

Reproductive Health for Resettling Refugee and Migrant Women?

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The negotiation of reproductive rights for refugee and migrant women is complicated by the experiences of displacement and migration. Notions of community, family and authorities, and rules of access to resources, are in constant flux and may differ from the traditional systems that migrant or resettling refugee women are familiar with. This article presents the qualitative findings of a three-year study focusing on the reproductive health of African and Middle Eastern refugee and migrant women resettled in Victoria. The issues discussed include women's problems of engaging with reproductive health services that they perceive as hostile and unforgiving of cultural differences, their difficulties in accessing family planning services, and the complications of addressing reproductive rights in rapidly evolving power relations within families and communities.

Over the last ten years, political and civil unrest in many countries has resulted in the migration to Australia of refugees and migrants with cultural backgrounds that are markedly different from the host population. These countries include several in the Sahel Belt of Africa and the Middle East (SAME). These are mostly developing countries, where female genital cutting (FGC) is traditionally practised, where Islam is often the predominant religion, and where women may be denied reproductive rights (Crowe 1997; Feldman & Clark 1996). Approximately 87,000 women now live in Australia from these countries (ABS 2002).

Refugees and displaced persons have frequently faced food shortages, have limited access to medical supplies and services, and usually have lived in crowded camp/temporary accommodation conditions. Women's experiences prior to migration of rape and other forms of sexual exploitation, and FGC, have major implications for reproductive health. Female migrants and refugees from SAME countries often have health problems related to their cultural beliefs, socio-economic status and poor environmental conditions prior to migration. Consequently, they continue to have a high risk for poor obstetric outcomes, greater parity, and higher prevalence of anaemia, urinary tract infections and sexually transmissible infections (Palmer et al 1999; UNHCR 1995; Kahler et al. 1996).

The Study

The National Health and Medical Research Council of Australia funded the three-year study that used in-depth interviews and focus groups discussions to enhance understanding of the complex interaction of social phenomenon such as immigration experience, social networks, subjective assessment of health status, health care and mental health, and the effect of these on reproductive health. Interviews were conducted using an open-ended unstructured format. Observational, focus group and interview data were supplemented with quantitative data, using the Comprehensive Quality of Life Inventory to assess subjective wellbeing (Cummins 1997). The results on wellbeing are not included in this article.

Women were recruited initially through a range of community and social groups, formal ethnic organisations and projects funded by various government and non-government organisations. The sample snowballed from these initial contacts to a total of 255 participants.

The researchers also played a strong advocacy role, both on the individual and community level in crisis situations, when issues were identified that needed following up. This often involved negotiation with women's hospital staff and other support services. The research team also maintained an on-going relationship with the relevant sections of the Victorian Department of Human Services. This ensured that the research evolved in response to the needs of both the community and policy makers. It also allowed emerging issues to be further investigated and for the findings to be constantly fed back through the research project's community advisory group. In addition, regular debriefing

sessions were held among the research team, particularly to support the bicultural research assistants who held a dual role of being from the same region and identifying with the women interviewed as well as working with the researchers.

Demographics

Women from the Sahel African countries were from Somalia, Ethiopia, Eritrea, Sudan and Nigeria. Most were recently arrived refugees to Australia (average five years) from refugee camps under the Humanitarian and Women at Risk programs (Manderson et al. 1998). The Women at Risk program was set up to offer priority resettlement to refugee women who had lost their husbands, brothers or father, and were, within the cultural and refugee context, 'without protection'.

The Middle Eastern women were from Egypt, Lebanon, Iraq, Jordan, Saudi Arabia and Syria, had a longer period of residency in Australia (average 13 years) and had immigrated mainly through family reunion and marriage migration programs. The exceptions were the Iraqi women who were largely refugees.

As a group of study participants, the women were from different countries, regions, and ethnic affiliations and were diverse in their levels of education and other socio-economic indicators. However, they shared experiences of the migration process, some similarity in cultural backgrounds and family life experiences, and experiences in accessing mainstream services in Australia. Participants were aged between 19 and 50. More than half were married (53%), the rest had never been married or were widowed, divorced, or separated from husbands who mostly worked overseas. In addition to interviews, two focus group discussions were held with women aged between 58 and 75 to provide some insight into the experiences of older women in the communities.

Most of the women had some education, but none of those working had been able to find employment that took advantage of their qualifications, and their employment was restricted largely to subordinate positions in the domestic and other service-related industries. This is not atypical for new immigrants (Markovic 2000). A majority of the women (70%) had 'health care cards', independently demonstrating a low level of income and a high dependency on welfare benefits and state subsidised concessions. Over a third of the women lived in low cost, state subsidised accommodation.

Female Genital Cutting

In this article, FGC refers to the range of cultural practices that involves varying degrees of excision and infibulation of parts of the female genitalia. The term 'cutting' is used in preference to 'mutilation' to avoid the implicit value judgement and to respect the wishes of the study's participants.

Under Australian legislation, FGC is illegal. Supplementing this legislation, a national government program includes funding at federal and state government levels for health education programs to prevent the practice on girls born in Australia (Department of Health and Aged Care 1995) and to facilitate access to health services for girls and women affected by, or at risk of, the practice (Allotey et al. 2001).

Within Victoria, the Family and Reproductive Rights Education Program (FARREP) involves the employment of bicultural workers from affected communities as cultural brokers to facilitate access to health and social services for women from their communities, assist in the identification of reproductive health needs, and enhance the provision of culturally responsive services by service providers.

Women in the study had a high level of understanding and acceptance of the legislation and FARREP. They were particularly concerned about the sensationalised portrayal of FGC in the media as barbaric which resulted in public and highly intrusive discussions of a private aspect of women's lives. The women expressed particular hostility towards the visit to Melbourne of one of the international 'ambassadors against FGC' as part of a

global campaign to eliminate the practice. The objection was not to the message to eliminate the practice, but rather to the strategy used. The ambassador was perceived as having 'sold out' on cultural values and cultural identity in the approach she had taken. The women perceived the public discussion as disempowering, appearing to suggest that, as women, they totally lacked agency and were highly victimised by their cultures. While this may have been the case, the process removed any choice they could have in representing themselves and their interests (Wray 2003).

One young woman requested assistance to find a doctor who would perform an excision of her inner labia. At 22 years, she was confident that her desire for FGC was not due to pressure from family or concerns about her ability to attract a partner. She was clear that having the procedure done was an important part of her sense of personal identity within her community and within Australia, and she was able to address all the objections that were presented by both the gynaecologist she approached and the FARREP bicultural workers from her community.

From her understanding of the issues, most of the health concerns related either to procedures performed under poor conditions, or to poor obstetric and gynaecological support, none of which would apply if she had the procedure performed by a qualified and skilful surgeon, and continued to have access to health care in Australia. She reported that she was exercising free choice and her rights as a mature woman to request the procedure. To date, she has been unable to find a medical practitioner to perform the procedure due to the legislation; she continues to be counselled by the medical practitioner who worked with the research team.

In general, women who had undergone FGC did not perceive themselves as being at higher risk for gynaecological complications. Most of the discussion on complications returned to the definitions of 'normal'. When reproductive health histories were taken for antenatal care, they were asked questions about painful menstruation and difficulties in passing urine. With their own bodies as their only reference point, most found that these questions either did not make sense or were difficult to answer.

This led to discussions about women's requests for re-infibulation following childbirth, a procedure that is illegal under current FGC legislation, and women needed clarification about the potential for the clitoris and labia to continue to grow if they were not excised. Women have perceived the illegality of re-infibulation as racist because non-African women are able to undergo procedures such as hymen repairs and labial reconstruction for cosmetic reasons (Allotey et al. 2001).

More significantly for the women, however, was a strong sense of needing to put the discussion of FGC into perspective. There were many other current priorities in their lives to do with the resettlement of their families. The FGC procedure, which would have occurred when they were very young, was not the most pressing issue for them. One woman reflected:

"What has happened has happened, it is in the past. Why do we have to keep going on about it?"

Maternal Health Services

"We come from a culture where having a baby is not a sickness. It is a time you go through pain, but at the end you have a baby, a gift from God. And then you come here [to Australia] and all the joy goes from the experience." An Eritrean participant.

The major reproductive health issues for participants were problems within maternity and obstetric services. For many, cultural and religious beliefs were cited to explain the inappropriateness of procedures performed routinely in antenatal care such as ultrasound and screening for foetal abnormalities. One participant said:

"[It is] bad luck to anticipate a gift you are about to be given. It's not like you can say you will give it back if it's not what you want."

None of the women who had received care from the Australian hospital maternity services reported termination as a choice that they would have contemplated had the foetus been found to have a defect.

Three women reported having terminations following amniocentesis, on the advice of the bicultural worker. They assumed the advice was in their best interest as it came from the bicultural worker, and they did not really perceive that they had a choice.

The role of the bicultural workers raised some discussion during focus groups. The women reported that they expected the workers to represent their interests because they had a broader knowledge of the system, and should - as fellow immigrants - be acting in the best interests of the client rather than of the services. Most women said they would prefer a professional interpreter of whom they had no other expectations. This was not always an option as 69% described at least one occasion when they were not able to gain access to an interpreter.

Communication and Culture

Poor communication as result both of unavailability of interpreters and of poor cross-cultural communication was a recurrent theme in the research.

A woman who had been infibulated described the trauma of a vaginal examination to assess cervical dilation when she presented to the hospital in labour. She stated that the attending obstetrician attempted to 'force in a speculum' prior to the de-infibulation procedure. Unrelated to the examination, she experienced other complications including cervical lacerations and postpartum haemorrhage. For her, the worst aspect of the ordeal was that although she was fluent in English, she was largely ignored, even when she asked directly for explanations of what was happening. The overall experience for her was sufficiently unpleasant for her to express her determination to avoid any obstetric or gynaecological examination or procedure for the rest of her life. In spite of pressure from her husband and extended family, she reported that she would not have any more children if she had to have them in Australia.

Racism within the health services was also a common complaint. This is an issue that is often difficult to verify because it is often based on perception and to some extent, subjective interpretation of actions. A 35-year-old Egyptian woman described her experience as follows:

"After I gave birth to my third child, I went home after having spent three days in the hospital. The day after I went home, I started bleeding very heavily with severe pain. I did not know what to do about it because my husband was at work and I was alone with the three young children. I put a big towel around myself and waited for him to come home. When he came home he rushed me to the hospital and as I climbed onto the bed in the room they gave me, the towel dropped on the floor and it was by this time, heavy with blood. When the nurse came in the room, she was very angry because I had made a mess on the floor. She said I was stupid and unclean and she knew my type. I could not say a word because I was in severe pain, but my husband tried to defend me. She walked out and another nurse came in and helped us. I hate going to hospital because it was a very bad experience and I do not like to be treated like that."

Fertility Control

Australia provides extensive options for fertility control through general practices and Family Planning Association clinics. However, women perceived a wider range of contraceptive options in the countries of origin and even in refugee camps, than were available in Australia. In addition, the family planning services the women had tried to

access through their general practitioners and the Family Planning Association did not appear to be aware of the economic and cultural realities of their client groups.

Most women said they were offered the pill, which they did not find effective. A few reported being offered 'the injection' (Depo-Provera) but if they requested anything other than these, the costs were prohibitive.

"I do not want to have any more children, I have three already. But I do not have clear information about the different options for birth control except the pill, which is cheap. I do not want to use the pills because I hear it is not good for women over 35 years. The doctor told me to buy the loop from the pharmacy and bring it back, but it was \$50. I can't afford that. I know in my country, family planning clinics are very common and everywhere, all contraception is very cheap and you can even put them on your shopping list when going to the market. Information is everywhere and there are media campaigns, community education and family planning is integrated so that we even can get services from work."

Inadequate access to information was the overwhelmingly complaint regarding both the range and side effects of contraceptives. A campaign in 1996 for informed choices in the use of Depo-Provera highlighted the need to improve access to information on contraceptive options for women in general and for immigrant women in particular (Lopata & Murdolo 1996).

Family Size

Discussions on variations of family size yielded a wide range of opinions. Many women at marriage had wanted large families and were under pressure from their extended family to do so. The general argument was that large families provided a sense of belonging and security, particularly in new environments. The need for this sense of security was stronger than the real difficulties described by women with large families in accessing affordable accommodation and ensuring social and material support for maintaining a large family.

Women particularly from the Middle Eastern countries talked about the importance of having a son as still being a priority in their need to continue to have children. Those who did not want large families were concerned about the lack of support for raising children. Many of the older women, however, argued that under Islam, they were not permitted to control family size and they had had disputes with their daughters and daughters-in-law over this issue. As a consequence, religious leaders from the communities have recently been involved in the development of the family planning education program to support women's choices for contraceptives such as the pill. The religious program focuses largely on the importance of birth spacing to women's health.

Personal Choices

Problems expressed in interacting with health services were simpler to address than those that highlighted women's experiences of reproductive choices within the immediate family and cultural context. While the study was conducted, most of the women were under the 'protection' of a male family member — husband, brother, father or uncle.

Several women spoke about the difficulties in re-adjusting to the control of male members of the family after they had learnt to cope on their own through the 'refugee journey'. Some concern was expressed about the threats husbands had made to arrange deportation of their wives if they did not do as they were told. In the list of suggestions for meeting health needs, many requested strategies for negotiating with husbands within a context where they had no other family support and a reluctance to discuss private family matters.

Reproductive health choices for procedures such as terminations were described as needing a very delicate process of negotiation because of the size and closeness of the

community. If women made the choice to the exclusion of their husbands, maintaining secrecy became absolutely critical to avoid the repercussions of going against what one woman described as 'tradition, religion and culture'.

A 29-year-old Ethiopian woman who lived with her young family in a high-density state-funded apartment complex had to be admitted into a general hospital for investigations of an abdominal mass after fainting in a shopping centre. Although it was explained to her husband that the problem was not pregnancy-related, an extensive process of negotiation involving one of the project bicultural workers was required to allay his fears and dispel rumours in the community of an abortion gone wrong.

Concerns for Young Women

Mothers expressed a general concern about the potential danger facing young girls growing up in Australia, without the guidance and support of the networks of family and community that had protected them in their home countries. Australian society was described as heavily focused on individualism to the exclusion of traditional values. Young people had access to welfare payments and were therefore not reliant on family. The society was also viewed as permissive with a strong emphasis on sexual exploration. In contrast, if sex is discussed, it is expected that mothers would introduce the topic or that girls close to the age of marriage would discuss it among their peers. A mother with two teenage daughters said:

"The 'victim' gets married and then she may become the informant for her peers. Information about sex is so frightening that they really should not be telling young girls about it in schools. If I had known about sex before I got married I would have been terrified to get married. Surprise is much safer."

Mothers thought that sex education as provided in the schools was not appropriate for girls who had experienced FGC and, as long as their daughters got married from within their own communities, the young men would know about FGC and be gentle and understanding of what to do. If a man cannot 'undo' his bride, he could call on older female relatives to help, although this attracts a 'levy'.

Unlike the older women and mothers, the young unmarried women (under 25 years) interviewed were keen to receive information and sex education, provided that it came from peers or others who could understand what it was like for them. In general they could not discuss issues such as period pain with their mothers. Some had been told by older friends and relatives that the pain would subside after they married and became sexually active. They expressed a great deal of interest in the possibility of health information sessions that would clarify some of these concerns.

Conclusion

The social realities of resettling refugee and migrant women and the effects on reproductive health in general and reproductive choices in particular are complex. The refugee journey, migration stress, loss of social networks, religious and cultural factors, access to health care and perceived racism and discrimination interact to affect the process through which reproductive health is negotiated.

The study highlights the continued need to address both clinical practice and social issues for the refugee and migrant communities. There is a clear need to address issues both within the migrant communities and the wider host community to ensure that women can be informed about and exercise their reproductive rights. At the same time, this study draws attention to the need to clarify further the interpretation of reproductive rights and to identify the institutions, structures and mechanisms that need to be in place to ensure that they are honoured.

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