Also recommended for consideration in individual interventions)

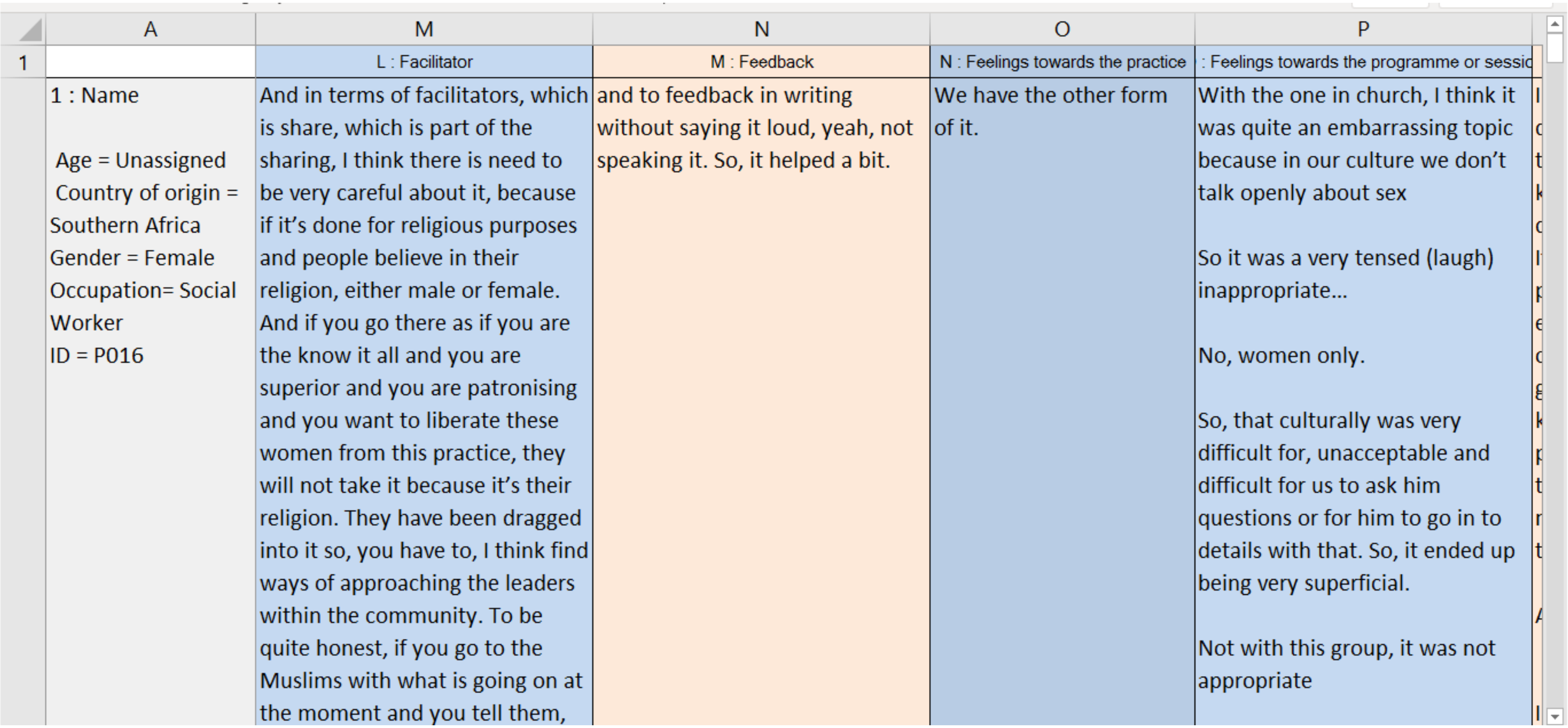
Active communication	**Attitudes and beliefs**	**FGM/C Knowledge**	**Social structures**	**Intervention Approach**	**Better Future**
Health professional duties: -Confidence levels and Knowledge levels in discussing FGM/C -Safeguarding -Counselling -Medical intervention (e.g. deinfibulation) -Reporting under 18 cases -Recording new and attendance cases -Educating about FGM/C **Media**: -Availability (e.g. internet videos) -Information accuracy -Illustrations and language -Public safety (e.g. media limitations) -Inclusivity (e.g. access to gadgets) -Convenience (easily used) **Use of illustrations**: -Type of illustrations (real vs. animated) -Acceptability by patience/service user **Language application:** -Acceptability (mother tongue vs. English) -Inclusivity (e.g. medical jargons) -Utterance (e.g. polite) -Body language **Sharing knowledge:** -Methods of approaching -Signposting -Information accuracy -Conversation normalisation -Early education -Disguised compliance -Timing	**Attitudes/feelings towards the practice:** -Deterring -Shock -Surprising **Attitudes/feelings towards the interventions:** -Embarrassment -Interests (e.g. acceptable information) **Sex education:** -Education materials (e.g. age appropriate) -Taboos -Timely education **Reasons for appointment attendance**: -Word of mouth/advertisements -Work requirements -Personal interest/complications **Religion**: -Affiliations -misconceptions **Cultural awareness:** Education of cultural diversities -Cultural environment (e.g. Urbanised cultures) -Cultural sensitivity	**General public and professionals' knowledge about FGM/C:** -Reasons for FGM/C -Consequences of FGM/C -Legality (local and international) -Religious relations with FGM/C **Confidence/doubts about knowledge levels regarding FGM/C** **Knowledge of body anatomy**	**Ethnic differences:** -Social structures -Beliefs -Acceptability of change -Knowledge about FGM/C (e.g. other practicing communities) -Locality **Gender issues**: -FGM/C male benefits -Preferred gender of health professional -Decision making **Generational differences**: -Respect (elders/older) -Decision making **Marriage**: -A reason for FGM/C -Impact due to FGM (Traumatic experiences) -Interventions such as deinfibulation -Cross-cultural marriages	**Venue:** -Accessibility -Safe space -Inclusivity -Layout **Resources/handouts:** -Language -Illustrations -Print vs electronic -Other forms (e.g. Bangles) -Availability **Health professional:** -Gender -Age -Conversance with FGM/C matters -Non-judgemental attitude -Affiliations with audience **Patient/service user:** -Gender -Education levels -Profession or occupation -Age -Interest on the subject -Knowledge about FGM/C -Country of origin -Residence	**Alternative to FGM/C** **Empowering women** **Safeguarding:** -Support services -Evaluation (summative vs. formulation)

Appendix 28: Examples of quotes reflected in some of the codes in the qualitative analysis framework

Example 1: Participant P016

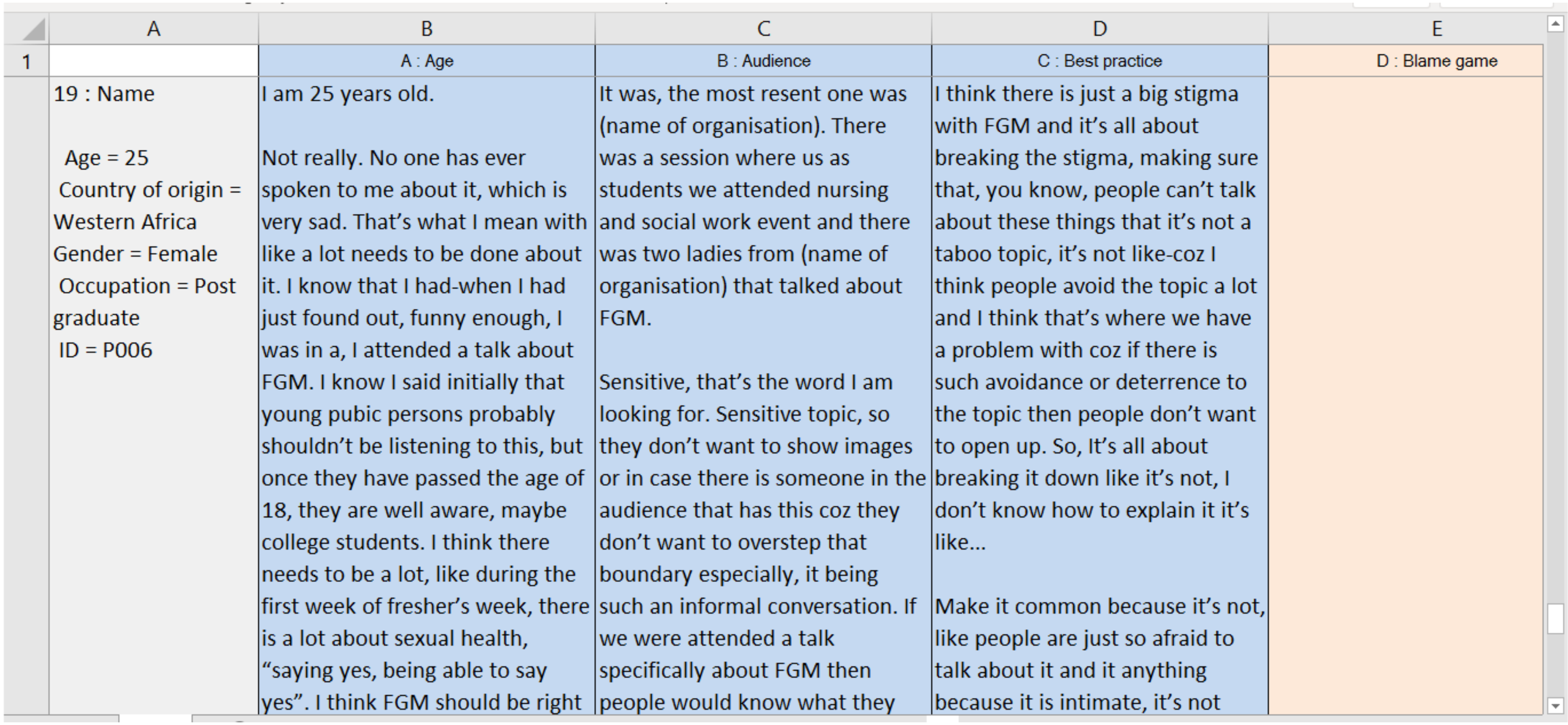


	A	B	C	D	E
1		A : Age	B : Audience	C : Best practice	D : Blame game
	1 : Name Age = Unassigned Country of origin = Southern Africa Gender = Female Occupation= Social Worker ID = P016		It also depend on also on the audience I think. If it's medical people, even their manuals or their books you see the graphic details. But if you are now talking to people like us, I don't think it serves any purpose to be graphic about it. And in terms of facilitators, which is share, which is part of the sharing, I think there is need to be very careful about it, because if it's done for religious purposes and people believe in their religion, either male or female. And if you go there as if you are the know it all and you are superior and you are patronising and you want to liberate these	Its educating them but who does the education?... community... And if I am not so sure, then may be identifying other people who are more knowledgeable and linking, yeah making sign posting, linking. Social media yes, we need to be very cautious. Its educating them but who does the education?... community...	women are involved women are involved

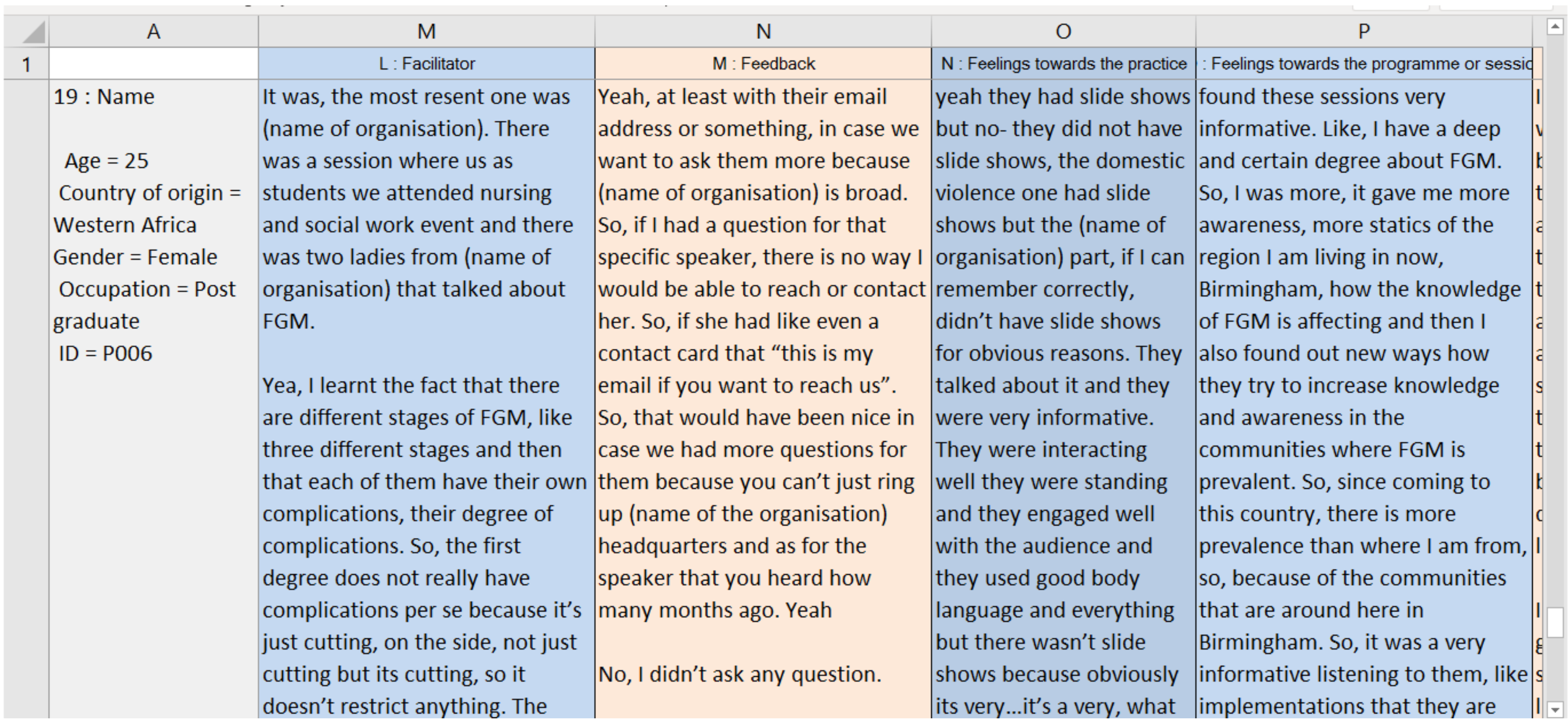


	A	M	N	O	P
1		L : Facilitator	M : Feedback	N : Feelings towards the practice	: Feelings towards the programme or sessi
	1 : Name Age = Unassigned Country of origin = Southern Africa Gender = Female Occupation= Social Worker ID = P016	And in terms of facilitators, which is share, which is part of the sharing, I think there is need to be very careful about it, because if it's done for religious purposes and people believe in their religion, either male or female. And if you go there as if you are the know it all and you are superior and you are patronising and you want to liberate these women from this practice, they will not take it because it's their religion. They have been dragged into it so, you have to, I think find ways of approaching the leaders within the community. To be quite honest, if you go to the Muslims with what is going on at the moment and you tell them,	and to feedback in writing without saying it loud, yeah, not speaking it. So, it helped a bit.	We have the other form of it.	With the one in church, I think it was quite an embarrassing topic because in our culture we don't talk openly about sex So it was a very tensed (laugh) inappropriate... No, women only. So, that culturally was very difficult for, unacceptable and difficult for us to ask him questions or for him to go in to details with that. So, it ended up being very superficial. Not with this group, it was not appropriate

Example 2: Participant P006

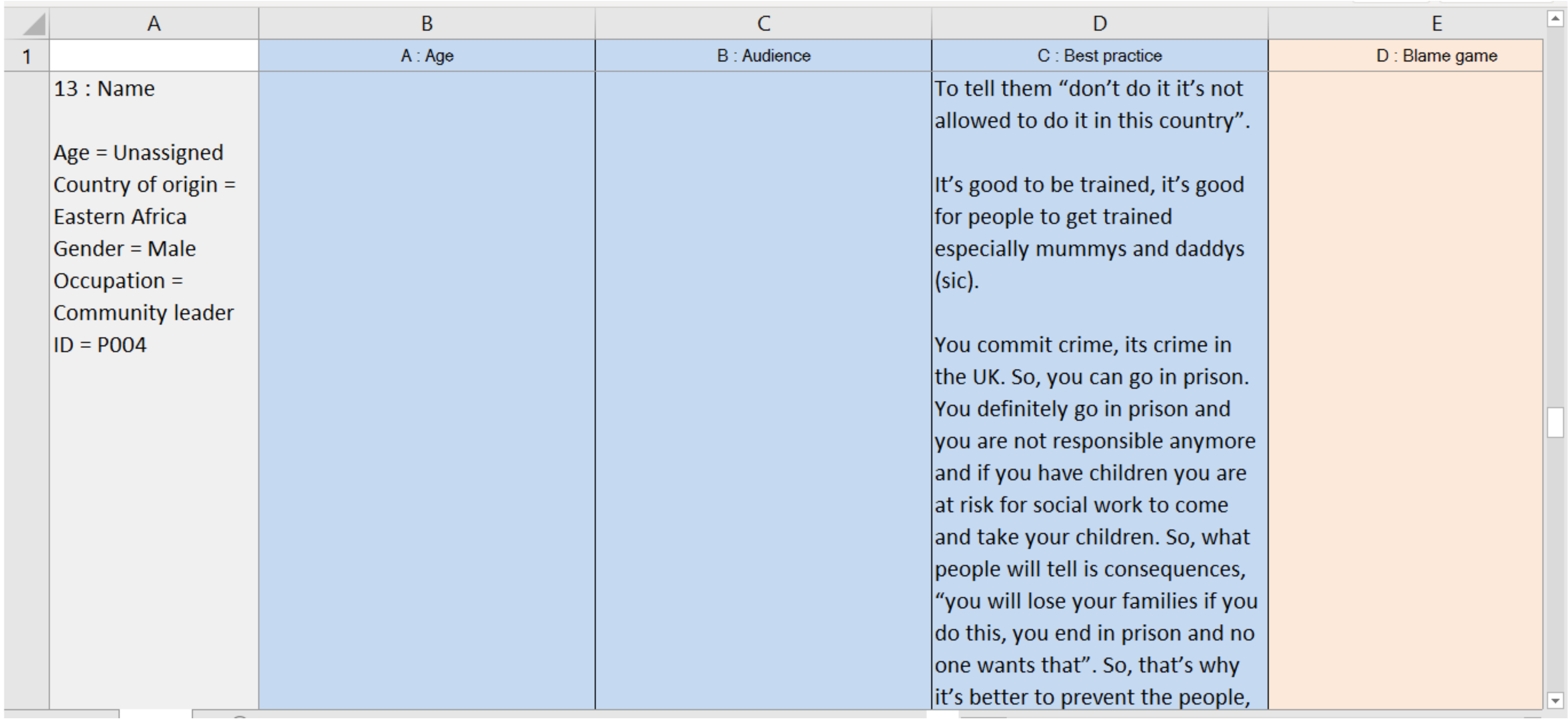


	A	B	C	D	E
1		A : Age	B : Audience	C : Best practice	D : Blame game
	19 : Name Age = 25 Country of origin = Western Africa Gender = Female Occupation = Post graduate ID = P006	I am 25 years old. Not really. No one has ever spoken to me about it, which is very sad. That’s what I mean with like a lot needs to be done about it. I know that I had-when I had just found out, funny enough, I was in a, I attended a talk about FGM. I know I said initially that young pubic persons probably shouldn’t be listening to this, but once they have passed the age of 18, they are well aware, maybe college students. I think there needs to be a lot, like during the first week of fresher’s week, there is a lot about sexual health, “saying yes, being able to say yes”. I think FGM should be right	It was, the most resent one was (name of organisation). There was a session where us as students we attended nursing and social work event and there was two ladies from (name of organisation) that talked about FGM. Sensitive, that’s the word I am looking for. Sensitive topic, so they don’t want to show images or in case there is someone in the audience that has this coz they don’t want to overstep that boundary especially, it being such an informal conversation. If we were attended a talk specifically about FGM then people would know what they	I think there is just a big stigma with FGM and it’s all about breaking the stigma, making sure that, you know, people can’t talk about these things that it’s not a taboo topic, it’s not like-coz I think people avoid the topic a lot and I think that’s where we have a problem with coz if there is such avoidance or deterrence to the topic then people don’t want to open up. So, It’s all about breaking it down like it’s not, I don’t know how to explain it it’s like... Make it common because it’s not, like people are just so afraid to talk about it and it anything because it is intimate, it’s not	

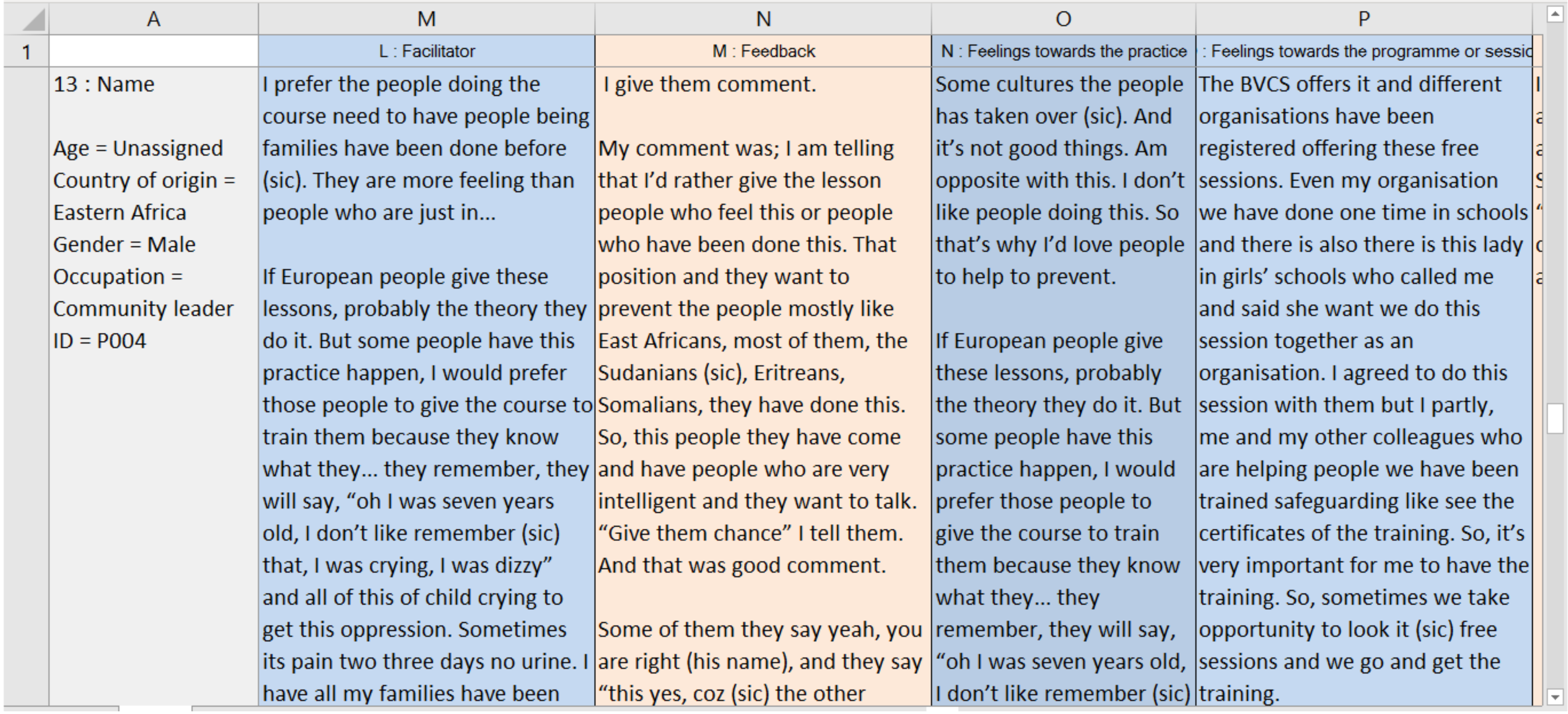


	A	M	N	O	P
1		L : Facilitator	M : Feedback	N : Feelings towards the practice	: Feelings towards the programme or sessi
	19 : Name Age = 25 Country of origin = Western Africa Gender = Female Occupation = Post graduate ID = P006	It was, the most resent one was (name of organisation). There was a session where us as students we attended nursing and social work event and there was two ladies from (name of organisation) that talked about FGM. Yea, I learnt the fact that there are different stages of FGM, like three different stages and then that each of them have their own complications, their degree of complications. So, the first degree does not really have complications per se because it's just cutting, on the side, not just cutting but its cutting, so it doesn't restrict anything. The	Yeah, at least with their email address or something, in case we want to ask them more because (name of organisation) is broad. So, if I had a question for that specific speaker, there is no way I would be able to reach or contact her. So, if she had like even a contact card that "this is my email if you want to reach us". So, that would have been nice in case we had more questions for them because you can't just ring up (name of the organisation) headquarters and as for the speaker that you heard how many months ago. Yeah No, I didn't ask any question.	yeah they had slide shows but no- they did not have slide shows, the domestic violence one had slide shows but the (name of organisation) part, if I can remember correctly, didn't have slide shows for obvious reasons. They talked about it and they were very informative. They were interacting well they were standing and they engaged well with the audience and they used good body language and everything but there wasn't slide shows because obviously its very...it's a very, what	found these sessions very informative. Like, I have a deep and certain degree about FGM. So, I was more, it gave me more awareness, more statics of the region I am living in now, Birmingham, how the knowledge of FGM is affecting and then I also found out new ways how they try to increase knowledge and awareness in the communities where FGM is prevalent. So, since coming to this country, there is more prevalence than where I am from, so, because of the communities that are around here in Birmingham. So, it was a very informative listening to them, like implementations that they are

Example 3: Participant P004



	A	B	C	D	E
1		A : Age	B : Audience	C : Best practice	D : Blame game
	13 : Name Age = Unassigned Country of origin = Eastern Africa Gender = Male Occupation = Community leader ID = P004			To tell them “don’t do it it’s not allowed to do it in this country”. It’s good to be trained, it’s good for people to get trained especially mummys and daddys (sic). You commit crime, its crime in the UK. So, you can go in prison. You definitely go in prison and you are not responsible anymore and if you have children you are at risk for social work to come and take your children. So, what people will tell is consequences, “you will lose your families if you do this, you end in prison and no one wants that”. So, that’s why it’s better to prevent the people,	



	A	M	N	O	P
1		L : Facilitator	M : Feedback	N : Feelings towards the practice	: Feelings towards the programme or sessic
	13 : Name Age = Unassigned Country of origin = Eastern Africa Gender = Male Occupation = Community leader ID = P004	I prefer the people doing the course need to have people being families have been done before (sic). They are more feeling than people who are just in... If European people give these lessons, probably the theory they do it. But some people have this practice happen, I would prefer those people to give the course to train them because they know what they... they remember, they will say, “oh I was seven years old, I don’t like remember (sic) that, I was crying, I was dizzy” and all of this of child crying to get this oppression. Sometimes its pain two three days no urine. I have all my families have been	I give them comment. My comment was; I am telling that I’d rather give the lesson people who feel this or people who have been done this. That position and they want to prevent the people mostly like East Africans, most of them, the Sudanians (sic), Eritreans, Somalians, they have done this. So, this people they have come and have people who are very intelligent and they want to talk. “Give them chance” I tell them. And that was good comment. Some of them they say yeah, you are right (his name), and they say “this yes, coz (sic) the other	Some cultures the people has taken over (sic). And it’s not good things. Am opposite with this. I don’t like people doing this. So that’s why I’d love people to help to prevent. If European people give these lessons, probably the theory they do it. But some people have this practice happen, I would prefer those people to give the course to train them because they know what they... they remember, they will say, “oh I was seven years old, I don’t like remember (sic)	The BVCS offers it and different organisations have been registered offering these free sessions. Even my organisation we have done one time in schools and there is also there is this lady in girls’ schools who called me and said she want we do this session together as an organisation. I agreed to do this session with them but I partly, me and my other colleagues who are helping people we have been trained safeguarding like see the certificates of the training. So, it’s very important for me to have the training. So, sometimes we take opportunity to look it (sic) free sessions and we go and get the training.