Our Selves Our Daughters

Community Engagement and Consultations Report

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CANADIAN WOMEN'S FOUNDATION

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Introduction

In 2008, a member of an African newcomer community in Winnipeg, a nurse, approached the Sexuality Education Resource Centre (SERC) about the need to address women's health concerns in her community. She asked if SERC would be interested in working in partnership to provide supports to women. Her strong desire to provide health information and assistance to women in her community was the main driver behind the development of *Our Selves Our Daughters.* As a nurse in her home country and another African country, she worked on health and information campaigns that addressed female genital cutting (FGC). She found that this traditional cultural practice could lead to many health problems and that women needed information and supports. She also identified a need to address prevention in the next generation of daughters

SERC was extremely interested in working with her on this issue. We began co-planning with a goal to provide women from her community accurate and useful information that would support improved health outcomes for themselves and their daughters and that would facilitate greater integration into Canadian society. We also planned to build cultural and professional competence in health care providers through training, with the aim of improving health care services to women who have experienced FGC. After initial consultations with community members, we realized that it was very important to adopt a community engagement model, one that would help build support, trust, and relationships between SERC and the community. This would enhance the education component and aid in our ultimate goal of supporting women.

Background

Female Genital Cutting (FGC)[1] is a practice deeply rooted in many cultures in Africa and the Middle East. Yet, there are other countries outside those regions or countries where the practice of FCG is current, such as Indonesia. Many ethnic groups practice FGC across 28 countries in Africa and the Middle East. Regions in these areas are regular sources of immigrants and refugees to Canada. Between 2005 and 2007, between 16% to 19% of Manitoba's immigrants and refugees came from Africa and the Middle East, many from FGC practising countries.[2]

[1] The term **female genital mutilation** gained growing support in the late 1970s to reinforce the view that it is a violation of human rights and to promote efforts to end the practice. The term, however, can be problematic when trying to change a cultural belief. Parents understandably resent the suggestion that they are "mutilating" their daughters. As a result, the term "cutting" has increasingly come to be used to avoid alienating communities.

[2] These represent a total number of 1570 immigrants and refugees in 2005, 1926 in 2006 and 1766 in 2007.

The World Health Organization (WHO 1999) describes FGC as all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons. Approximately 100 to 140 million women and girls worldwide have already undergone this procedure, and each year 3 million girls are at risk of FGC in the African continent alone (Population Reference Bureau 2008). The procedure is generally performed on girls under the age of 15 years, with nearly half of women who have experienced FGC living in the Horn of Africa (Egypt, Northern Sudan, Eritrea and Ethiopia). Several of the source countries for Manitoba's refugees, such as Ethiopia, Eritrea, Egypt, Sudan and Somalia, are countries with a relatively high prevalence of FGC. WHO estimates a prevalence of between 75 and 98 percent (WHO 2009). Although information on the extent of the practice in Western countries remains under researched, it is believed that FGC is also practised among immigrant communities throughout the world (WHO 2006).

FGC has been practised for centuries in parts of Africa and has more recently been adopted throughout other parts in the world. The reasons for the practice of FGC are multiple. They are associated with cultural norms around the socialization of girls into acceptable womanhood (Toubia 1995). This is related to young girls' eligibility for marriage, which ensures economic and social security for families. FGC is often perceived as a means of protecting the virginity and honor of girls, and ensuring fidelity among married women by mitigating the girls' sexual desires. In some societies, the practice is a means for "purifying" and "cleansing" girls (Davis *et al* 1999, Greiner 2007). In addition to these reasons, Zerai found that circumcision was believed to keep women healthy (i.e., fertile) or more esthetically pleasing (Zerai 2003).

Although the specific procedures vary according to ethnicity or geographic region, according to WHO they can be grouped into four main types:

- Type I - excision of the prepuce, with or without excision of part or all of the clitoris;

  Type II - excision of the clitoris with partial or total excision of the labia minora
- Type III - excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation);
- Type IV - pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue;
- Types I and II are the most commonly practised forms of FGC.

Impact on Girls' and Women's Health

There is a growing awareness that FGM/C poses immediate, short term and life-long health risks to girls and women (Dirie, 2005; WHO, 2006). The most common immediate health risk is the severe pain, heavy bleeding, infections, and trauma, as the operation may be performed without anesthesia in some situations (Dirie, 2005; WHO, 2006). Some long-term health risks are abscesses, and painful cysts which can interfere with childbirth, infertility, urine retention, and retention of menstrual blood in the vagina

(Dirie, 2005; WHO, 2006). Repeated deinfibulation (reopening the vaginal orifice after it has been stitched) to allow for delivery and reinfibulation (reducing the vaginal opening after deinfibulation) have serious health consequences (Dirie, 2005; WHO, 2006). Believed to be the first large-scale study of its kind, direct observation of more than 28,000 women in six African countries clearly showed that FGM/C is associated with several obstetric complications (WHO, 2006). In Canada, a high Caesarean section rate was identified as the number one health concern among affected women (Health Canada, 2000). A wide range of psychological problems, such as depression and phobias, are also associated with FGM/C (Health Canada, 2000).

Although difficult to assess, psychological and psychosomatic disorders have been attributed to the practice. Among these disorders can be found: changes in sleeping (sleeplessness and nightmares) and eating habits (loss of appetite, weight gain), mood disorders, symptoms of impaired cognition, and panic attacks (WHO 2006). Toubia assesses that "The psychological sequelae of female circumcision among immigrants differ from those where the practice is prevalent. Circumcised women living in societies where the procedure is not performed may have serious problems in developing their sexual identity." (1995: 6).

In addition, it is believed that FGC has important negative personal and social implications such as absenteeism, low academic performance, and loss of interest (WHO 2006). The relatively few studies on men within the context of FGM/C point out several male complications, such as, psychological problems, infections on the penis, and difficulties with penetration (Almroth et al., 2001; Magied & Musa, 2004).

Towards the Prevention of FGC

Whatever the reasons for performing FGC, the practice is an experience that involves the community as a whole. As such, prevention should involve collective approaches. Emphasis on changes at the level of the individual (or family) are deemed not to be as effective when dealing with a socially and culturally entrenched practice. Many approaches to changing the practice have been criticized for being largely based on Western ideas of legal, human rights, and feminist stands. This has lead to strong emotional debates on the matter. There is a need to reconcile a respect for cultural differences with human rights approaches.

Many programs have been developed to eradicate or mitigate the practice. In more than 20 African countries, the Inter-African Committee on Traditional Practices (IAC) with the collaboration of local non-governmental organizations (NGOs) has launched an extensive educational campaign aimed at eliminating FGC. Women in Egypt and Sudan recommended education as the best means to end this practice. Various African NGOs are involved in research and eradication campaigns. Education about the harmful effects of FGM and its illegality is provided to African immigrants in Australia, Canada, France, Holland, Norway, Sweden, the United Kingdom, and the United States (Reymond, Mouhamood and Ali, ND).

Research indicates that in order to eradicate the practice there is a need to understand the role of FGC in the different societies and develop alternative approaches oriented to fulfill the symbolic needs of the practice through other means. This suggests that there is a need to understand the reasons why people would continue the practice after having migrated to countries in the Western world. The research in this area is rather limited. A publication on attitude changes regarding FGC among Eritreans and Ethiopians in Sweden indicated that girls were at low risk of undergoing FGC due to changes in perspectives due to integration into the new society (Johnsdotter *et al.,* 2009). However, other reports, even in the same country and among different cultural groups, indicate that the practice continues (Ahlberg, et al., 2004). A recent study in London echoes these complex, and seemingly contradictory, findings (Norman *et al.*, 2009).

In order to fill in the information gap corresponding to prevention approaches in the West, we conducted a series of consultations through email or by phone with community agencies across the country that we found had dealt with FGC (i.e., Women's Health In Women's Hands in Toronto) or may be dealing with the issue (e.g. Edmonton-based Multicultural Health Brokers Co-op). Through a SERC volunteer, we also obtained a list of potential contacts through Toronto Public Health. We also conducted an Internet search on FGC in Canada to identify information and potential contacts. We made an effort to contact individuals and organizations in Halifax, Ottawa, Montreal, Ottawa and Toronto. Other than raising interest among those contacted, we were not able to gather much information on issues, programs, or approaches on FGC across Canada at this point in time. Except for the specific collective work towards the change in legislation enacted in the mid-nineties, no other community-based work was found.

In the early 1990s, members of affected communities in Ontario requested that the Minister Responsible for Women's Issues establish an Ontario FGM Prevention Task Force. The Task Force was mandated to develop and recommend strategies and policies designed to support girls and women who have been subjected to FGC, to prevent the continuation of the practice, and to support community work by and for women affected by genital mutilation (Ontario Human Right Commission, 2000). Anchored in the community, this work appeared to be successful because one of the main proponents, Women's Health in Women's Hands (WHIWH) health centre, involved women affected by FGC on their staff and board of directors, supported the engagement of women affected by FGC in taking the leadership in any prevention efforts, and incorporated a holistic approach to health (Tharao and Cornwell, 2007).

Our search into programs and activities addressing FGC in the Western world rendered very limited results. Beyond Canada, we found that pioneer work in the West has been done by the Foundation for Women's Health, Research and Development (FORWARD) in the United Kingdom. This organization has been committed to eliminating harmful

gender-based discriminatory practices that violate the sexual and reproductive health and rights of girls and women, such as FGC. Since the early 1980s, FORWARD has been working to eliminate the practice and provide support to women affected by FGC. Among its main activities, FORWARD provides evidence-based information, training, and resources in relation to FGC for professionals, community workers and the general public. It also supports girls and women facing a personal crisis as a consequence of FGC and can provide information about accessing specialist health care and counseling. FORWARD works with FGC practising communities to support and promote the rights and health of African girls and women, encourages the abandonment of FGC, and carries out lobbying and campaigning initiatives in relation to FGC and violence against women. (www.forward.org.uk).

We also found some work conducted in Australia. Family Planning Queensland led an education project on FGC that addressed the community and service providers. At the community level, the project engaged a team of bilingual community educators, male and female, who received training to provide education in their own languages. In addition to face-to-face education, the project used community media to increase awareness. (www.fpq.com.au).

Although in a very different context, prevention programs or strategies that occur in countries with a high prevalence of FGC can also enlighten relevant approaches to use outside such contexts. In this regard, research shows that some of the more successful approaches were participatory in nature (i.e. community members helped design and guide the program), were based on discussions about the reasons people chose to abandon FGC, and how they had been able to retain their social status (i.e. Positive Deviance Approach). The majority of these approaches involved popular education (e.g. development of slogans on matchboxes, use of puppets, or diverse media such as participatory video, art exhibits, radio) (Greiner *et al.* 2007, Monkman, Miles and Easton 2007).

Legal and Human Rights stand on FGC in Canada

Changes to the legislation have become part of the prevention approach that many nations have taken in order to protect girl children from FGC.[3] Canada has ratified a number of international conventions (i.e., Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), United Nations Convention on the Rights of the Child (CRC), and the Beijing Platform for Action) that have declared FGM/C as a human rights violation (Tharao & Cornwell, 2007)[4]. Owing to intense lobbying efforts to

[3] The practice has been outlawed in many African countries, including Egypt, Eritrea, Burkina Faso, Cote d'Ivoire, Djibouti, Guinea, Senegal, Tanzania and Togo.

[4] CEDAW addresses FGM/C within the context of unequal gender relations, and the CRC makes particular reference to traditional practices, including FGM/C (UNICEF, 2005). CRC classifies FGM/C as a practice that "compromises the child's right to life, right to physical integrity, right to highest attainable standard of health, and the right to freedom from physical or mental violence, injury or abuse" (UNICEF, 2005). Both

conform to international conventions, Canada amended its laws and declared FGM/C illegal in 1997 (Ontario Human Rights Commission, 2000, Tharao & Cornwell, 2007). Legislation that pertains to FGM/C includes both criminal law, and child protection law (Leye et al., 2007). In Canada FGM/C is considered child assault and is prohibited under sections 267 (assault causing bodily harm) or 268 (assault including maiming, wounding and disfiguring) of the criminal code. A person may also be charged with criminal negligence causing bodily harm (section 221) or criminal negligence causing death (section 220). Children under the age of 18 or any other adult acting on the child's behalf cannot consent to have FGM/C done on the child (Health Canada, 2000). However, this provision does not apply to medical procedures done by qualified health care practitioners if they consider the physical health of the child to be at risk. The criminal code can be used to protect girls and prevent them from being sent overseas to FGM/C practising countries, where they might be *cut* during their stay. People who do anything to transport a Canadian resident under the age of 18, or anybody else who aids them for the purposes of aggravated assault or causing bodily harm can be charged under section 23, and section 273.3 respectively (Health Canada, 2000). We were not able to identify any legal cases regarding FGC in Canada.[5]

As a gender-related persecution, Canada has also granted refugee status on the grounds of threatened FGM/C. For example, in 1994 a Somali mother was granted refugee status when she sought asylum on the grounds that her ten-year-old girl would have to undergo FGM/C if they were forced to return to Somalia (Tharao & Cornwell, 2007).

Since the criminal code has classified FGM/C as a child abuse, protecting the child from the practice falls under the mandate of provincial legislation (Health Canada, 2000). Accordingly, FGM/C is covered under Manitoba's Child and Family Services Act. Section 1(1) of the act defines "abuse" as one that results in "physical injury to the child" or "emotional disability of a permanent nature in the child or is likely to result in such a disability" (Manitoba Child and Family Services Manual, 2009). The provincial legislation makes it mandatory for anyone to report FGM/C to child protection authorities, if they are aware an offence has been committed or a child is at risk of being cut (Health Canada, 2000). Child protection authorities can intervene to protect the at-risk child. (Health Canada, 2000). No child protection laws or guidelines exist in Canada or Manitoba which deal specifically with FGM/C, but several countries have guidelines or protocols that are applicable at a local level (Health Canada, 2000; Leye et al., 2007; Manitoba Child and Family Services Manual, 2009). The Office of the Children's Advocate in Manitoba has an interest in protecting the rights of children and youth if

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these human rights frameworks, considered as benchmarks in the fight against FGM/C, call upon countries to enact laws to protect women and children (UNICEF, 2005).

[5] In North America, there is a documented case in the State of Georgia, U.S., where in 2006 an Ethiopian immigrant was sentenced to 10 years in prison for cutting his daughter. Prior to this first conviction involving FGC, two people in California (2004) were charged with "conspiring" to commit an act of female genital cutting. (information retrieved from http://en.wikipedia.org/wiki/Khalid_Adem#cite_ref-0 with references to many news reports).

they are involved or should be involved in the child welfare system (Children's Advocate, 2007). However, for both child protection authorities and the Children's Advocate to respond, cases have to be reported. The knowledge and attitudes of professionals and community members and the totality of actions of public officials working across several distinct levels influence the reporting of cases, evidence gathering, protection of at-risk girls, and the enforcement of criminal and child protection laws (Leye et al., 2007).

Canada's legal response is similar to other industrialized countries, such as the United States, Finland, France, Germany, Greece, the Netherlands and Switzerland, where FGM/C is covered under existing criminal laws regarding abuse of minors or assault that causes bodily harm (Gruenbaum, 2001; UNICEF, 2005). Other typical legal responses are the introduction of specific legislation criminalizing the practice such as that found in Norway, Sweden and the United Kingdom, or the modification of existing legislation to make specific reference to FGM/C, such as legislation in Belgium, Denmark, Italy and Spain (UNICEF, 2005). However, in a cross-country analysis of legislation pertaining to FGM/C in Belgium, France, Spain, Sweden and the UK, no evidence was found to suggest that specific legislation criminalizing the practice was more successful in implementing these laws or punishing the perpetrators than general criminal laws (Leye et al., 2007).

Summary

- Female Genital Cutting (FGC) is a practice deeply rooted in many cultures in Africa and the Middle East.

- Although information on the extent of the practice in Western countries remains under-researched, it is believed that FGC is also practiced among immigrant communities throughout the world (WHO 2006).

- The World Health Organization (WHO 1999) describes FGC as all procedures that involve partial or total removal of the female external genitals and/or injury to the female genital organs for cultural or any other non-therapeutic reasons.

- The reasons for the practice of FGC are multiple (e.g., eligibility for marriage, protecting the virginity and honor of girls, and ensuring fidelity among married women, keeping women healthy or more esthetically pleasing).

- There is a growing awareness that FGM/C poses immediate, short term and life-long health risks to girls and women.

- Prevention (i.e., eradication or mitigation) of FGC should involve collective approaches.

- There is a need to reconcile a respect for cultural differences with human rights approaches.

- Many programs have been developed to eradicate or mitigate the practice (e.g., educational campaigns).

- Successful programs appeared to be based on community-based approaches (i.e., engagement of women affected by FGC in all or many aspects of the program or organization, or incorporation of the issues into other women's health programs).

- Changes to the legislation have become part of the prevention approach that many nations have taken in order to protect girl children from FGC. Canada amended its laws and declared FGM/C illegal in 1997.

Our Selves Our Daughters: The Project in Action

In collaboration with the community, a number of objectives were established at the outset of the project. Implementation began in April 2009 and will end July 2010. The first stage of the project involved a process of community consultation and engagement (May-November 2009) to be followed by a series of education sessions (October 2009 – July 2010). The objectives are as follows:

1) To conduct a community consultation process for the purposes of relationship-building, gathering input and support, and sensitizing the community to the idea of addressing *Female Genital Cutting* (FGC)
2) To provide a safe forum for women to express and explore their beliefs and values, feelings, and attitudes related to sexual and reproductive health and FGC
3) To discuss and raise awareness of the cultural, religious, social, and gender-based facilitators of FGC, the reasons why some community members may not choose the practice, negative impacts of FGC, and FGC within a Canadian/migration context
4) To allow women to identify resulting health impacts and get support, information and resources to help them improve their health
5) Facilitate informed decision making by mothers with the ultimate aim of preventing the further practice of FGC with daughters
6) To increase participants' knowledge of Canadian society and laws
7) To enable participants to serve as informal resources for other women in their community
8) To enhance the capacity of Winnipeg service providers (health and social services) to work more effectively with women who have undergone FGC
9) To assess if there is broader individual and/or community support for future initiatives

Our Selves Our Daughters involves a two-stage community-based process. The first part of the project consisted of a process of **community engagement** and series of **consultations with women and community leaders**. This step will be followed by a series of **educational workshops** for women. These workshops will be designed with the input from consultation participants and will also be informed by feedback from workshop participants. We expect to create a respectful, safe environment to address a wide range of women's health issues related to pregnancy, childbirth, and common women's health concerns. The workshops will also explore women's traditional/cultural health practices including FGC. We will provide information about common health problems and give participants information regarding the Canadian health care system, and services that can provide assistance, as well as discuss health issues as they relate to Canadian laws. Workshops will be discussion-based and draw from women's experience, culture and knowledge. The overall goal is to help women generate ideas

for maintaining their strong cultural beliefs while defining and embracing positive changes for themselves and their daughters.

Initially one **community meeting** was planned for the end of the series of workshops. At this meeting, we would share findings from the consultations and the implementation of the education program. Participants would be engaged to provide direction in future steps. As the project has unfolded, we have added one set of **additional community meetings,** near the end of the consultation phase, to verify the findings and gather feedback and input on overall project implementation. We will also host the planned community meeting at the end of the project. Women's recommendations will also be shared **with doctors, nurses and other care providers.** This is intended to improve women's access to culturally safe health care within the Canadian health system.

The current report focuses on the first stage of the project: the consultation and research process and outcomes. An evaluation of the education sessions will be conducted throughout the project delivery and reported in August 2010.

Project Methodology

We have followed a community-based approach throughout the life of the project. As already indicated, the original idea of the project came from a community member. She was concerned about women's health and also the potential of continuation of FGC among girls after migration. To enhance community involvement and input, and to ensure that the many sectors of the community were represented in the project (e.g. different associations, ethnic groups, religious groups, ages, genders), we engaged male and female leaders and community women to learn about women's health concerns. In addition, we were interested in assessing the reception and readiness of the community to addressing sexual and reproductive health issues and sexuality, including FGC, from an education standpoint.

Consultation Process

We developed a process that blended community-based research methods with a community development approach. We decided to conduct a series of interviews and focus groups/consultation groups, using a qualitative methodology to arrive at an increased understanding about the topics of the project. This approach allowed us to engage the community, build relationships and trust, and to reach a deeper understanding of community and women's perspectives. Based on the advice from our community consultants and community members in the research team, we approached the consultations from a health perspective. As the project unfolded, and our understanding increased, we moved from a traditional health perspective to inquiring about the broader socio-cultural aspects of FGC.

Consultation Groups. During the period of June to September 2009 we organized five groups of women ranging from 5 to 8 participants, with a total of 30 participants. We

tried to ensure that the diversity in the community was represented in the groups. We reached out to women from all major ethnic, cultural, religious groups. We also made an effort to reach out to younger and older women in the community. Many of the older women turned out to be leaders as well (some of whom we interviewed on an individual basis).

In order to reach out and engage women in the project, we spoke with many community leaders from various community-based organizations where women congregate. Each of the community leaders spoke with several women and obtained their consent to pass along their contact information to the Project Coordinator. Then the project coordinator contacted each individual woman to invite them to a focus group session. There were two exceptions to this situation. One of the community leaders organized a group of women himself and even brought the participants to the location where the focus group was being held. In organizing this group, this leader indicated that the demand to attend was large. Scheduling was an issue and he had to make the decision to invite only women who were able to attend at the specific time the group was being held. The other exception concerns one participant who was referred by SERC staff.

Women responded positively to the project. Although we were able to accommodate 30 women, many more would have liked to attend. Such a positive response was attributed to the level of trust people had in the community leaders and to their personal knowledge of the Project Coordinator. In some cases, the women already knew SERC or had heard of the work that SERC had been doing with their community.

Most of the groups were held in first language with one of the co-facilitators interpreting. A community member was also hired to take detailed notes of the meetings. She took notes in first language and then translated them into English.

The groups were held at the Sexuality Education Resource Centre during the day (afternoon) and in the evening. The groups lasted between 1.5 to 2 hours. Women received an honorarium of $20 to defray any expenses related to attending the group, as well as in appreciation for their insights on the matter. A copy of the interview schedule is appended.

Individual Consultations or Interviews. We also conducted interviews with individual community members, including community leaders and other key community members, women in particular. Community leaders were those in positions of authority and trust in different community and religious organizations. We also conducted an interview with a physician from the community who has extensive knowledge of the health issues related to the practice of FGC. Interviews were largely conducted in English; interpretation was provided as necessary. (

To identify whom to interview, the Project Coordinator and one of the project consultants identified a number of key community leaders who were affiliated with the major social, religious, political, and ethnic groups in the community. Initially, 7 community organizations/leaders were identified (including an organized group of health care providers). Six leaders from different key community organizations were contacted. Five of these were consulted on an individual basis. A sixth representative of a faith-based organization was contacted with no reply. These leaders were all male. We also asked these leaders and other interviewees to identify other community members who should be invited to this consultation process. These interviews were held at locations that were convenient for the participants - at SERC or in the community.

The women leaders who were interviewed were approached because of their strong participation in organizing community activities as well as their potential insights into both the issues of the project and the dynamics of the community. Three women leaders were interviewed. One of the women had been engaged with SERC's work for some time. Another was approached by the project staff as a result of information about her active role in the community through another community agency. The third woman represents a different religious background and is affiliated with another community group not represented by the community leaders. In addition, one of the male leaders linked SERC to a community-based women's group. A former leader for this women's group participated in an interview.

We also conducted follow-up one-on-one interviews with three of the women who attended the group sessions. After the sessions, we assessed that a few of the participants were ready to provide a more in-depth understanding of the issues addressed during the group sessions. As well, these women were approached because they represented different points of views on the topic of FGC.

Researchers' Observations and Debrief. Interviewers kept notes of their encounters with individuals and groups. These notes reflected any salient issues, anticipated and unanticipated outcomes from the meetings, areas for further exploration, and their own views on the experience of learning from the community. Sometimes these notes were taken during debrief meetings with the rest of the project team.

Feedback Sessions with Community Members. Two additional group sessions or Community Meetings were conducted to verify and expand on the findings of the initial consultations. One session was designed to engage the women who participated in the consultation. Using a participatory process, with interpretation, SERC presented the main findings of the study and obtained confirmation on these, as well as further information on related topics. The women were also asked for their opinions on a few key points raised by one community leader primarily because these points were inconsistent with the overall findings of the consultation. (Session Process and Outline attached).

Community leaders were invited to attend a separate meeting. Most of the leaders we had consulted in person invited other leaders to the meeting. Eleven community leaders attended the session. There were seven men and four women in attendance. At the meeting, the project team presented the objectives, consultation process, and the main findings from the consultations. The findings were presented by the Project Coordinator in first language. This was followed by discussion about the information provided. Additional questions about the process and dissemination of the report and information stemming from the project were also discussed. The agenda of the meeting is appended. Copies of the draft of the report were provided to the participants of this meeting for further feedback. Three people replied by email.

Relevant data from the sessions and written feedback were also considered for analysis and included in this report.

Ethical issues

Upon request from some members of the community, including a few women, we decided not to identify the specific ethno-cultural/national group in this report, nor in our public discussions of this project. This project involves working with a relatively small community in Winnipeg that receives new arrivals. Information on community practices and worldviews could be easily misinterpreted and used inappropriately. Some participants felt the focus on practices such as FGC could further stigmatize the community. In order to protect the group's identity, many culturally specific issues and practices were also concealed in the report. However, it is worth mentioning that some other participants, women and leaders, were supportive of having the name of the community included in the report. They felt proud that a member of their community and their community, as a whole, was spearheading work on such a sensitive topic.

Participants in the consultation process were thoroughly briefed on the purpose of the project, the nature of their participation, and the management of the information. We assured the women that their participation was voluntary, the information was to be treated confidentially, and the raw data from the consultations was to be accessible to the members of the project team only. The information would be used to develop education sessions and shared with others without mentioning the name of the community or other identifying information. They signed an informed consent form written and explained verbally to them in first language. The consent form is appended.

The Participants

A total of thirty (N=30) women, five (5) male leaders, three (3) individual women and four (4) female community leaders participated in this consultation process. Community leaders represented community and faith-based organizations. These organizations perform different religious and social functions in the community. A major common characteristic is their role in facilitating the sponsorship and settlement of refugees.

Among the women attending the groups, about two thirds (N=19) had been in the country for 2 or less than 2 years (average of 14 months), ranging from 3 to 24 months. The rest of the participants (N=11) had been in Canada from 3 to 20 years with an average of 7.2 years. Most of the women had between 1 to 7 children, some born in Canada. They had children whose ages ranged from under a year to adult. However, most women had young children and a couple of them were pregnant. Most of the participants appeared to live in inner-city or downtown Winnipeg. The women represented the many ethnic groups found within the national community.

Findings

Insights into the Community

We engaged with a very diverse community made up largely of people **displaced by war**. Community members belonged to different ethnic groups. Many of them had lived in refugee camps and moved to Canada as **refugees**. Participants spoke of the impact of migration - in some cases with reference to the different moments throughout the migratory trajectory. Such experiences continue to bring them together to support people still in refugee camps or countries other than their home country who are trying to leave and find a safe place to live. The community counts on a number of organized activities that bring people together. It appears that there is a **high degree of community mobilization and organization**. For instance, most of the representatives from community organizations were in the process of organizing the sponsorship of refugees abroad. In spite of the number and diversity of groups, it appears that they are highly linked to each other.

The impact of migration was illustrated in many ways. Participants spoke of clear **cultural changes** they were experiencing, and the struggles faced in negotiating **cultural differences** and/or in trying to fulfill their **basic needs**. Some felt that this was related to the "overload" of information that they faced upon arrival to Canada. According to them, these challenges would lead to "confusion" about how to integrate successfully into Canadian society, including how to gain access to services and navigate the different systems. Not surprisingly, they indicated that fulfilling their basic needs, such as employment and housing, took precedence over their "health needs". This strong drive to gain employment as the foundation to a strong community was explained by their strong cultural belief in "**self-reliance**". One of the participants spoke at length about the sociopolitical context that supports this idea.

We also learned that the migratory trajectory had a **differential impact on women and men**. Many women find themselves leading their families as single mothers; others have to deal with the changes to gender roles supported by the new society. Men have their share of issues. Some felt they experienced hardship as result of moving into refugee camps; they were made to feel like "2nd class citizens". Now in Canada, men are still struggling. The new society often challenges their way of thinking and acting. When speaking about family relationships one participant said, "Men need to unlearn what they've learned."

Although on one hand this community appears to be highly cohesive and has access to resources that support mutual aid, community members – many of whom are fairly new to the country – are struggling with the process of adaptation.

Health and Well-being Issues and Concerns

We approached the main topics of this project (sexual health, sexuality and FGC) through a health lens. This was believed to be a safe way to approach more sensitive issues such as sexuality and sexual health. Therefore, we asked participants to relate their experiences with health and access to health care and later focused on specific experiences related to their sexual and reproductive health and FGC.

Many of the participants commented on the need for a **holistic approach** to health where the physical and mental aspects of health are fully considered. Not surprisingly, many of the **physical health** issues explored were related to perinatal and sexual health. Most of the participants were women in their reproductive years. Yet, many of the examples regarding access to care in Canada broadened that concern to other health issues (e.g., dental, respiratory, coronary, diabetes). Some women explored general aspects of health resulting from day to day activities. Many felt women were ill because of the heavy burden of having to work long hours at home in addition to working outside the home. Some said that women do not take care of themselves by not getting enough rest. This situation was explained within the cultural context of the gender-based division of labour within the home, where most men "don't help with the children, with cooking (…). The men come after work and usually get relaxed at home. I don't know how to fix this." Some women believed that women tend to become ill more often than men.

Many participants were quick to highlight that the **emotional well-being** of women had to be taken into consideration. In some cases, emotional or mental health issues were attributed to mothers' concerns over their children. In all, it was believed that women's worries affect their overall health. Women also mentioned mental health issues stemming from the refugee experience. Such experiences, women would point out, could lead to "stress" and "depression".

During the focus groups, we explored issues regarding **access to health care**. Participants had had a wide range of experiences accessing the Canadian health care system. They spoke of many encounters with the system, with most of the women having requested services at local hospital Emergency Rooms. This appeared to result from a lack of knowledge about where to go for different types of needs, as well as to the lack of (access to) family doctors. Most of the women spoke about their interaction with the system around perinatal issues, mostly labour and delivery, and issues related to their children's health. Overall, women's health related experiences with health care ranged over a continuum from positive to negative experiences.

Women indicated that they often do not raise reproductive health concerns with their health care providers. Some rely on the advice of close friends or qualified health care providers within the community (e.g., nurses) outside the clinical setting. One of the participants referred to "uterus' issues".

> "You could talk with your best friends, if you feel they could be confidential. If you have the health knowledge, you can take care of yourself and your health, because it is personal. Even when going to doctors, you don't tell everything."

However, many must interact with the health care system in particular around pregnancy, labour and delivery. One participant recalled her experience in these words: "after two nurses gave me medication for induced labour, they left (…) I was left alone. When I called for help, there was none. Then, I was frightened and got depressed."

Some of the experiences related to the **lack of competence** (cultural and otherwise) in dealing with women's or family needs. Some women felt that service providers did not stop to consider their reality. For example, one woman recalled being told during a visit to an emergency room that she should have thought of getting a babysitter prior to coming for services. Women were also surprised at the long waits they had to experience in the system overall. In addition, it was mentioned that service providers are not asking the right questions. For instance, one participant indicated that people may be taking over the counter or "familiar" or herbal medications and not realizing that they need to tell medical personnel about this.

Language barriers when accessing health services was another major topic brought up by the women. One participant indicated that she felt as if health care providers would not provide all the necessary information due to lack of understanding. In her words, "I do not communicate in English that much, and the health professionals do not force you to do something when they know that you do not understand them fully." For other women, the issue was the overall lack of information they received from doctors about their health conditions. This issue wasn't necessarily attributed to language barriers, but to provider-patient communication in the broader sense. Providers should be making an effort to communicate all the information necessary and patients should be able to ask all necessary questions.

A l**imited understanding of the way the health care system operates** was also illustrated in many instances. For instance, one participant indicated confusion when given contradictory information about breastfeeding by two separate providers. As great weight is given to the medical establishment, she was expecting consistency from providers at all levels. Another area of confusion was around the different protocols professionals seemed to follow compared to medical procedures back home. Women explained that back home doctors would immediately treat the symptoms and then seek to explain the problem, while here, doctors seemed to investigate the problem prior to providing medication. This latter practice leaves women suffering in pain until they can be seen by a physician. It also appeared that people would only access services when in pain or ill. Some women advocated for a change, for education that promotes regular "check-ups".

Participants showed a **great deal of agency** when engaging with the medical system. They provided examples of when they voiced their needs and concerns. Yet, in most cases they felt dismissed. A few examples illustrated better outcomes after advocating for their own needs. One poignant example of such agency was provided by a participant who, desperate to communicate to a physician who did not seem to understand her, pinched him on his hand in order to demonstrate the level of pain she was experiencing.

It is noteworthy that we found that many women tried to interpret their negative or non-fulfilling experiences by assuming that there were some sort of understandable issues in the system. For instance, it was common to hear women say "maybe, there was one nurse for too many people at that time." On the other hand, they also had some **recommendations** they felt would improve services. One participant said: "medical professionals should give more time to listen and give good information and medication to patients."

Sexuality and Sexual Health

Participants spoke about a number of issues concerning sexuality and sexual health at the individual, interpersonal, family, and community level. In this section, we describe participants' concerns at all these levels.

Intergenerational Issues

Women were concerned about regular **intergenerational conflicts** that affect a balanced family and community life. Many participants were concerned about "discipline". One of the participants explained, "parents have to know how to control their children and how to tell their children how to prevent illness and to avoid drug dealing activities". They believed that some of these potential negative outcomes were directly related to their status as newcomers within a new society. Their varying perspectives included examples of children controlling parents, of how strict parental rules may also contribute to miscommunication and family conflicts, and even how that can translate into children being taken into care by Child and Family Services.

The roots of many family conflicts pertained to differing realities and expectations around sexuality such as dating. Although most participants focused on parent-child relationships (likely because, after migration, many of the families are reduced to a nuclear family configuration), one participant indicated that sexuality education and communication within their culture would usually lie with aunts and uncles rather than parents.

Concerns about Youth

While it is clear that parent-children issues affect the families as a whole, some participants explained and illustrated specific **issues youth face**. They spoke about unplanned pregnancy in adolescents and youth, and early sexual initiation (i.e., intercourse) resulting from exposure to new cultural norms and expectations. In some

cases they went on to mention how the development of intimate relationships (undesirable by parents and community) have led to situations where community youth leave their homes, get involved in drug consumption and dealing and other illegal and criminal activities, and even fall sick.

Intimate Relationships

Beyond intergenerational issues, some participants talked about **intimate relationships** with their partners. They explained that, in general, there is **no open communication about sex** between partners/husbands and wives. It is understood that a **women's duty is to satisfy** her husband's desire for sexual intercourse. Women are believed to be "rude" or "not-respectable" if they voice their interest or desire to have sex. Some participants indicated that communication around sexuality is changing somewhat among younger men and women.

Some participants spoke about **how husbands** would **relate** to and address their wives. There were comparisons to men from other cultural backgrounds. They described men from their culture as "harsh". As one participant put it: "the language of [community group] men is harsh. They don't show love for a wife in words."

Sexual Health

As with most other communities, sexuality and sexual health are not topics of current conversation within this community. Some of the women pointed out that some information is passed on or learned when women get married. They believe that knowledge about sexual health is important. Many concerns were raised in regards to this issue. Women spoke about **perinatal care**, **sexually transmitted infections** (STIs), **HIV**, **hepatitis C** and **cervical cancer**. Cancer prevention and access to pap tests are also important topics for some of the women. They also brought up the need to have access to basic information on the **reproductive system** and anatomy, "because [women] don't know about their body, prevention of illness."

With regards to **STIs** and **HIV**, some felt that testing should be more readily available, and that women should know of the "health status" of their husbands. Some of them drew upon examples of women who unknowingly became infected with HIV by their husbands. (Some of these examples referred to experiences back in their home country.) They also strongly advocated for education on modes of transmission and ways to prevent STIs. This issue relates to the discussion about intimate relationships. Women expressed a need to know from husbands or doctors if they (husbands) had an STI, as some of these infections don't show symptoms until much later. One of the groups discussed the limitations women have in discussing with their husbands the regular use of condoms. One of the women made the point that "we don't talk to each other about these things." Women attending the feedback session further reflected upon this issue. They indicated that the request to use condoms within an established relationship meant "distrust" between partners and a loss of credibility in the marriage.

Female Genital Cutting

Initially, we were not sure of the extent to which women would share their experiences and views on FGC. Because this topic is not commonly or at least openly discussed, women may not have been ready to reflect on or articulate their views with others. Adding to this was the fact that these group consultations brought together a diverse group of women; some who already knew each other, some who were strangers. In this setting, women might not feel comfortable enough in a first meeting to reveal much information on this very culturally and personally rooted issue. We found, however, that many women were able to feel comfortable enough to share a number of relevant perspectives and stories related to this cultural practice.

While in many societies FGC is practiced as a rite of passage into womanhood, this is not the case for the community engaged in this project. **FGC is practised very early in girls' lives without celebration**. It appears that for this community this practice is a custom around which not much open and in-depth discussion occurs, even if parents of girls or others do not agree about the continuation of the practice. There would be an expectation around the continuation of this tradition with grandmothers (and sometimes other key family members) inquiring as to when their granddaughters would be circumcised. FGC is a practice left to women to arrange, perform, and deal with any outcomes (e.g. healing , complications). Women indicated that there was not much conversation about FGC with their husbands or other men for that matter. However, it was also apparent that this could be changing among younger generations. A few participants pointed out that they have talked about their experiences and views on FGC with cousins, and have read or heard about the issue as result of changes in legislation in countries where they lived prior to coming to Canada.

Overall, the women in the consultation groups were divided with regards to the continuation or discontinuation of the practice. Some women had strong opinions one way or the other; other women appeared to be conflicted around the issue.

Beliefs Regarding the Continuation of Practice

It appears that participants coming from different ethnic and religious backgrounds had different beliefs about the practice of FGC. Some of the women indicated that this is a **cultural practice** and as such should continue. There was also a generational distinction with **older women** being more inclined to support the continuation of the practice. On the other hand, it was more common to find younger women asserting that this tradition should be stopped. Many participants explained that one of the main beliefs behind circumcision or FGC is that by removing parts of girls' external genital organs, **sexual desire** is **minimized**. This permits a female who has reached puberty and adolescence to protect her virginity, and therefore her honor, with greater ease. It was also mentioned that historically, in many pastoralist groups, girls would have to look after the herd alone, leaving them exposed to the danger of being sexually assaulted

and even having unwanted children. The practice of FGC was believed to minimize such risk and also ensure **virginity**.

Other explanations concerned the belief that the practice would act as a way of "**cleansing**" the body. This would make girls and women "pure". In this case, it was explained, a woman would not touch herself because there would not be any physical urge to do so, and therefore she would remain "clean".

It is not surprising that many explanations existed in this community about the reasons why the practice continues or should continue. There were many intra-group differences because people came from different ethnic backgrounds where FGC takes many different forms, from "sunna" and "clitoridectomy" to "infibulation".

Reasons Supporting the Discontinuation of the Practice

Participants indicated that their mothers and grandmothers have supported the practice, and that they did so with the best interests of their daughters in mind. Yet, many of them had a different perspective than that of the previous generations. Some participants wondered how FGC **affected women's sexual pleasure**. To make the point that changes in genitalia would not curb women's sexual desire, one of the participants mentioned that sexual desire was dictated by the mind. FGC would have little impact on changing that aspect of women's sexuality. Yet, most believed that FGC had an impact on women's sexual experiences. One woman explained that women may feel like having sex; however, during a sexual encounter, she would not enjoy her experience because of FGC. One of the participants explained that "nobody should play with the body (…) all body parts are vital."

Another participant further analyzed the expectations that women have as result of living in a **new culture**. She mentioned that the **media** is playing a role in educating women of younger generations in Canada/North America. For instance, TV programs seemed to have reshaped women's needs and expectations regarding intimate relationships, including the role of sexual desire in their lives. Some of them referred to an episode of Oprah that addressed FGC.

Some participants believed that the **length of stay in Canada** would deter the practice. Some women believed that over time FGC would become irrelevant to the needs of the community (e.g., no need to have it done to ensure marriageability). In addition, changes in people's attitudes and in the practice, itself, were also attributed to an increased **level of education** in the community.

Although to a lesser extent, some women spoke of the **health effects** of the practice around labour and delivery. As one of the participants described to us:

> "having circumcision for females is wrong and creates problems; for example, when you give birth, it prolongs delivery and could lead to unnecessary bleeding, and could even cause death. So, it affects health."

While we found that opinions may have changed for some women prior to coming to Canada as result of anti-FGC campaigns abroad, the discontinuation of the practice may not be easy. One participant illustrated this point by telling the story of a relative back in her home country who decided to prevent the practice with his child, while the grandmother's position prevailed by arranging the practice herself without the knowledge and consent of the child's parents.

Legal Implications of the Practice in Canada

Most participants knew that FGC was **illegal in their home country**, and some knew that that was also the case in other countries in Africa, including countries where they have lived prior to coming to Canada. Yet, many believed that such rules were not effective in stopping the practice. One participant stated: "rule cannot stop it, talk cannot stop it." Now, FGC has become an increasingly hidden practice.

Many participants believed that most newcomers didn't know that the practice was **illegal in Canada**. During the consultations, everybody learned that this was the case. Some participants believed that in spite of the existence of a legal framework protecting children from FGC in Canada, there was some evidence that the **practice continued**.

Educating on Women's Health Issues

All participants agreed that **education on women's health issues was necessary**. Their health and wellness needs pointed to a comprehensive and holistic approach to dealing with women's health issues (including the emotional/mental and physical aspects). There was an overwhelming support to the overall project, with many participants commending the project coordinator for her vision and leadership. Most leaders, including two leaders with previous experience in working with SERC programming, also agreed on the need for the project and trusted SERC would be able to carry out the work in a responsive manner. There was a great deal of support to focus on women's health concerns at this point, with strong interest in expanding education to other sectors of the community such as youth and men.

Basic information on **anatomy** and, in particular, regarding the **reproductive system** as well as regarding child development (i.e., "body changes") was recommended. As most of the participants were in their reproductive years, **contraception** was another topic of interest. They also indicated interest in learning about this topic for their children's benefit. In the words of one participant: "My children are growing and I want to know more about [contraceptive methods] in order to help them effectively." Women also indicated wanting to learn more about **STIs** and **cervical cancer.**

As already indicated, some believed that providing information on how **FGC** affects women's health, in particular around pregnancy, labour and delivery, might contribute to the prevention of the practice. Yet, we learned that by and large women believed that their reproductive and sexual health concerns were not attributed or related to FGC. As FGC is widespread in the community and women may face similar health related issues, these can be more easily attributed to being a woman than to resulting from FGC. Women felt that with proper access to health care, women would be able to talk about FGC and address health related complaints. One of them said that back home women would not "complain" about negative health impacts due to FGC because it was just part of being a woman. Lack of access to health care was also an issue.

Some of the women clearly articulated the fact that addressing **FGC** was important to women's lives in Canada. One of them said "we can talk about this in Canada. It is our right. We need women's sessions so we can speak about it."

Some women were educated on FGC back home as part of the large prevention campaigns launched by the local government. Apparently, they learned about the reasons for keeping or disrupting the practice. One of the participants indicated that since the issue has become public back home, "it may be good to talk about it (…) in detail." However, not all participants appeared to know about these activities back home. Many came to Canada through other countries, having left their home country many years ago.

Overall, participants felt the need "to know more about [FGC]." One participant said: "In our culture, it is important. But here, it is good and bad. What are the effects? We need to know the effects on our children. Do we need to circumcise here? We don't know how it is seen in Canada." Interestingly, women also raised a number of questions and concerns about male circumcision.

Approaches to Education

There was support for a **participatory**, community-based approach to education. Women in the feedback session were concerned with building capacity in the community. Everyone advocated for having a **community person** as a leader in the implementation of such an education process. Women also supported having a co-facilitator to present information in English and present information on the local and Canadian cultural context.

Women preferred a **women only space** to be able to learn about sexual health issues in-depth. As one of the participants said: "it is good if they are only women. Women to women to talk openly." Some of them believed that this would help them get close to each other for support when needed. "Women can get together and discuss with each other and get close. When the opportunity comes up…it is a woman-to-woman issue. We can organize ourselves," said one of the participants. This opportunity for helping each other was extended to the need to protect their children. Women felt that new

learning on sexuality and sexual health would help educate their children. As one of the participants expressed: “then, you can educate and protect your children. The woman educates the children if we learn things properly (…). Education is very important.”
In addition, women spoke of the need to conduct the group sessions in a way that seemed familiar and fostered friendliness. A non-judgmental approach to their cultural and health practices was paramount to the participants.

Although most of the consultations were carried out through interpretation, many participants favored having information in **English** to **enhance their language skills**. Some of the participants would appreciate health related **vocabulary** and even practice writing in English. Some of them also emphasized the fact that many housebound women don’t have as much opportunity to improve their English. One participant explained: “it is a good opportunity to learn English as well. Since most of the women stay at home and they don’t know what is happening…”

Whatever the language(s) the information is related in, it was clear that participants advocated for education approaches that address a wide range of literacy levels and learning styles.

Practical Aspects to Education Delivery
All participants believed that education sessions were important. To accommodate their needs, questions about availability for a series of up to 10 sessions, time, location, and supports to facilitate access were discussed.

We asked participants to name the best location where education sessions should occur. In some cases, we prompted them with different options that we believed would be accessible or that other women had mentioned to us. Women preferred an accessible central location for the education sessions. They suggested a few potential places, with a strong preference for conducting the sessions at SERC’s facilities. Other options, in order of support, were the Immigrant and Refugee Community Organization (IRCOM), and lastly, one of the community organizations. The main reasons to support the different locations were: access to bus routes, proximity to their homes, access to women from all ethnic and religious backgrounds, a neutral space (i.e., SERC), proximity to their homes (i.e., IRCOM), and lastly a sense of familiarity (i.e., community organization).

Women preferred weekly sessions to be held on Saturday mornings or afternoons for a period of up to 3 hours. Some consultations were also held during the weekday, later in the week, and this appeared to be a possibility for some women, although one woman stated that having the group at the time when children came home (i.e. 3:30) was difficult for one of the participants.

Women spoke about the need to consider support for babysitting to ensure attendance. One woman mentioned that on-site babysitting for those with infants and small children

would be helpful. To enhance the learning environment, women felt that food was important with some expectations around this being "culturally appropriate". Some of the women indicated that the availability and choices of food or refreshments was secondary to the access to education. However, if food was to be provided it should be easy to handle to be able to consume as people participated in the education sessions.

Findings and Feedback from Community Leaders

In individual consultations with community leaders, and in the community meeting for feedback on the report and project, much useful information was shared. Our primary emphasis in this report has been on **women's direct sharing** in the consultations. However, in this section, we will provide an overview of key findings from our meetings with **leaders** – where much useful advice and insights were shared. In some cases, where SERC was prompted to change or adapt program direction, or address concerns, it is noted below.

All fourteen community leaders consulted were **strongly supportive** of the project, its intent and purpose. Most of what they shared was very consistent with what community women shared in the consultations, and also with SERC's approach to sexual health education with newcomer refugee women.

Community Engagement and Ongoing Communication
Based on one leader's initial comments, the design of the project was modified to include a stronger emphasis on **community engagement** for purposes of trust building and sensitization to the issue of FGC. As the consultations unfolded, all expressed support for widespread community consultations, and a number of leaders strongly supported the plan to speak directly to women. As one stated, "it has to come from the women…it's important to know how women see themselves." A number of leaders actively raised awareness and assisted in organizing consultation groups.

One leader suggested, and a few were interested in the idea of broadening the consultations to other communities, in part to help avoid possible stigmatization of this community. This fell beyond the scope of this project, but will be considered in future planning.

Leaders, through actions or words, have also indicated the desire to have **ongoing communications** with the project as it unfolds. The project is committed to maintaining communication through written updates and meetings.

Need for the Project
There was strong **support** for this project and its focus on **womens' health** and **FGC.** One leader stated that when newcomers have their orientation, they need one specifically on FGC. Another stated that women's roles are changing in the community. More women are getting an education and some, in the process of political struggles,

have experienced more gender parity. This leader felt this was an opportune time to carry out such a project to address FGC. At least a couple of leaders expressed, in strong terms, the need to end the practice of FGC.

Many leaders gave examples of women's "culture" not to share health problems with anybody - not husbands, not children. Women, they said, choose to "**suffer inside**." This project, therefore, was needed.

The numerous barriers that women face in **accessing the health care system** were explored at length: language barriers, lack of family doctors, lack of education on prevention/regular check ups, feelings of fear or shame in accessing physicians, lack of knowledge on how to access the health system, "lack of information about health topics," and "limited understanding of what the issues are and the medical language." One leader with experience in the field, described the many negative health impacts of FGC: impacts on women's sexuality, recurrent bladder or vaginal infections, difficulty in labour and delivery, unnecessary C-sections, etc. The need to engage and educate **service providers** was also strongly supported. The project will have a strong focus, therefore, on many aspects of women's health, on accessing health care; service provider training is also being planned.

Only two women leaders, who attended the community leaders meeting, questioned the need for the project, stating that the practice has stopped in their specific communities. Others quickly debated this point and spoke of the prevalence of the practice today in their home country and of the need to address prevention for daughters.

Beyond Women, Beyond Health

Interestingly, community leaders spoke eloquently about gender relations, power dynamics and change that is occurring in the community. At least three male leaders stated that a change in the practice of FGC requires a **change in the overall community**, and in particular among **men**. One stated, "if men are not involved, there won't be any change."

Another leader asserted that starting with women, who "have a big role in the make up of the family and the society," was very important, "timely and necessary." He went on to suggest that programs should be expanded to include, "**children, youth and older men**" to support the work done with women, and support overall community change.

A few leaders also discussed the wide range of pressing issues faced by their communities and expressed support for work in these areas: conflict in families, intergenerational communication and conflict, supports for single mothers, and bringing women and men together to talk about sexuality-related issues.

The importance of learning English was raised as a need. Some felt that incorporating opportunities to practice or learn English, a "multi-purpose" approach, would be useful.

SERC has taken these important ideas into consideration and works to address them through this project, future planning, and other projects we are currently implementing.

Stigma

The majority of leaders did not raise stigma as a concern. Of the two who did, one advised SERC to be very respectful of women and her advice was to "acknowledge that she loves her children. Don't victimize women."

Another leader spoke at length of his concerns that the community could be stereotyped and stigmatized because of "Canadian" views regarding FGC. He was also concerned that women, too, could be marginalized as they were made to realize that they are possibly different and "less than" Canadian women (the leader's opinion). In asking these questions to women in the feedback meeting, however, women **did not feel that their community was being stigmatized**, especially in light of the project's decision to maintain the confidentiality of the community. Nor did they feel that they felt "lessened" as a result of this type of education. At the time of the feedback meeting, some were already participants in an educational session and they felt it was very positive, friendly and safe - not negative or stigmatizing.

SERC has taken concerns about stigmatization very seriously, and early on in the project decided to maintain the confidentiality of the community we are working with. We are very careful of the language we use to describe FGC; for example, "traditional female health practices" (suggested by a leader) or "female circumcision" are terms used in situations where they were more appropriate. We also support an approach that is non-judgmental and participant centered. This has consistently resulted in an open, safe environment in which women can share freely and feel supported and valued.

Need for this Community Facilitator, From Their Community

There was strong support for a **group co-facilitator from their own community** and strong support expressed specifically for the **Project Coordinator** who would be facilitating the sessions. She is well known and respected in the community and received many compliments on her work, experience, professionalism, excellent use of her first language, as well as her courage and deep compassion for women in her community.

Trust in SERC

Leaders felt that **SERC was trusted** by women in the community and they trusted SERC to carry out this project. Many used the words "we trust SERC, "and one said, for example, "You (SERC) already broke the ice. We are proud of the project."

One leader did not express complete trust in SERC's ability to fully understand the cultural factors, historical context, and community dynamics that needed to be

understood in order to carry out this project. His suggestion was that SERC needed to involve community leaders directly in the educational groups with women. He felt that a community leader should, for example, introduce the sessions to express support and "co-empathize, suffer together" and provide "mutual empowerment" and support for the women. He also proposed that the community should provide cultural teachings to the women, to address the perceived shortcomings in terms of what SERC could provide.

However, because this sentiment was not expressed by other leaders, nor by any women in consultations, at this point SERC will maintain women-only sessions facilitated by the Project Coordinator (herself from the community) and female SERC staff.

Content/Approach of Educational Sessions/Cultural Competence

Rich and detailed information was shared about this **community's history and culture**, about the role and status of women, and of cultural shifts over time. Some highlighted the strengths of women in their culture, others focused on building an **analysis** that linked FGC to social instability resulting from colonization or war. Leaders shared various perspectives to enrich and enhance SERC's knowledge, analysis, and cultural competence.

As described earlier, there was strong support for a **womens' health focus**, and also one that was **holistic** and encompassed **mental wellbeing**. Suggestions were made on how to enhance recruitment and outreach and even evaluation. One leader stated that SERC needed to encourage the women to be "critical" because only then would SERC learn and improve programming.

A strong emphasis was placed on a **woman-only space**, where women feel safe to learn and share from one another: "it should be woman-to-woman"

Cultural competence was emphasized as leaders suggested that SERC examine their own beliefs and values, that we "understand and not judge" the culture. One leader suggested conducting research into the issue, which SERC has been doing for the duration of the project; SERC now has a very comprehensive collection of current literature on FGC and programs to address FGC around the world.

Many suggested we **hear first from the women** what is important to them, and use that as our guide for the content of the sessions. This has been SERC's guiding principle, and women's direction and voice are used as the basis for all key project decisions.

Accessibility and Logistics

Leaders raised several accessibility options including providing **childcare**, finding a **time** that most can meet, and having a **location that is accessible** to women: central, where

people already meet (e.g. EAL classes), that feels like “home,” (i.e. community organization/location). This latter suggestion, however, was not consistent with what women had said in consultations, so at the women’s feedback meeting, women were asked once again, what location would be best (and were presented with all options that had been raised to date). Again, SERC was seen as a neutral and accessible location and preferred by the majority of respondents.

Conclusions and Recommendations

Overview of Findings

There is limited understanding of immigrant and refugee women's sexual and reproductive health issues in Canada, let alone on female genital cutting. Work related to these issues that took place place in Canada in the early to mid-1990s resulted in important increased understanding on the matter and changes to legislation. However, we have not been able to identify any other work in this area since then.

Manitoba immigration demographics indicate the likelihood that women from countries where FGC is common will be accessing the province's health care system. Many of these women will also be in a position of deciding on the continuation of the practice with their daughters. Yet, there are no estimates of the prevalence of FGC in Manitoba.

The consultation process and meetings held with people from many sectors in the community led to a rich understanding of the issues faced by women in relation to sexuality and sexual and reproductive health.

As a result of this consultation process we have concluded that there is a great need and support for addressing the many topics described in the assessment. Sexuality and sexual and reproductive health issues for women should be addressed in a manner that acknowledges their lives as newcomers in a new socio-cultural context. The specific community we have engaged is largely composed of recently arrived, younger people. Women, men and families are struggling with meeting their basic needs (e.g., employment, housing, language training). It is clear that much strength and support can be found in the many community organizations that have been established to assist newcomers to settle and adapt. While many focus on settlement supports, others also see the need for supporting newcomer women by focusing on health education and prevention.

In the context of meeting the daily challenges of settlement and adaptation, participants did speak at length about health care. Access to the health care system is a major concern. Lack of cultural competence and language barriers contribute to the difficulties women and their families face in accessing proper care.

Women's exploration of sexuality and sexual health reflected a complexity of issues and understandings. Cultural changes were affecting their experiences and views in many areas, for example: their relationships with children – now strongly influenced by the larger environment (e.g. peers, media, school); intimate relationships with partners and husbands (as roles and dynamics changed in a new setting); and their own personal health knowledge, expectations, and experiences (as they have changed through migration, by exposure to Western culture, as influenced by culture of origin, by anti-

FGC campaigns, etc.). Some specific topics on which they requested more information include: women's sexual health, STIs, cervical cancer, and Hepatitis C .

Regarding FGC, we found differing views about the continuation or discontinuation of the practice. The issue sparked great interest among many participants. Arguments for continuation focused on the need to maintain culture and cultural identity, increased marriageability, men's sexual pleasure, control of female sexuality, and ideas around cleanliness. On the other hand, we heard from a number that the practice was harmful to women's experiences of sex, and to their mental, physical and emotional health. A number of factors are believed to contribute to changing the views on continuing the practice: education level; length of stay in Canada (including the role of media); the socio-political context they had experienced (e.g. if someone was from a political group where gender equality was greater, there was less likelihood of supporting the practice); and history of migration (e.g. if someone had heard the messages/participated in an anti-FGM campaign in a country of origin/during migration).

Implications for Community Education

About the content of the education sessions

CONSIDER A HOLISTIC APPROACH TO HEALTH

We learned that when dealing with women's health, we needed to approach the issue from a **holistic perspective**. This approach should give equal importance and weight to **women's physical and emotional well-being**, with a focus on reproductive health and sexuality, as these are usually not spoken about or addressed and are considered "private" issues. Also, prevention education should consider a broad understanding of health to include the complete physical, mental and *social* well-being of women.

PAY ATTENTION TO WOMEN'S SEXUALITY

Education should also strike a **balance between the physical health impacts related to FGC and the sexuality related issues**. Much of the prevention work on FGC has focused on the effects of the practice on women's physical health. However, we learned that women's interests also went beyond the impacts on their bodies. They spoke about the impacts on intimate relationships and their sexual identity. It appears there is also a need to explore the many cultural influences in Canada, including the role of media in influencing women's sexuality.

INTEGRATE FGC INFORMATION IN ADDRESSING WOMEN'S REPRODUCTIVE HEALTH

In the consultations, we learned that health problems resulting from FGC might not be attributed by women to FGC, but to women's identity in general. However, the literature and practice demonstrate clear connections between FGC and negative health outcomes. Therefore, we must fully **integrate the implications of FGC when addressing women's reproductive health**. All reproductive health problems related to FGC should

be included in the curriculum/education sessions. This would not only help women identify health problems (that they may have thought were "normal") and help them seek treatment, but it would further the goal of ending the practice of FGC.

INTEGRATE AN ANALYSIS OF CULTURE, GENDER AND SEXUALITY

A key to successfully supporting a change (as supported by the community) around FGC, is to assist participants to **deconstruct and analyze the many culture and gender-based reasons behind the continuation/preservation of the practice of FGC.** Women should be supported to explore and analyze the historical context, the cultural beliefs and values, the social and political forces that affect women, and that support this gender-based practice. An exploration of women's (and daughters') lives, roles, expectations, choices and power should be integrated to assist women in making informed decisions about their health and choices for their daughters.

INCORPORATE A PARTICIPATORY APPROACH AND ENABLE MUTUAL SUPPORT

Supporting a strong exchange between participants, ensuring that change is a collaborative process and one that comes from within a culture is important. Sessions should support a rich exchange between the diverse cultural, religious, political, and age groups found within this community. They should reflect the wide range of practices (e.g. from those who do not practice, to those who practice *sunna* to infibulation) and perspectives (e.g. those who uphold the traditions in community, those who are seeking change).

ENGAGE MEN

Although FGC is a women-held practice, it is also a whole community practice. This was strongly indicated by many male leaders who participated in the consultations. Their recommendation was that men need to be involved in addressing change around this practice. While the focus of work should remain on women and involving them in education, men's engagement should also be considered. Any work with men would need to first **assess men's perspectives and roles as allies/partners in this process**, and **address sexuality and reproductive health issues in relation to FGC**.

INCORPORATE INFORMATION ABOUT THE LAWS AND PROTOCOLS REGARDING FGC IN CANADA AND IN COUNTRIES OF ORIGIN

Information about the legal framework regarding FGC in Canada and in Manitoba needs to be incorporated in any education approach. Also, women need to know how laws are changing in countries of origin. Although many may assume that the practice is illegal in Canada, we found that not all were aware of this fact. This should be made explicit and clear for participants.

About the format of the education sessions

There was strong support for education sessions that are **participatory** in nature. This means activities that involve high level of participation and engagement. A participatory

approach would assist in addressing a wide range of **literacy levels and learning styles**. As discussed previously, it also supports a richness of exchange between participants and enables **within-culture change** and **mutual support.**

Research on the prevention approaches to FGC, mostly in countries with high prevalence, demonstrates the usefulness of **popular education and the media** to raise public awareness. Different literacy levels ought to be taken into consideration. Diverse means of communication should be part of continuous discussion with the community. It appears that women have gotten key information from TV programming. This has proven to be quite efficacious in terms of their discussion and analysis of the impact of FGC in their own lives and the lives of women in the community.

Many of the topics and issues involved gaining insight into practices and understandings that are deeply culturally rooted. The approach used, therefore, should be based on principles of **respect, non-judgment, and acknowledging strengths** - both among participants and between educators and participants.

The participants favored a **community person as a lead** in the process and to have exchange and discussion in first language. However, they also stated they would appreciate having information and exchange in English to increase their ability to attend to their own or their family's health, and in general to build English skills.

Intimate, **women's only space** for education exchange was preferred by this community. However, sustaining and building on access to information may require looking into other forms of education that may move beyond woman-only space or that may move across cultures.

It is paramount that participants have access to **accurate, nuanced, cultural interpretation** and interpretation that supports a full exploration of the issues.

In terms of practical aspects, women preferred a **central location** that allowed easy access (i.e., near major bus routes). They also favored a **neutral place** where they would feel completely free to participate in discussions. For the women attending the consultations, Saturdays or similar dates to those chosen for the consultations (e.g., later in the week in the afternoon) were the best options for education sessions.

A thorough **evaluation** of the education sessions is recommended. This should focus on all aspects of the education process such as the content, education approaches, and practical aspects of the training. In addition, the evaluation should focus on the outcomes of the education in women's lives such as changes in levels of awareness and intention to use the information or to change practices.

This project focused on one specific ethno-cultural community. Future evaluation and research should assess the feasibility to implement a similar project **across other ethno-cultural communities** affected by FGC.

Implications for Education with Service Providers

This project shed light on the many health problems women experience and the barriers they face in finding accessible, comprehensible, timely, culturally-sensitive health care. Education with health care providers is therefore of key importance. All topics as described in the previous section regarding the content of education with women in the community should be incorporated into the work with health care providers. It is equally important that there be a focus on building cultural competence and providing cultural safety for women. The first hurdle service providers will face will be fully understanding the social, historical and cultural contexts that support FGC across the globe. Education should provide an opportunity for service providers to examine their own values and beliefs in order to ultimately provide service in a non-judgmental manner - one that facilitates openness and a supportive environment for newcomer women affected by FGC.

Much of the information gathered has a clear connection to the health sector. However, the nature of FGC and the legal implications surrounding the practice indicate that training should also be extended to those working in the social services field. Health care providers should also become aware of the legal implications.

All education with service providers should deepen their understanding of how to approach and address sexuality related issues, including FGC, from a culturally competent framework, that is one that promotes cultural safety. Because of the legal and health implications of FGC, in particular with respect to daughters, careful consideration needs to be taken when engaging service providers across sectors. Some may find themselves in a “punitive” relationship with women and community and educational approaches need to be tailored to their various perspectives and mandates. Care needs to be taken not to jeopardize the reputation of communities, or to negate the positive role that women and community are playing in addressing change.

Implications at the Policy Level

The stories and information shared by the women in this project clearly reveal some gaps in access to health care and support the need for developing strategies beyond community-level work and the education of service providers.

Access to health care and other services hinges on the ability to communicate effectively. Language barriers are among the most significant barriers that prevent women from meaningful contact with different systems. Reliable interpretation services

in Winnipeg are slowly being developed by the Winnipeg Regional Health Authority (WRHA). The WRHA has established the Language Access Interpreter Services program. This program provides trained interpreters for a certain number of health care and social service facilities but mainly for appointment-based visits. However, we learned that women and other community members often cannot access these interpreter services because their main sources of health care are emergency and urgent care services and walk-in clinics, all non-appointment based. This leaves them in a situation where they are not able to communicate their history, their current symptoms, their social, psychological or cultural needs effectively (or at all). Nor are they able to receive a clear picture of treatment, protocols, or follow up.

In addition to increased access to interpretation across the health care system, policies and procedures should also include strategies to address cultural competence at a systemic level.

At the legal level, FGC is addressed by the criminal code and provincial legislation. As a province accepting increasing numbers of immigrants and refugees from FGM/C practising countries, Manitoba has a responsibility to protect the rights and welfare of resident women and children as mandated by Canadian law and provincial legislation. Since the reasons for the perpetuation of FGC are complex and deeply culturally-coded, and as the practice, while being addressed on global level, does not show signs of significant abatement, our recommendation is that systems should focus on fulfilling the economic and social security needs of newcomer families. An emphasis on strong punitive measures could have undesirable effects on communities and drive the practice underground, possibly preventing women from accessing care.

SERC is building a model to successfully engage FGC- practising immigrant communities and to work collaboratively to address women's health and promote a cultural shift and community-wide, sustainable changes around the practice of FGC. In doing this we are cognizant of the historical, cultural and gender-based context, motives, and perspectives as we explore and analyze the issue of FGC. What is needed now are more financial and human resources, additional research, networking support, and dynamic laws, policies and programs that can assist individuals and communities to establish and continue their fight against FGC.

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Appendices

Our Selves Our Daughters
Community Consultation

Preparation:

- Arrive at the site half hour before group starts to get food, seating, handouts, etc. ready
- Put up signs outside
- Make copies of handouts

Handouts/Documents:

- Project Summary
- Informed Consent forms
- Sign-up List for more info/further involvement
- Health Info Sheets (per Facilitators)

Duration: 2 hours

Agenda

30 min Welcome (main community language)

Housekeeping (main community language)
Project Summary (handed out Summary) (main community language)

- We are holding these consultation meetings to find out your ideas for a health education group for women
- We would also like to find out about access to health services, experiences with health services both good and bad
- Talk about traditions/cultural practices that may impact on women's health

Introductions (in both main community language/English)
Icebreaker (Tigrinya/English)
- number of children
- number of years in Canada

Informed Consent (reviewed line by in main community language)

1.5 hours Questions on Women's Health & Traditional Health Practices/Prevention

10 min Thank You/Next Steps
Sign –up sheet
Distribution of Honorarium
Double-check all consent forms

Questions

Process: Questions 1 and 2 asked in English. Questions 3 and 4, asked in Tigrinya. Question 5 in English. Summaries of all responses were interpreted into English.

1. Can you give us an example of when you received good health care (or medical care) in Canada?

Prompts:

- What was the health problem or issue?
- Who did you get good care from ?(name of place/Drs)

2. Can you give us an example of when you received poor health care (or medical care) in Canada?

Prompts

- What was the health problem or issue?
- Who did you go to/where did you go (get names of places/Drs)
- What happened?
- At what point did you seek medical care (if not explained)

3. You have given us some examples of health problems. Can you give us any more examples of common women's health problems –that you know women in the community experience?

Prompts

- What are some topics that we should address in our educational workshops?
- (if they raise FGC – ask more questions:
    - Is this an issue for women?
    - What is the issue/problem about
    - What do you think about the practice of FGC –what are your thoughts?

4. (If they don't raise FGC). We are also interested in looking at women's traditions and beliefs related to health. What are some traditional practices or beliefs that may affect health?

Prompts

- Are there beliefs that affect women's health or how we get help for our health problems
- Do you think there are any health problems related to female circumcision, if yes, what do you think they are?
- Female circumcision is a very sensitive issue – we realize it's not spoken about –but the world is changing on this issue – in Your country of origin, things are changing. What do these changes mean in Canada?

5. All of the ideas you have given us will help us with topics for the women's health workshops we are planning. We also want to know how we should deliver these workshops? What would be the best way to give education?

Prompts

- Where?
- When (time, day, month) & duration
- What kinds of things would make women feel comfortable and make it easier to talk

Informed Consent Form

Our Selves, Our Daughters Project

As part of this project, we are holding "consultations" (meetings) with small groups of community members to find out more about how women receive health care, what are some common health problems, and to discuss some cultural practices that may impact on women's and daughters' health.

Thank you for agreeing to be part of one of these groups. As a participant there are some things you should know:

- The group will be run by a facilitator, who will ask questions, and facilitate discussion;
- Your participation is voluntary and you are free to withdraw from the process at any time;
- You are free to decide to not answer any question;
- Discussion in these sessions is confidential. Please do not to share other people's personal information;
- We are writing down what is said and what happens in the group, so that we have an accurate record of what happened in the group. For this:
  a) There will be a note-taker sitting with the group taking notes of the discussion
  b) All the rough notes will be handed into the agency. All the notes taken will be stored at the agency.
  c) Information shared in the consultations will be used to improve workshops for women's health. Information will also be shared with our funder and service providers who can help improve the situation for women. We get permission from your community, if we want to share information with others (e.g. conferences, workshops, journals). In all cases, we will not talk about the XXX community, but will be more general (e.g. African communities). In all cases, no names or identifying information will be used. It will all be kept confidential
- You will receive $20 at the end of the session for participating in the group discussion;
- You will receive a copy of the Informed Consent Form to sign.

Questions about the project may be directed at any time to S. D. at 982-7816 or by email at XXXX or SERC's Special Project Coordinator, Shereen Denetto at 982-7812 or by email at shereend@serc.mb.ca or SERC's Research and Evaluation Coordinator at 982-78213 or by email at paulam@serc.mb.ca

I am fully aware of the nature of this project and have agreed to participate in it. I have read (or had it interpreted to me), understood and been given a copy of this consent form.

_____ _____

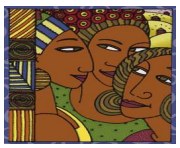
Participant's Signature Date

_____

Facilitator's Signature

Our Selves Our Daughters: Feedback Session with Women Attending Focus Groups (Nov. 12, 2009, SERC LL)

3:00	**Shereen/ S.D.**	**Greet Interpreters** and show them the flip charts Give them agreement forms.
As people arrive	**S.D.**	**Registration, Name Tags**
3:45 Start…	**Linda** **S.D.** interpreting all large group work	**Welcome/Overview** • Staff and interpreter introductions • Quick? Go around just names? • Washrooms • Verbal consent • Overview of what meeting is about, what we will be doing: o We spoke with 30 women from your community in consultation groups o We are writing a report with all the ideas you shared o This meeting is a chance for us to share with you what we have learned o This is also your chance to tell us if we are getting the right idea, or if we are missing some information o Paula will give you instructions for dividing into 4 groups to find out what we learned
	Paula	**Instructions for dividing up into 4 groups:** • Pick a photo from the container (pass around) • Everyone with a "mother and little girl" will go to the flip chart with that picture (point). *Same with other groups.* • We have put the main ideas that we learned from you – onto these four flipcharts • In your groups, the facilitator will tell you about important information we have learned from you • Then, she will ask you a few questions about that information • Your group will spend 15 minutes discussing that information • Then (*when you hear the music?)* your group will move to your right, to the next flip chart, to do the same thing • That way you will go to all four flipcharts • At the end, we will hear about your discussions – as a large group
	Shereen	**TIMER – CALLS OUT EVERY 15 MINUTES, AND/OR PLAYS MUSIC**
4 – 5		**Rotating Small Groups**
5 – 5:25	**Shereen can lead, but each Facilitator reports back**	**Large Group Report-Back** • Facilitators will go over the questions to highlight the key learnings – in particular if any new information was shared. • Each facilitator will share the information back to the whole group and ask if anything is missing.
5:25 – 5:30	**S.D.**	**Next Steps** • What is happening now with project (education sessions, meeting with community leaders, next steps) • Any more questions?
5:30 PM	**S.D./All**	**Thank you** Sign up if want copy of report



OUR SELVES, OUR DAUGHTERS:
A WOMEN'S HEALTH PROJECT

MEETING WITH COMMUNITY LEADERS

Date: **Thursday November 19, 2009**
Time: **6 PM – 8 PM**
Location: **SERC – 226 Osborne Street (NEW location!), corner of York and Osborne, Lower Level**

AGENDA

1. Welcome
2. Purpose of this meeting (overview of the agenda below)
3. Summary of Project Goals and Objectives
4. Process of the Project: What we have been doing. How we have done it. Some of the next steps.
5. Main themes from the Consultations with women and leaders in the community that are being put into a Consultations Report
6. Leaders' feedback on the Consultations findings/information
7. Policy recommendations – our funder is very interested in making policy recommendations about health care for women, for example. What are your ideas?
8. Distributing the Consultations Report. You have seen the information we have gathered. We will share the Consultations Report with you. NOTE: All information is confidential. No one can be identified. Nor can the community be identified. We do not identify your community. Instead, we refer to "African communities". What are your recommendations for distributing the report?
9. Process of finalizing the report (including recognizing project staff)
10. Communicating about the project as it continues
11. Thank you!