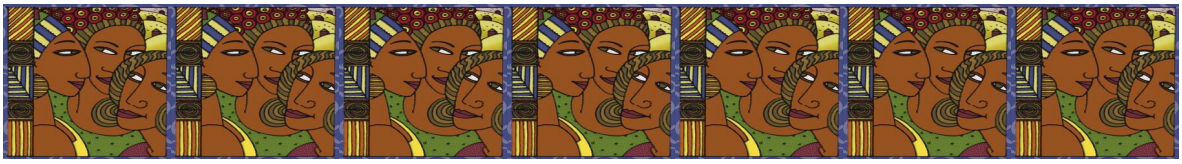

Our Selves, Our Daughters:

Community-Based Education and Engagement Addressing Female Genital Cutting (FGC) with Refugee and Immigrant African Women in Winnipeg – 2011-12.

Final Activity and Evaluation Report

April 2012

SERC
SEXUALITY EDUCATION RESOURCE CENTRE MB

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Acknowledgments

We would like to thank the many women, men and youth who shared their thoughts, feelings and rich cultural knowledge in the focus groups, consultations, education sessions, community meetings and evaluation of the project. We would also like to thank the leaders in the communities who so strongly support this project. We would also like to thank the service providers who saw the need to learn more about FGC and provide more accessible services for affected women. We are very grateful to our newest team members who have greatly enriched the work of the project. Last, we would like to thank our funders, below, for their support of this project.

Manitoba

THE WINNIPEG FOUNDATION

This project has been supported by grants from Manitoba Healthy Living, Seniors and Consumer Affairs and the Winnipeg Foundation.

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Introduction

Goal and Objectives

The overall goal of "Our Selves, Our Daughters" 2011-12 is to work closely with African refugee women, and allies in their communities, to enhance educational, health and socio-cultural supports to women affected by female genital cutting, and address prevention among daughters.

Objective 1: To hold culturally competent educational sessions that address female genital cutting (FGC) for women in an African community:

a. Where women can get effective information that addresses their questions about health, well-being, and sexuality
b. Where the topic of FGC, along with its connections to women's health and wellbeing, are integrated throughout
c. Where women are able to identify resulting health impacts and get support, information and resources to help them improve their health
d. Where awareness can be raised around the cultural, religious, social and gender-based facilitators of FGC; the reasons some may not choose the practice; and the Canadian/migration context of FGC
e. Where women feel free to engage in open discussion and debate, exploring deeply held values and beliefs, as well as new thoughts and ideas, without feeling judged or labeled
f. Where informed decision-making by mothers is facilitated, with the ultimate goal of preventing the further practice of FGC with daughters
g. Where participants will be supported to serve as informal resources for other women in their community

Objective 2: To engage a "Whole Community" team to promote community-level change that will enhance supports to women/mothers/daughters, and will address prevention of FGC.

Objective 3: To begin to engage a second community, through informal meetings, where there is a) a readiness to engage, b) a high prevalence of FGC, and c) a significant newcomer population within Winnipeg

Objective 4: To enhance the capacity of Winnipeg service providers (health and social services) and systems to be more responsive and culturally competent in providing care to women affected by FGC.

Objective 5: To support processes that are participant-driven and culturally responsive so that participants feel the services provided, and the project as a whole, are accessible and that their community, culture, gender and values are respected.

Objective 6: To address sustainability of the project by building individual and community capacity.

Overview of Activities

1. Community Consultation and Engagement with Two New Communities: Ethiopian & Somali Communities

This year, we expanded the scope of the project to include two new communities.

Originally we had planned to engage only one, but in our planning meetings, we realized that we had a difficult decision to make. We knew the Somali community might face a greater need than others because of a number of factors: 1) the high prevalence of the most severe type of FGC (and therefore, likely more adverse health impacts), and 2) the additional barriers that this community may face because of stereotyping and discrimination ("Islamophobia"). We knew from a few male leaders that this issue needed to be addressed but that it would require “the right” woman to be able to navigate this sensitive issue.

We also had strong interest expressed by an Ethiopian woman who had attended our service provider training and who said that the need for information and prevention in her community was pressing. This community has been one of the top 10 source countries to Manitoba in recent years and we knew that the population was sizeable.

In the end, we decided to do a scaled-down process of consultation and engagement with **both** communities.

We hired Community Facilitators from both communities who then conducted outreach with leaders. Through face-to-face meetings in the community, phone calls and emails, they accessed a broad range of formal and informal leaders across sub-groups in the community. Interestingly, most of the meetings with Somali elders/leaders had to be done with interpretation. This was less with the other communities we have worked with. The Community Facilitators then organized focus groups primarily with women. Within the project budget, we were only able to hold a men’s focus group in the Ethiopian community. We hope to hold a Somali men’s focus group in the next fiscal year.

Ethiopian community:

- Meetings with 5 leaders (e.g., churches, sponsorship-based group, woman informal leader). One leader was a non-Ethiopian Muslim leader (female) whose organization worked in various communities including Ethiopian and Somali communities
- Oromo-speaking women’s focus group (n=4)
- Amharic-speaking women’s focus group (n=4)
- Mixed language focus group with men (n=4)

Somali community:

- Meetings with eight elders/leaders (e.g. spiritual leaders, heads of tribal groups, go-to people when there is conflict or distress in the community, formal leaders of community organizations)

- 2 women's focus groups (17 in total)

Findings from the Ethiopian consultations and research process helped support the development of the Ethiopian-Eritrean women's group held in the Winter of 2011.

Two reports are in progress, as stand-alone reports for each community. Each will be available on SERC's website:

- Somali Community: Consultations on Female Genital Cutting (title to be confirmed)
- Ethiopian Community: Consultations on Female Genital Cutting (title to be confirmed)

2. Community Education with Women

We held two sets of 10-week, 3 hour educational sessions with newcomer women:

- In the summer, the first set of sessions was with **Eritrean women** (our original community) and was held in first language, Tigrinya. Attendance was higher than expected with an average of 16 women attending per session (we aimed for 13 women).

- In the winter, after holding consultations and focus groups with the Ethiopian community, we held a set of sessions with **both Eritrean and Ethiopian women**. Sessions were held in Amharic (an Ethiopian language also spoken by many Eritreans), with an Oromo interpreter (another Ethiopian language) for some participants. Attendance was solid with an average of 12 women per session, slightly lower than our projected (13).

- Upon request by Healthy Start Mom and Me, a special 1.5 hour session was held for FGC-affected women on October 31, 2011. Most of the women were Somali, with some Eritreans and Ethiopians. Two public health nurses and two outreach workers also attended the workshop. 10 women attended.

3. "Whole Community" Engagement and Education: Eritrean Community

Last year, we learned from the community that for change to occur around the issue of FGC, the whole community would have to change, including the men. They also said that change, particularly around intimacy and communication, is occurring more rapidly among the younger generation. Based on this information, we conducted a small Community Based Research (CBR) project to examine people's knowledge of FGC, their opinions and attitudes towards the practice, and the ways in which people do (or do not) conceptualize change around the issue.

All the focus groups had been held by the end of last year, but we had yet to complete data analysis. A participatory process was followed to build a collective and mutual understanding of the findings. A **community meeting on August 11**, inviting leaders, focus group participants and any others who were interested. While we had hoped to have 20 people attend, 13 actually came. Representation of different sectors of the community was excellent, with male and female youth attending, as well as men and

women, including some elders. With this small group, the discussion was rich and at times heated, as the CBE team shared preliminary findings (point form findings and quotations from the research were posted at stations around the room), and people were free to discuss and debate the points raised. Not only did we gain greater insights into the research findings, we also gained some ideas on how to proceed in our next phase of the project, community based education on change.

Feedback from the CBR team also provided cultural nuance and knowledge that helped greatly to contextualize findings.

Findings were published in two formats. The first is the usual form of report produced at SERC, tailored to a service provider audience/highly English-literate audience:

- Our Selves, Our Daughters – Women, Men and Youth's Perspectives of Female Genital Cutting and Change http://www.serc.mb.ca/SERC/SP/WA

The second report was designed to be more "community friendly" in that parts of it are written in plain language, and we emphasized the direct quotations of participants rather than our own analysis, so that this document could be used as a tool to support and provoke discussion and change at a community level. Graphic design and concept was tested at meetings across all three communities:

- "Talking Together About Change" (available for download soon, www.serc.mb.ca)

The CBR team was then **trained** as Community Based Educators (CBEs). We held 5, 3 hour training sessions: November 19 and 26th and December 3rd, 10th and 17th, 2011.

The CBE role evolved into a set of functions that involved outreach, coordination and facilitation of small and large group community **educational workshops with men, women, old and young**. The team organized the following educational workshops in February and March, 2012, on FGC and change:

- 4 small group workshops for adult women (n=6), adult men (n=9), female youth (n=5), male youth (n=9)
- 2 large community meetings/workshops for a mixed audiences (n=32 and 37)

4. Service Providers Training

This aspect of the project is still receiving a significant level of interest from service providers -both locally and nationally.

We provided workshops, consultations, and presented at various conferences as follows:

- New Directions (2nd workshop), 3 hour workshop, Monday April 18, 2011. 7 attended.
- BridgeCare Clinic brown bag lunch presentation April 16th. 3 attended.
- CancerCare, consultation about FGC and pap tests, cultural competence. June 20th, 2011.
- Public Health Nurses, Downtown Team, consultations, summer 2011 (2 nurses).
- Community Health Science, interview for student paper, summer 2011.

- Healthy Start Mom and Me Program and Site Teams: 2, 2 hour workshops (part 1 and part 2) on December 9th, 2011 and January 20th, 2012. Twenty-six attended the first part, and 18 attended the second.
- JASP: 15es Journées annuelles de santé publique, Montreal. We were invited to present with Dr. Bilkis Visandjee, University of Montreal, as part of a full day series of workshops on ethical challenges in public health. Our focus was to examine FGC through the lens of harm reduction. The talk was held on November 29, 2011. An audience of about 50 people attended, most public health practitioners, managers and policy makers from Quebec.
    - Video clips based on the co-presentation are available through this link: ethiquesantepop.ca
- 14th National Metropolis Conference, March 3, 2012, Toronto. We co-presented on our findings on community-level change, with a panel composed of Dr. Gillian Einstein, University of Toronto, two Somali team members, and Liette Perron of the Society of Obstetricians and Gynaecologists of Canada. Approximately 30 people attended.
- Guest presenter on Panel presentation "Muslim Women- Experiences in Health Care," hosted by the Intercultural Ethics Committee of the WRHA, December 5th, 2011. 20 attended.
- "Anthropologies of Sex and Sexuality" class. Invitation by Dr. Susan Frolich to present on March 8th. 20 attended.

5. Resource Development

Resource development occurred in the following areas:

1) Health Education with Newcomer Women Addressing FGC (Manual)

The work on the Manual continues, and is likely to be a multi-year process. A SERC Educator spent a fair amount of time over the summer, for example, capturing facilitators' notes and key messages. SERC is seeking additional funds for writing and editing support, which would enable us to complete the manual and make it available for download and distribution.

This Manual is being designed to give service providers a tool which they could use to implement groups with immigrant and refugee women that addressed sexual and reproductive health and FGC information and prevention.

2) Religious Leaders' Perspectives on FGC

From our latest phase of community based research on FGC and change, we learned that the perspectives of leaders, particularly religious leaders, had a strong influence on many community members. As one informant stated, "If a religious leader tells them to do it, they will." Members of the CBE team felt that if we had some documentation that reflected various religious perspectives that did not support FGC, that this would be an effective tool in their work to address change. The Project Facilitator met with Christian leaders of various denominations,

and also contacted Muslim leaders. She was unable to get a direct quote from a Muslim religious leader within the timeframe available, but used published information instead.

6. Exploration of a peer-based model

This year, we intended to complete our research into peer-mentorship models. Over this year, the project did discuss this concept at team meetings and we examined the information we had gathered to date, in terms of models and approaches. We have also met with the Strengthening Families Program, Mount Carmel Clinic, to learn from their experiences and to explore coordination and partnership opportunities. Also, we did hire and train first a set of Community Based Researchers, then later as a set of Community Based Educators.

In the coming year, we felt that we should 1) "complete" our current model or approach with the two new communities, especially since the Somali community is fairly distinct from the Eritrean and Ethiopian cultures and may bring new learnings 2) implement another phase of work with the CBEs, and examine more closely the supports needed and our internal capacity to meet these needs. Then, we felt in the next year (12-13), we can determine where we should 'land' in terms of future models. Should we maintain the current model, which involves strong partnership with community, but where the expertise is fairly agency-located? Or, should we move towards peer-based models that maximize community participation, and has many merits in terms of community capacity-building as well as sustainability?

7. Ongoing Communication and Engagement of Women and Community

A process of ongoing communication and engagement has evolved with the project. SERC is not a community development organization, but we have worked to maximize input and communication within the resources of the agency. Ongoing communication occurs in the following ways:

- A community meeting was held August 20th, 2011, with 13 attending. This meeting allowed the community and research participants to give their feedback on the initial draft findings of the research. We divided the room into two mixed groups (young/old, men/women) and the CBRs presented on key findings and direct quotations from the research. A great deal of discussion, sometimes quite passionate, about change, virginity, intergenerational and gender differences, the pros and cons of involving religious leaders, etc., ensued and formed the basis for a model for the community-based education that was to follow.
- Ongoing informal contacts in the community between the Project Facilitator and past participants, current participants, and community leaders
- Email updates with community leaders and key community contacts about project activities, funding, new reports, emerging findings, and so on
- Meetings upon request with individual community leaders and key contacts

- Attempts, wherever possible, to hire individuals from the communities with which we are working. This was one way to recognize the skills and talents within the community and to also provide newcomers with “Canadian” work experience, which is so important in securing employment

- The last large group sessions (Eritrean community) were also used as means of feedback on the work of the project. The staff team attended, and asked questions to gather feedback, and met individually with leaders who gave feedback and advice.

8. FGC Symposium: Focus on Canadian Approaches to Addressing Female Genital Cutting

In the spring of 2010 we submitted a grant proposal to the Canadian Institutes of Health Research (CIHR) in collaboration with local, national and international organizations and institutions (e.g., University of Manitoba, Université de Montréal, University of Toronto, University of Alberta, FORWARD UK and Women’s Health In Women’s Hands Toronto). We were successful in receiving funds. Healthy Living, Seniors and Consumer Affairs also contributed support to the Symposium.

The Symposium was held on May 5 and 6, 2011, in Winnipeg. Over these two days, 8 presenters from across Canada, plus one from the UK, spoke on their work addressing FGC in the areas of policy, community-based programming, research and clinical work. The SERC team also presented on research/community based programming. Presentations were followed by "Knowledge Exchange Sessions" to facilitate knowledge exchange, build collaboration and identify gaps and needs in this area.

The Symposium had maximum attendance. Forty-nine people registered and 46 of them actually attended. We also had a team of 4 notetakers/participants, plus 2 other SERC staff attend. On Friday afternoon, when there was a clinical focus, a group of 25 obstetrician-gynaecologist students joined the Symposium.

The overall objectives were:

- To present, summarize and discuss existing and ongoing research, programs, services and policies focused on Female Genital Cutting (FGC) in Canada and the Diaspora.
- 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.
- To establish a collaborative network of researchers and program planners and practitioners to promote knowledge exchange on FGC within the Diaspora.
- 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.

A full report was produced that synthesized the discussion and findings from the Symposium and is available for download at:

- Report on the FGC Symposium: Focus on Canadian Approaches to Addressing FGC http://www.serc.mb.ca/SERC/SP/WA
- Video clips of the FGC Symposium presentations will be available soon for viewing, linked through SERC's website (pending)

9. Resources on FGC

We added to our growing collection of resources (i.e., published papers, reports, websites, medical protocols, ethical papers, etc.). We have 52 new resources available for use by staff and service providers (i.e., we can send them the links to these resources by email).

10. Proposal to the Public Health Agency of Canada (PHAC) - Public Health Workforce Development Grants Pool

SERC, in partnership with the University of Manitoba Faculty of Nursing and with support from the Winnipeg Regional Health Authority, has submitted a proposal to PHAC to request funds for a project that would allow us to fully develop, within this project year, the Women's Manual, and also develop a set of teaching videos about FGC, for use by public health practitioners as well as those in other fields. No information has been received about the progress of the proposal.

11. Evaluation

An evaluation framework was developed and implemented to examine both process and outcome-based findings over the life of the project.

Participants Served

Community Participants (women, men, youth and community leaders)

We engaged a total of **194** immigrant and refugee participants in the **formal** activities of the project[1], and many more through informal processes of the project:

- Somali leaders (1 hr each) - 8 men
- Ethiopian leaders (1 hr each) - 5 people (2 women; 3 men)
- Somali women's 2 focus groups (3 hrs each) - 17 women
- Mixed group of women at Healthy Start Mom & Me (10 women)
- Ethiopian men/women's focus groups (2 women's, 1 men's gps) (2.5 hrs each) - 8 women; 4 men
- 10 week series of educational sessions (30 hours) – 16 Eritrean women (average)
- 10 week series of educational sessions (30 hours) – 12 Ethiopian-Eritrean women (average)
- Community meeting (Eritrean), 3 hours - 13 men/women
- Hiring and training of a team of Community Based Educators (15 hours of training each plus time spent organizing/holding focus groups plus one 2 hr debrief meeting): 3 people
- "Whole Community" education sessions: young women (5), young men (9), adult women (6), adult men (9) (2.5 hrs each); Large mixed groups (2.5 hours each) (32 & 37 attending)

Many more community members were in contact with the Project through **informal** means:

- Numerous additional phone calls and follow-up contacts with participants of the education sessions between sessions and after
- Informal conversations between the Project Facilitator and community members at community occasions, in places of worship, at birthdays, ceremonies, welcoming newcomers, and so on. Many times, a long discussion occurred about the project topics: contraceptives, reproductive health, FGC, STIs, orientation to the health system, and so on. It is likely that **dozens of hours** were spent on this type of informal community-level information exchange.
- Ongoing email updates and exchange with community leaders, from all communities

Service Providers

The project engaged a total of 246 service providers participated in the project in the following ways:

- 7 people attended a 3 hour workshop held for New Directions, primarily counsellors (2nd workshop)
- 3 people (physician, nurse, outreach) attended a hour hour/brown bag presentation at BridgeCare Clinic
- 1 person from CancerCare - consultation

[1] Although in some cases there is 'overlap', we have counted individuals per type of service, to reflect participation in the different aspects of the project.

- 2 Public Health Nurses- consultation
- 1 Community Health Sciences Student- project interview
- 31 attended a two-part workshop (total 4 hours) for Healthy Start Mom & Me Program/Site Teams
- 50 people: JASP conference in Montreal
- 30 people: 14th National Metropolis Conference in Toronto
- 20 people: WRHA Intercultural Ethics Panel on Muslim Women
- 20 people: Anthropology undergraduate class, University of Manitoba
- 81 attended the FGC Symposium in May 2011 (up to 2 days) (46 registered, 8 presenters, 2 notetaker/participants, 25 obstetrician-gynaecologist students)

Evaluation Overview

Methodology

The evaluation results included in this report primarily focus on the following areas of activity:

- Women's education sessions
- The "Whole Community" Community-Based Education process: training of the team and implementation of community-based education on change
- Healthy Start Mom and Me Part 1 & 2 Workshops provided to Program/Site Teams

There are other project activities that are described and evaluated in separate stand-alone reports (e.g., Somali Community Report, Ethiopian Community Report, FGC Symposium Report).

Women's Education Sessions

We held a focus group for the purpose of evaluation at the end of each 10 week series (See Appendices for a copy of the question guide).

All participants were informed of the purpose of the evaluation, the focus group procedures and the treatment and use of the data. We emphasized the fact that confidentiality was important and that no names would be used in any report, or in any other dissemination products or activities. We also ensured that participants understood that their involvement was voluntary and that they were free to answer (or not respond to) any of the questions, without negative repercussions.

Finally, we conducted a review of project documentation, for example, notes from planning meetings. We also tracked correspondence between staff and community members. All of this documentation became a part of the data set to be reviewed. Demographic data from the registration forms (e.g., age, number of children, length of stay in Canada) was used to develop the participants' profile.

Whole Community Community-Based Education Process

After this phase of the project was completed, we held an evaluation meeting with the CBE team to discuss overall processes of training, then session planning and implementation. The CBE team also conducted end-of-session brief evaluations (verbal questions) with participants after each community-based workshop.

Project documentation was also reviewed, for example, training session outlines, or community-education workshop outlines.

Service Providers

We focused our evaluation on our most formal workshop this year, the two part workshop for Healthy Start Mom and Me Program/Site teams. We used an end-of-session evaluation questionnaire to learn

about the changes participants perceived in their knowledge and awareness on the topics of the workshop, as well as about the applicability of the knowledge in their jobs. Finally, we asked about general aspects of the workshop, such as the extent to which the workshop was informative, responsive to their needs, and so on. We administered two such questionnaires at the end of each part of the workshop. We had a high post-training evaluation response rate of 85/83%. (See Appendices for a sample of the evaluation tools used).

For the presentation to the Anthropology class, we asked students to fill out simple post-session questionnaires. We also solicited feedback from the professor who requested the presentation.

Evaluation: Women's Education Sessions

Participants' Profile and Activities Description

We held two 10 week, 3 hour sessions. The first set was with Eritrean women. For the second, our target group was a mixed group of both Eritrean and Ethiopian women.

Eritrean women:

Sessions were held from July 15- September 2, 2011. Attendance was excellent, with 16 women attending on average. As with most groups, there was a group of women who attended less frequently, but there was a core group of 17 women who attended 7 or more sessions.

Of these core attendees, most were in their 20s and 30s (n=14) and 3 more women were between 40-70. Two were grandmothers. We had a mix of families -some with only girls (n=5), some with only boys (n=2), some with both (n=5) and four women had no children (one was single/young), and the others were in their 30s. Those with children had between 1 – 10 children per family. The average number of children was about 3 per family.

Eleven women were married, 2 were widowed, 2 had partners living in another country and two were single. Finally most of the women were fairly new to Canada, with the average length of stay just under 2 years. Some had been in Canada for only a few months.

Interestingly, at least 3 women identified as being born in Ethiopia, and as we have learned, there is some fluidity between these two countries. Some who are born in Ethiopia, identify as Eritrean, and vice versa.

Overall we felt we had recruited a fairly good cross section of the community - we had different generations and mothers of both girls and boys (seeing the issue as a 'whole community issue'). We accessed newcomers who would be most likely to lack information about health and FGC, and who faced the greatest barriers in accessing health care.

Mixed Ethiopian and Eritrean Women's Group:

Sessions were held from Jan 21, 2012 to March 24, 2012. Attendance was slightly lower than projected, and 12 women attended on average (projected, 13). A core group of 15 women attended 5 or more sessions, many of whom attended 9-10 sessions each.

Of these 15 core attendees, there was a good cross-section of ages. Most were in their 30s and 40s, with some youth/younger adults (n=3) and two women in their 50s. In this group, of those who had children, most had boys and girls (n=8), with one woman having only a girl, two having only boys. Four women

had no children (3 of these were youth/young adults). Those with children had between 1 – 9 children per family. The average number of children was about 3 per family.

Seven women were married, 3 were widowed, one had a partner living in another country and 4 were single. Finally most of the women were very new to Canada, with the average length of stay a little more than 2 years; some had only been in Canada for a few months.

Of the core group, all identified as Ethiopian in origin, with some of those attending less frequently being Eritrean.

Again we felt that in this group, we had accessed a fairly good cross-section of the community.

Session Content:

As with past groups, the strong rapport between the Facilitator and participants was evident. A very warm, safe atmosphere developed that was rich with discussion, dialogue, sharing and laughter. Content and timing had to be adjusted slightly for the Ethiopian-Eritrean sessions because for the first time in this project, we had an interpreter for those Oromo-speaking Ethiopians.

The following is a list of the main topics of the sessions. The subject of FGC was integrated throughout:

- Women's traditional health beliefs and practices
- Models of health care (e.g., Eastern traditions, Western medicine, naturopathy)
- Accessing health care in Manitoba (e.g., using the emergency/urgent care, attending walk-ins, finding a family doctor, knowing patients' rights, accessing medical coverage)
- Women's lives: affirmation of women's roles, stresses on women (household responsibilities, isolation, missing people/grief, poverty)
- Reproductive Health: Female and male anatomy (i.e., board games in participants' first languages), types of FGC, menopause, menstrual cycle/stages of pregnancy, labour and childbirth (including FGC-related complications), health prevention (PAP tests, HPV vaccines, breast health), short-term and long-term effects of FGC, STIs and HIV, safer sex negotiation, condom demonstration, birth control; male sexual health (undescended testes, "wet dreams," erectile dysfunction, male circumcision)
- Gender analysis: Examining, for example, the perception of women's bodily functions being considered 'unclean', the reasoning behind some cultures attempts to control women's sexuality, the construction of body image in Canada/media/health care, the dynamic of marriage/relationships and gender roles, the differential status of men women/girls boys

- Culture, values, sexuality and FGC – What is culture? How we learn beliefs and values? What are our beliefs and values? How does culture shape sexuality? Examples from women's culture – positives and negatives? How culture is changing "back home" and in Canada? Culture and values as they pertain to FGC – Why is it practiced? Why is it important? Why do people choose not to? What would be the impacts?
- Laws related to sexuality and FGC, including sexual exploitation laws and the age of sexual consent
- 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, women's sexual response

(See Appendices for the 10 week session outline)

Evaluation Results: Eritrean Women's Session (Summer 2011)

Relevant Topics and Impact on Women's Lives

Participants were quick to respond to the long list of sexual and reproductive health (SRH) issues they were exposed to, and discussed over the 10-week sessions. As much as they have learned about the topics, they were also quick to qualify the knowledge as "helpful" for them as women. As we will further describe in following sections, the approach utilized in this group put women at ease in speaking about SRH issues as they relate to the experience of FGC. The first respondent to the question referring to the main topics that had any impact on them made this clear. She said:

> We learned about the traditional practices, about our bodies, especially the reproductive parts, and also FGC and the facts of FGC, the negative consequences of FGC on females. I can say that I learned a lot and I took a lot of ideas. I learned about the discharge, the normal discharge, what is not normal, and usually we don't talk about that, it is a taboo. Therefore it becomes more clear form me, what is okay, which is not okay. Therefore it is more helpful for me.

Other participants reflected on their newfound awareness regarding FGC. They said:

> The biggest and the most important thing that I learned about is FGC. In our culture, we consider it is the best thing that we can give to our daughters; but here, I learned that it has the worst or bad consequences. Like the way we consider it the best that we can give, I learned that it has bad side effects to the health and to the girl or women.
>
> At the beginning I knew it was going to be an interesting topic. But we don't speak about these topics with our parents and our friends or anyone. Even though we knew circumcision was not good for the health of the female. We grow up in a society that thinks that circumcision is the best thing for the female. Even personally I don't agree with them, but I didn't know what the consequences are, not to have the same feeling, not to do...with the daughters. Thank you for everything.

Other women added other topics to the list of specific SRH issues. Besides "discharge," a physiological event that was believed to be "taboo"; women referred to "breast health", cancer, contraception, pregnancy and childbirth related issues, and HIV/AIDS. Participants appreciated not only getting knowledge in the abstract, but resources (e.g., "The other thing was about birth control – she brought the samples, they were excellent!"). Some of them were particularly grateful of having been able to have access to a visual representation of their bodies (e.g., "I never knew what the women's organs are, what is there, and therefore it is helpful to know what is there." "I saw my body …for me it was very informative to know what is there, to know my body.")

Another participant emphasized learning important issues regarding access to health care. She indicated:

> I learned about the patient's rights, the right of second opinion. If there is problem or difficulty with communication, to ask for interpreter- by that card it is very easy [the card that was developed for women to give to health care providers regarding health interpretation].

To the list of more commonly health related SRH topics, another participant added learning about intimate relationships and conflicts as relate to FGC.

> Before, it was not clear, for many people, why the divorce is happening, and why the relationship problems, and now it is clear for me, that it can be because of FGC and now it is very clear for me.

The issue of HIV/AIDS did not only refer to the topic as another STI, its mode of transmission and prevention; but, as one participant reflected, it concerned about issues of stigmatization and attitudes towards people living with HIV/AIDS that was appreciated.

Current and Potential Changes to Women's Lives

Access to health care

Participants felt confidence and empowered to seek more information in their encounter with the health care system:

> And patient rights, before, I did not know about getting a second opinion, but now I know if I'm not satisfied, I can ask for a 2nd opinion.

> I have goiter, and when I go to the doctor he told me about surgery. I was not understanding what he was saying, I only understand the word "surgery." But when I started the session, I knew I had the right of having the interpreter, and of having a 2nd opinion, and I learned about informed consent and I have the right to know, so I now have appointments with two doctors…before I used to start amoxicillin…and I'd end it if I was done, but now I take it to the end.

> I learned about the culture, our culture and this culture has some differences. Therefore it helped me to see the differences. As a newcomer you have to learn the culture…and it helped me to know the differences between cultures. And so about informed consent, before I sign, I have to know what I am signing, and I have to understand the procedures, therefore it was helpful for me to know what my rights are.

Communication about SRH issues with children

> Also to talk to our children, and to tell them, and support them to go for checkups. For example, about the discharge from any genitals, or the undescended testes. I insisted for my son to go for his checkup.

> About the yeast infection, not to do…to dry the genitals, for me and for my daughter, I start to look, and how my daughter's genitalia looks, so it was very helpful.

Preventing stigmatization of people living with HIV

> If I start to describe every change, the time will not be enough, but let me say some of the things. Like about HIV, because of not knowing how it transmits. I would stigmatize the patients, because I do not know how it transmits. And so now I would not stigmatize the patients.

Communicating about new knowledge with other newcomers

> I would like to use the education that I got from here. I would like to educate some newcomer who I sponsored. The other thing is that the resources, like the connecting to family doctors, I would like to show or tell them those.

Preventing FGC in new generation

> I have benefited a lot from this program, I don't think I will circumcise my daughter…Even the side effects. I was circumcised. I was lucky I didn't have any side effects, though my parents knew the side effects. And the long term infections, and the issues that are connected to them. I have learned a lot.

Dealing with Taboo Subjects

As indicated and illustrated in the first section, SRH topics are common taboo topics for this community. It was obvious that by the end of the session, the time this evaluation was conducted, women have gained a different perspective on this. One of the participants illustrated this change in the following manner:

> I used to think many of the topics were taboo and we should no talk about that one, and it is bad to talk about them. And I would say it is not good to talk about those words. But when I come here I feel confident to talk about those ones, and I talk about those ones. It was very helpful for me.

Another participant attributed the level of comfort to dealing with taboo subjects to the ability of the Facilitator to address the issues. She said:

> I find this program very interesting. I liked it very much. What I found very interesting, was [the Facilitator's] way of relating the issues, with her health background, what consequences they have on health.

They also felt that insight into overall participant's cultural backgrounds assisted in the process.

> [the Facilitator] knows our culture, and therefore the understanding was there. I remember whenever she say, "I know it is taboo in our culture, but let's start to talk about it". And therefore it was encouraging for me. It was taboo, but encouraging to start it.

The role of the Facilitator in ensuring an environment that would make participants feel comfortable in dealing with sensitive topics resonated with other participants. They spoke about the "openness", the "relaxed" demeanor "when she was covering some taboo topics (…) made us more comfortable." Another participant added:

> The environment was encouraging, and we're on the edge of giving birth, and being mothers, and taking care of children, and therefore there is responsibility associated with that, and therefore it was helpful to listen to the information and also you were encouraging us , therefore it was helpful.

> Yes, I have confidence. At first we started, we were bending our heads [demonstrates with her body] (laughter) by the 2nd group [session], we were sharing our own experiences!

Further, an approach where everyone was equally valued was attributed to the success of the group's level of cohesion. One of the participants illustrated this point when she said,

> The food was good, and the mood also, the environment was good. Thank you [name of facilitator]. We used not to know each other, but now we know each other and we become like family and we are seen as equal person to each other, to be seen as equal with each other.

Once the ice was broken, the women engaged in meaningful discussions that transcended the group. They still remain cognizant of the limitations about talking about sexuality in their community. However, now they appeared ready to advocate for opening up the conversations about sexuality in their communities as they already observed benefits.

> From my experience it was really helpful information, but I would like to give information for people, but many people when they hear the word 'sexuality', they think it will only be about sex, but sexuality doesn't only mean sex,…but it helps you to know what form of body you have, and if you have difficulties, it will help you to solve them. It would be helpful if people got information that talking about sexuality is not just about sex.

Teaching Approaches

In addition to the care and thoughtfulness in addressing sensitive issues, including and in particular FGC, participants appreciated some specific tools that helped them in their learning process. Visual materials, models and concrete resources made a significant impact.

> There were diagrams, models, therefore it was helpful to make it more clearer what we are saying. I would say to continue – the diagrams, the models, the samples, to see and touch it.

> I like the resources she gave us because you don't find it handy, you don't find it in some books. It was well organized.

However, for some the use of some of these resources, such as depictions of the body, produced some discomfort at the beginning. The level of comfort was built over time for this experience to change,

illustrating one more time that success on dealing with sexuality related issues can be in part attributed to the amount of time and the extent to which women are engaged in discussions. One of the participants illustrated this point by describing changes in her personal experience on the matter:

> When I used to come, at first it was not comfortable, even to see the pictures and then I started to hide them from my husband, not to see, but now I started to show my husband, "See this is the picture!" (lots of laughter)

These resources and the use of first language in the facilitation of the sessions were key in ensuring learning and engagement. Supported by many participants, one of the women said,

> It is good that it is in our language. Because I participate in different sessions, but they are not in my language, so the understanding is not good. I can say it was most important that it was in our language.

Suggestions for Improvement

The women in the group felt that they gained knowledge and awareness on the many topics shared during the 10 week session. However, as we have heard with other groups, these women felt they "were learning just the summary of that topic, and therefore, it was better if there was a wider discussion, and more activities related to that topics, like homework, ...like other classes." Others felt that not only got a "summary", but that it felt "rushed."

Some felt that although related they were exposed to a wide range of topics resulting in need for a "refresher" and many unanswered questions. Some advocated for some "refresher class…kind of reminder, revising, and widening the topics." This is also understandable in that women were trying not only to understand the topic, but also learn some key vocabulary in English in order to be able to use the knowledge in their daily life (e.g., going to the doctor). Some felt that the need to obtain more in-depth information was important to "feel more confident about what we learned."

While these women were prepared to attend more sessions; they also felt that this training should be recommended to other women in the community. One of them said, "I would recommend the continuity of the information…for others to get the information, like me. There are others who would need the information, like me."

Another important topic for the women was the need to have child-minding in place. They prefer to bring their children with them. Those who brought their children along appreciated the flexibility of the group to accommodate their needs. However, they were cognizant that they interrupt the discussions and activities of the group. To further accommodate their needs, many also supported the idea of having a change table in the washroom or another room for babies and toddlers.

Evaluation Results: Ethiopian-Eritrean Women's Session (Winter 2012)

Participating in the Sessions

The women in this group were seeking “to learn” health information. They greatly value the importance of increasing the health literacy. Some indicated their interest in learning about the prevention of diseases. It was clear that the women were interested in learning about reproductive health for their own benefit. However, it was as clear that health information was important for the community. The need to share health information with “friends, neighbours, and family” was a major motivating factor for women to attend the group. As one of the women said, “health is the first thing in life,” and as main caregivers it was their responsibility to share health information with others in their lives.

Learnings of the Sessions

Women were quick to reply to the question on the main areas of knowledge that made an impact on them. According to them the most useful topics were: the prevention of sexually transmitted infections, HIV, women’s bodies (anatomy), the prevention of reproductive cancers (e.g., Pap test), pregnancy (e.g., “stages of pregnancy”), birth control methods, and access to health care. Also, beyond any medical-based information, women appreciated that the information related to their own lives, and to “culture and women’s sexuality.” In this regards, one of the women said that she appreciated the information that related to communication about health concerns in the couple and beyond. She said this, “Because that helps in life.”

Women were amazed by each one of the topics; they felt that “it was helpful to [their] health and wellbeing (...) to feel empowered.” Further another participant who eagerly participated in the evaluation (something that was shown in part by her interest in expressing herself in English), said:

> I learned a lot of information. I wished I become a child again, start my life again, I didn’t know anything before, I got married, I have children, but feel that I didn’t know much before.

Later on she referred to this again when talking about FGC. Very emotively, she said that “if I were to be born again, I wish FGC [wouldn’t] happen [again to me]. Now, that she was able to understand much about reproductive health and make connections to her own reproductive life and experiences, she feels greatly fulfilled. However, at the same time she felt that had been in dark for many years, even after having to deal with reproductive health issues.

With regards to FGC, other women showed some signs of relief as they know that “change is coming.” They felt that now that education is provided (also referring to changes back home), and that there are laws to deal with the practice they felt more confident on a future without FGC.

Transfer of Knowledge

As already mentioned, sharing of new knowledge was important to women. In fact, this theme became a recurring one throughout the evaluation session. This sharing of knowledge occurred during the

sessions, where everyone's knowledge was appreciated. This was something that one of the participants wanted us to clearly understand when she said, "We learned about the women's wellbeing, health, talk about different points, we learn to share with others." Coming from a context where many of the issues of the session are considered taboo topics; being able to share among each other was a big step for these women.

This sense of agency was multiplied whenever they felt able to share the knowledge with others in their lives. As powerfully illustrated by one of the participants, "I learned a lot of information (...) I want to share this with everyone, even with my enemy, to protect himself."

However, women believed that much of the information would be helpful for their children, and youth in their community. Sexuality transmitted infections, and protection for them were remarkably important topics not only for the good of individuals, but for the good of public health. The ability of preventing disease was seen as a matter of "good citizenry" by one of the participants when she said, "STIs, even for our youth. We are mothers, for our children, this helps our children to protect themselves, so they can be good citizens, help them in the adaptation process, help children to be healthy, good citizens."

Also, women have made use of the information to change some of their own health practices. A topic that resonated with some of them related to common vaginal practices. As a result of learning how women's bodies work, some felt no need to continue with these practices, as illustrated in this quote, "With the information I gained about yeast infections, now I know that I don't need to wash inside with soap and water."

Another important topic that had an impact on women's actions was access to health services. They felt that, again, this was useful to them, but to newcomers in general. More aware of how to navigate the health care system, women now "... would tell [the many newcomers that come every day to Winnipeg] that if they don't have family doctors they can go to a walk-in clinic, how to access health services."

Facilitating Sexual and Reproductive Health Literacy

Women face many barriers to access health information. The dedication, "patience," and knowledge of the facilitator were greatly appreciated. Further, the non-judgmental approach was also reflected in women's comments such as the following, "I appreciate the patience [the Facilitator] has, the accepting of so many questions, in not a judgmental way."

The learning atmosphere created throughout the sessions allowed women to learn, "share ideas," and "have fun." This was clearly felt during the evaluation where women openly shared their views and supported each other's comments. Women grew to know each other quite closely. They appreciated "the relationship that developed here, too. Before we didn't know each other, now I started to miss them."

In addition to the creation of an environment where women could openly ask questions and feel at ease disclosing personal issues; women commented on the teaching approaches that helped them learn.

Among the most important methods was the use of anatomical models to observe and learn about women's and men's bodies. Further, women found that being able to see and touch different types of birth control methods was also very informative. They added that the condom demonstration was also useful (internal and external condoms). One of the women summarized the importance of materials supporting more abstract concepts and written information by saying,

> When there is any information written, no always easy to remember, but the pictures help me to remember, makes it easier to understand.

The facilitator used diagrams and pictures helping particulars "to understand things very easily." The handouts were also appreciated. Although the fact that the session was delivered in first language made lots of difference in the ability of women to grasp the information, and discuss the topics; the reading materials were cherished. Women would bring the material home to read on a regular basis, and share with others.

Suggestions for Improvement

Similarly to what we have heard over the years in this project, women in this group felt that they learned many new topics. However, "time was short." Additional time would have helped these participants to "to cover many questions, questions to be responded." In addition, they felt rushed to move from one topic to the next in order to cover the content.

In all, they felt that the time allotted to most of the topics was short as each one opened a new window of knowledge, leading to many questions. Although it appears that women would have benefitted from more in-depth information on any given topic, a few ventured some reproductive health matters of their own concern such as more information on "reproductive organs," and the "uterus" (e.g., prolapsed uterus), and reproductive cancers.

Without probing, one of the participants proposed a model that would work best for them. She was in favor of continuing 2 to 3 hour sessions, but to double-up the number of sessions. She even suggested 2 sessions per week.

> A: The time per day is okay, 2-3 hours, but I would like that the sessions double in number, like 2 sessions a week
> Q: Which days of the week would be best?
> A: Saturdays and Sundays

Weekends are best for women who have many family demands during the week. This idea was widely supported.

Again, similarly to other sessions, we learned about the difficulties women face in participating in the group. Most participants would prefer bringing their children along. This was believed to be the case mainly for two reasons. First, many of the participants have smaller children and prefer them nearby. Second, although the project provides some funds to offset childcare costs, these are not enough. The weekly $10 allocation is very limited, particularly for looking after numerous children. For instance, we

learned that two women interested in the sessions were not able to attend because have a number of younger children. It was suggested that we consider a community-based location where an additional room for children be used for on-site child-minding.

Evaluation: “Whole Community Change”

Participants' Profile and Activities Description

As mentioned, we re-hired the CBR team as Community Based Educators. We provided 5, 3 hour training workshops in November and December 2011, focusing on the following areas:

- Developing a plan for the workshop structure, approaches, topics
- Defining roles, timelines, a workplan
- Core FGC information: male/female anatomy; types of FGC; health impacts; reasons for the practice, etc.
- Culture & sexuality, intimacy, relationships, accessing health care in Canada
- Facilitation skills; organizing skills

In February and March 2012, the "Whole Community Team," i.e. the 3 CBEs plus the Project Facilitator, organized and delivered sessions involving participants from all sectors of their community.

As a team, they decided on the format, content and flow of the educational sessions on "change." The discussion was quite lengthy in deciding upon the best way to address change.

First, the team decided to hold 4 small-group workshops, 3 hours each, (10 people each) with the same sub-groups as the research phase: young women, young men, adult women, adult men. These workshops would focus on core health information and prevention messages about FGC. Their goal was to answer questions and provoke dialogue around: What is FGC? Why is it practiced? What are the possible health impacts? What are the laws back home and in Canada? etc.

Then, the team decided that building on our learnings from the August 2011 feedback session, where the findings and the quotations from the research phase were excellent tools for provoking discussion and dialogue, they planned to host one or two large community workshops (e.g. 30-40 people each).

The plan for the first workshop was to outline the findings from the research in two stages of mixed groups. First there would be two groups: one female, one male. Young and old would be included in each group, so the discussion should provoke intergenerational exchange of ideas, something that the research showed was greatly lacking with respect to this topic, despite the fact that youth were embodying change around a variety of issues, including those related to sexuality. The second half of the meeting would allow for same-age groups, but mixed male and female. This plan was also prompted by the research which showed that generally, men were much more open to change around FGC than women. Women were carrying out the practice so daughters would be marriageable, and yet men, especially young men were changing.

The second large workshop was meant to focus on community mobilizing and how the community might take on the process of change around FGC.

SERC staff provided some added supports during training, and the Project Facilitator and the CBE team were entirely responsible for detailed planning, recruiting, organizing, implementing, co-facilitating and evaluating the series of workshops. Portions of the workshops that focused on FGC specific content were facilitated for the most part by the Project Facilitator. The CBEs participated moreso as co-facilitators in the large group sessions.

(See Appendices for the planned outlines for the 3 workshops in the "Whole Community" process)

Evaluation Results: Whole Community Change

Community-Based Educators' Perspectives

Achievements

Training and Organizing

The CBEs felt that the training sessions were "well organized." First, they believed that the content properly addressed the concerns and issues raised during the research feedback session conducted in August 2011. They felt that in order to continue engaging with the community the key messages that were discussed in that "whole community" session were appropriate items to re-awake the conversation with other members of the community, likely those who have not attended the session nor participated in the project previously.

Second, the CBEs felt that they gained new important and more in-depth knowledge, particularly around "advantages and disadvantages" of FGC from a health perspective, that "would help [them] talk about the short-term and long-term consequences [with the community]." They appreciated the "medical perspective"; however, they also highlighted issues such as "the role of virginity, and marriageability" as important too. The CBEs considered that the social and cultural aspects associated with the continuation of this practice were as important as the health effects of the practice on the girl child and women.

Above all, they felt that as result of the training they "were ready to answer questions about sexuality." This means that they gained new knowledge, but they gained self-efficacy in their ability to address questions that other community members may pose during the education sessions, and beyond.

In spite that the training sessions were few (5) and mostly focused on planning aspects of the sessions, and key content; the CBEs felt ready to promote the events, and take charge of the process. They felt that the outline of the sessions that they had developed collectively, and the tasks expected of them in their roles were fair. CBEs were confident about being able to promote and recruit participants, and assist with some of the logistics aspects, and a few facilitation roles (e.g., lead icebreakers, opening comments, introductions, answer some questions, etc.).

Small Group Workshops: Young women, young men, adult women, adult men

The Team managed to recruit 5 to 9 participants per small-group workshop. They managed to recruit community members from different sectors, and a wide age range. These initial sessions were held at SERC.

According to the CBEs, all the participants were very receptive to the opportunity to participating and learning about sexuality, sexual health, and FGC. As one of the CBEs indicated “people were very eager to hear about the advantages and disadvantages of female circumcision, and above all related to women’s health…they were so appreciative!” Once young men got to listen, ask questions, and discuss they asked themselves “Where are the rest of the youth?” This was believed to be a sign of the importance of the topics for youth. In addition, in order to accommodate participants’ questions, all of the sessions went over the time allotted.

The CBEs attributed part of the success of the session to the Project Facilitator’s ability to deliver the session. In addition, they felt that the approach of the Project Facilitator to explain sexual and reproductive health issues, and how they relate to FGC facilitated stronger receptivity and openness on the part of the participants. CBEs illustrated this point by demonstrating how the Project Facilitator introduced the topics through the use of anatomical models. She did so by asking permission to the participants about the use of these models. This was believed to be an appropriate approach that considered potential negative reactions. In fact, participants became so comfortable, they asked to see many "taboo" items; men and boys asked to see sanitary napkins and tampons for example, and how they worked.

Many of the women realized about many connections between health issues to FGC. They said, “We don’t relate [reproductive health problems] to FGC.” This realization led to a flood of questions on women’s anatomy and many reproductive problems.

The other main topic incorporated in the session, virginity, particularly the issue of the hymen as a proof of virginity (and the fact that it may not be intact, despite virginity), was also well received generating important discussions in all groups. Participants were amazed to learn that the hymen could be broken or not complete even if a girl is a virgin. This was shocking to many because so much hinges on blood being evident after the marriage night. One older man told a very sad story about his daughter, who was married at the age of 14. He felt she was a "good girl" and only went back and forth to school (e.g., had not had sex). She was accused of not being virgin, and she was beaten repeatedly. The family tried to get her back, but when she was returned to her family, she died from her injuries. Her family was shamed in the eyes of the community because everyone believed the girl had not been a virgin. He stated that although this happened many years ago, the family has felt this shame even until recently.

Among the men’s group this topic led to other related matters such as the issue of “trust,” and the need to understand the reason why virginity may not be something to be concerned about such as “not to judge them for things that were out of their control like rape, or rape during war.” Adult women felt that this was an important discussion to have with men.

In all it appeared that there was some readiness or at least deep interest in the topic. Participants were highly satisfied at the end of the session, as illustrated by the following words of one of the CBEs:

> Men were very happy about the session. Most of them said at the end, “now we know the consequences of this traditional practice.” This was the moment they were waiting to hear. Once they heard this they felt at home, you can see they were positive, it was educative.

Learning did not only occur for the participants but for the CBEs themselves. They had another opportunity to “listen to their comments,” and a number of personal stories on the matter. The CBEs shared a number of sayings or proverbs that metaphorically represented participants’ views on change (e.g., the rough translation of a common saying: “foolish man’s doings, a wise man finds difficult to un-do”). This also tells us something about this two-way learning in that these sayings can be accommodated in education; but, also on the tenets of oral cultural whereby important teachings are more easily remembered and passed along when transmitted through these important sayings or proverbs.

Some of the participants in each group had been exposed to anti-FGC campaigns in Africa or in school. Still, they felt that these campaigns did not provide enough information on the health consequences, but focused on human rights issues in general.

Large Group Workshops

Participants to the small groups were invited to attend two more sessions where they would share their views and connect with younger, older, women and men. Most members of each one of these groups attended the following sessions together with a number of other new (unexpected) community members. There were 32 and 37 people attending these two sessions, which were held at the University of Winnipeg. The CBEs “were caught by surprise” with this turnout and the “many new faces.”

While it seems that youth were not very receptive to the idea of meeting to talk about FGC with their parents, the CBEs relayed that adult participants during the session said it was “good that there are so many youth with us.” This appeared to have been a good opportunity for communicating views and expectations across generations and gender. For instance, one of the parents asked youth to listen to their parents, but above all to be “kind” to them, because it is harder for parents to come to terms with the changes the youth, and themselves face in the new culture and society.

According to the CBEs, most participants were very open to “change” with regards to the practice of FGC. They felt that societal changes (e.g., immigration, living in a new culture, technology, attitudes towards changes in women’s roles and position in society, etc.) would contribute to the abandonment of FGC.

We asked the CBEs to share some of the comments that informally participants have shared with them about the sessions. One of them remember a participant saying that this is a “very good program, [to help] break our taboo, a taboo topic in our family.” SERC staff received this comment by email after the second large session, "I put myself as your member and started to share what I know and studied during

the workshop to my community and everyone who does not have any idea about this." The CBEs also heard many people request more sessions.

Challenges

Training Sessions

The CBEs mentioned a few challenges and shortcomings of the training received. In spite that they believed that much information on FGC has been shared with them through the training, which enabled them to feel confident about the topic, and address some of the questions; they were not prepared to lead the education sessions. In this regard, they believed that their title of “educators” was a misnomer.

They definitely felt that they were “in control of the program.” To that, one of the CBEs added, “we feel the objective is our [objective], the content is our, the outline reflects our participation.” However, more time would have been required for them to build their knowledge base and, above all, skills to facilitate the sessions solo. They also felt “rushed” during the sessions.

This program occupied a relatively small part of their daily lives within the proposed stretch of time. As such the project had to find ways to accommodate their schedules. This had an impact on the schedule of the sessions. The closer in time the sessions, the easier was to engage in learning and planning the activities.

The CBEs received “a lot of papers”, referring to reading material on the different topics raised during the sessions from content to facilitation skills. However, they did not have time to use them or review them all.

Education Sessions

In spite of the welcoming reception of the project in the community, recruitment to the initial set of sessions proved to be a challenge. First, “it took a long time for many to commit”; then, some were not able to attend the session. This was particularly the case involving adult and young men. Although a number of men confirmed their attendance to the initial group set for young men, and adult men; in both cases, the groups had to be rescheduled due to the number of last minute regrets. In both cases shifting work schedules, family obligations, and other impromptu commitments prevented men from attending the session. The team had to quickly communicate and reschedule the sessions, call back participants, and hope to have a good turnout. This challenge caused some distress among the CBEs, who appreciated the support offered by the Project Facilitator throughout this process.

When approaching past participants of the research process of this project, some of these community members asked about receiving an honorarium to participate. Drawing from their past experience as research participants, these participants were confused and disappointed by the fact that no honorarium was to be provided for attending education sessions. The decision to not offer anything to defray expenses was revisited and a babysitting amount, similar to what SERC offers for our other workshop series, was offered. The CBEs felt that this helped in that they were not trying to explain an apparent lack of consistency among SERC programs.

The fact that “many new faces” showed up to the first “whole community” session presented unexpected challenges. The original expectation was that all participants would come to this session with the basic information shared in the small groups. Although this proved to be the case for some, many new people came with none of the information that small group participants had. When the Project Facilitator greeted participants, gave a brief overview of the small group workshops, and then asked, "Are there any questions before we begin?" approximately eight people raised their hands.

Of course, to be responsive, the Project Facilitator did respond to their questions but found it challenging having to explain many reproductive health and FGC health related issues without any materials (e.g., transparencies or slide presentation, anatomical models). Further, all participants asked many questions provoking a feeling of “derailment” from the original agenda of the session. In addition, many new participants, by virtue of having lived in exile all their lives, needed translation into a different language, Arabic. Fortunately, a couple of the CBEs are well-versed in this language and were able to provide interpretation. This challenge left the CBEs “feeling that you haven’t done your job well,” in spite of the fact that the very topic of the session generated a vibrant and “good” discussion among participants and with the facilitators.

Another challenge presented during one of these sessions concerned the “story of origin of FGC” related by one of the participants. While this story was important to learn about some of the beliefs surrounding FGC, it seems to have been disruptive. The main challenge in this example was to the CBEs in their role of facilitators, as they felt compelled to find ways to address this story into an education moment.[2]

The CBEs faced another challenge when discussing the role of religious leaders in the process towards the abandonment of FGC. While some strongly believed the need to “avoid religion into this kind of discussion;” others felt that there was a role for religious leaders to speak up against FGC. Another message that raised concerns was the idea that “parents don’t mean to hurt” their daughters. This was challenged when one of the participants felt that FGC is “not done out of love, but out of fear when trying to protect the family name.”

In accord with youth’s prediction that they wouldn’t talk openly among parents or adults, the CBEs observed that youth participation throughout these sessions was lower, particularly among young women, some of whom were perceived as “embarrassed and uncomfortable.” However, some groupings of youth, for example, the Arabic speaking group, were much more animated in their discussions. We believe this may be because they felt that parents would not understand them easily.

[2] The story was one of many found in anthropological literature. In this story, a group of women wanted sex so badly, they raped a group of men. They were so sexually needy, they tied up the men so that they could have their way the next day. They were caught and were taken to the village elders. The elders felt that they as men could not address the problem directly themselves, as it dealt with women's bodies and needs, and so it was left to the women to perform FGC to curb their uncontrollable desires.

Impacts on the CBEs

> *When I met someone who has participated here and say that this was a wonderful program - that makes me feel good. Some change is happening*

As result of organizing and co-facilitating these sessions, the CBEs felt that this was a "positive experience" at the personal level. As we have already referred to, the CBEs gained important knowledge on FGC. Now, as result of planning, organizing, and co-facilitating some of the aspects of the education sessions they found that they were more confident to stand in front of a group. Among the comments made by the CBEs in this respect they said, "I learned to have courage and new ways of talking to people, lots about ethics of doing this work, and how to facilitate", and another added, "Makes you feel that you can speak to different people of different ages." They also mentioned having been able to work and make decisions as a "team."

With little ability to gain meaningful employment in his own field, one of the CBEs believed that this project allowed him to use some of his education, and become "stronger." Others believed that this was an education opportunity for all of them. One of them said, "Education matters, for future this kind of thing can make you grow." And another CBE who at times would ask himself, "Why am I doing this?" added the importance of the project in helping them make a contribution to their community:

> Personally when I look back and think when I began, almost two years, seeing this program moving successfully makes me feel proud of my own contribution to the community, always good feeling when you see your students and see them progressing.

They were also able to reach deeper into the community, and meet new people. This was the case for those who have not had much contact with sectors of the communities that have left their home country and settle in different places before arriving to Canada.

They continue to receive unsolicited positive comments from community members, and as such they believe that this is a "very positive program." This made them to "hope this program continues, and reaches many immigrant people's lives."

Participants' Perspectives

> *Our culture is a very sensitive regarding sexual topics, parents do not share a lot of information, therefore I believe more of this program will [help] break the barrier with our families and more education means more knowledge*

The CBEs conducted a short oral evaluation at the end of each of the sessions. They asked if participants felt they were able to understand the topics, about the way the information was presented, inquired about other related topics of interest; and about any suggestions for improvement of education sessions with the community. Here's a summary of their responses to these different areas of inquiry.

Understanding of the topic as result of the session

- Most participants indicated that the information shared helped them understand more about FGC, advantages and disadvantages, and different types of FGC. It helped them to "break the taboo topics among [their] families."
- Some made specific comments about new knowledge gained with regards to the reproductive anatomy. Many indicated they would share this information with family members, friends and others in the community.

Approaches to education

- Participants agreed that the methods used to share the information were relevant and appropriate. They appreciated the use of models and other materials, as well as the use of slides. One of the women shared that the use of some of these materials would help her to talk to her daughter about reproductive issues.
- They also felt that their "questions were answered"

Additional topics of interest

> *I hope if you could continue educating more different topics that are considered sensitive and taboo to our culture.*

- Health promotion and disease prevention
- Male and female sexual and reproductive health topics.
    - Pregnancy and childbirth
    - FGC and health
    - Birth control
    - HIV/AIDS
    - STI testing
    - Prevention (e.g., use of condom)
- Intimate relationships
    - Decision-making skills (e.g., "how to ask him to use condoms?")
    - Communication skills (e.g., "how to communicate in relationships")
    - "Sexual topics" for new couples

Suggestions for improvement

- Add more sessions
- Include session on FGC for the Entry Program for newcomers
- Use image of a child to illustrate male circumcision (in this culture, the only non-circumcised males are children)
- Ensure that more people in the community have access to this information, including youth to break the cycle of FGC
- Ensure that the matter of "proof of virginity" is included and discussed with parents and youth.
- Develop a youth-focused series of education sessions

- Ensure the time is well managed in the sessions (this comment was made in relation to the first whole community session)
- Conduct separate sessions for groups requesting translation
- Use plain language during translation
- Pay attention to the management of sensitive topics as they interface with religion.
- Revisit the “model of change” utilized during one of the sessions. This participant suggested to including, “[gaining] knowledge” as a step before “realizing the need for change.”
- Consider translating handouts

Evaluation: Service Provider Training – Healthy Start Mom & Me

Session 1 Evaluation Findings

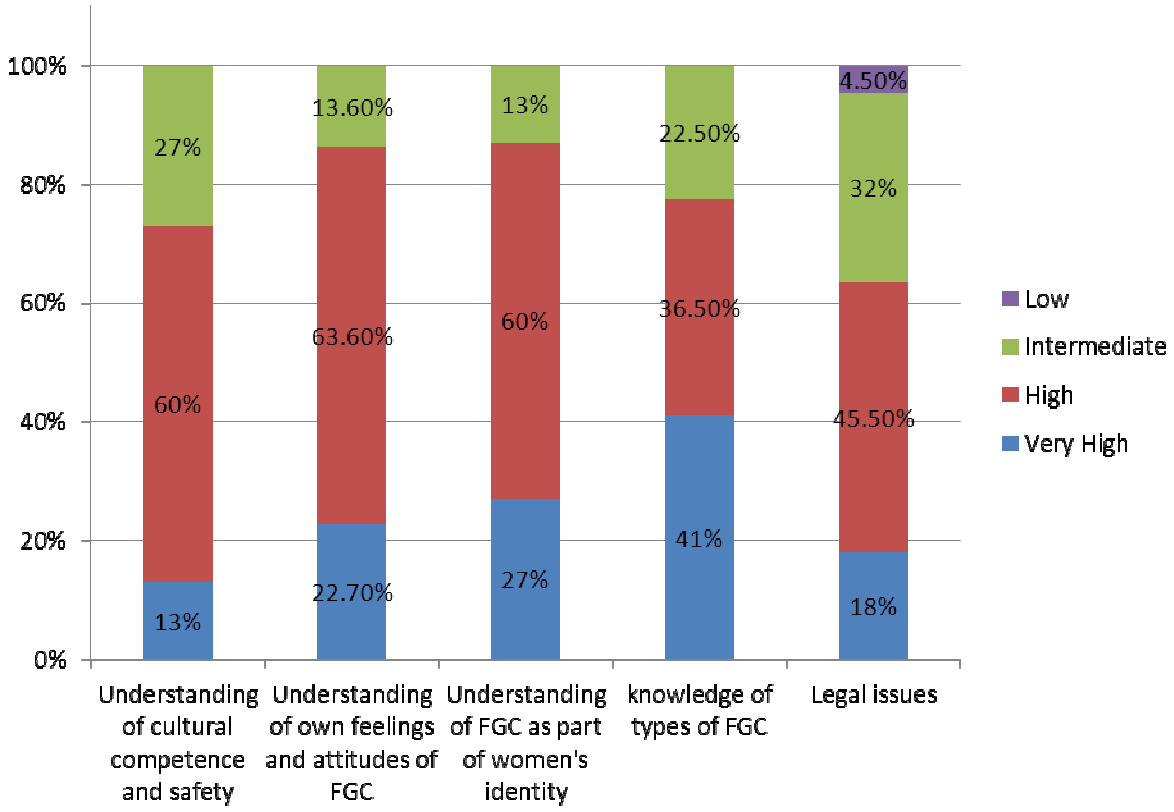
Respondents' profile

Twenty two participants provided evaluative feedback through the end-of-session written questionnaire (of a total of 26 participants). This represents an 85 percent response rate.

In the first session, we asked participants to tell us in what capacity or situations they would be working with women from FGC practising communities. About 82 percent of the participants responded to the question. Almost all respondents were currently working with newcomer women and communities affected by FGC. Among them were Public Health Nurses (n=6), outreach workers (n=6), health educators or facilitators (n=2), program coordinators (n=2), and dietitians (n=2), and a midwife. Most were providing perinatal related services.

Evaluation Outcomes

Following the objectives of the project, and the particular training session we set to measure increase in awareness on FGC, but more importantly changes in understanding of cultural competence and safety, and the use of knowledge within their own practice. The following chart represents the responses with regards to a series of measures for the session 1 (December 2011). Full explanation of the responses follows.



These results show that participants showed an increase in understanding on issues related to FGC in all areas after the training.

The greatest change was in participants' understanding of their own feelings and attitudes towards FGC, and the idea that FGC is part of women's identities. In addition, about equally, participants increased their understanding on cultural competence and safety, and their knowledge on types of FGC. To lesser extend participants increased their understanding of legal issues concerning FGC.

Application of Knowledge

Most participants believed that all the knowledge shared was relevant to their practice; in particular as almost all of them work directly with immigrant and refugee women from FGC affected communities in relation to their pregnancy and perinatal needs. For some there was practical knowledge such as basic information on FGC, types and health consequences.

Some of the participants were more specific on the knowledge they see applying. In such cases they indicated that new insights on "understanding of the meaning and experience of FGC for women" were relevant to their approach. An increased awareness on the practice was important to address their position on the matter. As such they felt that now they will be more "open", watch their language (non-

judgmental), become more reflexive on own views and feelings (e.g., “moving from "gut" to rational reactions to a variety of things”).

Need for Additional Information

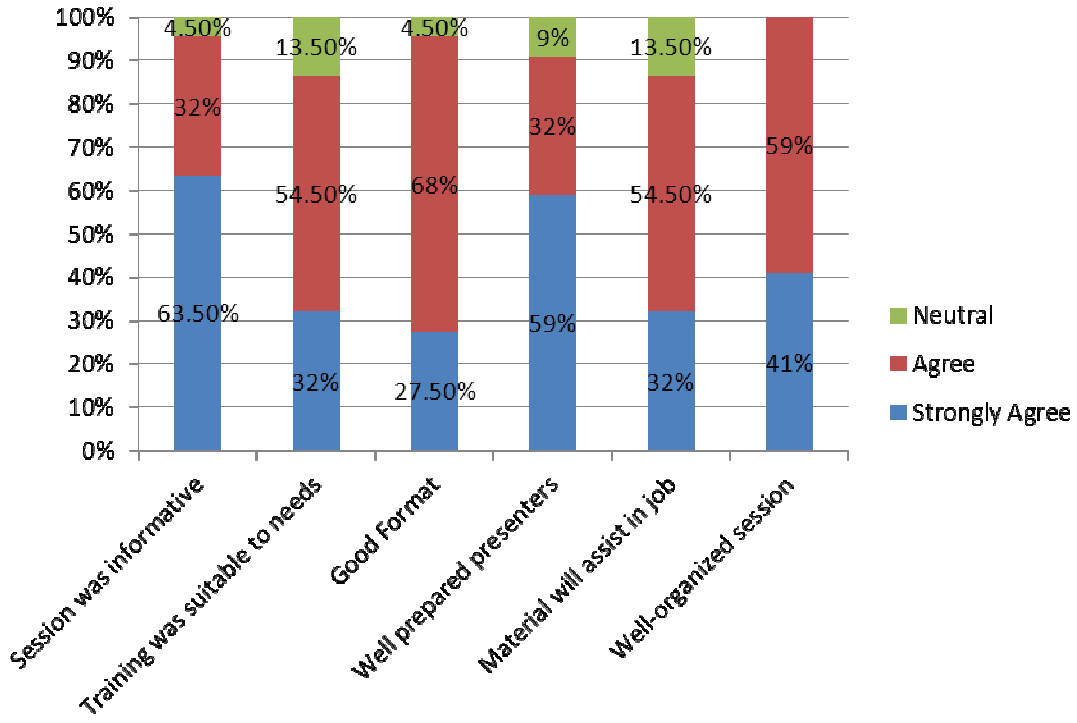
We asked participants to identify areas of knowledge that would increase their capacities as service providers. This was also in part important as such needs and gaps could shape the content of the second session. We identified four main areas of interests based on the responses.

- Working with women affected by FGC (e.g., “creating a safe space for disclosure of FGC”, “how to approach the subject with newcomers”).
- Specific information regarding sexuality and reproductive health (e.g., “childbirth & postpartum issues”, “sexual relations and FGC”).
- Resources available in the community to refer women affected by FGC (e.g., “needs for psychological support and community support”, “where to go? Doctors (…) sex educators, counselling…”).
- Increased knowledge on the practice of FGC from a sociocultural perspective (e.g., “ceremonial processes and who is present”, “how does this relate to body image (…)”, “perspectives from people performing the practice”).

Other topics mentioned were increased insight on women’s experiences with the health care system, and legal and ethical responsibilities of service providers.

General Aspects of Session 1

Participants were also asked to rate a number of aspects related to the workshop on a scale of 1 to 5 with 5 being the highest score.



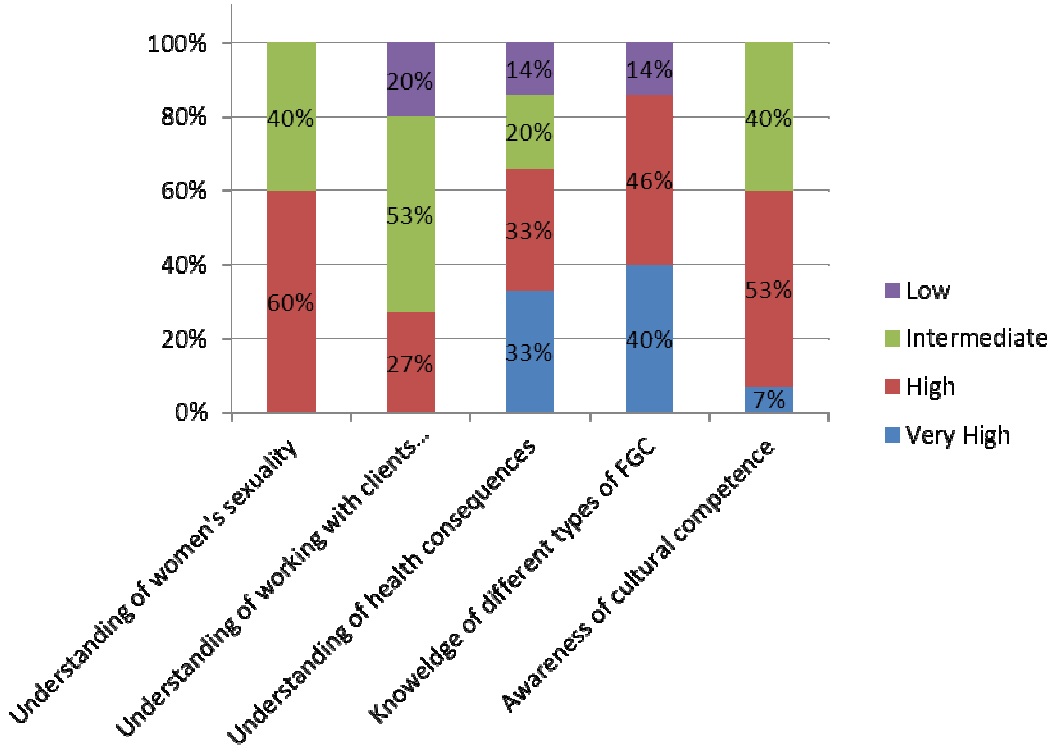
Participants rated the workshop very positively on all aspects. The highest rates were given to the level of organization of the session (100% agreed or strongly agreed that the workshop was well organized), followed by the fact that participants belief that the session was informative (95.5% strongly agreed or agreed that the session was informative). Most felt that the session followed a good format, felt that the presenters were well prepared.

Most participants agreed that the training was suitable to their needs, and that the material will assist them in their jobs (i.e., 32% strongly agreed, and 54.5% agreed).

By the end of the workshop, 86.5 percent (n=19) of the respondents indicated that they would attend part 2 of the session.

Session 2 Evaluation Findings

Most participants returned to the second session. There were a total of 13 returnees and an additional 5 new participants. Fifteen participants (i.e., 83 percent) returned their complete evaluation form at the end of the session.



Represented in this graph are mixed results with regards to participants perceptions in change in knowledge and understanding on the key different issues addressed in the session. Participants appeared to have increased their knowledge and understanding on the different types of FGC, and on the health consequences of FGC.

Although still showing positive results, to a lesser extent participants indicated changes in awareness of cultural competence, and their understanding of women's sexuality. This may be in part due to the fact that they may have already been exposed to the issues, including as some expressed in some of the later questions in the form, the fact that some content appeared to have been repetitious. Overall, it seems that less change occurred with regards to the understanding with regards to working with clients affected by FGC. Participants in the first session identified this area as one of the areas they wanted more information on. Although the session paid attention to some practical aspects on how to strengthen people's abilities to working with newcomer women, it may be that there was not enough

time to reflect on the matter, that participants realized that their level of competency was up to par with what was presented, or even that the content was too advanced.

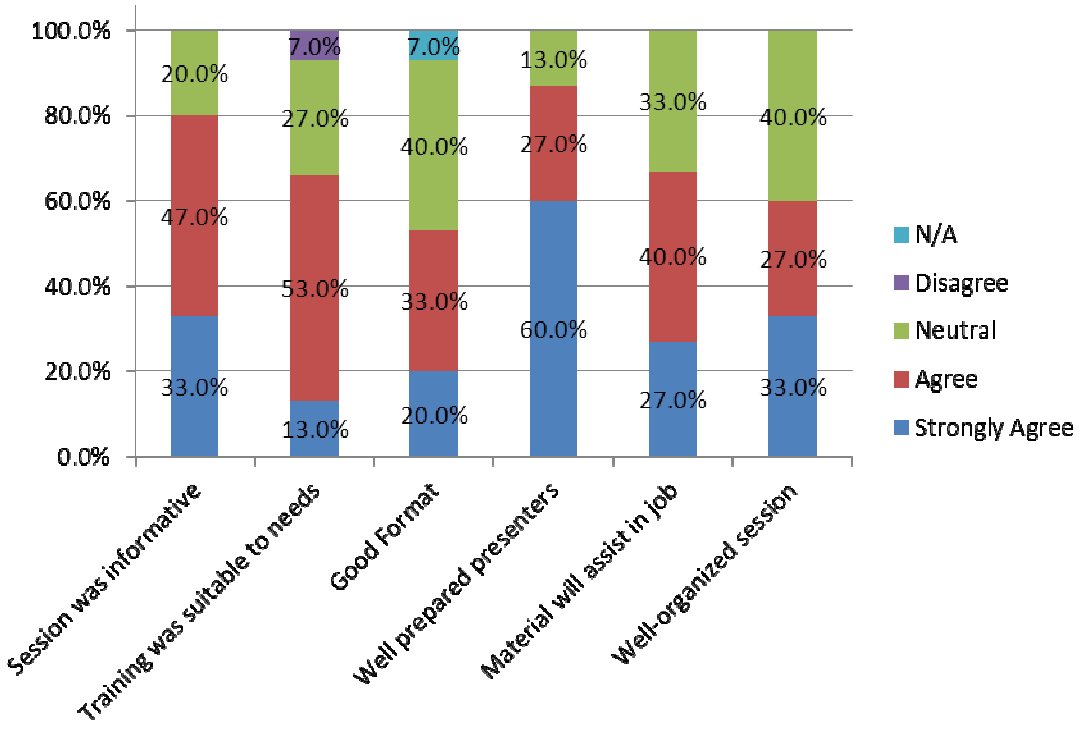
Use of the information

About half of the participants to the second session indicated some specific use of the information in their practice. All of the respondents indicated in some way having a better understanding on FGC that would result in “better service provision” due to increased competence in addressing FGC with clients. One of the participants highlighted having learned how to address the topics by “mirror(ing) sensitivity modelled by facilitators.” This seems to indicate that in spite of the mixed results with regards to their understanding on how to work with clients affected by FGC, participants became more confident in being able to use the information shared in the workshop in their jobs. Now, one major gap remains. Participants continue to request concrete information on available and accessible services where to refer women affected by FGC (e.g., doctors, counselling, clinics, specific website information).

General Aspects of Session 2

Participants rated the workshop very positively on most aspects. The highest rates were given to the level of preparedness of the presenters (87% strongly agreed or agreed that they were well prepared). This was followed by the belief that the session was informative (80% agreed or strongly agreed that the session was informative). This was followed by the level of preparedness of the presenters). To lesser extent people felt that the training was suitable to their needs or that the materials will assist them in their jobs (i.e., 66% and 67% respectively strongly agreed or agreed).

This time participants did not rate as high the format and the level of the organization of the session. This may be in part due to having to accommodate participants who did not attend session 1. More explanation on this follows.



As this was the first time that an expanded education session for service providers was delivered by the project, we asked participants about their opinions on the benefits of delivering the content in two sessions that were set far apart in time. The sessions were set in this manner to accommodate the participants to the first session.

It appeared that the participants who answered the question had two differing views on this. On the one hand, some of them felt that having the time in between sessions helped them to reflect on the content, something they appreciated. On the other hand, other participants felt that the sessions could be delivered closer in time or even in one consecutive day.

However, what most participants agreed on was on the fact that it should be a requirement that those attending the second workshop had participated in the first session. Participants felt that the content became repetitious as result of a few participants who needed the information shared in the first session to be able to understand the content provided in the second session. They felt that that had a negative impact on their experience of the workshop.

Evaluation: Service Provider Training- Anthropology Class

SERC was invited to present at the "Anthropology of Sex and Sexualities Course," Department of Anthropology, by Dr. Susan Frolich, on March 8th, 2012. Sixty percent of the students completed a short open-ended questionnaire through which we tried to identify where some of the main learning occurred, areas where additional information would have been beneficial, and what information or aspects of the discussion, if any, students would apply in their areas of study.

New Learning

Students identified a number of new areas of knowledge resulting from the presentation, and discussion. All the items raised indicate an increase in awareness on the complexities of FGC, its politics, and the politics of social interventions. More specifically, students increased their understanding of:

- the terminology surrounding this practice; that is the meaning and politics of the use of each main name associated with this practice (including the acronyms) such as "Female Circumcision", FGM, and FGC;
- diversity of the practice (e.g., different types of FGC), health consequences
- the extent of stigma experienced by women affected by FGC in a society where this is not a common practice, and in particular by health practitioners;
- the cultural and social underlying factors that contribute to the preservation of the practice (e.g., "that mothers did not do it to harm their children, they did it to protect them", "FGC has huge importance culturally, and it is important to be aware of the role of culture, values, beliefs and understanding.")
- local perspectives on FGC based on the "Our Daughters" project (including men's position on the practice)
- SERC's mandate, programs and activities.

Gaps in Knowledge

In order to advance the students' knowledge, and for consideration into future presentations with university students interested in cultural dimensions of FGC, we inquired on any possible gaps. Students pinpointed to more in-depth information on women, and community views, in countries where practice is prevalent and in countries where they become a minority; a deeper understanding on changes regarding the practice, from community-based to governmental actions; and, what appears to be a more in-depth discussion on "cultural relativism" vs. "universal values" surrounding the debates on FGC programs of change.

Knowledge Transfer

Finally, when asking students about the potential use of the information shared and discussed during the session, they identified that an increased understanding on the practice would help them approach it differently (e.g., "the western assumptions that we have about FGC", "just be more open", or "how to balance cultural relativism and ethnocentrism"). Some of the students were more specific by making

connections to their chosen professions in the education and health areas (e.g., “Even more careful of my reactions to a patients’ belief, not just physical reaction, but emotional. Use cultural awareness in a profession is incredibly important, especially in the medical field.”). Finally, other uses of the knowledge mentioned were the increased awareness on “the cultural aspects of how sexuality is constructed” through the topic of FGC, and the use of this example to analyze the “government representations of the practices.”

We complimented the students’ perspectives with feedback from the professor of this course, who wrote that the presenters “were well organized, had pitched the material at the right level for the students, fielded a wide range of questions, and engaged the students in new ways of thinking about the issue.” Dr. Frohlick concluded by saying that “I look forward to inviting them back next year in fact!”

Conclusions and Recommendations

This phase of the project successfully builds on earlier ones in incremental steps. At the heart of our project is change. In this case, we are working to support the cessation of a practice that has been carried out for literally thousands of years. Also, we are not an ethno-cultural agency, and as such, we must tread carefully and work closely with communities in a respectful manner and at their pace.

We continue to follow an iterative process that has brought us success to date - a process of consultation and building trust, learning and research, planning and implementation, reflection and evaluation, which then leads to the next phase of work. With each successive cycle, we deepen our knowledge about this complex issue, and build our expertise on how to best have a positive impact on women's and daughters' lives.

As in previous phases, strong support from the community is key to our success. We could not do this work or be successful without having the benefit of people's cultural knowledge and expertise - and their trust. This year, it has been a very positive experience to find that in the two new communities that we have engaged, there seems to be strong support for the work of this project, and a great need.

Our educational approaches create a culturally safe atmosphere wherein community members can openly discuss sensitive topics that are important to them, for the first time. Our findings confirm that we are having a direct impact on the health and wellness of women, and through them, their daughters. Through discussion and exchange, we explore long-held beliefs and values, and help community members connect with new concepts and information that facilitate change on the issue of FGC. By working on multiple levels in the community, we are able to support change starting with women, but also encompassing their husbands, children, friends and neighbours in this process of change.

As is evident from the recommendations from evaluation of all of the community-based educational workshops, there is a strong need for information about sexual and reproductive health in newcomer communities. Through this project, we are addressing a huge gap in services for newcomer women (and to some extent, men and youth) by providing much-needed information and referrals on sexual and reproductive health.

In this past year, we have also been surprised and gratified by the continued level of interest on the part of service providers and the expressed need for more introductory and in-depth workshops on cultural competence and FGC. Workshops have been received well and the evaluations point to further areas that this project might address. The high level of interest in the project and its activities also is a good indicator that we have highlighted an area that has not been addressed locally, if not nationally.

This year, we began to connect with 'new' newcomer communities who are expressing a need for this type of programming. Moving towards a multicultural model is an important step. We know that many of the newcomer communities in Winnipeg have high rates of FGC in countries of origin; while it made sense to "start small," and pilot the project with one community, our work this year has demonstrated that the need does exist in other communities in Winnipeg.

Recommendations for Action

Programmatic:

1. Continue to provide participatory, culturally competent **education sessions for newcomer women** that address the health impacts and prevention of FGC, and that explore the complexities of culture, identity, sexuality and change. Include women from all three communities. Specifically:

    a. Explore possibilities for expanded sessions and/or follow up sessions, providing more in-depth information on women's sexual and reproductive health, and on-site child-minding

2. Continue to build on the process of **"whole community change" by engaging community-based educators** to hold further community-based workshops with all sectors of the community (adults f/m, and youth f/m) in which this work was begun. Specifically:

    a. Consider an appropriate title that is reflective of the community-based educators' role; provide more time for training and supports including providing interpretation; emphasize verbal communication and minimize the amount of take-home papers/handouts; attend to community capacity building to address FGC, as an outcome of the training and community education process.

3. Support **capacity building of project staff** from communities, e.g., provisions for added mentoring, support and dialogue, involvement in broader SERC activities, etc.

4. Consider the strong need expressed by newcomer participants - both men and women, young and old- for the provision of **sexual and reproductive health information** presented in a culturally sensitive manner (e.g. pregnancy and childbirth, FGC and health, birth control HIV/AIDS, STI testing, prevention/condom use, relationships: decision-making, communication, "sexual topics" for new couples)

5. Develop **educational resources in first language**. Incorporate a process of community feedback whenever possible.

6. Closely examine the process of training and supporting a **peer-based model** (i.e. community based educators) and assess this model in the context of agency resources and capacity, as well as community needs and overall sustainability of this work.

7. Continue **training service providers** in a responsive manner, particularly those in the health care sector. Explore the idea of a next stage of training for those who have attended the introductory workshop for the development of in-depth practical skills.

8. Continue to integrate project learnings and approaches into **SERC core programming**, beliefs and policy.

9. Continue to compile, develop and **disseminate FGC and project-related resources**. Further develop the Draft Manual for Health Education with Newcomer Women Addressing FGC. Develop community-accessible summary reports of project and research learnings in Plain Language or translated.

10. Address the **ethical dimensions** of the project on an ongoing basis, such as the public use of the names of the community(ies) involved with the project, the engagement of systems that can be in a punitive relationship with communities, the messaging that SERC provides to media requests, SERC's position statement with respect to FGC, etc.

11. **Disseminate** project findings widely.

Advocate For:

1. More sexual and reproductive health services, information and supports, with first language cultural interpretation, for newcomers affected by FGC.
2. Cultural competence training at a systemic level
3. A focus on fulfilling the economic and social security needs of newcomer families (versus punitive approaches to FGC)

Appendices

Evaluation Tools: Focus Group Questions for Women's 10 Week Sessions

Evaluation Tools: Sample of Pre-test Questionnaire for Service Provider Training

Outline for Women's 10 Week Sessions

Outlines for 3 Phases of Community Based Education on "Whole Community Change"

EVALUTION TOOLS:

End-of Sessions Focus Group Interview Guide – Women's Sessions

1. What got you to the group / what are the reasons you decided to come to this group? Once you realized what the group was about, why did you decide to stay?

2. During the sessions you had the opportunity to talk and hear about different topics. What topics had an impact on you? Why? Probes: impact is attributed to the content, the speakers/educators or the discussion that they generated, due to important to participants personally or the community.

3. During the training the facilitators used a number of ways and education tools to help you understand and discuss all the issues we have talked about (e.g., lecture/presentations, group discussion, use of models, *handouts*, etc.). Which methods of training delivery do you prefer and why?

4. What helped you to actively participate in group conversations/discussions? Probes: people from same community, the facilitators, the climate of the sessions, etc.

5. How comfortable were you in the workshops? why or why not? Did any of the topics upset or embarrass you? Were you comfortable learning and talking to the other participants? Did you feel your culture and beliefs were respected and valued?

6. Can you tell me what happened in your life as a result of participating in the sessions/project? Probes: at individual, interpersonal (family) levels related to the project, ripple effects of being involved, unexpected consequences.

7. What suggestions can you give to the organizers for future development of these types of sessions, i.e., sessions that focus on women's health issues for newcomers? The group focused on women from your own community only, how do you feel about having similar sessions with women from other communities?

8. What else do you feel you need more information about?

9. How do you find the location in which the training was delivered? Probes: accessibility, arrangement of the physical space, other places this training can be delivered.

10. How important has been for you that the training help you to pay for childcare and transportation? Why? What would happen if we were not able to cover childcare costs (to the same extent)?

11. Overall, how satisfied are you with your experience as a participant in this project? What was the best part of the experience? What would be one thing that you would change about the experience?

12. Are there any other aspects of the sessions/project that you think would be useful for us to know?

Our Selves, Our Daughters Project: Exploring a culturally competent approach to understanding female circumcision

Part 1 - Workshop Evaluation – December 9, 2011

How would you rate yourself (as of today) on the following items?	Please circle one				
	Very Low	Low	Inter-mediate	High	Very High
1. Understanding of cultural competence and safety as result of attending this workshop	1	2	3	4	5
2. Understanding of my own feelings and attitudes of FGC as result of my participation in this workshop	1	2	3	4	5
3. Understanding of FGC as part of women's identity	1	2	3	4	5
4. Knowledge of different types of FGC	1	2	3	4	5
5. Understanding of legal issues related to FGC	1	2	3	4	5

Please **READ** the following comments and **CIRCLE** the number which best reflects your opinion.

1= Strongly Disagree and 5 = Strongly Agree

General Observations	Strongly Disagree				Strongly Agree
I found the session informative	**1**	**2**	**3**	**4**	**5**
I found the training suitable to my needs	**1**	**2**	**3**	**4**	**5**
The training format was good	**1**	**2**	**3**	**4**	**5**
The presenters were well prepared	**1**	**2**	**3**	**4**	**5**
The material will assist me in my job	**1**	**2**	**3**	**4**	**5**
The sessions were well-organized	**1**	**2**	**3**	**4**	**5**

1. What part(s) of the workshop will you **use** in your job? How?
2. Are you planning to attend the Part 2 workshop on January 20th? Yes ___ No ___
3. What **additional information** do you require regarding female genital cutting?
4. If you answered question 1 or 2, please tell us a bit about **your job** (e.g. outreach worker, public health nurse). As well, **in what capacity/situations** would you be working with immigrant/refugee women from FGC practising communities? (*Spacing deleted for report)*

10 Week Education Sessions with Women - List of Topics

Outline of Sessions

Session 1:

- Introductions / Expectations
- Health and Well-being; definition & flower
- Definition of sexuality
    - FGC a complex issue
    - Differing beliefs & feelings even within 1 community
- Accessing the health care system
    - How to find a family doctor (handout)
    - Language Access program

Session 2:

- Traditional practices (group exercise & debrief)
- Models of health care [East/Western medicine; naturopath; herbal medicine etc.)
    - Accessing a specialist
    - Medicine Safety handout
- What is covered by Manitoba Health Services Commission

Session 3:

- What happens at a doctor's appointment
- Patient's Rights
- Informed Consent
- Female anatomy – Magnella Board; include basics on FGC

Session 4:

- Breast exam
- Pelvic exam and Pap test
- Menstrual cycle
    - PMS
    - Dealing with PMS

Session 5:

- Male Anatomy
    - Facts re erectile dysfunction & Viagra
    - Marketing of sexuality related products
    - Sexual difficulties in a relationship – cultural aspects re communication and dealing with issues
- Pregnancy – sperm meets egg/ fertilization/ implantation
    - miscarriage

Session 6:

- Stages of Pregnancy
- Labour and childbirth
- Complications resulting from FGC

- Breastfeeding and cultural role of women's breasts

Session 7:
- How does birth control work?
- Different methods of birth control
- Where to get birth control

Session 8:
- Menopause
  - symptoms
  - yeast / bladder infections
  - coping with menopause
- Culture and women's sexuality / wellness
  - follow-up to discussion on breastfeeding in Canada
  - rights of the child to best nutrition i.e. breastmilk; mother has the right to breastfeed her child in public
- Culture and FGC
  - Why is FGC done?

Session 9:
- Continuation of FGC and culture
  - discussion re "breast ironing"
  - similarities/differences re FGC
  - discussion re protection of daughters
- Sexual Relationships
  - women's sexual pleasure and FGC
  - factors that affect a woman's sexual pleasure
- Communication in sexual relationships
  - about sexual pleasure and/or difficulties
  - issues in "negotiating" safer sex
- Condom demonstration

Session 10:
- STIs and HIV – factual information
- Review of issues re FGC
  - legalities in Canada and other countries
  - health consequences
- Cultural change
  - takes time/complex process
  - community change
  - women as leaders/teachers of change
- Evaluation

Community Education / Engagement Sessions Session 1

Objectives:

- Facilitators will assist participants in establishing a safe environment for discussing what is possibly new information about female circumcision.
- Participants will discuss the reasons why female circumcision is practised in their community.
- Participants will become aware of the possible health consequences associated with the practice of female circumcision. This information will be evidence-based from both a medical and cultural viewpoint.
- Participants will discuss their beliefs about female circumcision and how these beliefs relate to the abandonment of the practice of female circumcision in the community i.e. why the practice needs to change.

Key messages:

1. Cultural and traditional practices are important. Our goal is to find a balance between the old ways and new information about harm caused by a practice.
2. FGC is illegal in both Canada and Eritrea.
3. We understand that when FGC was done it was not intended to cause harm, but rather to protect the daughters.
4. It is OK to challenge people's attitudes about female circumcision.
5. This education session is not about blaming people or judging their actions. This information is being given not to stigmatize women – but to empower them in their decision-making.
6. The session should not present the information in such a negative light that young men will not want to be in a relationship with a circumcised woman.

Outline:

1. Welcome

- Introduction of facilitators / project / session etc.
- Disclosures: This session is about prevention – NOT intervention. FGC is against Canadian law. However, facilitators / project staff are *obligated* by law to report a plan to circumcise a child.

2. Participant introductions

3. Ground Rules – a group agreement about respect, confidentiality and SAFETY etc. ** Key message: People will not be judged for their beliefs and opinions.
4. Definition of Sexuality – using the sexuality Diagram

5. Why is FGC done? (Community-based Educator)
    - brainstorm the reasons
    - discuss in the context of controlling women's sexuality

6. Possible health consequences related to FGC (Simret)
    - basic anatomy and physiology
    - "types" of FGC
    - possible health consequences
    - impact on sexual health / relationship (e.g. pain)

7. Why does the practice of FGC need to end? (both educators)

    - culture: iceberg analogy (FGC a deeply held cultural tradition) there are changes happening in Eritrea – anti FGC campaigns, against the law in both Canada and Eritrea (going back to Eritrea not a way to avoid changing)
    - FGC not condoned by any religion
    - What new understanding about FGC as a 'harmful' practice have participants gained from this session?

8. Closure …. Evaluations …. (Community-based educator)
    - Reminder of session #2 (Topic and Date / time / location)

Resources:

Powerpoint and laptop / projector
Overhead projector and slides
A & P models
Handouts:

- Anatomy & Physiology (female & male)
- Types of FGC (handout with the tree)
- Consequences of FGC
- Culture (iceberg diagram)
- Model of Change
- Eritrean Declaration

Community Education / Engagement Sessions Session 2

Objectives:

- Facilitators will assist participants in establishing a safe environment for discussing what may be new information about female circumcision.
- Participants will discuss quotes from diverse groups of community members related the impact of FGC on relationships, role of virginity, role of FGC in future marriageability of girls, cultural change etc.
- Participants will have the opportunity to hear the opinions and beliefs across genders and generations.
- *How will we link this session to session #3 i.e. what is the process for deciding if session #3 is necessary/will be held?*

Key messages:

7. Cultural and traditional practices are important. Our goal is to find a balance between the old ways and new information about harm caused by a practice.
8. This education session is not about blaming people or judging their actions. This information is being given not to stigmatize women – but to empower them in their decision-making.
9. It is important for community members, especially male youth, not to stigmatize girls/women who have been circumcised.
10. How can the community effect change without creating victims and oppressors or being divisive?
11. This is a key time to look at change regarding what was considered an important cultural practice. Our goal is to find a balance between the old ways and new information about harm caused by FGC.

Outline:

1. Welcome …

- Introductions
- Reminder of ground rules

2. Review of group brainstorm/discussion during session #1 (Community Educator)
   - Purpose of today's gathering
   - Where the comments came from …

3. Participants will be divided into 2 groups;
   First part of the session: males (adults & youth) and females (adults & youth)

- each group will discuss a set of quotations from the focus groups
- CBEs will facilitate the discussion (*questions to be developed*)
- there will be a recorder for each group

Second part of session: adults (women & men) and youth (females & males)
- repeat the group discussion process

- **Note: will the recorders briefly summarize the group discussion at the end of each discussion i.e. before the break and at the end of the 2nd discussion session**

Summary of the session: Community-based Educator

- Today we were able to talk about "change"
- Cultural traditions are important! Culture changes for many reasons …
- Change causes fear and discomfort … but there are also positive aspects of change
- We, as a community, need to find a balance …
- Community mobilization – what does that look like?

5. Closure …..

- participants are invited back for session #3: a discussion of how the community can mobilize around the issue of FGC.

Resources:

Flipchart paper and markers and/or handouts of quotes from focus groups

Community Education / Engagement Session 3

Objectives:

- Participants will become aware of the comments generated during the community based research focus groups.
- Participants will be encouraged to consider cultural change around the issue of FGC.
- Participants will create a plan for providing information to other community members with the objective of ending the practice of FGC.
- Participants will become aware of SERC as a community resource.

- **** Printed focus group (community based research) comments will be posted around the room.***

Key Messages:

1. The Eritrean community can play a role in addressing the issues around female circumcision (FGC) and the need for cultural change.
2. It is important to break down the taboos regarding this issue. This can be accomplished through communication across the generations and across genders.

Outline:

Food served 12:00 - 12:30 pm

1. ***Start at 12:30*** Welcome (Simret & Heba - 5 mins.)
   Reminder: Ask those participants who speak Arabic to sit together so that Heba can interpret a summary of what is being said.

2. Ground Rules – reminder (Simret - 2 mins.)

3. Icebreaker discussion (Samson) [12:45 – 1pm]
   - Table groups will choose a recorder. Facilitators will distribute discussion questions to the groups. Each group will have a 5 minute discussion about their question. Each recorder will then report 2 key discussion points to the large group.

4. Presentation of focus group findings … [1:00 – 2:15 pm]
   [15 mins for each group/ 15 mins discussion]
   - The objectives of sharing the focus group comments is 1) to show the diversity that exists in the community 2) attitudes/beliefs about FGC are changing 3) address the gap between young men and young women … *How will this affect the community in the future?*
   - Simret, Heba, Samson & Tnsiew will present comments from community members who participated in each focus group.

5. Culture and change (Tnsiew) [2:15 – 2:45]

[15 mins.]

- presentation information about culture – Iceberg analogy
- Model of Change – describe the process
- Community change: acknowledge the challenges as well as the positive aspects associated with change

[15 mins.]

- mobilizing the community around issue of FGC – What ideas do people have for changing the beliefs about female circumcision?
- *create an action plan* for disseminating information etc. with the objective of ending FGC (?)

6. Evaluations / Closure …. [2:45 – 3 pm]

Resources:
Model of Change – handout and poster
Poster of Iceberg of culture

Types of FGC (with the tree)
Health consequences of FGC