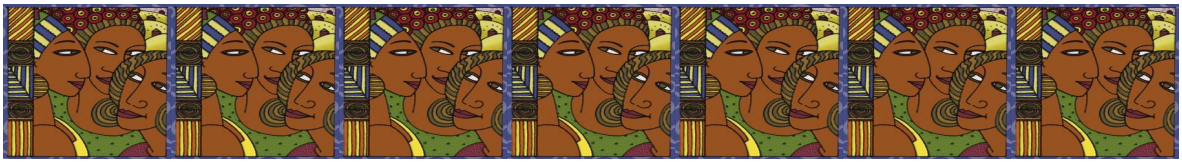

Our Selves, Our Daughters:

Community-Based Education and Engagement Addressing Female Genital Cutting (FGC) with Refugee and Immigrant African Women in Winnipeg 2012-13

Final Activity and Evaluation Report

March 31, 2013

SERC
SEXUALITY EDUCATION RESOURCE CENTRE MB

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Acknowledgments

We would like to thank the many newcomer women who attend our workshops and who shared their thoughts, feelings and rich cultural knowledge to make the session a vibrant experience. We would also like to thank the leaders in the communities who so strongly supported this project in many ways. We would also like to thank the service providers who saw the need to learn more about FGC and to provide more accessible services for affected women. We are very thankful for our excellent team who continue to provide services that cannot be found anywhere else. Last, we would like to thank our funder for their support of this project.

Manitoba

This project has been supported Manitoba Healthy Living, Seniors and Consumer Affairs.

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Introduction

This innovative, award-winning project has aroused great interest in various sectors. We have been invited to present on the project in Edmonton, Montreal and Toronto and Vancouver. The team has also been involved in co-publishing journal articles based on our work. This year, we were contacted by service providers in Calgary who want to learn from our project model. It is clear to us that few are working in this area and that many want to learn from this project in order to better meet the complex health needs of newcomer African women affected by female genital cutting (FGC).

At a community level, we have worked closely with first the Eritrean community and, more recently, have made inroads into the Ethiopian and Somali communities. This is exciting, as we move from a pilot stage to one where we are expanding our learnings and are becoming more inclusive of the diverse communities affected. In each case, we have hired a key woman who has taken on the role of Community Facilitator in her community, paving the way for relationships to be built and work to be done to address and prevent FGC in their communities.

In this year, we have focused on a number of different levels of work, including translating community-based research into action, providing direct community services and capacity building with newcomer women affected by FGC and their communities, offering service provider training, expanding resource development and translations, transforming research into sustainable models and disseminating of learnings.

Goal and Objectives

Goal: The overall goal of "Our Selves, Our Daughters" 2012-13 is to work closely with African refugee women and allies in their communities; to enhance educational, health and socio-cultural supports to women affected by FGC and to address prevention among daughters.

Objective 1: To engage women in three African newcomer communities in culturally competent sexual and reproductive health education sessions that address the health impacts of female FGC, as well as address prevention

Objective 2: To build capacity among women community organizers and the whole community to better address the health and wellness needs of the community with respect to FGC and address overall sexual and reproductive health

Objective 3: To develop community-accessible resources to use as tools for education and for promotion of community change regarding the issue of FGC

Objective 4: To provide resources and supports to service providers to be able to provide culturally competent care to women affected by FGC

Overview of Activities

1. Dissemination of Reports to Community Members and Leaders

Somali and Ethiopian Community-Based Research Reports

Last year, we had held sets of community consultations and focus groups as a means of building trust and relationships with two new communities, both of which had high rates of FGC in countries of origin. Our aim was also to build on our knowledge base and discover any differences in the way FGC is practiced and perceived. This in turn would better inform future work with these communities.

This year, we finalized the results into research reports. While the reports are written at a high level, we anticipate producing more community-accessible versions in the future. The reports will be posted to our new website. The website was launched in February 2013, so we are currently populating it with FGC information such as Somali and Ethiopian community reports, which will be found under Projects on the site.

Please note: We continue to maintain a certain level of confidentiality of the names of specific communities, depending upon the context. For reporting purposes, we use the names of ethno-cultural communities but in the consultations and research reports, we do not use the names. This is to help avoid the risk of creating further stigma and discrimination of these communities.

Reports have been well received by leaders and others in the community who received them. We have received requests from other service providers for more copies of the report for women in their group.

Community Friendly Report "Talking Together About Change"

This community-friendly report is designed as both a report (of research findings) but also as an educational tool. We have distributed it to various community members, leaders and women attending sessions, as well as focused this year on distributing it among focus group and feedback meeting participants.

- Posted to website: http://www.serc.mb.ca/resource-library/talking-together-about-change-community-friendly-report
- 90 reports distributed through targeted dissemination primarily to Eritrean adults and youth who participated in the original research focus groups, as well as leaders who supported the process – Leeway was given to Outreach Workers to give the reports to others who are from practicing communities and who feel the report is of interest and benefit to them
- 73 reports distributed on-demand to conferences, community leaders/organizers, settlement programs, funders, nursing and social work students, public health nurses, Healthy Start Mom and Me, Oasis/New Directions and Women's Health Clinic/Birth Centre

Feedback from service providers has been very positive, with some making requests for more copies that we cannot fulfill (i.e., our print run was for a total of 200 copies). Staff at Healthy Start Mom and Me distributed the report to a group of Somali women and even though the research occurred in another ethno-cultural community, they were fascinated by the report. The women told the Healthy Start staff person that they had no idea that such a resource existed and that it was good that it had been created. FGC is a taboo subject, they said, needing to be discussed more openly.

We know that in the community, this report is often seen as an important tool for starting and keeping the discussion going about FGC and prevention, outside the setting of our direct services.

2. Community Education

We held two sets of 10-week, three-hour educational sessions with newcomer women addressing needed information about health access; women's sexual and reproductive health; overall health and wellness, including issues such as migration, intimacy, gender expectations and relationships; health impacts of the practice of FGC and treatment access; and, finally, prevention of the practice of FGC in the next generation.

Somali Women's Group (Our first of such a group in this community)

The group was very well-attended. While we had slightly less than our target number (12), we did have an average of 10 women attending each group session and nine women attended between seven to 10 sessions. Since the group would run during Ramadan, we asked the women if they wanted to break for Ramadan and they declined. Women attended consistently, although there were definitely some learnings for the team about running a group when religious tenets prohibit sexuality-related conversations or even thoughts.

A note-taker was hired to take notes of the questions, reactions, dynamics and overall responses of the participants in the sessions. As a project team, we felt it was important to document these groups since it was the first such group we have held in the Somali community and we wanted to capture and incorporate new learnings into our ongoing work. An evaluation focus group was conducted by SERC's Research and Evaluation Coordinator.

Group participants were all very interested in the variety of topics included in the broader topic of women's health, such as health access, laws in Canada, reproductive health including STIs and HIV, social stigma, contraception and communicating with a partner. In addition, specific concerns arose, including fibroids, medications, infertility and traditional (sexual) health practices. The discussion of FGC prevention was incorporated throughout and staff observed women making connections between various health concerns and the practice of FGC.

Ethiopian-Eritrean Women's Group

Despite this being an extremely cold winter, we had excellent attendance for this group with an average of 11 women attending each group. To put this number in perspective, for our parents' groups, part of another project, we had 30 percent of projected attendance, which was largely due to the extremely cold weather.

Sessions were held in Amharic (an Ethiopian language also spoken by many Eritreans) with an Oromo interpreter (another Ethiopian language) for some participants. Group participants were highly interested in information shared about the body and sexual health. Many were amazed to learn about women's physiology and anatomy; how the body functions, how genetic traits are passed on and so on. Many were very interested and engaged in learning about common health problems and about the ways some problems are linked to FGC. This was an important topic to the women. Women also commented on learning about the importance of preventative care and what types of such care exists in Canada (e.g., Pap Tests). Some spoke of feeling enlightened having learned about health care access and about Eastern and Western philosophies of health care, which are topics they had never discussed or learned about before.

3. Service Provider Supports

Our ongoing work with women continues to reinforce the importance of providing supports and resources to service providers so they can provide culturally competent care for newcomer women affected by FGC.

Training

This year we provided the following training opportunities:

- Two three-hour workshops with a total of 19 service providers at Nine Circles Community Health Centre
- One-hour presentation at Community Health Sciences Colloquium with a total of 20 professors and students
- Ongoing communication with Calgary Sexual Health about possibility of developing an on-line training format regarding FGC for their staff, as well as possibly public health and immigrant serving organizations
- Two three-hour workshops with a total of 30 service providers from settlement, health and social services
- Three-hour workshop at the Western Canadian Sexual Health Conference in Vancouver in May 2012, with five attending and with linkages made with Calgary Sexual Health staff

Translations

Many newcomer women have not had access to English as an Additional Language (EAL) classes and their English is marginal. Literacy in first language varies as well but the women are eager to receive

handouts and reinforce that handouts in first language are most useful and accessible. When we produce handouts, they consistently report sharing them with friends and family members, which broadens the potential impact of the information.

Subject matter of the handouts included STIs, menstruation, menopause, access to health services and a doctor, informed consent, patient rights, Manitoba Health covereage, contraceptives, Pap Tests and health consequences of FGC. These are critical issues in supporting women's access to and choices in health care. Numbers of translated handouts is as follows:

- 16 Somali handouts
- 16 Amharic handouts
- Five or more Tigrinya handouts

We also translated our community-friendly version of our research in the Eritrean community into this community's first language:

- 100 designed and printed "Talking Together About Change" Translated into Tigrinya

Revising our Core Materials

For years, SERC has had a set of core materials about FGC. One of these is titled "Working with Women and Girls" and is about understanding and providing culturally competent care to women affected by FGC. SERC staff spent time over this year revising much of the content to reflect new understandings of FGC generated through this project and through our direct contact with communities. This task continues to be an ongoing process.

Publications

We have been busy collaborating with partners at universities and research-based organizations to complete and publish two chapters as follows (one being in French):

Migliardi, P. and Denetto, S. Women, Men and Youth's Perspectives of Female Genital Cutting and Change in Winnipeg. *In* Future Immigration Policies: Addressing Challenges and Opportunities During Integration into Canada (tentative title), K. Murphy Kilbride (ed.). Toronto: CERIS (Submitted for publication).

Vissandjée, B., Denetto, S., Migliardi, P. and Proctor, J. Défis d'intervention en contexte interculturel : le cas de pratiques traditionnelles telles que l'excision et de l'infibulation dans une perspective éthique et de santé publique au Canada. *In* Réduction des Méfaits et Tolérance en Santé Publique: Enjeux éthiques et Politiques. R. Masse (ed.) Les Presses de L'Université de Laval (2013).

Guide for Sexual Health Education and FGC Prevention with Newcomer Women

As we implement the project, we continue to update and further organize this manual. Currently, it remains as an in-house resource. Our SERC Facilitator is our lead in these kinds of curriculum development and writing projects and, as a part-time employee, her time is at a premium. In this kind of job, too, finding the blocks of time needed to capture the many different kinds of knowledge and exchange that would form the basis for such a Guide can be difficult. It is still a work in progress, although we are moving forward at capturing Facilitator knowledge on paper and organizing it so as to enhance its use for future sessions and a future guide.

FGC Webpage and videos

SERC launched its new website in February 2013. The project team advocated strongly for an FGC "button" on the home page, as well as a separate FGC webpage on the website. The FGC webpage is intend to be a site where we can provide access to all of the information generated from our project, as well as link to other relevant sites. Since it is relatively new, we plan to build on this basic starting point in subsequent years.

SERC's home page shows the FGC button:

http://www.serc.mb.ca/

Clicking on the button, takes one to the FGC webpage:

http://www.serc.mb.ca/projects/female-genital-cutting

The videos made from the FGC symposium will be uploaded onto the website or a link created so they can be viewed through YouTube.

4. Exploration of a peer-based model

This year, we consulted with two agency partners to learn more about their community-based, peer-based models for education and outreach: Manitoba Federation of Labour Occupational Health Centre and Mount Carmel Clinic's Strengthening Families Program.

There were many positive aspects of these peer-based models, including "cultural brokering," cultural knowledge and insider status of community-based educators as means of excellent comprehension and uptake by participants. Community-based educators know the needs of communities and are able to more easily access communities, including individuals are most marginalized within communities. Offering services in first language, as we have discovered with Amharic-speaking participants, brings many benefits in terms of facilitating increased comprehension and more robust two-way communication.

On the other hand, our discussions led us to realize the depth of training and support that is needed to support this kind of model. The front-end of implementing this type of approach would be very labour intensive in terms of recruiting, screening and developing training curricula and processes.

Our desire to examine a peer-based model was also motivated by our interest in building in sustainability of a project-funded activity. If the funding ended tomorrow, what skills and capacities would we leave in community to continue on with this work?

In designing the next year's project, we extended our capacity-building process whereby we have put resources into training and mentoring Community Facilitators from the three engaged communities. We plan to take our current model and build on it, providing more 'formal' capacity-building sessions for these key women and then working with them to deliver peer-based sessions in community.

5. Individual and Community Capacity Building

As mentioned, we have focused on building capacity in a few key individuals in the Somali and the Ethiopian communities.

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

- Frequent informal contacts in the community between the Project Facilitator, the Community Facilitators and past participants, current participants and community leaders
- E-mail updates to community leaders and key community contacts about project activities, funding, new reports, emerging findings and so on
- Meetings upon request with individual community leaders and key contacts
- Attempts, wherever possible, to hire individuals from the communities with which we are working as a way of recognizing the skills and talents within the community, as well as providing newcomers with "Canadian" work experience, which is so important in securing employment

6. Proposal to Jewish Foundation Manitoba

SERC applied and was successful in receiving approval for this small add-on project to the main Our Selves, Our Daughters Project. The funding will come from the Jewish Foundation of Manitoba – Women's Endowment Fund. This project is to be completed in the next fiscal year by December 2013.

We titled it "Tools for Change: Resources for African Newcomer Communities to Help Prevent Female Genital Cutting." In "Tools for Change," two community-friendly booklets will be developed that share stories and research from two newcomer communities. These booklets will be used to promote discussion and change at a community level around the issue of FGC. The project takes direction from newcomer women and ends with a community meeting to launch the resource and support community-led change.

7. Evaluation

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

Limitations

Our initial proposal submitted to the funder outlined a project and deliverables that required $10,000 more than was received. These are the areas in which we had to limit our work because of this revised amount of funds:

- We did not conduct further “Whole Community Education” and capacity building
- We completed slightly fewer translations than initially proposed
- We had limited time to adapt and revise the in-house Guide for the women’s sessions
- We had limited time to adapt and revise “Working with Women and Girls” core FGC article/resource
- We were unable to conduct formal (literature-based) research into peer-based models

Participants Served

Community Participants (Women, Men, Youth and Community Leaders)

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

- 10-week series of educational sessions (30 hours) – 8-10 Somali women (average)
- 10-week series of educational sessions (30 hours) – 11 Ethiopian-Eritrean women (average)

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

- Numerous additional phone calls and follow-up contacts with participants of the education sessions between sessions and after
- Informal conversations between the Project Facilitator and community members at community occasions, places of worship, birthday celebrations, ceremonies, introductions to newcomers and so on.
- Ongoing e-mail updates and exchanges with community leaders from all communities

Service Providers

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

- 24 staff over 2 sessions for Nine Circles CHC
- 30 service providers from community agencies over 2 separate sessions
- 13 students, Faculty of Anthropology, U of M
- 10 service providers at session presented in Vancouver at ASPSH conference
- 20 participants at Presentation at the Community Health Sciences Colloquium series
- Graduate student from Family Social Sciences using OSOD as case study for her masters' thesis – project to be complete this summer.
- University of Montreal student doing research on art therapy interviewed staff/shared her project for comments throughout the year
- 1 Health Educator from Calgary Sexual Health Centre, consulting on service provider training

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

Evaluation Overview

Methodology

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

Women's education sessions

Two three-hour workshops delivered with Nine Circles Community Health Centre

One three-hour workshop delivered at the Vancouver conference

Two three-hour workshops open to the public

Women's Education Sessions

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

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

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

Service Providers

We focused our evaluation on our most formal workshops this year: the three-hour workshops delivered four times. We used an end-of-session evaluation questionnaire to learn about the changes participants perceived in their knowledge and awareness on the topics of the workshop, as well as about the applicability of the knowledge in their jobs. Finally, we asked about general aspects of the workshop, such as the extent to which the workshop was informative, responsive to their needs and so on. We administered two such questionnaires at the end of each part of the workshop. (See Appendices for a sample of the evaluation tools used).

Evaluation: Somali Women's Education Sessions

Somali Women's Participants' Profile and Activities Description

This 10-week workshop series was held from June 10, 2012, to August 12, 2012, on Saturday afternoons with sessions running for three hours at SERC.

Attendance was very good with 10 women attending on average. A core group of very committed women attended seven to 10 sessions. We did have a few participants attend one or two session and then leave the group. We noted that some were younger and single, and questioned whether or not that was a factor in their dropping out. A number of younger single women stayed in the group so we cannot be sure. This issue is explored further in the evaluation.

In this group, we had an excellent range of ages represented, with equal numbers of women who were young (i.e., 18 to 29 years old), some being single, as well as who were in their 30s, 40s and 50s. It is important to have a multigenerational group in this project given that all circumcised women will need information about the impacts of FGC; younger women will have to make decisions in their own lives, if they marry and have children; and older women often have a strong say in maintaining the tradition.

There was also a good mix of women with no children, those with children and also those with grandchildren. Of those with children, all had both boys and girls. We feel it is important to have both mothers of boys and of girls attend sessions as FGC has a bearing on both in their future relationships. Mothers had four children on average with a range of family size from two to eight children. Ages of children ranged evenly from six to 25 years of age.

The average length of stay in Canada of these participants was 2.5 years, with many being very new to the country (i.e., four months up to a maximum of four years).

Session Content

As with past groups, the strong rapport between the Facilitator and participants was evident. A very warm, safe atmosphere developed that was rich with discussion, dialogue, sharing and laughter.

The following is a list of the main topics of the sessions, with the subject of FGC being integrated throughout:

- Women's traditional health beliefs and practices
- Models of health care: Eastern traditions, Western medicine, naturopathy)
- Accessing health care in Manitoba: using the emergency/urgent care, attending walk-ins, finding a family doctor, knowing patients' rights, accessing medical coverage)
- Women's lives: affirmation of women's roles, stresses on women (e.g., household responsibilities, isolation, missing people/grief, poverty)

- Reproductive Health: Female and male anatomy (i.e., board games in participants' first languages), types of FGC, menopause, menstrual cycle/stages of pregnancy, labour and childbirth (including FGC-related complications), health prevention (PAP tests, HPV vaccines, breast health), short-term and long-term effects of FGC, STIs and HIV, safer sex negotiation, condom demonstration, birth control, male sexual health (e.g., undescended testes, "wet dreams," erectile dysfunction, male circumcision)
- Gender analysis: examining the perception of women's bodily functions being considered 'unclean', the reasoning behind some cultures attempts to control women's sexuality, the construction of body image in Canada/media/health care, the dynamic of marriage/relationships and gender roles, the differential status of men women/girls boys
- Culture, values, sexuality and FGC: What is culture? How we learn beliefs and values? What are our beliefs and values? How does culture shape sexuality? Examples from women's culture – positives and negatives? How culture is changing "back home" and in Canada? Culture and values as they pertain to FGC – Why is it practiced? Why is it important? Why do people choose not to? What would be the impacts?
- Laws related to sexuality and FGC including sexual exploitation laws and the age of sexual consent
- Sharing of stories related to FGC: emotional and health impacts, beliefs and values, role of women, factors involving decision-making with respect to FGC
- Marriage and intimate relationships: women's sexual response

(See Appendices for the 10-week session outline)

Evaluation Findings

Motivation to Attend the Sessions

A Community Facilitator assisted with the outreach and recruitment for this session series. This method was enhanced by some of the participants, who invited along their friends.

More importantly for the women was that the group address "health issues." One of the women said that you "cannot get this information anywhere else. It's important to hear about health issues." Other women affirmed this comment, while other said that they felt they would learn new information. For instance, one woman mentioned "It's a lot of insight in the program, which [we] never heard. Therefore, it was important to be in the program."

Learning Outcomes

Among the new information received, participants found that they have learned about a number of topics, such as:

- FGC, particularly with regard to potential health effects (e.g., "can cause death because you bleed, and sexual urge will not be there, menstrual period problems, urinary problems.")

- Sexually transmitted infections and HIV, particularly regarding means of transmission and prevention (e.g., "You cannot get HIV through using the same toilets, mosquito bites, not from kissing or hugging" and "HIV is here, with us," referring to the fact that there is HIV in Canada)
- Menstruation
- Childbirth problems
- Sexual intercourse and relationships
- Breast health, in particular access to mammograms
- Access to health care (e.g., how to find a family doctor, patient's rights)
- Birth control

When asked if any of this was new information, most of the respondents to the question indicated that most of the new information concerned HIV, followed by birth control. The women provided examples of what they had learned, including that they found out that HIV could not be transmitted via mosquito bites, that transmission required exchange of bodily fluids and that there were means of preventing mother-to-child transmission. They also learned about "methods to prevent pregnancy that you could use here."

The topic of birth control appeared to be important to the participants. Some of the issues discussed concerned information on availability and accessibility to different methods. It seemed that some women did not have access to many of the alternative methods because they were receiving Employment and Income Assistance and, as such, did not have many choices. Furthermore, women who were on the Pill indicated that they were not fully informed of alternative options. In the sessions, they reported that they did not have real choices around raising issues about access to information during visits to their doctors.

Access to health care was discussed and triggered a lot of sharing of personal stories. The Community Facilitator shared one story of a participant who was repeatedly "yelled" at by her doctor, and another story of a woman who felt scolded by a health care provider for her child-rearing practices.

Overall, most participants felt that the topic of FGC, as addressed throughout the sessions, was the topic of major relevance and importance to them. According to one of the women, "This is what touched [us], the most important topic [was] FGC." In the interview with the Community Facilitator, more details regarding the issues discussed during the session came to light. The Community Facilitator commented that some of the women believed that FGC needed to be done for the men, while others did not know what part of their bodies had been cut (i.e., did not remember or know how the genitalia looked before FGC). The Community Facilitator also mentioned that the women were able to discuss the roles of religion and FGC, as well as legal matters, including the issue of taking girls back to countries of origin to be circumcised as being against the law. All these discussions led women to take or solidify a position in favor of the abandonment of the practice; for example, one woman stated, "I will never circumcise my daughters again." Furthermore, women showed impatience to comments from the Community Facilitator that time was needed for change to occur; they felt that FGC needed to stop immediately.

From Knowledge to Practice

A number of women felt that they would share the information with friends, children and other people in their community (e.g., "[this information] will help the community"). Interestingly, despite having participated in many weeks of education sessions, when asked, women appeared to have not passed along information to others. On the other hand, they felt that they would do so and provided some examples of what they would do as result of the sessions.

Women also reported understanding that whenever they were in pain they needed to go see a health care professional. They also mentioned learning about ways of preventing sexually related infections. Although women shared a great deal of information, they did not do so throughout all the session, which could be attributed to the fact that most of the sessions took place during Ramadan. During this period, women could not speak (or even think) about sexuality related issues, needed to demonstrate modesty and had to clear their mind of any spurious or distracting thoughts.

In any case, the Community Facilitator, as she interacted with the women outside the group, realized that the women and her relationship with the women had changed as result of coming to the group (e.g., "But now they are different than they were before" and "Also, now, they talk to each other. Now they can see it's our issue, a woman's issue, a woman's problem"). Now, the women would share more personal health concerns and, in her role, she felt more responsibility towards the women. She would continue to interpret for them whenever they had individual or intimate questions for the Project Facilitator.

Learning Approaches

As already alluded, conducting sessions addressing sexuality and sexual and reproductive health education during Ramadan presented some challenges for the Community Facilitator and even more so for the interpreter. The interpreter had to modify the messages to ensure that while the information was accurate, it was conveyed in a way that did not affect the ways women observed Ramadan. The interpreter shared with us a number of examples on how she would try to find metaphors or other figures to represent mostly sensitive information of sexual nature. Also, in spite of the fact that the group was described as "interactive", the lack of food intake due to Ramadan affected the energy of the group. The following expression from the Community Facilitator summarizes how different the group would have been had this been done outside of Ramadan, "If it wasn't for Ramadan, we could have danced!"

We asked participants how they felt Ramadan had affected their learning. They reported feeling that health was an acceptable issue to talk about during that time; however, they also said that they believed some topics, such as male genitalia, were inappropriate. Other content appeared to also be an issue; specifically, the visual representation of the genitalia. On the other hand, some of the women commented that they would use the "pictures" to show how infection or other illness would affect the genitalia and they continued to support the use of visual aids.

The women confirmed once again that women-only groups were paramount in discussing sexual and reproductive health issues given that they felt comfortable and safe during the sessions. Some of the women moved on to describe other possible models of education, including "husband-wife" dyads. In support of this idea, some felt that "there is no shame in telling of health issues."

Overall, women-only groups are more desirable and appropriate for women in this community. Indications of that were comments made about how it took time for women to feel at ease with the subject matter. With smiles and laughter, women said that the initial reception of the sessions was lukewarm and that it took some time to be "fine."

It was also noted that age difference within the group and marital status also has a moderating effect in the dynamic of the group. Younger, unmarried women were more "shy" during the sessions, as it may be culturally and/or religiously inappropriate for them to speak about sexuality-related issues when they are expected to not have any experiences with the topic. The Community Facilitator was alerted that this might be an issue during a break when a young woman said, "These older ones, they don't know that we learn this in school." That young woman was referring to the fact that other women in the group were disapproving of participation and of learning of such subject matter in the session. In order to increase the comfort level and participation of all women in the group, the Community Facilitator decided to highlight that some of the women may have already been exposed to the material in school and invited the younger ones to add any information. Doing so created space for the younger women to speak up and put older women at increased ease.

Despite such efforts, however, in examining the attendance data, we found out that about half of younger women registered dropped out after one or two sessions and that most of those women were single. Although we cannot jump to conclusions (given that about the same number of women of the same description continued to attend the sessions), this observation raises questions about the appropriateness of cross-generational groups within this community and/or has implications for changes in approach that might alleviate these dynamics (e.g., more up-front discussion of how to make a mixed-generation group work; small work groups divided up by age).

Having translated handouts available was important to the women. They would revisit them as they saw necessary. In addition to all that women learned in the group setting, some women appreciated follow-up information or answers to questions they received from the Community Facilitator.

Suggestions for Improvement

Because this was the first time that the women had attended an education session of this format, they did not have other points of references to compare and make suggestions on alternative approaches. It appeared that there was a high level of satisfaction with the sessions. To expand on this, we asked if there were any additional topics or information about which they wanted to learn. The women did not have any suggestions for new topics; however, they mentioned that the timeframe for some of the topics was too short. For instance, women did not know of available and accessible methods of birth controls in Canada and, therefore, women desired more time and information on this topic.

Furthermore, some of the women also appeared to refer to a need to learn more about natural family planning. A younger woman in the group also asked for more information on menstruation. Others added that information on topics outside health, such as finding a job, would be important to them. The Community Facilitator suggested more participatory activities, such as small group discussions to energize the group. She made such a recommendation as she recalled that the use of "case studies" worked very well.

Concerned with the abandonment of FGC, a suggestion was made to address the issue of marrying an uncircumcised woman with youth and the community. Such a suggestion was intended for women who still strongly believed in putting a premium on marrying women who are "not too hyper," something that is believed to be curbed via circumcision.

While the location and time was obviously appropriate for this group of women, a number of women interested in attending were unable to do so. The main barrier to attend the group was the lack of child-minding services at the group. While the sessions allocated funds to offset childcare expenses, doing so may have not been enough for some.

Recommendations

- Regarding the issue of having single and unmarried women attend with married and older women:
    - Assess outreach and recruitment processes and messaging
    - Assess educational approaches and formats in implementing the group (e.g., have opportunities for age-specific small group work)
    - Assess the ways we frame the group with the women once the sessions have started (e.g., have conversations early on about the importance of multiple generations in FGC prevention, while acknowledging the challenges of having single and married women together to talk about sexuality; encourage women to problem-solve with Facilitators)
- Educational approaches, structure and content:
    - Provide more information and time to address core sexuality-related health issues, including birth control (e.g., natural family planning) and menstruation
    - Increase participatory exercises to energize the group
    - Promote prevention of FGC and incorporate greater discussion around the issues of the next generation and change (e.g., Who do boys want to marry, circumcised or uncircumcised girls? What will happen to daughters who are circumcised? Uncircumcised?)
- Examine the issue of on-site child-minding to further address barriers to participation
- Conduct future programming outside the time of Ramadan and, if not possible, organize the sessions to have specific topics such as male anatomy, intimacy in relationships and so forth outside the time of Ramadan

- Consider adding more sessions since women ask for more information and/or time for topics and even for the evaluation (given that the women have a number of questions), or consider other options for ongoing access to SERC's services beyond the life of the group
- Consider partnerships with other organizations to address non-SERC mandate issues and to fulfill participants' information needs
- Expand our consultations about FGC and include men's and youth's perspectives

Evaluation: Eritrean-Ethiopian Women's Education Sessions

Eritrean-Ethiopian Women's Participants' Profile and Activities Description

This 10-week workshop series was held from January 26th, 2013 to March 30th, 2013, on Saturdays afternoons with sessions running for three hours at SERC.

Despite the frigid weather, attendance was very good with 11 women attending on average. A core group of nine very committed women attended seven to 10 sessions each.

In this group, we had an excellent range of ages represented, with equal numbers of women who were in their 20s, 30s and 40s and with an emphasis on women in their prime reproductive years. No women in the group identified as being grandmothers.

There were several younger women in the group who did not have children. Of those with children, the average number of children per family was four children. Family size ranged from one to six children and the ages of such children ranged from three months to 25 years of age.

Many of the women were very new to Canada, with an average length of stay of just under two years. Approximately two-thirds of the core group was originally from Ethiopia and one-third from Eritrea.

Session Content

See Somali Women's Sessions for main topic areas covered.

Evaluation Findings

Motivation to Attend the Sessions

> After I go home, I miss Saturdays. Simret's presentation and [her] smile made me like the sessions.

Women heard about the sessions through friends and project staff. When invited to attend, women did not know what to expect but they felt that the sessions would help them learn about the "new culture," "family planning," "sex" and intimacy (i.e., how to become more intimate with their partners). One of the participants shared her experience being invited to the group:

> Fitsum has always told me about this program. I never took it seriously. Finally she told me to come for one class and check it out. I loved it after I came once.

Women found that the sessions were very "informative" and "important" to them. One of the participants who had missed some sessions said, "I started late, and I am mad for the sessions I missed," illustrating how importance of the sessions.

The eagerness to continue coming to the sessions, proven by the high attendance rate, was the result of how meaningful these session were for women. Such an eagerness and high level of engagement cannot only be attributed to the content of the session but to the dynamics of the group. One of the participants, in comparing the session to other learning experiences, commented: "I am usually bored when I go to school; never in these sessions. I liked the instructor and the sessions. The presentation made me keep coming." High participation in answering the evaluation questions can be another indicator of what the sessions meant to this group of women.

Learning Outcomes

Every woman mentioned being highly satisfied with the sessions. Many said that they had "learned a lot." When asked about some specific topics that were more relevant to them, they reported being touched by a wide range of topics. As usual, FGC was incorporated throughout the sessions, which allowed for many discussions on how the practice of FGC looked across different ethnic groups. It was noted, however, unlike previous groups, that most women in this group agreed that FGC was changing back home and accepted this as a fact. Previously, we have observed a wide range of opinions regarding FCG, including the need to continue with FCG and the reported experience of having conflicted feelings about the issue. Consequently, it is not surprising than that most of the comments from the evaluation fell under the broad category of sexuality and reproduction rather than focusing on FGC as a specific topic.

From the sessions, participants learned new ideas about the body, including how the anatomy looks (e.g., many referred to how enlightening or "amazing" the "models" or other visual representations of the body were) and how the body works according to newfound notions (e.g., the presence of genes, the ways genes work to develop the body into one sex or the other). Women learned about the names of reproductive body parts, the process of pregnancy, markers of virginity, changes in the body over time, vaginal practices, cervical and breast cancer, and so forth. Some of the following quotes illustrate these points:

> I learnt about virginity. It was always my question [referring to markers in the body of virginity, specifically the different shapes of the hymen]

And another participant explained:

> I learned that fertility might happen in both men and women [referring to the fact that men have also something to do with reproduction and fertility]. I also learned how pregnancy happens [the rest of the group murmured "XX" and "XY" in support of this statement].

One participant lamented about not having had access to this information prior to the sessions, "The bad thing is I knew about it late in my life," which was a time when she was no longer able to naturally reproduce.

Along the lines of having obtained new science-based knowledge on pregnancy, other participants added:

> I remember the story that husband and wife couldn't have their own children for a long time because of the RH factor but they each had children after they got divorced. That is something really new and I would never forget.
>
> We have learned so many things that we didn't know. Some of these include how pregnancy happens, how to check children's testicles, how they should look and what is not normal.

Anatomical representations, body parts and changes in the body over the life span were also identified as important information:

> All the 10 sessions were fabulous. I learnt about fistula, how it happens and how dangerous it is. We also learnt about our bodies-cervix, uterus, fallopian tubes, ovaries and how our body functions.
>
> I liked learning about menopause. I felt like it is about me because I am approaching that stage. I learned [about] things to watch for: headache, hot flash, and the like. I have never heard about it before. I needed this information.

Other topics that caught women's attention were discussions on different health care philosophies and cultural differences, in general, as they relate to health and sexuality:

> I missed some classes but I liked all the classes I attended. You taught us about Eastern/ Western medical philosophy which I had no idea about. I learned the difference.
>
> You taught us the differences between our culture and the new culture with examples. Thank you for that.

Use of Knowledge

Some women mentioned what happened in their lives as a result of participating in these sessions. A few of them commented on changes in attitudes towards obtaining sexual and reproductive care. Women appeared to have been reticent in the past about going to see a doctor for such type of care. A couple of participants explained how things had changed for them:

> I usually don't want to go to a gynaecologist, for Pap Test, etc. Now I am not afraid to be seen.
>
> I also liked our discussion about women's health. In the past I didn't want the doctors to see my private area. This program gives me the courage to get tested and take care of myself.

Here, women were not only speaking about the fact that they were reticent about being seen as women, but being seen as *circumcised* women. Living with circumcision, many women had experienced

negative outcomes accessing health care (e.g., getting a Pap Test), which prevented them from accessing care.

Another participant talked about changes to common vaginal practices among the women:

> I learned that using cleaning soap and other fragrance inside the vagina is not good and also the risk of bubble bath, etc. I will not do this.

It was noted, however, that the session on vaginal practices brought about heated discussions. According to the Facilitators, most women were quite surprised to hear information on negative health outcomes of certain vaginal practices.

Consistently with previous series of sessions, women in this group also shared the information with others in their networks, which included translated written materials. As mentioned by one woman:

> I have gotten some idea about cancer, especially cervical and breast cancer. I discussed the ideas I gained from here with one of my friends at home and she wanted to attend the session. She always reads the materials I take from the session. This lady wanted to attend the sessions but was told that it is full.

As shown in this quote, the sharing of information also stimulates the interest of other women in the community, many of whom continue to be interested in attending future sessions.

Other women spoke about the importance of obtaining reliable information to share with their children. They felt that discussions at home were important to prevent their children from getting unreliable information elsewhere.

Learning Approaches

As usual, we inquired on the ways information was conveyed or knowledge was generated in the group. Most participants appreciated the visual aids used. On this matter, some referred to the models that represented the human body as helpful to understand different body parts, such as the difference between the vagina, uterus, and vulva. When discussing this item, one of the participants illustrated the point when she said, “For example, we go to the doctor and say I have a pain in my uterus, cervix, even though we have problem around the genitals [referring to the vulva].”

Participants not only appreciated the content, but the way discussions were encouraged. Participants agreed that during the session the felt free to talk pretty much “about anything.” One of the participants explained, “Especially the Facilitator made us to be open about taboo subjects in our culture. We talked freely.” Given the level of comfort achieved, women found “nothing embarrassing.”

Yet, some open demonstrations led some discomfort on some. One of the participants said, “Maybe because of my culture or religion, I didn’t like it when you (addressing the Facilitator) talked about, and demonstrated the use of condom for oral sex. It is good to hear about it but it really made me uncomfortable.” Even then, other women argued back by affirming the importance of knowing. They felt that they could teach their children with a solid foundation of knowledge.

According to the participants, learning was possible because they spoke the same language as the Facilitators (i.e., the sessions were conducted in first language). This was enhanced by the fact that the Facilitator would provide relevant or culturally congruent examples that helped with the learning. Some said that by having Facilitators that belonged to the same community, they were not afraid of being judged. Furthermore, they also valued the professional knowledge that the Facilitators provided. For instance, once woman commented, "There are a lot of things I heard about sexuality. By coming to this session, I got confirmation from a professional." Women also said that a women-only group helped with participation and discussion.

Suggestions for Improvement

As the conversation moved forward during the evaluation session, women posed a few questions indicating that women continued to seek knowledge and information about their health. Time was made to answer women's questions as they arose but, at times, the women had to be redirected to answer the questions being asked of them, possibly leaving some women's questions unanswered. When asked if there were topics that needed more attention or that should be added, women said that they would appreciate more information on cancer. As newcomers, women also said that there was settlement related information that they would appreciate and wished had been included in the project.

The women discussed the possibility of group sessions for heterosexual couples so that men would have access to the information; however, many argued that the women would not be as open to talk in front of their husbands.

As already indicated, all the participants mentioned having learned so much from the program and believing that others should be able to do so. They hoped that we conduct further outreach in the future so that other community members would have a chance to attend groups. The women recommended the session extend to women from other parts of Africa where FGC is practiced.

On Practical Aspects

In consideration of practical aspects that make the sessions accessible to the women, participants liked the **location** because of it being central and conveniently accessible by bus. They commented on access to **bus tickets** allowing them to participate to the extent that many would not have been able to attend without such support.

While little money is provided to offset **childcare** costs, the participants concurred that the amount was not enough to fully pay for childcare. To attend the sessions, the women would leave their children with family and friends, while a few would bring their children along. Some child-minding was provided during the sessions; however, this support was seen as inadequate mostly due to limited access to proper space. Many also shared that they knew other women interested in attending session but who were unable to do so because of the lack of childcare. Women recommended that serious attention be paid to this matter.

In addition, as the sessions started at the end of January during a particularly harsh winter, women suggested that the sessions take place in the summer and fall.

Recommendations

- Explore options for delivery that address childcare barriers to participation. It appears that women would better appreciate childminding services. Childminding services require access to safe and appropriate space while ensuring that the location of the sessions is also accessible via reliable and timely transportation.
- Continue to explore groups that include women from diverse ethnic and national backgrounds while addressing the language barriers. Groups have been successful because most of the information is relayed in first language or through interpretation/translation. This would be more difficult to accomplish in more linguistically diverse groups.
- Consider adding more sessions since women ask for more information and/or time for topics and even for the evaluation (given that the women have a number of questions), or consider other options for ongoing access to SERC's services beyond the life of the group
- Prioritize holding groups during the summer and/or fall, rather than during the winter
- Consider partnerships with other organizations to address non-SERC mandate issues and to fulfill participants' information needs
- Expand our consultations about FGC and include youth's perspectives
- Extend the group to include other FGC-affected communities

Evaluation: Service Provider Workshops

> *I am a practicing OB/GYN in Winnipeg, as well as the National Chair of the Social and Sexual Issues Committee of the Society of Obstetricians and Gynecologists of Canada. I had the pleasure of attending the informative seminar on female genital cutting led by Linda and Simret. Their presentation was excellent and informative. It is so important that health care providers understand the cultural context of this practice and are able to interact competently and respectfully with the women we care for. You may not fully realize the importance of your work in this area. Winnipeg is regarded as a leader in this area, both nationally and internationally, because you have a grassroots program that facilitates social change by listening to newcomers and working in their communities.*
>
> *~ Evaluative comment submitted by e-mail to SERC's Executive Director, after a participant attending a workshop*

Five half-day workshops were provided in the period 2012-2013. One of these workshops was delivered in the context of the Western Canadian Sexual Health Conference in Vancouver during May 2012.[2] Two additional workshops were provided to health and social service providers within the context of HIV support and care provision and the two remaining were open to service providers, in general.

In every situation, the groups were very diverse and included people working in health care, people working in social service, students, researchers, people working with newcomers on settlement-related issues and community health educators.

For the most part, participants worked in the social services area. The majority of these individuals worked with newcomers to fulfill a number of settlement needs, including employment, parenting or family programming, housing, counselling, support and advocacy and sexual health education. There were also a number involved in community health (e.g., from Nine Circles Community Health Centre) and a few participants from primary care (e.g., nurses, physicians, residents); all working with newcomer women to a certain extent. Another participant worked with service providers who provided support to newcomers. During this time, we also catered to a number of students planning to work with newcomers in the future or having completed school practicum involving newcomers.

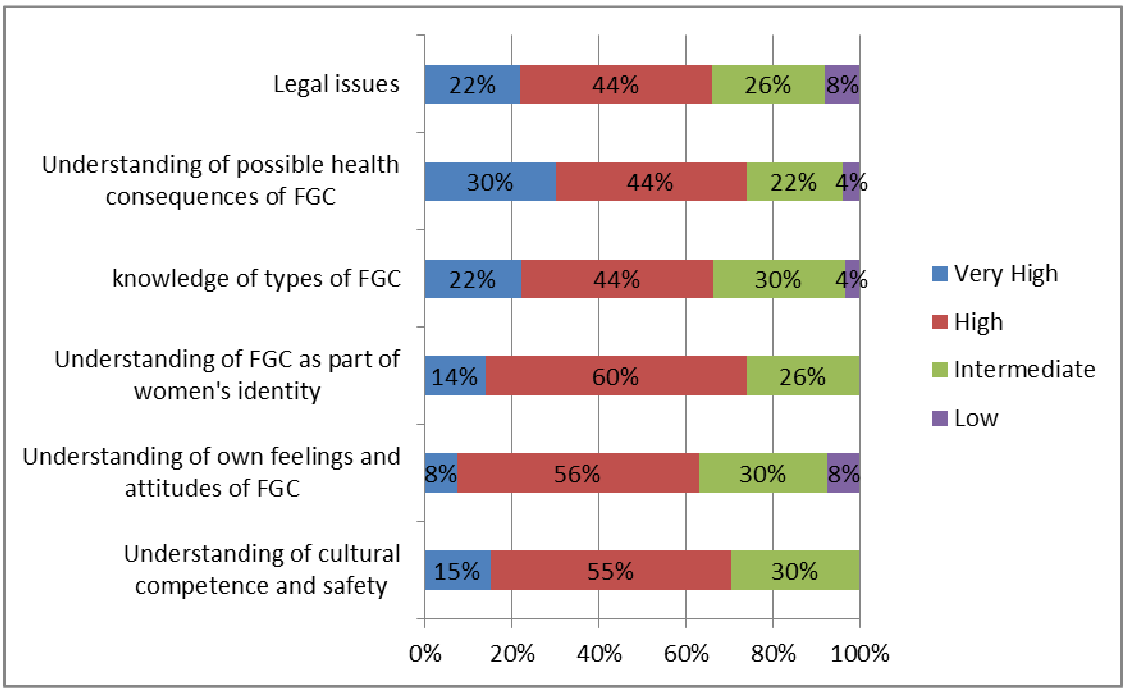
[2] Presentation available on the site of the conference, at http://www.aspsh.ca/sites/aspsh.ca/files/Linda%20Plenert%20-%20Our%20Selves,%20Our%20Daughters%20Vancouver%202012.pdf

Evaluation Outcomes

Here, we report on the findings of the evaluation of workshops conducted in Winnipeg. We measured changes in knowledge and awareness with regards to key areas of interest, such as understanding of FGC. There was positive uptake of all topics. Understanding of FGC as part of women's identity was the area of knowledge that experienced most change. Sixty percent of the respondents indicated a "high" understanding of this topic as result of the discussion, with an additional 14 percent indicating having a "very high" grasp of the topic. This was followed by changes in understanding of possible health consequences of FGC, with about three-quarters of the participants indicating "high" or "very high" understanding as result of the session.

Fifty-five percent of the respondents indicated having a "high" understanding of cultural competence and safety as result of attending the workshop and for an additional 15 percent it was "very high". Over half of the participants increased their understanding of their own feelings around FGC, rating this change as "high." Finally, over 65 percent of respondents rated having a "high" or "very high" understanding of legal issues and knowledge of different types of FGC.

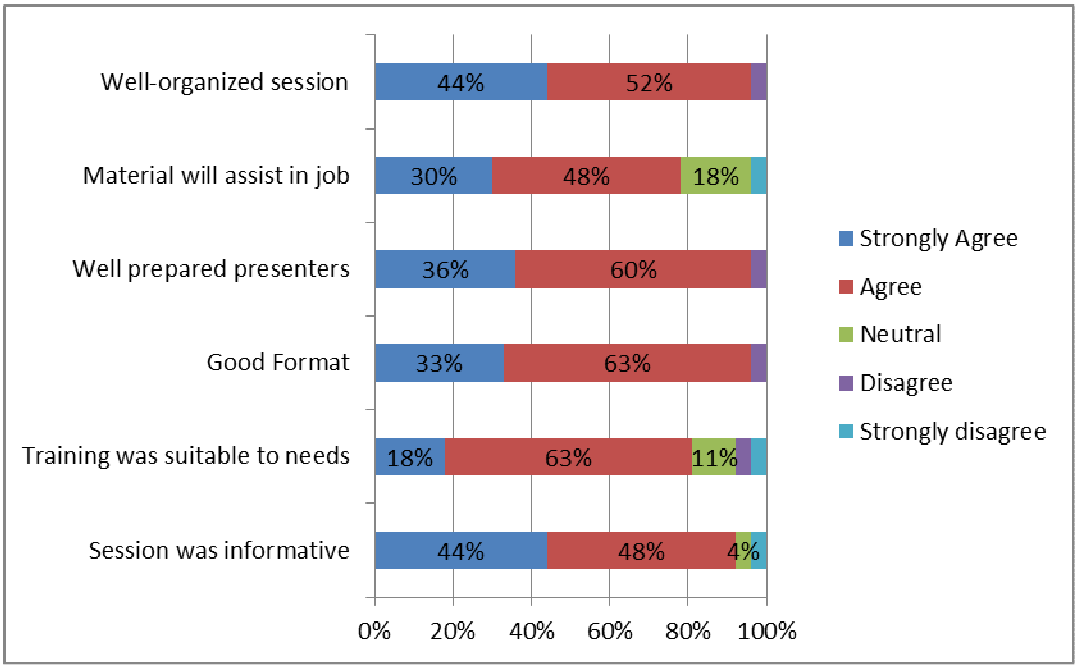
It is noticeable that 25 to 30 percent of participants also rated their understanding as "intermediate" with regard to the different measures, which can be attributed to a number of reasons. For instance, most participants closely related to the medical and health care fields rated lower changes to their understanding of types of FGC. Such a change may be the case given that they may have already been exposed to the basic information on this topic that was shared in the workshop. The same could be said with regards to principles of cultural competence and safety. On the other hand, we could also attribute some of the lower ratings to lack of time to delve into the many topics promised in the session or to the diversity of participants and their expectations.



Content and Process

We also asked participants to rate their level of satisfaction with regards to some areas of the workshop. As shown in the graph below, most participants "agreed" (48%) or "highly agreed" (44%) that the session was informative. Sixty-three percent "agreed" that the training was suitable to their needs. Over three-quarters of the participants "agreed" or "highly agreed" that the materials utilized or shared in the session would be of help in their work.

Sixty percent of the participants felt that the presenters were well-prepared, while an additional 36 percent "highly agreed" with the statement. Similarly, about the same number of participants felt the format of the session was good. Finally, over 95 percent of the participants "agreed" or "highly agreed" that the session was well-organized.



Use of the Information

Overall the knowledge gained in the session would help service providers in addressing FGC with their clients. As one of the participants indicated, "The background information (cultural aspects of FGC) and beliefs behind reasoning will help me be a better listener and helper."

Many felt that the workshop would help them "feel more comfortable" with regards to the topic of FGC. They also felt better prepared, attitude-wise, in working with people from groups where FGC is practiced and/or in receiving a disclosure of FGC from someone. One participant believed that by having gained a better understanding of beliefs and values behind the practice, she/he felt to more at ease with the whole topic. Another participant, who delivers sexual health education, felt that "more exposure to the topic makes [her] feel more comfortable," and encourages her "not to be as nervous about addressing FGC during a sexual health workshop." Along the same line, many others indicated that they would become "more accepting," and "less judgmental," while other reported having found an

"improved language to use with women," that helped to dispel some of their assumptions about FGC. It was also noted that not only was the information shared important in changing participants approaches and attitudes but that the demeanour and educational approached used by Simret, the Project Facilitator, helped people understand how they could "approach difficult issues" with community members.

A few participants told us that they were unsure or that they would not necessarily use the information directly in their jobs or workplace; however, since some were working with newcomers or planning to do so in the future, garnering a basic understanding of FGC was thought, by one participant, to help them "have a better (more positive)" view of FGC.

Providing Support for Future Work

In order to assess the potential efforts needed to support service providers in working in the areas of FGC, we asked participants to comment on any additional information that they would require about FGC. The participants identified the following areas of knowledge as being needed:

- Prevalence of FGC in Canada
- Further information on factors behind the practice of FGC
- More in-depth information on different types of FGC
- Further information on consequences to the female body (e.g., impact on the genitalia)
- Concrete information on legislation, including laws in African countries where FGC is practiced
- More practical approaches to broaching the subject in appropriate manner
- Access to resources:
    - List of organizations or care providers providing culturally safe/competent services to women affected by FGC
    - SERC's publications
    - Resources outside SERC

A few of the participants took the opportunity to also mention that having access to the presentation developed for the workshop and increasing the participation and exchange in the workshop would also be helpful.

Conclusions and Recommendations

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

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

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

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

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

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

This year, we have developed competencies in working with two new communities and the evaluative feedback, as well as informal feedback from the communities has been very positive. Moving towards a multicultural model has been an important step. We know that many of the newcomer communities in Winnipeg have high rates of FGC in countries of origin. While it made sense initially to "start small," and pilot the project with one community, our work this year has demonstrated that the need does exist in other communities in Winnipeg.

Recommendations for Action

Programmatic:

1. Continue to provide participatory, culturally competent in-depth **education workshop series for newcomer women** from communities practicing FGC that address the health impacts and prevention of FGC, and that explore the complexities of culture, identity, sexuality and change:

    a. Include women from all three communities and consider expanding to include other affected communities.

    b. Address group-specific recommendations documented in the body of this report.

2. Continue to follow the model that addresses **change at all levels of community**, engaging not only women but also youth and men.

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

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

5. Consider the strong need expressed by newcomer participants, both men and women, young and old, for the provision of **sexual and reproductive health information** presented in a culturally sensitive manner.

6. Develop **educational resources in first language** and incorporate a process of community feedback whenever possible.

7. Continue **training service providers** in a responsive manner and explore the idea of a next stage of training for those who have attended the introductory workshop for the development of in-depth practical skills.

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

9. Continue to compile, develop and **disseminate FGC and project-related resources**.

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

11. **Disseminate** project findings widely.

Advocate For:

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

Appendices

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

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

Outline for Women's 10-Week Sessions

EVALUTION TOOLS:

Our Selves Our Daughters

End-of-Session Focus Group Interview Guide (Somali Women's Group)

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

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

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

4. What helped you to actively participate in group conversations/discussions? (Probes: people from same community, the Facilitators, the climate of the sessions, interpretation and so forth)

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

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

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

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

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

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

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

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

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

Workshop Evaluation – March 26, 2013

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

Please **READ** the following comments and **CIRCLE** the number which best reflects your opinion (1= Strongly Disagree and 5 = Strongly Agree)

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

1. What part(s) of the workshop will you **use** in your job? How?

2. What **additional information** do you require regarding female genital cutting?

3. If you answered Question 1 or 2, please tell us a bit about **your job** (e.g., outreach worker, public health nurse). As well, **in what capacity/situations** would you be working with immigrant/refugee women from FGC practicing communities?

Our Selves, Our Daughters

Group 7: Eritrean-Ethiopian Session Jan – Mar 2013

Outline of Sessions

Session 1:

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

Session 2:

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

Session 3:

- Female anatomy – Magnell Board; include basics on FGC
- Menstrual cycle
- PMS Dealing with PMS
- UTIs and yeast infections and FGC

Session 4:

- What happens at a doctor's appointment
- Patient's Rights
- Informed Consent
- Breast exam
- Pelvic exam and Pap Test

Session 5:

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

Session 6:

- Stages of Pregnancy
- Labour and childbirth
- Complications resulting from FGC
- Breastfeeding and cultural role of women's breasts

Session 7:

- How does birth control work?
- Different methods of birth control
- Condom demonstration
- Where to get birth control
- Menopause symptoms and coping with menopause

Session 8:

- Culture and women's sexuality / wellness
    - Follow up discussion on breastfeeding in Canada
    - Breasts as sexual objects/decorating breasts/ exposing breasts/breastfeeding
    - Rights of the child to best nutrition (e.g., breast milk; mother has the right to breastfeed her child in public)

- Culture and FGC
    - Why is FGC done?
    - Discussion regarding breast ironing-similarities/differences re FGC
    - Discussion regarding protection of daughters

Session 9:

- Sexual Relationships
    - Women's sexual pleasure and FGC
    - Factors that affect a woman's sexual pleasure

- Communication in sexual relationships
    - About sexual pleasure and/or difficulties
    - Issues in "negotiating" safer sex

- STIs and HIV – Factual information

Session 10:

- Review of issues regarding FGC
    - Legalities in Canada and other countries
    - Health consequences

- Cultural change
    - Takes time/complex process
    - Community change
    - Women as leaders/teachers of change

- Give certificates
- Evaluation