THE SEXUAL HEALTH EDUCATION EXPERIENCES OF ERITREAN WOMEN IN TORONTO: AN EVALUATION OF THE RAISING SEXUALLY HEALTHY CHILDREN (RSHC) PROGRAM

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ABSTRACT

Very few studies have focused on the health knowledge and practices of Eritrean women and their children in Canada. The research surrounding Eritrean women and their children's awareness and exposure to sexual health education is even far more limited. This study aims to fill this gap in immigrant health research though an evaluation of the Raising Sexually Healthy Children (RSHC) Project, a sexual health education program for immigrant parents in Toronto. Evaluation is based on the Eritrean women's experiences of the RSHC Program as well any challenges and benefits they encountered throughout its implementation. Six Eritrean women including four program participants as well as two program coordinators were interviewed. Findings indicated that despite the cultural taboo of discussing issues of sexual health, the women gained a greater sense of confidence, openness, and acceptance towards this topic. The study concluded that the RSHC program was successful in assisting the Eritrean women participants to develop effective sexual health communication with their children, family members, and wider community.

Keywords: Sexual health education, sexual health needs, immigrant minority groups, Eritrean women, peer-education, immigrant women's health

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CHAPTER 1: INTRODUCTION

Canadian demographics have changed in recent years due to the increasing number of individuals and families from non-European countries (Statistics Canada, 2006). This group of immigrants often face many challenges as they are less familiar with the western model of healthcare and corresponding healthcare knowledge and practices. Extensive immigrant health research has shown that these immigrants encounter various cultural and structural barriers that may prevent them from using healthcare services (Beiser, 2005; McDonald & Kennedy, 2007; Vissandjée, 2010). Subsequently, these issues have prompted social services and healthcare sectors to find ways to reach out as well as address the unique needs of this population, particularly women (Wells, 2007).

Researchers in the field of healthcare recognize important issues related to immigrant women as noted by Hyman and Guruge (2002): "New immigrant women represent a diverse group who often face multiple cultural, linguistic and systemic barriers to adopting and maintaining healthy behaviour" (p. 183). This may be of additional concern given that those immigrant women with children are often the ones bearing the full responsibility of maintaining the health of their children thus putting them in direct contact with the healthcare system.

Despite considerable focus on immigrant women and their access to healthcare, sexual health education and awareness for these women is an area of health that has been neglected both in research and in practice (Burosch, 2009). It is expected that most Canadians who have attended public school will have been exposed to some form of sexual health education during their adolescent years. However, sexual health is often perceived as a taboo subject in many of these immigrant women's childhood communities and consequently, formal education surrounding this topic is very limited (Maticka-Tyndale, Shirpak, & Chinichian, 2007). This issue is of great concern as these attitudes and knowledge deficits can put the family at risk for sexual related health problems such as sexually transmitted illnesses (STIs), HIV/AIDS and for women, cervical and breast cancer. In addition, it can also create intergenerational and culture conflict between immigrant women and their children who are being exposed to both formal

(school) and informal (the media and friends) sources of sexual-related messages (Drummond, et al, 2011; Salehi & Flicker, 2010).

The Raising Sexually Healthy Children (RSHC) Program, a sexual health peer-education program for immigrant parents, is in part helping to address some of the unique sexual health awareness needs in particular ethnic minority communities. This study will specifically examine the Eritrean community and the impact the RSHC Program made on its women participants, their families, friends, and wider community. Evaluation of health promotion interventions such as the RSHC Program is essential in order to collect evidence about the effectiveness of its delivery, to identify ways to improve practice, to justify the use of resources, and to identify unexpected outcomes. Four studies have looked at this sexual health program since it was introduced in 1998, however, none of them has focused on the Eritrean community.

As of 2011, there were over 15 thousand Eritreans living in Canada while approximately half of them lived in the Greater Toronto Area (Bell, 2011). Research surrounding this population indicates that not only does this community face marginalization, but sexual health is commonly perceived as a sensitive and taboo area of discussion both in Eritrea and its diaspora (Dopico, 2006; Ogbagzy, 1999; Wilson, 1991). Bearing this in mind, it is crucial that research into this community is explored considering that such factors profoundly influence how Eritrean women respond to and manage the knowledge and practices of their own sexual health and the sexual health of their children.

This study aims to shed light in the area surrounding Eritrean women's experiences with sexual health knowledge through the means of an evaluation of the RSHC Program which was offered by the Eritrean-Canadian Community Centre (ECCC) in collaboration with Toronto Public Health. The evaluation seeks to explore the Eritrean women's beliefs, assumptions, expectations, and impression of the RSHC Program as well any challenges and benefits they encountered throughout its implementation. The study will also explore how the Program influenced the participants' communication with their children in regard to sexual health awareness as well as how the Program facilitated their ability to influence the wider community's sexual health knowledge and practices.

CHAPTER 2: LITERATURE REVIEW

This chapter on the literature review is organized into ten sections. The first section outlines the methodology of the search strategies while the second section gives a brief overview of the meaning of sexual health and implications of (sexual) health definitions in the execution of educational health and intervention programs. The third section discusses the importance of research on sexual health in immigrant minority communities while the fourth section explores the literature surrounding the general health knowledge and practices of immigrant women in Canada. A review of health studies that examine the cultural beliefs that influence preventative sexual healthcare practices among immigrants from non-European backgrounds women is looked at in the fifth section while section six examines sexual health intervention programs that make use of the peer-education model. Section seven is a description of the RSHC Program including its history and reasons behind its initial implementation as section eight addresses the RSHC Program within the Eritrean community while section eight briefly outlines the contents of the RSHC workshop manual. The ninth and final tenth section touches on previous studies and evaluations examining the Program's effectiveness in various ethnic communities in Toronto. Together these sections contextualize the reader's understandings of the importance of sexual health and intervention programs for minority immigrant women.

2.1 Search Strategies

A review of published literature was conducted by a search using the following electronic research databases: EBSCO Academic Search Premier, Google Scholar, Sociological Abstracts, Proquest Dissertations and Theses and the Working Paper Series housed at each of the five Canadian Metropolis Centres of Excellence. Government publications were retrieved from an advance key word search from Statistics Canada and the Health Canada website search engine. Papers were selected from a 15-year period beginning from 1997 to 2012 to capture the most recent literature within this time period. A range of search terms was used in various combinations. They included Canadian minority immigrant women, refugee or newcomer women; immigrant family, health practices, sexual health practices, sexual health education, sexual health knowledge, sexual health services; immigrant community health programs, public

health interventions, sexuality and migration, cervical cancer, breast cancer, sexually transmitted diseases, community health promotion in immigrant communities, train-the-trainer, peer-education.

In addition, the bibliographies of those works were reviewed for relevant literature. Google searches were also used to locate pertinent grey literature such as government and non-governmental organizational documents.

2.2 Sexual Health

Health Canada (2006) promotes the notion that sexual health is a vital and integral part of one's overall health and well-being and as such, it affects people of all ages and stages in their lives. Yet despite this recognition that sexual health is important throughout one's lifespan, the primary source of sexual health education remains, for the most part, in the public middle and high school curriculum. Very little provision has been made for sexual health education for adults beyond their adolescent years (Burosch, 2009; Maticka-Tyndale et al, 2007).

While it may be reasonable to expect that Canadians who have attended public school will have been exposed to some basic level of sexual health education during their school years, it cannot be assumed that immigrants arriving in Canada as adults have had the same kind of exposure. This may be of particular concern for immigrants who come from countries such as Eritrea, where public discussion surrounding sexual health is considered a societal taboo (Dopico, 2006). It is not surprising then, that immigrant mothers who come from such backgrounds may feel hesitant about allowing their children attend sexual health education classes in Canada, where it is a component in the public school health curriculum and where quite often, open dialogue of such issues is encouraged. In addition, these same reasons may also make it difficult for these women to discuss sexuality with their children at home or even access sexual health services themselves (Winnipeg's Sexuality Education Resource Centre. 2008).

The concept of 'sexual health' and the norms and values that surround its interpretation are derived from an array of sources and can vary from individual to individual over time. Its

meaning can be influenced by social and religious factors or derived strictly from a medical field's perspective and can change significantly based on the cultural, political and historical context in which it is defined (Giami, 2002). Given the complexities of meanings that this term can evoke, no single definition of sexual health will fully capture this diversity (Health Canada, 2003). *The Canadian Guidelines for Sexual Health Education* acknowledges this, but deems it necessary to provide a working definition as a guiding framework for the development of effective, comprehensive, and inclusive sexual health education. Adopted by the most recent definition put forth by the World Health Organization (WHO) in 2002, the Guidelines describe sexual health as:

> a state of physical, emotional, mental and social well-being related to sexuality: it is not merely the absence of disease or infirmity. Sexual health requires a positive and respectful approach to sexuality and relationships, as well as the possibility of having pleasurable and safe sexual experiences free of coercion, discrimination and violence. For sexual health to be maintained, the sexual rights of all persons must be respected, protected and fulfilled.
> (Health Canada, 2002, p. 4)

These guidelines note that Health Canada has endorsed this definition because it encompasses the complexities of sexual health as well as individuals' sexual health rights. However, the guidelines stress the importance of caution when using this term. The concept of 'health' itself has the potential of bearing certain authoritative medical connotations and could be used in a manner that expresses approval or disapproval of one's actions (Health Canada, 2003). Moreover, the term sexual health can bring about ideas of what is considered "proper" or "normal" sexuality or sexual behaviour (p. 7). Consequently, it is recommended by Health Canada (2003) that sexual health intervention programs should avoid making direct references to the definition of sexual health. It can be assumed that the RSHC Program has taken this approach as in its workshop manual, there is no reference made to a definition of sexual health.

Additionally, as indicated in one of the document's overview of the RSHC Program (Toronto Public Health, 2010), this is in part due to the fact that the Program's approach to sexual health education is taken in a manner that is respectful and open to the various meanings and understandings people from all different backgrounds have of this topic.

The RSHC Program is designed as a culture-sensitive sexual health education program for immigrants in respective communities. The program workshops therefore are aimed at addressing the sexual health needs of the specific, participating community. Service providers from the Eritrean-Canadian Community Centre (ECCC) believed that the sensitive and taboo nature of sexual health acted as barriers for Eritrean parents in that it prevented them from talking to their children about sexuality. In addition, these service providers from the centre along with many of its women members felt that there was a need for culturally and linguistically accessible sexual health information. From this, it was decided by the ECCC that a RSHC program organized and run by members of the Eritrean community, would best address these identified needs (Li, 2012).

The RSHC Program aims to develop an approach that is responsive and culturally sensitive to the needs of its participating ethnic community. In the case of the Eritrean group, the program tailored its delivery in several different ways so that it could meet the various needs of its participants while also providing a supportive learning environment. Firstly, the program consisted of Eritrean women only as discussing issues of sexual health amongst men would challenge traditional norms not to mention, create discomfort within the group. Furthermore, within Eritrean society, it is generally women who bear the responsibility of raising their children; therefore this program would be most relevant to their role as principal childcare provider. Secondly, the RSHC program manuals were translated into three of the most commonly spoken languages in Eritrea while one of the program coordinators, who spoke these three languages, acted as an interpreter during the workshop sessions. Thirdly, it was decided by the group that the most convenient time to attend the workshops were on weekends because the majority of the participants either worked during the week or attended school. Fourthly, these workshops were held in a meeting room at the Eritrean-Canadian Community

Centre-- a location very familiar to all the women, and easily accessible via public transit. Lastly, as an incentive to participate in the program as well as being receptive to the women's lower socio-economic status, the RSHC Program provided food at the workshop as well as transportation tokens to and from the location. This approach is in line with what is recommended by *The Canadian Guidelines for Sexual Health Education* when it comes to implementing effective sexual health education programs. The guidelines stress that such interventions should be responsive to an individual's ethnicity, gender, socioeconomic and religious background, and that it should reflect different social situations and learning environments. Moreover, it highlights the fact that ethno-cultural minorities require improved and non-judgmental access to sexual health education (Health Canada, 2003).

2.3 The Importance of Research on Sexual Health in Immigrant Minority Communities

The 2006 Census found that Toronto had the highest number of visible minorities among all metropolitan areas of Canada with over 2 million individuals identifying themselves as such. Between 2001 and 2006, Toronto took in 40% of all newcomers to Canada and 82% of them belonged to a visible minority group (Statistics Canada, 2010). According to a recent report, that number is only expected to grow. Statistics Canada projects that in Toronto and its surrounding municipalities, visible minorities could more than double in the next two decades, making up 63 percent of the region's total population by 2031 (Statistics Canada, as noted in Whittington, 2012). These statistics speak to the rise of Eritrean-Canadians. By some estimates, there are approximately 15,000 Canadians of Eritrean origin living within the GTA as of 2011 and that number is growing. Canada granted permanent residence to 744 Eritreans in 2010, up from 662 in 2009 and 470 in 2009 (Bell, 2011).

And while this community and others visible minority populations continue to grow in Toronto, so does the research on how healthcare providers can meet the unique needs of these groups. There has been considerable literature on immigrant health in recent years (Beiser, 2005; Fuller-Thompson et al, 2011; Hyman, 2004; Vissandjée et al, 2010); however, studies that specifically focus on minority immigrant women and their knowledge and practices as it pertains to sexual health education and services, are scarce. The assumption that can be made

from this is that research surrounding such highly sensitive topics must be met with due diligence, especially within immigrant minority populations where this subject is met with much stigma and taboo (Dopico, 2006).

Gaining access to immigrant minority women's populations for research can often be met with a variety of barriers. For example, their lack of interest in participation can be attributed to language barriers, distrust of the research process and criticism that research advances the researcher's career but does little to benefit the minority community (Berg, 1999). Similarly, issues of anonymity and confidentiality may deter immigrant women from participating due to the sensitive nature of a topic such as sexual health (Burosch, 2009). Furthermore, immigrant women who are juggling outside employment while managing a household and raising children have little time to participate in healthcare research (Berg, 1999). Nevertheless, these factors should not keep research from being pursued in this area. Since each group of potential research participants has unique issues and concerns, researchers must familiarize themselves and adapt to the values, beliefs and practices of their target group (Burosch, 2009). Moreover, as Canadian society becomes increasingly more diverse, the need for information surrounding the sexual health knowledge and practices of immigrant women will only increase. In light of the wide range of values, beliefs, experiences, and levels of health education related to sexual health represented in the immigrant population, it is imperative that this topic is explored. By doing so, it is the hope that such research will assist those working with this population, including healthcare providers, to become more responsive to the unique sexual health needs of this population.

2.4 Immigrant Women in Canada: General Health Knowledge and Practice

Much of the preliminary research that looks at immigrant health reveals that upon arrival in Canada, the health status of many recent immigrants begins to deteriorate as their length of time spent in Canada increases (Beiser, 2005; Fuller-Thomson et al, 2011; Hyman, 2001; McDonald & Kennedy, 2004; Vissandjée, Thurston & Nahar, 2010). This phenomenon is typically referred to as the "healthy immigrant effect." While both female and male immigrants are affected by such circumstances, it is immigrant minority women with children who are

more prone to illness and barriers in healthcare as they face additional challenges during the resettlement process (McDonald & Kennedy, 2004).

The gradual loss of health and well-being is attributed to a variety of multidimensional social factors (Fuller-Thompson et al, 2011). For example, many minority immigrant women face unemployment or work in unsafe or unhealthy working conditions, isolation and loneliness, prolonged social insecurity and feelings of vulnerability and depression arising through poverty, prejudice, and discrimination (Vissanjée et al, 2010). In general, the transition period is accompanied with feelings of up-rootedness, coupled with the need to function in an unfamiliar environment where they are confronted with the pressures to adapt to new gender roles, new norms, new values and new sets of expectations. This can all lead to feelings of distress manifested as depression and somatic complaints (Meleis, 2003). Further, in their home countries, many of these women had high levels of social capital in the form of friends and family, and could depend on these networks for additional childcare and social support. Once in Canada however, those support systems are lost and immigrant women often find themselves pressured by the demands of both employment and childcare (Fuller-Thomson, 2011). As Meleis (2003) points out: "Not only must immigrant women operate with these severely reduced support networks, but they do so in a context in which the entire constellation of attitudes and practices associated with childrearing has been altered" (p. 7). While they are generally used to being the primary caregiver in the family, they often find themselves faced with the unaccustomed role of 'head of the household.' For example, Matsuoka and Sorenson (1999) explain that in traditional Eritrean and Ethiopian society, the husband's role is the principal bread winner of the family and the one who upholds the most authority in family decision making while the woman maintains the domestic and childcare giver role. However, once the family moves to Canada, those traditional gender roles change. Many of the Eritrean or Ethiopian women felt that in addition to their husband, they too had to work in order to financially support their family. In addition, they were also the ones finding themselves with an increased role in their involvement in family decision-making outside the home. These decisions would often revolve around their children's formal education and health (Matsuoka & Sorenson, 1999).

When it comes to access of healthcare for immigrant minority women either for themselves or on behalf of their families, numerous studies show that the extent to which they are able to utilize the Canadian healthcare system is not just an issue of access to information and interpretative services, although lack of fluency in English is a significant barrier, but they face numerous cultural, structural and financial barriers (Burosch, 2009; Hyman & Guruge, 2002; Meadows, Thurston & Melton, 2001; Meleis, 2003; Vissanjée et al, 2007; Wells, 2009).

Firstly, cultural constructions of health and well-being have a profound impact on how women define their health status and the extent of which they deem it appropriate to access healthcare (Meleis, 2003; Vissanjée et al, 2001). For instance, Meadows et al., (2001) found that the immigrant minority women in their study tended to define their health primarily in terms of their ability to maintain the well-being of their family. Similarly, there is a belief among some cultures that the woman's role as nurturer of the family necessitates always attending to her family's needs before her own (Hyman & Guruge, 2002; Vahabi, 2010). In addition, many immigrant women are not used to formal health promotion initiatives and health services and are much more comfortable with accessing health information through informal social networks (Meleis, 2003). Several studies have also indicated there is a lack of mutual cultural literacy between immigrant women patients and Canadian healthcare providers as well as limited ethno-specific and gender health delivery matching (Buroshe, 2009; Maticka-Tyndale et al, 2007; Vissanjée et al, 2001).

Secondly, in terms of structural barriers, immigrant minority women face challenges when it comes to access to commuting to various healthcare facilities, absence of spouses or childcare, cold weather (Vahabi, 2010; Vissanjee et al, 2001) as well as a lack of knowledge and acquaintance with existing healthcare services including preventative healthcare practices (Beiser, 2005; Hyman, 2004). Finally, Cho (2012) argues that women who are sponsored or who are refugee claimants, are less likely to deal with ill health because of the financial ramifications.

In the end, these cultural, structural and financial barriers can all lead to the deterioration of immigrant health status over time because of the relative under-utilization of preventative health screening and under diagnosis and treatment of health problems (Austin et al, 2002; Bottorff et al, 2001; Matuk, 1999; McDonald & Kennedy, 2004; Vahabi, 2010; Vahabi, 2011). And with considerable variation in detail and specifics, almost all the research called for the development of culturally appropriate and accessible gender sensitive healthcare policies and practices, cultural sensitivity for service providers, and cultural competency at all levels of the healthcare system (Hyman & Guruge, 2002; Meleis, 2003; Vassanjée, 2007; Wells, 2007).

2.5 Minority Immigrant Women: Beliefs that Influence Preventative Sexual Healthcare Practices

Implicit in the meaning and understanding of sexual health is the idea that it encompasses an array of health problems including HIV/AIDS, sexually transmitted illnesses (STIs), [unintended] pregnancy and abortion, breast and cervical cancer, and infertility (Andrews, 2005; Health Canada, 2003). From this more medically-influenced perspective on sexual health, a review of minority immigrant women's health literature as it pertains to some of these illnesses is explored.

In Eritrea, female sexuality is widely perceived as a taboo area of discussion. Several studies touch on this topic and reveal that from an early age, Eritrean girls learn the importance of repressing their sexuality and subsequently, passivity and continence is expected (Wilson, 1991; Ogbagzy, 1999; Dopico, 2006). According to Dopico (2006), it is argued that:

> It is indecent for a woman to understand the structure and functions of her own body. Even basic education about reproductive and sexual health can cause fierce controversy. The confusion, embarrassment and ignorance that surround sex for many Eritreans continue into adulthood (p. 35).

Although these beliefs are within the context of Eritrean culture, similar views of this nature are also shared by other ethnic immigrant populations of non-European descent (Matin & LeBaron, 2004). Several researchers have argued that in addition to barriers of language, transportation, poverty, multiple role burden, etc., cultural beliefs surrounding women's sexuality have hindered their use and knowledge of sexually related healthcare services including birth control counseling, prenatal care, sexually transmitted disease treatment, and screening for breast and cervical cancer (Gupta et al, 2001).

In particular, extensive immigrant women's health research has demonstrated that immigrant and minority women generally have relatively low participation in preventative healthcare services such as Pap smears (a procedure used for cervical cancer screening), breast exams, and mammograms (Austin, Ahmad, McNally, and Stewart, 2002; Gupta, et al, 2001; Hyman & Guruge, 2002; MacDonald & Kennedy, 2007; Matuk, 1998; Vahabi, 2010).

Having breast and cervical cancer screenings are preventative health actions that are influenced by the individuals' cultural values, religious beliefs and social setting. The idea of disclosing personal information related to their sexual activity and exposing body parts is inappropriate and may cause extreme feelings of discomfort for some women, particularly when the doctor is a male (Matuk, 1999). Likewise, several studies reveal immigrant Muslim women are reluctant to undergo cervical cancer screenings because there is a belief that the procedure threatens their religious values such as putting premarital virginity at risk (Matin & LeBaron, 2004).

Furthermore, newcomer women may forgo breast and cervical cancer screening due to a lack of understanding of the importance of having these procedures performed (Gupta et al 2001; Mutuk, 1999; Vahabi, 2010, 2011). For example, research looking at immigrant women from various ethnic backgrounds including Hispanic, Asian, and Middle Eastern populations show that such screening practices are perceived as more of a diagnostic process rather than as a means of a preventative measure (Austin et al, 2002; Gupta et al, 2001; Vahabi, 2010). Additionally, there are wide-spread fears surrounding cancer and the belief that the disease cannot be cured (Austin et al, 2002) This has led to an avoidance of discussion of the subject

which is contributing to low participation levels of education programs promoting such screenings (Austin et al, 2002; Vahabi, 2010). Meleis (2003) points out that lack of breast and cervical cancer knowledge may be influenced by the healthcare experiences in one's native country. In many developing nations, preventative medical care programs and strategies remain limited. Patients are responsible for the cost of their healthcare so they may be inclined to use traditional homecare remedies first before seeking professional health advice (Meleis, 2003; Vahabi, 2010).

Burosch (2009) and Maticka-Tyndale's et al (2007) studies are two pertinent sources of literature that add to the very limited Canadian research on sexual health education for immigrant minority women. The authors of both studies discuss the dilemmas faced by countries such as Canada that are becoming increasingly diverse, and that are struggling to "fill the gaps" in sexual health education and services for immigrant women in culturally sensitive and inclusive ways. Both studies were conducted in Ontario and used a qualitative approach through a community-based framework.

Through a feminist lens, Burosch's study (2009) focuses on immigrant women from diverse ethno-cultural backgrounds representing Africa, Asia, the Middle East, and South America. The research examines these women's experiences learning about sexual health and sexuality across their lifetimes as well as accessing sexual health services in Canada. The study demonstrates the dynamic and very complex nature of women's attitudes, beliefs, behaviours, and strategies as it relates to their sexuality and sexual health particularly in the context of migration. The findings indicate that sexual health education for these women are acquired through informal sources such as their life experience (family, ethnic/cultural community), the media, and women's kin and friendship networks as well as formal sources which include school, healthcare centres, and faith groups. Through these sources of information, arise messages about gender and sexuality and their influences in women's lives. For example, messages about moral responsibility coming from within the context of their cultural community and faith groups often emphasize the value of a woman's virginity and the importance of her remaining 'pure' to maintain her own honour and the honour of her family.

Factors such as culture, religion, political contexts, and family values provide sources of meaning for women to make sense of their experiences related to sexual health education (Burosch, 2009).

Burosch (2009) also found that the migration and acculturation process provided both benefits and challenges in their perceived openness of women's sexuality and sexual health in Canadian society. For example, some women felt they benefited from an increase in awareness and knowledge related to contraception, pregnancy, reproductive health and sexual transmitted illnesses. Nevertheless, other women found that living in a more sexually liberal society caused conflict as it clashed with traditional value and belief systems. These challenges were also felt by women in Maticka-Tyndale et al (2007) study that looked at married couples from Iran and their experiences with health services and information related to sexual health. Female participants expressed the difficulty they had in adjusting to Canadian society where sexually related themes and images are portrayed in many aspects of public life –an environment very different from the one they were raised in where there is no public discourse surrounding sexually-related issues (Maticka-Tyndale et al, 2007). This research reveals that significant barriers exist for these couples including culturally inappropriate and insensitive healthcare services, language difficulties, shyness and embarrassment.

Both Maticka-Tyndale et al (2007) and Burosche (2009) studies noted the importance of the delivery of sexual health services that target the specific needs of those from particular cultures and ethnicities. Evidence of this included participants' accounts of misunderstandings and inappropriate or even offensive questions or suggestions made by health practitioners who were unfamiliar with patients' cultural norms related to sexuality. Participants believed their needs and concerns were different from their Canadian counterparts and wanted confidential, linguistically and ethno-specific matched sources of sexual health information and services (Burosch, 2009; Maticka-Tyndale et al; 2007).

While both these studies speak to the importance and often ignored needs of immigrant women and their exposure to sexual health, both were in complete contrast in how they approached their choice of study participants. Burosch's (2009) study represented the voices of women from a various countries and ethnic backgrounds and she argued that studying participants from only one country would not represent the experiences of a multi-cultural population.

On the other hand, however, the Maticka-Tyndale et al (2007) study looked only at Iranian immigrant women and their experiences and needs related to sexual health services in a small town in Canada. The authors in this analysis noted the importance of the deliverance of sexual health services that target the specific needs of those from particular cultures and ethnicities. Examples from the study provided accounts of misunderstandings and inappropriate or even offensive questions or suggestions made by health practitioners who were unfamiliar with their patients' cultural norms related to sexuality. Participants believed their needs and concerns were different from their Canadian counterparts and wanted confidential, linguistically and culturally accessible sources of information.

Women who emigrate from the same country or are of the same ethnicity share many historical events, values and norms driven by their heritage therefore, this approach is especially vital for a health promotion program like the RSHC project as it addresses a subject that is especially sensitive to many immigrant groups who share a more conservative view on sexual health and sexuality issues. Wong (2001) in her study exploring the Raising Sexually Healthy Children Program in the Chinese community, supports Maticka-Tyndale et al (2007). She contends that many health promotion programs fail because the interventions are not relevant to the target population; to be effective, health promotion programs, materials and messages must be similar with the cultural dynamics of each specific community (Wong, 2001).

2.6 Sexual Health Interventions

The lack of knowledge or exposure to sexual health education and services among immigrant minority populations highlights the need for the development of culturally sensitive

and inclusive sexual health intervention programs in Canada (Burosch, 2009; Maticka-Tyndale et al, 2007). Drummond et al (2011) note that simply distributing information to a community is unlikely to influence health behaviours, especially for those who are not receptive to Western-oriented health promotion tactics. The authors argue that to overcome such a resistance to change, health information must be delivered by members of the target group rather than by 'outsiders.' This particular method of health promotion programs has been termed "peer education."

The Raising Sexually Healthy Children (RSHC) Program uses the peer-education approach by having those who participated in the program educate other parents and members from the same community about family sexual health. As part of the program, participants develop the necessary skills for delivering presentations to the community or facilitating informal discussions among family and friends on sexual health. Such peer-education programs are considered an effective and culturally sensitive way to disseminate knowledge about various health issues in culturally and linguistically diverse communities whereas direct interaction between service providers and community members is sometimes regarded as culturally insensitive and inappropriate (Brown, 2011; Drummond et al, 2011; Karen & Connie, 2007; Majumdar & Roberts, 1998; Wong, 2001). Advocates of peer education claim that the approach has the advantage of being able to educate the "hard to reach" as the educators know where to recruit their peers. Moreover, peer education empowers recipients by involving them as educators as well as learners (Brown, 2009; Drummond et al 2011).

Wong (2001) expands on the discussion of empowerment through community participation as a health promotion strategy in her case study of the RSHC Program. She contends that health promotion programs that use multiple strategies such as community participation, partnership, empowerment education and capacity building contribute to empowerment at the individual and community levels. Until recently, heath promotion programs have tended to use single-track strategies such as stand-alone health education programs that focus on individual lifestyle changes and information giving (Majumdar & Roberts, 1998). These programs have

limited impact on individual behavioural change and on public health as a whole. The new vision of health promotion is concerned not only with providing health information but also with developing skills and confidence in individuals and communities to take action in improving health (Wong, 2001).

Findings from Brown's (2009) study also exploring RSHC Program within Toronto's Chinese community found that the peer-education approach used, helped to foster a sense of empowerment in the Chinese community. Wong's (2001) study also paralleled these results adding that:

> "...empowerment education programs [such as the RSHC Project] are useful in promoting health among racialized and marginalized immigrants who experience structural barriers to acculturation and integration. In addition to skills building and knowledge acquisition, these programs facilitate citizen participation, relationship development, mutual support, and collective actions" (p. 118).

Currently, there is a worldwide trend moving from traditional health education to peer-education for HIV/AIDS prevention, particularly in resource-poor countries in Africa and for immigrant communities within Western-host nations (Drummond et al, 2011). For example, one study exploring the effects of a behavioural intervention for prevention of HIV and STIs among a disadvantaged, impoverished Roma settlement in Bulgaria found the peer-education model to be extremely beneficial in increasing sexual health knowledge and safer sex practices within the community. Trained and engaged leaders of Roma men's social networks counseled members of their own social network on risk prevention. Findings indicated that there was a decrease in self-reported unprotected sex as well as lower rates of STIs in the intervention groups compared with control groups. The study also found that peer-driven approaches can be much more cost-effective than professionally delivered counseling and can potentially reach large numbers of "hidden" community members who might be difficult to engage in traditional public health counselling (Kelly et al, 2006).

Kocken's et al (2001) evaluative study of a peer-led AIDS education program for Turkish and Moroccan immigrants in The Netherlands concluded that such a peer-education program was very effective. The researchers found that misunderstandings with respect to the transmission of HIV were cleared up and the risk appraisal for AIDS infection was improved. Further, Majumdar et al (1998) evaluative study exploring a peer-education program for immigrant women in Canada was equally as beneficial in increasing knowledge as well as altering attitudes about AIDS. The women involved in the study were assessed through six different agencies in the community. The cultural groups with the same ethnicity belonged to the same ethnic organization, had the same language and emigrated from the same country. They included: Central and South Americans, Arabs, Barbadians, Indians, Bangladeshis, and Laotians. Not only did results of the study find that participants exhibited a significant increase in knowledge but the training helped to foster a more positive opinion of those infected with AIDS.

Drummond et al (2011) believes that peer-led community workshops on sexual health were effective in overcoming cultural barriers related to sexual health within a West-African community living in Australia. The authors suspect that this was because community members took the peer educators' involvement as an endorsement signifying that sexual health was a matter of importance for the community and that they could discuss information that ran counter to cultural beliefs. Furthermore, the peer educators' involvement might have been perceived as permission to talk openly about issues normally considered taboo (Drummond et al, 2011).

2.7 The Raising Sexually Healthy Children (RSCH) Program

Beginning in 1998, health professionals from Toronto Public Health and service providers from the Portuguese, Spanish, Chinese and Vietnamese communities formed the Toronto Talks Sex Ethno-Cultural Outreach Subcommittees. The group felt they needed to address some of the challenges they were facing when it came to sexual health issues, in particular, immigrant youth sexual health, sexual health education at home, and parent-child communication. The

idea of developing a peer-parent leader training program was put forward as an important means of addressing these sexual health concerns and from that, the Raising Sexually Healthy Children (RSHC) Program was established (Brown, 2011). Through the use of a 'train-the-trainer' method, peer parent leaders are trained by sexual health educators and service providers in the community. These trained peer leaders from their ethnic community then organize and facilitate outreach services, workshops and presentations as well as develop resource material related to sexual health. The information provided is language and culturally specific in order to meet the unique sexual health needs of those participating ethnic communities (Toronto Public Health, 2010).

The RSHC Program is designed to make use of the Community-Capacity Building model in which community members' knowledge, awareness and skills are developed using their own capabilities (Toronto Public Health, 2010). Verity (2007) proposes that community capacity building can be viewed as a notion that describes 'community' effort, time, resources, leadership, and commitment directed towards the community's identified goals. The model also emphasizes the importance of forming strong partnerships with other available support systems and using their expertise to develop sustainable outcomes for their community (Toronto Public Health, 2010).

Due to growing interest and success, the RSHC Program has greatly expanded across the Toronto area and now includes participating groups from the Tamil, Korean and Bengalese communities. Most recently, four agencies serving the French-speaking African, Somali, Ghanaian, and Eritrean community expressed interest and have since implemented the program beginning in 2010 (Toronto Public Health, 2010).

2.8 The RSHC Program and the Eritrean Community

In the spring of 2010, the Eritrean-Canadian Community Centre (ECCC) was approached by Toronto Public Health in an attempt to involve the Eritrean community in the RSHC Program. Due to the growing concerns Eritrean parents were having over the messages their children were receiving about sex in the media and at school, the idea of implementing such a sexual

health program was positively received. Shortly following this decision, two Eritrean service providers took part in a Toronto Public Health workshop designed to help them become trained sexual health educators. In addition to informational/recruitment flyers about the RSHC Program distributed throughout the Eritrean community, service providers from the Eritrean-Canadian Community Centre also recruited Eritrean women with children who they felt could benefit from the program. Only women, as opposed to men, were recruited because in most African cultures, women are primarily responsible for the health and welfare of their family (Drummond et al, 2011).

The following winter 2010 through to 2011, 17 Eritrean women participated in the RSHC Program facilitated by the three Eritrean service providers along with a sexual health promoter from Toronto Public Health. The Program was held at the Eritrean-Canadian Community Centre and was divided into nine full day workshops, delivered over the course of several months. During the workshop sessions, all participants were given a RSHC workshop manual as a guide to follow along while the facilitators made use of the workshop materials and outlines. The workshops were designed to be highly participatory and included a mix of small and large group discussions, class presentations and both individual and group activities. In Eritrea, there are over nine languages spoken and many of the participating women had varying levels of understanding of either one or a few of these languages. However, due to limited resources, the workshop manuals could only be translated into three of Eritrean's official languages: Tigrigna, Amharic, and Arabic. Throughout the workshop sessions, these languages were used interchangeably along with other local, Eritrean languages by both the facilitators and participants, depending on the needs of the women.

2.9 The RSHC Program's Workshop Content

The RSHC Program's Workshop Manual (2008) along with the accompanying workshop lesson plans were developed by Toronto Public Health in consultation with members of the Eritrean community to ensure that the material covered in the workshops was worded and presented in a culturally sensitive manner. It is divided into several sections including an introductory piece outlining the goals and expectations of the role that participants play in the

RSHC Program, tips on successful discussion groups, ground rules of the program and the "do's and don'ts" of workshop practices (pp. 1-6).

The introductory workshop centres on the discussion of the various meanings given to the term 'sexuality,' based on the participants' own interpretations. The workshop then covers material on where children get their messages about sex and sexuality and what kind of information those messages entail. There is a focus on "Family of Origin" where there is an opportunity for participants to share and reflect on how they learned about sexuality and the role their family played in learning about these issues. The final half of the session looks at what is expected from them as a children's sexual health educator as well as ways they can help their children grow up sexually healthy. Examples include, talking to children in ways that embrace both genders, teaching children the correct words of all body parts; encouraging everyone in the family (children and adults) to share his or her feelings; helping children understand what is and what is not appropriate behaviour, without making them feel guilty or ashamed.

The second workshop focuses on developing parent-child communication skills through the use of "I-messages." This technique is used as an effective means to express feelings without judging or blaming others during conflict situations. For example, if the child is rubbing his genitals at the dinner table. His father says, "That's disgusting." The response suggested by the workshop manual is: "I feel uncomfortable when you rub yourself when other people can see you. I know it feels good, but this something we do in private. You can do that in your room." (p. 24). The workshop also then goes into detail about the sexual development of children as well as how family sexuality education can help to protect children from sexual abuse.

The final workshop looks at ways of responding to children's questions about sexuality. It addresses why these questions need to be addressed, when they should be answered, and what should be said in response to the questions. Practice scenario cards are included in the manual so that it allows participants to practice among themselves so that when topics related

to sexuality arise unexpectedly with children, they are prepared. For example, one scenario card indicates what you should do if you are watching a TV program with your 8 year-old and one of the characters says someone was raped. The manual suggests that you ask your child what they think it is and then explain to them that it means forcing someone to have sex when they do not want to and that it is a crime and can hurt a person and make them feel bad (Toronto Public Health, 2008).

2.10 Previous Research and Evaluation on the Raising Sexually Healthy Children (RSHC) Program

There have been four major research studies done on the Raising Sexually Children (RSCH) Program since the program began in 1998. The first two were evaluative studies that were undertaken in the program's earlier stages and were carried out as pilot projects in the Chinese (Wong, 2001) and Vietnamese (Toronto Public Health, 2000, as cited in Brown, 2011) communities. Through the use of interviews, focus groups, document analysis, surveys, and participant observation, both studies conveyed multiple, positive short-term outcomes such as immigrant parents' empowerment, improved family relations, increased participation, and support networks, and expanded partnerships and collaborations in relevant communities (Toronto Public Health, 2000; Wong, 2001).

Wong (2001) undertook a comprehensive participatory action project and discovered that the RSHC program served as an important avenue for empowerment and community participation among Chinese immigrant mothers.

In 2008, Toronto Public Health began exploration into a third research study that compared three RSHC Programs delivered in the Chinese, Portuguese and Tamil communities. Making use of both qualitative and quantitative data, the study was undertaken to commemorate the 10th anniversary of this health promotion program and took into account participation at the individual, group, and community levels. The purpose of the project was to examine the processes and outcomes of the RSHC programs by identifying any positive or negative impacts within the featured communities in an attempt to further strengthen the program (Toronto Public Health, 2010). Major findings indicated that participants experienced an increase in

understanding children's sexuality, improved parent-child communication and relationships at home, and continued enthusiasm in promoting family sex education in the community through formal networks such as school and faith organizations. Additionally, all participants recommended that the program should continue and expand within and outside their ethnic communities (Toronto Public Health, 2010).

The final and most recent study looking at the RSHC Program, explored parent-child sexual health communication in Chinese immigrant families. The study also looked at the influences of parenting style and acculturation and how those factors affected such sexual health communication between both Chinese parents who participated in the RSHC Program and those who did not (Brown, 2011). Through the use of in-depth interviews, this was the only RSHC study that took into account the views of children.

Included in Brown's (2011) data acquisition was the collection and analysis of the training manual from the RSHC Program. She notes that she was able to participate in a RSHC training session and from that, was able to gain an understanding of how the program contents were delivered. This involvement, which one would classify as participant observation, was merely mentioned and no elaboration was given (e.g. what session she participated in, what topics were discussed and how she gained the trust of the other participants, given that it was a session delivered to an unidentified African group). Identifying these factors and developing a discussion around it may have provided further insight into the analysis of the Program.

Findings of Brown's study revealed that discrepancies existed in what was defined as "sexual health communication" by both parents and their children. For example, parents felt sexual health communication encompassed conversations about dating, relationships, attraction, affection, and discreet warnings about sexual activity and the physical and emotional consequences that can come with irresponsible sexual behaviour. These discussions parents had with their children did not include detailed information about the use of condoms, pregnancy, sexually transmitted infections, homosexuality, etc. Their children, on the other hand, felt that such specifics should be included in these discussions. Therefore, they did not

perceive their parents' messages on sexual health as sexual health communication (Brown, 2011).

In addition, there were also indications of influences of acculturation on sexual health communication within Chinese families. For example, Chinese parents perceived sex-related values in contemporary Chinese culture shifting toward a more Western perspective. This means that typical Chinese parenting is moving from a strict, hierarchical approach to a more open, flexible and communicative style. Further, they feel that the Chinese people in Canada (and in China) are becoming more open and curious about sex and sexuality as sex related themes are discussed more openly in the media and among young people. Children, however, felt that acculturation had no effect on their parents' parenting style and all believed that their parents maintained a consistent approach to parenting post-immigration (Brown, 2011).

Although Brown's (2011) study provided invaluable insight into parent-child sexual health communication and the influences of the RSHC Program, there were differences in the perceived benefits of the Program between the children and their parents. For instance, Brown (2011) concludes that the RSHC Program influenced Chinese parents' openness and facilitation towards sexual health communication with their children. Nevertheless, in the study, children indicate otherwise. They felt conversations about sex lacked specific information. Clearly, if the parents who participated in the RSHC Program felt that such openness and facilitation towards sexual health communication was gained through their involvement in the Program, their children would not feel this way.

Findings on all four previous RSHC Program studies from various ethnic communities found that participants in the program experienced an increase in sexual health knowledge. Such knowledge pertained to children's sexual development, parent-child communication skills, and Canadian parenting strategies. Much discussion and analysis revolved around these findings, however, there was little, in-depth exploration into the effects the program had on the participants' self-development and learning experience as it related to their own feelings, views and beliefs surrounding sexual health. There was some mention in Toronto Public Health's

(2008) most recent evaluation case study that showed an increase in open-mindedness towards diverse sexual values, however little detail is given as to what and how those values were influenced by participants' involvement in the program as well as the sustainability of those changed values over time. Wong's (2001) study is the only one that examines in detail the changes of personal attitudes towards sexual values among the RSHC participants. For example, she notes that several of the RSHC participants became increasingly accepting and understanding around issues of sexual orientation and homosexuality. Discussion on conflicting religious and cultural views surrounding this topic was explored and how ultimately, the RSHC Program influenced these changes in beliefs. This study also intends to examine any changes in regard to how the RSHC Program influenced Eritrean participants' sexual health attitudes and beliefs.

To date, there have been no previous studies done on the Eritrean population and its involvement in the RSHC Program. This paper aims to consider the Eritrean women participants' experiences with the program as their practices and beliefs surrounding sexual health issues may be very different than that of pervious populations looked at within the RSHC Program. Further, due to the cultural suppression of female sexuality as well as the societal taboos that exist around sexual health, Eritrean women, their families and wider community face their own, unique and significant challenges when it comes to this subject.

CHAPTER 3: METHODOLOGY

3.1 Research Purpose, Design, and Questions

The purpose of this evaluative study was to assess the effectiveness of the RSHC program in promoting and facilitating the Eritrean women's abilities to reflect and discuss sexual health with their family and the community at large. The study sought to address the following questions:

1. What kind of benefits, if any, did the Eritrean women encounter as a result of their participation in the program?

2. What kind of challenges, if any, did both the RSHC participants and coordinators encounter as a result of their involvement in program?

3. How did the RSHC program influence the participants' beliefs, attitudes, and practices surrounding sexual health and sexuality issues?

4. How did the participants feel that the RSHC program was effective in facilitating their ability to influence their family members, friends, and wider community's sexual health knowledge and practices?

3.2 Sample, Recruitment Strategies

A convenience sample of six women was recruited for this study. They consisted of two RSHC program coordinators and four RSHC program participants. The two program coordinators were both members of the Eritrean community and had been trained by sexual health educators from Toronto Public Health. One was a settlement service provider working for the Eritrean-Canadian Community Centre and the other was a community member hired by the Centre. The four RSHC program participants met the following study inclusion criteria: 1) Eritrean women who participated in the RSHC Program, 2) able to understand and communicate in English, and 3) graduated from the course in May 2011.

Following several meetings discussing the proposed research with the Eritrean-Canadian Community Centre (ECCC), a letter of approval indicating its support for the study was obtained and the settlement service provider worker at the ECCC (one of the two Eritrean's RSHC project coordinators), was assigned to assist with the recruitment. (see appendix A)

The recruitment process for the RSHC program participants included the following: 1) An email entailing information about the study in English was sent to all 17 Eritrean RSHC participants by the administrative assistant at the ECCC. (see appendix B) This approach generated no response; 2) The settlement service provider assigned to the project then informed the women about the study at one of the Eritrean women's monthly social gatherings known as a *mahaber* which was held at one of the participants' home. She distributed the information sheet about the study, prepared in English, among the attendees. She also asked participants' permission to invite the principal investigator to their next monthly social gathering; 3) In the following monthly meeting the PI was invited to discuss her study with the participants. The contact information of women who showed interest in the study were collected by the PI; 4) The PI contacted the interested participants by phone explained the study again, assessed their eligibility and set a convenient time and place for the interview.

The study protocol received ethical approval from the Human Subjects Review Committee at Ryerson University. All participants were informed of their rights to withdraw from the study at any time and without penalty.

3.3 Data Collection

All data were collected during face-to-face interviews conducted in English by the PI after obtaining the participants' consent forms. Interviews with RSHC Eritrean participants took place in the participants' respective homes as all four had children at home and felt it was the most convenient place for them. The interviews with RSHC Program coordinators were held at the University of Toronto's Ontario Institute for Studies of Education (OISE). This location was decided by both coordinators as it was convenient for them and it offered a quiet, relaxed environment. The data collection involved completing a short socio-demographic questionnaire

and participating in a face-face interview. Face-Face interviews were conducted using an interview guide, which directed the flow of the conversation. It was not intended to be followed rigidly but rather acted as point of reference in case the conservation lagged. The interview guide and socio-demographic forms for the RSHC participants slightly differed from that used with the RSHC program coordinators. The interviews lasted for approximately 50 minutes. Details related to the questionnaire and interview guide are presented below.

3.4 Socio-Demographic Questionnaires

A brief, self-completed socio-demographic questionnaire was distributed at the onset of each face-face interview with the four RSHC participants and two project coordinators. (see appendix C and appendix D). Socio-demographic questionnaires are useful in providing contextual information which help to understand factors that may influence the participants' responses.

3.5 Interviews with RSHC participants

The semi-structured face-to-face interviews captured the participants' feelings, expectations and overall thoughts about the RSHC Program as well as any problems or benefits they may have encountered as a result of their participation. It offered an opportunity to capture their words, ideas, thoughts and the meanings they attached to their experiences. Some of the questions discussed were: (a) How do people in your community feel about sexual health? (b) Why did you decide to participate in the RSHC Program? (c) How did you feel about sexual health before you took the RSHC Program? (d) How did you feel about sexual health issues after your experience in the RSHC Program? (e) Have you been able to use the information you learned in the program within your community? (see appendix E for the complete interview guide).

3.6 Interviews with RSHC program coordinators

Two of the program's project coordinators who facilitated the RSHC course for the Eritrean group were also interviewed, using a slightly different interview guide. Through their community outreach and networks, these key informants were able to provide insight at a wide

level which may not have been captured through the interviews with the RSHC Program participants. This use of data triangulation in the study offered two different perspectives thus helping to facilitate a deeper understanding of the program outcomes.

Some of the questions discussed with the program coordinators were: (a) In your opinion, are there any barriers that exist within in the Eritrean community when it comes to sexual health? (b) What impact do you think the program had on the participants? (c) In your opinion did the program meet your expectations? (d) How could the program be improved or modified? (e) What were the strengths and weaknesses of the program? (see appendix F for the complete interview guide).

3.7 Data Analysis, Theoretical Framework, and Trustworthiness

Semi-structured interviews in qualitative research are an interactive and dynamic process in which the participant takes on an active role in directing the flow of the conversation (Trochim & Donnelly, 2007). This form of interviewing was selected for this study because such descriptive methods serve to understand the world from the subject's point of view while also revealing the meaning the participants attached to their experiences. This technique is conducive to descriptive phenomenological research methods whereby the study is concerned with the direct voices of the participants and emphasizing the importance of personal perspective and interpretation. The descriptive phenomenological research approach seeks to describe rather than explain and to start from a perspective free from hypothesis or preconceptions (Burosch, 2009). All six interviews were audio recorded and transcribed verbatim. The data was then analysed by systematically reading through the text and noting any significant concepts, passages, and words. Any relevant themes that emerged from the data were then organized into various sections and analyzed independently using both the responses from the interviews and the existing research on the topic.

The paper is guided by a feminist theoretical framework because it is a "research that seeks to build knowledge about women" and "is designed to hear their voices (Yegidis & Weinbach, 2006, p. 181). Using a feminist theoretical perspective, this evaluative study sought to explore the unique sexual health education experiences of Eritrean women and frame them within their cultural context. It centres on the women's experiences with sexual health and the meanings they attribute to them. As research from a feminist perspective is a way of giving the subjective situation of women greater visibility" (Burosch, 2009).

To maintain the integrity of the data within this study, several measures were taken to establish its credibility and authenticity. Credibility was achieved through a member check which involved follow-up telephone calls to the participants. Preliminary findings were presented to the participants, where they were asked to consider the interpretations, correct any errors, recall additional things not included in the findings, and clarify any misunderstandings. In addition, the use of data triangulation was applied through the representation of both the participants of the RSHC as well as the program coordinators. Both parties exemplified the varying perspectives and views of the program's effectiveness and thereby adding to the credibility of the research. Lastly, authenticity was established through the use of direct quotes. The interviews of the participants were audio recorded and transcribed verbatim.

3.8 Ethical Considerations

Since the issues of sexual health and sexuality are often perceived as highly sensitive topics and can invoke cultural taboos within the Eritrean community, various measures were taken to protect the participants' identity as well as ensure the absence or lessen the possibility of anxiety or discomfort.

Upon initial contact, the Principal Investigator (PI) explained the study verbally and discussed the information outlined on the consent form in an attempt to confirm that every participant understood the purpose and nature of the study as well as their rights.

Informed consent was indicated by written agreement and each participant was given a copy of the consent forms which contained the contact information of the PI should the participant have any questions or concerns (see appendix G, appendix H). Assurances were also offered by the PI that confidentiality would be respected at all times and that in no way would the participants be identified or identifiable as pseudonyms were used throughout the study.

Finally, it should be noted that participants were not pressured in any way to partake in the study. It was made clear throughout the interview and described in the consent form that participation in the study was strictly voluntary and that participants had the option to withdraw from the study at any point without penalty.

CHAPTER 4: FINDINGS

4.1 Socio-Demographic Profile of RSHC Eritrean Program Participants

TABLE 1

Pseudonym	Helen	Joan	Susan	Sarah
Number of Years in Canada	3	22	4	2
Age	37	50	40	30
Relationship Status	Married	Married	Widowed	Married
Number of Children	4	4	3	1
Languages Spoken at Home	Tigrinya Arabic English	Arabic English	Arabic Amharic English	Tigrinya Amharic English
Level of Education	Secondary School	Post-Secondary	Secondary School	Post-Secondary
Employment Status	Unemployed	Employed (ESL Teacher)	Unemployed	Unemployed
Religion	Muslim	*N/A	Christian	Christian
***Importance of Religion**	10	10	10	8

*N/A indicates this question was left un-answered.

*Importance of Religion was measured on a scale of 1 to 10: 1 representing not important and 10 representing very important

4.2 Socio-Demographic Profile of Program Coordinators

TABLE 2

Pseudonym	Mena	Naomi
Number of Years Working with the RSHC Program	2.5	2.5
Age	42	43
Languages Spoken	Tigrinya, Amharic, English, Arabic	English, Amharic
Level of Education	Post Graduate	Post Graduate

The average age of the RSHC participants was 39 ranging from 30 to 50 years. The majority were married (75%) and had one to four children (ranging from 3 months to 22 years) all of whom lived with them at home in the Greater Toronto Area. Approximately half of the participants were highly educated (completed post- secondary education). The participants' average length of stay in Canada was approximately 8 years. They all indicated that English was spoken at home along with a combination of one or two of the following languages: Tigrinya, Arabic or Amharic. The majority of the participants (75%) were unemployed with the exception of one who listed her occupation as an English as a Second Language (ESL) Teacher. Two of the participants were Christian, one was Muslim and one chose not to disclose her religious affiliation. Religion was considered important by all the participants.

Both coordinators, age 42 and 43, worked with the Eritrean RSHC program for two and a half years on contract. One is employed by the Eritrean-Canadian Community Centre as a settlement worker, and she speaks four languages: Tigrinya, Amharic, English, and Arabic. The other program coordinator speaks English and Amharic. Both have post-graduate degrees.

4.3 Interview Findings

Several different themes emerged from across participants' responses to the various questions asked of them in the interviews. These themes were re-grouped, for presentation purposes, under the appropriate original research question.

What kind of benefits, if any, did the Eritrean women encounter as a result of their participation in the program?

Based on this first research question, three major themes transpired: Understanding the meaning of sexual health education, camaraderie, and supportive environment**.**

4.3.1 Understanding the Meaning of Sexual Health Education

All the participants and the coordinators of the RSHC Program believed that the program had a tremendous positive effect on them. This was largely due to the vast amount of information presented and discussed with them during the course of the program. All the women shared the belief that their interpretation of sexuality and sexual heath expanded considerably; that there was much more to the topic than just the physical action of having sex or the study of women and men's sexual organs. This is evident in the following statement from one of the RSHC participants:

Before the program, thanks God, I was interested in the science; I read a lot about that, on the internet, the biology and anatomy of the body, so I was already interested. And I thought I had a lot of knowledge on those issues but when I came to this course, I see how little knowledge I actually had. Sex education is more than that. Like I learned that we have to think about how we feel about our body, how to use biology and anatomy sex organs and everything. Sex is more deeper, with the feelings, every situation, it's not like there are two different sex genders and so on, or there are two different sex organs, it's more. It's more about understanding, of feelings and expression (Sarah, age 30)

Another participant expressed her thoughts on how the program opened up her view on the meaning of sexual health and the various issues this topic encompasses as follows:

Before for me, I never think about sex health in the way of topics like homosexuality, protection [from] sexual violence, healthy relationships with your partner like emotions, teaching and communicating to our kids about respect for their bodies. Because, you know, the media--television and movies and even other kids at school can sometimes be a bad influence on them. Now I know, that there is a lot more to sex education than just, you know, sex (Susan, age 40).

Similarly, one of the coordinators of the program reflected on her own self-learning process in regard to how she felt about the program's curriculum. She explained that she too felt she

was experiencing a similar learning curve as the other women when it came to the meaning of sexual health as she had, stating that:

At first, I thought, I can't talk to them about sex, but the issue is different; it's not just about sex; it's human sexuality. A lot of things then come to our minds: it means family, marriage, children, health. For some people when they hear 'human sexuality' they only see sexuality. It doesn't mean sex, there are a lot of things. The RSHC Program has a lot of components to it. For example, it covers sexual abuse or violence, domestic violence, you have child harassment, even verbal abuse, or sexual touching. It is forbidden, even touching, without your permission, which is illegal. So this field, it is very interesting, to teach to the family, to teach to the children, to be aware about it. (Project Coordinator Mena, age 43)

The participants' desire for others within and outside their community to experience and gain the same knowledge they acquired through this education program was expressed by all. When asked if she would recommend the program to others, one participant explained:

*I wish everybody knows what I know now. Because when we are in this society, we think that we know and we have enough knowledge to raise a family, to help our neighbours or anyone who needs our help. But this program helps very much and it shows how much lack of knowledge we [did] have (*Susan, age 40).

4.3.2 Camaraderie

All the women reflected fondly on the development of relationships that formed as a result of the time spent together and the stories they shared amongst themselves over the six month course of the program.

We became such good friends--all of us. We learned together, even I didn't know many of the women before and now I know them so well. (Sarah, age 30).

Close ties were made and continue to remain strong as most of the women mentioned that they continue to get together on a monthly basis. When asked about they believed to be one of the biggest benefits of the program, two participants explained:

We learned a lot and still because of that program, we are close friends. We meet each month. (Susan, age 40)

It is very comforting and social for me. Even discussions like this [sexual health] come up. It gives me great joy. (Helen, age 37)

One of the program coordinators also remarked upon the friendship that the women shared:

*The friendship inside that room was incredible. If you were to ask me what the most poignant thing the program had to offer, it would be the comradeship inside that room. (*Program Coordinator Naomi, age 43).

4.3.3 Supportive Environment

As stressed by all the women, discussion on sexual health and sexuality issues is unwelcomed in Eritrean society. Nevertheless, the women felt that they were able to open up and share their feelings with each other about these issues. They were all aware of the fact that they had experienced a culture of silence surrounding this topic within their community but by coming together, in a supportive environment, they were able express themselves freely. One participant's description of this experience summarizes it well:

Some of us don't share the same language but we all are from Eritrea, similar cultures and we had the same views on sex when we were young. You know, everybody's culture in Eritrea, even in many other countries in Africa—sex is not talked about openly, even if it comes up, it's like a joke, even among friends. Hush, hush thing. So when we were together, we all know that was the way. That made things easier. To know that others feel the same. I think that brought us closer. We could understand each other and feel free to say anything
(Susan, age 40).

These remarks were also shared by one of the program coordinators as reflected in the following statement describing the value of programs like the RSHC in helping to overcome the conservative views surrounding sexuality:

We did see a common ground among all the different ethnic communities and that is that sexuality is a taboo, it is repressed, suppressed, and you don't talk about it. And for these women to come to this really supportive environment, and to be able to explore something that is so obviously permeating their every being, and they're actually encouraged to voice it, it is so liberating for them, it is such a huge sigh of relief-- That they find themselves in touch with a part of them that they've never been in touch with before because they've never been allowed (Program Coordinator Naomi, age 43).

This was also echoed by one participant when reflecting on her ability to discuss sexual health issues within the RSHC workshop group:

*Before, sometimes, some questions, you don't want to be open, as I told you because of that culture that isn't open about these things. Should I talk about it? Should I escape it? Now, when they mention a sexual health topic, you are very interested in hearing about it and now, here in this program, we can. We can talk freely about these things. It's exciting. I can ask whatever and feel no shame (*Sarah, age 30).

What kind of challenges, if any, did both the RSHC participants and coordinators encounter as a result of their involvement in the program?

In the discussions with the RSHC participants, a few issues arose regarding negative experiences they encountered during their participation in the program. Those included: the time commitment to the program and problems with the delivery of language interpretation being made within the workshops. In addition, both program coordinators and one participant also expressed the challenges related to lack of funding in supporting and sustaining the program.

4.3.4 Time Commitment

From November 2010 to April 2011, the Eritrean women who participated in the RSHC Program met once a month for a full day workshop. The workshops were generally held on a Saturday from approximately 11am to 4pm. When asked about how the program could be improved, one participant suggested the possibility of having access to RSHC materials and teachings at home. She felt it might be easier for her because her weekend was her only time off and by devoting a full day to the workshop caused her to "stress" because she already was spending limited time at home during the week.

They [the participants] have kids and not a lot of time. They are learning but also supporting their house too. The women are so busy, especially if they have children and a husband. You have to work or go to school so you give up some of that as you didn't have time. At the time of the program, I was going to school and I had homework and things. I felt it was difficult to do it all, especially on a Saturday, I needed the time to do things I didn't have time to do during the week (Sarah, age 30).

One of the program coordinators also weighed in heavily on this subject as it relates to the time that is required for the women to peer educate other members from their community. She felt that many of the women have children and other commitments and despite the

effectiveness of the peer education model, she believed it puts a lot of pressure on the women to volunteer their time and speak to others and give presentations in their community on sexual health:

How do you extract, yet more time from people who already have no time and expect them to be peer leaders, out in front, engaging with the community when they have all these other stressors? They are already coming from racialized, marginalized communities and you're asking them to take this on? .... It's something all the coordinators talk about, how much time is required? How much time is too much time? We really need to be sensitive about this (Program Coordinator, Naomi, age 43).

4.3.5 Problems with the Delivery of Workshop Language Interpretation

Not all the women in the group spoke the same language. Among the 17 women, four languages were spoken: Tigrigna, Arabic, Amharic, and English. While English was the common second language used by all, their proficiently levels varied, so at times the need for an interpreter was great. One program coordinator could speak all four of these languages so during the workshops she would act as the principal interpreter for those who needed it. However, one participant expressed a concern with this. She felt that these interpretations could, at times, be problematic. For example, she explained how the meanings of thoughts expressed by those women contributing to the workshop discussions were not always clearly conveyed by the interpreter. Or sometimes the interpretation would take time and those expressing their ideas would forget what they wanted to say. In the end, she believed that these issues became problematic and resulted in a loss of connection within the group.

You have to go by language, not by country because there are some Eritrean people who speak Arabic, some Eritrean people who speak Tigrigna; this country has many different languages. If you go by language, it's better because language connects people. So what we did in our program, the coordinator who is Eritrean speaks some of the different languages from Eritrea so she was put in the middle so she could translate [the women's discussions]. The other women participants also helped in translation because they spoke other languages as well. But sometimes, you know, the person who makes a comment has to wait for the translation to be made, sometimes it has to be translated into many languages and that takes time and then when all the translations are finished, the person [who made the initial comment] sometimes forgets what she was staying and loses the rest of what they wanted to say. Or you cannot send your message across the way you wanted. Sometimes you can be misunderstood. You can see it

in the people's expressions; you see a disconnection between the person who is speaking and the person who is listening (Joan, age 50).

Another participant also voiced her thoughts on this stating that:

When they make the translations, sometimes it was hard to understand. And even for me, once I said a question, even the translator, she didn't understand me, what I meant.... we discussed condoms and I wanted to know about the school, the high school and there is a health clinic and I heard about nurses in schools, how they are having condoms for the kids. It was difficult some women thought I said something else and I was frustrating, you know. (Sarah, age 30)

4.3.6 Lack of Funding

It was noted by both program coordinators that there was a "lack of funding" for the program. There was mention of a need to financially support the participants in their effort to peer educate those in their community about sexual health.

> *Maybe the women could get support. (Sarah, age 30)*

> *.....And no honorarium for them. They are such champions in their community. That would have made such a difference. Considering the value of these women's lives, they have work, children, social obligations, they committed a lot of time and work towards this and we would have loved to reward them [financially]. We really would have like to have given them money for this.*
> (Project Coordinator, Naomi, age 43)

Additionally, it was stated that initially over 20 Eritrean women showed up to the first RSHC workshop which well exceeded the 10 participant limit. As such, the project coordinators explained that their resources were stretched.

The funding was not enough, especially with the Eritrean community because it went well beyond its scope. Initially, over 20 women signed up [for the program] and it was really hard to turn some of them down because we only had a budget for 10. Nevertheless, we decided to go-ahead even with 17. But it was difficult, the budget, was 10 women…..definitely not enough money. (Program Coordinator, Naomi, age 43).

If only there was more funding. They [Eritrean women interested in participating in the program] keep calling me. They are interested in participating but the funding is finished. (Program Coordinator, Mena, age 44).

How did the RSHC program influence the participants' beliefs, attitudes, and practices surrounding sexual health and sexuality issues?

The women discussed many instances in which they felt much more open and accepting of sexual health related practices or beliefs compared to how they felt prior to the program. This is the first theme of three related to this third research question. Gaining more confidence when addressing some of these issues was another theme that emerged from the interviews and both project coordinators attested to this while providing accounts of their observations. In addition, several women mentioned the role that language played in their learning process and how it facilitated a sense of comfort when talking about particular sexual body parts. Language is the final theme looked at under this research question.

4.3.7 Increase in Openness and Acceptance

All the participants expressed with much keenness their ability to feel more "open" in both communication with their children as well as in their willingness to accept different ideas and beliefs surrounding sexual health and sexuality. When the two topics of children masturbating and homosexuality arose, this theme of openness and acceptance became especially evident. They spoke about how they would react to this situation both before and after their participation in the RSHC Program. The following statements reflect the participants' views as how the program changed their attitude in sexual health communication:

Before, when I saw a child touching himself, I would scold him. Tell him to stop. Now I realize that this is normal. A child will suck his thumb, or touch his ear, this is normal, it feels good. The same when a child is touching himself in other areas. But the mother will yell at him. Now, we know that this sort of thing is normal, natural like the thumb. I can now understand this and tell the child to go to his room, to do this in private. (Sarah, age 30).

I used to think masturbating was wrong, that it is unpleasant, not nice, even rude, inappropriate. I know now, that is not the case. It's normal, it's a natural feeling. The thing is, it's inappropriate during certain time. The women in the group told stories about their children touching themselves, how uncomfortable that is. We were taught those things are bad, but you know, it's not all bad. It's like anything else. Like scratching your ear when it itches. It's a reaction. If you tell your kids, "don't do that!" Yell at them not to touch their private parts, what

does that mean? That their private parts are not good? That is a bad message and they will think everything down there is bad. No, we tell them, it's okay to touch them, just do it privately. (Helen, age 37)

Some participants discussed their understanding and acceptance of homosexuality, despite their claim that Christianity or Islam "doesn't agree" with it. They found themselves encountering the issues of homosexuality through interactions with their children. One participant recalled a conversation with her daughter about lesbians:

Sometimes, you know, it doesn't always go with our religion, our culture, but this is reality here in Canada and I am used to it now. These topics will come up and we have found ways to accept it. My daughter is at university. And she told me that two of her professors are lesbians. And I said to her, "really? how do you know?" She said that a friend told her. "Really, a friend? Is that right? And she said, she saw pictures of the wedding. She thought it was okay. And I feel that okay, so six, seven years ago, I might not have this discussion but now, I say, okay, so what? (Joan, age 50).

Another participant reflection on homosexuality was also noteworthy:

I remember at the time I was taking the course, one afternoon, I was watching the news, Anderson Cooper came out, he was gay. And I said [to my children] you know, I like Anderson Cooper show, but suddenly, I don't like him anymore. My kids said, "Mum! You are taking this program, how can you say this? Mum, you can't judge him, he is a good person and you are taking this program, don't say this!" You see! My kids know me. They realize this and I realized this. I cannot think this way. This is who Anderson is and it doesn't change who he is as a person. He is a good person, that is what matters (Susan, age 40).

Another topic that gained much attention during the interviews was the idea of teenage romance. There seemed to be a growing acceptance among all the participants that in Canada, it is "normal" and "okay" for their teenage daughters or sons to be in a relationship. One participant sees this issue differently after taking the program:

Before, I didn't think it was okay because these kids need to focus on studies. Their education is so important. Yes, they do, but if I forbid them, they will find a way-behind my back. It's better for you to know and then you can help them if they are in trouble. Guide them, give them information, it's important that you know, so they can be open with you (Helen, age 37).

Another participant also pointed out that although she just has an infant daughter, she will have to face this issue in the future:

If you approach it the right way, with open communication with your child, then it's okay. I never used to think this way, but I do now. It's so important that they know from you—the right information on this first. (Sarah, age 30)

When asked about what kind of impact she believed the RSHC Program had on the women participants, one coordinator discussed that by having an opportunity to discuss issues of sexual health and sexuality with other women of the same culture, may have been a very beneficial for their psyche. She shared these thoughts:

Up until this program, many of their assumptions and attitudes about sexual health were largely unconscious because these aren't things that they have discussed, these are not things to bring up, but coming to the program and exploring that and digging that all up was very powerful for them because all of a sudden, they could stand back and say "ohhhh, so that's why I think that way, it's because my parents or friends said that." They reached all the way back to their childhood and found stories about circumstances, instances that had a profound impact on their attitudes on sexual health. That's really prying when you do that; when all of a sudden, all these suppressed feelings and attitudes rise to the surface because you're about to explore them. (Program Coordinator Naomi, age 43)

One participant explained that when she was growing up, she didn't and wasn't permitted be in a relationship until she was ready to marry:

In Eritrea it was not acceptable for girls to have boyfriends, so I used to think the same. But here [in Canada], I can't be like that. I have two young daughters and here, I can't control them, what happens at school. I can only control that they are educated, smart about these things and know they can come to me to talk if they have a problem. That is most important. I tell them, education comes first for now but they are going to have feelings, it's normal. (Susan, age 40).

One participant explained that this issue is an often reoccurring and anxiety provoking topic that is discussed amongst close friends with teenage daughters. She felt that after taking this program she is now able to provide advice to her friends about their young daughters forming relationships.

Even all the women I speak to, they worry about their daughters marrying young. That would be the killer. I thought the same before but I asked them why and they explain that they want them to have an education. I tell them, they will have these kind of relationships, they will have these kind of emotional attachments to the other sex, they can't help that, you can't either, so what are you gonna do?(Joan, age 50)

4.3.8 Increase in Confidence

All of the participants reflected on how "curious" and "interested" they were about the program but that such curiosity quickly turned to feelings of uneasiness, apprehension as well as shyness as soon as the first workshop was underway.

I was feeling so excited and nervous at the same time but then the first day, ohh, wow, I was embarrassed. (Sarah, age 30)

The first day, everyone was like, what am I doing here? We had a break and everyone was looking around. We knew it was something odd, we never talked about it but at the same time, we really wanted to know. (Helen, age 37)

Nevertheless, as time went on, much of this discomfort diminished. One participant highlighted the progression of how she perceived herself and the other participants' feelings:

At the beginning, it was difficult. But towards the end of the first section, we knew we are all from the same background. It doesn't make you happy but in a sense, you say, okay, I belong in this classroom, we are all the same so let's learn together. After the third session, we were feeling more comfortable. (Joan, age 50)

*I feel stronger about these issues now. I can talk openly about it. Before, oh no way. In our culture, we never talk about sexuality and health. I can talk to my friends and even family now, I can feel better because I have this knowledge.... for example, my sister-in law has a question about her kids and how they are behaving when it comes to sex, I tell her right away, like tell them [her children] about the women and man's bodies. Tell them about how babies are made, tell them about sex, tell them to be careful. Tell them about it because they will hear about it at school, on TV. Open communication is best. (*Susan, age 40)

One participant mentioned the impact the course had on the raising of her infant daughter and how prepared she feels now as a result:

I am so happy to get this chance, as you see my daughter, I am a new mother. I feel I get this knowledge, it's perfect and very effective to my life. Okay, my childhood is passed, I didn't know

*at that time… it's just passed, I can't change that. But thank God I get the knowledge to have a sexually healthy child and have the opportunity to raise her in a sexually healthy way. I feel very excited about that. (*Sarah, age 30)

Both program coordinators commented on how confident the women became over the course of the program.

They were so at ease when they were discussing their views on sexuality and sexual health with each other or in front of the group.
(Program Coordinator, Naomi, age 43)

At the beginning of the program, the women would laugh a lot during the discussion of sex. Now, they go up in front of the class and talk freely about sex. They feel more open, full of confidence, stronger. Even some participants who had difficulty with English, they now feel more confident in English. In fact, they feel their English was improved. (Program Coordinator, Mena, age 44)

4.3.9 Language

It was noted by all women participants that discussing issues related to sexual health in English was easier for them. Sexual related terms in a second language such as English didn't seem to carry with them the kind of discomfort as those same terms did in their native language.

You know, in Arabic, we have these words, but you don't mention it. It's the culture, it makes it hidden, you just don't mention it, you don't talk about it. (Joan, age 50)

When you hear it in your language, for example, the body parts, it's difficult to say, I don't know why because when I knew, I was like, "oh wow, I prefer the English one! When I say it in English, it's easier. (Sarah, age 30)

It's much easier to say the words in English because it doesn't have the same power and also it's engraved in your brain, it's taboo in your language. But when you say it in English, it feels easier, like any other body part --eye ear... you don't feel that power, it doesn't take any effort, like in my language you may feel apprehensive, like you think a lot before you say it. In English, it's so easy, it just comes out. (Joan, age 50)

For example, when they talk about breasts, they don't say breasts ,they say "up there" We have it in my language, but we feel we can't say it. Or I remember my mum saying to me to 'clean

between your legs. In English, we say the vagina. We have this word in my language, but I never heard my mum say that. Or for breasts, we would say, 'up there.' (Helen, age 30).

In some cases, the women weren't even aware of the sexual health term in their native language. One participant's experience illustrated this realization:

Some [RSHC workshop documents] have been translated into Amharic, but you know, I learned it in English first. For example, the word 'genitals', I don't know this word in my language. Pubic hair too..... we just say 'hair.' (Susan, age 40)

<u>How did the Eritrean women feel about their ability to communicate to or influence their family members, friends, and wider community's sexual health knowledge and practices following their participation in the RSHC Program?</u>

This final research question prompted two themes to emerge in relation to the Eritrean women's sexual health communication outside the RSHC Program: increased sexual health communication with their children and educating others within their community about sexual health issues they may be facing with their own children.

4.3.10 Increased parent-child sexual health communication

One of the principal features of the RSHC Program's curriculum is to provide the participants with very specific communication tools to speak to their children not just about sexual health but as one of the program coordinators stressed, it aims to guide them in all topics related to better parent-child communication.

"...it's *about opening up the lines of communication with their children. How do you speak to them in a respectful manner, in a way that you don't judge them, in a way so that they will trust you so that when they need to come to you to talk about these difficult subjects, the openness is there. (Naomi, program coordinator, age 43)*

"I decided to do this course for my children. I wish the whole community would know what I know. It makes your life easier, it makes your kids' life easier. It makes you understand your kids and also it brings better communication. We didn't grow up here, so this program teaches us how to understand the kids' culture here. They are curious about sex, so tell them the truth, don't hide things, they need to know because they will get this information in other ways, sometimes in bad ways. For example, a commercial about women's products on TV... they will ask about it, so I can tell them about the woman's cycle. This is important. (Susan, age 40)

*We need to have more communication with our children; explain things; make eye contact, tell them how we feel. Even when the children touch their organs, we have to tell them that they can do that privately, just not in front of other people. Tell them it's normal, it's okay. Because they are going to do it anyway. But if we get mad at them, they are going to think they are bad people or these issues are bad. But we have to make sure they understand there are times and places for those things. And make them understand also, that it's okay to do that, but only themselves. (*Sarah, age 30).

It was an eye opener for me. Sometimes, you know, it doesn't always go with our religion, our culture, but this is reality here in Canada and I am used to it now. These topics will come up and we have found ways to accept it. And respect it too. For example, private things, you know, like when there is someone they like, they talk about how far they can go. If they [their children] like somebody, what does "like" mean? Or where can this relationship go? We discuss these types of things (Susan, age 40).

One program coordinator spoke of how the RSHC program was extremely useful for the women in that it provided them with practical, parent-child sexual heal communication strategies despite growing up in a society where discussion on sexual health was "shameful" or "not normal" even with their own mothers.

Most of the women in the program were mothers, and most were there because they have children and have faced these issues and they have come to the course because they don't know how to handle, it, how to approach it, whether is it necessary to approach it at all. Furthermore, the topic is not something they feel they can speak freely about. But now, finally there are some answers. (Program Coordinator, Naomi, age 43)

When asked about the benefits of the RSHC Program, all of the women referred to having a "good connection" or "better" or "more open" relationships with their children.

Before they get their periods, usually here in Canada, their mothers talk to their daughters about this. But in my culture, mothers don't talk to you about this. We don't have this closeness-- it's hush, hush. If you have a cousin or a sister, you are very lucky, But really, it has to be the mum, especially here [in Canada], the family core is becoming smaller. It's becoming mother, father and kids. Aunts, cousins, they are busy with her life or they are not there. So the mother has to be there. I tell her [my daughter], if you have problems, you can come to me, I want her to feel free. Because I am your mum. I can be your friend if you want, I will be your teacher, I will be your doctor, whatever you want in that moment. Because when you have a problem, I want you to feel you can come to me. And also, with my son. Many people think that boys, when it comes to sex, they are closer to their dads. Not my son, he is 22 but he tells me everything he wants to know. And sometimes he says, please don't mention this to my dad (Joan, age 50).

I remember studying about sexual health, on the paper, my daughter, she read it. She said, "I saw the paper! Mum! What is this? Give this to me." I sat her down, and told her about sexuality and explained that I am studying this for her. At first, she didn't accept this, she was angry. For example, my religion, my culture, it's not open. That is why my daughter was surprised. Even for me, as a nurse, I had to study the anatomy, and I felt uncomfortable. But step by step, it got better. It's the same with this program (Sarah, age 37).

One program coordinator commented on how the program was very helpful for mothers in terms of how to deal with their children when they are exposed to sexual related images or messages outside their home.

The ECCC works with a lot of newcomers, especially women with children. Many of these mothers are not educated. The child comes here young and he will grow up as a Canadian. The mother's mentality is like back home, they will be completely different. He will be exposed to the west and it's better to have him educated about these kinds of things from his mother. There is a lot of information out there, from the internet, from TV, from subway. Even if the mother doesn't tell them, they will get it. Back home [in Eritrea], it is hidden, they don't have access to it. But here, TV, movies, subway, internet, school-everywhere. Either directly, indirectly, they will get it. Even at school. With the The RSHC Program , they can learn how to work with their children when it comes to these things. (Program Coordinator, Mena, age 44)

These views were also supported by two of the participants.

In my country, we do not have to worry about our children seeing or hearing about sex at school or in the media. It's not part of the culture. But here, it's different. There are a lot of dangerous things outside. We need to protect and teach our children so that they are aware, so they can be themselves. We have the right information now so we can teach them how to deal with the sex in the media, the things they learn at school from their friends (Sarah, age 30).

I remember, my son in grade 3, imagine, grade 3, and this kid, he brought porn to school, in his bag. It was his mother's. And he, my son, came home from school and said, to me, 'Mum, when people get older, do they grow hair, except on their head? And their armpits? ' And I said yes. [And he said] 'Where else? Because, I saw it, between their legs? And I said, where did you see it? ' A kid brought the magazine to school. And then I thought, I have to go to school. You know, even the teacher did not know. And the next day at school, the kid brought the same magazine to school again. This time, they were giggling and showing it under the table. It is curiosity for them. But the parents have to be very careful, you know, the kids don't understand anything. I had to explain to him. My son was disgusted, I can tell, for 3 or 4 days, he wasn't comfortable, you know, you can see the face, I lost his child-face because he was just thinking about that thing. "It looks ugly mum!" I went to the school and met with the teacher. But yes, they will be exposed, if they live here. (Joan, age 50)

4.3.11 Educating others on sexual health outside the immediate family

The community capacity building model and peer-education approach used by the RSCH Program encourages those who participated in the program to educate other parents and members from the same community about sexual health and sexuality issues. The program helps participants develop the necessary skills for delivering presentations to the community or facilitating informal discussions among family and friends on sexual health. When asked if they shared any of the information they learned in the program with others, all four participants gave accounts on their experiences with this.

I know this boy, he is 6 years old, and he touches his genitals. His mother is a friend from school and she knows I took this program and asked me what should I do? And I said, don't say it's a bad thing to touch his genitals. I explained to her if she says it's bad, he will think he is a bad person. She can just tell him to do it in private or just distract him with other things. Before, I would have judged him, but now, I don't judge him, I give advice. (Susan, age 40)

During the course, I was attending ESL classes and I got a chance to discuss these issues with my class, what I am learning and such things. I get a chance to discuss sexual health with the other women in my class. I talk about how they need to keep open relationship, talk to their children about men and women and how babies are made, parts of the body, relationships, things like that. It may not have been super effective, but at least I say something, and they listen at that time. I hope it helps them. .....I was discussing these issues with my cousin's wife, she lives in Calgary. So I see that she is understanding. She has a teenager, she is the mother of 3 teenagers. So it's a lot of conflict with them. And when I talk to her, she understands them. I feel I am helping her. I feel it's very important, and even here, I have the same relationships, with my friend's children. Our culture is a rude to our children. We just say, "Do this, do that!" But to have been a participant of this course, helps me understand the fact that we need to listen to children, make eye contact. I discuss this with those families and feel that I am making a difference. I see that she improves her relations with her kids improving. (Sarah, age 30)

I talk to other mothers of my kids' friends. Sometimes they ask me advice on what to talk to their kids about on relationships, they worry about their daughters marrying young. I also gave 3 to 4 workshops with the Somali community. At the first workshop, you saw on their faces, the discomfort, but I said to them, I know how you feel, that is how I felt. But then after some time, they started talking..... the workshops are on everything, from relationships, to sex, to how to communicate with their kids about sex, on masturbations-everything I learned in the workshop. (Joan, age 50)

We start at home as far as how you talk to your kids. How you respond to your kids' questions about sex. If I see other parents' responding the same way I would have responded, I jump in

and tell them so.....For example, if they are yelling at their kids about touching themselves, I tell them that it's okay for the kids to play with themselves, it's natural. I tell them, I used to do the same but it will make your kid not want to discuss these things later on. If they are abused or something, they won't tell you because you used to tell them it's bad (Helen, age 37).

One of the program coordinators discussed the overwhelming interest from women in the Eritrean community to partake in any upcoming RSHC Programs:

They keep calling me- they are interested in participating. The news spread, they now know and they want to know, where and when the next course is offered. (Program Coordinator, Mena, age 44)

CHAPTER 5: DISCUSSION

This chapter includes an interpretive discussion of the ten essential themes highlighted in the study's major findings. They include: understanding the meaning of sexual health education, camaraderie and supportive environment, time commitment and lack of funding, the delivery of language interpretation, increase of confidence and educating others on sexual health, language, and finally an increase parent-child sexual health communication.

5.1 Understanding the Meaning of Sexual Health Education

All of the participants in the study pointed out that they had been brought up in more conservative societies where discussion of sexual health and sexuality was largely taboo. Before the participants joined the program, they had a limited perspective on the meaning of sexual health education. Their understanding was focused on either sexual behaviour or the scientific approach which centres on sexual organs. At most, a few of them explained they had received some formal education at school regarding the anatomy of the female and male bodies but when it came to their own parents and other family members, the topic of sexual health was rarely touched upon. This culture of silence on issues of sexual health experienced by the women in their own families could be explained by Espin (1999). She argues that in many regions of the world, mothers and other older women may transmit values to their children and other younger women about sexual issues; however, these messages are rarely conveyed in a structural way (e.g. "Let me teach you about this topic"). In most cultures, messages about sexuality are conveyed through half-muttered comments, behaviour, example and powerfully, through silence (Dopico, 2006; Espin, 1999; Ogbagzy, 1999).

After their participation in the program, the women in this study felt that they no longer believed that sexual health education was only related to sexual behaviour or the biology of sexual body parts but that its meaning incorporated everything from relationships to masturbation to homosexuality and most importantly, to how it is related to the health and well-being of their children. Their new found understanding of sexual health and all it

encompasses seemed to diminish the powerful silence and taboo that is traditionally associated with sexual health and sexuality issues in their culture.

5.2 Camaraderie and Supportive Environment

As highlighted in Fessahaie's (2003) work focused on Eritrean women's identity in Canada, it is tradition in many African cultures, including Eritrean, for women to come together and socialize. This practice is especially important when living in another country as it provides an opportunity for the women to maintain their cultural heritage and customs. Fessahaie, (2003) explained that these gatherings also reaffirm the women in their role as mothers and provides them with advice and support when it comes to childcare practices and other settlement challenges they may be facing in their lives.

The opportunity to connect with women from their own ethno-cultural group and share in their experiences and ideas as well as gain further information about various issues related to sexual health and their children was met with much enthusiasm. It became very apparent through the interviews that many of the women developed a deep sense of community within the group and close relationships formed as a result. These findings were also heavily supported by Wong (2001) and Brown's (2011) studies on the RSHC Program and the deep sense of community connection that was established within the participating Chinese groups.

The RSHC program's approach encourages a lot of participation from its participants and thus presented many opportunities for the women to share stories and discuss their experiences related to issues of sexual health. Not only were the women able to learn from each others' lived experiences, but they were able to form close relationships—an aspect which has also been recommended by previous literature on health promotion strategies as it can often lead to repeated exposure to health messages (Alberta Health Services, 2009; Giarratano, Bustamante-Forest., & Carter, 2005; Turner & Shephherd, 1999; Zarate-Abbott et al., 2008). For example, Turner and Shepherd (1999), contend that one advantage of using peers in health promotion programs is that the participants will often spend a great deal of time socializing with each other, thus the opportunity for frequent reinforcement of patterns of behaviour

exists. They argue that messages reinforced through ongoing contact are likely to be far more effective than a one-off talk or presentation by a public health promoter. This was shown to be the case as the participants in this study spoke of how they continued to discuss issues related to sexual health at their monthly get-togethers. The evident bond and trust that was developed amongst the women, as a result of their experience in the RSHC program, enabled them to maintain sexual health dialogue that otherwise would potentially not have occurred.

5.3 Time Commitment and Lack of Funding

The concern over the amount of time that was required to attend a full day workshop was expressed by one of the participants. As indicated in the findings, she explained that for some women who have a family and who work or attend school during the work-week, they may have had difficulty giving up a Saturday to attend a workshop. She suggested providing participants of the program with RSHC reading materials and teachings at home. This participant had a higher level of education than the other women in the program so perhaps that is why she felt more confident learning on her own. It should be noted, however, that this participant had previously mentioned that she benefited from the close friendships that were developed as a result of her participation in the workshops. This indicates that even though the participant recognized that friendship was a positive outcome of the program, she perhaps did not take into account that in a self-study health promotion program, this benefit would not be realized.

As a peer-education model, the RSHC program is designed to provide the necessary tools (workshop guides, promotional materials, informational resources, mentor support, etc.) to encourage participants to undertake sexual health education workshops or initiate discussion on this topic with others in their community. Many of the women discussed instances in talking and offering advice to their extended family members, friends, and classmates about these issues. Their 'peer education' discussions may not have taken a lot of resources or time, however, it was noted by one of the program coordinators that the expectation imposed on the participants to take on larger health promotional endeavors such as workshops, may be asking a lot given that many of the women already have "so many commitments." As a result, the

program coordinator did not feel comfortable that the participants would not be financially compensated for their efforts and felt that if the program were to be successful, financial incentives should be offered.

Several studies evaluating peer-education health interventions have noted that financial incentives may be essential to the recruitment and retention of peer leaders and the success of various peer education health programs (Brownstein et al., 2005; Krieger et al., 2009; Wolin & Rueckhaus). The coalition of one project struggled to determine whether compensating peer leaders would compromise the role of 'natural helper' or provide an important employment opportunity (Plescia et al., 2008). Other studies found that not hiring volunteers after the initial training period, or failure to provide supportive resources (coverage of transportation costs), negatively impacted the program's length and effectiveness (Brownstein et al., 2005; Krieger et al., 2009; Wolin & Rueckhaus).

5.4 Delivery of Language Interpretation

The literature stresses that not only is immigrant health promotion most effective when congruent with the population's values, beliefs, and practices but also when it is provided in the first language and dialect of and at an appropriate literacy and health literacy level of the target population (Alberta Health Services, 200; Drummond et al., 2011; Majumdar & Roberts, 1998; Zarate-Abbott et al., 2008). The RSHC program aims to follow this approach as it has with its delivery in several different ethnic communities. Based on previous studies looking at the RSHC program in the Chinese community (Brown, 2011; Wong, 2001) and one evaluation case study comparing the experiences of members from the Chinese, Tamil, and Portuguese communities (Toronto Public Health, 2010), there were no reports that suggested RSHC participants experienced language problems within the program. In the Eritrean RSHC program however, not all the participants spoke the same language so one of the program coordinators acted as an interpreter as she was fluent in four of the languages most commonly spoken in Eritrea: English, Amharic, Tigrigna, and Arabic. As highlighted in the findings of this study, two of the participants felt that the language interpretation during the workshop sessions could at times

be “frustrating” as ideas were not always conveyed clearly in their delivery. This no doubt hindered the flow of discussion and caused confusion within the group, thereby confirming the need for immigrant health promotion programs to be linguistically specific to the target group.

5.5 Increase in Confidence and Educating Others on Sexual Health

One of the principal goals set out in the RSHC program is to increase participants’ knowledge on sexual health education as well as support them in the development of effective parent-child sexual health communication and skills. As a limitation of the study, it is noted that the voices of the children or other community members for that matter, could not be included in this evaluation study. Therefore, assessing the effectiveness of how successful the women were in communicating with their children and the community cannot be fully elaborated upon. Nevertheless, all of the women described experiences of offering advice and initiating sexual health communication with their children, relatives and friends. In addition, as indicated by both program coordinators, there was and continues to be an overwhelming response from women within the Eritrean community interested in participating in a RSHC program. This fact in itself is a testament to the 17 women who are evidently reaching out to the community and sharing what they have learned with others.

The program coordinators also discussed how they observed a growth in confidence in the women as the program progressed. Similar findings were also reported in Wong’s (2001) and Brown (2011) findings. Wong (2001) concluded in her study that as the Chinese RSHC participants became more confident with their parenting skills and experienced the positive outcome of their behavioural changes in parent-child sexual health communication, they began to look beyond their own individual needs to those of the community. Their new positive attitude towards sexual health education motivated them to share their knowledge and experiences with other parents. Wong’s (2001) discussion provides valuable insight into why there was an increase in confidence exhibited by the Eritrean participants as well.

5.6 Increase in Openness and Acceptance

Two of the participants reflected on their increased acceptance of sexual orientation and homosexuality. In both instances, it was the participants' own children's exposure to and acceptance of homosexuality that along with what they learned in the RSHC Program, potentially changed their views on the issue. This shift in thinking from a "not open culture" in Eritrea to a "more open culture" in Canada was, in part, facilitated by their children. It is not clear whether the Eritrean women's children would have volunteered their beliefs on their acceptance of homosexuality had their mothers not been in the RSHC program or if they expressed these beliefs because they were aware of the fact that they were in the program.

Regardless, it's important to highlight that together these scenarios point to the generational acculturation differences between immigrants and their children. There has been a considerable amount of research that claims that children of immigrant parents are able to culturally adjust faster than their parents and that this is a major source of potential conflict in parent-child relationships and negative youth outcomes in immigrant families (Brown, 2011; Espin, 1999; Fessahaie, 2003; Tyyskä, 2008; Tyyskä & Colavecchia, 2001; Wong, 2001). Despite the extensive literature on this subject however, it appears as if there has been little examination into how children's faster rate of acculturation has in any way *positively* affected an immigrant family. The potential impact the women's children had on their acceptance of homosexuality highlights the importance as well as the need to consider how the acculturation processes of both child and parent may affect each other's shift in values.

One last thoughtful observation that emerged from the findings was the small role or lack of influence that religion played in the women's increase in openness and acceptance of sexual related issues. Although the participants were not specifically asked if their religion had an impact on how they felt about sexual health and sexuality issues, several of them mentioned that in addition to their culture, their religion was not "open" to topics surrounding this discussion. The women seemed to recognize the fact that even though the religious institution to which they belonged may contradict some of the sexual health and sexuality views promoted by the RSHC program, they were able to set aside those differences and be more receptive and

accepting to new ideas and beliefs. These findings were especially significant because all four participants indicated in their socio-demographic forms that religion played an important role in their lives.

5.7 Language

As indicated in the findings, all of the participants stated that discussing sexual health and sexuality issues in English was "easier" for them than in their native language. Coming from cultures that have fairly traditional or more conservative views on sexual health frequently make it difficult to discuss this topic. English, however, provides a vehicle for discussing sexual issues that are too embarrassing to discuss with forbidden words in one's first language. Espin (1999) has provided insight into this phenomenon and explains that a second language can act to facilitate the emergence and discussion of certain topics that may be taboo in the native language. "Speaking in another language may provide a means to express what is inexpressible in the first language—either because the first language does not have the vocabulary or because the person censors herself from saying certain taboo things in the first language" (p. 138).

This theory is supported by one of the women when she described learning about certain sexual health terms such as 'genitals' that she believed did not exist in her native Amharic. Furthermore, Espin (1999) has demonstrated that words related to sexuality in the language of origin elicit a sense of anxiety and they can cause more angst than taboo words in the second language. As such, speaking in English may have distanced the women from these emotionally charged words in their native tongue and helped them express themselves more comfortably.

5.8 Increased parent-child sexual health communication

As expressed by several of the participants, raising children in a society where they are exposed to sexuality messages in the media, at school, and with friends, can be challenging given that they did not encounter these types of messages while growing up in their native country of Eritrea. The participants touched on this when they explained how they struggled to apply traditional Eritrean parenting in a Canadian context when they found their young children

masturbating. Nevertheless, after taking the program, they explained that they were able to learn and apply alternative parenting techniques including how to communicate more openly with their children, how to develop trust and how to reason and discipline children without yelling.

Similar findings were also noted in Brown's (2011) study on the effects the RSHC program had on its Chinese participants. The study noted that in the end, the participants' involvement in the RSHC Program enabled them to rediscover their individual [and collective] capabilities and re-establish a sense of empowerment over their lives thus having more control in the raising of their children.

Malcolm Knowles' cognitive learning theory (as cited in Brown et al, 2005) provides a framework for teaching strategies utilized in the RSHC Program. Cognitive learning incorporates the practice of having learners participate actively in the learning process whereby the focus is on the ability to learn content which has immediate application (Brown et al, 2005). For instance, the Eritrean women were encouraged to integrate their learning into day-to-day interactions with their children, family and friends. They were then encouraged to share and to discuss their applied learning experiences with the others in the group which facilitated an informal learning environment that allowed for input and discussion from the learners. This format supports research that has found that 'interactive' health intervention programs are more effective than passive or demonstrative formats (Hannula et al., 2008).

As the findings demonstrate, all Eritrean women participants reported becoming more open to talking about sexual health and sexuality; providing their children with education and information, reflecting on their own sexual values, and being aware of their influence on their children. Overall, the four women who participated in the program reported implementing what they learned from the RSHC in sexual health education with their children, and they perceived these efforts as having facilitated open sexual health communication with their children. Findings on three other RSHC Program studies from various ethnic communities also corroborated these findings (Brown, 2011; Toronto Public Health, 2010; Wong, 2001).

Hyman and Guruge (2002) note that cultural norms of collectivist societies and communities tend to place family and community health above the needs of individuals. Eritrean women are no exception to these practices as they frequently spoke about their commitment to the health and well-being of their children as well as the fact that they were taking this course for the sake of them. Wong (2001) speaks to this in her study of the RSHC program in the Chinese community and concludes that community programs that attract participation by immigrant women are usually related to parenting or care giving issues. This is especially evident for Eritrean women who carry the traditional, domestic role of caring for the family and "serving as the pillar of their home" (Fessahaie, 2003, p. 91).

As a result of this, Wong's (2001) call for health promoters and service providers to recognize parenting programs as an entry point to community participation by immigrant women is well-founded.

> Instead of providing parenting or health information in isolation and reinforcing the children's needs over the women's own needs, we must develop empowerment education programs that facilitate the development of peer support, encourage self-care and build individual and community capacity. (Wong, 2001, p. 85)

CHAPTER 6: LIMITATIONS OF THE STUDY

In all research there are shortcomings and this investigation on the evaluation of the RSHC program is no different. Briefly, there are four main limitations of this study which include small sample size, non-representation of child participants, and social desirability bias and the fact that the data collection was in English.

6.1 Small Sample Size

Of the 17 Eritrean women who participated in the RSHC program, only four responded to taking part in an interview. The other two participants in the study were the program coordinators. It is important to acknowledge that a sample size of six individuals is not large enough from which to draw general conclusions. Therefore this paper does not assume to do so, and the reader is asked to accept its findings with the knowledge of such limitations

6.2 Non-Representation of Child Participants

Due to the limited scope of this research project, this study was unable to include the direct voices of the children whose parents participated in the RSHC program. This would have been useful in this evaluation because it would have offered insight into how the children perceived their mothers' sexual health communication before and after participation in the program. In addition, children's views on how they saw themselves as directly benefiting from their mother's participation in the RSCH program would have put to test one of the principal goals of the program which is better parent-child sexual health communication.

6.3 Social Desirability Bias

Topics surrounding issues of sexual health and sexuality have often been attributed to social desirability bias which has been shown to influence how individuals respond to these kinds of issues (Bryman & Teevan, 2005). The RSHC program participants may have responded in a manner that they believed would be viewed favourably by others, that is, indicating that they do in fact feel genuinely more comfortable, open, and accepting of issues related sexual health and sexuality. The study does not take into account a measure of social desirability bias, nevertheless, all means were taken to ensure that participants' confidentiality was protected which in turn has helped to diminish the potential impact of such biases.

6.4 Data Collection in English

The fact that the some of the women participants were not completely fluent in English has to be taken into consideration as a limitation of the study. To eliminate any miscommunication and misunderstanding in the interpretation of their narratives, a member check was performed with all participants. Follow-up telephone calls were made in order to ensure that their voices were accurately represented and to clarify the data. Any changes offered by the participants were then incorporated into the final results.

CHAPTER 7: RECOMMENDATIONS

7.1 Recommendations for Research

In light of the study findings and the preceding discussion, this paper will outline several recommendations for both research and practice.

7.1.1 Evaluation of the RSHC Program on a Longitudinal Level

An evaluative study looking at the RSHC program over time would allow researchers to determine whether parent-child sexual health communication was caused by or influenced by parental participation in the program or another factor. If researchers could directly observe or investigate the behaviours of parents and children prior to the RSHC involvement, during the RSHC involvement, and 5 years after participation in the program, this might provide valuable insight into the overall influences of the program on a variety of factors such as parent-child sexual health communication.

7.1.2 Researcher Participation

Enabling a researcher to participate in actual RSHC workshops would help gain a better understanding of how the workshops are conducted, how participants learn and participate, and it would also help to identify which issues are important to participants of particular groups.

7.1.3 Inclusion of RSHC Program Participants' Children

The use of children's voices in this evaluative study would have offered another perspective into how the children perceived their mothers' sexual health communication before and after participation in the program. In addition, children's views on how they saw themselves as directly benefiting from their mother's participation in the RSCH Program would have put to test one of the principal goals of the program which is better parent-child sexual health communication. Furthermore, if we are to understand fully the impact children have on their parents' acculturation process, we need to account for the experiences and perceptions of all family members, not only immigrant parents (Tyyskä & Colavecchia, 2001). As indicated by the

participants in the findings of this study, the Eritrean women are consistently seeking opportunities for more effective parenting. A good starting point is to create more and richer dialogue between the parties across the generational divide.

7.1.4 In-Depth Analysis of the Effects of the Peer-Education Model

The peer-education approach used by the RSCH Program encourages those who participated in the program to educate others about sexual health and sexuality issues. The program helps participants develop the necessary skills for delivering presentations to the community or facilitating informal discussions among family and friends on sexual health. It would be useful to explore in more detail the number of individuals, extended family members, classmates and/or groups, organizations, etc. who were reached by the RSHC participants in their attempt to share what they learned from the program. By examining how many others in the community were affected and exposed to this sexual health information, it may allow for more valuable insight into the evaluation of a peer-education model.

7.1.5 Exploration into the Role of a Second Language in Sexual Health Interventions

As indicated in the findings, all of the participants expressed that having conversations about sexual health in English was "easier" for them than in their native tongue. The notion that English is used as a vehicle for sexual health communication and the use of 'forbidden' sexual health terms in one's first language is an area of immigrant health research that warrants exploration.

7.2 Recommendations for Practice

7.2.1.Increase in Funding

The lack of stable funding was identified as a key barrier to the sustainability of the program as far as financially compensating the women for their peer-education efforts as well as making the RSHC Program accessible to the growing number of Eritrean women expressing interest in participating in it. There simply was not enough funding to keep up with the demand and offer the program at least once per year. As one program coordinator stressed: "If Toronto Public

Health, the city, and other levels of government really value this work and really understand the bigger picture of how healthy community affects us all and that we are all in this together, then we should get more funding." Funding for health promotional programs such as the RSHC is critical to the development and maintenance of ethno-specific institutions and health-promoting practices that empower immigrant groups and support them in the sustainability of their health and the health of their families (Toronto Public Health, 2008).

7.2.2. Providing Language Specific programs

Based on the Eritrean women's feelings of confusion and disruption that was brought on by language interpretation during the workshop sessions, it is recommended that future RSHC workshops held within the Eritrean community, be language specific thereby discontinuing the use of an interpreter.

CHAPTER 8: CONCLUSION

This evaluative study was the first study that explored the experiences of Eritrean women who participated in the RSHC Program. The study was able to highlight the diversity of the Eritrean women's experiences related to sexual health and sexuality and how those experiences impacted their children, family, and community. Further, the study was able to demonstrate the dynamic, fluid, and complex nature of their attitudes, behaviours, and strategies related to issues of sexual health by locating them within the broader context of their life experiences. The exploration of the participants' experiences and thoughts about sexual health education, while not necessarily generalizable to other ethnic populations, can potentially produce valuable insight for both the Eritrean-Canadian Community Centre and for those public health educators and planners of the Raising Sexually Healthy Children Program. It is the hope that these organizations can learn from this study so that it may provide even more effective RSHC Programs in the future.

Finally, the Raising Sexually Healthy Children Program is an extremely worthwhile health promotion program that facilitated not only increased sexual-health communication within Eritrean immigrant families and its community, but also an increase in confidence towards parenting in a new environment, and an improved sense of connection among community members. Nevertheless, the lack of resources to establish and further strengthen a stable operational structure for the RSHC program impedes the program's ability to meet the increasing needs of immigrant parents as more newcomer families settle in the city of Toronto.

APPENDICES

Appendix A. Letter of Support from Eritrean-Canadian Community Centre

Eritrean Canadian Community Centre of Metropolitan Toronto; 550 St. Clair Ave. West, Toronto, Ontario, M6C 1A5
Tel. (416) 658 8580 Fax (416) 658 7442 Web. www.eccctoronto.ca

Date: April 4, 2012

Subject: Research on Raising Sexually Healthy Children

Dear Ms Julia,

We would like to thank you for your interest to research with Eritrean Women in raising Sexually Healthy Children Peer Leader project .The Eritrean Canadian Community Centre of Metropolitan Toronto (ECCC) is nonprofit charitable organization which has been providing settlement and other social services to the Eritreans, East African descents and other community members at large in the GTA since 1985. It is our pleasure to help you with your study and Ms. Salma Abubaker, (Settlement Worker) will be the contact person.

Thank you, once again for your interest to work with the Eritrean community

Kibrom Debru
Executive Director

ERITREAN CANADIAN COMMUNITY CENTRE OF METROPOLITAN TORONTO

ECCC IS NOT FOR PROFIT CHARITABLE ORGANIZATION

APPENDIX B. Recruitment Email to RSHC Participants

Greetings!

My name is Julia Keech. I am a graduate student at Ryerson University in the Immigration and Settlement Program. I am evaluating the effectiveness of the Raising Sexually Healthy Children (RSHC) Program which was offered by the Eritrean-Canadian Community Centre in collaboration with Toronto Public Health. I am recruiting Eritrean women who participated during March to May 2011 to explore their beliefs, values and satisfaction with the program. The reason for the study is to improve the RSHC Program so that it can become more helpful and beneficial for future RSHC programs both within the Eritrean community and outside.

You are invited to participate if you are:

→ An Eritrean or Ethiopian woman who participated in the Raising Sexually Healthy Children Program during March-May 2011.
→ Willing to share your experiences, beliefs, and satisfaction with the RSHC Program in an interview
→ Able to speak and read in English
→ Available to meet on [*insert potential dates and times here*]

If you are interested in attending a focus group:

→Respond to me (Julia) via email: **julia.keech@ryerson.ca**
→Please note that your participation is on a volunteer basis
→The interview will be approximately 2 hours

Thanks very much and please don't hesitate to contact me if you have any questions, need more information or are interested in participating in the study.

Best regards,

Julia Keech

APPENDIX C. Socio-Demographic Forms for RSHC Participants

RYERSON UNIVERSITY

Questionnaire for RSHC Program Coordinators

The Sexual Health Education Experience of Eritreans in Toronto:
An Evaluation of the "Raising Sexually Healthy Children Program"

1. How long have you been involved in the RSHC Program?_____

2. How long have you lived in Canada? _____

3. Do you have children?

□ Yes How many? _____ How old are they? _____

□ No

4. What language do you speak?

□ Tigrinya

□ Arabic

□ Amharic

□ English

□ Other: _____

5. Select your level(s) of education. Check all that apply and list the field of study in the space provided.

□ Primary/Elementary School

□ Secondary School

□ Post-Secondary _____

□ Masters _____

□ PhD _____

□ Other_____

6. Are you currently working?

□ Yes What is your occupation? _____

□ No

APPENDIX D. Socio-Demographic Forms for RSHC Program Coordinators

RYERSON UNIVERSITY

Questionnaire for Interview Participants

The Sexual Health Education Experience of Eritreans in Toronto:
An Evaluation of the "Raising Sexually Healthy Children Program"

1. What is your date of birth? _____

2. How long have you lived in Canada? _____

3. At what age did you arrive in Canada? _____

4. What is your marital status:
□ Single/Never Married □ Married □ Divorced □ Widowed □ Separated and other

5. Do you have children?
□ Yes How many? _____ How old are they? _____
□ No

6. Are you currently living alone?
□ Yes
□ No Who are you living with? _____

7. What language do you speak at home? (Check all that apply).
□ Tigrinya
□ Arabic
□ Amharic
□ English
□ Other: _____

8. Select your level(s) of education. Check all that apply and list the field of study in the space provided.
□ Primary/Elementary School
□ Secondary School
□ Post-Secondary _____

□ Masters _____

□ PhD _____

□ Other_____

9. Are you currently working?

□ Yes What is your occupation? _____

□ No

10. What is your religion? _____

11. Do you participate in religious events/ceremonies?

□ Yes

□ No

12. On a scale of 1 to 10, how important is it for you to follow or practice your religious beliefs and values? 10 represents very important and 1 represents not important.

_____

10 9 8 7 6 5 4 3 2 1

Very Important Not Important

APPENDIX E. RSHC Participants' Interview Guide

RSHC Program Participants' Interview Script

Background

I will welcome the participants and thank them for coming to the group. I will engage in some light conversation, introduce myself and then go over the study information sheet and consent forms. I will be sure to be clear that the participants have no questions or concerns about the study before the focus group begins. I will also emphasize that the participant can stop participating in the discussion at any time. Following obtaining the consent form, I will then ask them to fill out the anonymous, socio-demographic questionnaire.

Preamble

Before we start our conversation, I want to say that I feel like a learner in this discussion too. I know that some people may find sexual health topics difficult or embarrassing to talk about. If you ever get uncomfortable as we talk or if there is a question that you don't want to answer, please just let me know and we can change the subject or stop talking. If you say something that you are uncomfortable with and want it erased from the audio-tape (if audio-tape has been approved by all participants), just stop the conversation and I will make a note of it and make sure it is taken out. I also want you to know that if I say something that makes you uncomfortable or that offends you, please let me know. So hopefully we can work together to talk about these things in a way that's comfortable for both of us. Do you have any questions before we begin? It is okay if I start the tape-recorder now?

Topics and Questions

1. General

a) How do people in your community feel about sexual health?
b) Do you think people in your community feel comfortable discussing sexual health? If so, why? If not, why not?
c) Do you think there are any barriers (challenges, difficulties) in talking about sexual health?
d) Are there any sexual health resources/services available in your community?
   i) What types of resources?
   ii) Do people in your community use these resources/services?
   iii) What group of people in your community use these resources/services? (e.g. young, old, women/men, etc)

2. The RSHC Program

a) How did you hear about the RSHC Program?

b) What made you decide to participate in the program?

(E.g. Why did you do it? Were your friends participating? Who influenced you?)

3. Pre Raising Sexually Healthy Children Program ("If you can all go back to before you took the program, your life before it....")

a) What did you think or how did you feel about **sexual health** before?

b) What did you think or how did you feel about **sex education**?

4. Post Participation of the RSHC Program:

a) How did you feel about your experience in the RSHC Program?

b) What were the challenges of participating in the program?

c) What were the benefits of participating in the program?

d) What did you learn from the program?

e) Did the program change you in anyway? (e.g. your beliefs, views, practices, etc.) If yes, how and why? In not, why not?

f) Have you been able to use the information you learned from the program in your personal life (self, family, friends?)

g) Have you been able to use the information you learned from the program within your community? (e.g. work, school, community organizations etc.)

6. Moving Forward

a) In your opinion, how could the program be improved/modified?

b) What are the strengths of the program?

c) Would you recommend this program to others? If yes, why and to whom? If not, why not?

7. Additional Comments

a) Are there any last points/issues which we may or may not have discussed and you would like raise?

8. Closing

I want to thank you all for coming. This really means a lot to me and to the research that will be done on this in the hopes that the program will continue to grow and improve

APPENDIX F. Program Coordinators' Interview Script

Background

I will engage in some light conversation, introduce myself and then go over the study information sheet and consent forms. I will be sure to be clear that the participant has no questions or concerns about the study before the interview begins. I will also emphasize that the participant can stop participating in the discussion at any time. I will start by asking general questions and background information in terms of his or her experiences and understanding of the needs of the community. These preliminary questions will then be followed by more specific questions about his or her own experiences and interactions with those participants of the RSHC program as well questions about the overall effectiveness of the program. Lastly, I will ask about the strengths and barriers of the RSHC program and leave room at the end for any last comments.

Topics and Questions

1. Background/General

a) How long have you been involved with the RSHC Program?
b) Why did the Eritrean-Canadian Community Centre decide to become involved with the RSHC Program?
c) What do you think are the sexual health needs of the Eritrean Community?
d) In your opinion, are there any barriers that exist within the Eritrean community when it comes to sexual health?
d) In your opinion, are there any positive developments that exist in the provision of sexual health within the community?

2.Experience of working with the RSHC Program

a)What was your role/function in the program?
b) How would you describe your experience working with the RSHC program?
c) How did you feel collaborating with Toronto Public Health?
d) In your opinion, what were the negative aspects or challenges of the program?
e) In your opinion, what were the positive aspects of the program?

3. Effectiveness of the RSHC Program

Based on your observations and experiences working with the program:

a) What impact (or effect) do you think the program had on the participants?

b) What impact (or effect) do you think the program had on the Eritrean Community in large? (in regards to sexual health promotion, awareness etc.)

c) In your opinion, did the program meet your expectations?

4. Strengths and Barriers

a) In your opinion, how could the program be improved/modified?

b) In your opinion, what are the strengths of this program?

c) In your opinion, what are the weaknesses of this program?

d) Do you think that a similar model, such as the Community Capacity Building model that was used for the RSHC program, could work for other health programs/issues in the Eritrean Community? If yes, please explain. If no, please explain.

5. Additional Comments

a) Are there any last points/issues which we may or may not have discussed and you would like raise?

6. Closing

I want to thank you for taking the time to speak with me today. This really means a lot to me and to the research that will be done on this in the hopes that the RSHC program will continue to grow and improve.

APPENDIX G. Informed Consent for RSHC Participants

RYERSON UNIVERSITY

Study Information and Consent Form for RSHC Participants

The Sexual Health Education Experience of Eritreans in Toronto:
An Evaluation of the "Raising Sexually Healthy Children Program"

Main Researcher: Julia Keech, Graduate Student in Immigration and Settlement Studies, Ryerson University
Major Research Paper (MRP) Supervisor: Dr. Mandana Vahabi, Associate Professor of Nursing Daphne Cockwell School of Nursing, Ryerson University

Purpose of the Research: We are conducting a study to learn more about how you found the classes offered on Raising Sexually Healthy Children (RSHC) by the Eritrean-Canadian Community Centre (ECCC). Your participation will be very useful for our understanding of how useful sexual health education programs can be for immigrant populations. The research will focus on your experiences with the RSHC Program during May 2010 to March 2011.

Description of the Research: If you agree to take part in this study, I will ask you to fill out a short list of questions about yourself and discuss your experiences with me in an informal interview.The discussion will be in English and it will take approximately 1 hour to complete. We will talk about a variety of issues such as your beliefs, expectations, and overall thoughts of the program, as well any problems/benefits you encountered. For example, questions on whether people in your community talk openly and freely about sexuality and sexual health practices with their children; how they view the use of birth control etc; why you decided to participate in the RSHC Program, and how the program helped you and how it could be improved will be asked.

Risks: We do not expect this study to cause you or others any known harm. However, you may experience some unexpected emotions during the talking and sharing. If you feel upset during the group interview, we will provide you with support. We will also give you information on and a list of support services in the community.

Benefits: You may not benefit directly from this study. However, you may find it helpful to share your ideas and talk to other members about in your cultural community with similar experiences. We will use what we learn from this study to help develop more useful, sexual health programs to serve your community.

Confidentiality: We will keep what you share in this informal interview confidential, except in situations where we are required by law to release the information (e.g., if we hear information that a child has been or is being abused; if we hear that you may harm yourself, that there is reason to believe that you are at risk to commit suicide; or if we hear that someone has threatened your life or someone else's life, etc.).

We will strictly protect your identity in this study. You do not have to provide any information that will identify you. You may also choose to use a name that you make up instead of using your real name. We will make notes and record the discussion on tape. This is only to make sure that we do not miss any of your valuable ideas and opinions. When we turn the tape recording into writing, we will remove all the information that identifies you. We will store all the tapes, notes and paper research data in a locked cabinet in a secured office. We will protect the data in the computer using passwords and save the data on a secured computer system. The study reports will never show your name or any information that identifies you. Only the research team will listen to the audio-tapes and read the data of this study. We will destroy all the audio-tapes when we complete this study. We will also destroy all the written data five years after we complete this study.

Your Rights: Your taking part in this study is completely voluntary. You have the right to choose not to take part in this study. You do not have to answer any questions that you do not feel comfortable with. You can also withdraw from the study at any time during or after the discussion group. Withdrawing from this study will cause no penalty. It will not affect your relationship with the Eritrean-Canadian Community Centre, the researchers or anyone else for that matter.

To clearly summarize what is outlined above, **I understand that:**

- The interview will be assisted by Julia Keech
- Participation in this study is voluntary.
- The length of time for the interview is approximately a hour.
- I can stop participation in the study at any time without penalty.
- The interview may be audio-taped and then written out word for word.
- If I do not agree on having the discussion tape-recorded, it will not be and notes will be taken. **Please note the consent form regarding permission for using an audio-tape at the bottom of this document.
- All audio-tapes will be destroyed when the study is complete and all the written data will be destroyed five years after the study is complete.

- The discussions may be read by Julia's supervisor, Dr. Mandana Vahabi. She too, will be required to keep all information in the transcripts confidential.
- My name, any names, places or other identifying information that I mention in the interview will be removed from the transcript before the research is published.
- The records of the interview will be kept confidential and I will not be identified in any written or spoken presentation of the study.
- Quotes from the interview might be used in the final write up and presentation of the study. I can choose to have my quotes used or choose not to have them used indicating this at the bottom of this document.

The information that I provide in the interview will help create Julia Keech's project write-up (Major Research Paper) for her program of study and may appear online in academic journals, academic conferences and in other local media. The study findings will be presented to academic staff at Ryerson University, the Eritrean-Canadian Community Centre or Toronto Public Health.

If at any time I have questions about the study, if I experience negative effects as the result of my participation or if I wish to withdraw my consent, I can contact the following people:

Julia Keech
Masters of Immigration and Settlement Student
Immigration and Settlement Studies
Ryerson University
Email: julia.keech@ryserson.ca

Dr. Mandana Vahabi
Associate Professor of Nursing
Daphne Cockwell School of Nursing
Ryerson University
Email: mvahabi@gwemail.ryerson.ca
Phone: 416-9795332 Ext. 2725

I give permission to audiotape the discussion group. I acknowledge that a copy of this form has been given to me.

_____

Participant Name & Telephone Number | Signature | Date

_____

Witness Name (Person obtaining consent) | Signature | Date

1. I have read and understand the information given to me. I have received a copy of this form. I agree to participate in this study. Yes_____ No_____

2. Quotations may be used from the discussion group. Yes_____ No_____

Participant Signature:_____Date: _____

Researcher Signature_____Date:_____

Participant Code Number:_____

APPENDIX H: Informed Consent for RSHC Program Coordinators

RYERSON UNIVERSITY

Study Information and Consent Form for RSHC Program Coordinator Participants

The Sexual Health Education Experience of Eritreans in Toronto:
An Evaluation of the "Raising Sexually Healthy Children Program"

Main Researcher: Julia Keech, Graduate Student in Immigration and Settlement Studies, Ryerson University
Major Research Paper (MRP) Supervisor: Dr. Mandana Vahabi, Associate Professor of Nursing Daphne Cockwell School of Nursing, Ryerson University

Purpose of the Research: I am conducting a study to learn more about how you felt, as a facilitator of the Raising Sexually Healthy Children (RSHC) within the Eritrean-Canadian Community Centre (ECCC). Your participation will be very useful for understanding how useful sexual health education programs can be for immigrant populations. The research will focus on your experiences with the RSHC Program during May 2010 to March 2011.

Description of the Research: If you agree to take part in this study, your participation will involve an informal interview which will last approximately one hour. We will talk about a variety of issues such as your beliefs, expectations and overall thoughts of the RSHC Program, as well as any problems or benefits you encountered. For example, questions about your role within the program as well as reasons for introducing it will be asked. In addition, I will ask questions about what you believe are the sexual health needs of the Eritrean Community, any negative or positive aspects of the program, the impact you think the program had on the community, and how the program could be improved.

Risks: I do not expect this study to cause you any known harm.

Benefits: You may not benefit directly from this study. However, the information you provide may help in the development of more useful, sexual health education programs both within and outside your community.

Confidentiality: Your identity will be strictly protected in this study. You do not have to provide any information that will identify you. You may also choose to use a name that you make up instead of using your real name. I will make notes and record the discussion on tape. This is only to make sure that I do not miss any of your valuable ideas and opinions. When I turn the tape recording into writing, I will remove all the information that identifies you. I will store all the tapes, notes and paper research data in a locked cabinet in a secured office. I will protect

the data in the computer using passwords and save the data on a secured computer system. The study reports will never show your name or any information that identifies you. Only the research team will listen to the audio-tapes and read the data of this study. I will then destroy all the audio-tapes when the study is completed. In addition, all the written data will be destroyed five years after the study is completed.

Your Rights: Your participation in this study is completely voluntary and you have the right to choose not to take part in this study. You do not have to answer any questions that you do not feel comfortable with. You can also withdraw from the study at any time during or after the interview and as such, this will cause no penalty.

To clearly summarize what is outlined above, **I understand that:**

- The interview will be facilitated by Julia Keech
- Participation in this study is voluntary.
- The length of time for the interview is approximately 1 hour.
- I can stop participation in the study at any time without penalty.
- The interview may be audio-taped and then written out word for word.
- If I do not agree on having the interview tape-recorded, it will not be and notes will be taken. **Please note the consent form regarding permission for using an audio-tape at the bottom of this document.
- All audio-tapes will be destroyed when the study is complete and all the written data will be destroyed five years after the study is complete.
- The interview may be read by Julia's supervisor, Dr. Mandana Vahabi. She too, will be required to keep all information in the transcripts confidential.
- My name, any names, places or other identifying information that I mention in the interview will be removed from the transcript before the research is published.
- The records of the interview will be kept confidential and I will be not identified in any written or spoken presentation of the study.
- Quotes from the interview might be used in the final write up and presentation of the study. I can choose to have my quotes used or choose not to have them used indicating this at the bottom of this document.

The information that I provide in the interview will help create Julia Keech's project write-up (Major Research Paper) for her program of study and may appear online in academic journals, academic conferences and in other local media. The study findings will be presented to academic staff at Ryerson University and possibly the Eritrean-Canadian Community Centre or staff at Toronto Public Health.

If at any time I have questions about the study, if I experience negative effects as the result of my participation or if I wish to withdraw my consent, I can contact the following people:

Julia Keech
Masters of Immigration and Settlement Student
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Phone: 416-433-7080

Dr. Mandana Vahabi
Associate Professor of Nursing
Daphne Cockwell School of Nursing
Ryerson University
Email: mvahabi@gwemail.ryerson.ca
Phone: 416-9795332 Ext. 2725

I give permission to audiotape the interview. I acknowledge that a copy of this form has been given to me.

_____

Participant Name & Telephone Number | Signature | Date

_____

Witness Name (Person obtaining consent) | Signature | Date

1. I have read and understand the information given to me. I have received a copy of this form. I agree to participate in this study. Yes_____ No_____

2. Quotations may be used from the interview. Yes_____ No_____

Participant Signature:_____Date: _____

Researcher Signature_____Date:_____

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