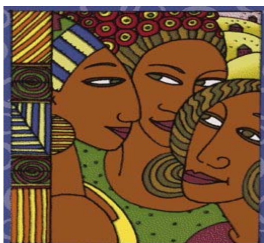

OUR SELVES, OUR DAUGHTERS:

Community Based Education Addressing Women's Health and Female Genital Cutting (FGC) with Refugee and Immigrant Women in Winnipeg

PHASE 1 ACTIVITIES OVERVIEW & PHASE 2 PROJECT OUTLINE

In April 2009, SERC received funding to conduct Phase 1 of the "Our Selves, Our Daughters" project from (now) Manitoba Healthy Living, Youth and Seniors ($30,000). Funds were matched by the Canadian Women's Foundation ($27, 500).

Phase 1 began in April 2009 and is scheduled to end July 2010.

Phase 1 Activities Overview

Goal

The goal of "Our Selves, Our Daughters" Phase 1 is to engage refugee and immigrant women from a specific African community[1] in Winnipeg in culturally competent educational sessions that address Female Genital Cutting (FGC).[2] This will be done by exploring women's sexual and reproductive health issues and impacts, by examining the social and cultural factors that support or detract from the practice, and by providing good information to support informed decision-making that would lead to prevention in the next generation of daughters. The project also aims to increase cultural competence in health and service providers through training.

Impetus for Project – Community Invitation

The idea for this project originated in a specific African community from a woman employed as an interpreter for one of SERC's programs, a nurse and community educator who had worked in two African countries on anti-FGC initiatives. Her passion is to work with women to help eradicate this longstanding community tradition and women-held practice, in a manner that respects and affirms women and community. She is also dedicated to helping women identify and receive supports or treatment for FGC-related health impacts. SERC was very excited to receive this invitation to collaborate and address this important area of sexual and reproductive health.

---

[1] In our initial consultations with community, one leader suggested we maintain the confidentiality of this community to avoid stigmatization. We continue to hold to this practice, although there have been other leaders who have since stated that they are pleased the project is taking place in their community and support the use of their community's name.

[2] At a community level, we use different terms depending upon what is appropriate – e.g. we use "female circumcision" or "traditional female health practices" or "FGC."

Main Activities

As of January 1, 2010 we are 9 months into this 15 month project. Main activities include:

- **Community Consultations and Community Engagement**. Based on feedback from a community leader with whom SERC has collaborated on other projects for the past 3 years, SERC sought additional funding and began the project with a 6 month process of community consultations. The goal of the consultations was to build stronger relationships and trust with the community, raise the profile of this 'taboo' issue, sensitize the community to the idea of addressing FGC, gather ideas and input, and build a broader base of support (i.e. identify allies, resources, advisors). Initially, a list of community leaders was developed. The project met with five men and three women community leaders. The project also interviewed a physician from the community with a passion for addressing FGC and much experience in assisting women to receive appropriate, knowledgeable health care. All the leaders were strongly supportive of the project. They shared important information about culture, values, and their perspectives on the issue. Strong emphasis was placed on the great importance of health education and information for newcomer women. Some gave concrete suggestions on how to run educational sessions. Many also assisted greatly in organizing focus groups with women and by raising the issue in their community. Thirty women participated in focus groups and five (with some overlap) in individual interviews.

- **Community Consultations Report**. A report with a full literature review was drafted, focusing on the information shared by women in the consultations. Some information was also gathered from women's and immigrant organizations in different Canadian cities, to see what is or has been done to address FGC in Canada. (Note: there seems to be little occurring currently – with some prior work carried out in Toronto in the 1990s around the time that FGC was criminalized in Canada). A participatory process was used to gather feedback on the report; a Women's Community Meeting and a Leaders' Community Meeting were held, affirming the bulk of the findings, and providing added nuance, corrections and feedback that were all incorporated into the report. A major goal of the meetings was to clarify and get permission for dissemination of the report. Both leaders and women clearly expressed their support for dissemination of the findings (with the community identity remaining confidential).

> One community leader sent in this feedback on the draft consultations report: "*I read the draft and it is really interesting and insightful. Its approaches and organization is simple, clear, practical and implementable… well done. We appreciate the thoughtfulness you have to our community and all the efforts you are doing for the benefit of our women in particular and our families in general. This definitely will have great impact and will play important role in transforming the community from poor awareness on health, consequences of traditional healing practices, Canadian health system, to basic understanding of health issues and practices… Women have a big role in the makeup of the family and the society. Thus equipping them with basic health education is both timely and necessary. Personally I am so happy with the things done and the plans ahead. The opportunity created for our women is really good. And I am sure it will be fruitful. Should you need any assistance or help we are always on your side, and please feel free to contact us.*"

The **Consultation Report findings** focus on these key areas:

Women's health and well-being issues and concerns (e.g. holistic approach, physical health as well as emotional well-being; numerous examples of experiences with and barriers to accessing health care; recommendations for improved health care services)

"After two nurses gave me medication for induced labour, they left (…) I was left alone. When I called for help, there was none. Then, I was frightened and got depressed"

Sexuality and Sexual Health (e.g. intergenerational issues/conflict, youth issues, intimate relationships, sexual and reproductive health concerns, FGC – why it is practiced, its cultural meaning, reasons for the practice, legal stance in country of origin and Canada, changing cultural beliefs around the practice)

"We need to know more about it [FGC]. In our culture, it is important. But here, it is good and bad. What are the effects? We need to know the effects on our children. … We don't know how it is seen here in Canada."

Education on Women's Health Issues (e.g. content and approaches regarding women's holistic health, sexuality, and the issue of FGC)

Women can get together and discuss with each other and get close. When the opportunity comes up…it is a woman-to-woman issue.

- **Community Education Sessions**. In Phase 1, we are holding three, 10-week educational sessions with 10 women each. The approach we use is participant-centred, discussion-based and culturally competent. The starting point for many discussions is women's own culture and knowledge, and central to all discussions is the exploration of women's lives and their roles in family and community. The content and direction was shaped by the consultations, and directly informed by each group's participation.

  Ten women attended the first group; attendance was very consistent. Early on, a strong rapport between facilitators (one of whom is from the community) and participants was evident. A very warm, safe atmosphere developed, rich with discussion, dialogue, sharing and laughter. The majority of these newcomer women had been in Canada two years or less, with one woman here for four, another for eight. Participants all had children (1- 6 children); three were grandmothers.

Women's expectations of the first session included: *People need help with interpretation; when a person has health problems, they can explain symptoms better… HIV…Cancer…Hypertension… General women's health… Information on men… Female genital cutting… Traditional health practices –what can be practiced in Canada?... How to access healthcare… Changes in workload, stress, lack of sleep*

The topic of FGC was integrated throughout the sessions – most areas discussed below were linked to the issue of FGC:

- Western, Eastern, herbal/traditional philosophies of health and common practices
- Accessing health care in MB (emergency, walk in, patients' rights)
- Women's lives: affirmation of women's roles; stresses on women (household responsibilities, isolation, missing people/grief, poverty)
- Reproductive Health: Female and male anatomy (e.g. using a specially developed board with labels in first language that women placed – or guessed), menopause, menstrual cycle, pregnancy, labour and childbirth (including FGC related complications), health prevention (PAP tests, HPV vaccines, breast health)
- Gender analysis: Examining, for example, why women's bodily functions are seen as 'unclean', why/how do cultures try to control women's sexuality, body image in Canada/media/health care, marriage/relationships and gender roles, differential status of men women/girls boys
- Culture and values – How we learn values, who do we learn them from? Examples from women's culture –positives and negatives. How culture is changing "back home" and in Canada.
- Culture and sexuality: beliefs, values and feelings; cultural change
- Laws related to sexuality and FGC
- Sharing of stories related to FGC – emotional and health impacts, beliefs and values, role of women, factors involving decision-making with respect to FGC
- Marriage and intimate relationships between men and women

An Activities and Evaluation Report will be completed near the end of this phase of the project. In the meantime, these are some women's words shared in the evaluation:

> *"Before when I feel something, I used to say 'it will leave me.' After coming to sessions I realized that if I feel illness I should … see a doctor"*
>
> *"Circumcision- I knew it is not good thing for women; now I know why it is not good. When we have a baby, our body (skin) cannot open widely as it should"*
>
> *"Learned about FGC, pregnancy and labour… the baby's well-being."*
>
> *"From not knowing, we came to knowledge. This knowledge made it in our heart to share it with others in our community. From this time we moved forward one step"*
>
> *"When I sit here I remember what I passed before and what I can pass to my children and grandchildren. I remember what passed before because I did not know"*
>
> *"Equally I feel happy for whole week after I come here. I will miss this."*

- **Ongoing Communication and Engagement of the Community**. A process of ongoing communication and engagement has evolved with the project. Within the resources of the agency, we have attempted to maintain communications with those engaged through consultations:

  Women: All 30 participants in focus groups opted to give us their names, when asked if they would like to be contacted about further work of the project. All were invited and many attended the Women's Community Meeting to give feedback on the Consultations Report and the overall project. Here, they expressed strong support for the project and in particular for the educational sessions. These sessions have been drawing from the pool of consultation participants, and many women remain in contact with the Project Coordinator. Many more have heard of the project word-of-mouth, and have asked to be put on a 'waiting list' for future educational groups.

  > A woman leader emailed the project: *I am very proud to be with…the last meeting with community leaders… I am very proud of you all, and I am proud of [Project Coordinator] to have the important [information] for women in [community to] specially go forward. It is the best project. [We are] proud to have…her with big heart and soul. She is luck[y] to have you in her side, without your help we can do nothing, so go forward - I am sure you [will]…blow their mind.*

  Leaders: The Leaders' Community Meeting was also very successful. Most leaders brought another leader with them. Eleven women and men attended. The majority expressed strong support for the project. Many were happy if not proud to have the project happening in their community. One leader expressed his overall support, but shared some comments that could be construed as constructive criticism. Another leader asked about the need for women's education sessions addressing FGC, but it was clarified by other leaders attending that the need for both education and prevention are great. Some gave examples from the community to substantiate this need. Another leader requested a follow up meeting with SERC to find out more information and discuss potential linkages between the project and various community groups. Overall, SERC felt the meeting demonstrated strong support at a community level for the project. Leaders' insights and recommendations are being fed into the project. The project remains in contact with all leaders, through email, written updates, and an open invitation to meet and discuss the project on an ongoing basis. The project supports a process of ongoing learning from the community and women. As is to be expected, there is not always consensus from the community on a given issue or decision. Therefore, the project uses women's direct feedback as the deciding factor for key project decisions. (Note: more information about the few areas where there was not complete consensus among community leaders, and the decision-making process followed, is included in the Consultations Report and Project Activity and Evaluation reports - pending).

There will be at least one more community meeting and celebration involving women and leaders, near the end of the project.

- An **Evaluation Framework** has been developed to examine both process and outcome-based learnings over the life of the project.
- **Service Providers**. Workshops will be held for service providers to share project learnings, including information about FGC and a culturally competent approach to service provision.
- A **Working Guide** will be developed by collating project materials

Phase 2 Draft Project Outline (as of January 2010)

There is strong evidence of success in Phase 1. An Evaluation report will be completed at the end of the project, but to date, there are many indicators of success that arise from community consultations and from the women attending the education sessions themselves:

- Strong community support to address women's health and FGC and to expand the project to address a whole community approach to change
- Women's support to do the same, and strong interest in participating directly in groups ('waiting list' for education workshops)
- Women education sessions: high levels of satisfaction, feelings of safety and feeling respected, evidence of mutual support/breaking down of isolation, high level of engagement and discussion in groups, in-depth discussion of FGC, culture, values, women's lives; indications that women have explored the socio-cultural, gender-based, and legal factors that support and detract from the practice and are now well-informed about the possible health impacts related to FGC, evidence that there is a shift in thinking among some participants about the need for the practice, and exploration of what the community as a whole needs to address in order for the practice to change

The following Draft Project Outline for Phase 2 has been developed, flowing directly from recommendations made by women and leaders in the consultations process and educational sessions:

- Multi-year project, 2.5 years over 3 fiscal years, beginning July 2010
- Continue to engage first community (the community the project is currently working with):
  - Women's participatory health education sessions on women's sexual and reproductive health, integrating FGC health impacts and prevention
  - Whole Community component: team of adults/youth from the community as researchers/educators, to conduct research with men/women/youth in community. Examine perceptions of FGC and means, at a community level, of addressing change and increasing supports to women/mothers/daughters. A "Whole Community" approach to addressing FGC.
- Expanding to one more affected community where there is a) readiness to engage, b) a high prevalence of FGC, and c) which is a significant newcomer population in Winnipeg
- Community Engagement
  - (see above: "Whole Community component")
  - (see above: Expanding to another community)
  - Establish Community Advisory Committee which meets regularly

    - 2-3 large Community Meetings over life of project, for broader input and accountability
- Capacity Building:
    - Peer Mentors Model to support individual and community capacity building with women and men; allies who are identified through the project, who, through discussion, dialogue and training, would serve as peer mentors to support improved health outcomes for women and a community shift around issue of FGC
- Resource Development:
    - Translation into first language of key project materials
    - Consultation reports (e.g. Whole Community Perspectives on Addressing FGC; second community's Consultations Report)
    - Manual for Health Education with Newcomer Women (Integrating FGC)
- Research: conduct research to determine prevalence, e.g. how many women in Manitoba/Winnipeg are affected currently by FGC
- Service provider training/systems advocacy: Follow up on recommendations from Phase 1 to address improved, culturally sensitive health care provision for newcomer women affected by FGC.

This project has been supported with grants from Manitoba Healthy Living, Youth and Seniors and from the Canadian Women's Foundation and its partners.