MANUAL

Culturally Sensitive
Sexual and Reproductive Health Education

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1 INTRODUCTION

1.1 Vision

At 'Expertisecentrum Kraamzorg Volle Maan', a maternity care expertise centre, we want to inform vulnerable target groups about the full range of available contraception methods, so they can make a conscious choice for themselves and their families, regardless of their origin or religion.
An additional goal is to empower (vulnerable) women and men to make them more resilient vis-à-vis their partners and family doctors, so that they can stand up for themselves.
We start with the essential basic information about fertility and both female and male anatomy, because this knowledge is often lacking. This requires a safe setting where taboos and myths about contraception and sexuality can be discussed.

1.2 Purpose

It's not always easy to broach the topics of sexuality and reproductive health – especially in our super-diverse society, where people from different backgrounds and cultures, holding different values and beliefs, come into contact with one another.

Hanan: *"My interest and motivation to draw up this script stem from my own practical experience as a midwife. Over the years, I've encountered a lot of taboos and ignorance, with all the consequences this can have. I also got some questions from colleagues who were unable to process these experiences within their own frame of reference."*

The purpose of this manual is to provide counsellors with insights, helping them to understand how they can provide sexual and reproductive health education in a culturally sensitive manner to both adults and teenagers with different cultural and religious backgrounds. It explains how to broach the topic of birth control, focusing on taboos, communication barriers, the influence of family members and relatives, and Western versus non-Western norms and values.

The manual contains both a theoretical and a practical section.

The first section, **'Counsellor Insights'**, presents some essential background knowledge in terms of culturally sensitive education that every counsellor should be aware of. This theoretical part deals with the views on sexuality and birth control held in different cultures and religions, but only to clarify, not to over-culturalize or stigmatize. The counsellor's attitude and approach are of fundamental importance. Every counsellor should be aware of their own cultural and religious perspective in order to strive for neutrality in their presentation of facts and information.

The second section, **'Course Outline'**, is the practical part, supported by an information kit containing visual and didactic material. Counsellors taking this course are expected to have adequate basic knowledge of the currently prevalent information on sexuality, contraception and birth control.

This is a practical application aimed at increasing **health literacy**, i.e. increasing knowledge or skills in terms of health. This concept is defined as "the knowledge, motivation and competence to access, understand, appraise and apply health information in order to make decisions in everyday life regarding healthcare, disease prevention and health promotion, thereby maintaining or improving one's own health throughout one's life" (Sørensen et al., 2012; Vancorenland et al., 2014).
A joint study by CM, UCL and KUL has revealed that in Brussels, only 52.5% of the population has an adequate level of health literacy (Vancorenland et al., 2014). This means that 47.5% of Brussels residents have an insufficient level of health literacy.

Providing information alone is not enough to change behaviour (education only accounts for 20% of **behavioural change**). The way the information is presented can make a big difference. With the following three adjustments, you can achieve up to 60% behavioural change: make the information tangible, personalize it, and ensure that there is interaction. It's also important to connect to the individual's personal values, which ultimately determine their behaviour. These values can be different for every group. Social norms are a great motivator (Cross, 2013). Switzler (2012) also states that "skillpower" (knowledge, personal skills) and social motivation are major factors.

The information kit aims to contribute to this in three ways:

We want to impart **knowledge** in a comprehensible way, **adapted to the target group**: using illustrations and demonstration tools to inform women about the functioning of their bodies and to familiarize them with the possibilities of family planning.

There is also a **referral** section: where can women go if they have certain questions or concerns after the information session? The kit includes various publications from specific organizations.

The third aspect of the kit is very important: stimulating the **exchange** of experiences, being able to ask **questions**, discussing and **breaking taboos** through dialogue, and increasing communication and social skills.

All this is necessary to give women the confidence to make a conscious choice for themselves and their families.

1.3 Project history

In 2006, the Volle Maan maternity care expertise centre conducted a literature study on the influence of contraceptive behaviour on the abortion percentage in immigrants, and took stock of the needs of hospitals and organizations in Brussels. This was done in light of the high abortion rates in the Brussels Capital Region, in part due to a high number of abortions among immigrant women. This survey shows the specific need to provide more education on contraception to vulnerable target groups.

In 2008, after consultation with the Flemish Community Commission (*Vlaamse Gemeenschapscommissie*, VGC), Sensoa (the Flemish sexual health expertise centre) and several Brussels-based organizations working with vulnerable (pregnant) women in Brussels, the Volle Maan maternity care expertise centre submitted a project request concerning 'vulnerable (pregnant) women in Brussels'.

Based on existing materials and our own experiences, a preliminary training package was developed and tested. In the evaluation phase, the additional needs of vulnerable (pregnant) women were identified. The different organizations' visions on contraception were also recorded.

In cooperation with Sensoa, a 'contraception' course package – including a script and a physical kit – was put together, tested, evaluated and adjusted where needed.

All this took place between 2009 and 2012, after which the 50 physical kits were presented to the public and distributed throughout Brussels and Flanders.

In view of high demand, an extra set of kits was produced in 2017.

1.4 Description of the target group

We live in a multicultural and multi-ethnic society with different cultures, even within the 'native' population. Due to successive immigration flows, our country's population diversity has increased in recent decades. It will therefore become increasingly difficult to describe our current complex society using concepts such as Belgian and non-Belgian, new Belgian, native, immigrant, migrant, newcomer, or in terms of different nationalities or us-versus-them perspectives. Nowadays, the preferred term is 'person with a migration background', rather than 'immigrant' (or Dutch *'allochtoon'*).

Furthermore, we now live in a '**super-diverse**' society – a concept that shifts the emphasis from people having diverse origins to the fact that there is great diversity *within* this diversity.

It is therefore no simple task to circumscribe the target group of this course. That's why it's important to take a moment to define the terms used in this manual.

The wording we have chosen is: 'vulnerable (pregnant) women in Brussels'.

Our definition of '**vulnerable**' is based on the concept of socially vulnerable families as defined and used by the Flemish child welfare agency 'Kind & Gezin':

*"Socially vulnerable families are families threatened with exclusion or living in exclusion. These families have **poor access** to socially valued goods such as work, income, housing, education and health care. These are five of the six areas that we discuss at Kind & Gezin when we talk about social disadvantage.*

*And in the case of immigrant families, there are two additional aspects that increase the risk of exclusion: the **language gap** and the **cultural gap**".*

In this project, we want to focus especially on the latter two elements that make it harder for some groups to find the right information. This doesn't mean they meet all the criteria of social disadvantage.

Research and surveys have shown a particular need for education and information in first- and second-generation individuals with a non-Western migration background. This means that social workers need training and educational material for this specific target group.

In order to bridge the language gap to some extent, this package contains a lot of visual material. Of course, an interpreter can also be present if necessary. As far as the culture gap is concerned, this manual focuses heavily on culturally sensitive elements.

Furthermore, we are convinced that this **educational package can also be used** (in its entirety or in part) as a preventive method for other target groups, for instance in **schools, youth movements, asylum centres, community health centres** ... Parts of it can also be used for individual questions.

2 COUNSELLOR INSIGHTS

2.1 Counsellor profile

We do not require prospective counsellors who will be using this course package to have a specific degree. However, we do want to discuss the necessary background knowledge on the subject of sexual and reproductive health and the right educational attitude.

2.1.1 An empathic and convinced attitude

A basic precondition for anyone giving this course is the ability to speak fluently about this topic, with a very empathic and understanding attitude. Speaking to a group, asking questions about sexuality and expressing your opinion without judging anyone are things you must be comfortable with.

Openness, sincerity and sometimes being vulnerable are important in order to establish trust.

Motivation and conviction seem only logical, but it's still important to discuss these aspects. Motivation tends to be contagious in a group. In order to guide and motivate a group, you have to believe what you teach. Only then can you overcome the initial reluctance among participants, which is definitely present at first.

Having people in a group connect and bond is best done through interaction.

2.1.2 Personal values and standards

Being aware of your own set of values and standards when it comes to sexuality, contraception, religion and relationships is very important.

After all, it's quite likely that group participants will ask you personal questions. You are not obliged to answer these questions, but you should be prepared to set and defend your own personal boundaries.

You should be able to give an honest, well-defined answer without judging or discriminating, and show openness and tolerance towards values and standards that differ from your own.

Be aware of your own cultural perspective. Don't present your own standards, values and opinions about relationships and sexuality as superior to others. Avoid a paternalistic attitude; instead, engage in dialogue.

Try to put yourself in the other person's shoes and show interest in important cultural issues.

2.1.3 Communication

Focus on language

It's important to know the country of origin of the participants and the language they speak. Consult with the organizers to find out which language will be understood the most (Dutch/French/English/...). The course should preferably be taught in that language if possible, or translated by interpreters. This is why we've opted to use a lot of visual material to support the course.

Means of communication

Verbal communication is an interaction – an exchange of information between two or more individuals. One person conveys a message and another person receives it. Communication is considered successful when the effect of the message on the listener corresponds to the speaker's intention.

If this is not the case, this is because the signals that are sent, perceived and received – either consciously or subconsciously – can be interpreted in different ways. Being aware of your own body language, facial expressions and gestures is essential. That's why it's important to ask for feedback regularly over the course of every session.

Another problem that can arise is that people don't listen carefully to each other and ask unnecessary questions. Setting a good example by actively listening and structuring what has been said will help you facilitate effective communication. Empathizing with others and accepting them with an authentic and sincere attitude creates an atmosphere that allows open and honest communication.

In the case of topics that seem sensitive or taboo, it's also important to keep an eye on the participants' non-verbal communication cues in order to respect their boundaries. You can then turn to the group and ask a question if you don't understand something someone has said (e.g. 'I see that some people don't agree with this, am I getting it right when I say ... can someone explain to me ...') and let the group take it from there.

It's important to be open to dialogue and to listen attentively to what the participants have to say, as this can contribute to the quality of the course. As a counsellor, you don't have to know everything about other cultures or religions, but you have to be interested and ask questions.

2.1.4 Humour

Laughter is universal, which makes humour a good means of communication to broach and discuss difficult topics.

More and more studies point to the useful effects of humour.

Laughter is relaxing and helps people deal with their fears, it creates a sense of group solidarity and allows participants to bond. This can make topics that are sensitive or taboo easier to discuss. Humour soothes, disarms, relaxes, connects, liberates, breaks the ice and lowers stress. Humour also stimulates the memory, making it easier to remember information. Everyone knows that laughter is the best medicine, and yet it is often underutilized.

At the beginning of a session you will feel some tension in the air, as most of these women will be quiet at first. But that doesn't mean they're not curious about what you have to say. You don't need to have a particular talent for humour, but as soon as a funny or silly situation arises, it's best to seize that opportunity to create a relaxed atmosphere.

Humour should not be hurtful, sexist, discriminating or exaggerated. There are many types of humour. You should start not by reasoning within your own context, but by putting yourself in the shoes of the target group and picking the right moment, with mutual respect.

2.1.5 Discussions or conflicts

In a group, discussions may arise when it comes to certain topics. It's not an easy task to steer these in the right direction without spoiling the atmosphere and interaction. If the atmosphere is already hostile or tense, it's not a good time to start talking about sexuality. In that case it's better to start with a general topic such as health, the menstrual cycle and body changes.

It's important to approach discussions in a neutral and impartial manner and to resolve them with respect for everyone's opinion. Everyone has their own opinion, but as the facilitator of dialogue you don't always need to express your opinion, let alone impose it.

To frame the discussion, you can use your background knowledge and scientific information.

Respecting opinions, values and norms that don't correspond to your own is of vital importance. If you yourself have a hard time with what is being said in the group, you should bring it up for discussion in the group. Otherwise it can negatively influence the further course of events.

In your role as the counsellor and facilitator of dialogue, you should never present your own knowledge as the ultimate and only truth; your role is to supplement the group's existing knowledge and adjust it where necessary. That way, you establish basic trust.

2.1.6 Security and privacy

A safe group atmosphere is an important precondition in order to be able to broach themes such as relationships, sexuality and birth control. Participants should feel that they can talk freely, without being judged.

If the atmosphere is tense, you can start by exchanging experiences to see which topics they would like to discuss, until the atmosphere is safe (again).

At the beginning, you agree that what is said in the group stays in the group, and that everyone's opinion is to be respected. Especially in groups of people from many different cultural and religious backgrounds, it's best to split them up into smaller groups. Discussions about what is good and what is bad can be brought to the whole group, in order to reach an overall conclusion. It's up to you as the counsellor to keep the conversation on the right track.

It's important to start from a place of mutual respect for each participant's privacy and boundaries. If these are not clear, it's best to check with the group what they want to discuss in what order, for instance, or which topics are particularly interesting to them.

2.2 Culturally sensitive counsellor insights

2.2.1 What is cultural sensitivity?

What do we mean by **cultural sensitivity**?

Making people more culturally sensitive means making them aware of the discrepancy – and the need for balance – between the one-sided (Western) cultural determinants of care provision and the diverse cultural determinants of care demand (Council for Public Health and Health Care, n.d.).

Cultural anthropology teaches us that behaviours don't reveal their real meaning if we don't relate them to the culture in which they're embedded.

In order to provide culturally sensitive sexual and reproductive education, it's important to have insight into the attitudes, values, standards and religious beliefs of the target group and to be able to discuss taboo subjects.

It's more than just providing information – this insight is essential.

As mentioned in the introduction, different cultures and religions are discussed in this manual, but only to clarify certain aspects, **not** to **over-culturalize** or stigmatize. By no means do we intend to generalize, as the aim is merely to discuss the sensitivities specific to different groups of people by applying knowledge. This can be a basis for dialogue in heterogeneous groups.

In addition to one's cultural background, every individual is also influenced and shaped by characteristics such as age, social class, sex and gender, sexual orientation, family situation, migration background, ethnicity, physical and mental ability, education, geographical location, media use, residence status, language, health status, religion, wealth, property, social development, nationality, skin colour, and so on. These are not just 'details', but veritable axes of identity. They shape who we are and what position we get, and are able to take, in society. Every individual stands at a different intersection of these various **axes of identity**. This is called intersectional thinking – a way of thinking about differences and power inequality. All these axes intersect and influence each other. Together, they determine our position, our behaviour and our thinking. The opportunities presented to us are also related to this. After all, society holds certain characteristics in higher esteem or considers them more 'normal' than others (Jong & Van Zin and *ella* vzw, 2016).

Intercultural communication is about bridging differences in the way messages are coded and interpreted. This bridging is facilitated when you become aware that these differences exist. Knowledge of cultural differences also helps, because you can then make adjustments in the way your message is coded and interpreted, so that there is a greater chance of a good mutual understanding (Women's Council, 2014).

In **interculturalization**, the emphasis is on the diversity of ethnic-cultural backgrounds of migrants, which needs to be recognized when providing services. Interculturalization is not a goal to be achieved, but a means to an end: it helps improve the quality of care for migrants and it helps match care supply to care demand. It's a policy aimed at making healthcare facilities more culturally sensitive, so they can provide the same quality of care and equal access to care to both foreign and native (potential) care seekers (Council for Public Health and Health Care, n.d.).

2.2.2 The Western View of Sexuality and Reproductive Health

It's important for us as Belgian care providers to realize that we operate within the framework of Western European culture and history. This awareness of our own frame of reference is important, because it influences the way we work and interact.

In the sixties, the sexual revolution brought about a change in the attitude towards sexuality in Western European culture. Sexual acts are considered normal, as long as they take place between consenting adults and don't affect the integrity of the partners.

The **sexual revolution** is a Western concept, focusing on individual development and fulfilment, and questioning both marriage and the traditional patriarchal nuclear family. Sexuality was disconnected from procreation with the advent of the pill as a means of contraception.

Today, the consequences of sexual freedom are apparent throughout society: in the media, advertising, magazines, the internet, music, fashion, clothing, and so on. Everywhere you look, you are confronted with it.

On the other hand, the sexual revolution opened up discussion on the topic of sexuality. Openness was created to talk about contraception, including the possibility of discussing abuse.

For some years now, we've been hearing about **hypersexualization**. More and more parents and educators are confronted with the influence of sexuality on the media, the internet and the advertising world. Advertisers are using sexuality in their ads, often objectifying women's bodies in the process, which is detrimental to women's self-image.

According to Jocelyne Robert, sex therapist and author, children in the twenty-first century are stimulated early on to behave sexually like adults. She has observed this particularly in Western countries (*Centre de Documentation et d'Information de la Fédération Laïque de Centres de Planning Familial* (FCLPF-CEDIF, 2011).

Puberty is a crucial moment when teenagers go in search of their own identity, looking for role models to relate to in terms of clothing, attitudes, behaviours, idols, music, and so on. These are all important identity-building elements, determining whether or not one belongs to a certain group.

Prof. Adriaenssens notes that young people do explicitly ask for boundaries and authority. They

want someone, preferably their parents, to tell them what is right and what is wrong.

Sex therapist Nathalie Trépanier has been studying the subject for several years now and visits schools to educate students. She recommends that parents communicate more proactively with their children about sexuality, in order to empower them and make them more resilient to this societal hypersexualization that is often trivialized in the media, yet doesn't necessarily correspond to reality (FLCPF-CEDIF, 2011).

2.2.3 Sexual and reproductive health of people with a migration background in Belgium

Of course, people of foreign origin need proper follow-up within the healthcare system, including when it comes to reproductive health, but they don't always have access to it.

To put things in perspective: the **risk of poverty** is 12% for Belgians, 18% for people from north-western Europe, and 22% for southern Europeans (Spain). For people of Turkish origin this is 33%, and 54% for people of Moroccan origin. The situation is even more precarious for undocumented migrants, whose risk of poverty is 95% (Dierckx et al., 2011).

A recent ULB study commissioned by the King Baudouin Foundation shows that **41.5% of children in Brussels are born into poverty**, and 27.6% even into deep poverty (De Spiegelaere et al., 2017).

During the perinatal period, the socio-economic situation of mothers deteriorates. Coming from a non-European country, and especially from sub-Saharan Africa, increases the risk of poverty, as does single parenthood. Add to this the fact that 75% of mothers giving birth in Brussels have a migration background, and that one in every six children is born into a single-parent family, and it becomes clear that many children in Brussels are born in precarious circumstances (De Spiegelaere et al., 2017).

A. Abortion and Contraceptive Use in Figures

We start off by using data from the literature study conducted at KULeuven commissioned by the Volle Maan expertise centre in 2011.

In Brussels, the heart of Europe, there is a high number of abortion clients with a migration background.

Immigrant women are significantly more likely to undergo an abortion, and contraceptive use is significantly lower among immigrant abortion clients than among native Belgian abortion clients. A significant proportion of immigrant women does not use any form of contraception or uses it incorrectly, increasing the likelihood of an abortion. This leads us to draw some essential conclusions.

There is an important difference between the use of contraception by newcomers and by established, mostly second-generation, young women. Among newcomers, ignorance and insufficient knowledge play a crucial role, due to the poor socio-economic situation many of these women find themselves in. Established immigrant women usually have this knowledge, and in many cases do use contraception. However, they don't always use it correctly. This is mainly due to culturally and/or religiously determined representations, which in many cases have a major influence on the contraceptive behaviour of these women (Peeters & Ben Abdeslam, 2011).

Next, we provide relevant information from the report on the 'Round Table on Vulnerable Migrants' (Sensoa, 2011).

The report of the National Evaluation Commission on Termination of Pregnancy does not provide detailed information on the number of immigrant women and girls undergoing an abortion in our country. Research among clients of abortion centres in Flanders and Brussels shows that 40% of the women undergoing an abortion are of migrant origin, 80% of whom are newcomers (Vissers, 2004).

When we look at girls under the age of 20, we see a vast difference in abortion rates between Flanders and Brussels: 4/1000 in Flanders, 11/1000 in Brussels. This difference is due to the percentage of non-Belgians, which is higher in Brussels.

Research by Goosen et al. (2009) indicates that in the Netherlands, too, high abortion rates are observed among asylum seekers who are pregnant upon arrival or who became pregnant in the months following their arrival. In the case of underage asylum seekers, both birth and abortion rates are higher than in the average Dutch population. Van Rooijen (2007) points out that the abortion rate among asylum seekers in the Netherlands is almost four times higher than among native Dutch women.

Other actors also emphasize the need for more basic information on contraception, where you can get it, how much it costs and how you can get it reimbursed. There are many misconceptions about contraceptives, how to use them correctly, when to use them and their long-term impact. They typically stem from a general lack of knowledge about one's own body, fertility and pregnancy. Unplanned/unwanted pregnancy is a frequent reason for consultation. An abortion is often not explicitly requested because it is considered (culturally) inappropriate.

B. Information from test cases

The following quotes were taken from the first test phase of the 'Vulnerable (pregnant) women in Brussels' project in 2009, at which time a survey was held among 94 vulnerable women in Brussels.

"When I was young, this was never talked about. I was only told that girls who menstruate have to stay away from boys. I'm starting to have more questions about that as I get older."

"My parents assume that I'm not sexually active, so we never talk about it at home – the subject is completely off the table."

"I've stopped taking contraception, because otherwise the blood will pile up in my body and I'll get a brain haemorrhage."

"I freaked out the first time I had my period. I didn't dare to talk about it with my mother and I thought I was going to die."

After the first few information sessions given by the Volle Maan expertise centre at five Brussels organizations that reach out to vulnerable (pregnant) women, an evaluation report was drawn up, containing a quantitative and a qualitative part. The latter in particular confirms that there is still a lot of work to be done to further propagate reproductive health information.

In the qualitative part, it was found that:

- ignorance and myths affect the use of contraception;
- most participants received their information about contraception from people close to them;
- both first- and second-generation immigrants reported that they were insufficiently informed by their doctors about the full range of available contraception methods and their side effects;
- everyone felt that men also needed to be encouraged to participate;
- most women said contraception is expensive, but essential.

C. Conclusion

All the research and literature studies point to a manifest lack of information about contraception and to the high preventive value of proper education. Vulnerable women literally live in conditions that leave them disadvantaged (both financially and materially) and isolated. Then there's also a great deal of ignorance and cultural taboos that make them even more vulnerable. Due to various factors, they find themselves in a situation where they are forced to prioritize their daily basic needs (food, water and shelter) over their own sexual and reproductive health, with all the consequences this can have. They remain extremely isolated and often only ask for help when it's too late.

Without wanting to generalize, the biggest difference between Western natives and non-Western immigrants does seem to be their level of sexual freedom. And while the sexual revolution has made sexuality discussible, it has also led to hypersexualization. Some young people are having a difficult time setting their own personal boundaries because society puts sexuality in the spotlight in so many ways, including when it comes to advertising, clothing, food, and so on.

On the other hand, there appears to be a lot of poverty, exclusion, ignorance and sexual taboo thinking among non-Western immigrants. This makes them more vulnerable. There is also a component of fear, in that they find sexuality in Western countries too free and they want to protect their children by not talking about it.

2.2.4 Sexual education in different cultural and religious contexts

Young people's sexual norms and values are shaped by both their religious and their cultural backgrounds, which are intertwined. Parents, friends, personal experiences, media and other elements in society also exert an influence on them.

People who come from a different culture, and who settle in another country, are confronted with norms and values that may or may not be completely **different** from those in their country of origin. It takes time and effort to adapt to this. The confrontation with free interactions in relationships, sexuality and contraception in Western countries can be quite shocking for some. There is also a component of **fear**, in that they find sexuality in Western countries too free and they want to **protect** their children by not talking about it.

Religion in itself is not always an obstacle to sexuality; often, cultural traditions are the most important determinants of how people deal with it.

Young people from different countries and cultures have usually had a completely different upbringing. When working with multicultural and multireligious groups, it's important to develop a programme that speaks to young people in terms of content and methodology, while recognizing, respecting and appreciating their differences (Van Ginneken, 2004).

> *"The way I was raised is that you should never use any sort of contraception, or even talk about it."*
>
> *"In Central Africa, my faith doesn't condone using a condom, as condoms are linked to prostitution."*
>
> *"People are discouraged from using an IUD because there would be conception, so it's a form of abortion."*

A. Taboo

It's important to be aware that immigrant women's contraceptive behaviour is a complex phenomenon, because their cultural and religious background can have a major influence on their sexual behaviour – including the use of contraception (Peeters & Ben Abdeslam, 2011).

The needs of vulnerable migrants with respect to their sexual and reproductive health need to be understood from their cultural background. The taboo on talking about sexuality has been cited frequently in this regard. Both professionals and people from the target group have indicated that it's difficult to talk about contraception, abortion, sexual experiences, teenage pregnancies, virginity, circumcision, HIV and homosexuality. They don't talk about such topics with their partners or family members, and there are barriers to overcome to even consider counselling. Talking to an outsider about intimate subjects is very difficult, even for Western women.

People's attitudes towards fertility and contraception are largely influenced by their culture. Abortion, for example, is a difficult topic in some cultures, while it's easier to broach in others. **Male/female relationships** are different in every culture, which often leads to confusion about what behaviour is expected of them in relationships between men and women. **Cultural and religious beliefs may clash**. There are various beliefs and views when it comes to marriage, pregnancy, breastfeeding and sexuality (Sensoa, 2011).

Several researchers, including Loeber (2003), Rademakers et al. (2005) and Decoodt et al. (2009) point out that taboos, myths and cultural traditions may affect (vulnerable) migrants' sexual and reproductive health. The consequences of never talking about sexuality can be significant: contraception is not requested, HIV tests are not carried out, (honour-related) violence is not reported, abortion is not up for discussion. For example, Decoodt et al. (2009) state that Roma girls and women in Temse and Sint-Niklaas are getting more and more access to contraception, but this is kept quiet, as it's still very much a taboo in their community. Since girls are often married off young, this leads to pregnancies at an early age (Sensoa, 2011).

Because of their migration background and the (cultural) taboo to talk about sexuality, many migrants have an **information deficit**. Both professionals and migrants themselves indicate that they lack basic knowledge about their own bodies, fertility, contraception and sexually transmitted diseases. They are also often unsure about what constitutes **acceptable sexual behaviour**, making it more difficult for them to report sexual violence and to grasp open displays of prostitution or transsexuality. They also want more information about divorce. In addition, some migrants indicate that they would like more information on specific aspects, e.g. African women want to know what to do after a circumcision and where they can get an HIV test. People living with HIV want to know whether and how they can still have children. Several members of the target group have indicated that they would like to get information from multiple sources (Sensoa, 2011).

B. Talking about sexuality

"Talking about contraception is not allowed, because that would indicate that you're sexually active, which is not allowed before marriage."

"Talking about sexuality is taboo in our culture. So very little is said about it during childhood, and as a result we have a lack of knowledge about contraception."

With family and with each other

Several studies on sexuality carried out by the Dutch Rutgers Nisso Group among young Moroccans showed that most of them had not received any education or information from their parents on sexual development, let alone about the experience of sexuality, which is even more taboo.

Shame in particular, but also the **lack of conversation skills**, keeps parents from providing sex education.

In addition, these young people also indicated that, out of shame and respect, they would rather not talk about sexuality with their parents, even though they know there are no religious barriers to talking about it (Berhili, 2010).

Boys find it relatively difficult to talk about the risks associated with sexual behaviour. Girls say it's especially difficult for them to talk about sexual feelings and desires.

If sexuality is brought up at all in their families, it is mostly to condemn 'non-legitimate sex'. It's considered **inappropriate** to talk about sex with one's parents. People feel ashamed. The fact that the subject of sexuality is swept under the rug can create problems for young people.

It also turns out that young Moroccans and Turks rate their own so-called 'interaction competence' lower than young people with a Dutch, Surinamese or Antillean background (University of Maastricht for SOA Aids Nederland, 2005). This **interaction competence** refers to various skills: being able to talk about sex, knowing what you want and what the other person wants, being confident about your appearance and performance, being able to set boundaries, and respecting one's sexual partner. These skills are needed to ensure that sexual contact is safe for both partners (Azough, 2007).

With care providers

Schoevers et al. (2009) suggest that aid workers should actively ask about gynaecological and psychological problems.

Migrants say they appreciate it when their doctor or counsellor **takes the initiative** to broach the topic of sexuality. This empowers them to ask the counsellor more questions. Both counsellors and migrants are **reluctant** to talk about sexuality, but migrants are actually asking to break the taboo. For example, asking for condoms is a major hurdle for them to take, so they want condoms to be easily accessible. "*They should give free condoms, for instance when they give out food. People shouldn't have to ask for them. That is a major obstacle.*" There needs to be a sense of openness, trust and safety to be able to talk about this sensitive topic (Sensoa, HIVsam and ICRH, 2011).

The **PLISSIT model** (Mercer, 2008) can help professionals discuss sexual health. The acronym refers to four different levels of intervention:

Permission: "allowing" someone to talk about a sensitive subject – for instance by asking how things are going and then segueing from more general to more intimate topics, thereby signalling that sexual health is a normal and appropriate topic, and that you are willing to listen in an open and non-judgmental way. Simply feeling able and allowed to express sexual concerns and to broach certain topics can often be a big part of the solution.

Limited Information is about providing only the information that is relevant to the situation at hand, so as not to overwhelm the care recipient with too much information.

Specific Suggestions: giving specific advice related to the topics discussed, such as advice on the use of contraception, safe sex, better communication with one's partner, and so on.

Intensive Therapy: referring the care recipient to a specialist in case of specific issues (Mercer, 2008).

It's also important to keep the different dimensions of sexuality in mind. The **biopsychosocial** model emphasizes that sexuality is not just about biological factors, since psychological and social aspects also play a role, and that there is constant interaction between them.

C. Conclusion

Both the surveys in our project and other research and interviews have revealed a lot of myths surrounding sexuality, and significant cultural and religious taboos when it comes to communicating about it.

Young people receive hardly any sex education at home, because it's considered a given that they will not be sexually active before marriage, even though this is not always the case in reality. In addition, young people say that, out of shame and respect, they would rather not to talk about it with their parents.

Parents are often not sufficiently equipped to provide sex education. They are held back by a lack of communication skills, ignorance and cultural barriers, and they don't know where to start.

Since the subject is so sensitive and there's a lot of reluctance, it's up to the counsellor to ask direct questions in order to assess the situation and to be able to help.

Both parents and young people need culturally sensitive information.

Culture and religion have a tremendous influence on the experience of sexuality. The next chapter will provide some insight into the impact of culture and religion on sexual and reproductive health.

2.2.5 The Difference Between Religious and Cultural Aspects

Religion is about believing in a higher supernatural and divine power. Religious people firmly believe in the existence of one or more gods. This belief, combined with the assumption of an entire set of related ideas and precepts, influences people's values and norms, their views and their behaviour. However, religion is about more than that. Above all, it's a system that provides meaning and purpose. On the basis of their religion, believers often give a certain meaning, purpose and value to life. Religious precepts contain both implicit and explicit norms governing sexual behaviour (Van Ginneken, 2004).

A **culture** can be defined as a set of unwritten values and norms, passed on from generation to generation, that form the basis for people to live together. We are all born into a certain culture, and in the earliest stages of our lives this culture is instilled in us during our upbringing. Children learn to understand and use certain symbols and signs, even though their meaning can vary greatly from culture to culture.

Different countries have different cultures: in non-Western countries, for instance, group culture is much more important, while Western culture is focused more on the development of the individual.

The existing differences between cultures reflect the different efforts that each society has had to make to survive in its specific reality. Without this process, it would be impossible for a child to live within a particular culture. Culture is experienced differently by each of us. Each person is the result of a mixture of their culture and their own individual characteristics and experiences. This process is further enriched if you live in two or more cultures at the same time.

Cultures change all the time and are not static, as they are subject to processes in which old habits make way for new ones.

There is not always a clear divide between religion and culture: sometimes they overlap, and sometimes they are even strongly intertwined. Religion is always embedded in a certain culture. Given that they influence people's opinions and behaviour, religion and culture also have an effect on daily life – and thus on personal and sexual expressions and experiences (Van Ginneken, 2004).

2.2.6 Religion, Sexuality and Reproductive Health

The influence of **religion** on sexuality has been proved by studies comparing strictly religious people to less strict believers (Van Ginneken, 2004). The conclusions were as follows:

- Religion influences the moment of first sexual contact, as many believers vow not to have sexual contact before marriage.
- Religion determines the method of contraception used.
- Religion influences which sexual acts one might try out.
- Religion influences the expression of sexual orientation.

- Believers report greater mental and physical satisfaction with their sex life, despite the fact that their religion seems to impose certain sexual limitations.

Since the surveys and research conducted in our project also show that religion has a major influence on sexual and reproductive health, it's important for counsellors to have insight into the views on sexuality that are held in different religions.

Of course, it would be impossible to describe all the world's religions in this document. Given that the vulnerable target groups identified in this project mainly include Muslims (North-African, Turkish, Iraqi, Chechen) and Christians (Romanian, Central-African, Filipino, Brazilian), we will delve deeper into these two religions below.

A. Christianity

The two largest forms of Christianity are Catholicism and Protestantism (with the latter including a number of different movements). With regard to sexuality, these two differ mainly in how strictly the rules and guidelines are adhered to.

According to strict Christian doctrine, sexuality is only allowed after **marriage**, until which time believers are expected to maintain their virginity.

Christian immigrants from Asia, Africa and Eastern or other European countries are devout (and more orthodox) followers of religious guidelines. Some immigrants consider themselves to be part of Eastern Christianity, which is technically neither Catholicism nor Protestantism. This movement emerged in another time (1054 A.D.) and place (the Middle and Far East). The culture of their country of origin has an extensive influence on the religious experience of Christian immigrants. Sometimes they blend rituals from other (smaller) religions, such as ancestor worship and a certain focus on the supernatural, with those of the Christian faith.

Rules for sexuality are usually imposed by the community and religious leaders. In general, Christian migrants strictly abide by these rules and guidelines. They are more likely to disapprove of premarital and extramarital sex and therefore less likely to give their children the freedom to go out and experiment with relationships.

Contraception is not condoned by Orthodox Christians, while moderate believers do condone its use and even consider it a positive development, both individually and socially.

Abortion is not accepted by many Catholic believers, although in most Western European countries it has been legalized under certain conditions. The Belgian abortion law of 3 April 1990 allows abortion for any reason until the 14th week of pregnancy, and after 14 weeks only if the child has an incurable abnormality or if the pregnancy endangers the life of the mother. Christians from non-Western countries are more strongly opposed to abortion, even if it's legal in their home country.

Talking about sexuality, both to one's family and to outsiders, is still a sensitive matter for both Catholics and Protestants. It's rarely done openly, especially among fellow immigrants, who generally adhere more strictly to religious rules and guidelines.

Sex education would be welcomed more by moderate believers than by Orthodox Christians, who are more likely to find it reprehensible. When educating Christian immigrants, it's important to take into account feelings of **shame** among young people, and possibly a negative attitude of parents towards sex education. Involving parents in sex education might reduce the fear that their children would be encouraged to have sex as a result.

Eliminating prejudices is another important aspect when giving information to young people with a Protestant or Catholic background. For instance, many young people from Eastern Europe believe that the pill and IUDs can cause cancer, and that coitus interruptus is only meant to increase male potency (Van Ginneken, 2004).

B. Islam

Islam recognizes that people have a sexual drive, and therefore sexuality is not solely meant for reproduction, but also to be enjoyed after **marriage** (between a man and a woman). Both have the duty to satisfy their spouse's sexual needs. Boys and girls who are not yet married are expected to maintain their virginity. However, reality tells a different story. For Muslims, faith and culture are often strongly intertwined. Sometimes the two are mixed up. Female genital mutilation, for example, is wrongly associated with Islamic rules and regulations.

Often such things are attributed to religion, while in reality they are a matter of culture or interpretation, as is the case for the myth of virginity. Nowhere in the Quran does it say that women should be able to prove their virginity on their wedding night. In practice, sexual morals are causing problems for many women.

Contraception is used to buy some time between pregnancies, to avoid jeopardizing the health of both mother and child(ren). In light of this, only temporary contraceptives (condoms, the pill, a patch, an implant, a vaginal ring or an IUD) may be used, so long as they aren't harmful to the woman's health. Some women will be opposed to an IUD, because conception may occur due to the fusion of the ovum and the sperm, so they might consider it a form of abortion. There are also women who got an implant, but had it removed because they hadn't been informed about the side effects, such as intermittent bleeding and, in the long term, no more bleeding. Many women in the project have indicated that it's important for them to still be able to menstruate while on contraception. They either want to be able to prove that they are still fertile, or they believe in the common myth that blood would accumulate in the body and cause disease. Because the values and norms of each woman are different, it's important to have a good conversation with each individual woman about what exactly it is that she wants, and which advantages and disadvantages that may have, so there are no unpleasant surprises down the road. Most women indicated in the survey that they received hardly any information from their doctor about the possibilities and the pros and cons. Sterilization is not allowed, unless the woman's health and life are in danger.

Within Islam, **abortion** is not completely forbidden. Many scholars draw the line for abortion at the moment the foetus gains a soul. For some, this 'ensoulment' can occur as late as the fourth month, while others limit the period to forty or fifty days. After four months, abortion is out of the question, except when the mother's life is at risk. The subject is highly debatable, and closely linked to the religious view of birth control. However, there has never been a complete ban. Much of Islam's regulation of abortion is based on the religious view of foetal development. The Quran, the prophet Muhammad and modern science actually have rather similar views when it comes to reproduction and the different stages of development of the foetus (*Imam Abdulwahid van Bommel in Islam, Love and Sexuality*).

Since premarital sex is not allowed, in the event that an unmarried woman gets pregnant, abortion always takes place in complete secrecy in the countries of origin. The social control principles of **honour** and shame weigh so heavily in these societies that any abortion is kept secret. This can perhaps be compared to the 1950s in Belgium, before the sexual revolution.

Nevertheless, it is important for the existential processing of the abortion to look at the moral framework of the religion the woman adheres to. It's good to know, then, that the dominant view in both legal and religious literature tends towards general consent (Azough, 2007).

Sexual **education** is **a right and an obligation** in Islam, provided that it is carried out in sexually separated groups or within the married couple. In reality, however, this right is rarely claimed and there's a great deal of ignorance. The same ignorance is found in the first generation of migrants who came here to escape poverty and to build a better future.

There are relatively many first-generation Muslims in Belgium who can neither read nor write. Their religion was passed on to them orally by their parents and grandparents, including many cultural taboos and myths about sexuality that don't correspond to Islam. In turn, they have verbally transmitted these stories to their children, who are now the second generation. Ignorance and cultural myths are important causes of many sexual and reproductive health problems.

The second-generation Muslims, who were mostly born here and who also studied here, experience difficulties due to the **discrepancy** between what was instilled at home and what they experience in Western society (school and social life). Young people also have the opportunity to study and to better understand and grasp things. Yet on the one hand they want to remain loyal to their families, who sacrificed themselves for them, and on the other hand they want to evolve within Western society. This means that the sexual experience of these young people doesn't always go smoothly and that their parents don't have an easy time of it either, because they don't talk about it. That's why educating these two target groups is very important, taking into account their cultural sensitivities.

It's important to take the views of young people and their parents seriously when talking to them, and not to judge them. You should respect their opinion if they think they should remain virgins until marriage, or if they don't want to embarrass their family.

Attention should be paid to questions such as: How important is being a virgin to you? What exactly is a virgin? Why is there a difference between girls and boys? Is it a cultural or a religious difference? Do you feel you can communicate your desires and boundaries during sexual contact? How do you know what the other person wants and doesn't want? Do you use contraception? Is the subject of sexuality something we can talk about? What place does your religion take in your sexual experience? How is it that boys who call themselves Muslims are sexually active, while according to the Quran both women and men are to remain virgins until marriage? ... You can use these types of questions to identify their views and concerns.

Sex education is really necessary, not only because both parents and young people lack basic knowledge, but also because there are cultural taboos that make everything even more complicated.

2.2.7 Culture-specific topics

Gender, virginity, family honour, female circumcision and HIV taboos are discussed in the following texts, because having some background knowledge on these issues is very important in order to correctly respond to questions and reactions from participants.

A. Man-woman relationships

When talking about sexuality, gender (in)equality is a topic that should certainly not be overlooked.

Gender is about social differences between the two sexes, about the inequalities associated with them or arising from them (Women's Council, 2014). For example, men and women are assigned different tasks and responsibilities by society and have to live up to different expectations in terms of behaviour and attitude. The problem is not that men are different from women, but it's unfair when the responsibilities of girls/women and boys/men are not valued in the same way, when they are not given the same opportunities, and when they don't have the same rights.

Especially when it comes to expressing sexuality, women are silenced and censored much more than men.

Serious manifestations of this are much stricter morals in terms of girls' sexual behaviour, sexual harassment and sexual violence, and even female circumcision and honour killing.

During the information session, you should be aware that there may be women present who are, or have been, the victim of sexual abuse or domestic **violence**, and who might be triggered by talking about sexual issues or even about communicating with their partner.

In addition to providing a safe environment and empowering women, men should also be involved in changing this system.

Empowering women

The Women's Council provides the following clarification (2014):

*"**Empowerment** of women: this means taking specific actions with and for women, focusing on the different dimensions of empowerment. This 'separate' approach is justified because differences in equality and parity between men and women still exist and because certain issues (such as reproductive health) will always require a specific approach.*

For the practical implementation of empowerment, different dimensions can be distinguished:

- ***inner strength** (wanting), which mainly refers to strengthening women's self-confidence and self-esteem*
- ***the power of knowledge** (knowing), which refers to learning new things, acquiring new insights and skills*
- ***social strength** (being able), breaking free from isolation, belonging to a group and drawing strength from it, strengthening one's position in society*
- ***economic strength** (having) initially means 'being able to take care of your family'; for asylum seekers, it's about having somewhere to stay after having fled dire circumstances, having access to food, healthcare, education ...'.*

Involving men

The Rutgers expertise centre suggests that men are sometimes viewed too one-dimensionally as a threat. The centre warns that failure to involve men as caring partners and fathers would be a missed opportunity.

In order to break gender stereotypes and rigid gender roles, men and boys need to be involved in sexual and reproductive health and sex education. There is increasing evidence of a positive impact of **committed fatherhood** on both child, mother and father. This is reflected in better health, better communication and less domestic violence. Respect and understanding between men and women should be fostered (Ploem, 2016).

This can already start when talking about contraception and family planning. Preferably, this is done in separate men's groups, with male counsellors.

In our project, we've also counselled a group of men. Their reaction was positive: they were interested and wanted to know more. It is necessary, however, to have all-male groups receive counselling from a man, because there are fewer barriers then and the work can be done in a safe atmosphere, with respect for one another's beliefs.

Discuss masculinity, and offer room for new, more positive forms of masculinity
(= **gender-transformative** approach).

B. Virginity and family honour

Virginity

"If people know you're deflowered, well, then to be perfectly blunt, you are a whore. You didn't follow the rules of your own culture and you hurt your parents immensely, because they trusted you. It's just an absolute disgrace to them."

"My mother would fear for my future, that I would never be able to marry. I think she would go to the doctor with me. I think she would die of sorrow, and that's why I wouldn't tell her. I don't think I'd ever do anything in my life to cause her such grief."

"My mother knows I'm not a virgin anymore. Only my mother knows, not my father. She completely lost it. Really, she was just sitting alone, crying."

"No, I won't tell my parents. It would hurt them beyond repair. I have a good relationship with my mother, we have a very strong bond and I tell her almost everything. But I just can't talk to her about things like that, because she just wouldn't understand."

(Mouthaan & De Neef, 1997)

An internet research conducted by Maastricht University for SOA Aids Nederland (2005) has shown that virginity is very important to many of the young Moroccan Muslims who participated in 'Islam and Sexuality'. A majority of them consider the **virginity standard** to be good, sensible and even very important. For example, 85% of the respondents were of the opinion that girls should adhere to it, while 78% said the same standard applies to boys. Turkish youngsters didn't feel as strongly in this regard: 47% said girls should stick to the norm, and 43% said the same goes for boys (Azough, 2007).

Another study on virginity examined the origins of women applying for **hymen reconstruction** and the effect of education about virginity myths and misunderstandings (van Moorst et al., 2010).

It turns out that gynaecologists in Europe are reporting an increasing number of patients requesting hymen reconstruction out of fear for social repercussions if their future spouse and/or in-laws were to discover that they had been sexually active before marriage.

This study is the first to describe both the psychosocial and sexual health status of women who request a hymen reconstruction and the post-operative follow-up. The majority of these women had no history of consensual sexual intercourse.

Of the 82 women, 36.6% reported no blood loss during first intercourse; 30.4% lost their virginity due to **sexual assault**. Of all 82 women, 47.5% reported a history of sexual violence. In 45.5% of cases, there had been a sexual relationship in which the partner had promised marriage. 36.6% of the women had had one or more abortions.

Many of them were desperate, fearing that their past would be revealed. Some women had been the subject of rumours, followed by threats to undergo "virginity tests", threats of violence, forced examination by a doctor ... anything to "make them confess". At the time of their first visit, all of them were convinced that reconstructive surgery was their only hope.

However, this study shows that through **empowerment and knowledge**, 74.6% of women would decide against this type of surgery. The women who were still of the opinion that a hymen reconstruction was necessary were very happy with this decision, despite the fact that they often had to resort to other "tricks" to simulate virginity. After all, a hymen reconstruction alone doesn't fix everything, as most of these women won't bleed, and even then, **bleeding** isn't the only proof they have to provide. All women believed that the main problems are attitudes,

ignorance, and double standards.

"It's true, we can't have sex before we're married. But I had been with my boyfriend for so long, so we ended up doing it anyway. I just took the pill, but accidents can happen. That's when I got pregnant. The biggest problem now is I can't tell my parents I'm pregnant. Because I'm 100% sure that I'll get kicked out of the house. The thing is, I get along really well with my parents. I was actually against an abortion myself, but there is no way I can have this baby, so I have no other choice." (Mouthaan & De Neef, 1997)

Research in Flanders has shown that one in five immigrant abortion clients is of Turkish or Moroccan origin. In spite of their common Muslim background, Turkish and (especially second-generation) Moroccan women hold vastly different views. The Moroccan women are very young, often unmarried, living with their parents or on their own, and often want to terminate their pregnancy due to relationship problems. By contrast, Turkish abortion clients are usually married and often already have children (Neefs, 2004).

"You hear different things every day. Your family tells you that you'll bleed and then the newspaper tells you otherwise. So you get confused. First you believe this, then that."

Internet discussions reveal that a number of Moroccan and Turkish girls are aware of the **mythical** nature of the **hymen**. However, there are also girls who are worried about bleeding during their wedding night, and especially young boys continue to believe in it. Some boys even make threats to their future wife, should she turn out not be 'intact' on the big night. Many girls think it's a kind of coffee filter, a gauze-like membrane the menstrual blood passes through. And on the wedding night it absolutely has to rip, says gynaecologist Obdeien-van Welij. Any bleeding during first sexual intercourse is almost always due to cramping (**Azough, 2007**).

In Brussels, a debate was held between gynaecologists, doctors and aid workers from St Peter's Hospital, the Hôpital Français, Planning Familial Marolles and the Belgian professional association of gynaecologists. Every year the number of applications for so-called hymen certificates at hospitals and family planning centres increases: although they are difficult to quantify, there were 2,760 applications in 2004, compared to 1,448 in 2000.

As this procedure is technically one of several types of vaginoplasty, it's hard to determine whether an operation involved a hymen reconstruction or another vaginal procedure. However, researchers and gynaecologists confirm that there has been an increase in hymen reconstructions.

Gynaecologists in Brussels hospitals are aware of the issue, but they're rather divided on it: some agree to perform such reconstructions in order to save these girls from the consequences their family would otherwise impose (according to Dr Verougstraete), while others feel that issuing certificates and performing hymen reconstruction surgery is in contradiction with the precepts of gender equality and with the principle that couples should be formed on the basis of honesty (Dr Laurent Bisschot).

In theory, the virginity requirement applies to both girls and boys, but in practice, boys don't have to abide by it. Both parents and friends often accept that boys are sexually active before marriage. By this **double standard**, girls have to bend over backwards while boys are let off the hook. Female virginity is also much more commonly referred to in everyday vernacular than male virginity, even though both partners are expected to enter into marriage as virgins. And then there's the fact that an intact hymen is considered proof of virginity, while there are actually many other ways a girl can lose or rupture her hymen without even knowing it – sometimes even from birth.

The various customs associated with hymen ceremonies, as practised in many villages, have no valid foundation – neither in the sources of Islam, nor in the historical reality of the prophetic

example. The ritual of showing the blood of the broken hymen on a bed sheet to the eager crowd outside, followed by either the acceptance or the dramatic rejection of the bride, is beyond unethical and repugnant (Azough, 2007).

Family Honour

Honour is about a person, or a family, being a fully respected member of the **social community**, based on behaviour that falls within the norms of that community. Each individual represents their entire family. In many communities, however, different codes of conduct and social roles apply to girls/women than to boys/men – not least when it comes to chastity. It can already be considered dishonourable for a girl simply to hang out with boys, let alone fall in love with a boy who doesn't live up to certain criteria for approval. Boys can also be targeted, especially boys who like boys, but the consequences for girls are often much more serious (IGVM, 2013).

Talking about sexuality can also be considered sinful, even in sexual and relational education, which doesn't make this any easier (Bériot, 2013).

Girls carry a heavy burden. The honour of a family depends in part on the sexual behaviour of its daughters. In other words: daughters have to avoid displaying any sexual behaviour in order to please their parents. The fact that sexual behaviour in girls and women is considered so very problematic is not so much due to Islamic sources, as these dictate the same clear rules for both men and women. Despite the fact that boys, too, are to dress modestly and marry as virgins according to Islamic standards, much less attention is paid to their clothing and behaviour. The study 'Sex under the age of 25' shows that boys (who refer to themselves as Muslims) tend to make full use of this freedom. It turns out that Muslim boys actually have more experience with sexual intercourse than their Christian and even non-religious peers (Azough, 2007).

The mere suspicion that a girl might be sexually active is enough to warrant utter **disapproval**. That's why girls who are sexually active will often keep it a secret. Unmarried motherhood is not something many girls would wish upon themselves. Family honour plays a key role in this regard. Nevertheless, these girls are becoming more emancipated and empowered. They don't want to disappoint their parents, or they live in fear of reprisal. In the worst case, their sexual behaviour could lead to **honour killing**, which is when a dishonoured daughter is murdered by a male family member, possibly acting in collusion with (part of) the rest of the family. Contrary to what is often believed in the West, honour killings are not Islamic in nature, but rather a regional cultural phenomenon. This practice has been documented in Turkey, Egypt, Jordan, Iraq, Iran, Syria, Israel, the Arabian Peninsula, Somalia, Pakistan and Afghanistan. And yet, honour killing is explicitly forbidden by the laws of Islam. Although these rules are interpreted differently by some spiritual leaders, honour killing is generally not condoned.

However, it is much more common to resort to lighter forms of **honour-related violence**, such as restricting girls' after-school activities, monitoring their mobile phones, psychological abuse including name-calling and threats, and social ostracism (pretending the person is dead, breaking off any and all contact), which can cause major trauma (IGVM, 2013).

In conclusion, honour has a huge impact on the lives of girls growing up in a culture where it's very important for women to save their honour, but not for men. While virginity can also be a conscious choice, which is to be respected, virginity should not weigh on the honour of the family and on the double standard allowing only boys to be sexually active. This is a cultural phenomenon that can only be gradually phased out through knowledge and education.

This mentality can only be changed by educating parents, especially where there are high levels of ignorance, empowering young people and making it easier to discuss the subject at school, in women's organizations, centres, and so on.

C. Female genital mutilation

Female circumcision, or female genital mutilation (FGM), includes all procedures relating to the total or partial removal of the external female genitalia, or any other damage to the female genitalia for cultural or other non-medical reasons (WHO, 1997).

The World Health Organization distinguishes four types of FGM:

Type 1 (clitoridectomy): partial or total removal of the clitoris and/or the prepuce of the clitoris;

Type 2 (excision): partial or total removal of the clitoris and labia minora, with or without removal of the labia majora;

Type 3 (infibulation): narrowing of the vaginal opening through removal and sewing together of the labia minora and/or labia majora, with or without removal of the clitoris;

Type 4: any other harmful procedure on the female genitalia for non-medical reasons, such as puncturing, piercing, cutting, incision and burning.

These practices are documented in

- various ethnic groups in 28 African countries;
- some ethnic groups on the Arabian Peninsula and in Indonesia;
- and also in host countries in Europe and in the United States, Canada, Australia and New Zealand.

In the African countries where such practices are used, they are carried out by old women, traditional midwives, barbers, and sometimes doctors or midwives in regular healthcare, even though they are forbidden by the World Health Organization.

In Western countries, families either call upon a local female "expert" or they send the girl on holiday to the homeland to have the procedure done. Female genital mutilation usually takes place between the ages of 4 and 14, but sometimes even in newborn babies, or just before marriage, depending on the ethnic group.

In **Belgium**, more than 13,000 women and girls have been the victim of genital mutilation and more than 4,000 girls are still at risk of being subjected to it (GAMS Belgium vzw, 2016).

Female genital mutilation (FGM) was long regarded as a tradition and, out of respect for culture and peoples, international organizations did not take a stand against it. Finally, in the late 1980s, FGM was recognized by the World Health Organization as a human rights violation.

The most recent United Nations Interagency Statement reaffirms – rightly so – that FGM is 'a form of gender inequality deeply rooted in social, economic and political structures'. The fact that it is so deeply entrenched explains in part why the fight against this practice is such a long and arduous one.

The population groups concerned cite several reasons to justify these practices in all their forms. The reasons usually invoked vary from one country and population group to another, but there is also variation within populations, depending on age or gender.

Respecting customs or traditions: The question "Why circumcise?" is usually answered with: "It's always been done this way, that's just the way it is. It's natural, it's normal."

Social connectedness, social inclusion: "To be just like everyone else, to avoid being excluded or ostracized."

Marriage: "Uncircumcised girls will never find a husband." Together with respecting tradition, this is the most frequently mentioned reason. Some girls are circumcised again right before they

get married, either if it is considered that it wasn't done properly, or if the scar left by infibulation later opened spontaneously. Some mothers know the risks of FGM, but admit that in their community, these are outweighed by the risk of not being able to marry. Despite the possible complications of FGM, they believe it's the best thing to do for their daughters.

Virginity, chastity, marital fidelity: FGM is seen as a way to uphold the family's honour by suppressing sexual desires before marriage, thereby ensuring that the girl remains docile and "serious" rather than frivolous. In polygamous marriages, the man might fail to satisfy all of his wives, so some of them might get frustrated and attempt to start an extramarital affair, in which case FGM is seen as a way to maintain the man's honour.

Fertility: there are many myths surrounding fertility. FGM is said to increase fertility and also the child's chances of survival. For example, in certain communities it is believed that the clitoris, if not cut off, would grow as big as a penis; or that the clitoris is a dangerous organ that could injure the man during penetration (or make him impotent or infertile); or that it makes giving birth more difficult.

Seduction, beauty: population groups who perform infibulations in particular tend to ascribe ugliness to open, "gaping" genitals. Genitals that are sewn closed and shaved or waxed are considered more hygienic, making the woman more attractive.

Purity, cleanliness: girls who have not yet been circumcised or infibulated are considered impure or unclean, and are therefore not allowed to carry out certain tasks such as preparing or serving meals.

Religion (Islam): FGM was a common practice well before the advent of monotheistic religions, and especially Islam. However, even though FGM or infibulation is not imposed by the Quran or other religious scriptures, certain communities do practise it in the belief that their religion requires it. It should be noted here that FGM also occurs in Christian communities (Catholics, Protestants, Copts), in Ethiopian Jewish communities (the Falachas) and among animists. Religious leaders have differing views on the matter: some encourage these practices, others consider them independent of religion and others still try to eradicate them. As regards Islam, Sunni leaders in 2006 spoke out against FGM at an international conference at the University of Al-Azhar, Cairo (fatwa stating that FGM is unfounded in Islamic law).

Although circumcision is not cited by the general population as being particularly just, we can nevertheless assume that this element, too, encourages the continuation of these practices. After all, female genital mutilations are a source of income and social recognition for the female "expert" circumsisers, so they have no interest in shutting down their business.

In many countries, FGM is being practised at an increasingly young age. According to a study by Demographics and Health Surveys (DHS) in Yemen in 1997, a whopping 97% of cases of FGM occurred in the first month of life (at an average age of 7.6 days). This can no longer be considered an initiation rite to mark the transition to adulthood. Instead, it's a confirmation of identity: the identity of the group that etches its law onto the bodies of individual group members, but also the identity of the woman (chaste bride, wife, mother, subordinate), which must be repeated and reaffirmed. This way, the woman's body is brought in line with the status ascribed to women.

What's important, therefore, is the cutting itself. It doesn't matter whether the rites usually associated with a circumcision are followed. In order to be accepted by the group, everyone of the female sex must undergo this procedure: previous generations have undergone it, and tradition is law. The social pressure is crippling.

Women who have their daughters circumcised do so, in their minds, with the best of intentions. By respecting tradition, they want to **protect** their daughters from shame, social exclusion and isolation. In all groups practising FGM, there is a word for an uncircumcised girl. The worst

way to insult a girl or a woman in Mali, for instance, is to call her a *bilakoro* (the word for 'uncircumcised girl' in Bambara).

When Malian women are asked why women are still circumcised in their country (where more than 90% of women between the ages of 15 and 49 have undergone FGM), they all answer: *"Because we've always done that, because it's our custom. You don't leave a child bilakoro."*

A recent study carried out in Belgium has shed light on the concept of circumcision systems in a way that allows mutilations to be considered from a global perspective. FGM is not an isolated practice that belongs exclusively to the private sphere and the world of women. Quite on the contrary, it is part of a set of rituals and daily practices aimed at defining the role and status of both men and women (FPS Public Health and GAMS Belgium vzw, 2011). Female genital mutilation is a cultural practice that can be discouraged by educating parents and young people, just like hymen reconstruction. They are both procedures imposed on women so they can belong and be a 'real, proper woman'.

D. Taboos surrounding Human Immunodeficiency Virus (HIV/AIDS)

Talking about sexuality is taboo, especially if one is HIV-positive.

Our project showed that creating **trust** was very crucial during information sessions, and even more important for people who are HIV-positive. It can take a long time before they're sufficiently convinced of your sincerity and professional confidentiality. Only when they're sure that you won't "report" them will they feel safe.

Some women have had bad experiences with this, when their counsellor needed a second opinion and outed them to a third party. They often live in isolation to guard their secret and they won't share it with everyone. For these women in particular, education is very important, because they have a lot of questions: Can I still have children? Are there specialists I can turn to? Can I get psychological support from a confidential advisor without being judged? ...

Research by Schoevers et al. (2010) among women without legal residence in the Netherlands indicates that professionals should be bound to secrecy. The importance of a relationship of trust is also mentioned by the Roma women in Temse and Sint-Niklaas in the research of Decoodt and De Reu (2009). They mainly choose to use services when they have confidence in specific staff members, rather than confidence in the functioning of the organization itself. Similarly, in the work with refugee women in the Netherlands who are victims of sexual violence, the creation of a confidential atmosphere proved to be a prerequisite to any meaningful communication (Sensoa, 2011).

Breaking down barriers is an important part of prevention work, and this can only be done by creating trust and by providing education and information.

3 COURSE OUTLINE

3.1 Practical arrangements:

Safety and trust in a group are the most important prerequisites for being able to talk effectively about highly personal issues such as relationships and sexuality.

Because many people attach great importance to hospitality, it's always good to provide **catering** with some biscuits or a sandwich (taking into account the group's food preferences). This is a nice way to attract participants.

It would also be good to provide **childcare**, if possible, because care providers often report that mothers with young children don't show up for education sessions. Keep in mind when inviting people that most of these women **lack organization skills**, as they have never been taught to to keep to a schedule. It's therefore best to call them the day before and remind them of the session.

Given the high reluctance, taboos and ignorance surrounding these topics, it's best to have **separate sessions** for women (with a female counsellor) and for men (with a male counsellor). When educating groups of students in schools, the gender of the counsellor is less relevant, as young people tend to be less reluctant than vulnerable women or men.

3.2 Script overview:

Objective	Materials	Method	Time frame	Tips
Introducing yourself.	Write down the name people can use to address you on a sticker, a piece of paper, a blackboard/ whiteboard ...	Introduce yourself with your full name, your role, and what you will be talking about.	2’	A go some you oblig creat
Getting to know the participants.	Stickers, paper and pens. World map.	Allow everyone to introduce themselves. Ask for everyone's name and surname, whether they have children, where they come from and which languages they speak or understand.	15’	Be s The writt This has and parti inter

Objective	Materials	Method	Time frame	Tips
Familiarizing the participants with basic group rules and arrangements.	R: Respect I: Interaction P: Privacy Write on flip chart / whiteboard / blackboard ...	Agreeing on rules: - **R**especting each other's opinions - Enabling **I**nteraction - **P**rivacy and safety	5’	This noth discu betw
Familiarizing the participants with the female and male genitals.	Visuals illustrating: - the female genitals - the hymen - female genital mutilation (FGM) - the male genitals - world map indicating where FGM occurs	- The anatomy of the internal and external female and male genitalia is explained. - The hymen and FGM are discussed.	45’	This 1/ In fema feel relax male 2/ A 3/ A as th cultu

Objective	Materials	Method	Time frame
Providing the participants with insight into: - the menstrual cycle - the mechanism of conception	Visuals illustrating: - the menstrual cycle - conception - the role of hormones in the menstrual cycle and in oral contraception	Explain the cycle, hormonal function and conception.	30’
Familiarizing the participants with the different methods of contraception.	The different contraceptive options such as the pill, patch, IUD ...	Lay out the contraceptives on a table. Ask who recognizes one of them and who can explain what it is to the others.	90’ (or longer)
The participants know how to use a condom correctly.	Condom demonstration wit h Oscar Visuals: - cross section of the penis - a circumcised and an uncircumcised penis	Different types of penises (circumcised and uncircumcised) can be illustrated by means of diagrams and drawings. Start by demonstrating the condom yourself and then ask who wants to try it.	15’
The participants know what sexually transmitted diseases (STDs) are.	Background information on STDs, see STD guide in the kit. The goal is not to train participants specifically on this subject but rather to provide them	Interaction and elaborating on the participants' questions. If there are no questions, you can wait until the condom demo to	

	with the necessary basic insights to discuss this further with their doctor.	ask if the participants know whether a condom offers protection against STDs and HIV. and then elaborate on this.	
Objective	**Materials**	**Method**	**Time frame**
The participants get an answer to their questions and know where to go.	Provide booklets or brochures on contraception and fertility in various languages. Hand out free condoms.	Hand out booklets, brochures and condoms.	5' (at least)
The participants give feedback about the session.	Oral evaluation by the participants; the counsellor takes notes. Written evaluations are not recommended because of language or writing problems.	Ask direct questions about: - The content of the course: was the info complete, clear and correct? - How about the way the information was presented? (e.g. use of materials,...) - the counsellor - the group - the organization.	5'

3.3 The script

3.3.1 Counsellor introduction

Objective:

The group knows the name and role of the counsellor and the programme.

Materials:

Write down the name people can use to address you on a sticker, a piece of paper, a blackboard/ whiteboard ...

Time frame: 5 minutes

Method:

It goes without saying you should be comfortable talking to a group of people.

Introduce yourself with your full name, what your role is (in which organization), and what you'll be talking about.

Tips:

A good way to break the ice is to share something about yourself, e.g. whether you have children or not. This is a simple way to create more openness in the group.

Taking the time to introduce yourself is important. It not only gives people an idea of who you are, but it also enables you to talk about taboo subjects more easily afterwards. Experience shows that if you don't, people are going to ask if you're married and if you have children anyway. In their eyes, your credibility often depends on your situation or status (as a parent, counsellor, doctor ...). That's why it's better to anticipate this and make it a kind of icebreaker.

3.3.2 Introduction

Objective:

The counsellor has insight into the background and knowledge of each participant.

Materials:

Stickers or paper and pens to write down the names of the participants.

Time frame: 15 minutes

Method:

Allow everyone to introduce themselves: ask for their name and surname, whether they have children, where they come from and which languages they speak or understand. You can use the world map.

Tips:

Keep in mind that there may be people who are illiterate. You can suggest that you write down everyone's name by first asking who would like that, and then allowing those who want to write it down themselves to do so, thereby avoiding embarrassment for people who can't write.

Asking which language they speak is important because you have to take this into account in

the rest of the session, for example by providing an interpreter (make arrangements with the organizer beforehand), showing more visual material and not explaining things too quickly.

Direct questions have a positive effect on the atmosphere and confidence levels, showing the participants that the counsellor is interested in them.

Vulnerable people have often suffered many setbacks in their lives, e.g. due to poverty, unemployment or a low level of education, so it's a good idea to boost their self-esteem and self-confidence by reflecting on their family situation for a moment.

3.3.3 Group rules according to the RIP (Respect, Interaction and Privacy) method

Objective:

Familiarizing the participants with basic group rules and arrangements.

Preventing misunderstandings and stimulating communication.

Respecting one another's opinions. Creating an atmosphere of mutual trust.

Materials:

Board or flip chart and marker to write down RIP rules.

Time frame: 5 minutes

Method:

Explaining the RIP method:

Respect every opinion by refraining from expressing judgment and by listening to one another without interrupting.

Interaction should always be possible, i.e. participants shouldn't hesitate to ask questions throughout the session.

Privacy and security are guaranteed: everything that's discussed stays in the group. No one is obliged to share everything.

Tips:

This is a good time to mention that nothing is taboo, that everything can be discussed in a safe atmosphere of trust between the participants. Also important is the fact that the groups are women-only or men-only.

While you as the counsellor can guarantee professional secrecy, the same cannot be said for the group.

You can only try to ensure that others treat what is shared in the group with respect.

3.3.4 Discussing the female and male genitals

Objective:

Familiarizing the participants with the female and male genitals.

Participants know what a hymen is and the different forms it can take.

Participants know what female genital mutilation (FGM) is and what the different types are.

Myths and falsehoods about the hymen and FGM are debunked by knowledge transfer and group discussions.

Materials:

Pictures of:

the female genitals; the hymen;

female genital mutilation (FGM); world map indicating where FGM occurs;

the male genitals.

Time frame: 45 minutes

Method:

The anatomy of the internal and external genitalia is explained. Experience shows that many women and men in this target group don't know what the internal female and male anatomy looks like and how it functions. Take the time to explain this basic information in simple terms, using the photos.

Specific attention should be paid to the hymen. Participants might ask several questions about the hymen, or they might remain perfectly silent, listening attentively. Here you can talk about myths and the taboos in order to discuss them and share knowledge about them. Allow for some time to answer questions.

Depending on the atmosphere and target group, you can also discuss female genital mutilation (FGM) by asking if anyone has heard about it, and what they think about it. Use the visual material for knowledge transfer and to open up dialogue. The world map showing the spread and percentages of female circumcision makes it clear that this practice is not limited to Africa.

Tips:

As this is a sensitive subject, it's best to start with the female genitalia; if you feel the atmosphere is sufficiently relaxed, you can move on to the male genitalia.

Humour can have a facilitating effect.

Allowing interaction is important, as this is the ideal time to discuss cultural taboos with the group, e.g. myths and falsehoods about the hymen, what and where the clitoris is, and so on.

3.3.5 Menstrual Cycle and Fertility

Objective:

The group has insight into the menstrual cycle and the mechanism of conception.

Materials:

Visual material about the cycle, conception and the role of hormones in the menstrual cycle and oral contraception.

Time frame: 30 minutes

Method:

Explain the cycle, hormonal function and conception.

Tips:

This is a good time to debunk myths, such as the belief that menstrual blood accumulates in the body and causes disease, infertility or brain haemorrhages.

Pay attention to this when discussing it with the group. Use the visual materials to show the cycle with or without the pill (see diagram showing the role of hormones in the menstrual cycle and in oral contraception).

3.3.6 Contraception options and demonstration

Objective:

Familiarizing the participants with the different methods of contraception.

The participants know how to use a condom correctly.

The participants know what STDs and HIV are.

Materials:

Visuals illustrating different contraception options: the pill, IUD, implant, vaginal ring, patch, hormonal shot, female condom, emergency pill, diaphragm.
Condom demo with the Oscar penis.
STD explanation: refer to the SoaAids guide on sexually transmitted diseases in the kit.

Time frame: 1 h 45'

Method:

Lay out the contraceptives on a table and ask who recognizes which ones and who can explain what they are to the others.

Enable interaction.

Different types of penises (circumcised and uncircumcised) can be illustrated by means of diagrams and drawings.

Start by demonstrating the condom yourself and then ask who wants to try it.

STDs can be discussed during the explanation of contraception, e.g. by asking whether the pill, IUD, patch, condom ... offer protection against STDs and HIV. It's best to bring this up in an interactive and playful way.

Tips:

By the time you get to the topic of contraception, the atmosphere is usually already a bit more relaxed. You may get a lot of questions, so it's important to have a thorough grasp of the subject matter!

Here you can ask the participants how condom use is regarded within their culture and how they can make taboos discussible. This creates interaction, understanding, trust and knowledge transfer.

Before you start the condom demo, explain the penis using the diagrams and drawings, and ask what everyone thinks of it. When the atmosphere is relaxed, you can continue with the condom demo.

It is best to leave the participants free to choose whether they want to try putting on the condom.

The very fact that they're there, attending the course, is already a step forward in their empowerment. You can also hand out free condoms to anyone who wants them.

Sometimes there's not enough time to explain everything in detail. It's best to emphasize that they can always go see their doctor for more information.

3.3.7 Wrap-up and Evaluation

Round of Questions and Referral

Objective:

The participants get an answer to their questions and know where to go if they have any further questions after the session.

Materials:

Booklets and brochures on contraception and fertility in various languages, Zanzu cards to hand out to participants.

Time frame: 5 minutes

Method:

Invite participants to ask any unanswered questions. You need to be able to gauge the urgency of a question and the underlying situation, so you can refer the participant as accurately as possible.

Hand out cards, booklets, brochures.

Point out the relevant address in a booklet or brochure in case of a specific question.

Hand out free condoms.

Tips:

After the session, some participants may come up to you to ask something they don't want to share with the group. You may hear some harrowing stories, so you need to be prepared for this. Take your time to engage with them.

Make an appointment to see them again if you think more time is needed, or refer them immediately to a highly specialized organization where they can definitely get help, and help them make an appointment if needed.

Also ask what the participants feel was missing from the presentation and refer them, if possible, to organizations to get answers.

Evaluation

Objective:

The participants and the organizers give feedback about the session.

Materials:

Oral evaluation by the participants and the organizers. Write down relevant feedback so you can make adjustments to the education programme.

Time frame:5 minutes

Method:

Ask direct standard questions: What did you think about:

- the content of the course: was the information complete, clear and correct?
- the way the information was presented (e.g. use of materials,...)
- the counsellor
- the group
- the organization?

Tips:

Feedback is always useful to get an outside perspective on your course and way of working. It also allows you to improve future sessions.

4 CONCLUSION

This project started from concrete experiences at the Volle Maan maternity care expertise centre, where we felt that there was a need for culturally sensitive education for vulnerable target groups. This was also scientifically substantiated in the elaboration of this script.

In the field, there turned out to be a specific need for material tailored to the target group, as well as appropriate background information for counsellors providing training sessions.

Through more cooperation between practitioners and policy-makers, signals from the workplace can be picked up early on and, if necessary, resources can be made available to provide an appropriate response. Universities and other higher education institutions can play an important research role and can help to build bridges between practitioners and government.

Research in different countries has led to consensus on the following findings: a high abortion rate and number of unwanted pregnancies in Europe among immigrant girls and women; the need for preventive education to eliminate ignorance and taboos; the influence of cultural traditions on sexual and reproductive health; and the impact of disadvantage on making the right choices.

Adequate resources to run an ongoing campaign should enable health professionals and counsellors to work preventively with specific target groups.

We hope that the Volle Maan maternity care expertise centre has contributed to this. After all, the ultimate goal of this script is to help vulnerable target groups make the right choices after receiving culturally sensitive information about contraception.

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6 APPENDICES

6.1 Evaluation of the project with vulnerable (pregnant) women

Evaluation report for the 2009 project phase

1. Evaluation of the project with vulnerable (pregnant) women in Brussels.

A. Figures

Seven education sessions were held at 4 organizations.

Education sessions	Participants
Nasci[1] 16.10.2008 + 29.05.2009 + 23.10.2009	5 +10 + 9
Huis Der Gezinnen 19.12.2008 + 30.01.2009	6 +15
BON[2] 09.06.2009 + 16.07.2009	14
Planning Familiale Schaerbeek groupe Bah 18.06.2009	8
Link vzw 08.10.2009	27
Total	94

Composition of the different groups.

1/ Nationality:

Mixed groups of different nationalities: Algerian, Belgian, Brazilian, African, Romanian, Moroccan, Turkish, Vietnamese, Albanian, Chechen, German, Iraqi, Filipino.

2/ Generations:

First, second and third generation.

3/ Languages spoken:

Everything was arranged with the organizers in Dutch, but the sessions were mainly given in French, with some additional explanations in English, Moroccan Arabic and sometimes Dutch.

[1] Dienstencentrum voor het kind
[2] Brussels Onthaalbureau

4/ Duration and time:

The allotted time for each session was two hours. However, with participants often coming in late, the allotted time was usually too short (in combination with the fact that there was a lot of interaction between participants).

5/ Background knowledge:

4 out of 5 participants (of all generations) were not educated.

B. Content

Questions A through D were only answered by participants.

A. **Information on contraception**:

1. ***Where do you get your information on contraception?***

- Most participants get information from people close to them
- Participants also get information from their doctor
BUT:
- not sufficiently informed by doctor: offer and possible side effects not thoroughly discussed (they'd rather take nothing than medication that makes them feel worse)
- Participants are reluctant to ask questions about pros and cons of contraception.

	Nasci 16.10.2008 + 29.05.2009 + 23.10.2009	**Huis der gezinnen 19.12.2008 + 30.01.2009**	**BON 09.06.2009 + 16.07.2009**	**Planning Familial Schaerbeek groupe BAH 18.06.2009**	**Link vzw 08.10.2009**
From friends / people close to them	**x**	**x**	**x**	**x**	**x**
Info often provided by GP	**x**	**x**	**x**	**x**	**x**
Usually GP doesn't explain contraception offer and risks	**x**	**x**	**x**	**x**	**x**
This is the first time there is clear info on contraception			**x**		

B. **Contraception use**:

1. What type of contraception do you use?

Usually none, due to health issues or lack of information from their GP about possible side effects.
- Those who do use contraception have often tried everything: the pill, IUD, implant ...
- Bad experiences have led some to believe that their fertility was affected (reinforced by ignorance and myths).

	Nasci 16.10.2008 + 29.05.2009 + 23.10.2009	**Huis der gezinnen 19.12.2008 + 30.01.2009**	**BON 09.06.2009 + 16.07.2009**	**Planning Familial Schaerbeek groupe BAH 18.06.2009**	**Link vzw 08.10.2009**
Usually no contraception	**x**			**x**	**x**
No contraception due to health issues			**x**	**x**	

2. Was this a personal choice?

Usually their own decision

	Nasci 29.05.2009 +23.10.2009	**Huis der gezinnen 19.12.2008 + 30.01.2009**	**BON 09.06.2009 + 16.07.2009**	**Planning Familial Schaerbeek groupe BAH 18.06.2009**	**Link vzw 08.10.2009**
Personal choice	**x**		**x**	**x**	
Together with their partner			**x**	**x**	
The man decides				**x**	

3. What role did your partner play in this choice?

Only together with their partner when it doesn't go well

	Nasci 16.10.2008 + 29.05.2009	**Huis der gezinnen 19.12.2008 + 30.01.2009**	**BON 09.06.2009 + 16.07.2009**	**Planning Familial Schaerbeek groupe BAH 18.06.2009**	**Link vzw 08.10.2009**
Majority decides on their own	**x**		**x**	**x**	**x**

4. Do you think it's necessary to inform men?

Men should also be informed so they can participate in family planning.

	Nasci 16.10.2008 + 29.05.2009 + 23.10.2009	**Huis der gezinnen 19.12.2008 + 30.01.2009**	**BON 09.06.2009 + 16.07.2009**	**Planning Familial Schaerbeek groupe BAH 18.06.2009**	**Link vzw 08.10.2009**
Men should also be informed	**x**	**x**	**x**	**x**	**x**

C. ***Attitudes / taboos and myths:***

5. Are there any methods of contraception you don't want to use because of cultural taboos or religious values?

- Religious upbringing, raised to believe that contraception shouldn't be used or even talked about.
- Talking about contraception is not allowed, because that would indicate that you're sexually active, which is not allowed before marriage.
- In Central Africa, faith often does not allow the use of condoms + condoms are linked to prostitution.
- Family influence (through bad experiences) in combination with religious values and cultural myths (ignorance) make it difficult to make the right choice.
- Talking about sexuality is taboo in certain cultures, so very little is said about it during childhood -> consequence: lack of knowledge about contraception.
- People are discouraged from using an IUD because there would be conception -> considered a form of abortion.
- Faith does not allow permanent sterilization (except under special circumstances).
- One participant said that the pill is forbidden in her faith, because each child is the creation of God and this should not be interfered with.
- Back then, they only had a choice between the pill and a hormonal shot. Hardly any information provided by the GP, resulting in negative experiences, leading to distrust of contraception.

Conclusion: A lot of ignorance, unfounded ideas and myths, e.g.: blood piling up in the body if you don't menstruate.

	Nasci 16.10.2008 + 29.05.2009 + 23.10.2009	Huis der gezinnen 19.12.2008	BON 09.06.2009 + 16.07.2009	Planning Familial Schaerbeek groupe BAH 18.06.2009	Link vzw 08.10.2009
A lot of ignorance, unfounded ideas and myths	x[3]	x	x	x	x
Not allowed by upbringing, religion	x		x	x	x
Family influence	x[4]		x		

D. Financial component:

6. Is contraception affordable to you? If you are experiencing financial difficulties, do you know who or where you can turn to for financial support?

- Too expensive, but they have to to buy it.
- The majority of respondents don't know where they can get financial support, and if they do, it involves a lot of paperwork/red tape.

	Nasci 29.05.09 + 23.10.2009	Huis der gezinnen 19.12.2008 + 30.01.2009	BON 09.06.2009 + 16.07.2009	Planning Familial Schaerbeek groupe BAH 18.06.2009	Link vzw 08.10.2009
Too expensive	x		x	x	x
No idea where to get financial support	x		x	x	x

[3] only 16.10.2008 + 29.05.09
[4] only 16.10.2008 + 29.05.09

E. **Evaluation of the sessions**

By the organizing party, the teacher and the participants.

1. What did you think of the session?

Teacher:
French was understood the most by participants.
Important icebreakers: humour and personal experiences.
Knowledge of cultures and religions is a big advantage.
Group should not be too big (e.g. Link vzw 08.10.2009 with 27 participants: people are less forthcoming, reluctant to talk about intimacy, interaction is more difficult)

pros:
- a lot of interaction during the session thanks to the use of visual material
- interesting to draw comparisons between 1st, 2nd and 3rd generations.
- external teacher

cons:
- a lot of ignorance & myths
- not enough time because there were many questions
- many people were late due to other responsibilities
- provide interpreters in case there are many languages

Organizing party:
- Successful education session
- Material used was clear and very good
- Teacher knows the target group very well and has a tailor-made approach for mothers
- Knowledge of several languages was an advantage. However, using several languages makes the session more complex
- Use of simple terms helps people to understand.
- These women don't use planners or schedules, so it's very important to remind them regularly (especially the day before).

Participants (usually providing feedback orally due to language or literacy issues):
- Very good and instructive
- They now know what to ask next time they go to the doctor's.
- Very interesting theme and a lot of possibilities for interaction
- Learned new things
- Highly relevant subject as there are still many misunderstandings
- Teacher is motivated, answers everyone's questions, good didactic approach.
- Clearly explained
- Suggestion to teach mixed groups, though this may require breaking taboos first
- Interest in the theme of female circumcision

Organizing party	**Nasci 16.10.2008 + 29.05.09 + 23.10.2009**	**Huis der gezinnen 19.12.2008 + 30.01.2009**	**BON 09.06.2009 + 16.07.2009**	**Planning Familial Schaerbeek Groupe BAH 18.06.2009**	**Link vzw 08.10.2009**
Regular promotion is important	**x**[5]				
Successful session	**x**	**x**	**x**		
Clear educational material		**x**	**x**		
Tailor-made approach		**x**			
Complex due to different languages	**x**[6]				
Humour and same cultural background icebreaker				**x**	

Participants	**Nasci 16.10.2008 + 29.05.2009 + 23.10.2009**	**Huis der gezinnen 19.12.2008 + 30.01.2009**	**BON 09.06.2009 + 16.07.2009**	**Planning Familial Schaerbeek groupe BAH 18.06.2009**	**Link vzw 08.10.2009**
More insight into the female anatomy and available types of contraception	**x**	**x**	**x**	**x**	

Teacher	**Nasci 16.10.2008 + 29.05.09 + 23.10.2009**	**Huis der gezinnen 19.12.2008 + 30.01.2009**	**BON 09.06.2009 + 16.07.2009**	**Planning Familial Schaerbeek groupe BAH 18.06.2009**	**Link vzw 08.10.2009**
High interaction	**x**	**x**	**x**	**x**	
High ignorance		**x**	**x**	**x**	
Limited time	**x**	**x**			
1st-generation participants			**x**	**x**	

2. What did you think of the materials used?

Teacher:

Educational material included:

- *Sensoa contraception kit*
- *Idriss kit (e.g. menstrual cycle)*
- *Teacher's own material from the expertise centre, adapted to the target group*

Participants:

Good and clear, plenty of things to show the group, lots of visual and tangible material

[5] only applicable to 16.10.2008 + 29.05.09

[6] only applicable to 16.10.2008 + 29.05.09

Organizer:
good and clear educational material

2. Findings

From a quantitative point of view, points to keep in mind are:

- different nationalities were present during the training sessions
- from different generations
- the allotted time per session was too short
- the majority of participants were uneducated

The qualitative evaluation revealed elements including:

- Ignorance and myths influence the use of contraception
- Most participants received their information about contraception from people close to them
- Both first- and second-generation immigrants reported that they were insufficiently informed by their doctors about the full range and side effects of contraception
- Everyone agrees that men also need to be encouraged to participate
- Most people said contraception is expensive, but essential

► i.e. lack of correct information!

3. Finally

While some of our findings cannot be remedied within the scope of this project, they are important enough to discuss with the organizations involved. These include:

- ✓ working with groups of men;
- ✓ empowering women themselves.

Other findings are part of our broader role as a maternity care expertise centre, including:

- ✓ raising awareness among GPs and other primary care providers in order to optimize contraception education and information.

6.2 Contents of the kit

The items in the kit are NOT suitable for use. They are placebo materials, destined only for use in training sessions or demonstrations.

Contraception

5 male condoms (Zanzu/Sensoa)	☐
female condom (Femidon)	☐
emergency pill = morning-after pill (Levodonna sandoz)	☐
hormonal implant (Implanon)	☐
vaginal ring (NuvaRing)	☐
the pill (Mithra)	☐
copper intrauterine device (Flexi-T by Prosan)	☐
diaphragm (Caya)	☐
patch pill (Evra patch)	☐
hormonal shot (Depo-Provera)	☐

Other materials

Oscar: demonstration penis	☐
3D model of a uterus to demonstrate IUD	☐
vaginal ring applicator	☐
pregnancy test	☐
speculum	☐
cervical smear kit (including brush, swab and Ayre spatula)	☐

Illustrations

- vagina with and without hymen: p. 1
- menstrual cycle: p. 2-7
- various hymens: p. 8-12
- female circumcision: p. 13-14
- hormone cycle with/without contraception: p. 15
- the male genitals: p. 16
- circumcised penis: p. 17
- penis cross section: p. 18
- Sensiplan menstrual cycle overview
- comparison of the menstrual cycle off and on the pill
- GAMS world map showing female circumcision prevalence

Publications

- Zanzu.be website cards
- Vrouwelijke Genitale Verminking/Vrouwenbesnijdenis (GAMS Belgium) NL+FR
- Geen besnijdenis voor mijn dochter (GAMS Belgium) NL+FR
- Seksueel Overdraagbare aandoeningen (SOAAIDS)
- Een moeilijke beslissing rond zwangerschap (FARA)
- Waar een wet is, is een weg: Abortus (LUNA)
- Breek de stilte: partnergeweld (IGVM)
- Seksueel Geweld. Wat nu? (IGVM)
- Eergerelateerd geweld (IGVM)
- Vouwfolder Welke anticonceptie kiezen (Bayer)
- Wat is het beste voorbehoedsmiddel voor jou? (MSD)
- Folder Caya, een nieuw pessarium (Memidis Pharma)
- Sensiplan (Natural Family Planning)
- La contraception (FLCPF)
- Kind in Beeld: Contraceptie (KIND&GEZIN)

Explanation of some of the items

There is a speculum and a set for taking smears (with a swab, cervical brush and Ayre spatula). Use this if there are any questions about visiting a gynaecologist or sexual health.

An applicator is available for insertion of the vaginal ring as an alternative to insertion by hand (optional). The ring is pushed flat into the applicator and inserted into the vagina. Pharmacies offer complimentary applicators when the NuvaRing is purchased.

The Caya is a new over-the-counter diaphragm that doesn't require prior adjustment by a doctor. This is a hormone-free contraceptive. Please note that this must always be used in combination with a spermicide gel.

There is a model of the uterus to show where the IUD should be placed. You can slide the IUD in and out by way of demonstration. Our demo IUDs are made of copper only, but the actual hormonal IUDs are the same size and are inserted in the same way, in the same place.

Notes on the Sensiplan menstrual cycle poster:
Relatively infertile phase: this is related to the coming ovulation; i.e. this phase can be longer or shorter depending on the time of the next ovulation, which means it cannot be determined in advance.
Absolutely infertile phase: is clearer, as there is absolute infertility once the ovum has died off, i.e. some 12 to 18 hours after ovulation (in medicine, this is often rounded up to 24 hours for ease of reference). That's why there's a short period of fertility after ovulation (the yellow bar).