



**Symposium on
Female Genital Cutting (FGC):
Focus on Canadian Approaches
to Addressing FGC
Report**

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Introduction and Background

Immigration levels are rising in Canada. Among these newcomers are an increasing proportion of refugees from African countries. In Manitoba for example, one of the top 10 source countries for immigrants is Ethiopia. For 2009 in addition to Ethiopia, the top refugee source countries also include Congo, Somalia, Eritrea, and Sudan.¹

The literature clearly describes the large marginalization and barriers faced by refugees or racialized newcomers such as labor market insertion, language, access to health and social services, appropriate health care.² Research involving communities affected by FGC conducted by the Sexuality Education Resource Centre (SERC) highlights the following barriers and issues related to health care provision and access: language barriers, cross-cultural misunderstandings and lack of cultural competence among care providers, among others.³

Compounding these barriers is the fact that many African newcomer women are coming from countries where 75 to 98% of women and girls experience female genital cutting (FGC). The literature describes the many negative health impacts - both physical and psychological, that can stem from FGC.⁴ Therefore, there is a significant group of refugee newcomer women in Canada who are likely to face additional health concerns. Our research findings indicate that the practice is deeply rooted in tradition and women's identity and is still widely accepted among many of these newcomer women, but that change is occurring. Few are aware that many of the health concerns they experience are linked to FGC. Additionally, not all newcomer women from FGC-practicing countries are aware that it is illegal in Canada. These factors demonstrate a need to address health care related gaps experienced by African newcomer women affected by FGC along with the need to look at the prevention of this practice among girls in Canada.

In April 2009, SERC, in partnership with a nurse from an African newcomer community, received funding to conduct a two-phase 15 month project to conduct community based research and to address health impacts and prevention of FGC with African newcomer women. Phase 1 consisted of a community-based research process. We conducted 5 focus groups with a total of 30 women and follow-up individual interviews with 3 of these participants. We

¹ Data provided by Manitoba Labour and Immigration on March 2011.

² For instance, Chalmers and Omer-Hashi (2002) What Somali women say about giving birth in Canada. *Journal of Reproductive and Infant Psychology*, Vol. 20, No 4; Chalmers and Omer-Hashi (2000) Somali Women's Birth Experiences in Canada after Earlier Female Genital Mutilation, *Birth*, Vol. 27 No.4. Hyman, Ilene (2009) Racism as a Determinant of Health in Canada, Policy Brief, http://canada.metropolis.net/pdfs/racism_policy_brief_e.pdf Retrieved June 2010. Vissandjee B, Desmeules M, Cao Z, Abdool S, Kazanjian A. (2004) Integrating ethnicity and migration as determinants of Canadian women's health. *BMC Women's Health* 4(suppl 1):S32.

³ SERC (2009) *Our Selves Our Daughters: Community Engagement and Consultation Report* <http://www.serc.mb.ca/content/dload/download.2010-06-09.7508641937/file>

⁴ For instance, Toubia (1995) Female Circumcision as a Public Health Issue, *N Engl J Med* Vol. 332, No. 3. Australian National University (2006, June 2). Female Genital Mutilation Affects Births: Study. *ScienceDaily*. Retrieved September 16, 2011, World Health Organization (2006) Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries <http://www.who.int/reproductivehealth/publications/fgm/fgm-obstetric-study-en.pdf>, retrieved August 2011.

interviewed 3 women and 5 men in leadership positions in their community, and a physician from an African newcomer community in Winnipeg. This research phase emphasized an ethical process, public participation, and examined the key issue through a gender-lens, i.e. examining the cultural, social and gender-based facilitators and detractors of the practice of FGC, from both men's and women's perspectives. The research phase achieved two main outcomes: 1) research findings generated about newcomer refugee women's holistic health needs, issues, beliefs (and those pertaining to FGC) that would inform and enhance our ability to engage and address health impacts of women experiencing FGC and address prevention in the next generation of daughters, and 2) greater trust and relationships with the community that helped guide and facilitate project implementation. A Community Consultations and Engagement Report was produced and disseminated with key stakeholders.

The second phase of the project involved the implementation of health education workshops with newcomer refugee women, examining the socio-cultural and gender-based construction of the practice of FGC, identifying and providing information on common health impacts of FGC.) and exploring, in a safe environment, concepts of change in the practice, given the current Canadian social and legal context, as well as the changing landscape globally on this issue.

In developing and implementing this project, SERC attempted to access other research and programming related to FGC that may be occurring across Canada. We found almost no Canadian based published research on the topic (addressing FGC in a post-migration context). We were able to find a few groups in various Canadian cities that are currently engaged in research and/or practice on the issue. There does not exist, however, any "research community" as such, nor any vehicle for supporting the exchange of information, knowledge translation, building partnerships between research projects/teams nor connections between researchers and knowledge users on this issue.

The local evolution of the project led to the need to engage with others working on FGC related projects in the national and international arenas. The first logical step was to facilitate a space for mutual exchange of research findings, experiences and expertise. In consultation with a series of interested parties, the Symposium took shape. Most of the presenters became consultants in the organizing process and other presenters were identified through the process of organizing.

Symposium Objectives

The overall goal of the two-day Symposium was to promote knowledge exchange for improving health policies, programming and services for women who have undergone female genital cutting on a continuum from prevention to care. The specific objectives were:

1. To present, summarize and discuss existing and ongoing research, programs, services and policies focused on Female Genital Cutting (FGC) in Canada and the Diaspora.

2. To identify and articulate key implications for improved planning and implementation of programs, and of health services and policies for immigrant girls, women and communities from countries where FGC is prevalent.
3. To establish a collaborative network of researchers and program planners and practitioners to promote knowledge exchange on FGC within the Diaspora.
4. To identify research gaps and develop an applied research agenda and “best practices” related to FGC care and prevention in immigrant populations where FGC is prevalent.

The Program

The Symposium was open to practitioners and program planners, researchers and community members interested and involved in working with immigrant communities where FGC is prevalent. This two-day workshop focused on the following research and program areas:

- Social and health research on FGC from a comprehensive view of women’s sexuality and a population health perspective (e.g., biological, social, cultural).
- Effective policies, programs and services, including health policies, which better serve immigrant and refugee women and their communities affected by FGC.
- Assessment of the impact of research, programs and services on immigrant and refugee women and their communities affected by FGC.
- Assessment of the gaps in information, research, health policies and programming.

The Symposium followed a participatory approach to stimulate participants’ engagement through thought-provoking keynote presentations, discussions on the current state of research, and on current health policies, services and programming on FGC in Canada and elsewhere. The following sections of the report provide an overview of the presentations and small group discussions, as well as a description of the attendees.

Presentations

The presentations were grouped in blocks under the following topics: Overview, Historical Context, Social and Community-Based Research in Canada; Community-based service provision; Policy; and Clinical.

Introduction to the issues

The first day of the Symposium began with an introduction on the topic of FGC/M from the perspective of strong advocate and counsellor for Diaspora women with FGM, Mrs. Kowser Omer-Hashi. Omer-Hashi provided a poignant introduction to the complexities of providing support to women affected by FGM in a health care system lacking cultural competence and compassion. It was based on this reality that Kowser proceeded to become more vocal and visible in the fight toward the eradication of FGM in Canada. As a lobbyist for change, Omer-Hashi provided an important insight on what is to be a Somali woman advocating for legislative and systemic changes while dealing with community backlash.

This introduction was followed by a look at early activism in Canada. Notisha Massaquoi, Executive Director of Women's Health In Women's Hands Community Health Centre (WHIWH), provided a look at how organizational leadership and feminist organizing laid the groundwork for FGM eradication in Canada. She also showcased the strategies employed by her agency to work effectively with FGM affected women. She highlighted the feminist debates on FGM by presenting the encounters between western feminists and those feminist in FGM practicing countries. The use of a Violence Against Women's framework became paramount to build an appropriate FGM prevention response. Notisha concluded that in order to be successful in providing care and assisting women with the cause, it is important to understand FGM as both a health and human rights issue, have sufficient resources, address changes in policy and legislation, partner with impacted communities, service providers and government .

Local Community-Based Research

The second part of the morning was dedicated to highlighting local community-based research. The Sexuality Education Resource Centre presented on the findings of their research involving women and some preliminary findings on later research on FGC and change with women, men and youth. The research process incorporated principles of community development and community-based research (e.g., invitation and direction from community, participatory process, cultural competence, research to action). Findings from the research involving 30 women and 9 men and women in leadership position revealed important concerns with access to the health care system; concerns with regards to children and family with regards to sexuality related issues; lack of communication and information about these topics. FGC was viewed to protect girls and women, not meant to harm them. Some of the participants were somewhat knowledgeable of ill health effects of the practices and others were not able to attribute some women's health issues to the practice. They also showed some skepticism to the role of legislation in change; but, believed that education and increased awareness on FGC within a health and culturally competent framework was desirable. Strong support from women and leaders to involve men led to a second research project that also extended to youth. Preliminary findings indicate an interest in addressing FGC at the community level across all sectors.

Community-Based Service Provision and Programming

In the afternoon, participants were exposed to models of community-based service provision for women impacted by FGC. Notisha Massaquoi spoke about the WIWH's model of care. Based on the principles and recommendations from the 1974 Lalonde's report, WIWH focuses their work on a population with highest level of health risk exposure. Their own research revealed that among the most pressing health concerns for participating women were: depression, preventive medicine, psychological complaints, poverty, hypertension, assault, menopausal symptoms, pregnancy, post-traumatic stress disorder and diabetes. In addition, she observed the barriers to care for women in the study such as service setting, transportation, lack of culturally competent staff, and lack of time to access care were important factors determining women's health. She, then, went to explain an anti-oppression health care framework used by WIWH designed to address these issues. This includes: involving

marginalized groups in decision making at all levels of the healthcare organization; ensuring that healthcare providers are representative of client populations; offer integrated multidisciplinary services; be willing to take healthcare services to the community and develop services based on client definitions of accessibility, cultural acceptability and availability of services

Naana Otoo-Oyortey presented on the approaches taken by FORWARD, an African Diaspora led charity working to safeguard and advance the health and rights of African girls and women in the UK and in Africa. FGM, child marriage and related health issues are main focus of FORWARD's work. Naana anchored her presentation on current FGC prevalence data and information on FGC specific health services accessed by women in the UK. Community engagement and capacity-building are important hallmarks of FORWARD's approach. This approach was illustrated through their women and youth focused-work, the *PEER* participatory research project. In this project, community members were trained to conduct research with their peers. Among the main findings, the research revealed that women are under pressure by older female relatives to continue the practice, and that mothers need to be highly motivated to resist such an ongoing pressure. Some women would "fake" their daughter's circumcision to avoid such a pressure. While exploring access to health care the *PEER* project collected stories where the incompetence of health care providers was evident. Based on these findings, FORWARD has implemented leadership, social and mental supports, health advocacy and drop-in for women. They are also working with youth to build leadership and peer mentoring, counselling support and a school-based awareness and support program. All these programs and approaches have generated many lessons learned, including the need to address other needs of women, acknowledge that women may not be aware of FGM as an issue, the need for strong partnerships, the need to involve youth and men, and build bridges between health care providers and women.

Simret Daniel and Linda Plenert presented on SERC's community-based education resulting from women's specific needs. The underlying philosophy was to provide information as a way of enabling women to understand their own health concerns within a framework of overall health and well-being. As well, every topic was considered a path to discussing FGC in the context of health promotion and prevention. Among the outcomes from this work, they found that, in general, women had little knowledge about their own bodies and how their reproductive systems functioned so that became a major focus of the sessions. We needed to spend time discussing and negotiating health facts versus beliefs in cultural practices, evil spirits etc. for many of the topics. The sessions provided information with the intention of helping women re-frame the longstanding cultural practice of female circumcision. There were lively discussions about the beliefs and realities surrounding FGC. Because female circumcision is an important part of a woman's cultural and sexual identity, the impact of FGC on a woman's sexuality, specifically, was also addressed. Gradual work on sexuality issues led to a final discussion about addressing the barriers to changing entrenched cultural practices and whether or not being in a new culture helped or hindered this process. The project encouraged

participants to see themselves as role models because the dilemma about FGC is now being discussed in the community.

Policy

On the morning of the second day participants were exposed into FGC policy related issues. Ms. Massaquoi reflected upon the policy development in Canada. She highlighted some of the pivotal events leading to legislative changes such as the provision of asylum to a Somali woman fleeing to protect her child from FGM in 1994; Ontario Government lobbying led to the formation of the inter-ministerial Task Force on FGM under the direction of the Ontario Women; and, the strong presence of WHIWH at the UN Fourth World Conference on Women in Beijing, where FGM was recognized as violence against women. Then, Ms. Massaquoi described the process leading to changes in the federal legislation. In 1997, the Federal Government proposed changes in legislation to criminalize FGM through the provision of Bill C-27. The final Bill was passed on May 1997. The legislation has remained the same since then.

Ms. Naana Otoo-Oyortey described the process of policy development in the UK. Ms. Otoo-Oyortey focused on the latest policy development in UK. The Female Genital Mutilation Act 2003 applies to England and Wales, while Scotland has its own legislation on FGM (the Prohibition of FGM Act 2005). The new Law introduces three main changes, including: change the name of the procedure to FGM from female circumcision; 'extraterritoriality'; increased penalty from 5 years to 14 years of imprisonment or a fine or both (for Offence to commit FGM, to aid, abet, counsel or procure a girl to commit FGM, for someone in the UK to aid, abet, counsel or procure FGM outside of UK that is carried out by a person who is not a UK national or resident, any act done outside UK by UK National or resident).

Doctoral candidate, Ms. Najla Barnawi, presented detailed background information on FGC/M, including information on the practice, and the legislation. Then, she described policies concerning the health care system. Ms. Barnawi was concerned with the impact of such policies on circumcised pregnant immigrant women. She indicated that most policies address primary prevention of the practice highlighting a need for policies dealing with secondary prevention. She based her arguments on research findings on the maternity experiences of immigrant women where lack of cultural competence was evident. Then, she suggested the need for maternity guidelines for circumcised women, the main focus of her future qualitative research. She proposed a closer connection between women and health care providers. In this way, the clinical and cultural dimensions of the issue would be equally addressed and represented in the guidelines.

Clinical

In the afternoon, Ms. Omer-Hashi continued to draw from her personal and professional experience to highlight issues of concerns for women affected by FGC. Her lifelong journey of advocacy led Kowser to engage in further work to raise awareness and educate health care professionals, teachers and community workers to better assist women. Trying to support and advocate for women led to not only confronting the lack of competencies of the health care

system, but having to confront her own cultural community. In this regards, she personally paid a “price” for challenging cultural norms. This became increasingly challenging leading to having to somewhat give up the work. However, her strong conviction towards the cause continues to translate into support for current FGC work. Her personal story illustrates on the challenges of those involved, but also shed light on the concrete struggles and positive outcomes that change in this area.

Dr. Lisa Avery situated the issue of FGC in the clinical practice from a reproductive health perspective. She spoke about the health complications attributed to FGC to then discuss them from a practical perspective. Drawing on her personal experience providing obstetrical care to women affected by FGC in Canada, Dr. Avery engaged the audience by presenting “case studies”. Her cases clearly illustrate the health outcomes of incompetent care (e.g., disengaging from prenatal care due to insensitive comments by physician resulting in complications at labour); ethical dilemmas (e.g., responding to request for a C-section instead of deinfibulation or request for reinfibulation after birth). Among the main issues highlighted were the lack of knowledge and understanding, lack of cultural competency or sensitivity, the focus on biomedical aspects. She also provoked participants to think about the practice of FGC vs. genital piercing or vaginal cosmetic surgery; the practice of terminations of pregnancy for sex selection vs. non sex selection; the practice of FGC vs. male circumcision, the prescription regulations for viagra vs. emergency contraception and even the practice of premarital vs. postmarital sex. She indicated that in order to move forward on this area of work, we need to develop a framework to ensure clinical competency that involves communities; carry out more research; and develop networks and partnerships.

Dr. Gillian Einstein presented on her original research on the neurological consequences of FGC. Using a very mixed-method research approach, Dr. Einstein gained quantitative and qualitative data on a group of Somali-Canadian women in Toronto. She interviewed and tested pressure/touch thresholds to touch in the vulvar region of women to understand how they feel about their circumcision, their bodies and their perception of pain. Researchers found that while most of the women reported feeling healthy, most of those who proceeded to the test had extremely low pressure/touch thresholds in at least one region of the vulva in spite of the fact that in conversation, they say nothing about chronic vulvar pain. We learned that the meanings of pain vary and as such attention should be pay to this issue, as women with infibulation may suffer from chronic pain. Effective communication and culturally safe approaches are required to address this important aspect of women’s lives.

Dr. Bilkis Vissandjée reflected on her pioneer research in the area of immigrant health, including FGC in Canada conducted in 1998-2002. Commissioned by Health Canada at the time, the research team faced a number of challenges regarding the methodology and ethics corresponding to this project. One of the most salient regarded the negotiation between the needs of the funder and the possibility of research (e.g., the funder was interested in learning about the prevalence of FGC in Canada). The project was multi-site, and involved a number of communities and languages, and mostly men and women in their reproductive years that had

been in Canada between 3 to 5 years, and of different immigration status. Dr. Vissandjée explained the intricacies of selecting methods of research and dealing with practical issues such as ethnic and gender matching between fieldworker and interviewee where there is a dearth of evidence on best approaches in this area, among other issues. The project sought direction from community members and people working with immigrants. There was no direct question on FGC; however, some of the participants spoke about the practice. According to the participants FGC continued to occur, people knew of other community members that have brought their daughters to their home countries to get the procedure done, fathers were not as keen, but mothers felt that they needed to fulfill their obligation, and they also knew that the practice was illegal in Canada. However, there was also a sense that there were alternatives for girls in Canada. Further, women's experiences with the medical system also demonstrated a clear need to address gaps in appropriate services. This resulted in recommendations for developing and putting in practice "reasonable measures". Dr. Vissandjée finalized advocating for a more personalized approach based on use of "common sense" to better serve women's and communities affected by FGC.

On behalf of the Society of Obstetricians and Gynecologists (SOGC), Ms. Liette Perron presented on the involvement of the organization in the work towards the elimination of FGM/C. Following a detailed presentation on SOGC, Ms. Perron spoke about their past and current involvement on FGM/C work. Starting in 1992, SOGC developed a position statement on the matter to then, publish on clinical management approaches and tools and participate in international events or programs. Ms. Perron then turned to present on the current work on the issue. SOGC is the process of developing a renewed position statement and a clinical guideline. As she could not present on the specific content of either of these documents, Ms. Perron spoke about the processes involved in their development (e.g., literature review, consultation with key stakeholders, surveys, SOGC committees). Faced by the lack of local research, much of the information for these documents was drawn from literature from other countries. Yet, the findings from these documents confirm findings from old Canadian research (e.g., lack of cultural competence).

The Participants

All fields of interest were represented at the Symposium. While most of the participants belonged to the health care or social services field, there was still a significant number of academic or researchers and to lesser extent those involved in policymaking. Most in the health care services were midwives, public health nurses or residents.⁵⁶ As per those in the social services field, many were involved in providing settlement services to newcomers or provide therapy or counseling services.

⁵ A large contingent of resident of the University of Manitoba Medicine program attended the session that focused on Clinical issues.

⁶ In order to attract physicians to the event we secured accreditation by the Society of Obstetrician and Gynecologists and the College of Family Physician Canada.

As part of the registration process we asked potential participants to tell us about previous training or education on FGC in the past, current work with women affected by FGC, type of direct work/services provided, and expectations in attending the Symposium.

Based on the understanding that many would be interested in the Symposium and to be able to reach out and secure the participation of those with definite experience and expertise in the area, we established a selection process early in the registration stages. As the registration process slowed down and we received many inquiries for participation, we decided to broaden the scope of the scope of the Symposium to allow for flow of expert information to those with strong interest in the field. We also were able to increase the number of participants in general.

We considered all the responses from those with confirmed attendance for analysis (N=47). Over **thirty eight percent** (38 %) of the participants indicated having had **no training or education on FGC**, including a few who has had little exposure. Another twenty-one percent (21%) had participated in education sessions led by SERC or used SERC reading materials. A number of participants had conducted extensive research or reading on the topic as part of academic research and assignments, journalistic/documentary assignment (about fifteen percent). A few cited their personal experience working with FGC affected women as their previous learning on the matter, while others referred to university training that involved discussion or learning on the topic.

Approximately nineteen percent did not work with newcomer women affected by FGC. However, among those currently working with affected communities only 35 percent did actual FGC- related work with women (mostly in the clinical area).

Researchers who attended were addressing clinical, sociological, epidemiological research in a variety of settings.

Among the most salient expectations were:

- Build relationships with researchers, program planners and practitioners for programming, policy or research purposes
- Clinical management / improve quality of care
- Learning about ongoing research and programs
- Policy related issues
- Education and counseling/best supports for women
- Understandings and responses in Canada
- Community-based or engagement approaches
- Culturally competent approaches
- Overall education on the topic

This wide range of expectations, including for many, information on basic issues concerning FGC indicate the attendance of participants with very heterogeneous experience and exposure to the issue.

Knowledge Exchange Sessions

A series of discussion groups, called “Knowledge Exchange Sessions” (KES), followed a set of presentations each morning and afternoon, except for the morning of second day when participants requested a longer question and answer period to further discuss policy related issues raised in the presentations.

Simultaneous discussion groups focused on the following four topic areas: *Community-based programming/Health promotion, Clinical, Policy and Research*. The group discussions lasted about 45 minutes and were facilitated SERC’s staff with support from one or more of the presenters. A note-taker was assigned to each group to compile detailed notes resulting from the discussions. Facilitators also made point-form notes.

Participants chose to attend the group of their interest. They were encouraged to move from one discussion group to the next. However, a number of participants (mostly those interested in clinical issues) decided to stay in the same group to engage in deeper conversations.

Purpose of the discussion group:

- To facilitate an exchange of ideas based on participants’ experiences and views on the topic
- To debrief and discuss issues stimulated by the presentations
- To help the discussion move forward in relation to the identified areas – i.e., clinical, health promotion/community-based programming, policy and research
- To highlight areas of work that require future attention

In order to ensure and maintain the level of discussion, a series of non-directive questions were offered to the group. Some of these questions were “What are some of the current practices in the clinical field concerning FGC?” or “What are some of the gaps within the clinical field that need to be addressed? What are some of the “best/promising practices” that would be helpful to women?” or “What are the ethical issues or questions that arise with regard to clinical approaches to FGC?”

Participants in small group discussions asked questions intended to fill gaps in their knowledge. Their questions, comments and observations highlighted areas that required further attention from a research perspective. In some cases, participants had contradictory viewpoints. The standpoints shared were informed by participants’ level of knowledge and engagement in FGC, and demonstrated a wide spectrum in understanding and analysis of the complexities inherent in dealing with such a complex and controversial topic. Some participants shared specific information on policies and programs, in considerable detail, based on their current work or research.

The following notes summarize the discussions generated in each of the four topic areas. They are meant to reflect the wide range of perspectives and issues shared in that particular area.

Community-Based Programming and Health Promotion

Women's Concerns:

- Need for appropriate information with regards to regular health promotion and prevention such as cervical cancer screening/pap smears
- Postnatal visits allow for greater level of privacy and safety for discussing issues of sex/sexuality
- Postnatal visits present an opportunity to educate women about where to get information and even on how to educate children about sexuality
- Perinatal work allows for gaining understanding on experiences of FGC (e.g. from anger to acceptance to outright change)
- In other contexts than those dealing with reproductive health, FGC becomes a more elusive topic (e.g., in the context of family violence prevention)
- FGC is not addressed as much in the Diaspora as in Africa, women may not speak openly because it is not publicly evident, or out of legal concerns, or just because they may feel that there is an opportunity for change.
- Some women feel pressured to change and feel that their culture is being judged once they settle in Canada.
- Gender specific groups and private home visits associated with reproductive health issues facilitate communication about FGC (i.e., women are more open to bring up their personal or general issues associated with the practice).

Cultural Safety Approaches

- Service providers appeared to be ill equipped to assist their clients in relation to specific FGC related requests. They pointed out to the need more specific information about the practice, reasons for the practices, and its implications.
- Approaches to assess the need to look into FGC and how to broach the issue with clients were suggested as areas of need.
 - Approaches to building trust (e.g., give permission to ask “sensitive” questions, ensure space and time are on the women’s side)
 - Ensuring non-judgmental approaches (e.g., prevent situations where women are pressured to change)
 - Finding commonalities in women’s experiences to connect
 - Ensuring that service providers are competent and comfortable addressing sexuality, sexual and reproductive health issues and able to seize the opportunity to address FGC.
 - Introduction of health perspective as a way of bridging the topic
 - Approaches the help balance the potential need to disclose to authorities (e.g., child protection) while maintaining a trusting relationship with families/parents.
 - Approaches that address all concerns faced by newcomers

- Approaches to engage community to gain acceptance and prevent backlash. Particular approaches engaging the whole family in discussion on FGC in safe environment.
- Ensuring that other professionals than those with medical background are able to carry legitimate messages on FGC (i.e., belief lack of authority on the issue if not addressed by those with medical background).
- Approaches to work with youth without necessary parental involvement.
- Approaches that allow to account for transnational relationships with regards to decision-making in FGC (e.g., travel back home after birth of a girl)
- Challenges of youth living in Canada (with other family members) while parents back in home country and following their expectations concerning their sexuality or sexual behaviours
- Approaches to engage new mothers in the prevention on FGC with their newborn daughters.

Engaging Community

- Make presentations to existing or established groups of newcomers (e.g., Healthy Start, EAL classes)
- Engage religious leaders to address FGC as not a religion mandated practice (e.g., it appears that there is greater adherence to the practice when it is connected to religion)
- Addressing main concerns of communities and families and find entry points such as health to address FGC (i.e., FGC presented within the context of overall sexual and reproductive health information).

Education: general / adults

- Include focus of *African women advocating for change in Africa and around the world*.
- Relate message that FGC is not a religious requirement.
- Incorporate FGC within sexuality-related education (e.g., relationships, anatomy, communicating about sexuality such as SERC's and some other approaches – “Speakeasy” in UK).
- Strike a balance between providing information soon enough after arrival while ensuring that other (health) related issues are also addressed. Information will need to be provided over time.
- Introduce the topic in EAL class as mixed groups would allow for the discussion of taboo topics in their culture, and would include men's perspectives.
- Service providers need to engage parents in education that addresses the consequences, including beliefs regarding outcomes of not circumcising.
- Make information more visible as many newcomers are coming from countries where campaigns (anti-FGC) are visible (e.g., posters in health clinics).
- Attend to differences in FGC practices (e.g., who is involved, how, what the practice involves, specific reasons behind, degree of openness in communication about FGC, etc.)

- Look at examples such as in the Netherlands where a new Declaration against FGM is given to parents to prevent their daughters from undergoing the procedure when visiting their home countries. The declaration is translated into various languages.

Education with Youth

- Integrate FGC into school curriculum for all students, not just targeted to ethno-specific groups while ensuring an understanding that not every girl/woman from these communities is circumcised.
- Train young people as advocates or champions for change (e.g., education sessions incorporating culture, identity, change etc., peer to peer training, arts-based approaches, etc.) while acknowledging potential for short-term commitment to a program and ensuring well developed messages they can carry forward with them.
- When working with youth consider that some may have experienced FGC, some not. Bridging differing experiences presents challenges. It is important to slowly introduce FGC.
- Attend to ethical issues when using arts-based approaches that bring about youth personal experiences (e.g., film)
- Assess best methods of education (e.g., poster in schools, videos, education sessions)
- Intergenerational program that requires youth to interview older community or family members on FGC.
- Sexuality education sessions for mothers and daughters to have open conversations about sexuality that include FGC.
- Information to youth should be passed along when young to enhance prevention efforts, while acknowledging the challenge that for young children it may be difficult to understand.
- Peer to peer approaches have proven successful.

Legal Issues

- Service providers or community advocates need to understand and pass along key messages on current FGC related policies.
- Prevention approaches around holiday period when children may be at significant risk. Messaging to include health perspective and legal issues.
- Lack of knowledge regarding FGC cases and the law in Canada to observe how the issue is treated by different authorities.
- Need for discussions on different policy approaches from child protection, criminal, immigration laws, taken by western/high income countries and their impact.

Policy

In this session, participants debated issues regarding policy and legislation and the overall political climate as well as policy related issues at the level of the health care system.

Broad Level Policy and Legislation

Social and political climate affecting policy discussions and development in Canada

- Lack of government commitment to gender equality
- Eradication of women's services, women's bodies, advocacy groups, etc. at a national level
 - Anti-choice government
 - Anti-immigrant_sentiment
 - Many immigrant serving agencies are going to lose funding
- Lack of champions (e.g., need strong organizations to lead, lack of formal networks addressing the issue, limited political leadership interested in FGC)
- Barriers to engaged participation in policy/clinical guidelines development
- Community lobby has not stopped, just legislation has 'stagnated'. Barrier is that national women's lobby groups have been dismantled

Lack of policy/limited policy work

- 'General policies' addressing immigrant women's health concerns do not exist (e.g., policies for maternal-child health at provincial level)
- Need policy to look at inequities, not just FGC.
- After Bill C27 amendments in mid-1990s nothing has been further developed

Refugee Board (RB) needs more changes to their policies

- Examples of many women asking the RB for refugee status, but some do not get it. "I remember being a witness to a case. This woman's first daughter was not yet an adult so she could come but the second couldn't be brought in."
- Refugee status is supposed to be given with the threat of FGC, but in some countries FGC is illegal, but it continues. "Canada is not aware of these nuances and differences in legislation and its implementation"

Health Care Related Policies

Lack of unified, updated clinical guidelines

- No unified or updated clinical guidelines in Canada ((e.g., informed options with regards to C-section, de-infibulation, vaginal delivery, etc.)
- Lack of knowledge of where to refer to for appropriate and consistent guidance.
- Clinical and cultural dimensions are poorly addressed in current guidelines (e.g., offering vaginal delivery and re-infibulation as an option for women to respect culture/preserve sense of identity.

Policy direction in Canada: focus on prosecution of those continuing the practice of FGC, and on overall legal approaches AND/OR focus on providing supports for women already affected by FGC and prevention education

- There are major ethical challenges to developing policy. The issue is very complex. As legislation and policy is enacted, they impact on families and communities. How do we reconcile "respect for culture," with "you have to change"? What will happen to their

families, for example, a woman is de-infibulated after birth? There needs to be bigger picture view

- There is a law against FGM in many countries, but the challenge is in how to implement it. It is very difficult to enforce partly because daughters do not want to get families in trouble
- Need to focus on “secondary prevention” i.e., care/treatment/supports (cultural competence for service providers) for women affected by FGC versus legislation (primary prevention)
- There is a need for both - supports to women already circumcised and also prevention of FGC; addressing one helps address the other. a “two-pronged approach”
- State needs to come out firmly against it PLUS education ; if only follow a legal approach, will drive FGC underground
- “The law must be firmly affirmed irrespective of education. Even in countries like Mali, there are incredible programs, but in terms of law they are still struggling. Education must go on irrespective of the law.”
- Working with statutory agencies (e.g., CFS, police) can force FGC to go underground. Therefore, community based education is an important policy direction
- “In Burkina-Faso there is a law that puts excisors in jail. What good does it do? People go across the border to get it done.” In Mali, there is no law, they are working on prevention/education
- In situations where there was a law only, it did not work to eradicate the practice, “it went underground.”
- In the UK/Europe there is strong emphasis on prosecution; e.g., the compulsory examination of girls bodies in France

Policy/guidelines that have been developed in Canada –not disseminated? Used?

- E.g., Ontario women’s directorate, guidelines re FGC education

Research and information needed to inform policy

- Lack data to know what are the health consequences of decisions (e.g., health consequences of C-section to avoid de-infibulation)
- The current practice here is to offer an episiotomy rather than de-infibulation. However, people are doing this without clear clinical guidelines, ones that outline the implications of each choice or decision
- Need to evaluate the application of a uniform standard for antenatal care (i.e., number and timing of visits) to all women. Some women, upon assessment, may need fewer visits, for example, and some women affected by FGC may need more. Research findings would assist in changes in policy and specific guidelines.
- No systems for data collection in Manitoba (medical records) for FGC, including lack of ethnicity data; cannot therefore get prevalence, impacts, etc.
- No means of tracking prevalence in next generation.

- Need to further understand the impact of current national/local policies, as well as the effectiveness of policies in other high income countries.
- Need to better understand the impacts of legislation on immigrant communities (in context of racism, lack of cultural competence).

Fee-for-service and other medical system barriers

- Need to ensure that care providers have adequate time to provide holistic care
- “The medical system is ‘you are in, you are out’”. There is insufficient time for care providers to address the complexities of FGC. The short time allocated to patients is partially driven by the billing system.
- Need for more salaried doctors versus fee-for-service
- Assess alternative models of care such as African women’s wellness centres
- Lack of emphasis on midwifery care/nurse practitioners versus obstetrician-gynecologists. This is driven partly by power dynamics, as well as by billing incentives.

Health Interpretation

- Lack of access to health interpreters in general
- Lack of access to health interpreters for an appropriate period of time to talk about issues; prepare women for childbirth, etc.

Harm reduction

- Zero tolerance to any form of FGC vs. harm reduction approach (e.g., under medical supervision to mitigate the process while eradication of the practice takes its course).
- Evidence in the literature of harm reduction approaches, yet FGC is considered a human rights violation. No room for harm reduction/accommodating lesser forms of FGC.
- In Canada, health professionals are against FGC. Women do not have a choice (e.g., no re-infibulation after delivery)
- “Do no Harm” approach will impact on cultural aspects. What we consider ‘harm’ may be considered “good” in a different culture, and what we consider “help” may be considered harm by a patient. Importance of taking into account the full person, including her ethnic/cultural identity, not just the physical aspect.

Recognition of links between cosmetic vaginal surgery and FGC

- Need to expand the analysis of the debate on FGC to include legitimized forms of FGC (i.e., vaginal surgeries) in the West.

Pre-service training for health care practitioners

- Challenges making FGC related training a core competency when there is barely enough time to cover what are considered ‘the essentials’
- Cultural competence training at systemic level , e.g. maternal care –both cultural and clinical dimensions

Foreign trained physicians

- Lengthy process of accreditation
- Lack of sexual and reproductive health and FGC training in some countries of origin

Lack of Service provider training (non-medical)

School-based prevention/information: NOT SURE WHAT TO DO WITH THIS RE POLICY

- Example given of past work of SERC and the Winnipeg School Division- teachers provide information to children saying, “This is an issue, you shouldn’t tolerate this.” Kids understood. There was evidence that some doctors were performing FGC in Manitoba; kids being taken home and circumcised.

Clinical

Overall FGC practice

- The practice differs by country and community involved (e.g., done during early childhood, as a rite of passage to adulthood or right before marriage).
- There are different reasons for FGC (e.g., to prevent pre-marital and extramarital sex, financial motives by physicians, etc.).

Health related complications of FGC

- There is no significant research about the causes of prolonged labour in women with FGC. It is speculated that psychological or anatomical cause like severe narrowing of the vaginal opening and the fibrosis of the pelvic tissue from repeated incisions and episiotomy can be important contributing factors.
- Prolonged delivery in women with certain types of FGC put the mother and baby at risk.
- Postpartum complications due to the lengthy healing period resulting from vaginal delivery depending on type of FGC/M, episiotomy, presence and direction of tears.

Experience and current practices in the clinical field in dealing with women with FGC

- Lack of available clear guidelines for physicians dealing with labour and delivery or other gynecological presentations.
- Many women would not seek antenatal care due to barriers (e.g., access to female doctors or midwives). This situation increases the chances for undesirable complications during delivery.
- Personnel with training or experience in dealing with FGC where practice is common are better prepared (increased level of comfort, more specific clinical skills)
- Access to midwives may increase access to appropriate care for women with FGC (e.g., ability to discuss their sensitive health issues including FGC freely).
- Attend to cultural differences in labour and delivery is important (e.g., women may not express pain or request pain medication as result of cultural belief that the expression of pain especially during delivery may be considered shameful).
- Address FGC with teenagers during birth control related visits.

Gaps within the clinical field

- Need to examine the application of standard antenatal care (number and times of visits and investigations) to women affected by FGC. Special antenatal care guidelines are required to help health care providers give efficient antenatal care to women.
- Lack of basic knowledge among health care providers about FGC. There is no particular training and education about the FGC issues during the years of study at medical school in Canada or even about cross cultural sexual differences. It appears that during training they ignore this area with significant consequences for women. For example,
 - Many of health care providers do not know how to proceed during delivery or other gynecological procedures.
 - Lack of interest among family physicians to provide antenatal care
 - Lack of cultural sensitivity dealing with women sexual issues
- There is no clear policy regarding delivery for women with FGC. Increase in numbers of refugees from FGC affected countries creates a serious need to develop guidelines to help health care providers.
- Lack of reliable data on the number of women with FGC who migrated to Canada.
- Observe the need for multi-disciplinary team in care and the role of nurses, physicians and others in the care of women affected by FGC.

Approaches for Action

Health Care providers

- Educate medical students about the cross cultural sexual differences especially FGM.
- Provide education to physicians and midwives (e.g., training on how and when to de-infibulate).
- Access the Doctors experience and knowledge working/worked in refugee camps and NGOs with women with FGC.
- Cut a 'generous' episiotomy instead of cutting the FGC.
- Learn how to reduce damage/ tearing.
- Consider informed consent/ trust/ relationship with physicians-often different doctor at antenatal care and at delivery. We have to consider how to transfer knowledge to delivery. Record conversations and records women bring to the hospital or there has to be good discussion at the triage when she checks in. Australian forms for pregnancy does include FGM/C in the checklist on the form and ensures it can be addressed during transfer of care.
- Dilemmas and contradictions regarding re-infibulation/re-stitching as result of vaginal delivery (i.e., full choice of re-infibulation as an adult vs. no re-infibulation) vis-à-vis the wide availability of cosmetic vaginal surgeries.

Newcomers

- Strengthen information transfer by giving information to newcomers especially refugees about access to midwives.

- Create more programs or education opportunities to deal with sexuality education between newcomers and refugees (e.g., incorporate more detailed information in initial orientation sessions for newcomers, widened the access to translated resource materials).

Guidelines, strategies

- Obstetricians and gynecologists, midwives, social workers and community-based workers are responsible parties about writing guidelines.
- Guidelines to consider the assessment on certain clinical procedures such as re-infibulate when appropriate.
- Resources list to help connect culturally competent health centres and physicians could be useful (e.g., appropriate referrals if individual physicians are struggling)
- Our strategy in dealing with FGC is to eradicate FGC, not to do harm reduction strategy like the harm reduction strategy in dealing with addiction.
- Clinical guidelines in Canada are in the process of development (SOGC). There will be soon released and shared.

Law and Ethics

- Need to develop approaches to prevent continuation of practice in the Diaspora.
- Increased understanding of the legal and health ramification of some practices (e.g., re-infibulation for women with FGC after delivery, disclosure of potential FGC in children).
- The role of discussing circumcision in general (female and male) from a legal standpoint.
- Ethical dilemmas around the provision of elective Caesarean section for women who prefer avoid de-infibulation as there are complications for those planning a large family.

The following are examples of questions that were posed during the session. They reveal the state of knowledge among the participants (i.e., gaps) and expectations that the Symposium/group would be able to fulfill them.

- What are the reasons for doing FGC?
- What is the age for doing FGM?
- What are the causes of prolonged labour in women with FGC?
- Is there any specific antenatal care for women with FGC?
- What are the FGM complications during delivery? And during postpartum?
- Does the postpartum wound healing in woman with FGM different from female without FGM?
- Does anyone have experience dealing with women having FGC?
- What are some of current practices in the clinical field concerning FGC?
- Does a midwife deal with women having FGC during delivery from the legal and professional aspect? Does a midwife do de-infibulation?
- Do we restore pre-birth state after birth?
- What is the policy here in Manitoba regarding the re-infibulation after delivery?

- How do you see the idea of harm reduction strategy in dealing with FGC like the harm reduction strategy dealing with addiction?
- What are the numbers of African immigrants have FGC and in the reproductive age?
- Who are the responsible parties for developing clinical guidelines?
- How will you be sure that your guidelines are acceptable to follow?
- What are some of the gaps within the clinical field that need to be addressed?
- What need to be done to help women?
- When attending child birth and a daughter is born, can we find a way to talk about potential practice of FGM with this child?
- What are the legal implications, as a health care provider, if a female ask to get re-infibulated at her husband request?
- What are the ethical issues that arise with regards to clinical approaches to FGC?
- What do you think about male circumcision?
- Does the SOGC guideline consider the community values?
- Why are women not referred to nurses?
- Why is the language regarding the practice inconsistent (i.e., mutilation, cutting, circumcision)?

Research

Overall, it was clear that participants believed that there was very limited research on FGC in Canada. After some research conducted in the 1990s, not much has happened until recently (including SERC's and Dr. Einstein research). Those interested in this area of work have to rely on findings generated in other context such as Europe, where the immigration experience and the systems (e.g., political, health care, etc.) are different that in Canada.

Areas of Research

Youth-focused Research

- **Impact of the “changing Diaspora” on youth sexuality**
 - Impact of inter-racial or intercultural intimate relationships involving young women affected by FGC.
 - Changes in perceptions of what is beautiful or erotic life among youth affected by FGC in the immigrant context
 - Same sex relationships involving women affected by FGC
 - Ethical dilemmas faced by youth (in particular females affected by FGC) with regards to their own sexuality/engaging in sexual activity
 - Psychological issues faced by youth affected by FGC
 - Implications to accessing and using birth control and abortion services for young women affected by FGC
 - Access to health care services by adolescent or young girls
 - Addressing sexuality related topics as whole, and then incorporating or seeking insight on FGC and sexual practices as part of a more holistic approach (e.g., sexual initiation, issues of pleasure, etc.).

Understanding the impact of “prevention” of FGC in families/communities

- Impact of changes in the practice for individuals, families and the community
 - Understanding the loss of tradition for communities and in particular for mothers
 - Understanding identity changes within the immigrant context
 - Impact of legislative change over time (does legislation have an impact? How so?)
- Better understanding on the inclusion of FGC in schools (e.g., approaches used, integration in curriculum or ad hoc/targeted within certain communities?)

Better understanding of the implication of FGC beyond their physical/reproductive related issues, i.e., mental health/wellbeing

- Research on psychological and mental health implications of FGC.

Understanding what are the actual issues for women affected by FGC in the Diaspora/ Focus on other issues/inclusion of the topic (also methodological/ethical issue)

- FGC is rarely brought up as a topic of conversation. Other topics are the main focus of concern and interest for newcomers.
- FGC may be such a common experience among women and the community that is not an issue (e.g., even conversation about “what a good woman is” may not lead to references to the topic).
- Some entry points may be around sexual and reproductive health issues or general women’s health.

Better understanding of the experiences of women accessing care

- Meaning of “good” care regarding FGC from women’s perspectives
- Assessing changes in care over time for women affected by FGC (those longer in Canada or the Diaspora)
- Access to health care services by adolescent or young girls
- Understanding late presentation for pre-natal services or lack of appropriate services during regular pre-natal services (i.e., FGC not addressed)

Understanding of women’s experience with FGC across the lifespan

- Older women and menopause related issues
- Young women and sexual and reproductive issues
- Comparing experiences of women affected by FGC (e.g., those who have experienced across cultures, including women accessing genital corrective surgeries in the West)
- Knowledge of the transmission of cultural traditions/deal with changes in the new society, e.g., parenting programs with newcomers/how do they address FGC and need for change

Better understanding of FGC “picture” in the Diaspora

- Prevalence and incidence studies

Health Care/Service Providers/Education system Focused

- Understanding the experiences and knowledge, and skills of health care professions in dealing with FGC. Need to have a baseline in order to build better pre/in-service training and measure change over time.
- Understanding the competence of providers and the system as a whole. For instance, policies in place that assist in decision-making such as consistency of data collected
- Deeper understanding of the translation of cultural competence in health care settings if, when it is happening
- Understanding if current perinatal models of care are “good enough” across communities and for everyone
- Better understanding of the medicalization of FGC, including the approaches to FGC and genital corrective surgeries/cosmetic surgeries.
- Lack of proper data collection systems that account for FGC (e.g., UK – part of clinical care in order to provide best care. Australia, everybody is asked regardless of colour, origin same as with HIV and hepatitis)

Policy related research

- Further research on comparative policies to understand the conditions that foster the use of different policy frameworks and strategies
- Impact of the legislative change – has this prevented the practice from continuing? What are the consequences of the legislation at the criminal and child protection level in Canada?

Methodological Approaches

- Need to approach the issue without focusing on the genitalia. How do we ensure that we address FGC while not asking about it/while taking into account the whole person/body experience?
- Consider entry points to the topic when women bring up sexuality related issues, relationship issues, perinatal care, parenting approaches/ meaning of “good” parent(ing) in different cultures, etc.
- Support for community-based approaches, that include peer-led research
- Consider all type of methodological approaches, i.e., qualitative and quantitative, and mixed methods.
- Consider the researcher’s stance. There is a need to take into account own biases – what does that do to the choices surrounding the methodology

Ethics

- Acknowledge women being experts of their bodies as an important when talking with community that has been marginalized

Evaluation of the Symposium

We developed a pre and post Symposium questionnaire to determine changes in participants’ understanding of FGC related issues (e.g., knowledge of FGC in Canada, cultural competence,

policies, research, etc.). The pre and post training questionnaire responses from the Symposium were compiled in a spreadsheet. The responses were then analyzed to determine the changes in participants' knowledge.

There were fifty-five (55) registrants in attendance for the two-day event. Forty-two (42) participants responded to the Pre-symposium questionnaire (72% response rate) and thirty-seven (37) responded to the Post event questionnaire (67% response rate). Of these, we were able to match a high number of pre and post evaluation forms, i.e. thirty-one (31) pre and post evaluations. This represented an eighty-four percent (84%) response rate to the pre and post training evaluation. Among the respondents were health care professionals (nurses, residents, midwives) (9), students (4), program managers and government consultants (4), academic and researchers (3), social workers (3), among the rest were outreach workers, educators, activists, community workers, and a filmmaker and a program evaluator. Respondents worked at community health centres, hospitals, universities, NGOs, government and other organizations.

Five additional people returned the post session questionnaire designed to collect evaluative comments from those attending the Clinical session on Friday afternoon.

Symposium Outcomes

The following table describes the changes in knowledge and understanding reported by participants, in a number of areas, based on the matched pre and post symposium questionnaires. Participants had to rate their agreement to the items (1= Strongly Agree to 5= Strongly disagree).

We found that all respondents found their understanding and knowledge enhanced as result of the two-day Symposium. The larger impact occurred in relation to their knowledge of FGC in Canada and developed countries. Participants also benefited from an enhanced understanding of their own feelings and attitudes about FGC as a result of this symposium and of the current state of the research in the field. The lowest changes occurred around issues such as their understanding of cultural competence and the ability to deliver culturally competent service. For some, this may have been attributable to already having a high level of cultural competence and experience in service delivery. Alternatively, it may be attributable to the lack of focus on skill-building at the Symposium. However, the analysis of the “usefulness of the knowledge to participants’ practices” revealed that many reported “culturally safe approaches to work” as key learnings from the Symposium (see page 29 for further analysis).

	Pre (n=31)	Post (n=31)	Difference
Knowledge of Female Genital Cutting in Canada and developed countries	2.5 (45% indicated intermediate level of knowledge, and 42% low or very low level)	3.7 (64.5% indicated high or very high level of knowledge – the rest intermediate, but all showing sign of increased knowledge)	1.2

Understanding of cultural competence	3.2 (36% indicated intermediate level of knowledge, 38 % high or very high and 26% low or very low level)	3.8 (71% indicated high and very high level of knowledge, and 29% intermediate level)	.6
Understanding of my own feelings and attitudes about FGC as a result of my participation in this symposium	3 (32% indicated intermediate level of knowledge, 42 % high or very high and 19.5% low or very low level)	4.1 (6.4% indicated intermediate level of knowledge, 64.5 % high level, 25.8% very high)	1.1
Ability to deliver culturally competent service (or programming, policy or research) for/about women affected by FGC	2.8 (26% indicated high or very high ability to deliver culturally competent service for women with FGC while 32% indicated low or very low)	3.5 (51.5% high or very high), 35.5% intermediate, and about 10% low)	.7
Understanding of current FGC related research	2.4 (61% low and very low, 19.5 intermediate, and 19.5% high or very high)	3.5 (61% high or very high, 32% intermediate)	1.1
Understanding of FGC clinical guidelines	2.2 (64.5% low and very low, 26% intermediate, and about 10% high)	2.8 (42% intermediate, 29% high or very high, 6.5% low)	.6
Knowledge of community education and engagement activities regarding FGC	2.5 (over 48% low and very low, 29% intermediate, and 22.5% high)	3.5 (39% intermediate, 48% high)	1
Understanding of legal issues and policies related to FGC	2.4 (13% high or very high, 22.5% very low, 29% low, 35.5% intermediate)	3.5 (32% intermediate, 42% high, 13% very high)	1.1

General Aspects of the Symposium

At the end of the event we asked participants to rate their opinions on general aspects of the Symposium. In this case, we used data from all who responded to the post questionnaire (N=42).

Participants rated the Symposium very positively on all aspects. In particular, they found the event informative, the information applicable to their work, and the program well organized. The lowest rating was given to the format of the sessions.

I found the symposium informative	4.6
I found the symposium suitable to my needs	4.3
The format was good (i.e., 2 days, panel presentations plus discussion groups)	4

The presenters were well prepared	4.2
The information will assist me in my work	4.4
The program was well-organized	4.4

While many participants commented on the positive aspects of the Symposium such as the calibre of the presenters, the level of the discussion, and the ability to connect and network with people working on FGFC, participants were also open to share some of their critiques. Among these were the “rushed” or packed presentations followed by a short period for questions and answers. A few respondents were dissatisfied by the lack of time allotted to the presentations and the fact that they had to ‘rush’ through their presentation. Presenters were not able to cover all their points in detail and for unstructured presentations, time was a major constrain. A few participants indicated that they had too little prior exposure to be able to process all the information provided. One participant commented on the heavy focus on policy and the lack of research findings presented on clinical aspects. Some of the respondents commented on the Knowledge Exchange Sessions. These comments are addressed in the following section.

A few comments were made around the logistics of the event: there were no moveable microphones to capture all the comments and responses from participants in the larger sessions; not everyone was able to see the slides; the fact that presenters were video recorded⁷; some hospitality issues (food, chairs).

Effectiveness of Knowledge Exchange Sessions

For the most part, participants were satisfied with the Knowledge Exchange Sessions. Most of the comments were positive. Participants felt that through these sessions they were able to learn “so many thing that [they] never heard about”, have an “opportunity to explore certain topics in depth” or “debrief [presentations] in small groups”, and an opportunity to “network”. A participant found the sessions more effective when presenters were in attendance.

However, there were some strong critiques with regards to time constraints, facilitation issues such as not being able to include all participants in the discussion or dealing with one or two talkative participants, the fact that one set of sessions was held at the end of day two (people some did not re-group after the KES and therefore did not participate in closing).

One person believed that the time should have been allocated for presentations only, while another one believed that longer question and answer periods at the end of the presentations would have been more beneficial.

⁷ One of the presenters openly requested not to be videotaped.

Valuable Knowledge

We asked participants to describe any new information or approaches they found of value. Among the areas of knowledge participants found valuable were: to learn about policy development in the Diaspora (n=8), including its complexities; comparisons across countries; and agreements and disagreements on different policy approaches.

Others found basic information on FGC, the reasons behind the practice, where is happening, how is happening, the impact of FGC on women, was of most value. A few participants mentioned that requiring participants to have a basic level of information on FGC would have been desirable. That would have helped them to integrate the new knowledge more easily.

A number of respondents found it valuable to learn about the different approaches used to work with the community. To describe this they used a number of short phrases such as: “holistic approach”, “cultural competency/sensitivity”, “looking at this issue holistically not only sexuality”, “changing cultural attitudes around sensitive issues”, “collaborative approach”, etc.

Others were surprised to see how much work needs to happen for the health care system to properly respond to women’s health concerns, including the lack of guidelines. Others reflected on specific presentations that addressed the effects of FGC at the neurological level, the work happening in the UK, or clinical perspectives.

Potential Impact of Knowledge Shared

We were interested in knowing *if and how participants would use the information and knowledge shared through the Symposium in their work*. Many respondents believed that all or most of the information was useful and relevant to their work. Some were more specific. A large number of participants emphasized the use of *culturally safe approaches, a re-occurring them* throughout the presentations and discussions. The following quotes from participants illustrate this:

Approaches to work within the community re: changing cultural attitudes around sensitive issues

Having awareness regarding this issue and being sensitive to healthcare needs/issues

Cultural sensitivity and understanding and concept of FGM as violence against women. Have to balance this in providing safe, sensitive care.

Other aspects of the experience or knowledge that participants found to be potentially useful in their work included *access to resources* (information package/websites), *networks* and specific contacts for practitioners. Many focused on *research* related issues such as the development of a research agenda, access to research findings to share with community and ethical considerations in research to be the specific areas of future application. Finally some focused on *policy* related issues (e.g., use of information for policy development and advocacy).

Required Additional Information

Among the areas of further interest, participants suggested a series of topics for education that would be to their benefit. The main areas related to the need to attain more *clinical related details* such as access to concrete guidelines, more in-depth discussion on reinfibulation, the association of HIV or STIs to FGC, and research findings on approaches that are clinically successful. Other participants were interested in *epidemiological information* (i.e., prevalence data from Canada/Manitoba) or updated information on *policy and legal development*. Access to specific *education materials* like websites, reading materials, etc. was also requested by some participants, for their use in working with women and girls, and service providers.

Some participants felt a need for more practical information such as specific education tools, specific approaches to discussing or presenting on the topic of FGC, a list of contacts of qualified practitioners, including those in the sexual and reproductive health field, and presentations from health care providers who are currently providing care to women.

A few participants hoped to get access to copies of the presentations and reports generated by the Symposium.

Some of the local participants were hoping for the establishment of a network of researchers and community workers and members from or working with affected communities.

Post-Symposium Meeting

Participants to the Symposium were invited to a follow-up half day meeting to review and reflect upon participants' experiences and knowledge generated during the two-day event. Eleven participants attended the meeting. In attendance were four of the out-of-town presenters, three symposium participants and SERC staff.

The meeting not only allowed for the reflection on key issues stemming from the discussions at the event; but, allowed for expanded knowledge exchange resulting from these as well.

Among the highlights from the discussion was the need to expand collaboration between participants. Some concrete ideas for collaboration in **research** were presented. For instance, collaborative publications, sharing of resources/bibliographies, translate publications in first language, increased collaboration between research and advocacy, sharing principles in which research should be built on (e.g., acknowledgement of women's strengths, avoiding victimization, honour women's voices/participation, etc.). There was an interest to collaborate on peer reviewed publications.

With regards to **clinical** related issues, participants discussed the future of the care to be guided by new set of clinical guidelines developed by the Society of Obstetricians and Gynecologists (SOGC). They suggested SERC to follow up to gather more information on the process and the

possibility to participate in the discussion of the draft of the guidelines. This became a concrete follow-up action.

Other discussion on this topic revolved around other people who should be included in future discussions, the need to shift how the body of a circumcised woman is perceived (i.e., different body rather than an obstetrical problem), need to develop clear guidelines that address how 'cultural competency' in this area works or looks like.

Different ideas concerning **community-based or health promotion programming** were also discussed. Among these was the need for intense community engagement, the exploration with the communities of the reasons for the practice, alternative prevention strategies, addressing youth perspectives on change.

The group also discussed the use of the terminology to refer to the practice. Female genital cutting, circumcision or mutilation, all present problems. For instance, a circumcised woman would never referred herself as 'mutilated', and the term 'cutting' minimized the issue to another Western practice. Most would believe that only concerns women affected by infibulation. Another important distinction with regards to language related to "who is talking". There was an acknowledgment that this has long been debated and continues to this day. Even in Africa the different terms are used.

Conclusions

The Symposium achieved its main objectives in that stimulated a significant and meaningful exchange of knowledge on Female Genital Cutting. Participants from all sectors, the academia, the community, community organizations, medical and health care system, public health and those in the policy areas all contributed to a two-day filled with information. On the other hand, the presentations and discussions also pointed out to the gaps in all areas of work.

After years of dormancy in Canada, **research** is just incipient and scarce. A year in preparation, the Symposium became the stage for an opportunity to look back to what has been accomplished since FGC became public in the early and mid- 1990s, including a few new studies that have just taken place in Canada. Interestingly is to note that about all these studies demonstrate the application of community-based research approaches.

Participants' discussions led to an impressive number of research areas and even specific questions that deserve attention in the context of the Diaspora. These topics concern a number of disciplines and even call for interdisciplinary approaches. For instance, clinical research is needed to truly understand specific changes in care that beyond training in cultural competence.

Policy has been another area that has not received much attention. After a flurry of activity leading to the changes in legislations in the 1990s, participants wondered about the impact of such approach and the next steps in this realm. Participants learned about the current

developments in the UK and debated the application of such policies within the Canadian context. Policies concerning the health care systems were also discussed. Although skimming the surface, the SOGC gave a sneak preview of the process leading to a new set of medical guidelines to be released later in 2011.

While access to clinical guidelines was welcome, the very idea of having to follow [strict] guidelines on such a sensitive topic brought forward some uneasiness among some participants. Presentations and information shared in the area of **clinical** work shed light on the complexities of providing culturally competent and safe services to women affected by FGC. They also highlighted some important ethical concerns while deciding the approach to care required in any given situation. It was clear that there is a dearth of research in the clinical area.

Not least important is the community-based work that involves community engagement in **education and health promotion**. In this regard, we learned that meaningful collaboration with affected communities is key to successful services and programming. In addition, it was helpful to hear that consideration to women's lives is important when providing FGC related information. The involvement of other community members such as men and youth was also reflected. Building leadership capacity, the inclusion of mental health, advocacy and other supports are among key approaches to health promotion.

Again, increasing work in all areas explored is needed. As a catalyst to move forward the development and translation of knowledge in many areas concerning FGC in Canada. Promising relationships have been formed as result of this work.

