

## **Attitudes to Fertility, Sexual Health and Motherhood amongst a Sample of Non-Irish National Minority Ethnic Women Living in Ireland**

*Catherine Conlon, Joan O'Connor and Siobhán Ní Chatháin*



## Foreword

I am proud to introduce this report on the views and experiences of women from some of Ireland's migrant communities on fertility, sexual health and motherhood.

This is the 36th report to be commissioned by the Crisis Pregnancy Programme. Like many of its predecessors, it is a ground-breaking study in the Irish context, as little data exists in this area.

The researchers overcame many methodological challenges in order to secure the participation of a diverse range of women aged 18-30 from Ireland's Chinese, Muslim, Nigerian and Polish communities. The result is a report in which the voices of these women can be clearly heard, giving many insights into the complexities of negotiating sexuality, motherhood and healthcare as a member of a migrant community in Ireland.

The research reveals that migrant women share many perspectives with Irish women in how they feel about fertility, sex and motherhood; however, differences do exist. For example, some migrant women still prefer to use healthcare services within their own communities or even their own countries of origin, either because they believe Irish healthcare will not fully meet their needs or because they do not know about the services available or how to access them. However, migrant women in the study also reported of positive experiences of Irish healthcare, especially where a staff member responded sensitively to their particular needs.

This qualitative study is not representative of migrant women's experiences, and it is likely that other nationalities living in Ireland, not represented here, will have their own unique experiences. Nonetheless, the study demonstrates that cultural norms and expectations can influence migrant women's attitudes towards sexual behaviour and family formation. In turn, these norms and expectations have a bearing on migrant women's need for and use of sexual health and maternity services.

The study findings provide an important direction for service providers and policymakers in terms of making sure migrant women know about the services that are available to them and ensuring that women experience culturally-sensitive care when they access any part of the healthcare system. This is particularly important given the findings that migrant women in this study were at heightened risk of crisis pregnancy and sexually transmitted infections.

I would like to thank the authors of the study, Dr. Catherine Conlon, Joan O'Connor and Siobhán Ní Chatháin, for their expertise in capturing such rich data from a hard-to-reach population. I also thank the project Advisory Group members for contributing

their expertise and commitment to this project from the outset: Diane Nurse, HSE Social Inclusion, Dr. David Weakliam, HSE Public Health, and Mary Smith, HSE Crisis Pregnancy Programme.

Most important of all, I sincerely thank the 81 women who participated in the study and generously shared their experiences on sensitive, and sometimes difficult, topics. It is my hope that their valuable contribution will be the basis for measures to improve awareness of and responsiveness to cultural difference throughout the Irish healthcare system, and to ensuring that Irish sexual health and crisis pregnancy support services continue to develop to fully meet the needs of migrant communities.

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Dr Catherine Conlon, Joan O'Connor, Dr Siobhán Ní Chatháin

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## Executive summary

### Approach taken to researching young migrant women's sexual well-being

This research is concerned with exploring the meanings young migrant and minority ethnic women aged 18-30 living in Ireland bring to their sexual relationships, sexual health, and reproductive healthcare decisions, including contraceptive use, pregnancy and motherhood. This in-depth, qualitative study considers how legal, cultural, social and economic factors play out in their decisions and practices. The main purpose of this work is to ensure greater understanding and sensitivity to the specific needs and issues of concern for non-Irish national and ethnic minority women in relation to their sexual well-being.

Comparative to other Northern and European countries, Ireland's status as a country of immigration is relatively recent. While a small number of minority ethnic communities have been established for some time in Ireland, overall ethnic diversity is emergent in Irish society, so that many minority ethnic communities are at this time equivalent to migrant communities. Many of the young women in this study are first-generation migrants who have come alone or with families to live in Ireland within the past twenty years or less.

The underdevelopment of research on this issue in the Irish context means that the study is building on a very low knowledge base and as such constitutes an initial exploratory study. The sensitivity of the topic of interest and marginalisation of the population of interest were also issues to consider in the design of the study. Taken together these issues provided a strong rationale for the selection of social justice orientated methodologies, and a community-based participatory research approach was taken.

The study design comprised:

- Consultation with stakeholder organisations for cultural immersion in the topic and to assess the cultural appropriateness of the research approach.
- Engaging peer researchers to be involved in the data-generation process.
- Qualitative, in-depth interviews with a sample young migrant and minority ethnic women aged 18-30.

The study focuses on four communities within the overall migrant and minority ethnic community in Ireland – Chinese, Nigerian, Polish and Muslim – selected for diversity based on analysis of recent patterns of migration into Ireland. Qualitative interviews with women aged between eighteen and thirty years from each community drew out detailed accounts of their individual experiences, views and needs in relation to sexual and reproductive health. Such an approach generates a nuanced and detailed picture of the particularities and specificities of risk, care and support needs of our study group, to help inform the formation of policy and service delivery in the context of a more ethnically diverse and transient population.

It is important to highlight that this is a qualitative study and does not claim to be representative of the views of all non-Irish minority ethnic communities, nor, indeed, is it representative of the views of all Chinese, Nigerian, Muslim or Polish women living in Ireland. As described above, this is an exploratory study, qualitative in nature, and serves to describe in a robust and rigorous way key issues raised by the women interviewed.

The core element of the project comprised in-depth interviews with a total of 81 women participating in one-to-one interviews (N=26), friendship pair interviews (N=4) and nine focus group interviews (N=51). Peer researchers were engaged in the study so that all participants were offered the option of being interviewed by a peer researcher, including the option of being interviewed in their own language. The premise of this approach is that in-depth learning from a purposefully selected sub-set of the overall population can generate insights and understandings of relevance.

### **Cross-cultural meanings and messages regarding sexuality, fertility and motherhood**

Understanding the particular meanings attributed to female sexuality, fertility and motherhood in the diverse cultural contexts of the women studied reveal commonalities and disparities between the dominant Irish and newcomer and/or minority ethnic cultures that make up contemporary Ireland.

Despite the diversity of backgrounds of the women interviewed, a common feature of their socialisation regarding sexuality was that as young girls they intuitively came to know key messages. Messages that were internalised by the women included that it is a girl's specific responsibility to control sexual morality, that contact with boys is censured and contingent on girl's behaviour, that sexual propriety or transgression by a girl reflects not just on herself as an individual, but on her family, friends and wider community and that pregnancy threatens life chances and the respectability not only of the girl but also her family and even her wider community. It was the girl's duty to avoid these negative outcomes. These ideas resonate with meanings of heterosexuality derived in the Irish context, where heterosexuality is gendered, with double standards attributed to male and female sexual activity and power is asymmetrically distributed in favour of males (Hyde and Howlett, 2004; Murphy-Lawless et al., 2004 and 2006 and Mayock et al., 2007). While these key messages were imparted at home and through other key social and cultural institutions such as school or church, communication mostly came through indirect or implicit means in all of the cultural contexts represented in the study group. While more formal sexual education and some greater degree of openness pertains in the Irish context, it is still the case that influences on young people's sexual lives are not restricted to explicit or formal messages about sex but instead are embodied in an array of subtle and complex forms of communication, shaped by gender and social positioning (Mayock et al., 2007).

Meanwhile we noted some specific cultural emphases among the accounts of women in the study. In particular, female sexual chastity and high educational attainment featured as two key sources of social capital, in contexts where marriage is highly valued and power and control is vested in the male in the making of a marriage. The Muslim women in the study depicted sexual intimacy or motherhood before marriage as forbidden in Islamic law. Chinese women referred to the legacy of their culture where 'dowry' exchanges at marriage, though dying out, are still practised. Aware that a woman 'loses face' and 'loses value' in dowry or monetary terms on marriage if considered 'unchaste', Chinese women spoke of the practice of 'hymen reconstruction' emerging as a way of managing such implications of sexual experimentation before marriage. Another issue featuring among the study group, particularly for young Nigerian women, who had mostly migrated with their families, was how migration itself creates particular pressures in relation to avoiding non-marital pregnancy. The meaning suggested is that migrant families are expected to progress and succeed in their new country, and so a young woman becoming pregnant is a greater 'failure' when those 'back home' are considered: failure by her to optimise enhanced educational opportunities in her new country of residence and failure by her family to maintain the moral standards of their 'old' country of origin. This creates particular conditions for the possibility of crisis pregnancy among young migrant women. Meanwhile Polish women in the study were more likely to consider that attitudes are changing in their cultural context, so that chastity and marriage were no longer central to the life chances and reputation of women and their families. Finally, the enduring impact of being subjected to the traditional practice of female genital mutilation featured in this study and demonstrates how sexual and reproductive health services in Ireland need to be aware and knowledgeable of particular global sexual and reproductive health issues.

These issues illustrate how young women who are forging their sexual identities while traversing cultural contexts strive to negotiate conflicts and commonalities between their originating and their host cultures.

### **Experiences of formal sex education**

Formal sex education is a key policy approach to enhancing sexual well-being among young people. As a snapshot in time, the picture emerging in this research is one where young migrant women have grown up in contexts where sex education at home and/or in schools ranges from absent to highly variable, with comprehensive sex education the exception. Those who attended schools in Ireland and encountered some sex education there also reported variable levels of effectiveness in the approaches taken. Meanwhile, in the Irish context rapid diffusion of sexually-permissive popular culture materials in recent years, particularly via the internet, has meant that young women encounter a wide array of information relating to sexuality. The interviews revealed that migrant women can find themselves immersed in permissive sexual messages while feeling uninformed and lacking in skills to feel in command of their sexual lives. The effects of such confusion can be very challenging for young women to navigate.

### Negotiating sexual well-being, fertility and motherhood across cultural contexts

The diverse contexts and circumstances within which young migrant women came to Ireland, and are now living in Ireland, shape their experiences of forging and carrying out relationships, including sexual relationships, and in turn their capacity for managing sexual well-being, fertility and motherhood.

In their early sexual experiences, younger migrant women in our study identified particular conditions for sexual risk-taking. Young women's depiction of the discourses of sexuality they encountered at home, in school and in popular culture were highly discordant. There was a particular disparity between messages encountered at home and those encountered in teen magazines and the internet - the primary sources of information and advice for many women in the study. Seeking to make sense of mixed messages and varied levels of openness across the domains of home, community, school and media can give rise to young women coming to fear their bodies, feeling a lack of control over their own sexuality and reproductive capacity and holding conflicting expectations between the varying discourses of sexuality they have encountered. This is exacerbated when the young woman enters a more permissive sexual culture.

Lack of knowledge about sex and fertility was a factor in sexual risk-taking for some women in the study. Some women felt that there were greater pressures and opportunities to be sexually active in Ireland, a country they perceived as being generally more sexually permissive than their countries of origin. These women considered themselves to be ill-equipped for the pressures to be sexually active they encountered in Ireland and the attendant need to protect themselves against pregnancy and sexually transmitted diseases. As regards the nature of risk women considered, contracting sexually transmitted infections did not feature or seem to enter their consciousness as much as the risk of an unwanted pregnancy. This resonates with findings from the Irish context (Murphy-Lawless et al., 2004), where women equated 'safe sex' with not getting pregnant and avoiding the sanctions imposed on women by society for engaging in sexual behaviours. Women's fear of pregnancy often related more to parental discovery of sexual activity than to the prospect of motherhood. This fear can pervade a young woman's sexual sense of self - detracting from a sense of agency, control and acknowledgement of being sexually active and any attendant risks that would facilitate adopting safe-sex strategies including contraceptive use.

Experiences of unprotected sex recounted in the study were associated with risk-taking for intimacy, pressure from sexual partners, lack of sexual health knowledge as well as self-esteem and self-care issues and issues of access to contraception. Some women found it hard to get contraception, and this contributed to the conditions for sexual risk-taking; for example, some women had issues with accessing contraceptive services under the General Medical Scheme (GMS). There was some evidence of women being reticent about using hormonal contraception, as well as a general lack of information about different types of contraception. The research demonstrates that responsibility for

maintaining morality including through the avoidance of pregnancy remains principally vested in young women. Women experienced pressure in the form of emotional blackmail from males who resisted using condoms. Women's accounts included early sexual experiences where women were not sufficiently knowledgeable or empowered to ask their partners to use a condom, which resulted in unwanted pregnancy or having to access emergency contraception. The interplay of factors - including pressure on women to have sex before they are ready, male resistance to condom use, difficulties in accessing contraception, resistance to using hormonal contraception, and lack of knowledge about sexual health in general - put the women in this study group at increased risk of unwanted pregnancy and STIs, in comparison to young Irish women.

Entitlement to Irish health services usage varies according to legal status. There were clear and distinct patterns in how women from the different groups viewed and accessed the Irish healthcare system. Legal status was an important factor in determining use of Irish services, but other factors, such as cultural preferences, also featured. At the same time, women with no or limited entitlement, such as Polish and Chinese women, described engaging in 'transnational' health service usage. Accessing sexual health services, in particular contraception, on a 'transnational' basis was done for reasons to do with cost, familiarity, language, preferences of approaches taken, easier access and barriers to accessing Irish services. Often this resulted in women establishing no contact with local sexual and reproductive health services, leaving them at risk of being unable to avail of such supports and services locally and quickly if the need arose.

There were low levels of familiarity and connectedness with crisis pregnancy support services (CPSS) among young migrant women in this study. One issue arising relates to the 'localised' terminology of 'crisis pregnancy' which is very particular and requires local 'tacit knowledge' to understand the shared meanings that have attached to the terms over time. The accounts of the women in the study group who did experience a crisis pregnancy illustrate lack of knowledge about crisis pregnancy support services resulting in them being more isolated and reliant on personal networks, particularly parents. Meanwhile, as noted above, migration can create particular conditions for pregnancy among young unmarried daughters to be perceived as a crisis, making such services all the more relevant to the group.

### **Motherhood**

Ideal circumstances for motherhood are described by women as including the personal attributes of maturity (age, 'personal development'), 'readiness', relational factors (marriage, suitable partner, familial support) and circumstantial factors, in particular financial security. Being married and being financially secure were the predominant considerations for women in their decisions about having a child. This partly resonates with Irish research conducted in 2010 (Fine-Davis, 2011), which found that psychological factors, such as finding a suitable partner, and the quality of the relationship with a partner were most important for men and women in their decisions about having children,

followed by economic factors. In the Fine-Davies study, however, many adults did not view marriage as a precondition for having children. In the current study the issue of motherhood as an expectation and the pressure on women to enter motherhood under 'appropriate' circumstances emerged across the four groups. Traditional marriage and family values continued to exert their influence on women living here in Ireland whether within families of origin or not. Nearly all of the participants in our study believed that they would have children at a relatively young age - before 30 - in contrast to the average childbearing age (31) of their Irish contemporaries. For example, many of the Polish women describe experiencing pressure generally from their family and extended family to get married and to have children in their twenties.

While participants expressed their views on the ideal circumstances for motherhood, the situations of some mothers in the study were considerably different, particularly where they had become mothers in Ireland while young and unmarried. They described feeling isolated and having little support from partners and/or wider families. Cultural norms and pressures seemed to factor in the withholding of support, women feeling a sense of shame, and in some cases experiencing abandonment and rejection.

Women discussed their perceptions of the challenges of motherhood in a new country specifically. These related to challenges for women in general such as trying to balance a mothering role with earning a living, as well as challenges specific to their cultural and ethnic backgrounds. Cultural pressures cited include stronger gender differentiation of roles, which place the responsibility for childrearing solely on women. The outcome of these pressures could be stress, loneliness and isolation. In particular, women in the Nigerian and Muslim groups considered that a much greater responsibility on mothers with regard to parenting persisted, despite crossing cultural boundaries.

A key concern for considering or entering motherhood in Ireland related to migrant women's capacity to interpret and establish their entitlements to ante-natal care, maternity benefit, maternity leave, protection in employment during maternity and the myriad of supports available to support women during pregnancy and early motherhood. In general, Chinese women had little information on maternity supports available in this country. Expectations of formal supports were low - shaped by cultural practice of extensive support from mothers both among Polish and Chinese families where mothers are depicted as playing a stronger role in advising their daughters about child-rearing, and in caring for new-born babies. In the absence of this support from their mothers, and in a context where women are not accessing existing social supports, migrant women living in Ireland can experience greater isolation in caring for young babies than if they were living in their home countries, and as compared to Irish women who often have a wider support network as well as greater awareness of and access to supports.



### Cross-cultural encounters in sexual and reproductive health services

As stated above, women's engagement with, and patterns of use of Irish health services including sexual and reproductive health services depend on the conditions under which women are living in Ireland. Research internationally has demonstrated that a newcomer's legal status is a key factor determining access to and use of health services. This is a key feature in our study too, and the variation of grounds on which women were resident here made for variation in their rights and access to services. Other barriers encountered by women included lack of knowledge about SRH services, language and communication difficulties, issues related to accessing SRH services through primary health care, cost, and impact of cultural silences and shame.

Where young women did not have entitlement to health services due to their legal status, as was the case with some Chinese women in our study, particular barriers arose, making it difficult for them to engage with Irish health services. The Chinese women's stance towards Irish health services generally was characterised by a feeling of being at a life-stage where health issues were not a feature and therefore entitlement to health services was of marginal concern. Some women referred to anecdotal perceptions of the primary healthcare service as expensive and entailing long queues or delays for appointments. Reticence to use Irish services that was based on cultural approaches to medicine and a preference for Chinese medical philosophy over Western approaches was expressed by some participants. These factors converged so that young Chinese women's health service usage patterns tended to entail being self-reliant through self-diagnosis and management of health issues using a combination of medicines brought from home or bought over the counter. This entailed buying contraceptives in bulk when on a return visit home, asking someone in China to post contraception, ordering contraceptives over the internet or acquiring contraception from someone in one's own network outside of the health service.

Similar barriers operated for Polish women for whom affordability to access health services featured and medical card entitlement was restricted due to a Habitual Residence Condition. The issue of the transnational use of sexual and reproductive health care featured most among the Polish study group. Polish women tended to return home frequently and retained very strong connections to their home country including their health service providers in Poland. A striking feature of Polish women's accounts was the expectation that all sexual health matters would be dealt with by a gynaecologist rather than by a general practitioner within the primary healthcare system as in the Irish case. This caused them to see the Irish system as less specialised. Transnational use of services also included obtaining medical supplies including contraceptives in Poland for use when in Ireland.

In practice not having entitlement to services operated as a key barrier to *becoming informed* of the various elements of health services and options for support in the event of a health issue or crisis arising. Given the reliance of health policy makers and providers

on primary healthcare as a point of contact and information for specialist areas within the service, it is no surprise to hear that groups who make no contact with this system remain uninformed of specialist services such as sexual and reproductive healthcare services or crisis pregnancy counselling and support services

In contrast, the young Muslim women in our study were mostly second-generation migrants and were thus integrated into the Irish health system through their families. Many of the Nigerian women were here with their families and had established their relationship and access to services through their families as opposed to in their own right. Women from both the Nigerian and Muslim groups had concerns regarding confidentiality and being able to use SRH services without their parents' permission or knowledge, due to the taboos surrounding extra-marital sex and pregnancy. Women referred to how cultural silences and a sense of shame in relation to sexuality inhibited them asking a GP about sexual health services. Cost featured as a barrier for those who either did not have a medical card in their own right or were not willing to trust the family GP with keeping their consultation regarding sexual issues confidential.

Muslim and Nigerian women discussed their experiences of interacting with health services here, raising issues relating to intercultural competence on the part of service providers. While some incidences of stereotyping and prejudice were recounted by women, Muslim participants did not have high expectations that service providers would have an awareness of religious or cultural characteristics or requirements. None of the women in the Muslim group employed the language of 'rights' when talking about the accommodation of cultural difference and most would have been pleasantly surprised to encounter service providers with knowledge of their particular religious or cultural values or practices. Women in general acknowledged the fact that a health care system within the current economic context will inevitably be undermined in its potential to enhance the intercultural capacity of services and personnel.

From the accounts of women in our study, encounters with health services would be more effective where the following factors were accommodated: some awareness and expression of cultural sensitivity amongst health service personnel of potential for specific requirements related to a woman's cultural and religious identity; the provision of a female doctor where feasible, if preferred by the service user; attention to language/communication difficulties to allow for optimum understanding in the care relationship; a caring attitude, particularly if this is a migrant woman's first encounter with health services, and understanding that a migrant woman may be used to a different healthcare approach, and therefore would require more explanation and more information about healthcare procedures. Overall, women in this study agreed that inter-cultural competence in sexual and reproductive health services entailed being respectful, receptive and open, rather than having an in-depth knowledge of specific cultural traits or traditions.

## Recommendations

The following recommendations arise from our research findings:

### *Increasing cultural sensitivities and partnership in sex education*

1. Initiatives to reach migrant and newcomer communities with existing materials are necessary, key among them being the 'b4udecide' campaign. It is recommended that the b4udecide campaign be developed to have greater multi-cultural presence and relevance on both the web-site platform as well as in printed materials. This should be combined with a targeted awareness-raising programme to reach migrant and new communities with the campaign messages.
2. The development of multi-cultural awareness materials for parents within this framework is necessary, highlighting the importance of acceptance and support.
3. Information regarding the availability of CPSS and messages regarding the importance of supporting young women with a crisis pregnancy should be disseminated to migrant communities; these messages should be targeted particularly to young women and their parents.
4. An openness and sensitivity to cultural diversity needs to underpin the delivery of all SPHE/RSE programmes, such as the TRUST resource and the 'b4udecide' programme, in school, community and youthwork settings. Multi-cultural awareness should be a part of all teacher and youthwork training in this area.
5. Migrant rights organisations should be provided with RSE training by the National Youth Council of Ireland (NYCI) and other bodies working with community based organisations; the NYCI and other such organisations should strive to include the needs of new communities in their policy and practice.
6. Specific issues to have regard to developing multi-cultural sexuality education programmes were also identified, in particular the continued relevance of Hyde and Howlett's (2004, 97) recommendation that sex education materials should be underpinned by an egalitarian sexual discourse aimed at dissolving deeply engrained gender codes.

### *Building information and access to sexual and reproductive health services for young migrant women*

1. The language used in public communications programmes should be accessibility-proofed to assess the reliance on 'tacit' localised references and to assess its capacity to reach new communities. Recommendations within the HSE National Intercultural Health Strategy 2007-2012 set out clear principles for interpretation and translation that can be useful here.
2. Both the 'Think Contraception' and 'Positive Options' campaigns should be developed further with reference to multi-cultural content and dissemination. In addition, the translation and targeted dissemination of materials within the Positive Options campaign would address the expressed need for information regarding maternity care, benefits, protection in employment and early motherhood supports.

3. Liaison with the HSE, again within the framework of the National Intercultural Health Strategy, regarding initiatives to inform migrants of how the primary healthcare system works would be beneficial, given the importance of this route for accessing information regarding SRH care. Within HSE East Cairde have particularly focused on promoting access to primary healthcare among migrant and newcomer communities and their initiatives could be examined for learning in this regard.
4. If representative research supports the findings in this research regarding the very low engagement of Chinese women with primary healthcare in Ireland, consideration should be given to undertaking an initiative with private health insurance providers to provide all migrant clients with information to increase uptake of services by these women. Information should be provided about primary health care services at a minimum but ideally also about sexual health and crisis pregnancy counselling and support services.
5. Public communications programmes need to incorporate targeted components for specific communities. Our study groups made recommendations relating to the best ways of disseminating information to their communities

#### *Quality and cultural competence of sexual and reproductive health services*

1. Health practitioners should be mindful to avoid a 'them-and-us' attitude and should instead strive to develop an inclusive perspective that still allows for difference. Women considered that health professionals demonstrating a manner of respect and receptiveness towards cultural, ethnic or faith specificities of new communities would be adequate, rather than having an in-depth knowledge of specific cultural traits or traditions.
2. While a background awareness of religious/cultural characteristics/traditions was seen as beneficial, it was considered that a patient, open and caring attitude was of greater significance in shaping the interaction between service providers and service users. Linguistic, communicative competencies and multi-cultural understanding would be greatly enhanced by the advancement of the recommendations within the NIHS 2007-2012 for promoting greater culturally diversity and awareness within their human resources remit.
3. The issue of female genital mutilation (FGM) featured in this study. The account in the report of the woman who survived this practice highlights the importance of the current initiative to implement legislation making the practice illegal to perform here or making it an offence to remove a young girl from the State for the purposes of performing FGM upon her. The legislation also has implications for service delivery and needs to be accompanied by a process of awareness-raising among the general population as well as developing further such work already commenced with health service providers in maternity and other sexual and reproductive health settings.

### *Further research*

1. Further quantitative and representative research is required to assess the degree to which findings in this study are generalisable to the broader population of the groups studied here.
2. This study focused only on issues for young migrant women aged 18-30. Similar research is required with additional non-Irish national groups not included in this study, as well as with non-Irish national men and non-Irish national women aged 30 and over.
3. Ethnicity as well as nationality needs to be captured in health statistics to allow for the specificity of minority ethnic groups' needs to be adequately captured. While the Health Information and Quality Authority (HIQA) is the authority best placed to mainstream attention to ethnic diversity in health service data-collection systems, the format for including 'ethnicity' as a category in recent Census questionnaires is a useful reference model here.
4. Ethnicity and cultural diversity should be retained as a key 'variable' in the design of future studies in this area by the CPP, as in the model of the recent ICCP 2010 study.

## 1.0 Introduction: Sexual and reproductive health issues for young women in migrant and minority ethnic communities

### 1.1 Background to the study

This research is concerned with exploring the meanings young migrant and minority ethnic women aged 18-30 living in Ireland bring to their sexual relationships, sexual health, and reproductive healthcare decisions, including contraceptive use, pregnancy and motherhood. This research reflects the objectives of the 2004 Crisis Pregnancy Agency report *Understanding how sexually active women think about fertility, sex and motherhood* (Murphy-Lawless, Oaks & Brady, 2004) which addressed the same issues with young women from the majority Irish population exclusively. That research, which was exploratory in nature, captured the meanings young women attribute to their fertility and fertility-related decisions in relation to life objectives and women's changing roles in education, careers, relationships, and motherhood. It reflected the views of a group of women in terms of socio-economic status, geographic location, and relationship history. This research seeks to explore these topics and expand upon previous research by undertaking a qualitative enquiry, also exploratory in nature, into how young women in new communities in Ireland think about these same issues.

Comparative to other northern and European countries, Ireland's status as a country of immigration is relatively recent. While a small number of minority ethnic communities have been established for some time in Ireland, ethnic diversity is emergent in Irish society such that many minority ethnic communities are at this time equivalent to migrant communities. Many of the young women in this study are first-generation migrants who have come alone or with families to live in Ireland within the past twenty years or less. Some are second-generation members of migrant families who have settled in Ireland and were born and educated here and identify themselves as of Irish nationality. The main purpose of this work is to ensure greater understanding and sensitivity to the specific needs and issues of concern for migrant and minority ethnic women in relation to their sexual health. The aim of the research is to provide insights to help build multi-cultural competency in this area among sexual and reproductive health policymakers and service providers in recognition of our multi-cultural society.

In this chapter we outline the particular focus of the research and highlight key learning from other studies and countries, drawing from research exemplars to provide a backdrop into the body of this report which is based on in-depth interviews with young migrant and minority ethnic women living in Ireland in 2011. The approach taken in this exploratory study does not seek to generate a statistically representative picture of issues for this group. Another study, the second Irish Contraception and Crisis Pregnancy Study (ICCP 2010) is being undertaken for the HSE Crisis Pregnancy Programme (CPP) by the Royal College of Surgeons in Ireland (RCSI) and Amárach Research. This is a survey of knowledge, attitudes and behaviours of men and women in relation to crisis pregnancy, contraception, and sexual health and is a follow-on project from the ICCP 2003 study,

published in 2004. In the 2010 round of the study, a dedicated module targeting the inclusion of migrant and minority ethnic women was part of the study design, and the report includes data on the experiences of Nigerian and Polish women living in Ireland. As with the current study, this reflects the concern of the CPP to have regard to specific needs of women in new and minority ethnic communities.

The approach of the study entailed focusing in on four communities within the overall migrant and minority ethnic community in Ireland – Chinese, Nigerian, Polish and Muslim – and carrying out in-depth, qualitative interviews with women aged between eighteen and thirty years from each community. The aim of the interviews was to draw out detailed accounts of the experiences, views and needs of these women in relation to sexual and reproductive health. Such an approach generates a nuanced and detailed picture of the particular risk, care and support needs of the women, which need to be addressed by policymakers and services in the context of a more diverse and transient population. Migration and transition to a new cultural environment bring challenges for individual young women seeking to live out a healthy and fulfilling sexual life as well as for policymakers and service providers whose purpose and remit it is to provide them with the capacity and resources to do so.

## 1.2 Research questions

In embarking on this exploratory and in-depth study, a wide range of questions and objectives were posed, including:

- To explore how living in Ireland impacts upon non-Irish national ethnic minority women's attitudes toward and experiences of fertility, sex, and motherhood, and to consider how an individual's expectations of living in Ireland are implicated in her current sexual health experiences and decision-making processes.
- To identify the issues most relevant to the population of interest in relation to fertility control, sexual health and motherhood.
- To identify the various ways in which crisis pregnancy features in the lives of non-Irish national ethnic minority women living in Ireland, while considering the role of social identity and ethnicity in participants' views and experiences of crisis pregnancy.
- To compare research findings with those published in the CPA-commissioned studies *Understanding How Sexually Active Women Think About Fertility, Sex and Motherhood* (Murphy-Lawless et al., 2004 and 2006) and to relate research findings to the social and political backdrop of Ireland's changing demographic profile.
- To examine variations among the sample and to offer analytic and evidence-based insights into the reasons behind these identified differences, having regard to the impact of cultural norms, religion and ethnicity.
- To explore the psychological (e.g., attitudinal and motivational), social (e.g., the role of the family, intimate relationships, peer group, employment, and education) and cultural (e.g., religion, nationality, traditional values, and ethnic identity) factors which impact upon each participant's sexual health attitudes and behaviours.

- To identify major facilitators and barriers – among the cohort of participants – to accessing health and social services which address crisis pregnancy, family planning, and sexual health, and to make recommendations for improving upon non-Irish national ethnic minority women’s knowledge of, access to, and use of such services.
- To use the research findings as grounds for recommending ways of making targeted and evidence-based improvements to Ireland’s sexual health services for non-Irish national ethnic minority women.

### 1.3 Who are migrant newcomer and/or minority ethnic young women in Ireland?

As stated earlier, Ireland has only become a country of immigration in the last thirty years, since the 1990s. However, it is important to emphasise that non-Irish national women under thirty living in Ireland are a broad and heterogeneous group in terms of nationality, ethnicity, language skills, religion and legal status, with heterogeneity existing *among* the newcomer migrant and ethnic groups in Ireland as well as *within* these groups. The term ‘minority ethnic women’ refers to women who live in Ireland and who define themselves or are defined with reference to their ethnic identity which is ‘other’ than the majority ethnic group on the island of white Irish<sup>1</sup>. Ireland’s situation is interesting given the extent, pace and heterogeneity of its recent immigration patterns.

According to Census 2006<sup>2</sup>, just over 10% of the population (420,000 people) were foreign nationals. The Central Statistics Office (CSO) produces up-to-date data on population and migration estimates based on the Quarterly National Household Survey (QNHS). Table 1 in Appendix 1 presents migration flows for the period 2006 to 2011. Looking at overall trends, the number of foreign residents in Ireland peaked at the end of 2007 to 485,300 (13.8%) in the final quarter of 2007, and then fell back to 445,000 (12.6%) by the second quarter of 2009 (O’Connell and Joyce, 2010).

Based on 2006 Census data, the top ten countries of origin of non-Irish nationals resident in Ireland were:

1. The UK including Northern Ireland
2. Poland
3. Lithuania
4. Nigeria
5. Latvia
6. United States
7. China
8. Germany
9. Philippines
10. France

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<sup>1</sup> Travellers represent an indigenous ethnic minority group to Ireland but are not a target group in this study as our interest is in the intersection of migrant and minority ethnic status.

<sup>2</sup> The 2006 Census was the latest data available at the time of the research.



Northern Ireland and Britain continue to be the source of the highest number of non-Irish nationals living in the Irish State. The United States and the EU15 countries of Germany and France also feature among the top ten sources of in-migration. The number of immigrants from the twelve countries most recently acceded to the EU (EU12)<sup>3</sup> countries and the rest of the world<sup>4</sup> was estimated to be 42,100 (males) and 30,600 (females) in 2006. Recent immigrants have predominantly come from the new member states of the European Union: their numbers grew from 31,000 in 2004 to almost 211,000 in 2008.

According to McGinnity et al. (2006) the main channels of legal immigration for non-EU migrants are as work-permit holders, through the asylum system, as students or as dependents of legal residents. Work-permit holders make up the majority of non-EU immigrants on whom information was available; asylum seekers were a substantial minority. The number of employment permits<sup>5</sup> issued to citizens of all countries declined from 23,604 in 2007 to 13,567 in 2008, and dropped further in 2009 to 7,962 (Joyce, 2010). The table below presents the top five countries of origin for employment permit recipients for 2006-2010.

**Table 1.1: Employment permits issued and renewed by country of nationality**

	2006	2007	2008	2009	2010
1st	Philippines (3286)	India (4069)	India (3334)	India (1788)	India (1997)
2nd	India (1805)	Philippines (3885)	Philippines (2210)	Philippines (1426)	Philippines (1223)
3rd	Ukraine (1476)	South Africa (1461)	America (867)	America (553)	Romania (771)
4th	South Africa (1469)	Ukraine (1412)	South Africa (752)	Malaysia (462)	America (382)
5th	Romania (1267)	America (1209)	China (661)	China (411)	Brazil (343)

Source: Department of Enterprise, Trade and Employment. [www.entemp.ie](http://www.entemp.ie)

Table 1.1 illustrates that employment-permit data disaggregated by country shows the main nationalities to whom permits were issued (new and renewed permits) over the past four years: India, Philippines, America, South Africa, Ukraine, Malaysia, China, and Brazil. Joyce (2010) presents additional information on the number of immigrants, derived from data on Certificates of Registration, which are issued by the Garda National Immigration Bureau (GNIB) to lawfully resident non-EEA nationals who expect to stay in the State for more than three months.

The Certificate of Registration contains one of a number of different immigration stamps, set out in Table 1.2 below, which illustrates the diversity of legal status held by migrants living in Ireland presently. In 2009 there were a total of 166,387 (referring to new registrations and renewals) persons registered with GNIB, showing an increase of over 6% from 2007.

3 EU12: defined as the 10 accession countries who joined the EU on 1 May 2004 (i.e. Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia, Slovenia) and includes the two new accession states who joined the EU on 1 January 2007 (i.e. Bulgaria and Romania).

4 Rest of the World includes all countries except the UK, rest of EU 15 and the USA.

5 Includes work permits, spousal work permits, group permits, green cards and intra company transfer permits.

**Table 1.2: Different categories of immigration stamps**

Stamp	Category	2007	2008	2009
1	Issued to non-EEA nationals who have an employment permit or business permission	31,472	32,040	23,417
1A	Issued to non-EEA nationals permitted to remain in Ireland for the purpose of full time training with a named body until a specified date. Other employment is not allowed.	-	66	887
2	Issued to non-EEA national students who are permitted to work under certain conditions.	36,019	41,156	41,639
2A	Issued to non-EEA national students who are not permitted to work.	3,701	3,850	3,879
3	Issued to non-EEA nationals who are not permitted to work.	17,220	17,480	17,554
4	Issued to people who are permitted to work without needing an employment permit or business permission: Non-EU EEA nationals; Spouses and dependants of Irish and EEA nationals; People who have permission to remain on the basis of parentage of an Irish child; Convention and Programme refugees; People granted leave to remain; Non-EEA nationals on intra-company transfer; Temporary registered doctors; Non-EEA nationals who have working visas or work authorisations.	63,748	63,794	70,803
4EU FAM	Issued to non-EEA national family members of EU citizens who have exercised their right to move to and live in Ireland under the European Communities (Free Movement of Persons) Regulations 2006. People holding this stamp are permitted to work without needing an employment permit or business permission, and they can apply for a residence card under the 2006 Regulations.	1,660	3,727	5,208

Stamp	Category	2007	2008	2009
5	Issued to non-EEA nationals who have lived in Ireland for at least eight years and who have been permitted by the Minister for Justice, Equality and Law Reform to remain in Ireland without condition as to time. Holders of this stamp do not need an employment permit or business permission in order to work.	149	218	548
6	Can be placed on the foreign passport of an Irish citizen who has dual citizenship, and who wants their entitlement to remain in Ireland to be endorsed on their foreign passport.	17	26	61
Unrecorded		1,260	1,985	2,391
A		6	2	
B		1	-	
Total		155,253	164,344	166,387

Source: Department of Justice, Equality and Law Reform, as presented in Joyce (2010)

Table 1.3 below shows country of origin data for the ten largest national groups to whom Certificates of Registration were issued in 2008.

**Table 1.3: Country of origin and certificates of registration**

	Country of origin	Number registered 2008
1st	India	18,018
2nd	China	15,624
3rd	Nigeria	14,401
4th	Philippines	12,218
5th	America	11,302
6th	Brazil	10,385
7th	Pakistan	7,221
8th	South Africa	5,843
9th	Australia	5,331
10th	Mauritius	5,016

Source: Department of Justice, Equality and Law Reform, as presented in O'Connell and Joyce (2010)

In 2009, figures (new registrations and renewals) for the range of immigration stamps issued to non-EEA nationals were as follows:

- Employment permit holders or business permission: 23,417
- Students: 45,518
- Non-EEA nationals who are not permitted to work: 17,554
- Those who have permission to work<sup>6</sup>: 70,803

There are no estimates for the number of non-EEA migrants living and/or working illegally in Ireland (Ruhs, 2009). Feldman, Gilmartin, Loyal and Migge (2008)<sup>7</sup> identify irregular migrants as persons who are undocumented and/or unauthorised to work and live in Ireland. The Migrant Rights Centre Ireland has estimated that there are in the region of 30,000 illegal migrants living here.<sup>8</sup>

### 1.3.1 Age and sex composition of migrants to Ireland

Figures from the CSO demonstrate that there has been a sharp decline in the number of immigrants in recent years. The proportion of female immigration increased from 2006 to 2008, before levelling off with male immigration from 2009, resulting in a roughly equal level of immigration among women and men (CSO 2009, 2010).

**Table 1.4: Trends in immigration by sex and year**

Year	Total number of immigrants	Female immigrants	%	Male immigrants	%
2004	58,500	28,000	48	30,500	52
2005	84,600	37,100	44	47,500	56
2006	107,800	47,500	44	60,300	56
2007	109,500	52,100	47	57,400	53
2008	83,800	43,900	52	39,900	48
2009	57,300	29,100	51	28,200	49
2010	30,800	15,500	50	15,300	50

Source: [www.cso.ie](http://www.cso.ie)

The non-Irish national population has a different demographic profile to that of the Irish population. Based on figures from Census 2006, the non-Irish were dominated by people in their twenties and thirties, and there were significantly more men than women. Approximately 20 percent of women from the non-Irish national population were aged between 20-34 years of age. In the indigenous Irish population there is an equal number of men and women, and the population is spread more evenly across the age ranges. The sex ratio disparity was more marked among the younger age groups, where the largest numbers of men were found, having said that, there were more men than women in every age group under 70 years (CSO, 2008).

<sup>6</sup> Issued to people who are permitted to work without needing a work permit or business permission: non EU EEA nationals, spouses and dependents of Irish and EEA nationals, people who have permission to remain on the basis of parentage of an Irish child, Convention and Programme refugees, those granted leave to remain; intra-company transfers; temporary registered doctors; work visas or work authorisations.

<sup>7</sup> Feldman, A., Gilmartin, M., Loyal, S. and Migge, B. (2008) *Getting On: From Migration to Integration*. Dublin: Immigrant Council of Ireland.

<sup>8</sup> Irish Times, Friday, 7th January, 2011, accessed at: <http://www.irishtimes.com/newspaper/ireland/2011/0107/1224286964504.html>

**Table 1.5: Females by age group and nationality, 2006**

Age/nationality	EU 15 – 25 Accession states	Other European nationality	Africa	Asia
20-24 years	13,571	1,209	1,393	3,791
25-29 years	13,997	2,710	2,795	5,434
Total	27,568	3,919	4,188	9,225

Source: [www.cso.ie](http://www.cso.ie)

Again, based on figures from Census 2006, almost 42 percent of non-Irish nationals were married, and approximately 46 percent were single (never married). In terms of household composition, non-family households predominated, particularly among nationals of the recent accession states<sup>9</sup>. Almost one-in-five married non-Irish nationals did not live with their spouse at the time of the census.

#### 1.4 Integration issues for migrant and minority ethnic women

Changing patterns of migration, discussed in section 1.3, mean that people living in Ireland now come from diverse ethnic and cultural backgrounds and they may be migrant workers, asylum seekers or refugees, foreign students and members of new or established minority ethnic communities. Ethnic groups possess their own cultural identity, language, customs and practices, while each individual within the group will possess his or her own unique life experiences and health, social, emotional, vocational and psychological needs (HSE, 2008).

It is generally recognised that people from minority ethnic groups are more vulnerable to poverty and social exclusion. The importance of addressing the social determinants of health has been emphasised by organisations working with minority ethnic communities, where low pay, poor accommodation, poor working conditions, social isolation, discrimination and racism all have an impact on inequalities in health (Pillinger, 2008). Poor access to services is often experienced by undocumented, low-skilled workers and those seeking asylum or who have refugee status (Pillinger, 2008).

Analysis of literature on migrant women’s sexual and reproductive health needs suggests that, regardless of migration status, migrant women face common barriers accessing relevant national health services (Gagnon, 2004; Gushulak and Mac-Pherson, 2004; HSE, 2008; Pillinger, 2008; EN-HERA!, 2009; UNFPA, 2010). The barriers comprise legal, administrative and financial barriers; communication issues; socio-economic, personal and socio-cultural factors; deficiencies in knowledge and information; mental health issues (EN-HERA!, 2009). Globally, disparities exist between countries in terms of access to reproductive health with, for example, access in sub-Saharan Africa linked to key social and economic background characteristics, i.e. age (for contraceptive prevalence and unmet need for family planning), urban or rural residence, household wealth and educational attainment (UNFPA, 2010). It is important to be mindful, therefore, of the

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<sup>9</sup> EU15-EU25 Accession States: Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia.

impact of social, cultural and economic factors on non-Irish national women's current attitudes and decision-making about their sexual health and reproductive healthcare as they are now in Ireland.

There has been minimal research carried out on the experiences of minority ethnic women in general in Ireland, including in relation to their sexual health and reproductive health needs and experiences. According to the report of the *National Intercultural Health Strategy 2007-2012* (HSE, 2008), while much has been documented in recent times in relation to the situation of asylum seekers, refugees and migrants, relatively little information is available around the health and care needs of people from established minority ethnic groups and cultures in Ireland, for example, the Polish and Chinese communities (HSE, 2008).

Beyond Ireland, research on the impact of migration on health issues has been found to be limited also. Gagnon, Tuck and Barkun (2004), looking at the global experience of health issues for resettling refugee women, conducted a systematic review of questionnaires in fifty-nine studies and concluded that the role of human migration on health has, to date, been addressed largely in terms of infectious disease risk to host country nationals as a result of immigration. They concluded that the relationship of migration to other areas of health, including reproductive health, has been relatively neglected (2004: 111). Gushulak and Mac-Pherson (2004) discuss the role of place in relation to how it shapes one's encounters with health services. They assert that "place" as regards migrant women can be thought of in three distinct phases (pre-migration, migration, post-migration), each associated with particular health concerns and power issues for women passing through these phases. During pre-migration, women are living in their countries of origin with the health, health-risk profiles, and relational power dynamics of women with characteristics similar to theirs. During and post-migration, the "place" in which they find themselves and the general health status and power dynamic associated with that place will vary considerably depending on the immigration class in to which they fall. Independent or family immigrants generally choose to re-establish themselves in another country and usually have the economic means for establishing themselves post-migration. They will often have some capacity in the language of the new country and may have a network of relatives or friends there to provide support settling in. Refugees, in contrast, have been forced to leave their countries due to conflict or natural disasters and leaving is often unplanned. The place of arrival is often not chosen; instead the country of immigration may be where the person could get to or may have been selected under a resettlement programme. Refugees may not have the same financial resources, language capacity or networks as other migrants. In the Irish case the system of direct provision does not provide those within the asylum-seeking process independent access to financial resources above a very minimum level. Asylum seekers' sense of place is precarious until a decision on their application is made and so they enter into the society and find their place here post-migration in the context of limited power and autonomy. Their analysis highlights the importance of legal status to one's migration experience.

While research in this area at European level generally is also sparse, the WHO Regional Office for Europe pays specific attention to migrant populations, citing evidence that indicators of reproductive morbidity are higher for migrant populations than for the resident population<sup>10</sup> (WHO, 2007). Research from EN-HERA, the European Network for the Promotion of Sexual and Reproductive Health & Rights of Refugees and Asylum Seekers in Europe & beyond, indicates that refugees, asylum seekers and undocumented migrants have less access to sexual and reproductive health services - including family planning and safe abortion services - suffer from higher maternal morbidity, experience poorer pregnancy outcomes, report higher levels of HIV and other sexually transmitted infections, and are more likely to become victims of gender-based violence (EN-HERA, 2009a:25).

The UK Family Planning Association's Handbook on Sexual Health and Asylum Seekers and Refugees (Wilson, Sanders and Dumper, 2007) provides a summary of the sexual health issues that may affect asylum seekers and refugees. The authors note that the longer someone is in a country and the more stable their immigration status, the more likely they will be able to cope with sexual health and related issues. Findings from community research carried out in 2004 on sexual health concerns and needs of asylum seekers and refugees in Yorkshire revealed a sense of powerlessness, which operated at a number of levels: women in relation to their men and the community; girls in relation to their families; asylum seekers and refugees in relation to health professionals and interpreters; and refugee communities in relation to the 'host' community. Many issues related to sex and sexuality depend on men's and women's relationships with each other. Often, for economic, political and social reasons, women have less power in relationships than men do, and are not in a position to protect themselves from unwanted sex, sexually transmitted infections or from violence ([www.who.int/en](http://www.who.int/en), accessed December 2010). The report identified relationships and sexuality education (RSE) as a highly relevant issue, RSE which is underpinned by the notion of empowering individuals to make choices relevant to them.

Toronto, as one of the world's most ethnically-diverse cities, being home to more than 200 distinct ethnic origins speaking over 140 different languages, is a context where immigration is well established. A survey of teenagers living in the city, Toronto Teen Survey (TTS) addressed sexual health information promotion and care provision for youth living in Toronto and included a specific focus on ethnic youth (Flicker, Flynn, Larkin, Travers, Guta, Pole and Layne 2009). While 43% of second-generation and Canadian youth had accessed sexual health services, only 27% of longer-term immigrant and 23% of newcomer youth had done so. Reasons given by newcomer and longer-term immigrant youth for not accessing sexual health services were: not knowing about services; not knowing if they would have to pay for services; believing the doctor or clinic staff could tell their parents; being afraid of being judged or embarrassed by peers and staff and fears of racism.

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<sup>10</sup> See WHO Regional Office for Europe website: [http://www.euro.who.int/reproductivehealth/areas/20071101\\_10](http://www.euro.who.int/reproductivehealth/areas/20071101_10)

Service providers offered some additional reasons why newcomer and longer-term immigrant youth may not access sexual health services, including that youth who are non-status might be afraid of being reported to immigration authorities. Service providers also explained that funding policies may mandate service providers to enquire about clients' immigration status but this can 'spook' a young person. As regards features that would make a service accessible, newcomer youth emphasised staff who understand or speak their language and the gender of service provider; Muslim youth emphasised the need for staff to be sensitive to their religion. Project recommendations specific to newcomer youth included the need to:

- Recognise that newcomer youth have to navigate a new and complex system and need support to understand it.
- Train staff to know the confidentiality policies of their agency so that they respect youth privacy.
- Inform youth about their rights and agency complaint procedures.
- Be upfront with youth and/or their parents about how confidentiality is handled.
- Be explicit in all communications that non-status youth are welcome and detail the services offered free of charge.
- Provide sexual health programming for youth and also separate sessions designed for their parents, or invite a sexual health promoter to host sexual health workshops for youth or their parents within migrant youth initiative.
- Build sexual health education into ESL classes and other programmes targeting newcomer and longer-term immigrant youth to ensure they receive the instruction offered in regular classroom settings.
- Refer youth to accessible culturally-relevant services and online sites where they can get more information about sexual health.

*(Flicker et al., 2009)*

Finally, with regard to approaches to researching this issue, EN-HERA (2009a) highlight the following gaps and issues in research on sexual and reproductive health of refugees, asylum seekers and migrants:

- Rigour in definitions followed in relation to immigration status.
- Focus on undocumented migrants and younger migrants.
- Preventative measures, including in relation to unwanted pregnancies, unsafe abortions, sexually transmitted diseases, and sexual and gender based violence.
- Sexual education and the promotion of healthy sexual behaviour.
- Quality of service.
- Understanding health determinants and their interaction, including socio-cultural factors, cultural taboos, political/legal factors, socio-economic factors and personal factors e.g. gender, education and so on.



- Application of social justice orientated methodologies particularly qualitative methods from the perspective of the researched as well as community-based participatory research approaches.

### 1.5 Migrant-specific initiatives in Irish health policy to date

In the Irish context, the report of the *National Intercultural Health Strategy 2007-2012* (Health Service Executive 2008) recognised that people from minority ethnic groups may be reluctant to avail of Ireland's healthcare services because of issues relating to language barriers, poor knowledge of their entitlements, and difficulties in accessing GP services (Health Service Executive, 2008). The report also suggested that young service users from minority ethnic groups may experience feelings of isolation and stress when trying to reconcile cultural expectations with the values of their peer group and therefore may require additional support around their sexual health choices (HSE, 2008). The report acknowledged that for women specifically, experiences of stress, stigma and isolation can be compounded in relation to maternity and reproductive healthcare, rape and domestic violence and unwanted pregnancy and/or sexually transmitted infections arising from sexual violence (HSE, 2008). The report noted anecdotal evidence indicating that migrant women may be forced into accessing unsafe or 'backstreet' abortions. A possible reason proposed related to uncertain residence status/legal status, resulting in a woman being fearful to travel to her home country for a termination, as travelling outside of Ireland may negatively impact on her residence status (HSE, 2008).

In the Irish context a broad range of issues that act as barriers to accessing and participating in health services for migrants and minority ethnic communities have been identified (Pillinger, 2008). Differential rights and entitlements due to a person's residence or immigration status and the operation of the Habitual Residence Condition in Ireland operate as key barriers. Undocumented persons in particular are fearful of accessing health services, including GP services, causing problems in accessing contraception on prescription, reproductive health care and maternity services through the public health system. Women may find the cost of services prohibitive and therefore may either self-medicate or wait until the opportunity arises to return to their home country to avail of treatment there. Lack of information and awareness as to entitlements, and unfamiliarity with Irish health services, in particular the system of primary healthcare, which can be different to the system in women's countries of origin, can act as barriers. Language operates as a key barrier. Finally, a 'them-and-us' attitude was found to exist amongst Irish maternity service providers towards minority ethnic women as service users (Lyons, O'Keeffe, Clarke and Staines, 2008).

### 1.6 Overview and outline of the report

This research is concerned with exploring the meanings young migrant and minority ethnic women aged 18-30 living in Ireland bring to their sexual relationships, sexual health and reproductive healthcare decisions, including contraceptive use, pregnancy and motherhood. It is an exploratory study focusing in on four communities within the

overall migrant and minority ethnic community in Ireland – Chinese, Nigerian, Polish and Muslim – involving in-depth, qualitative interviews with a small number of women from each community to draw out detailed accounts of their experiences, views and needs in relation to sexual and reproductive health. Such an approach generates a nuanced and detailed picture of the particularities and specificities of the risk, care and support needs policy makers and services need to address in the context of a more diverse and transient population.

As stated earlier, comparative to other northern and European countries, Ireland's status as a country of immigration is relatively recent. While a small number of minority ethnic communities have been established for some time in Ireland, ethnic diversity is emergent in Irish society so that many minority ethnic communities are at this time equivalent to migrant communities. Many of the young women in this study are first-generation migrants who have come alone or with families to live in Ireland within the past twenty years or less. Some are second-generation members of migrant families who have settled in Ireland and were born here, educated here and identify themselves as being of Irish nationality. The main purpose of this work is to provide data to promote greater understanding and sensitivity to the specific needs and issues of concern for migrant and minority ethnic women in relation to their sexual health.

Newcomer migrant young women in Ireland are diverse in terms of their countries and cultures of origin; moreover, diversity exists *within* communities as well. Northern Ireland and Britain continue to be the source of the highest number of non-Irish nationals living in the Irish Republic, with the United States, Germany and France also featuring among the top ten sources of immigration. However, significant numbers of immigrants from the twelve countries most recently acceded to the EU (EU12 countries)<sup>11</sup> and the Rest of the World<sup>12</sup> are now present in Ireland. The main channels of legal immigration for non-EU migrants are as work permit holders, through the asylum system, as students or as dependents of legal residents. Legal or residence status is a key determinant of a migrant's entitlements regarding access to services in their host country. Therefore, it is important to be mindful of how migrant women's attitudes and decision-making about their sexual and reproductive lives and health in Ireland are shaped by social, cultural, legal and economic factors.

This report seeks to explore young migrant women's sexual and reproductive health perspectives and needs based on in-depth, qualitative information and considers how legal, cultural, social and economic factors play out in their decisions and practices. Chapter two sets out the methodological approach of the study. Chapter three focuses on cultural issues to explore the meanings and attitudes attaching to female sexuality encountered by the young women in the study within their own families and cultures of origin. Chapter four considers the sex education and knowledge-sources women in the study encountered as they grew up in their country of origin and/or here in Ireland. Chapter five explores women's accounts of negotiating sexual risks as they embark on

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11 EU12: defined as the 10 accession countries who joined the EU on 1 May 2004. (i.e. Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia, Slovenia) and includes the 2 new accession states who joined the EU on 1 January 2007 (i.e. Bulgaria and Romania).

12 Rest of the World includes all countries except the UK, rest of EU 15 and the USA.

their early sexual careers and seek to exercise autonomy and control over their sexual relationships and reproductive capacity. In Chapter six issues raised for women who are becoming mothers in their new country are discussed. Chapter seven discusses women's levels of awareness, access and use of sexual and reproductive health services in Ireland, as well as accounts of using services on a transnational basis or through personal networks and sources outside the formal healthcare system. Chapter eight continues the focus on services to address issues of quality and cultural competency arising in this research. Finally, chapter nine presents the study's conclusions and recommendations towards enhancing multi-cultural competency among sexual and reproductive health policymakers and service providers in Ireland, in recognition of our multi-cultural society.

## 2.0 Research approach and methodology

### 2.1 Introduction

The gaps and issues in research on the sexual and reproductive health of migrant and minority ethnic women discussed in the introduction above centrally informed the approach taken in this research. The underdevelopment of research on this topic in the Irish context means that the study is building on a very low knowledge base, and as such constitutes an initial exploratory research phase. The sensitivity of the topic of interest was a second issue to be considered in carrying out the work. Finally the marginalisation of the population of interest was a third factor in informing our design. Taken together these issues provided a strong rationale for the selection of social-justice orientated methodologies comprising qualitative, interpretive methods designed to empower the participation and perspective of the migrant women through the use of community-based participatory research approaches. The study design, based on participatory research principles, comprised consultation with stakeholder organisations and qualitative, interview-based research with young migrant and minority ethnic women aged 18-30.

### 2.2 Defining parameters of study group

While the focus of the research is on migrant and minority ethnic women aged 18-30 living in Ireland, as we saw earlier the population contains within it many sites of diversity. The study design entailed selecting out groups within the overall migrant population, based on either nationality or ethnic identity, to engage with in an in-depth way. The premise of this approach was that in-depth learning from a purposefully selected sub-set of the overall population would generate insights and understandings of relevance. This contrasts with an approach that would claim to be statistically representative, a claim not made here.

To identify the sub-set of the overall population of young migrant women to focus on in this study, the overall population of migrants in Ireland were first profiled along key top-level variables to identify communities within which our study group (women aged 18-30) was well represented. These variables were:

- Age
- Gender
- Immigration status
- Family status
- Country of origin

Analysis of migration data was drawn from a range of sources including CSO data from both Census 2006 and the Quarterly National Household Survey (QNHS), Garda National Immigration Bureau (GNIB) data for Certificates of Registration issued in 2009 and the annual report of the Office of the Refugee Applications Commissioner. Secondary data sources were also used, including papers on migration in Ireland by the ESRI and

academics writing in the area<sup>13</sup>. Given the salience of language and cultural factors in shaping migrants' access to services we decided to focus only on groups from countries whose first language is not English and who do not share Ireland's white Western cultural perspective. Excluding those whose first language was not English, omitted migrants from Northern Ireland, Britain and the United States. To allow us to explore how salient the issue of legal status and differential entitlement to access services is for migrant women, we also excluded migrants from countries within the EU15. Analysis of immigration trends to Ireland from outside of EU15 and US indicated the following countries of origin to be groups of potential interest for the project:

- Polish
- Nigerian
- Chinese
- Filipino
- Indian
- Pakistani
- Brazilian

Analysis of data available for each national group listed above indicated that feasible population sampling frames in relation to our target age and gender, as well as diversity in relation to family status, ethnicity, migration status and settlement patterns into Ireland would be optimal if we focused on Polish, Nigerian and Chinese communities.

With reference to our overlapping interest in migrant and minority ethnic status, we had noted that international literature indicated the importance of cultural and religious background in shaping attitudes and practices in relation to fertility, motherhood, sexual health and related service use. Specific issues for Muslim women as migrants or residents in non-Islamic states were highlighted in the literature (Dialmy, 2010; Flicker et al., 2009 and Coleman, 2008). Ireland's historically mono-cultural context, for which change is both recent and contested, generated an interest among us in ensuring the perspective of Muslim women would be included in the study. While there is a growing Muslim community in Ireland, no single national group within the migrant community could be identified that would represent a feasible sampling frame. We decided therefore to select a fourth target group based on ethnicity rather than country of origin comprising women of Muslim faith.

Our sampling strategy then comprised targeting women from three national groups: Polish, Chinese and Nigerian as well as one religious/ethnic group, Muslim women, for involvement in qualitative interviews. Meanwhile, we were aware that there was potential overlap between religious, ethnic and nationality identities in our sample, for

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13 Feldman, A., Gilmartin, M., Loyal, S., & Migge, B. (2008) *Getting On: From Migration to Integration*. Dublin: Immigrant Council of Ireland

Joyce, C. (2010) Annual Policy Report on Migration and Asylum 2009: Ireland. European Migration Network. Dublin: ESRI

Quinn, E. (2010) *Satisfying Labour Demand through Migration: Ireland*. Dublin: ESRI

O'Connell, P., & Joyce, C. (2010) *International Migration in Ireland, 2009*. Working paper No. 339. Dublin: ESRI

Ruhs, M (2009) *Ireland: From Rapid Immigration to Recession*. Available at: <http://www.migrationinformation.org/Feature/display.cfm?ID=740>

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example, Nigerian Muslim women, and both allowed for and welcomed this. To facilitate implementing a community-based, participatory research approach, defined regions where our target group were collectively located and organised in significant numbers were sought within which to locate our fieldwork. Looking at settlement patterns for each of our groups within Ireland, we decided to concentrate our fieldwork as follows:

- Fieldwork with the Nigerian community in the North-East corridor from Balbriggan in north County Dublin through to Louth, incorporating the large urban centres of Drogheda and Dundalk.
- Fieldwork with the Polish community in Cork city.
- Fieldwork with the Chinese community in Dublin.
- Fieldwork with the Muslim community in Dublin, where large worship and cultural centres are based.

We were, however, open to including women from across any study site if this was compatible with the overall interests of the study; for example, in working with the Muslim community in Dublin a young Nigerian was identified through our recruitment processes, similarly, when generating a second focus group of Polish participants in Cork posed difficult, one was organised with Polish women in Dublin.

### **2.3 Consultation with migrant rights organisations**

For the first phase of the field research we embarked on a phase of awareness-raising and consultation with migrant rights organisations (MROs) at national level, to further our participatory research principles and increase awareness of the wider applicability of the study to the migrant and minority ethnic community as a whole in Ireland. This had a two-way focus. MROs were viewed as best placed to understand the cultural sensitivities raised by the research and so consulting with them on research design issues would increase the capacity of the research to be culturally appropriate. This in turn would enhance the study's potential success in engaging the target study group in the research process, including generating networks through which the data-collection could be pursued. Furthermore, raising awareness with migrant rights organisations (MROs) on the terms, scope and potential benefits of the research for the study group would pave the way for dissemination of research outputs and the attendant positive change that this would bring for the overall population of migrant and minority ethnic young women in Ireland.

A comprehensive list of MROs was compiled and researchers embarked on a process of telephone and email contact to engage with organisations operating at a national level. The process included one-to-one contact with organisations as well as a public seminar organised in conjunction with Cairde, a community development organisation working to tackle health inequalities among ethnic minority communities, which is funded by HSE East. Cairde has offices in Dublin and Balbriggan. Cairde's Ethnic Minorities Health Forum is a forum of ethnic minority community groups who meet regularly to identify

and address issues that impact on the health of their communities; as such the Forum has a large target group within MRO stakeholders relevant to this study. MROs in the large database of Cairde's Health Forum, supplemented by additional MROs identified as potential stakeholders with an interest in this area, were invited to a seminar as part of the Forum on April 13th 2011. The seminar set out:

- The remit of the research
- Research principles and approach
- Research outputs

The following MROs were represented at the seminar: Cairde; Latvian Embassy; Somali Association of Ireland; Together-Razem (Cork Polish Group); Migrant Rights Centre of Ireland; Exchange House; Congo Lisanga; Horn of Africa People's Association; Afghan Community of Ireland; Southside Chinese Residents Association; New Communities Partnership; and School of Nursing DCU. Issues highlighted by participants included the importance and relevance of the research, a welcome for the approach being taken, cultural sensitivities within different communities and potential barriers to accessing general sexual and reproductive health (SRH) services for migrant and minority ethnic women.

Following the seminar, an email survey was carried out targeting a large sample of MROs purposively selected to reach organisations with a specific interest in health and/or women's issues. The sampling frame comprised Cairde's Ethnic Minorities Health Forum and the Trinity College Dublin Immigration Initiative directory. The following sampling criteria were applied:

- All MROs on Cairde Ethnic Minorities Health Forum list.
- Dublin-based organisations with a health and/or woman specific focus drawn from the Trinity Immigration Initiative Directory.
- All regional MROs.

The survey instrument sought to assess:

- The place of SRH in the remit of the organisation.
- The extent to which sexual health, fertility and/or motherhood issues feature as part of the work of the organisation.
- Aspects of sexual health, fertility and/or motherhood MROs address as part of their work.
- Whether women approach the organisation with issues related to sexual health, fertility and/or motherhood and what issues feature.
- Opinions on what the study should focus on in order to be of benefit to the women they represent.

There was a very low response rate from the survey, with only six completed questionnaires returned. Follow-up work in relation to the survey component indicated that the reason for this was two-fold:

1. Organisations in this sector are stretched in terms of their capacity. Many organisations are staffed by volunteers, and emails may have been received into mail-boxes into which many communications are received and which are checked irregularly.
2. The issues of sexual and reproductive health have not made their way onto the core agenda of many MROs, whose focus remains primarily on right-to-remain issues, followed by provision of advice and support in relation to accessing basic entitlements, for example, welfare and housing. While health service access generally might feature, a particular focus on SRH did not.

Thus, our learning from MROs in this phase of the project was based on multiple data-sources including:

- One-to-one meetings
- Seminar discussion
- Survey replies

#### **2.4 Consultations with 'key informants' in each site**

In general, our consultations with MROs demonstrated that there was both a need for and an interest in an initiative being taken in the area of SRH for migrant and minority ethnic women. The particular research approach of this study was welcomed, as the community perceived themselves as often being a target for research, without much input or perceived benefit. Key insights gleaned from this phase of the research, as well as the low success of our survey element, prompted us to introduce a further local-level consultation element to the study based in each of the four sites listed above. During consultations with AkiDwA, a key migrant women's organisation, staff put forward a proposal to convene a discussion group of what they termed 'migrant women leaders' in our communities of interest. By 'migrant women leaders' we are referring to women who hold positions of community leadership for young migrant and minority ethnic women and girls at local level, similar to the notion of 'key informants'.

The purpose of the discussion group would be to hear the leaders' views on and understanding of the research topic, the issues to be addressed and the approach to be taken in the study. The model appealed to us as a means of consultation and cultural immersion with each group at local level. In turn it offered a very productive entry point for us to connect with women from our target groups at local level, from which a peer researcher could be recruited and networks for recruiting participants generated. Convening a migrant women leaders' forum had been an aspiration of AkiDwA for some time. The opportunity to advance that objective in a way that supported our research, while being mutually beneficial to AkiDwA, was consistent with our participatory research principles.



Convening discussion groups with migrant women leaders attached to our selected communities of interest moved the research into an interim phase between consultation with MROs and interviews with women. It was a key step in our entry into networks through which we could engage both peer researchers and research participants. In addition, the cultural immersion it afforded us generated important information on the context in which young migrant and minority ethnic women negotiate sexuality, fertility and motherhood in Ireland.

The purpose of the discussion groups was to hear the leaders' views and understanding of the research topic, the issues being addressed and the approach to be taken in the study. In turn, the engagement in such a detailed briefing of women involved at community level with our communities of interest would build a strong relationship with women who could facilitate the fieldwork. However, the 'fit' of the model had to be assessed and modified for each of our four constituencies of interest as set out below.

At each group we outlined the focus for the research and our research approach and set out the following themes for discussion:

- Sensitivity of the research.
- Marginalisation of young minority ethnic and migrant women.
- Norms regarding education and openness about sexuality.
- Meanings and place of sexuality in young women's lives.
- Norms in forming relationships.
- Expectations of fertility.
- Norms re family planning including contraceptive use.
- Place of motherhood in women's lives.
- Negotiating sexual relations and safety.
- Knowledge and use of sexual health services.
- Knowledge and use of family planning services.
- Knowledge and use of crisis pregnancy services.

In addition, our research approach was set out, particularly engaging a peer researcher and using network methods of sampling and recruitment of young women for interview, and assistance of the women was sought.

#### **2.4.1 Discussion group - Nigerian/African community**

For this study group we decided to hold two discussion groups - one in Dublin and one in Drogheda. Dublin-based AkiDwA has both strong links and high credibility with women at a national level. Their networks include women-centred MROs working on issues very relevant to the focus of this research. Thus, as well as a discussion group in our fieldwork area, we decided to hold a discussion group in Dublin convened through AkiDwA. This group straddled Phase One - consultation with MROs - and Phase Two - discussions

with women community leaders in our fieldwork area. Ten women attended the Dublin discussion group including representation from AkiDwA, African Women Development Initiative; Diaspora Women Initiative; Integration of African Children in Ireland; African Women in Academia; Women's Integration Network, Athy and *Beauty From Ashes*, NGO Supporting Survivors of Trauma, Domestic and Gender-Based Violence.

Our target area for conducting fieldwork with the Nigerian community was the North East corridor from Balbriggan through Drogheda up to Dundalk, Co. Louth. Cairde Balbriggan, AkiDwA, Louth African Women's Group and Louth Minority Ethnic Consortium were key organisations we liaised with to convene the discussion group for this area. Twelve women attended the discussion group in Drogheda, including representation from Cairde Balbriggan; Migrant Integration and Social Inclusion Programme (MISIP), Drogheda; Culture Connect, Clogherhead; Louth Minority Ethnic Consortium; African Women's Group, Fingal; and Louth African Women's Group. A young woman, Helena Salako, proposed for the peer researcher role by attendees at the group had been recruited as a peer researcher and attended the Drogheda group.

In both the Dublin and the Drogheda groups, there was representation of the Muslim community and issues specific to Muslim women were discussed. A young Muslim woman, Ifrah Ahmed, identified through AkiDwA's networks, was recruited as a peer researcher to the study.

#### **2.4.2 Discussion group - Polish community**

Initial scoping of the Polish community in Cork identified two key MROs for the Polish community there – RAZEM and My Cork. A volunteer in RAZEM, Agata Halas, who was interested and supportive of the project from the outset, was recruited as a peer researcher. The peer researcher for the Polish community in Cork was in place prior to the discussion group and instrumental in convening it. Eight women attended, including representation from RAZEM, MyCork and the Polish Consulate, women who were working in health-related fields in Cork city, and a Polish PhD student looking at experiences of maternity services for Polish women living in Ireland.

A second discussion group for Polish women living in Dublin was held in Parasol, a counselling centre for the Polish community located in the city centre. This arose out of the high level of interest expressed in the project by key contacts in the Polish community based in Dublin with whom we had engaged during Phase Two of the study. Five women attended, including a journalist with a Polish newspaper, *Polski Express*; a Polish staff member of a Crisis Pregnancy Programme funded service; a woman who conducted a course in natural family-planning methods through the church and a Polish woman living in Ireland pregnant with her second child. A member of Parasol, Aleksandra Hytros, was recruited as a supplementary peer researcher for interviews with Polish women in Dublin.

### **2.4.3 Discussion group - Muslim community**

The Islamic Cultural Centre of Ireland (ICCI) was identified as a key contact point for the Muslim community, given the presence of a Women's Coordinator in the Centre, as well as high levels of interest in the research. The Women's Coordinator generated a group of twelve Muslim women from a variety of backgrounds to participate in a discussion group held at ICCI. The discussion group was attended by women from a range of backgrounds including Palestinian, Egyptian, Nigerian, Iraqi, Libyan, Sudanese, and Pakistani. A young woman, Sarah El Habbash, nominated by member/s of the group, was recruited as a peer researcher for the study.

### **2.4.4 Discussion group - Chinese community**

While Cairde's health worker for the Chinese community came on board the project in the early stages, it was not possible to engage other Chinese-specific MROs in the study. There is no identifiable support group for the Chinese community with a remit in or close to this area. Instead, we identified key contacts of individual members of the Chinese community who are in academic, voluntary and/or employment positions that facilitate knowledge of issues faced by the community. Key contacts identified included: the Information Officer in Crosscare's Migrant Project, who authored a minor thesis and research article on identity among second-generation Chinese people in Ireland; a Chinese PhD student in Trinity College Dublin Immigration Initiative; and an International Student Officer in a Dublin college.

Convening a group for a workshop or discussion for the Chinese community was discussed with these and other contacts, such as a Chinese GP. However, bringing people together was a challenge. The consensus among individual members of the community we explored this with was that such forms of civic engagement as participation in research is not culturally familiar to the Chinese community. Free or leisure time is not a strong feature of people's lives so as to allow them availability to make such contributions. For this reason, in the case of the Chinese community a migrant women leaders' discussion group was not possible. Rather, consultations to explore cultural issues as well as to build networks for identifying peer researchers and research participants were conducted on a one-to-one basis rather than in a group format, as was the case for the other three target groups.

A young woman, Chenmeng Zhang, nominated by one of the key contacts from the Chinese community, was recruited as a peer researcher for the study.

## **2.5 Qualitative interviews with migrant and minority ethnic women aged 18-30**

This final phase of the study involved generating in-depth information from the perspective of migrant, minority ethnic women living out fertility, sexuality and (prospective) motherhood in their everyday lives with a targeted, sub-set of the overall population. A key feature of this element of the study was the involvement of peer researchers.

### 2.5.1 Peer researcher involvement

It was proposed from the outset to involve a peer researcher working with the two lead researchers and to generate interviews with women in a multiple of qualitative formats. As described above, peer researchers were generated through our network-building with each community in turn. In the case of the Nigerian and Chinese study groups, all the fieldwork took place in one site and one peer researcher had the capacity to undertake all interviews. In the case of the Polish study group, interviews were conducted in both Dublin and Cork and so two peer researchers, one in each site, were recruited. For the Muslim community, one young woman who was a second-generation 'newcomer' to Ireland was recruited through the ICCI, while a second young migrant Muslim with wider and active connections with migrant rights' organisations and networks was also recruited. We considered the variation in both women's locations within the Muslim community would allow for diversity in the Muslim women recruited for the study.

Peer researchers could offer participants the option of being interviewed by a person who shared some common experiences and identities in either their native language or English. The role of peer researchers was considered to be crucial in allowing research participants control over how and who they told their experiences to, given the power differential between the two principal researchers, as older, white Irish, academic/professional, host-population members, and young black migrant research participants.

Meanwhile, migrant women leaders had cautioned us, as research professionals, to ensure that when engaging peer researchers, conditions of work, particularly in relation to remuneration, needed to reflect the skill and labour entailed in their work. Thus pay scales of research assistants in academic positions were adhered to in setting hourly rates of pay for peer researchers engaged in the study.

Peer-researcher training took place at the end of May 2011 with an intensive day of training delivered by the two principal investigators (PIs). The training covered the following areas:

- Introducing ourselves and the study
- Role of peer researcher in the research approach
- Focus groups: overview of method and role-playing
- One-to-one interviews: overview and role-playing
- Review of interviews, recording and note-taking
- Ethical concerns
- Engaging participants, preparing for focus groups/interviews. Agreement on support needs for peer researchers

Peer researchers were de-briefed after interviews and transcripts were reviewed and feedback given for quality control. Interviews by principal investigators were also transcribed by peer researchers, which allowed for learning from PI interviews.

### 2.5.2 Qualitative interview data-set

The data-set proposed for the study comprised two focus groups and between five and seven one-to-one or friendship-pair interviews from within each community. A multi-pronged approach to engaging women in focus groups, one-to-one or friendship-pair interviews was taken, with participants themselves nominating which format of interview they had a preference for. Recruitment procedures for participants involved:

- Network or snowball sampling through MRO representatives attending discussion group
- Network or snowball sampling through peer researchers
- Network or snowball sampling through other MROs engaged in other phases of the research
- Using social media targeting our community of interest

As mentioned above, the data-collection focused on selected sites to make the sampling process manageable and to facilitate achieving heterogeneity. As samples were generated they were continually assessed to see what social locations were occupied by the women who had participated (for example, legal status, language competency, education level, social class) and to identify what locations, we needed to target to achieve as diverse a sample as possible. When a particular characteristic was found to be missing in the sample, for example, undocumented worker, the networks built up by the researcher in the specific site would be pursued and snowballed out to strive to reach someone in such a situation. Some communities and cultures had much better established and more diverse networks than others, which were more insular and individualised, usually reflecting cultural practices as well as stage of integration and establishment in the Irish context. This meant that achieving heterogeneity within some groups was more difficult, placing limitations on samples *within* groups. However, *across* the sample, strong heterogeneity was achieved, as illustrated by the tables in Appendix 4. While we do not claim representativeness for the sample, we would consider that we reached a diverse enough group to have the various social locations of migrant and minority ethnic women aged 18-30 feature in the study group.

**Table 2.1: Overview of qualitative interview study group [See Appendix 4 for detailed data-set]**

Group	Focus groups	One-to-one	Friendship pair (N=2)	Total N
Nigerian	3 (N=16)	5	1 (N=2)	23
Chinese	2 (N=13)	6	1 (N=2)	21
Polish	2 (N=10)	9	0	19
Muslim	2 (N=12)	6	0	18
Total	9 (n= 51)	26	2 (N = 4)	81

The diversity of approaches to interviewing meant that altogether 81 women were involved in interviews, a relatively large number for a study of this kind. The sample size for each study group - ranging from 18 to 23 - was sufficient to meet the data requirements for a qualitative research study in their own right. When taken together, we consider the overall data-set makes for a very comprehensive qualitative research data-set.

### 2.5.3 Approach to interviewing

Pursuant to the participatory and grounded or open research approach underpinning this study, interviews were carried out in an unstructured way so as to allow participants to direct how they responded to the research questions. Rather than administering a structured set of questions to participants, researchers would outline to each woman the concerns that framed the research at the start of the research interview or conversation and then proceed through an unstructured discussion led by the woman participant. Meanwhile, researchers would retain key reference points framing the interview and use these to keep the interview 'on-track'. De Vault and Gross characterise such an approach as:

*A process of seeking meanings together ... the researcher share[s] with the interviewee the concerns that animate the research, so that the conversation can unfold as a collaborative moment of meaning making. (2007: 181)*

Women were told of the focus of the study and invited to recount the key issues, attitudes and experiences they considered relevant following their own narrative (in pair/individual interviews) or group dynamic (in focus group interviews), having regard to the focus of the study. Participants determined the duration and scope of the interview. This meant that in some cases women did not discuss particular aspects of their experience, either because they did not want to discuss it or did not themselves consider it to be relevant. Given the sensitivity of the topic, participants in individual interviews sometimes became emotional or upset, and this was acknowledged and discussed by the researcher; women were given time to release these feelings and recover.

Each of the three interviewing methods used in the study generated particular kinds of data and insights: focus group interviews involved the young women in a peer discussion

focusing principally on the socio-cultural factors shaping their practices, views and experiences, rather than detailing personal experiences; individual one-to-one interviews focused more on personal experiences and reflective insights women had gained through these; friendship-pair interviews incorporated personal experiences and references to socio-cultural influences shaping their sexual and reproductive lives. During analysis it was clear that there were very useful and productive synergies across each of the types of data that at times could clarify, confirm and/or contextualise issues discussed.

As mentioned earlier, women could opt to participate in interviews in their 'native' language or in English (if these were different). Within each group some women opted to be interviewed in their own language: two of five one-to-one interviews with Nigerian women were carried out in Yoruba; four of seven one-to-one interviews with Chinese women were carried out in Mandarin, while both focus groups were bi-lingual Mandarin/English; seven of nine one-to-one interviews and both focus groups with Polish women were carried out in Polish, and one focus group with Muslim women was bilingual, while one of the six one-to-one interviews was conducted in the woman's native language. In qualitative research, interviews translated from languages not native to or spoken by those interpreting the data can raise issues regarding the capacity for the full meaning to be conveyed and understood. In this study all native language interviews were conducted by the peer researchers, who went on to translate them. As peer researchers were well informed of the focus of the study, their translations not only converted the meaning into English but also contained elaborations to convey the fullest meaning with reference to the research topic. This meant, for example, that where euphemisms or culturally specific references featured in the conversation, peer researchers would draw out the fullest interpretation in translation. At the same time, literal translations were left, to allow the native Irish researchers to understand how sexual matters were 'framed' in the woman's native language and culture. We consider that these features of our research approach did make for more meaningful access to cross-cultural understandings. They also allowed women potentially most excluded to take part and gave the researchers very 'close' understandings of the cultural meanings attaching to sexuality among the communities of women studied.

## **2.6 Data-analysis process**

For analysis, all interviews were transcribed, and anonymised to remove all identifiers of the participant. Transcribed interviews were imported onto the qualitative data-analysis software NVivo for analysis. The primary analytical procedure was to code interviews for key themes combining both a deductive and inductive approach. Deductive coding involved having regard to the aims and objectives of the study and coding data for key categories addressing these issues. Inductive coding entailed identifying issues arising from women's talk that neither the aims and objectives nor research literature had anticipated but which we identified as illuminating new understandings of the research topic. The three authors, including both principal investigators, were involved in coding and interpreting the data, with cross-checking of coding the principal means for inter-coding reliability.

Key codes were collated to build core explanatory categories and the data from each interview relating to these categories were assembled to understand the dimensions of the category. A principal means of understanding the data was to compare and contrast what each category meant to individuals as well as our four groups to have regard to the particular situations of each participant and national or ethnic group.

### **2.7 Ethical and quality issues**

Ethical approval for this study was secured from the Irish College of General Practitioners (ICGP), ensuring processes followed in data collection, processing and storage adhered to rigorous ethical standards. In following participatory research methods and principles, particularly in the close involvement and engagement with representative groups of young migrant women within our target communities of Polish, Muslim, Nigerian and Chinese, we sought to conduct this research in an accountable way, which we consider strengthens it both in terms of ethics and quality.

### **2.8 Overview of methodological approach to the study**

The underdevelopment of research on this topic in the Irish context means that the study is building on a very low knowledge base and as such constitutes an initial exploratory research phase. The sensitivity of the topic of interest and marginalisation of the population of interest were further issues to consider in the design of the study. Taken together these issues provided a strong rationale for the selection of social justice orientated methodologies comprising qualitative, interpretive methods designed to empower the participation and perspective of the constituency of interest through the use of community-based participatory research approaches. The study design then comprised:

- Consultation with stakeholder organisations for cultural immersion in the topic and to assess the cultural appropriateness of the research approach
- Engaging peer researchers
- Qualitative, in-depth interviews with a sample young migrant and minority ethnic women aged 18-30

Selection of a sample of migrant and minority ethnic women for this study had regard to how the population contains within it many sites of diversity. The premise of this approach is that in-depth learning from a purposefully selected sub-set of the overall population would generate insights and understandings of relevance. This contrasts with an approach that would claim to be statistically representative, one not made for this study. We were also cognisant of how Ireland's status as a country of immigration is relatively recent. While a small number of minority ethnic communities have been established for some time in Ireland, ethnic diversity is emergent in Irish society, so that many minority ethnic communities are at this time equivalent to migrant communities. Many of the young women in this study were first-generation migrants who have come alone or with families to live in Ireland within the past twenty years or less. Some were second-



generation members of migrant families who have settled in Ireland and were born here, educated here and identify themselves as of Irish nationality. Overall, however, it is important to bear in mind that the communities women were drawn from were essentially migrant communities.

Analysis of data available for migrant nationalities other than EU15 States and the United States indicated that feasible population sampling frames in relation to our sites of interest (such as age, diversity in family status, migration status etc.) would be optimal if we focused on Polish, Nigerian and Chinese communities. We selected a fourth group based on ethnicity rather than country of origin, comprising women of Muslim faith. The Muslim community have a long-established presence in Ireland, which meant that not all women in this group were migrants: some were second-generation 'newcomers', who had been born and educated in Ireland.

Fieldwork was based in defined regions where our target group are collectively located and organised in significant numbers. This facilitated implementation of the community-based participatory research approach. Looking at settlement patterns for each of our groups within Ireland, we concentrated our fieldwork as follows (with some flexibility allowed for within in our sampling procedures):

- Fieldwork with the Nigerian community in North-East corridor from Balbriggan in north County Dublin through to Louth, incorporating the large urban centres of Drogheda and Dundalk
- Fieldwork with the Polish community in Cork city
- Fieldwork with the Chinese community in Dublin
- Fieldwork with the Muslim community in Dublin, where large worship and cultural centres are based

The first phase of the field research entailed a phase of consultation and awareness-raising with migrant rights' organisations (MROs) at national level. This had a two-way focus. MROs were viewed as best placed to understand the cultural sensitivities raised by the research, and so consulting with them on research-design issues would increase the capacity of the research to be culturally appropriate. This in turn would enhance the study's potential success in engaging the target study group in the research process, including generating networks through which the data collection could be pursued. This exercise generated some very useful insights but was limited in its effectiveness. Reasons identified for this were that organisations in the sector are very stretched in their capacity and that the issues of sexual and reproductive health (SRH) have not made their way onto the core agenda of many MROs.

Taking a more targeted approach, then, we undertook a phase of detailed consultations with 'key informants' for our target groups in each study site. Discussion groups of 'migrant women leaders' in our communities of interest allowed us hear their views on

the research topic, the issues to be addressed and the approach to be taken in the study. This allowed for detailed consultation and cultural immersion with each group at local level and an assessment of the cultural 'fit' of our research approach. In turn, it offered a very productive entry point for us to make contact with women from our target groups at local level, a place from which a peer researcher could be recruited and a way of accessing networks for recruiting participants. This model was followed with Nigerian, Polish and Muslim women, while individual consultations were carried out with key informants of the Chinese community, reflecting the responsiveness of the study to the cultural contexts of each study group.

In the final and core stage of the project in-depth interviews were carried out with a total of 81 women participating in either one-to-one, unstructured interviews (N=26), friendship-pair unstructured interviews (N=4), or focus group interviews (N=51). Interviews were carried out in an unstructured way so as to allow participants to direct how they responded to the research questions. Peer researchers were engaged in this phase of the study and all participants were offered the option of being interviewed by a peer researcher, including the option of being interviewed in their own language.

All interviews were transcribed, and anonymised to remove all identifiers of the participants. Transcribed interviews were imported onto the qualitative data-analysis software NVivo for analysis. Coding of interviews was both deductive, having regard to the aims and objectives of the study, and inductive, identifying issues arising from women's talk that neither the study's aims and objectives nor research literature had anticipated. A principal means of understanding the data was to compare and contrast what each category meant to individuals as well as our four groups, to have regard to the particular situations of each participant and national or ethnic group. Consultations with representative organisations and the use of participatory research methods and principles enhanced the accountability of this research process and in turn its ethics and quality.

### 3.0 Cultural meanings of female sexuality, fertility and pregnancy

#### 3.1 Introduction

This chapter describes the key messages and practices regarding female sexuality the women in the study group acquired in their particular cultural settings of origin. It includes socialisation and emerging understanding of gender roles and responsibilities, as well as the means of 'transmission' of such messages. Understanding the particular meanings attributed to female sexuality in the diverse cultural contexts of migrant and minority ethnic women reveals commonalities and disparities between the dominant Irish and newcomer and/or minority ethnic cultures that make up contemporary Ireland. Key messages about female sexuality and expectations of contexts in which women would become mothers are described, and particular issues for sexual and reproductive health policy and services are highlighted. References to traditional practices such as female genital mutilation (FGM) or testing for virginity feature, as well as practices such as hymen reconstruction. These demonstrate the importance of sexual and reproductive health services in Ireland becoming aware and knowledgeable of particular global sexual and reproductive health issues.

#### 3.2 Key messages about female sexuality, fertility and pregnancy

Dispersed throughout women's narratives on sexuality, fertility and motherhood was the influence of social, cultural, political, economic, and religious mores on their upbringing, their sexual knowledge and education, their sexuality, and their development as a woman. Despite the diversity of backgrounds among the study group there was consensus among women that the issue of sexuality had not been directly or openly discussed within their families or communities as they were growing up:

*No our parents didn't talk to us about sex at all. We give them a lot of respect so it's very difficult to sit with them and discuss such things. Any child that discussed sexual issues is seen as wayward.*

[Suliat, Muslim, aged 26]

*J: Oh I'm very shy, I'm shy of myself, of being naked, of my sexual preferences and I normally don't talk about sex because I'm even shy to think about sex. [Laughs]*

*I: Where do you think it comes from?*

*J: Yes, maybe because I'm not well educated. For me it's kind of taboo. That's the way I was learnt at home; we didn't talk about it.*

[Julita, Polish, aged 23]

Women's sexual behaviour as reflecting not just on herself as an individual, but on her family, friends and wider community was a feature of the cultural framing of sexuality, also described by women. The notion of being a 'good girl' recurred many times throughout the narratives of young women across the study, again regardless of origin. The meaning it carried was that a young woman needs to maintain a certain standard with

regard to her sexual behaviour, and to ensure that her reputation remains intact. Chinese, Nigerian, Muslim and, albeit to a lesser degree, Polish women agreed that according to their cultural norms, the expectation is that women will wait until they are married before they start having sexual relations. The concept of being a good girl was described by Mei, a Chinese woman, as the main message regarding female sexual behaviour:

*Because I think, em, most parents told us about that, if you think like this [have an interest in sex], is not good girl.*

[Mei, Chinese, aged 29]

The notion of the 'good girl' was also referred to by Changying, in terms of Chinese people's attitudes to women going out with Irish men:

*They have this view that if a girl hangs out with foreigners, she is not a good girl.*

[Changying, Chinese, aged 22]

Women in the Muslim group described the particular meaning sex and motherhood outside of marriage carries within the community and how it is forbidden in Islamic law. However, as Marjana below described, young women have the capacity to reconcile the teachings of Islam with how sexuality is inherent in humanity:

*M: Most Muslims are celibates and they follow through that. It's a very small, small majority of people that would have a baby outside of marriage.*

*I: And what happens if a girl gets pregnant outside of marriage?*

*M: Like in any community you will be frowned upon. People are gonna frown upon her in this society cause now she is another statistic, another teenage statistic. They are going to look at her like this in a society. But then if you're going to make it smaller and you're looking at the Muslim society, then they're going to frown upon her in an Islamic way. They're going to tell her what she did is haram [forbidden in Islam], and it defies against Islam, and she is wrong. There is going to be people talking behind her back. There's going to be bad looks and people whispering, name calling, etc. But I don't agree with this. I think everybody - I'm a Muslim and I've made mistakes - but we're all humans and if the girl has sex outside of marriage then it's just another mistake. And if she really means that she's sorry then she is sorry. I don't get this just keep reminding her, 'You did this, and you did this', you know what I mean. She's at such a sensitive age in her life and if you're going to keep adding on to it then you will push her away from the religion. You will push her. But if the Muslim community took this girl in, got her to talk to the Imam, tell her what the Quoran says about celibacy and maybe give her a lecture and maybe get her to attend some seminars on the issue, instead of looking down upon her and judging her. Because if you do that you will push her further away from the religion and that's the worst thing you can ever do. So I disagree with that and I would never frown upon someone who had a baby outside of wedlock.*

[Marjana, Muslim, aged 18]

For women across all of the groups messages regarding appropriate sexual behaviour for women were imparted at home and through other key social and cultural institutions such as school or church:

*W: I also think that the Catholic Church had a huge influence on this. The Church used to play a moral role, I don't know if it still does but then it was showing us the model that a woman should be such a person: she should respect herself, sex outside of marriage wasn't allowed, and it all formed the sexuality.*

*I: In what way?*

*W: For a very long time I was thinking that sex outside the marriage is not good....*

*[Sighs] For a very long time.*

*(Weronika, Polish, aged 30)*

*Q: I think in China, apart from parents who don't like the idea of girls being in a relationship or anyone in high school being in a relationship, the school you are in might also have problems with students involved in relationships. When I was in high school, there was a rule in school that boys and girls shouldn't be too close. If they ever found out, they would take points off from your exams. Or you would be expelled from the school, the worst case.*

*I: Are schools normally so strict?*

*Q: Some better schools. Yeah, it depends. There were still some students - rebels - they acted against the rule.*

*I: That's very strict. So school is using a threat?*

*Q: In our traditional views, we shouldn't be too close with boys in high school ... it's like the culture.*

*(Qingzhao, Chinese, aged 24)*

Li related the case where Chinese schools take a role in monitoring sexual relations to parents' interest in high educational attainment for their daughters:

*Because 18 is during high school, the last year of high school, and they think you should focus on your studies and especially in China the students have a lot of pressures to go to the top universities. And if you want to go to a good university you have to study very hard. And the parents always think that if you fall in love with someone you can't focus on your study and you will think about other things. So it will waste a lot of time. And if you chat with your partner, and chat with your boyfriend, that will waste a lot of time. And they will forbid this, so, if they find out, you are having some feelings for someone, they will talk with you, they will say no, you can't do this, you are still too young, and you don't know what love is and you should just study, and maybe when you go to a good university at around 20 or 21, you can start to date with a boy, or something like that.*

*(Li, Chinese, aged 25)*

What is interesting about this feature of Chinese's women's sexual socialisation for this study is the extent to which intimate relationships are monitored, as well as being deferred until much later than in the Irish context. Other women in the study group confirmed Li's account of dating starting in late teenage years or early twenties for Chinese women.

Nigerian women, too, described a very strong emphasis among parents on their education and the threat posed to their life chances by relationships with boys, becoming sexually active and the risk of pregnancy:

*Like, the Nigerian community is, like - I think the African community in general is the same, like. Like, where we come from is, like, just, like, you go to school, you don't - you just get good grades and stuff. And, like, one thing my mum likes to do, she likes to compare me - like my cousins and stuff, back in Nigeria, and just be like, 'Look at your cousin here: she just finished last year and doing medicine,' and stuff. And, like, I would just take that in; I would just feel really bad, and I will just keep going and I will just feel like I have to keep going and my - then my education is important.*

(Ivie, Nigerian, aged 19)

Specific to the migrant experience, there was a sense among Nigerian women interviewed that an additional burden of responsibility was placed on daughters to optimise the educational opportunities offered in their new country, by parents who perceived these as opportunities their decision to emigrate had created for them.

*It is all about bringing shame to your family. Because when you come over here, people over in Africa they feel, they feel like you have everything here. Like you should be on top of it. Like you should be the smartest. You should have all the money. You should have all the cars and stuff. Once they hear that your own daughter is pregnant: oh you brought shame. Even when you were back there, people don't get pregnant. You come here, you get pregnant, they feel like that is all - what you have been doing with your life over there? Basically, they blame your parent as well as - 'cause your parent also have parent, and they have extended family as well. So it doesn't reflect alone on your parent. It reflects on everyone as well. Yeah, back home also.*

(NFG 3, aged 18-20)

Another form of monitoring young women's sexual activity to ensure chastity that featured in this study was the practice of testing for virginity, which was personally experienced by Suliati, a Nigerian member of the Muslim group. She had grown up in North Africa and described how her mother had once used a traditional method of testing for virginity when she suspected her of having spent time with boys. The interview was carried out in her own language and the term 'de-virgined' is a literal translation of the term used by Suliati:

*S: I remember an incident which occurred sometime while in school. I went out with my friends and came home late. My mother had been expecting me. On arrival, she [...] said I've been sleeping with boys. She said I'd been de-virgined and insisted on testing me.*

*I: So how did she test you?*

*S: She inserted an egg in my private and said if the egg had a free passage then I've had sex and if not she'll let me go.*

*I: If I can ask, did she put the egg in your private?*

*S: Yes she did. But the egg didn't get through so she left me.*

(Suliat, Muslim, aged 26)

Chinese women described the pressure on a woman not to be sexually active before marriage. Otherwise, she is seen as having lost her value, both in material terms and in terms of her and her family's reputation, termed as 'losing face'. In a culture where 'dowry' exchanges at marriage are still practised, women described an attitude among their parents' generation that a woman who is no longer a virgin has less value so she and her family will receive less money from the man's family on marrying:

*A lot of parents will say that if their daughters have a sexual relationship before they get married, they will think it's losing face and, yeah, they will think this girl has no personal value, and they will think she has lost her virginity, so from the boy's viewpoint, they will they will look down upon her. So they will just maybe get married, they will not agree with requirements or something like that. You know, in China, because when we get married, the boy should give the girl some money.*

(Li, Chinese, aged 25)

Changying noted that many of her friends from her area in China believed that losing their virginity before marriage undermined their social standing and negatively affected their marriage prospects. The strength of this meaning in Chinese culture is underscored in particular by the recurrent references to 'hymen reconstruction' among the young Chinese women interviewed. Hymen reconstruction is a surgical procedure to replace the hymen, which according to the Chinese women's accounts was carried out in order to conceal previous sexual relations by young single women. Undergoing surgery to reconstruct their hymen so as to conceal prior sexual experience to avoid being rejected by a prospective suitor for marriage was described as an active feature of how young Chinese women manage their sexual reputations:

*Where I am from is really small. A lot of my friends, like the one who had the abortion, after she broke up with her boyfriend, she was so upset, she was worried that she wasn't a virgin any more, and she had the abortion; nobody would want her in the future ... I told her it's her decision to do hymen repair but I would never want a boyfriend like that. I also told her not to stay in [our town], that little place, all her life. She should go out and see different things. Not all the guys are like the guys from my*

*region; not all the guys are so narrow-minded. Because she wasn't the only one who told me the same worries. Every female friend of mine, they told me the same thing after they lost their virginity. They were like, 'What can I do? I am not a virgin any more, I can't find a boyfriend in the future.'*

(Changying, Chinese, aged 22)

*L: And they always think that you are losing the value. So if you depart from your partner, and if you go to find another boyfriend, you always can't find the good one because you have lost your virginity, so it's not a good girl any more.*

*I: So you're not a good girl any more. Is that a big thing, to be a good girl?*

*L: Yes, I think so. And you know, this is very sensitive, sensitive topic in China, and especially for the girls who will get married. They always want their partner to think they are a virgin and they didn't have sex before and even though they have. Because you know nowadays in China, a lot of hospitals they can just do some surgery and to make you have...*

*I: Hymen?*

*L: Yeah, again.*

...

*L: And you know, the very strange thing is that in China, their boyfriend, and they always think that if we split up some day later, and I will do such hymen surgery. So no one will find this out. I think in a kind of relationship, you shouldn't have this kind of worry because they should be normal and such. Like in western countries, if you have sex before marriage, no-one will just look down on you, right? They will think you are normal; you are still a very good girl. So I think this is not a very good thing.*

(Li, Chinese, aged 25)

The importance of forming a marriage in Chinese culture is underscored by Yuan's declaration that if she was not married by age 30 she would accept an arranged marriage:

*Y: But, but you can't deny that girls are more popular before they reach the age of 30. No matter in China or in Ireland, it's the same.*

*I: You mean you can find someone better if you are younger?*

*Y: I still want to ... before 30.*

*I: You have the sense of crisis?*

*Y: Absolutely. There is a deadline. If I am approaching the deadline and I still haven't found anyone, I will go for a blind marriage.*

*I: Arranged marriage?*

*Y: Yeah, yeah. I would sometimes think about those things.*

(Yuan, Chinese, aged 24)

The importance of marriage for women, and in turn the importance of 'chastity' in order to be deemed 'marriageable', also featured among Nigerian participants. Young friends Nimma and Asa, aged 18 and 20, referred to how having a child before marriage would diminish a woman's chances of marriage and be imputed against the character of her family:



*N: Because, you know, [with] Nigerians it's all about culture. This family is not a good family - they will tag you. You're not well brought up. You will be looked at - you will be like a reject.*

*I: A reflection on your parents?*

*A: Because marriage is a thing that they would go to your family and find out what kind of family you are living in and how you were raised - if you were a well brought up child and all that. When you have a child the chances of you getting married is very slim.*

*(Nimma and Asa, Nigerian, aged 18 and 20)*

This indicates the sense of broader social ownership over women's sexuality: a woman's sexual behaviour reflects not just on herself as an individual, but on her family, friends and wider community.

Of the women represented in the study, it was Polish women who were more likely to consider that attitudes were changing in their cultural context, so that chastity and marriage were no longer central to the life chances and reputation of women and their families. Malina attributed such changing attitudes to the opening up of Polish society to outside social and cultural influences post 1989, after the fall of communism in Poland and across Eastern Europe in general:

*But it was that girls who were sexually active early were called harlots, seen in a bad light. Upbringing has a lot to do with it: In some families it would be seen as OK - it happened, we will not cry over it, but in some you could have nearly been cursed.*

*(Malina, Polish, aged 27)*

She described how she and her mother held different attitudes towards her sister becoming pregnant:

*Parents were always saying that you have to start a family from that proper-good side: first marriage, then children. In our family three older kids started from this side, the youngest sister started from getting pregnant, and then marriage. My mum was calling me here in Ireland saying that child we have a problem, so I was saying to her, 'Mum, what problem?' I was expecting it and my Mum was crying, but I smiled and said that Mum we live in different times now, secondly it's a reason for joy, that you may have another grandchild, be happy that she didn't decide to do the abortion. For me it's not any reason for shame...*

*We cannot reject a girl who got pregnant because she puscila się - offered herself sexually. We don't live in times like that. But I think that it's changing for kids born after 1988. It becomes more tolerable because of people going abroad. It's more tolerable that there are couples who live without the marriage, cohabiting.*

*(Malina, Polish, aged 27)*

From the discussion above, we can see some issues common among women across the study group as a whole, including how the issue of sexuality had not been directly or openly discussed in their home, the pervasive emphasis placed on being a 'good girl', regardless of cultural location, and how sexual propriety or transgression by a woman reflects not just on herself as an individual, but on her family, friends and wider community. Key messages were imparted at home and through other key social and cultural institutions such as school or church. Muslim women depicted sexual intimacy or motherhood before marriage as forbidden in Islamic law. Chinese women described extensive involvement of schools in managing young women's sexuality, suggesting that chastity and educational attainment for women are both related to how a woman is 'valued'. The 'risks' posed to a woman by 'transgressing' norms of chastity were related to life chances, particularly educational attainment, and also prospects for a good marriage. In the Chinese context where 'dowry' exchanges at marriage are still practised, women described an attitude among their parents' generation that a woman who 'loses face' sexually, 'loses value' in dowry or monetary terms on marriage. Among Chinese women references to 'hymen reconstruction' featured as a way of managing the implications of sexual experimentation before marriage. The risk of pregnancy associated with young women's sexual activity was characterised as posing risks to women's life chances, particularly in relation to educational attainment. While we saw this already featuring for Chinese women, it was also a marked feature of Nigerian women's accounts. This was related to the importance of taking educational opportunities offered in the host country has for migrant families, who see this as a form of confirmation that the efforts they made to relocate their family are worthwhile. Meanwhile, Polish women were more likely to consider that attitudes were changing in their cultural context, so that chastity and marriage were no longer central to the life chances and reputation of women and their families.

Despite the diversity of backgrounds of the women interviewed, a common feature of socialisation regarding sexuality was that as young girls they intuitively came to know key messages, such as it is girls' specific responsibility to control sexual morality, contact with boys is censured and contingent on girl's behaviour, and pregnancy threatens life chances and the respectability not only of the girl but also her family and even her wider community, and it was her duty to avoid this. Issues relating to sexuality were often communicated through indirect or implicit means in all of the cultural contexts represented in the study. However the 'unspoken rules' were made very clear. Women from each of the diverse national, cultural and ethnic backgrounds represented in the study noted a strong, explicit association of fear, shame and guilt with sex and pregnancy before marriage in the cultural messages they received. It is interesting to relate these findings to Mayock et al.'s (2007) depiction of the Irish context, wherein they described how influences on young people's sexual lives are clearly not restricted to explicit or formal messages about sex; instead, they are embodied in an array of subtle and complex forms of communication and are shaped by gender and social positioning. Daughters' sexuality was more likely to be regulated by parents through messages of abstinence

and chastity, while sons tended to be cast as sexual predators, who needed to protect themselves against the unwanted consequences of sexual activity (Mayock et al., 2007: 20).

Women across the study described coming from cultural contexts wherein female sexuality is highly monitored and where women's social value is contingent on their marital prospects. Female sexual chastity and high educational attainment are two key sources of capital in a context where marriage is highly valued and power and control in the making of a marriage are vested in the male. It is interesting to note how migration itself can create a particular pressure in relation to avoiding non-marital pregnancy. The meaning suggested is that migrant families are expected by those 'back home' to progress and succeed and so a daughter becoming pregnant is a greater 'failure'. This creates particular conditions for the prospect of a crisis pregnancy among young migrant women.

### 3.3 Gendered nature of sexuality

A key feature of the discussion above was the way in which sexuality is gender, and power in the field of sexuality is distributed asymmetrically between young women and men. Social meanings of female (hetero) sexuality have been found in many studies to differentiate by gender so that masculinity and femininity are intertwined with sexuality in particular ways (Hyde and Howlett, 2004; Jackson, 2006; Holland et al., 2003 and 1998; Schefer and Ruiters, 1998; Lees, 1993). Holland et al. (2003) describe it thus:

*Modest femininity [that] requires a young woman to construct a disembodied sexuality rather than actively embodying feminine sexuality (2003, 85).*

This raises concerns for the extent to which young women can exercise control over their own sexual bodies and sexuality. Sue Lee's (1993) seminal study of young women's (hetero) sexuality argues that sexual behaviour is formed by powerful social discourses rather than biology (Lees, 1993: 48). Holland et al. (1998) argue that heterosexuality is masculinity, as models of adult heterosexuality shore up hegemonic masculinity. These discourses construct the male as agent and female as potential victim in a model of heterosexuality involving both physical and moral danger (1998:56). Heterosexuality has been identified as a site for the asymmetrical exercise of power on women's bodies through constructions of passive and disembodied femininity in contrast to active, embodied masculinity. Holland et al. (1998: 68) argue that a male sexual discourse dominates and circumscribes the form and content of 'girl talk'. They argue that young women experience and respond to social pressures to construct their bodies as passive, fragmented, and located in the here and now. Such disembodiment and location in the immediate leaves many young women unprepared to become or recognise themselves as sexual (Holland et al., 2003: 85).

When contrasted with young men's sexual talk, Holland et al. (2003) found young men presented themselves as embodied sexual actors, commenting that:

*It might seem that nothing could be more embodied than the female reproductive function: menstruation, fertilisation, growth of the foetus within the body, [and] birth ... [yet] in the social construction of sexuality it is the male who is embodied – in his body – and the female who is disembodied (2003: 88).*

Polish Weronika's account of her understanding of how she should behave in relationships with boys reflects such a perspective. She described always keeping young men at a distance and putting up a barrier so that no man could get close to her, to avoid the 'moral danger' referred to above. At this vantage point she is questioned whether that was consistent with her leading a fulfilling sexual life:

*That physical contact needs to be kept away, to hold on to my self-value. I don't much regret it but sometimes I feel that I could have been experiencing nice times with boys, but because I was so distant I lost a lot. Lots of boys were resigning very fast. It looked like I was a princess waiting for a knight that will fight for me ... I dislike it in Poland. I have started to see relationships in a different way - not only that a woman is to be 'courted', sitting in the armchair and waiting for a man to entertain her and to prove his interests.*

(Weronika, Polish, aged 30)

The notion of being a good girl, and protecting your reputation was evident from a number of the Chinese women's accounts. Changying warned her friend who was engaging in casual sex that she would get a reputation amongst the community if she continued. Changying believes that women have more to lose than men do from engaging in casual sex, and that ultimately men will lose respect for a woman, and will not want to have a committed relationship with her or get married:

*She is in college and she has four years to go. I don't want to come back here in four years' time and everyone knows about her as soon as I mention her name. I told her not to ruin her reputation like that. Reputation is very important for girls. Not matter being serious or not, I told her that there would be one day that she gets bored with it. Some guys can probably do it for the rest of their lives. How many girls can do it for the rest of their lives? How many? She will definitely get bored, tired, when she gets to 30, 40 years old and then she will realise that nobody wants to have a serious relationship with her.*

(Changying, Chinese, aged 22)

While some women described a process whereby they internalised messages of how to behave and regulated their behaviour as well as their friends' in line with that, others

mentioned ways in which their parents actively policed their behaviours. Chinese Jiao talked of how her mother chaperoned her during her early relationships:

*When my mother knew that I was in a relationship, she went to my school and watched me every day after school. I couldn't walk back home with my boyfriend because my mother was there. She was really nervous. (Jiao, Chinese, aged 18)*

Nigerian participant Fola described a high level of regulation and control imposed on her by her father regarding contact with boys:

*F: It wasn't really my mum - it was my dad. Cos, like, I'm the oldest and he - And I do have brothers - I have three brothers. But, and he just made it clear that if he sees a boy near me, basically the boy is gone, like. [All laugh] Like, he just, he can't - I cannot have friends at, like, friends as, as boys because they...*

*I: What would he say to you [Fola]?*

*F: He would just be like, 'You better stay away from all those boys.' Ehm, 'If they come near you, you fight them away. If they try to touch you anywhere punch them.' And stuff like that. [All laugh] You know what I mean?. But like, I just, I... Because growing up here I just feel like it is not necessary. Because not all of them want to like touch you that way. Like some of them are actually your friends. Like, my brothers' friends that come to the house, I do talk to them. But my dad sees that as OK, cos they are my brothers' friend. But if I say, 'Oh! I have a friend is a boy that is coming down,' he will have a fist. He will go mad like that. I just tend to avoid boys, ehm, like talking about boys to my dad or something. But if it is my mum - like my mum knows, my mum is grand. Like, she just cop on basically that, like, I can't have boys as friends. Like, not all of them is, like, vicious, like, they will rape me. Like stuff that.*

*(NFG3, Fola, aged 18-20)*

This last sentence indicates that Fola's father may have been motivated by genuine fears for her safety. However, for Fola this was incongruent with the socio/cultural context in which she was living, where friendships between boys and girls are the norm.

Sexual double standards featured in some women's accounts, again, across more than one of the study groups. Young Polish women described how they were not expected to take the initiative in encounters with men or be sexually active during school and college:

*In Poland if I started to talk to a man in a pub, I would very quickly be judged - he would probably be shocked, not knowing what I want from him; it would be seen as a lack of good taste when a women starts a conversation, and also I would be scanned head to toes by him to check if I am attractive enough to keep talking to me. I have lived here for six years, but that's what I remember.*

*(Weronika, Polish, aged 30)*

Different expectations of male sexual drive and interest were also expressed, again across groups. Chinese Changying discussed a male friend who paid a sex-worker for sex after his relationship broke up and expressed understanding that a male would need to have his sexual drive fulfilled:

*My friend went for a prostitute after he broke up with his girlfriend. I think it's understandable that guys can't stay alone after losing their virginities, because they have already experienced that ... Once the guy is not a virgin any more that he has experienced this, it's easier for him to want to have sex with his girlfriend.*

(Changying, Chinese, aged 22)

*Women are looking for an equality of rights but the truth is you can't change the way guys are thinking. He is a winner but she is an easy girl. And no-one is going to change their thinking ever.*

(Justyna, Polish, aged 19)

Chinese Li was aware that this was a 'double standard' and discussed it with some of her male friends who wanted their future wives to be virgins:

*L: I think so, yeah, they have sex with other girls before and I always laugh at them on this thing. I said, 'You have sex before, why you always ask your girlfriend don't have sex?' But they said it's very hard for them to accept because they will think this girl is not pure and they have some sexual relationship with other men, when they have sex, maybe they will always think about this.*

*I: Really?*

*L: Yeah...*

*I: So is there, how do you say, do you see that as a double-standard idea?*

*L: Yes. And I always think you have a double standard and it's not fair to a girl or a woman, right? So, but they said they can't control this. Yeah, this is rooted in the heart. And a male friend of mine even told me that if you have sex before your marriage, don't tell your husband after you get married.*

(Li, Chinese, aged 25)

The accounts of women in this study correspond to research findings about the meaning of heterosexuality in Western contexts, wherein sexuality is gendered, double standards are attributed to male and female sexual activity and power is asymmetrically distributed in favour of males. In the Irish context, studies such as Hyde and Howlett, 2004; Murphy-Lawless et al., 2004 and 2006 and Mayock et al., 2007 all confirm that such double standards are experienced by Irish women too. The young migrant women in our study groups did not tend to reject or question such a construction of female sexuality. Rather, there was evidence of participants accepting them as normal and some references to conceding to them, in the most extreme cases through recourse to hymen reconstruction among Chinese women. Women earlier described close control and monitoring of female

sexual behaviour by parents and communities. For those young migrant women who were in Ireland independently such distance from parental and community monitoring created new opportunities and also pressures to have sexual relations. These findings suggest that young migrant women may experience conflict between their sexual feelings and practices and their willingness or preparedness to recognise themselves as sexual, sexually active and at risk of pregnancy or sexually transmitted infections. This represents one particular set of challenges to Irish sexual and reproductive health services who seek to engage with young migrant women.

### 3.4 Female genital mutilation

Within our study group the issue of female genital mutilation (FGM) featured. FGM is a traditional practice most common in the western, eastern, and north-eastern regions of Africa, in some countries in Asia and the Middle East<sup>14</sup>. FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. The practice is related to cultural meanings of proper sexual behaviour for women, intended to reduce and curtail women's libido and thereby contain female sexual interest, pleasure and activity. It is recognised internationally as a violation of human rights of girls and women and an extreme form of discrimination against women. (WHO. 2010) However, the practice continues and so countries receiving migrant women from places where it is still practiced need to be cognisant of the care issues this raises, such as dealing with the long-term physical and psychological consequences associated with FGM as well as particular issues raised during childbirth for a woman who has undergone FGM.

The account of Suliat, interviewed for this study, highlights the consequences endured by women who have been subject to the practice:

*S: I was mutilated when I was young so that I won't be promiscuous. They believed if they remove the clitoris, it would decrease the urge for sex. It became hard for me because it takes me time before I can enjoy sex. My clitoris is no longer there so I hardly enjoy sex.*

...

*S: I was five years old when I had it done. An old woman did it for me. She used a knife with four men holding me down while she cut my clitoris. I lost a lot of blood. But the woman squeezed some leaves and applied the juice on my wound to stop the blood. I was five, but I will never forget.*

*I: Was it not a doctor who did it?*

*S: No, it wasn't a doctor. It was an old woman from my father's family. Doctors don't circumcise girls but only boys.*

...

*S: I had severe pain the day it was done. It is after three days before I had relief. The only thing now is that I don't enjoy sex. I just lie down like a log; I don't enjoy it at all.*

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14 WHO Fact sheet N°241, February 2010, <http://www.who.int/mediacentre/factsheets/fs241/en/>

*The clitoris, which allows petting and turns a woman on, had been removed in my own case. That gives me a feeling of incompleteness. It takes away my confidence. I cannot stand and talk in a group. Whenever I remember I was mutilated I feel very angry and low emotionally.*

...

*S: it is a terrible experience because FGM is hazardous to the health, especially at childbirth. There are three types of FGM - it is possible for someone to have the three types.*

*I: Can you tell us the three types?*

*S: The one I had is the first type where only the clitoris is removed. In the second type, the clitoris is removed with the two lips of the vagina. The third type they cut the clitoris and the two lips of the vagina and the passage of the vagina is also sewn with a little passage left for sexual intercourse so that the husband can enjoy her.*

*I: It's not good for a woman but good for a man?*

*S: Yes, everything they do is for the man's pleasure. It is the man's pleasure. This type creates problems for the woman at childbirth because the passage where a baby comes out had been partially sewn.*

[Suliat, Muslim, aged 30]

Suliat believed that the purpose of the operation was to prevent her from being promiscuous and that in her culture the sole priority is men's pleasure. From her account it is clear that this violation has had long-term consequences. FGM is a feature of migrant women's sexual health needs that Irish sexual and reproductive health services need to be cognisant of. They must also be informed of best practice in relation to responding in an holistic way to the issues it raises for women who have survived FGM.

### 3.5 Overview of cultural meanings of female sexuality

This chapter set out key messages and practices regarding female sexuality the women in the study group acquired in their particular cultural settings of origin. It also described the means by which such messages were conveyed. Understanding the particular meanings attributed to female sexuality in the diverse cultural contexts of migrant and minority ethnic women revealed commonalities and disparities between the dominant Irish and newcomer and/or minority ethnic cultures that make up contemporary Ireland.

Despite the diversity of backgrounds of the women interviewed, a common feature of socialisation regarding sexuality was that as young girls they intuitively came to know key messages such as: that it is girls' specific responsibility to control sexual morality, that contact with boys is censured and contingent on girls' behaviour and that pregnancy threatens the life chances and the respectability not only of the girl but also her family and even her wider community, and it was her duty to avoid this. Key messages regarding sexuality were often communicated through indirect or implicit means in all of the cultural contexts represented in the study. However, the 'unspoken rules' were made very clear. Women from each of the diverse national, cultural and ethnic backgrounds



represented in the study noted a strong, explicit association of fear, shame and guilt with sex and pregnancy before marriage in the cultural messages they received. It is interesting to relate these findings to Mayock et al.'s (2007) depiction of the Irish context wherein they described how influences on young people's sexual lives are clearly not restricted to explicit or formal messages about sex; instead, they are embodied in an array of subtle and complex forms of communication and are shaped by gender and social positioning. Daughters' sexuality was more likely to be regulated by parents through messages of abstinence and chastity, while sons tended to be cast as sexual predators, who needed to protect themselves against the unwanted consequences of sexual activity (Mayock et al., 2007: 20).

Women across the study described coming from cultural contexts wherein female sexuality is highly monitored and where women's social value is contingent on their marital prospects. Female sexual chastity and high educational attainment are two key sources of capital in contexts where marriage is highly valued and power and control is vested in the male in the making of a marriage. It is interesting to note how migration itself creates particular pressures in relation to avoiding non-marital pregnancy. The meaning suggested is that migrant families are expected by those 'back home' to progress and succeed, and so a young woman becoming pregnant is a greater 'failure' - failure by her to optimise enhanced educational opportunities in her new country of residence and failure by her family to maintain the moral standards of their 'old' country of origin. This creates particular conditions for the possibility of crisis pregnancy among young migrant women.

The accounts of women in this study correspond to research findings regarding the meaning of heterosexuality in Western contexts, wherein sexuality is gendered, double standards are attributed to male and female sexual activity and power is asymmetrically distributed in favour of men. Women in our study groups did not tend to reject or question such a construction of female sexuality. Rather, there was evidence of participants accepting them as normal and some references to conceding to them, such as some Chinese women accepting the practice of hymen reconstruction in order to adhere to the expectation that women do not engage in sex before marriage.

While women described close control and monitoring of female sexual behaviour by parents and communities, for young migrant women who came to Ireland independently such distance from parental and community monitoring created new opportunities and also pressures to have sexual relations. These findings suggest that young migrant women may experience conflict between their sexual feelings and practices and their willingness or preparedness to recognise themselves as sexual, sexually active and at risk of pregnancy or sexually transmitted infections. This presents a particular set of challenges to Irish sexual and reproductive health services who seek to engage with young migrant women.

The issue of female genital mutilation (FGM) featured within our study group, with one woman describing being subjected to this violation at an early age. Her account demonstrates that there are long-term consequences for women who survive FGM and that Irish sexual and reproductive health services need to be cognisant of how this can be a feature of migrant women's sexual health needs. This requires services to be informed of best practice about how to respond in an holistic way to the issues FGM raises for survivors of the practice. Traditional practices such as female genital mutilation or testing for virginity, as well the practice of hymen reconstruction raised by women in our study demonstrate the importance of sexual and reproductive health services in Ireland becoming aware and knowledgeable of particular global sexual and reproductive health issues.

## 4.0 Sex education

### 4.1 Introduction

This chapter explores women's attitudes and experiences of sex education growing up in their countries of origin, and here in Ireland. Key sources of knowledge for information, understanding, and insight about sex and relationships were identified by the women and form the themes of this chapter: the home, the school, media and peers. These reflect sources of sex education identified in previous Irish studies. The chapter first briefly sets out research findings about sex education in the Irish and European contexts as well as findings relating to migrant sex education in the well-established multi-cultural context of Toronto, Canada. Findings from our study group regarding sex education received before and since coming to Ireland are then presented.

### 4.2 Sex education in Irish, European and multi-ethnic contexts

Previous research carried out by the Crisis Pregnancy Programme on sex education in the Irish context as well as young Irish women's attitudes to sexuality, pregnancy and motherhood portrays the sex education culture and context into which the migrant women in our study group have entered. It provides a useful backdrop against which to compare and contrast the accounts of the young migrant women in this study.

Research in the Irish context has found that information, understanding and insight about sex and relationships for young people principally comes from the four sources of peers, the media, schools and parents (Mayock et al., 2007 and Hyde and Howlett, 2004). Mayock et al. (2007) reported how Irish literature in this area consistently found young people cite same-sex peers as a key source of information and advice on matters related to romantic and sexual relationships. In their research with students they noted how respondents frequently cited friends and the media as sources of information about sex but were highly critical of the accuracy of these knowledge sources. Many also felt that opportunities to talk about such issues with parents were often limited and, in any case, embarrassing. In Murphy-Lawless et al.'s (2004) study young Irish women reported sex education from the family was almost exclusively through mothers and described it as problematic due to embarrassment on the part of parents and children alike in discussing sex combined with the context wherein children were seeking independence from parental perspectives and unlikely to accept what parents say.

School has been depicted as a setting where young people have opportunities to learn about sex and relationships (Mayock et al. 2007, 40). A previous CPP study showed that school-based sex education is complex, with factors associated with teachers, pupils, and prevailing ideologies about sex creating difficulties with its delivery (Hyde and Howlett, 2004). Mayock et al.'s (2007) study of the sex education curriculum introduced into Irish schools in the mid-1990s, Relationships and Sexuality Education (RSE), set out how the aim of the RSE programme is to help children to:

*Acquire a knowledge and understanding of human relationships and sexuality through processes which will enable them to form values and establish behaviours within a moral, spiritual and social framework.*

(Department of Education Guidelines on RSE, 1997: 4, cited in Mayock et al., 2007: pp)

Some young people in the studies wanted more detailed information and discussion about sex and sexual relationships, both in and out of school. For a large number, the school created a more neutral 'zone' in which to discuss a range of issues related to sexuality and relationships (Mayock et al. 2007: 238). In terms of content, in addition to more scientific knowledge, young women favoured greater coverage of the contextual and emotional aspects of sex; young men tended to want more information on the physical dimensions of sex relating to technique and performance (Mayock et al., 2007).

The Irish studies recognise that schools do not attempt to meet all of the relationships and sexuality education needs of a young person; school will not be the only source of such information and messages a young person receives. In Murphy-Lawless et al.'s study (2004) school sex education lessons were described as uniformly disappointing across the entire age range described as inadequate, embarrassing for teachers and students alike biologically orientated and so de-contextualised as to be meaningless e.g. facts on STIs without broader competency in managing intimacy being discussed.

While such qualitative research reveals the frustration many young people feel when they do not receive comprehensive sex and relationships education at home or at school, recent quantitative and representative research (McBride, Morgan and McGee, 2012) suggests that provision of sex education in Ireland is improving. 71% of respondents aged 18-25 in the McBride et al. study rated their sex education as very helpful or helpful in preparing them for adult relationships.

In the Murphy-Lawless study reliance on one's peer group was the most common approach to becoming informed about sex, but this was fraught with concerns about misinformation and inaccuracy. The authors also noted how women described that having sex as a teenager could be a secretive undertaking, given a general climate of disapproval, which could result in women being ashamed or frightened to share their concerns or problems. The media was other source of information women mentioned and principal among this was British teen magazines. Murphy-Lawless et al. (2004) concluded that what women identified as crucially lacking was a holistic approach to sex education, which took into account feelings and emotions as much as biology.

To place Irish provision in a wider context, the European Society of Contraception Expert Group on Sexuality Education (Loeber, Reuter, Apter, van der Doef, Lazdane and Pinter, 2010) considered aspects of sexuality education and its implementation in different parts of Europe. They characterise the aim of sexuality education as being to enable young people to acquire knowledge, attitudes, skills and values to make appropriate choices in

their sexual behaviour and thus experience a healthy sex life that is age-appropriate. They note how sexuality education has been widely recognised as essential for sexual health, but the content and principles that form the basis of this education have changed over time and differ widely among the countries of Europe. Across Europe different definitions and terminology are used to refer to sexuality education, varying from 'family life education' (e.g., Hungary, Poland, Slovakia) to 'life skills education' (Estonia, Latvia) and 'sex and relationships education' (e.g., Belgium, Cyprus) (Loeber et al., 2010: 172).

Finally, to consider a context where immigration is more established than the Irish context a study from Toronto on issues of sexuality among teenagers (Flicker et al., 2009) provides a useful contrast. Toronto is one of the world's most ethnically-diverse cities, being home to more than 200 distinct ethnic origins speaking over 140 different languages. Half of Toronto's population was born outside of Canada, and the survey over-sampled racialised youth to ensure the inclusion of a frequently disenfranchised group; one third of the study group were born outside Canada, making the findings very relevant to our research. The study reported that recent newcomers to Canada were at greatest risk of missing out on sex education, especially if they did not receive it in high school. Time spent in Canada plays a determining role in access to sexual health education, especially for youth in the school system. By the age of 18, 97% of Canadian-born youth surveyed had received some sexual health education. Immigrant youth living in Canada for more than four years reported similar levels of sexual health education. However, newcomers, those in Canada three years or less, had slightly lower levels of sexual health education at age 13, and significantly lower rates by the age of 18. While less than 6% of second-generation Canadian and longer-term immigrant youth had not received sexual health education, 19% of newcomer youth said they had not received any sexual health education. Newcomer and longer-term immigrants said they wanted to get sex education in schools. However, the study noted how if a newcomer misses sex education in school year where it is delivered, there are rarely other opportunities to catch up. Another key finding here was how many newcomer youth wanted their parents to be educated about sexual health.

#### **4.3 Sources of sex education for migrant and minority ethnic women**

Women across the four groups in the one-to-one interviews and focus group discussions were asked about their experiences of sex education growing up as teenagers and more recently in adulthood. Topics that emerged from these discussions included home and community sources of sex education, school as a source of sex education and informal sources of sex education: popular culture and media.

#### **4.4 Home and community as sources of sex education**

As referred to in the previous chapter, sex education and general openness about sexuality at home was not a strong feature for any of the women, regardless of ethnic background or country of origin. The majority of participants said that their parents were not comfortable talking about sex with them, or in many cases even the changes

occurring in their bodies at puberty. Sexuality remained a hidden topic, and was not discussed in an open and natural way at home. Many women did not feel that as children they could broach these topics with their parents without feeling fear:

*I wouldn't have gone to primary school here so when I was in Nigeria I went to a primary school. I wouldn't have been at the stage of having sexual education. But when I had it here it was a case of, 'Mum, I need €12 for the talk in school.' 'Alright here is your money. Go away.' And I didn't come home saying, 'Oh we talked about this today and they showed us this.' It was never spoken about again. Like she had to sign a form saying you know this is what it is about, and she kind of left the school to deal with it. You don't come home and discuss or, you know, talk about it with your mum or your dad or whatever it was ... Learn in school - that's it - end of story.*

(NFG1, Omorose, aged 20 - 29)

Women from the Nigerian and Chinese groups in particular tended to have been sheltered from any awareness of the reproductive body or sexuality until the arrival of their period. They described how encountering the onset of puberty in a knowledge vacuum left them feeling alienated from their own bodies.

*S: Even when I had my first period, I didn't know how to use sanitary and I didn't know what was going on. Only then my mum told me something, but she didn't explain.*

*I: She didn't explain why you were...*

*S: No. So I didn't have any sex education at all from my parents. I started to know about sex gradually by myself. When we went to church, this was mentioned in the Bible. But things like this are kind of hidden in China. They won't, say when the priest was preaching, he couldn't just openly say that you can't have sex before marriage.*

(Shu, Chinese, aged 23)

Shu did not understand the 'facts of life' until she was in her first year of college. Her account demonstrated that growing up she did not have any access to sources of information in this area:

*I think it wasn't until I was either in the last year of high school, or the first year of college, that I knew how a baby was born. During that time, and before that time, I was very curious, probably because there was no internet back then, not until I was in secondary school, and then I had a computer. There were no books as such available and the books I could borrow from school library would be historic and cultural books.*

(Shu, Chinese, aged 23)

The impact of such an information vacuum meant that many young women described being frightened when their first period arrived. For example, Fola, a young Nigerian woman, described being unaware of any aspect of fertility or sexuality until the arrival of her period, a matter that was left entirely to her mother to explain. As for many women

across our study groups, the message imparted was that pregnancy was now a possibility arising from relations with boys and heavily prohibited. Also illustrative of the accounts of many women, the effect of how the matter was dealt with for Fola was to close down the prospect that she would resort to her parents as a source of guidance in dealing with her emerging sexual feelings and experiences:

*F: That was when the whole sex thing started. When you get, like, when I got my period I thought something was wrong with me. I actually thought I was abnormal or something. And I went to my mum and my mum was like 'It is OK.' And I was actually burning my eyes. I was like 'Oh my God - What is happening? Like, I'm bleeding from where...' Like, my dad was there as well. And my dad was like, 'OK, I'm gonna leave.' And I was just like, 'Why is he leaving?' You know that kind of way? Then my mum sat me down and explained everything to me. And then she only put in, like, a little bit of talking about sex. But she just said, like, it is when, like, if you miss your period and you have sex with a boy, you get pregnant and that was the whole sex education. Over. [All laugh.] And I was like, 'Oh, that is grand.' And then I went to school and found out all these things and I was like 'Oh my God!'*

*I: That was when you had sexual education in classes?*

*F: Yeah. And I was like, 'Oh my God,' my mum was right, but she didn't tell me anything like this. So if - I was like, I wasn't going to go ask my mum, 'Oh Mum, what is this?' Because we all know what will happen, like.*

[NFG 3, Fola, aged 18-20]

As Fola refers to, a common reason given by young women for not broaching the issue of sexuality with parents was because parents would interpret their questioning as indicating their involvement in sexual activity, which Ivie describes below:

*Iv: was really scared, like, to talk to my mum or dad about sex because they would think I was doing it, like; like I am really scared. Like to, like, approach my mum and say, like, 'Oh talk to...' Because I feel very uncomfortable and I just don't want to talk to her because I just don't want them to have the feeling that I am doing it.*

*I: How do you know she would say that, because as you said you have never asked her?*

*Iv: Yeah, well I just know, like I know my mum, like she is very quick to like you know, she would just assume. Like my mum, cause like in an African household like it is very strict and stuff like they like, religion as well. When it come to religion like you are not meant to have sex before marriage and all that stuff that all, it's all really strict and hassled, so my mum would just assume am doing it. I think anyway and I don't think I would like that.*

[Ivie, Nigerian, aged 18]

Muslim Suliati, who had grown up in North Africa before moving to Ireland in her early twenties, also described a cultural silence around sexuality between parents and children:

*No - our parents didn't talk to us about sex at all. We give them a lot of respect so it's very difficult to sit with them and discuss such things. Any child that discussed sexual issues is seen as wayward.*

[Suliat, Muslim, aged 27]

Some Muslim women who grew up and attended school in Ireland depicted a situation where parents were silent about sexuality with their daughters beyond the teachings of Islam regarding relations between the sexes:

*F: I think it must be an Arab, or that kind of background. You don't really discuss those things at home.*

*I: What about the rest of ye?*

*Many: Oh same. Same.*

*I: You wouldn't discuss it in the house? With parents?*

*B: No. God no! [Laughter.]*

*I: And what about puberty and when you start having your periods and all that?*

*B: Oh no. You would have the usual mother daughter talk, obviously. But not about sex or anything. 'Cause they know that you'll learn that in school at secondary.*

*C: Yeah, they know.*

*F: And it's almost instilled in you from a young age that there are boundaries between male and female interaction and that kind of thing.*

[MFG1, Fiza, Batool, Cala, aged 17-25]

Many Polish women also described how when they were growing up, silence and censure reigned in their homes when it came to the topic of sex and the sexual body:

*In my home [...] we don't need to talk about sex, my parents were raising us to be more restrained in these spheres. My mum was always embarrassed when she was to talk to us about puberty etc. Poor ... she was crying when she had to tell us that we have to start using females' pads, or that we may be sexually active in the future. Intercourse was a taboo in the house. Us as children, if there were scenes in the movies when actors started to kiss or were undressing, my dad wasn't expelling us from the house, but he was making us understand that it wasn't a proper film for children, that we had to go to sleep. So there wasn't much openness in feeling that, when there is a right time for us we may know about sex and about sexually maturing. But it wasn't talked about, the sex, in my house.*

[Malina, Polish, aged 27]

Chinese women described how parents tended to wait until their children were older before broaching the subject of sex with them, if they did at all, often leaving it until children were well into their twenties:



*M: And we don't know this from my parents, before 20 years, yeah.*

*I: Why? Because they don't talk?*

*M: I think they are nervous, and they are embarrassed to say these ... but at that time, maybe 30 years, 20 years ago, yeah, so my parents never, never...*

*I: Talked?*

*M: Yeah, talked to me like that. But when I was 25, after 25 years, my mother told me something about that. I know it's late but in China it's true, yeah ... and even [laughs] it's true, but it's like a joke. Em, I don't know how to use condom before I'm 26. Yeah, and I never know how to, because I don't know what that...*

*I: What it is?*

*M: What that, yeah, what is condom.*

(Mei, Chinese, aged 29)

Chinese women also spoke about the awkwardness their parents had when it came to discussing sexual topics with them. Yuan provided an example of this, emphasising her perception that being from a rural part of China might also be a factor in this reticence. It is interesting how she comments on her parents' education as a factor that could not cut across such an attitude to sexuality:

*I think I roughly knew where I came from but I didn't have any sex education at all because my parents were well educated and they were quite embarrassed by such topics. They never tried to talk to me about those things. I am not from a big city. I am from a small town.*

(Yuan, Chinese, aged 24)

Jiao's account evokes her parents' attitude of sexual repression, which closed down any opportunities for her to explore sexuality. This repression was further illustrated by the fear her parents had when she was in a relationship, and the vigilance with which they monitored her behaviour, leaving her no space to discuss sexual issues with either parent:

*When my mother knew that I was in a relationship, she went to my school and watched me every day after school. I couldn't walk back home with my boyfriend because my mother was there. She was really nervous. My father would never talk about anything like that in front of me. For example, my mother was changing clothes and she would say, 'Ah, your dad is coming, close the door!' It was like my father never saw my mother naked before. My mother was always shy when she changed her clothes. I think they were just pretending in front of me. Everyone in my family is like that.*

(Jiao, Chinese, aged 18)

#### 4.4.1 Communicating in euphemisms

A common feature of women's depictions of how messages and information about sexuality were conveyed was a euphemistic approach to the issue of sexuality, intimacy

and fertility management so that there was no context to the discussion of pregnancy and abortion. For Nigerian woman Yetunde, her parents' approach to the topic of sexuality and reproduction, which relied on euphemisms rather than direct interaction, was a source of confusion for her when she was younger; but she came to understand the messages:

*It was basically 'Be careful. Be careful.' But I didn't really understand what it meant at that age. But as you grow up you sort of get what they meant by 'Be careful' and you take it in. So it wasn't something that was sort of controversial, not like, 'Why? Why?' It was just, 'Be careful about yourself,' 'Watch the way you walk around boys,' 'Don't stay too close to the boys.' Like, stay to the girls, obviously.*

[NFG3, Yetunde, aged 18-20]

Damilola, a Muslim woman who grew up with her family in North Africa described how her curiosity about changes in her body was met with silence by her mother:

*D: Like, maybe when I was 10, I was 11, I started asking questions; I started asking myself questions. I was young; I was naïve, I could not even comprehend the questions I was asking myself.*

*I: And what kind of questions were you asking yourself?*

*D: I started asking myself that why do I have breasts? Why do I have hair in my armpit, you understand? Why is things changing in my body? In my private part I began to see hair and all that, so all this changes. I was curious about them. My mother wouldn't really talk about it so...*

*I: To what extent did your mum talk about sex and all? Did she mention it? What would she say?*

*D: Really my mother didn't really talk about sex: the basic thing is [Yoruba word] meaning 'Don't get pregnant.' That is what they are always ringing in our head: Don't get pregnant, don't get pregnant, don't get pregnant. And they don't, they can't, I don't think they can or they will never sit you down and say, 'When you do this it is called sex,' and all that. They don't talk about sex - they just, they just give you some attitudes, like. They just want to imbibe the fear into you, like, it - It is, 'Don't just have sex!' That is my parents for you. My mother for you.*

[Damilola, Nigerian, aged 30]

Chinese Jia's mother confined her discussion to warning her daughter against having sex, but even this was without direct use of sexual language:

*My mother, not in detail, she just sometimes reminded me 'Don't do it. You're still too young. You're still too young and don't do it till you grow up,' or something like that.*

[Jia, Chinese, aged 24]

For Polish Danuta her mother imparted to her and her sister the key message that they should not become pregnant, while emphasising that if it did happen they should seek her support rather than considering abortion:

*My mum, my parents were not touching on sexuality related topics. Both me and my sister were not talking to parents about sex. I think that we get that knowledge mostly from friends and occasional accidental talks ... In my case, what I only remember was around abortion. My mum was saying to us even at age 15 that we have to mind ourselves and be careful, but nothing concretely said of what, how etc. But I remember my mum saying that if it happened that we got pregnant, we are not to be scared and to say it and that the child will be raised ... Yes, I knew about support, but my mum didn't talk to me about contraception. I knew that she would have been giving the support in case of pregnancy, but I wasn't sure that she knows if I know what to do.*

[Danuta, Polish, aged 23]

#### 4.4.2 Parents' efforts to overcome silence

Some women described how parents struggled with the tensions between the cultural meanings of sexuality they were immersed in and an acknowledgement of the responsibility they had to prepare their daughters for the sexual and reproductive domain of their lives. Polish Zofia's mother assumed this responsibility by accruing the information in textbooks and giving the books to her daughter. Parents seemed to rely on texts as a resource to overcome their inability to have a direct discussion with their daughters:

*I didn't talk to my mum about sexuality, I don't think that any of my parents would be open enough to talk directly, but I remember that my mum brought me some books in the subject, lots of books. It was never any direct contact between us, I cannot even imagine it, but the fact is that she didn't leave me on my own, she found these magazines etc and committed herself to do it. It's a bit easier now, but still there are subjects about which I would never talk to my mum.*

[Zofia, Polish, aged 29]

Chinese Shufen described a similar approach being taken in her home, though in contrast, her account makes reference to her father:

*S: My mother, my parents, didn't tell me anything. I think, one, one of my father's friends told him, said, 'You have to teach your daughter.' and then my father said, 'Oh, she is very knowledgeable, she can read books, books tell everything...'*

*I: So that was your father's...*

*S: Yeah, he is, I think they are a little bit shy about this kind of thing.*

[CFG1, Shufen, aged 32]

Young Muslim women Marjana and Iram, who grew up in Ireland, described how their mothers did discuss sexuality openly with them, which they endorsed as important for the well-being of young women. Marjana argued that meeting the needs of young women to be knowledgeable about sexuality should not be superseded by reference to religious teaching:

*I think when you're around a teenager your mother would kind of explain to you what goes on. Depending on each family, when each mother explains it to a child. I think I was around fifteen when my mam explained it to me properly ... But in my family we tend to be very open-minded and we're very open as a family. So we discuss things very openly, which I like. But that's not in every Muslim family. I think sometimes more strict families would not go into detail of what happens. And if a girl goes into a marriage, she's going into it blind, which is kind of leaving her at a downfall because she should. People need to be open-minded about things. We need to talk about sex, we need to talk about STIs, we need to talk about everything else. It's better to – it's the only way you can better yourself - by educating yourself, so.*

(Marjana, Muslim, aged 18)

*Ir: I was more taught about it from my mother before anyone else. We talked about contraception in secondary school but I already knew about it. I know a lot of people whose mothers didn't say anything to them -, they just knew that their kids knew. But, erm, I think if you're more westernised and your parents are more westernised, then it's normal to say something to them. But I've noticed, how can I say it? Erm, more harder parents, restricted parents wouldn't say anything to them, until they are obviously quite older.*

*I: And do you think that would have an effect on them growing up and trying to find out about these issues?*

*Ir: I think they would obviously find out about them through friends, but I think if they don't find out about it through their parents then I think the kids would rebel or to do more stuff that's not allowed and not to be more open with their parents at all. Like, you need to have that trust and go up to your parents and go up to them and tell them stuff. And that would obviously come from the parents being able to talk to you. And if they don't then you're obviously gonna be more wary and more hesitant to talk to them about that kind of thing, which I don't think is good.*

(Iram, Muslim, aged 20)

Women whose parents did talk with them and informed them about aspects of sexuality were conscious that their experience was not common. While the majority of Chinese participants stated that their parents were awkward and shy when it came to educating them about sex, Liping had the opposite experience, where her mother encouraged openness in discussing sexuality, resulting in her daughter having a more mature and responsible attitude towards sexual activity:

*L: My father is not very open but my mother is. She wants to be close to the younger generation, to share their way of thinking. She hopes to be a friend to us as well as a parent.*

*I: And did that work? Were you able to be open with her?*

*L: Yeah. The more open she is, the more I am aware that I won't have casual relationships. If I ever have a boyfriend, I would definitely tell her and she would hope to meet up with my boyfriend.*

[CFG1, Liping, aged 26-32]

Polish Ewa described her experience of sex education growing up in quite a religious and conservative home, yet her mother was open in discussing sex and contraception with her when she was a teenager:

*My experience is different from probably most of girls, my peers. I am quite old. My mum was very conservative, and I was growing up in a very religious house, but my mum was also open to talk about sex freely with me, so when I was 15 my mum educated me completely about contraception. But I am also aware that among my friends if girls were asking their mums about, for example, what is a condom, mum's answer would be: 'So have you finished your homework?' So my friends were not mostly able to speak freely with their parents.*

[Ewa, Polish, aged 30]

#### 4.4.3 Cultural context for silence

Polish participants discussed how their parents' capacity to discuss sexuality and contraception with them was shaped by their particular cultural context. Participants understood that when their parents were growing up, they themselves did not receive any sexual education, nor had they the same access to information sources as young people have today. They were also concerned with changing the social and political system that existed in Poland at that time, and were products of that system in many ways. Aniela illustrates the lack of knowledge her mother had about contraception:

*As you were talking I have just reminded myself that it was me who taught my mother about contraceptives while talking about it to my younger sister. My mum was sitting and listening and I saw her eyes opening wider with surprise. It turned out that she only knew about condoms, and not too much about it. Also the contraceptive pill, but she only heard about it, and we were grown up to talk about it. So similarly to what you are saying, my mum wasn't talking to us, because she lacked basic knowledge in the subject.*

[Aniela, Polish, aged 28]

Polish participants described a restrictive environment created by the communist system, including prohibition on the contraceptive pill. The collapse of Communism in 1989 and the subsequent opening up to outside influences were identified as changes that allowed

this generation of women learn about sex through the media, for example, by watching MTV music videos and being able to read magazines containing information about sexual concerns.

In turn, in the Chinese group, Ying makes the point that her mother's generation had to acquire sound knowledge about contraception, as they were strictly subject to the one-child policy. However, the treatment of sexuality is no more open than women from other contexts describe, so that women now in their twenties are still missing information about prevention of pregnancy:

*Y: Abortion is legal in China but I think for older generations - like thirties or forties - they'd be more aware of using contraception, because there's like single-child policy and there still is, in the sense that if you're from a single-child family and your husband is from a single-child family, then you can have two children. But otherwise you can have one. I'm not sure about how it is set.*

*I: Oh, so the rule exists where you can only have one child?*

*Y: Yeah, like for my mom's generation. I'm the only child so for them I think they are more aware of using contraception, but for the younger generation, like, the younger girls in schools and universities, I think it's because the lack of knowledge they have and they wouldn't think of the importance of using contraception; they would take the risks and they'd think the chance is small and it's OK, so I think they need to raise the awareness at home.*

(Ying, Chinese, aged 25)

#### 4.4.4 Overview of parents as a source of sex education for migrant women

Sex education and general openness about sexuality at home was not a strong feature for many of the women in this study, regardless of ethnic background or country of origin. Most parents were not comfortable talking about sex, and it remained a hidden topic, so women came to feel they could not broach these topics with their parents without feeling fear. Some parents were depicted as deferring to schools to provide sex education without taking up responsibility themselves. Nigerian and Chinese women, as well as Muslim women who grew up in Islamic countries, in particular described an information vacuum regarding the sexual and reproductive body, leaving them ill-prepared for the arrival of menstrual periods as well as intimate relationships. In such contexts young women in turn desisted from broaching the topic of sex with parents for fear this would be interpreted as them being wayward or engaged in a sexual relationship.

Women interpreted silence around sexuality as indicative of condemnation of sexual relationships. This was often reinforced by euphemistic messages such as 'Be careful,' 'Don't do it' and 'Don't get pregnant,' which in the absence of 'concrete' information and guidance did not meet young women's needs. While in the minority, there were some contrasting accounts of parents who did try to overcome silences regarding sexuality, even where parents found this personally challenging. For some women this involved

being given reading materials while for others, parents - usually mothers - did engage in open discussion about sexuality with reference to the norms of society rather than personal or religious norms and teachings. The appreciation expressed by young women towards their mothers for providing them with guidance in the sexual realm demonstrates the value of such an approach. It also contrasts starkly with the accounts of women who felt bereft of the information and guidance they needed where parents did not do so. In relaying their own experiences of silences regarding sexuality, women were, however, aware of the cultural environment in which their parents had grown up and understood that their parents in turn had been poorly equipped for educating their children about sex and sexuality.

#### 4.5 School as a source of sex education

Within the overall study group, some women attended school only in their country of origin, some attended in both their country of origin and Ireland and others attended school only in Ireland. The section below explores women's accounts of sex education in schools in these different circumstances.

##### 4.5.1 Accounts of school sex education in country of origin

The younger Polish women talked of a recently-introduced programme in their schools entitled 'Family Life Sexual Education'. Krystyna explained how in her school in Poland it was called '*Family Life Education*' because according to her the word sex is still a taboo in Polish schools, and so is not used in the title. This programme was taught by their Religion teacher. Krystyna commented:

*K: I didn't find these classes useful. We were educating him [teacher]. He was using metaphors of birds and bees instead of normal talk and we were 16, 17 so... this was school education.*

*I: So it wasn't your level at all?*

*K: No, he was only teaching this subject. It was an optional subject; that kind of lesson took place every three weeks. Sometimes we were just talking about random things, not connected to sexual education at all.*

(Krystyna, Polish, aged 21)

The accounts of Polish women demonstrated variability in the provision of sex education in Polish schools. Juliana relates this to her attending a private school while others had attended the public school system:

*In my secondary school I had some 'Preparation to Live in Family' classes, which I consider to be great; it was helpful. That was a teacher for us, the class was divided - separately boys, separately girls; we spoke about methods of contraception used by females and by males. It helped me in the future to make choices about contraceptive methods ... Maybe I was lucky, because I was in a private school, so teachers had much more time for separate students, and there weren't that many people in the*

*class. But my sister at the same time attended regular public school and as far as I know she didn't have classes like I did. From what I know from her, maybe because of the teachers, but all sexual topics were discussed with embarrassment. Our teacher was very pleasant and open, so we knew that we could have talked freely. That was a good experience.*

(Julianna, Polish, aged 19)

*K: From secondary school nothing. In gymnasium<sup>15</sup> we had a great teacher - she was able to handle all the hard questions guys were asking sometimes ... and she could always find answers for us. So education in gymnasium was cool - we got lots of important information ... I remember her as an open, easy-going person, not ashamed to talk about sex.*

*I: So this openness was good? And what was she talking about? Contraception, sexual intercourse, periods?*

*K: Yes, sexual intercourse, contraception. I remember guys asked her about difficult questions and she always knew the answers.*

(Karina, Polish, aged 24)

In Poland the sex-education curriculum had changed in recent years, and more efforts were being made to deliver sex education. However, the accounts of the Polish women indicated that individual schools and teachers were a key factor in the effectiveness of school-based sex education. Likewise, Chinese women talked of sex education as having been recently introduced into their education system and therefore they were being taught about sexual issues by teachers who they considered to have no competency, experience or comfort about speaking on this topic with their students. Most of the Chinese women who discussed sex education in school described it as incomprehensive, inadequate and badly taught where it existed at all. School was not considered to be a good source of information on sex and relationships, and most women just learned about biology and anatomy, covering the male and female reproductive organs.

Shu depicted her experience of sex education in secondary school as being focused solely on biology and the male and female reproductive organs. Practical information about sex and fertility was not provided. Shu hopes things will change and more comprehensive information will be provided to young people in China, who she thinks are having sex nowadays without using any contraception.

*You know I think in China, the biology lesson is not so good as in Europe because I have a friend who is just moved to France since we were young and she said absolutely that kind of lesson in France is totally, totally different from China, and they will tell you why the women will get pregnant and how it works, yeah, and what should you do after that or something like that - how you can protect yourself ... But in China, we don't have these kind of lessons. Although they said that they will give you some lessons*

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<sup>15</sup> Polish education system comprises: primary school: ages 7-13 years old, gymnasium: ages 13-16 years old, secondary school: another two, three or four years.



*about the sexual health or something like that, but actually, eh, it just a little bit, em, just about the text on the books and the teachers always to talk about this kind of topics.*

(Li, Chinese, aged 25)

*S: During the time I was in secondary school, the first year of secondary school, we started to have the physiology health lesson.*

*I: You mean from secondary school?*

*S: Yes. We had absolutely nothing when I was in primary school. Only until I went to secondary school. We didn't have it during the first year, actually; it was during the second year. But I don't think the lesson was good.*

*I: It wasn't good?*

*S: No. Because it took place in a big hall. And all the students from the same grade. Boys and girls were mixed together. It was like three or four classes, or more, and the hall was full with students. I felt, the teacher, you know, the teacher was male and he was around 50 or 60 years old and he gave us the lesson. I think back then, there was a nationwide trend from the government that there should be sex education. But because there was traditional thoughts involved and teachers were shy about this subject, as far as I can remember, there was nothing about not to have sex or how to have sex. He only talked about boys, girls having periods and boys having wet dreams ... What I remember most was that we only had this lesson during the second year of secondary school and there were only three or four lessons throughout the year. He talked about very general things and there was no other education like this at all. That was pretty much it.*

*I: So what he taught you was mostly biological, like the differences between boys and girls?*

*S: Yeah, like reproductive organs. And the teacher was too shy to show the models.*  
(Shu, Chinese, aged 23)

A striking feature of the accounts of the diverse women who came from across China and were of various ages was their account of the awkwardness teachers displayed when covering the biological element of the curriculum dealing with the reproductive system:

*Y: I remember we had biology lessons in primary school, or middle school. There was one chapter about sex education in the biology book but our teacher didn't teach us anything and skipped that chapter. We were told to learn this chapter ourselves...*

*I: Read it yourselves.*

*Y: [Laughs] But we didn't know what to learn from it. So it was skipped and we didn't have any exams on this subject. So it was skipped. It was the same in high school. I didn't know much about sex from primary school or high school. I didn't know anything and it was blank ... Teachers didn't teach us anything in the university either. But if you started a relationship, you got to know those things.*

(Yuan, Chinese, aged 24)

*I remember it was in biology class that there was some introduction about this. Our school, our school was kind of, like, outside the city so people were quite innocent and conservative; well the students were not so, but the teachers were. It was a male teacher giving us the biology lessons. He didn't say a word when he was giving us the biology lesson about reproductive organs. He wrote on the board. He wrote down every point on the board and he said, 'Now you are going to read the book yourselves.' We were really embarrassed, you know, because we were quite open among ourselves, students, but we always tried to pretend in class. We were quite shy, and boys and girls in class would avoid that chapter. Our education was a failure. Our school wasn't like the ones in the city, which would have very good sex education.*

[Changying, Chinese, aged 22]

One feature of the Chinese system was the presentations by commercial companies producing sanitary products, which were addressed to girls close to the end of primary-school cycle. These presentations informed the students of the prospect of menstruating and how to use sanitary products. A number of Chinese women such as Ying mentioned such presentations in their schools and viewed them positively. It is interesting to note in her account the traditional attitudes attributed to her mother:

*Yeah. When I was in primary school, around 11, so in fifth or the last year of primary school, they probably gave us sex education talk but very basic. But what I thought they did good was there was sex education specially for girls, and when you would have your period. They actually got us a sanitary company and they got us very pretty packs of sanitary. So back then most girls in the class didn't get their period but they made it a really positive thing for us. So when I had my first period at the age of 12 I was very proud for the whole day! I felt like I was a grown up, so my mom told me how to use them, but I knew what it was when I came cause I already knew you'd be bleeding, and so my mom told me how to use it and what not to do, like drink cold drinks and different things but she didn't tell me what it meant for a woman, the period.*

[Ying, Chinese, aged 25]

Among the Nigerian and Muslim groups most women had attended school in Ireland and been exposed to some sex education here. Lisha, who had attended only primary school in her country of origin, described how sex education had not featured at all for her in school, while at home there were also silences about sexuality:

*L: No it's not part of what they taught us at all. I don't know if they teach it at secondary level because I stopped school at primary level - that's why I can't speak English. The belief is that a child must reach a certain age before exposing him or her to sexual issues. This is the reason why parents don't use actual names when talking about privates. Things like this did not allow us learn much.*

*I: Can you give me an example of how they talk about it?*

*L: If they talk about penis, they'll say 'insect' or vagina they call 'below'.*

[Lisha, Muslim, aged 22]

#### 4.5.2 Accounts of sex education in Irish schools

A majority of women in the Muslim study group had attended school in Ireland, while a small number of women in the Nigerian and Polish groups had attended some years of schooling here also. For migrant women coming to school sex education within the Irish school system it could represent a marked improvement on what they had received in their home country, depending on the approach taken. Where discussion of sexuality was very closed down at home, Irish school-based sex education represented an important supplementary source of information to home or community sources. This was a feature of the Nigerian women's accounts:

*F: That was when the whole sex thing started. When you get, like, when I got my period, I thought something was wrong with me. I actually thought I was abnormal or something. And I went to my mum and my mum was like 'It is OK.' ... I went to school and found out all this things and I was like, 'Oh my God!'*

*I: That was when you had sexual education in classes?*

*F: Yeah. And I was like, 'Oh my God,' my mum was right, but she didn't tell me anything like this. So if - I was like, I wasn't going to go ask my mum, 'Oh Mum, what is this?' Because we all know what will happen, like.*

*I: She is gonna ask if you are having sex?*

*F: Yeah, and it is just gonna get rough.*

(NFG 3, Fola, aged 18-20)

However, as noted earlier, variability in the sex education provided could mean young women found it of little relevance. Lisha, whose Muslim family moved to Ireland while she was in primary school, described how her father withheld permission for her to attend sex education in primary school but permitted her attend it in secondary school. She argued that the content of the classes in her second year in secondary school was behind the level of knowledge available to young girls from peers:

*I really didn't have much [sex education in school]. We had one when we were in sixth class. I remember that - sixth class one you have to get signed by a parent. Because my mum wasn't good, I had to get signed by my dad, which was odd, and he didn't know what would be taught in class. He thought the best thing for me was not to go at all. And we had another one in, eehm, my second year. I went to that one - he let me go to that one. It was just basic kind of protections and the kind of diseases you can get. But by that age I already knew a few stuff myself. And that was the last I had in school. I had to pick the rest on my own.*

(Lisha, Muslim, aged 22)

Justyna was critical of some aspects of sex education in an Irish school but found a drama workshop on the theme of HIV/AIDS to be powerful, and effective in delivering a safe-sex message. That workshop was organised when she was in third year in secondary school, and when she became sexually active two years later, she reported that the safe-sex

message stayed with her, and influenced her in terms of behaving responsibly and practising safe sex:

*I: What about sexual education in your school?*

*J: It was a taboo in both schools.*

*I: Both? Here and in Poland?*

*J: Yeah, well in Poland I was in gymnasium [14-15 years old]. I think discussion of these topics starts later on in high school. But it should start earlier, despite kids being shy.*

*I: And here in Ireland?*

*J: We had a workshop but my school is a typical catholic school so words like 'condom' are banned. So they couldn't show us details.*

*I: So what did this workshop look like?*

*J: Well we had a couple of workshops. One was about periods – how much blood is a girl losing etc. And one was fun. There was an actor and he was pretending he got AIDS. We didn't know it, so at the beginning we were laughing and then he said his story, how that happened and we all started to cry. I was touched.*

*I: So you didn't know he was an actor?*

*J: No, at the end he stood up and he said, 'Dave is not his real name but he is somewhere out there', which was shocking. Yeah but this was very good. I became aware.*

(Justyna, Polish, aged 19)

She argued that where teachers are delivering sex education there is a disjuncture between the content and way of discussing sexuality and what young women need in order to manage the encounters they have with sexuality in everyday life. This limits how effective it can be in empowering them to feel competent and confident in what they depict as a highly sexualised culture:

*J: I understand the Catholic ethos in schools, but times have changed. There should be more education for teenagers.*

*I: So more of sexual education but on a level suitable for teenagers?*

*J: Exactly, but their language is dirty - not the way it should be; they use profanity in their everyday language; for example, 'give me a blowjob' to a friend. You can see vulgar sources of knowledge they have about sexuality. Internet...*

*I: It's because they have no other sources?*

*J: Yes. They have no other sources and no idea.*

*I: This is what you think Ireland needs?*

*J: Open discussion, about the Karma Sutra or something. I watch a programme on TV, it's after 10pm and it's about embarrassing illnesses. Doctors are so open talking about diseases and they are not ashamed of talking about it. It is normal to talk. A teenager who is watching these episodes might learn something or think: 'Wait a minute, so is it a mycosis or not? Should I be worried?' She won't get this information*

*at school so she might infect others with a disease. Stupid thing ... People think they are just little, innocent girls but they know a lot and they talk to each other.*  
[Justyna, Polish, aged 19]

Finally, among some Muslim women it was argued that the secular underpinnings of sexual education in Irish schools did not take into account the diverse moral and religious backgrounds of students:

*S: In school they'd just say use protection, but they would never say you should be married. They said, 'OK, basically you're gonna do it, so use protection. And if you don't, well then...' And omg. But in Islam it's more of a spiritual thing as well as a physical thing. So...*

*I: So you feel what you were taught in school was not appropriate?*

*S: It wasn't appropriate at all. Like I was never told to respect your body. I was never told if I was in a relationship and all. They talk about it like we were animals. You know the whole thing around relationship is love and understanding. The man just doesn't...*

*C: No, listen. Sorry, sorry - this society is different and we have to respect that as well. They will not understand from our Islamic point of view. But from what we're taught [in school], we're taught it's our health more than anything. If you're going to do it, just protect yourself. And they have a point. But they don't talk about it from a religious point of view. But the fact that, like, I went to a Christian school - they should have been teaching no sex before marriage, but they weren't. It was more teaching you to protect yourself 'cause they know you're going to do it, instead of...*

*I: So you think they made the presumption that you are going to have sex?*

*All respondents: Yeah.*

*F: They should be teaching them what goes by their religion.*

*S: And, like, respect yourself and all. There was nothing like you should be in a good relationship. Or was never told of the importance of being in a good relationship or it wasn't just about sex but everything around that. Committed relationship and the man shouldn't be after one thing. You should respect your body.*

[MFG1, Shireen, Cala, Fiza, aged 17-25]

#### **4.5.3 Overview of accounts of school-based sex education**

There was general agreement among this study group with the view that sex education provided through school was orientated to biological aspects and limited in its capacity to prepare young women to be sexual actors in the world. In many descriptions of school-based sex education in their country of origin, sexuality was only an emerging topic of instruction on the curriculum, so that students found teachers ill-prepared and uneasy in discussing the topic. Chinese women in particular talked of teachers being ill at ease with the topic. In general, individual schools and teachers were a key factor in the effectiveness of school-based sex education, while the scope and duration of the lessons were considered too limited to be effective.

However, there were minority accounts of women who found the sex education they received at school had met their needs for information and built their capacity to negotiate safe, enjoyable sexual relationships. Where this was women's experience they tended to describe a very comprehensive treatment of sexual issues, crucially with a teacher who was comfortable and open discussing the topic.

For migrant women coming to school sex education within the Irish school system this could represent a marked improvement on what they had received in previous schools attended or at home, when discussion of sexuality with parents was closed down at home. However, as with their countries of origin, variability in the sex education provided could mean young women found it of little help or relevance. Where innovative and relevant formats and content were delivered, this was seen as most effective. However, too often women remarked that the content was not compatible with the discourses and pressures related to sexuality they encounter in everyday life. Finally, within the Muslim study group concerns were expressed for the precedence given to secular messages in sex-education content to the exclusion of religious values as a point of reference. Overall, then, varied experiences of formal sex education featured both across the groups as well as within the accounts of individual young women.

#### 4.6 Media and peers as informal sources of sex education

As other studies have found, for the women in this study informal sources - in particular magazines aimed at young teenage women, television and the internet - have become a key sources of information on sexuality. Julita described how teenage magazines and television filled the vacuum left by parents' inability to discuss sexuality with their daughters:

*J: Well we didn't talk about it at home at all. It was taboo. At school there was biology and there was a subject called family planning. What else? Teen magazines and TV. No-one ever sat and talked to me seriously about these topics.*

*I: But you seem to be educated, you planned your pregnancy when you were 17. You had a baby at a particular moment of your life when you wanted?*

*J: Well yeah, but all I knew came from magazines mostly, and school. I didn't get my knowledge at home.*

[Julita, Polish, aged 23]

Ivie, a 19-year-old Nigerian woman who had moved to Ireland with her family and attended secondary school here, talked about her reliance on the internet as a source of information to try to understand talk she heard among her peers. She regretted very much not having a trusted source, in her case her mother, to discuss her questions with:

*Iv: My mum... my mum wouldn't really like ... like talk to me about sex, like., It was like kind of like, she didn't tell me, like, much about it. Like, I would have to find out by myself, like. I found out from my friends and in school and like, like, the things that*

*we would talk about, like, in school, like, was really shocked because ... She wouldn't, never told me; I had to find out by myself, basically - on the internet, and stuff. I was really shocked. I didn't think, like, my mum would keep stuff like this away from me, like, but she did, and it really upset 'cause I really wanted to know, like, from my own parents, but sure they didn't tell me anything about it.*

*I: And what kind of things would you go, would you go online and look for?*

*Iv: Like I won't really go online and look for stuff, I was just like, like, see things on Facebook and stuff. People would tell me things and I'm like, 'What does that mean?' and they would have to tell me themselves, like.*

*I: So what kind of things did you talk to your ... you say people talk to you about sex - was it your peer group or...?*

*Iv: Yeah, like my friends, basically. I'm the innocent one in the group. Like they would say something I wouldn't be sure, like; they basically taught me all this things, like, 'cause I never knew about it.*

*I: So what kind of things do they teach you?*

*Iv: Like about contraception [she laughs]. I can't say the word.*

*I: Contraception?*

*Iv: Yeah, and, like, just, like, sex and stuff - how it felt and different things, like. Like the nicknames for it and stuff, and different stuff that, you know.*

*(Ivie, Nigerian, aged 19)*

Television was another key source. Shu talked about her lack of sex education from her parents when she was growing up in China. She attributes this deficit in knowledge to cultural and religious factors, as well as to her parents' own low level of education:

*S: And I gradually knew more about sex from the TV programmes and things like that. And myself would think about things like that, and how exactly things happened. I am a protestant, and when I was growing up ... My parents didn't have much education. My dad went to primary school and my mum didn't go to school at all. They never gave me any reproductive education.*

*I: Sex education?*

*S: Yeah. Even when I had my first period, I didn't know how to use sanitary and I didn't know what was going on. Only then my mum told me something, but she didn't explain.*

*I: She didn't explain why you were...*

*S: No. So I didn't have any sex education at all from my parents. I started to know about sex gradually by myself. When we went to church, this was mentioned in the Bible. But things like this are kind of hidden in China.*

*(Shu, Chinese, aged 23)*

Li was critical of the sex education she received at school and argued that this resulted in her and her peer group being heavily reliant on internet sources for information and education regarding sexuality:

*We don't have very good education about sexual health and when we grow to my age we always just can only search on the internet and maybe to look at websites about some sexual health and talk with friends.*

(Li, Chinese, aged 25)

Sources of information cited by other research participants were Taiwanese love stories, science education programmes on Chinese television, night-time radio programmes and magazines. A number of participants remarked on first learning about sex when they were staying in college dormitories with fellow students aged between 18 and 22 years:

*I: So before 18 really, you did not have a lot of information about sex?*

*M: Yeah, yeah, I don't know anything.*

*I: You knew very little?*

*M: Actually about sexual thing, I don't know anything.*

*I: Really?*

*M: I only know, em, there are one woman and one man together [laughs], Just like this.*

(Mei, Chinese, aged 29)

For Polish women the collapse of Communism and the opening up to outside influences following 1989 were identified as changes that allowed this generation of women learn about sex through the media, watching MTV music videos, and reading magazines containing information about sexual concerns. Karina remembers that her main sources of information were friends, school, and magazines, as she did not have access to the internet at that time. Both Klara and Krystyna cite the internet as their main source of information about sex and relationships when they were growing up, and for Klara older friends and cousins were her other main sources.

Younger women in the study were most inclined to rely on the internet or magazines as their main sources of knowledge about sexuality. The internet was cited by many participants as a source of information about sexual matters. For example, Shu said that when she came to Ireland she learned of a website for Chinese students living abroad, '6 Park', which showed pornographic films. She described feeling frightened watching these films, and of the ways in which women were portrayed on them:

*S: And there was a lot of pornography on that website. And I did know a little before, but one time I was very curious. Because at home you would be told not to go to any pornographic websites and not to see those things, and not to do this and that. But I was very curious as I was told how the girls were portrayed when they were discussing that. So I went to that website once and because, probably, I just and I was scared at that time.*

*I: You were?*

*S: Yeah because I think Lust Caution was after all a film. It's filmed in an artistic way, it was like ... But the website...*



*I: It exposed intentionally.*

*S: That's right. And the '6 Park' was completely pornographic, completely, very over the top. And I think they sometimes, two people having sex with somebody else watching beside, I think that was exaggerated. So I was scared by that at that time and I didn't, I only went to the website once and never went back again.*

[Shu, Chinese, aged 23]

#### **4.6.1 Effect of rapid diffusion of information in multi-media context**

A feature of women's accounts was how proliferation and access to media with highly accessible and permissive sexual content - in particular the internet, but also teenage magazines - meant that they perceived a wide chasm in knowledge, attitudes and behaviours between themselves and girls just a couple of years younger. They described how messages encountered in popular media such as teen magazines can be challenging for them, as they feel under pressure to be comfortable and conversant with a high level of sexualisation. This pressure was described by Justyna, who attended an Irish secondary school. At 19 she finds younger Polish girls living in Ireland at a distance from her in terms of sexual knowledge, attitudes and behaviour. She considered that the pervasiveness of information and discussion about sexuality within teen media and the internet subjects teenage girls to increasing sexualisation at younger ages, which she experienced as peer pressure:

*J: I know some Polish girls - they're younger than me, girls from my school. We have a lunch together sometimes at school so all the stories they are telling - it's horrible.*

*I: For example?*

*J: Words they were using, or I don't know how to say that ... They were eating bananas and suggesting something ... They were buying 'Bravo' [teen magazine] and reading some sex advice. Unpalatable behaviour. This is a tough act to follow.*

*I: Immature?*

*J: Yes, exactly - immature. It was crazy. Now I think - dirty. Me and my other friend were talking about it and thinking, 'Oh my God, we were at the playground when we were their age' ... And some other girls in my brother's age...*

*I: How old is he?*

*J: He's turning fifteen soon ... They were kissing at the party and everybody was thinking they are lesbian. I thought, 'Oh my God - fourteen years old - they've just finished primary school. The world is changing.*

*I: You think it's the world changing?*

*J: I don't know, but I think access to all these teen magazines is so easy, to the internet, and there's a pressure too. It used to be taboo.*

[Justyna, Polish, aged 19]

Weronika reflected on her experience of acquiring information from popular magazines, films and through talking to friends and argued that it would have met her needs much better if an adult could have spoken to her about sexuality, so that she could have become more aware and made healthier choices:

*I can only think that it would be healthier and better for a young woman to have possibilities that somebody talked to her, so she could be more aware, be able to choose. 'Cause in knowing, being aware of how sexuality becomes formed, we are more able to decide and make conscious decisions. I didn't have the knowledge so I wasn't able always to decide in a right way.*

(Weronika, Polish, aged 30)

In contrast to the failure by her parents to discuss sexuality openly, Weronika had aspirations to be involved in her own daughter's acquisition of sexual knowledge, but she acknowledged that she and others like her would need support to be able to implement such a changed cultural practice in talking openly as a parent to their child about sex:

*I think that I have a little girl. I would like her to have a healthy attitude towards sex. I wished she could respect herself, and not treat sex in a hackneyed way. I think that if there was a programme on how to talk to children about sex - the programme directed to parents - I would surely want to take part in it. I think that focusing on parents is important; I don't think that I am the only one, that many parents have problems with it.*

(Weronika, Polish, aged 30)

#### **4.6.2 Overview of the media and peers as informal sources of sex education**

Media sources, in particular magazines aimed at young teenage women, television and the internet have become key sources of information on sexuality. These sources are particularly relied upon and referred to when young women encounter an information vacuum on sexuality at home and in schools. For some women, and in particular for the Chinese women in this study, there was a wide chasm between silence regarding sexuality within trusted family circles and the highly permissive and explicit messages in popular media. This left women confused about how to negotiate safe and fulfilling sexual relationships and concerned that they would not be conversant and comfortable in the highly sexualised youth culture they find themselves within. All agreed that it would be much healthier for a young woman if they had a trusted mentor with which to discuss the questions and emotions raised for them by the information and messages they encountered in popular media sources and conversations with friends and peers.

#### **4.7 Overview of sex education issues raised by migrant women**

The picture of sex education encountered by the women in the study is one of silences, fragmented information, emerging sex education policies and provision in schools and recent, rapid diffusion of highly permissive sexual messages among multi-media sources (in particular popular culture media for teenagers, and the internet), all giving rise to rapid sexualisation of young women. Silences between parents and daughters were marked. Yet messages regarding the responsibility of girls in relation to sexual morality still managed to become established at an early age, even before girls were explicitly aware of what it was they were expected to be responsible for or how to behave accordingly. This happened without any explicit discussion of this between parents and

daughters. Rather, awareness seemed to emerge as a gradual realisation of tacit rules of behaviour accompanied by an internalisation of these rules. The vagueness of the instructions perhaps makes the internalisation all the more effective. These messages are reinforced throughout girls' development, particularly from the onset of puberty. Reliance on euphemisms and obfuscation was commonplace, and frequently resulted in misunderstandings and confusion.

Young women from across the multi-cultural study group and global locations recounted commonalities in messages received, including warnings about their propensity to become pregnant in the vicinity of men without any additional information and the implicit message that they were responsible for 'good' behaviour.

Young women's depiction of the discourses of sexuality they encountered at home, in school and in popular culture were highly discordant. There was a particular disparity between messages encountered at home and those encountered in teen magazines and the internet - the primary sources of information and advice for many women in the study. As they sought to make sense of this through discussion with peers, the silences encountered at home and at school left them without any trusted mentor to talk to when mixed emotions, confusion, worries or simply a desire to talk arose. A consequence of such mixed messages and levels of openness across the domains of home, community, school and media is that young women may come to fear their bodies, feel a lack of control over their own sexuality and reproductive capacity and encounter hugely conflicting expectations between the varying discourses of sexuality they have encountered.

Research with young Irish women provides a comparable picture among the indigenous population for whom information, understanding and insight about sex and relationships came principally from the four sources of peers, the media, schools and parents (Mayock et al., 2007 and Hyde and Howlett, 2004). Talk about sexuality with parents has been found to be limited, resulting in friends and the media becoming the principal sources of information about sex, albeit sources whose accuracy was much criticised. Murphy-Lawless et al. (2004) recognise how parents and children talking about sexuality is inherently problematic, given the context wherein children are seeking independence from parental perspectives and unlikely to accept what parents say. Similarly, Hyde, Carney, Drennan, Butler, Lohan and Howlett (2009) reported that even where parents were willing to provide sex and relationships education to their children they often resorted to vague moral messages; moreover, teenagers were often reluctant to discuss such matters with their parents and blocked parents' attempts to communicate. This meant that very little meaningful or practical information was given by parents to their teenage children.

Mayock et al. (2007) found young Irish respondents considered school a more neutral 'zone' in which to discuss a range of issues related to sexuality and relationships, yet young women identified the need for greater coverage of the contextual and emotional aspects of sex. Murphy-Lawless et al.'s study (2004) found school sex education lessons

were described as uniformly disappointing across the entire age range: inadequate, embarrassing for teachers and students alike biologically orientated and so de-contextualised as to be meaningless. Difficulties in the delivery of school-based sex education have also been noted due to factors associated with teachers, pupils, and prevailing ideologies about sex (Hyde and Howlett, 2004). The Irish studies recognise that schools alone cannot meet all of the relationships and sexuality education needs of a young person, nor will they be the only source of sex and relationship information and messages a young person receives. Murphy-Lawless et al. (2004) concluded that what women identified as crucially lacking was a holistic approach to sex education, which took into account feelings and emotions as much as biology. In a nationally representative study (Layte et al., 2006) just over 50% of 18-24 year old respondents and around a third of 25-34 year olds had received sex education on sexual feelings, relationships and emotions. Although sex education provision in Ireland remains inconsistent, there is some suggestion that the provision of sex education in Ireland is improving. 71% of respondents aged 18-25 in another representative Irish study (McBride et al., 2012) rated their sex education as very helpful or helpful in preparing them for adult relationships.

Hyde and Howlett (2004, 97) set out recommendations aimed at dissolving deeply-engrained gender codes through strategies such as consciousness-raising about the way in which gender codes operate in intimate encounters. They also advocated measures to equip young women with negotiating skills to enable them to maintain the boundaries with which they are comfortable and the confidence to insist on safer sex. They frame this as an egalitarian sexual discourse, and it is noteworthy how they argue that it is likely to have a much better chance of succeeding where parents and significant others draw on the same egalitarian discourse.

As a snapshot in time, our study findings reflect how migrant women now aged 18-30 interviewed here encountered sex education in schools as an emerging feature of their educational experience and one which teachers were not well equipped to deliver. Those who attended schools in Ireland and encountered some sex education therein also reported variable levels of effectiveness in the approaches taken. In turn, parents' were described as being mostly inhibited in their discussions about sexuality with their daughters. This left young women reliant on informal sources of peers and media sources for sex education. Rapid diffusion of sexually-permissive popular-culture materials in recent years, particularly via internet, has meant that young women are able to access a wide array of information relating to sexuality. The challenge is for them to be able to assimilate these messages and meanings into their own cultural, moral, family and community contexts when silences - particularly between parents and children - persist. The picture emerging in this research is one where young migrant women have grown up in contexts where sex education at home and/or in schools ranges from absent to highly variable, with comprehensive sex education the exception. Meanwhile, highly permissive messages about sexuality and accompanying high levels of pressure to be sexually active pervade popular culture and media directed towards these age groups. Migrant women

who come to Ireland independently of family, and even those who come within families, find themselves immersed in permissive sexual messages and contexts, while feeling uninformed and lacking in skills to feel in command of their sexual lives. The effects of such confusion can be very challenging for young women to navigate, as our next chapter discusses.

## 5.0 Negotiating sexual risks

### 5.1 Introduction

This chapter moves on to discuss women's accounts of negotiating sexuality and attendant risks as migrant women in a new cultural context. It first conceptualises 'safe sex' through the accounts of women in the study, demonstrating the range of concerns women bring to their sexual activities. The chapter explores how the diverse contexts within which young migrant women are living in Ireland shape their experiences of forging and carrying out relationships, including sexual relationships, and in turn their capacity and approach for managing sexual risk. Issues creating conditions for sexual risk-taking are explored, including risk-taking for intimacy, male resistance to condom use, female reticence regarding hormonal contraceptive use, difficulties accessing contraception and perception of a highly sexualised youth culture in Ireland. The engagement, familiarity and connection of the group with crisis pregnancy support services (CPSS) is explored, given the specific remit of this component of the Irish healthcare system in supporting safe sexual practices. Women's understanding of the regulation of abortion services in Ireland, as well as awareness of and access to CPSS in the event of a crisis pregnancy is also explored.

### 5.2 Conceptualising 'safe sex'

There was a diversity of perspectives on what 'safe sex' meant, depending on one's age and life-stage, circumstances and knowledge base. Perspectives ranged from avoiding parental discovery of sexual activity, through protection against pregnancy and/or sexually transmitted infections (STIs) to having the capacity to assert consent or dissent with a male partner in relation to sexual practices they might propose.

Among the Nigerian women, there was consensus that the meaning of safe sex in a young woman's early sexual career is to avoid parental discovery. Here 'safe sex' is equated with not getting pregnant and avoiding the sanctions imposed on women by society for engaging in sexual behaviours. Omorose below portrays the challenges faced by young women embarking on heterosexual relationships trying to cope emotionally with the knowledge that they are going against the wishes of their parents. This means concerns about parents' disapproval are to the fore when negotiating sexual relationships, as opposed to the need to protect oneself against pregnancy and STIs:

*So, I am sure a lot of girls, even 15 year olds or whatever, in Nigeria their parents would have not talked to them about sex. They might be sexually active, but as long as they're not pregnant that's safe sex for them. Safe sex is not getting caught. Safe sex wasn't about, 'Oh you know, my mum [what would she think]?' No. It wasn't about that, it was probably going on in the background, 'cause as she says, you get to the stage where you start, as she says, to 'misbehave'.*

(NFG1, Omorose, aged 20-29)

Confirming this, another young Nigerian woman described her own experience of embarking on her sexual career and using no contraception, despite fearing pregnancy and equally her parents coming to know she was having sex. Fear of pregnancy was more related to parental discovery of sexual activity than to the prospect of motherhood:

*Well, as for me, I have a boyfriend and we practise sex regularly. But I don't use the, ehm, I don't really use contraception all the time. But there was a stage where I thought I was, I was pregnant ... I would talk to my friends about it. It was very, it was very risky situation for me. Because I was scared. And in terms of my parent and my family, I didn't want them to be disappointed in me or anything. And I didn't want them to know that I was having unsafe sex. But, yeah, I just...*

(NFG2, aged 18-20)

This young woman's account illustrates how fear of parental discovery can pervade a young woman's sexual sense of self and sense of agency in their early heterosexual experience. Meanwhile, such sense of self and agency are critical to having the capacity to assess the risk of pregnancy and engage in fertility management through contraceptive use.

Chinese women similarly tended to perceive themselves as lacking knowledge about sexuality and managing fertility, as well as being subject to strict constraints on being sexually active when at home. Shu below recounts a story of how one of her housemates became pregnant shortly after arriving in Ireland but without believing that the sexual intimacy she had been engaged in was 'sex', in the meaning of carrying the risk of pregnancy:

*So one of the girls she had sex with someone just over one month after she came here. She didn't have much experience and she said it didn't, what she explained to me, she explained to us was that she didn't have sex and she didn't understand why she got pregnant.*

(Shu, Chinese, aged 23)

There was consensus among Chinese respondents that young Chinese students experienced both pressures and opportunities to be sexually active now that they were abroad, away from parental supervision and involved in a very youth-orientated group. Coupled with a sense of greater sexual permissiveness generally in Ireland, young Chinese women in the study group characterised themselves as ill-equipped for the pressures to be sexually active and the need to protect themselves against pregnancy and sexually transmitted diseases:

*Younger girls in schools and universities, I think it's because the lack of knowledge they have and they wouldn't think of the importance of using contraception; they would take the risks and they'd think the chance is small and it's OK. So I think they need to raise the awareness at home.*

(Ying, Chinese, aged 25)

In discussing the dual aspects of safe sex in relation to both pregnancy and STIs some participants indicated that the focus on avoiding pregnancy can detract attention from avoiding STIs. For example, Nigerian Chinua highlighted how the focus on avoiding pregnancy and related stigma can obliterate awareness of STIs:

*I: When you were seventeen you were saying your immediate thought was pregnancy and not infections?*

*C: Yes, I didn't. The only reason I was thinking about pregnancy is because it's a taboo for a young African girl in my community to get pregnant. Never mind STDs. Like, come on.*

[Chinua, Nigerian, aged 25]

However, Chinua was aware of both risks to the extent that when she decided to have a child with her boyfriend at age 23 they both underwent an STI test before relinquishing use of condoms:

*C: We talked about it and we were like yeah we'd like to have a baby for each other and then we consulted a GP to see if we're safe for each other.*

*I: What do you mean by that?*

*C: So we don't use condoms or whatever, in terms of contracting anything.*

[Chinua, Nigerian, aged 25]

When Marjana from the Muslim group was asked about her understanding of safe sex, contraception was the first thing that came to mind:

*I: And what about safe sex - what do you understand by the term?*

*M: Oh, contraception, using contraception and educating people on safe sex is what I would consider it.*

[Marjana, Muslim, aged 18]

Interestingly, when Nyla, also a member of the Muslim group, was asked about the concept of safe sex, she didn't refer to contraception, but to the selection of the right partner and the manner in which courtship is conducted. For Nyla, sexual safety was more to do with the nature and circumstances of the relationship in which intimacy takes place. Similarly, Julita emphasised the emotional aspects of a secure and loving relationship as fundamental to her understanding of safe sex:

*I: Could you tell me your opinion about safe sex? What does it mean to you?*

*J: Not a casual sex, I think sex is safe with a person you love and if he loves you too. And you know it.*

*I: So this safety is directly connected to emotions you feel?*

*J: Yes, even a crisis pregnancy is not a tragedy then. You have a person you love by your side for the rest of your life.*

[Julita, Polish, aged 23]



Some women, such as Polish women Julita (23) and Karina (24), equated casual sex with sexual risk-taking. The issues they highlighted were the lack of fulfilment such sexual relations would provide for them as well as the risk of contracting an STI or becoming pregnant with a person who would feel no responsibility to them or the child that could result. Karina argued:

*K: No ... no, no. I've never been tempted to do it. I think I have to feel something for this person; I need some kind of certainty to have sex. I'm not sure if that kind of fast-fuck would be pleasant for me. I don't know; I've never been tempted to do it ... I would be afraid of it, I think.*

*I: Of what?*

*K: Diseases and first of all unwanted pregnancy. I like a boy at the party I go to bed with him and what would I do later? Where to find him? I could rear a child by myself like my sister's friend but I'd like my children to know who their father is. Even if it's a father who is only paying maintenance, I just want my child to know who his father is otherwise what should I say to him? I don't know who your father is! I'm not that kind of woman. I like flirting all right but nothing else. It has never happened to me in young age so I think it won't happen in the future.*

[Karina, Polish, aged 24]

When Martyna (Polish, aged 30) was discussing her understanding of safe sex, she included situations where a man would propose engaging in certain sexual practices, which she would not feel comfortable about. She contrasts agreeing to attend strip clubs with a boyfriend when she was younger despite her discomfort, with her recent confidence to refuse a boyfriend who proposed engaging in a 'threesome':

*Some methods that some men like to perform actions, types of sex which is completely not what I would like to do! That would be as well not safe in terms of from emotional thing that I don't want to do that and you won't force me to do that! ... Once one man asked me if I could do a threesome with him and another woman and I was like, 'Are you crazy?'*

...

*I used to feel comfortable with that, I wouldn't feel comfortable now, but we used to go, with my long-term partner, to this striptease club and he would be so happy I'm going with him and I would be happy myself too. Ha ha! But if I think of that now it was for him because it was his fantasy, there were naked women around and men, and I would finish (end up) with him that night, but now thinking about it I would never do that again.*

[Martyna, Polish, aged 30]

### 5.2.1 Overview of conceptualisation of 'safe sex'

A range of perspectives on 'safe sex' were evident among the study group and were often related to the contexts in which these young migrants came to Ireland. Younger Nigerian

women, for example, who were living within their (migrant) family household described how their greatest concern about early sexual activity was parental discovery. Women's fear of pregnancy often related more to parental discovery of sexual activity than to the prospect of motherhood, suggesting that this fear pervades a young woman's sexual sense of self - a key factor in failure to address attendant risks. For young Chinese women, who tended to come to Ireland for short periods independently of their families, being away from parental supervision and being involved in a very youth-orientated group represented a form of freedom that sat in stark contrast to the high level of monitoring they described themselves as subject to when at home. The freedom, coupled with a perceived sense of greater sexual permissiveness generally in Ireland, created both pressures and opportunities to be sexually active, which in turn created conditions for sexual risk-taking. The young Chinese women in our study group characterised themselves as ill-equipped for the pressures to be sexually active or to protect themselves against unplanned pregnancy and sexually transmitted infections. Awareness of the risk of pregnancy related to diverse forms of sexual intimacy, such as highlighted in the CPP's 'Think Contraception' campaign, would seem highly relevant to this group in particular.

Among the study group, the notion of safe sex encompassed avoiding parental discovery of sexual activity, using contraception for protection against pregnancy, protecting against sexually transmitted infections, secure, trusting or positive relationships versus casual, unequal or conflictual relationships, both partners being tested for STIs and having the capacity to assert consent or dissent to sexual acts proposed by a partner. While protecting against STIs did feature, it seemed that the emphasis on pregnancy-related risks could obliterate awareness of risks related to STIs. Mention of STIs was made by only a few women, one of whom had contracted an STI as a consequence of unprotected sex with boyfriends who had convinced her that this behaviour was safe. Two other women remarked that they considered themselves lucky not to have contracted an STI arising from previous casual encounters.

There are complex reasons for risk-taking and many forms it can take. Within this study we saw how some young women engaged in sexual behaviour that is 'risky' without being aware of the risk (such as engaging in intimate sexual acts that lead to pregnancy without realising the risk of pregnancy inherent in the act). For others risk-taking entailed failure to address a risk to avoid other consequences (for example, having sex knowing about the risk of pregnancy but not using contraception in order to minimise the risk of parental discovery). It would appear that strategies to keep oneself 'safe' or failing to protect oneself from risk or danger are related to self-care and self-worth.

Being empowered to practise safe sex, then, seems to entail gaining self-confidence and self-esteem, as well as knowledge and awareness. It is important to bear in mind here the earlier discussion regarding the asymmetrical power dynamic between males and females in heterosexual relations and how these operate at the socio-cultural level,

regardless of the intentions and actions of the male partner in any given relationship. We saw diverse levels of capacity among the women across this study group to practise safe sex. The young Chinese women in our study in particular displayed the need for greater capacity building in this area.

### 5.3 Avoiding sexual risks

Diversity featured in the strategies women described to avoid or manage sexual risk. There were women in the study group who had not embarked on any sexual relationship. This was attributed to adhering to their family's value systems and avoiding risk of shame or pregnancy or to adhering closely to the teachings of their faith. For example, young Nigerian friends Nimma and Asa were kept under close surveillance by their parents and had not had much experience of relationships with boys at all. They had not contemplated sexual relationships outside of marriage for fear of pregnancy:

*N: Getting pregnant at a young age is seen as a really bad thing - an abomination. Like, it shouldn't happen.*

*A: The idea was that your life is over and you cannot go back to school anymore... Shame, your friends. [Laughs.]*

*A: The family will disown you and stuff like that.*

*N: It was seen as probably your parents didn't bring you up properly.*

(Nimma, Nigerian, aged 20 and Asa, Nigerian, aged 23)

Asa, went on to discuss the expectation that women would remain virgins until marriage. It would have been advocated by authority figures in women's lives but in fact is less binding or pronounced nowadays. She noted the paradoxical attitudes of boys in regard to this expectation, noting their expectations of virginity as a valued or necessary characteristic in a potential marriage partner as varying and diminished relative to the past.

Nimma indicated a high degree of respect for the values and guidance received from her family, but did not aspire to complete adherence - she considered it 'advice'. While Nimma indicated a capacity to manage and negotiate her own sexuality, she also expressed a certain level of discomfort in being caught between the discrepancies in the values of and 'pressures' from her peers, the values and norms of her cultural/family background, as well as her own physical-emotional desires and her socio-economic aspirations.

Asa distinguished her values from those of her peers in relation to socialising and alcohol consumption. She described her friends as having hostile attitudes to her being a non-drinker and she expressed a lack of comprehension for their behaviour in relation to alcohol. Similarly, Nimma did not completely identify with her peer group's values. She discussed the importance of knowing 'your limits' in relationships, whether with female friends (as regards drinking and socialising) or boyfriends (in negotiating intimacy). This she saw as an important element of self-care and managing her sexuality.

Some women in the Muslim group emphasised how observing their faith meant that sexual relations outside marriage were strictly forbidden for them, thereby avoiding the risk of pre-marital pregnancy:

*I: Would you have ever considered having sex outside marriage?*

*Ir: Hell no. No, no, I wouldn't.*

*I: And why is that?*

*Ir: The main reason, the main reason is because it's prohibited in my religion. And then also - well mainly it's just that it's not allowed in my religion. And I wouldn't even risk it, to be honest. Like the chances of getting pregnant and all that stuff. Like even religion aside, I wouldn't, it wouldn't be something I'd consider.*

*I: Risk it in what sense?*

*Ir: In the sense that I'd get pregnant or you never know what could happen.*

(Iram, Muslim, aged 20)

Nyla, a young, recently married Muslim woman, described chastity as a means to protect oneself from unplanned pregnancy:

*Young girls can have fun. But be careful, be careful of who you're dating, what you are doing. Do not listen to what they are saying. Some guys lie - 'I love you. I want to marry you'. They make you pregnant and leave you and stay on your own. So it is good to wait when you are ready. When you are 17, it's OK. When you are 18, it's OK. You are girl enough so you can start dating. It's not about going and having it - you can have boyfriend without doing that. Yes, because in my country if you are dating someone it's not all about sex.*

(Nyla, Muslim, aged 21)

She acknowledged the challenges entailed in trying to negotiate sexual boundaries with boyfriends. In the extract below she recalled an experience where a previous boyfriend tried to pressure her into having sex by questioning her love and saying that having sex was a way to prove the integrity of her feelings for him. For Nyla, chastity and marriage were a positive choice which brought her benefits in being able to manage her sexuality, fulfil her aspirations and construct and maintain a positive self-identity.

*N: Crazy, crazy. Because when I had this boyfriend always talking about sex. I was like, 'Are you kidding me or what? Can you not just stay with me without asking me?' It's not good because I know I want to stay with him forever. Sometimes he'll say, 'You don't love me. You don't love me. You have to prove to me.' Because I know you are a boy and I'm a girl. If I give you my body, you'll have me and dump me and go on your own. Because they want to know all the girls.*

*I: What do you mean by 'They want to know all the girls'? Is it that they want to have sex with all the girls, yeah? How did you find that? How did you resist that?*

*N: My boyfriend, we didn't last for long so because he was always asking me and I said*

*no. So he dumped me and go for another one.*

(Nyla, Muslim, aged 21)

Among younger Muslim women there was an expectation that crisis pregnancy would not feature in their community, and in the rare case that it did, families would try and deal with it themselves, either by encouraging the young woman to get married or to have the baby overseas:

*I: Are there cases where a Muslim falls pregnant outside a marriage context?*

*B: There have been.*

*A: Yeah.*

*C: But the cases are very rare.*

*A: And they're very closed. Like families would do their best not to disclose it. Not necessarily hide it 'cause there's only so much you can hide. But they may suggest that the girl gets married or have the baby overseas.*

*S: Maybe if you get divorced, then find out that you're pregnant.*

*A: But that's different 'cause the woman was married. See, the idea is that the conception is within a marriage. But if it happened outside a marriage then that's what the family is trying to hide.*

*I: And maybe to encourage them to get married?*

*F: Yeah.*

*A: Yeah. But if it's a Muslim girl and a non-Muslim boy, then - like someone they met in college - I can't imagine. Like, I don't know anyone in that situation.*

(MFG1, (Aadila, Batool, Cala, Fiza and Shireen, MFG1, aged 18-25)

Among the Chinese study group also there were young women who were not sexually active and were of the view that avoiding sex before marriage was the best way for a woman to protect herself from a myriad of issues including losing social value or capital, pregnancy, social ostracisation and parental condemnation, as Jia describes:

*J: I think it's OK, but we need protection, but for me I prefer after marriage. That's what my mom was always telling me: for boys they're OK but as a girl you need to be careful because all the pain you feel, and boys just don't care or something. You need to protect yourself.*

*I: So your parents, they are worried about the pain, say emotional?*

*J: Like, yeah sometimes it happens, yeah abortion and sometimes mental or the boy just leaves or something like that so my mom said, 'You need to be careful, every step you want to do it, you need to think it over.' It's better for me, like, after marriage.*

(Jia, Chinese, aged 24)

While sexually active, Karina (Polish, aged 24) explained that avoiding casual sex was central to her in avoiding sexual risk-taking. Justyna (Polish, aged 19) described acquiring awareness and a sense of responsibility in relation to avoiding sexual risk from the sex

education sessions she received in an Irish secondary school. In one component of the curriculum an actor who was playing the part of a man who was HIV positive came and spoke to the class about avoiding sexual risk-taking. This message was very strong and had a long-lasting impact on Justyna's behaviour, so much so that two years later, before having sex with her current boyfriend, she requested that he be tested for STIs.

Avoiding sexual risks, therefore, for some women in the study involved abstaining from having sex until marriage because of the cultural repercussions, involving shame and fear of an unplanned pregnancy amongst family and community members; for others it meant not engaging in casual sex. For others chastity and observing one's faith was a means to protect themselves from sexual risk-taking. Muslim participants noted that a crisis pregnancy – for them one that occurs outside of marriage - was rare amongst their community, and if it did happen, all efforts would be made to keep it secret from other members of the community.

The practice of celibacy did feature in this study to a much greater extent than it would have in research with the Irish indigenous population, where there is an acceptance that sexual experimentation is part of the life-stages of young adulthood.

#### 5.4 Sexual risk-taking

Some participants in our study group had had sex when they were teenagers, but the majority of became sexually active when they were older, in their twenties. Various reasons for sexual risk-taking were given in women's accounts, which are discussed below:

- Risk-taking for intimacy
- Attitudes to using contraception
- Taking risks with unprotected sex
- Issues in accessing contraception
- Male attitudes to addressing sexual risk
- Female reticence about hormonal contraception
- Sexualised youth culture in contemporary Ireland

##### 5.4.1 Risk-taking for intimacy

As expected, sexual interest, desire and seeking out intimate relationships featured in women's accounts of entering into heterosexual relationships and being sexually involved. Lisha explained seeking out intimacy in a sexual relationship in order to feel loved after her mother developed a debilitating illness and could not relate to her children as before:

*I wasn't really feeling the love I used to feel. So I thought if I go out I would find the love there, so that was how I got hooked with my first boyfriend. He was very loving and then I got pregnant when I was 16. That was when everything started crashing down in the house.*

(Lisha, Muslim, aged 22)

Martyna described sexual risk-taking in her early sexual career so as to experience the enjoyment of sex, but after an episode where she had to use emergency contraception she re-evaluated her behaviour:

*I changed my attitude after that incident this year as it was a one-night stand which turned into longer and I was very scared as the condom broke, that's why we went for that morning-after pill and it made me think, 'Do I really want to do that? ... Do I really need to have sex that much to risk this?'*

(Martyna, Polish, aged 30)

#### 5.4.2 Attitudes to using contraception

Participants in the study had experiences of using different forms of contraception including condoms, the contraceptive pill, emergency contraception, hormonal implant and IUD, as well as natural family-planning methods. Condoms and the contraceptive pill were the most popular forms of contraception used by women. Generally, the women related contraception to safe sex and saw contraception as a positive and useful tool to control fertility and protect oneself against risk. Degni, Mazengo, Vaskilampi and Essen (2008) note that nowadays there is a remarkable diversity of views among Muslims concerning the use of contraception. The question of whether Muslims reject or accept it is explained by their own beliefs, values, attitudes, interpretations, and knowledge of contraception. In our study group, Marjana from the Muslim group strongly advocated contraceptive use to protect against unintended and unwanted consequences of sex and in order to facilitate family planning:

*I: And what would your attitude be towards using contraception?*

*M: I don't see why people shouldn't use contraception. Unless you want to start a family, well obviously, but you should practise safe sex. Why not? Say for example, a Muslim girl that got married young and she's in college - She wouldn't want a baby right now. So you'd have to use contraception. So her and her husband can have safe sex without having to worry about getting pregnant because she's in school/college, he's working, and they might not have the finance yet to have a baby, 'cause they're expensive. So I think definitely women should use contraception.*

*I: Were you ever given information or advice about contraception during your teenage years by either your mother, the GP, people you know?*

*M: Yeah. I think it was in secondary school when we had a kind of 'sex ed' as well. And it just kind of said in general the kind of contraceptions you can use - the condom, the pill, even you can get a chip in and there's kind of different things you can do. But never has anybody said to me, 'Oh you should go on the pill or you should consider going on the pill.' So that has never happened, unless you go on the pill for different medical reasons like acne or back problems and stuff like that. But no, nothing else really.*

*I: And have you ever had experience using contraception?*

*M: No, never.*

(Marjana, Muslim, aged 18)

Although contraceptive use was not directly relevant to Marjana's own experience she was very much aware of contraception and in favour of the provision of education, information and support services with regard to contraception, STIs, unplanned pregnancy and sexual/reproductive health generally:

*I: You have a lot of information which you would have learned about it in school or parents, etc. But do you think there are clinics out there that help people with these issues? With people who haven't had safe sex or who get pregnant or want to know about contraception and all. Do you know of any clinics out there?*

*M: Mhmm. There's one near the Ha'penny bridge. It's called the Women's Centre and there's another on Dame Street as well. That's two in town that women can go to and seek help. So there definitely is.*

*I: And do you think they do good work out there?*

*M: Yeah, definitely. From what I've heard they do good work and promote safe sex. And there's a service where they provide counselling as well and they support women. Somebody with unplanned pregnancy, they'll give them information, they'll give them flyers and talk to a counsellor. So there definitely is.*

(Marjana, Muslim, aged 18)

Iram also articulated this pragmatic attitude to contraception, although, like Marjana, she was celibate:

*I just think you should be more smart about it and wait, like. Or if you're going to have sex then be smart enough to use contraception.*

(Iram, Muslim, aged 20)

Other members of the Muslim group, however, had differing attitudes towards contraception, with some seeing it as irrelevant to their own needs, experiences and values.

Amongst participants of Muslim Focus Group 2 (MFG2) there seemed to be an acceptance of the fact that male partners would not use condoms, as well as an acknowledgement that women are not educated in how to protect themselves from further pregnancies:

*T: But for me I think condom is the best.*

*P: But again condom wouldn't be 100% safe.*

*T: No condom is 100% safe but the hardest thing is getting your husband to use contraception with you. Especially if it's your husband they don't like to...*

*P: And even when he's African.*

*I: Would he agree or disagree to contraception according to religion?*

*B: Well according to the religion they say no. Unless the person is sick, has an illness or your husband is away from the country.*

*T: Oh as in when the man is travelling around. Oh and I think for a woman that gets*



*pregnant easily like a woman as soon as she has a child she will get pregnant again so some women get frustrated after the first two or three babies because they were so quick. But I don't even think Somali women are educated on protecting themselves against a pregnancy.*

(MFG2, Taballah, aged 26, Parveen, aged 21 and Beena, aged 32)

### 5.4.3 Taking risks with unprotected sex

There were a number of women in the study who disclosed experiences of unprotected sex. Nkoyo recounted that she first began having sex at the age of 16 and for the following five years had unprotected sex having been told it was OK to have sex without protection by the boyfriends she had during this period. She became emotional talking about this time, having contracted an STI and subsequently having been dumped by a boyfriend after she told him of this:

*I: In terms of sex and contraception for you, and dealing with sex growing up, how was that for you?*

*N: Basically, I started having sex at the age of 16 and for, like, five years that followed I had unprotected sex between those years. [Pause. Respondent gets emotional and cries.]*

*I: Take a minute. If you are not happy to go on we can stop and continue another time.*

*N: No, it's fine. I will continue. I had like two, three boyfriends between those years and they all said it was OK to have sex without protection. I got STIs.*

*[Respondent is emotional and cries.]*

*I: It is OK if you don't feel like you can go on.*

*N: It's OK - it will be good for me to finally have a chance to get it out.*

*I: OK, just take a few minutes then.*

*N: I am OK now. When I told my boyfriend at the time about my STI, he left me. That was it for me [...] the beginning. I was very shy but I still had to get myself some help. I walked into a chemist who prescribed drugs for me which made me better. After that I became very careful till I met the guy that got me pregnant. And that is how I had my baby.*

(Nkoyo, Nigerian, aged 30)

Exploring contraceptive use with the Polish women demonstrated that the majority had used some form of contraception at some point in their sexual lives. However, contraceptive use amongst the women varied considerably, with some not using any form of contraception, and others having patterns of intermittent usage. Both Ruta and Martyna discussed experiences of unprotected sex with men, one with her short-term boyfriend, and the other arising from a casual encounter. They both had to rely on emergency contraception after these experiences. Likewise, Ying did not use contraception on a number of occasions and had to avail of emergency contraception. She described herself as just getting carried away:

*Y: The thing is things are happening around me and you get ... erm*

*I: Caught up and forget about yourself, kind of?*

*Y: Yeah exactly - that's it.*

(Ying, Chinese, aged 25)

Looking back on her younger more inexperienced self and in the meantime having gained awareness and confidence, she made reference to a man's role in taking responsibility for practising safe sex and the importance for women to develop the skills to negotiate their own needs and boundaries.

Julita (age 23) and Karina (age 24) of the Polish group reported that they had never used any form of contraception. The main form of birth control Karina relied on was the withdrawal method, as she did not wish to experience any side-effects from the pill and none of her sexual partners wanted to use condoms. Likewise, Krystyna (21) reported having unprotected sex and only using condoms a couple of times before becoming pregnant.

Murphy-Lawless et al. (2004) found in their study that with the exception of one woman all respondents had experiences of unprotected sex. In this research, experiences of unprotected sex were disclosed by over half of the participants, and were associated with risk-taking for intimacy, pressure from sexual partners, and women's lack of sexual knowledge and self-esteem.

#### **5.4.4 Issues in accessing contraception**

A number of women raised issues with accessing contraception, related to cost, lack of information, problems when changing GPs and a refusal by a GP to prescribe the contraceptive pill. The implications of accessing contraception transnationally were also discussed. For women in this study who did wish to use hormonal contraception, issues in accessing their method of choice featured in a number of ways but were primarily related to cost and the extent to which young migrant women were connected in with Irish health services.

Lack of knowledge or awareness of fertility and contraception was an impediment to some of the participants in engaging in safe sex or preventing pregnancy. For Lisha, contraception simply wasn't on her radar at the time of her first sexual relationship during her teens, resulting in a crisis pregnancy. She described herself as not knowing anything about contraception and explained that sex education classes discussing contraception had occurred three years previously for her and at the time had seemed irrelevant. She felt her mother may have been a source of advice but she was ill and unavailable to her at the time.

The issue of cost was a factor for two women who were of low-income status, such that they were eligible for the General Medical Scheme (GMS). Both encountered issues in

accessing contraceptive services under the GMS, and crisis pregnancies resulted for both of them. Polish Agata (29) described how when she moved to a new rural locality in the south of Ireland she attended the GP assigned to her there under the GMS for a prescription for hormonal contraception, only to discover the GP refused on conscientious objection grounds. She then had to change GPs and is highly critical of the length of time it took to do so through the GMS. In the interim, without having access to a doctor to prescribe hormonal contraceptives, she became pregnant, which was a crisis for her. Young Muslim woman Lisha (22), who had a crisis pregnancy when she was sixteen and became a lone mother, described how this gave her access to a medical card in her own right which she planned to use to access the contraceptive pill. However she began a relationship when waiting on her medical card to come through and became pregnant before getting the pill organised.

Migrant women were often aware of the cost of their hormonal contraception of choice in their country of origin and where this was comparatively significantly cheaper their tendency was to access contraception on a 'transnational' basis. (See Chapters 7 and 8 below for further discussion on this). This took the form of buying contraception in bulk before travelling to Ireland or when home on visits, ordering it on-line or asking contacts back home to send supplies by post because of ease of access as well as lower costs incurred. Among our study group these issues featured in both Chinese and Polish women's accounts, more so than for the other two groups. Ying's account highlights interesting ways in which such practices can create conditions for sexual risk-taking. When asked about crisis pregnancy Ying (25) said that as well as not fully appreciating the risk of pregnancy, she would feel awkward in this country seeking contraception and would prefer to do that in China, when she returns to visit:

*Y: So I think for most crisis pregnancies girls don't know this would happen to you and you always think it's someone else's story and you wouldn't think it would happen to you. And honestly I felt awkward as well, a reason why there would be crisis pregnancies as well, I felt awkward to go get the contraception so I would go back home once a year and because condoms were cheaper back home I'd...*

*I: Stock up?*

*Y: Yeah!*

(Ying, Chinese, aged 25)

However 'stocking up' entails bulk buying when in China. Ying recalled her experience of buying condoms in a pharmacy in China and the embarrassment she experienced when doing this, perhaps feeling self-conscious at purchasing condoms in such large quantities:

*Y: It's a very funny experience and I remember once back home I was in a very large supermarket and there were different types and I was deciding on what to do. And then some sales woman comes up to me and goes, 'How may I help you?' and I just*

*go, 'Ohh Noooo! I just want to cover myself up'. So I just wanted to get them and leave; I didn't want anyone's advice or anyone's help. And so she was like, 'OK?' I was like, 'I'm OK' and she was like, 'You can try this and that,' and I was embarrassed taking four packs. I remember me and my friend, she was the one I was telling you about her parents being open about sex or whatever with their daughter. So we went to the supermarket and bought condoms and I just threw them to her side. For me that was really, something you'd be shy about.*

...

*Girls don't usually choose the pills and would be ashamed with buying pills or condoms so that's also a reason why they'd have nothing when having sex, especially for younger girls afraid of being judged.*

*I: Would the younger girls be frowned upon?*

*Y: I think when you go to a pharmacy, a sales assistant, they will judge; quite harsh to the younger girls.*

*(Ying, Chinese, aged 25)*

Ying's account illustrates how relying on transnational means of accessing contraception to the exclusion of making any contact with local sexual and reproductive health services can leave women at risk of being unable to access the necessary information and support services in this country when needed.

#### **5.4.5 Male attitudes to addressing sexual risk**

In discussing the role of men, young women often encountered male resistance to condom use. Women's accounts of negotiating safe sex with young men evoke the discussion in Chapter 3 above of the double standard wherein responsibility for maintaining morality - including through the avoidance of pregnancy - is vested in young women. This seems to have the effect within intimate sexual encounters that young males can abdicate responsibility and leave female partners feeling pressurised to engage in sexual risk-taking. The participants in Nigerian Focus Group 2, Atua, Oni, and Esosa (aged 23, 18 and 23 respectively) depicted the difficulties faced by young women in trying to negotiate safe sex with highly resistant male partners. The passage below is a composite narrative of Atua and Oni's experiences, in which they describe some of the tactics used by partners in the struggle over the use of condoms:

*O: Then he will start bringing up stuff like, 'Now you are cheating on me.'*

*O: Or, 'You don't trust me.'*

*I: He says?*

*All: Yeah, Ahha.*

*A: He'd be like, 'You're cheating, that's why you want me to use condoms. If you weren't cheating you'd just go like that, but you're cheating and doing something outside there, that's why you want me to use condoms.'*

*O: They think if you love him then you'd do it to make him happy.*

*A: Yeah. 'If you love me then let it be, because you don't you want me to use condom'  
Aha.*

[NFG 2, Atua, aged 23 and Oni, aged 18]

The participants found that when they sought to assert control over the sexual encounter in seeking to pursue a safe-sex strategy, this was countered by their partners' querying of the genuineness of their feelings or commitment, by calling into question the girl's moral character, thus undermining her position and eroding her resolve.

Chinese Changying discussed gender-differentiated attitudes in relation to using contraception, which she considered to be universal:

*And the guys, no matter Chinese or foreigners, they don't like wearing condoms. They are the same. Don't believe what is shown on the TV that foreigners have strong sense of safe sex. They also prefer not wearing condoms if they don't have to.*

[Changying, Chinese, aged 22]

Ruta described how she had encountered resistance to condom use when in a cross-cultural relationship at age 15. She felt her boyfriend put greater emphasis on sex than she would have expected with a Polish boyfriend and described him as being resistant to condom use:

*We were together for three months. But he was treating me like I was a rug or something... He would only call me when he wanted to have sex and that kind of thing, so I wasn't used to it! Polish community isn't based around sex only. Like when the guy and the girl go out and if the girl has too many sexual partners it would be very, very bad and seen as a bad thing!*

...

*Usually we put on a condom or something but this time he just did it and climbs into bed and I'm like, 'What did you just do?!' So I stood up and go, 'What did you just do?' And he was like, 'I dunno - I just came' and I was like 'What?!' ... He never asked me if I was taking contraception or anything, and I didn't take anything that time and I was like, 'Do you want to have a baby? Do you think at all?!' and he was like, 'Sorry I was in seventh heaven and I didn't think about anything' and I was like, 'Wow!' Like back then a 15-year-old girl, I was like, 'Oh my God what will I do now?' And when I went out of there I took the [morning after] pill and I was like, 'Wow! I can't believe I nearly got pregnant at 15.'*

[Ruta, Polish, aged 19]

Ruta attended her GP for emergency contraception and continued to attend him for contraceptive advice and contraceptive prescriptions. She did realise that this episode had put her at risk of contracting an STI and she had a HIV test done. However, in this instance she used a free HIV test service offered at her college rather than attending her GP, for

reasons of privacy. This highlights how STIs may carry greater stigma than contraception and pregnancy for young women considering GP consultations.

Nigerian Chinua recounted a similar story to Ruta of an early sexual relationship when she was not sufficiently knowledgeable or empowered to ensure her partner used a condom, which in her case led to pregnancy:

*C: Like, the first time I got pregnant it was the first time I had sex and the guy tricked me into believing he was wearing a condom. I didn't know what a condom was or looked like. I didn't. Even though I knew of the word condom I didn't know how it looked.*

*I: Or how to know if he was using it or not?*

*C: Exactly. I said to him 'Can you put on a condom?' and he goes to me, 'Yeah, I already am,' and then a month later and I find out I'm pregnant. Imagine. And I was only seventeen.*

...

*C: No, I didn't [know]. Imagine, the worst mistake I could have done was not knowing whether he was wearing condoms or not. Like, how can I not know that?*

[Chinua, Nigerian, aged 25]

While such stories of male abdication of responsibility for sexual risk-taking and regard for their partner's well-being abound, there is also evidence that in some cases behind such recourse to discourses of male sexual prowess there are some situations where the young man's lack of knowledge and confidence regarding how to use condoms is a factor in sexual risk-taking. For example, it is interesting to note in the quote below how Jiao describes both the young woman and man as inexperienced and lacking in knowledge about sex and fertility, which seems to be the reason for the risk-taking:

*I think guys don't want to use it and girls are too shy to tell them to use it. Guys would say 'It's OK not to use it. It's OK not to use it'. I think girls are too shy to mention it. Like the girl I used to live with who was a year older than me, she has become a mother now this year. They were together for two months and they already slept together and that was her boyfriend's first time ... the guy never wore condoms even though they knew she would get pregnant. They thought it didn't matter. And then the girl got pregnant.*

[Jiao, Chinese, aged 18]

#### **5.4.6 Female reticence about hormonal contraception**

Such male resistance to using condoms - the primary non-hormonal contraceptive - creates conditions whereby effective contraceptive management becomes principally related to women using hormonal contraception. However, women may reject hormonal contraception because of side-effects, including weight-gain, and perceived health risks, such as risk of cervical cancer (Murphy Lawless et al. 2004). These same issues featured in the current study with young migrant and minority ethnic women in Ireland.

*Y: I'd prefer using condoms than pills because I was on pills for two weeks on holidays, on the beach in Thailand, so that was the only reason because I didn't want a period, but I put on a huge amount of weight. But I didn't like the idea of taking pills constantly, just didn't think it was healthy for my body, so I stopped it. Condoms are the ideal option for me now.*

(Ying, Chinese, aged 25)

*C: Just the condom - after the injection, I took the coil, even that didn't work for me! I felt like I was getting fat and the doctor said 'Oh no, no - it's just in your head' and I was like, 'I'm getting fat!' So I took it off.*

*I: How long did you use it for?*

*C: I was on that for three months but anything that has to be inserted in me or injected in me I think would disrupt my system and hormones, so I've stayed away from it and go with the condom.*

(Chinua, Nigerian, aged 25)

*I: Are you using any contraception method this time?*

*K: No. I've never used any contraception.*

*I: Is there any particular reason for that?*

*K: No. Just like that. I didn't want to take pills because I've heard a lot about it: putting on weight, side-effects of using and things like that. Condoms - I've never tried - none of my partners wanted it as it's uncomfortable. For me it doesn't matter.*

(Karina, Polish, aged 24)

#### **5.4.7 Perception of sexualised youth culture in contemporary Ireland**

Many young migrant women commented that they considered Ireland had a more permissive sexual culture than their country of origin or cultural background would support. They felt this permissive culture created new pressures for them to be sexually active and new conditions for risk-taking. Justyna described observing a highly permissive sexual culture among young, mostly Irish, girls in the Irish secondary school she attended and described high levels of risk-taking practised as games among girls and boys in school. She connected sexual risk-taking with consuming alcohol at a young age, which she thought to be a particular Irish issue. Justyna described one such sexual game involving 'shag bands', wherein wearing different coloured rubber elastic bands signified the different forms of sexual activity the wearer is willing to engage in. Justyna sold these bands in the shop where she was working and so was aware how young people used them and their understanding of their meaning:

*J: Some parents were coming and asking for elastics just because it was popular and everybody had them. But there were also girls who knew exactly what it was all about: "Oh they have got black! Black! Black! We gonna take one of those," because black means "all the way".*

*I: And you didn't want to play this game?*

*J: Oh you kidding me? I'm too old for these kinds of things. It's for kids 12-14 years old.*

*I: But it's about sex?*

*J: Ye, but older people don't play these games; bottle of wine somewhere in woods and spinning the bottle. Alcohol is helpful. Irish kids start drinking early.*

(Justyna, Polish, aged 19)

Ruta also connected the practice of early drinking among youth in Ireland with sexual risk-taking, reflecting on her own experience. She moved to Ireland when she was 13 years of age with her family and by age 15 described herself as drinking a lot when she went out. She talks about meeting the boy who would become her first sexual partner at that time and describes a general casualness about drinking, relationships and sex that characterised this stage of her life:

*We met at a party and he goes to me, 'Do you want to [get together]?' and I was like, 'Yeah sure'. I was drunk off my face and was like, 'Yeah, whatever. Let's be friends, boyfriend, girlfriend.' So we were texting for a while and then we, it was purely based on sex.*

(Ruta, Polish, aged 19)

#### 5.4.8 Overview of sexual risk-taking

Before discussing sexual risk-taking it is interesting to note how celibacy featured in this study to a much greater extent than the issue featured in research with the Irish indigenous population, where there is an acceptance that sexual experimentation is part of the life-stages of young adulthood. In particular young Muslim women, young Nigerian women who describe their parents as 'traditional', and young Chinese women did refer to celibacy as a strong part of their worldview.

Risk-taking featured in a number of forms in this research. Experiences of unprotected sex were associated with risk-taking for intimacy, pressure from sexual partners, and women's lack of sexual knowledge and self-esteem. Some young women described seeking out intimacy at an early age which would develop quickly into sexual relationships without the girls having the knowledge and capacity necessary to address pregnancy or STI prevention.

In discussing the role of men in addressing sexual risk, young women in this study concurred with findings of other studies reporting they often encountered male resistance to condom use. The sexual double standard discussed previously wherein responsibility for maintaining morality, avoiding pregnancy and so on is vested in young women seems to have the effect within intimate sexual encounters that young males can abdicate responsibility and leave female partners feeling pressurised to engage in sexual risk-taking.



Strategies by men to avoid condom use recounted included querying the genuineness of the woman's feelings or commitment and calling into question the woman's moral character by suggestions of promiscuity, thereby undermining any request the woman made to have condoms used and eroding her resolve. Meanwhile behind such recourse to these discourses of male sexual prowess there also seemed to be evidence that both young men and young women may not use condoms out of lack of knowledge and confidence regarding how to use them.

Difficulty accessing contraception also featured as a reason for risk-taking. Access to contraception support services was affected by cost, lack of sexual health knowledge and information, problems when changing GPs and a GP's refusal to prescribe the contraceptive pill. Not accessing localised SRH information, as well as embarrassment about accessing contraception here, and a reliance on transnational sources for contraception can combine to make women more vulnerable to the risks of unprotected sex and crisis pregnancy.

In this research, experiences of unprotected sex were disclosed by over half of the participants, and were associated with risk-taking for intimacy, pressure from sexual partners, and women's lack of sexual knowledge and self-esteem. In discussing their notions of safe sex many women were more concerned with parents' disapproval and discovery of their sexual activity, than they were with the consequences for them of engaging in unprotected sex, be that pregnancy or STIs. In fact, the risk of contracting STIs did not seem to feature much in their accounts much; nor did it enter their consciousness as much as the risk of an unwanted pregnancy. In a context of risk-taking encompassing elements of pressure on women to have sex before they are ready, male resistance to condom use, difficulties in accessing contraception, and lack of knowledge about sexual health in general, it was evident that for some women, the interplay of these factors put them at increased risk of unwanted pregnancy and STIs, in comparison to young Irish women.

Finally some young migrant women considered Ireland to have a more permissive sexual culture than their countries of origin or cultural background and also considered consuming alcohol at a young age a practice here that leads to sexual risk-taking.

### **5.5 Crisis pregnancy support services (CPSS)**

Given the extensive development in recent years of sexual and reproductive health services within a crisis pregnancy support service framework, the next section turns to consider the extent to which women in this study group were engaged, familiar and connected with this component of the Irish healthcare system.

### 5.5.1 Language and 'tacit knowledge' as barriers

It is to be expected that people coming to live in Ireland whose mother language is not English will find language a barrier, at least initially. Even those quite proficient at English have to adjust to accent as well as terminology and technical language specific to a country and its healthcare system. The notion of 'tacit knowledge', whereby those of us 'native' or 'local' to an area come to understand shared meanings and phrases that are potentially ambiguous or unintelligible out of that specific context, explains how meaning as much as language can act as a barrier. In the Irish sexual health context specifically the terminology of 'crisis pregnancy' is a very particular term with unique and crucially, local meaning (Conlon, 2010). Taking this example of a term that is so vital in the lexicon of sexual and reproductive health services is a good illustration of the level of translation and local understandings that need to be achieved by a newcomer to Ireland so that services can become fully accessible to them.

Yuan remarked that if she did attend a sexual health clinic, or a GP, she would spend time before the appointment looking up the relevant terms, and also bring a dictionary with her. Yuan is well educated and working full-time in a company in this country and so is at an advantage in terms of confidence in her linguistic abilities. When asked about whether she felt Chinese women would understand materials relating to crisis pregnancy she explained:

*I think they probably use some terms which you won't pay much attention to their meanings. So I probably would miss the information ... I think people here, the education they receive is quite different from the education at home. So they treat you like locals ... they treat you the same, so they don't provide any extra information. But I think sometimes they should treat us differently, separately. Some information should be widely provided.*

(Yuan, Chinese, aged 24)

Shufen, who worked in a university, had noticed CPSS information leaflets but assumed they were not relevant to her, only to students. The majority of the Polish women were not aware of crisis pregnancy supports, including information. One exception was 19-year-old college student Ruta, who was aware of the Positive Options (crisis pregnancy counselling information) service through information distributed in her college. Ruta said that she would like Positive Options information to be available for non-English speakers.

There was confusion as to the legal status of abortion in Ireland, both in the Irish State and on the island as a whole. There was also confusion about the situation regarding information on abortion services available legally abroad. Polish Agata searched the internet for services in Ireland that would advise her on the option of abortion and found information on Marie Stopes. Based on this search she formed the view that this was the only information and advice service for women with crisis pregnancy in Ireland.

*One clinic in Dublin is providing information services and this is it. Abortion is illegal here but women have the right to know about all sort of different options.*

[Agata, Polish, aged 29]

Chinese Nuying demonstrated some awareness of crisis pregnancy supports in Ireland but her knowledge was very vague.

*I heard from one of my friends there is kind of people that they can support you abortion in Ireland but it is illegal but they exactly exist here. Maybe it's like, it's not in the public but in private like this or just as I said, go to other countries to do that.*

[Nuying, Chinese, aged 24]

Nuying's uncertainty regarding support services for crisis pregnancy in Ireland reflected that of many Chinese women in the study.

Of all crisis pregnancy services Cura seemed to be the most well-known of the providers among both the Nigerian and Muslim participants – and was the one most likely to be mentioned by name. The other service provider identified by name by participants in the Muslim group was the Irish Family Planning Clinic. Other participants living in urban areas were aware of the location of services simply due to noticing the shop-front but could not name them or discuss the nature of supports provided. Many of the Muslim participants, such as Iram below, considered crisis pregnancy services as irrelevant to their own needs or experiences:

*I: Do you know any clinics in Ireland you would go to visit if you had a crisis pregnancy and needed to get information on how to cope and handle it?*

*Ir: There's one in [suburb] I think. The health - what's it called again? Oh, like the health centre in [suburb] with the dentist as well. I remember, 'cause I went there for my teeth before and they had all these posters up around it. And they'd be like, 'An unplanned pregnancy - it's not the worst case scenario, end of the world.' And they had all these notices around it but I didn't pay attention to them. But I know they do have information there, so I'm presuming they have help, give help.*

*I: Do you know of places that offer counselling for women as well?*

*Ir: Honestly, I don't. If it were something I thought about or if I was having sex, then I would educate myself and know about it. But because I amn't, then I don't know. I have never been interested or felt the need to learn about it.*

[Iram, Muslim, aged 20]

*I: And do you know of any services for women who have crisis pregnancies?*

*M: Erm, yeah. I think it's called Cura. There's a number and they provide counselling. They tell you about, well they give you information that you want. Yeah, I think it's called Cura with a 'C'.*

[Marjana, Muslim, aged 18]

### 5.5.2 Accessing medical abortion

Among the accounts of women in the study there were some references to a perception that medical abortion, that is 'the abortion pill', could be obtained in Ireland. Chinese women in the study recounted instances of other Chinese women in their network of friends who had accessed the abortion pill through the internet. Jiao, in a friendship-pair interview with her friend Changying, both aged 18, recounted how her housemate had taken the abortion pill when she was three months pregnant. The woman had accessed the abortion pill through a friend who arranged for it to be sent from China. She took the pill and then contacted emergency medical services with Jiao's help:

*After she took the tablets and she said that she was having a miscarriage. She asked me to call the emergency. I was very curious why. I was very curious why she would take the tablets first.*

...

*So she took the tablets and then she said there was a sharp pain in her tummy and she told me to call the ambulance. So I dialled the number and I told them on the phone that there was a pregnant woman and she was having a miscarriage.*

(Jiao, Chinese, aged 18)

The evidence from this study is that there are low levels of familiarity and connectedness with crisis pregnancy support services (CPSS) among migrant women. One issue arising relates to the 'localised' terminology of 'crisis pregnancy', which is very particular and requires local 'tacit knowledge' to understand the shared meanings that have attached to the term over time. Among our study group Muslim women did not tend to see CPSS as relevant to them, while migrant women were not very well informed of CPSS. Cura was the service most likely to be cited by those in the study. There was evidence of confusion as to the legal status of abortion and how to access information about services overseas. There were some references to a perception that medical abortion or 'the abortion pill' is obtainable in Ireland through the internet or through networks of friends.

## 5.6 Crisis pregnancy experiences

There were women in the study group who had experienced crisis pregnancy while living in Ireland, some of whom decided on abortion and others on motherhood.

### 5.6.1 Deciding on abortion

A number of women in the study group disclosed that they had been pregnant and had decided on abortion in the past. A young Nigerian woman focus-group participant described becoming pregnant at age 19. She told how she decided on abortion so as to avoid the judgement and stigma that she expected she would encounter from her family and community:

*I started having sex at the age of 18 and I got pregnant at the age of 19. So my mum must not know about it. So I had to find a solution for it - I had to abort it. So after aborting that then I knew. Yes, now the pains of aborting it, everything associated with that. Then you have to just put yourself together and let me do thing right, let just start doing them right ... I was too young then. Everybody expected much more from me than what I was giving them, and I was ashamed myself that 'What am I going to say? What are my friends going to say about me?' 'You know friends... this is my best friend - the next minute, they have done it before, like, 'She's pregnant; she's pregnant.' Backbiting, gossiping behind, when you know the feelings. You have to stay at the corner crying. The rejection, the sidelining, you know.*

(NFG1, Damilola, aged 20-29)

Another young Nigerian woman Chinua became pregnant at age 17. She told a friend within the Nigerian community, her friend's mother learned of the pregnancy and in turn told Chinua's mother. Chinua recounts her mother making the decision on abortion for her and how she had to go through a protracted process of registering as resident with her aunt in England in order to access subsidised abortion, as her family could not pay privately.

*C: So my mom was like, 'Come here. Can I have a word with you?' And I was like, 'Yeah, ok.' So then she goes, 'Don't lie to me. Just tell me the truth. Are you pregnant?' And I denied it. She said, 'Just tell me the truth.' And I denied it for fear of rejection and for fear of so many things she would do. But eventually after so many persuasions I came clean. And then she was like 'Fine. Fair enough. There's only one thing to do - abortion.' And we drove all around Ireland looking for a clinic. But as you know there is none ... So the next option was my aunt in London. We booked a flight straight away.*

*I: And how did you feel about this situation?*

*C: At first I thought there's no two ways about it, and I had to say yes! I'm too young for this. But hear this: it took me three months to get a doctor to do the abortion for me in London. Because we had to pay for it, but my mom didn't have the money, so she had to get registered through NHS, all that system and pretend I was living in London, 'cause you have to be a resident to get it for free.*

(Chinua, Nigerian, aged 25)

Polish Agata was aged 29 and married when she became pregnant in Ireland. She and her husband decided on abortion as the pregnancy was unplanned and they felt they did not have the resources to support another child. Agata had no knowledge of crisis pregnancy supports and sought information through the internet. Through this search she found the Marie Stopes clinic based in Dublin and she remained of the view that this was the only service for women dealing with a crisis pregnancy:

*One clinic in Dublin is providing information services and this is it. Abortion is illegal here but women have the right to know about all sort of different options.*

(Agata, Polish, aged 29)

### 5.6.2 Deciding on motherhood

Within the study group there were women in both the Nigerian and Muslim group who had become pregnant and decided on motherhood. Chinua had a crisis pregnancy and abortion at age 17 but went on at age 24 to decide with her boyfriend that they would have a child. She describes how her mother was still unhappy about that pregnancy but accepted it when she saw that her daughter now had the resources to support herself and her child:

*Ever since I was pregnant recently she was like, 'I wasn't expecting you to do that! I thought you were so much smarter than that! You've got an education and your whole life ahead of you! You've got a career and this and that,' and I'm like, 'Sorry mum! Sorry mum! Sorry mum', until I had the baby and she fell in love with her and was happy! She saw that I wasn't a burden and didn't ask for any money or whatever! I was independent and taking responsibility of my own actions!*

[Chinua, Nigerian, aged 25]

Nigerian Chinua's account illustrates how pregnancy among younger women who have not finished school or who do not have the resources to live independently can be viewed very differently to when the pregnancy occurs when a woman can support herself and her child.

Two other young women, one of whom was Muslim, became pregnant at age 16 and found their families dealt with them very harshly, which they related to strong condemnation of non-marital pregnancy among their family. Nigerian Atua became pregnant at age 16 and described how her mother brought her to a pregnancy counselling service hoping to receive information on accessing abortion. However, she was unaware of the legal situation regarding the provision of abortion in Ireland as well as the particular organisation's position not to provide information on abortion services in other jurisdictions. The pregnancy counselling process did not address the option of abortion and Atua describes how after participating in the counselling process her mother decided that continuing the pregnancy was the best option. In her account her own position was not central to the outcome of the process.

*I went down there [to counselling service]. And, you know, you're not allowed to do an abortion. She [the counsellor] was thinking of me having a baby and wanted to keep in touch. So she was there. My mother said she would support me and all. So I was thinking about it: OK. That's fine. She was talking to my mom, and I was talking to my mom about when I have the baby, my mom would take care of the child. But when I had the baby my mom wasn't there ... It was very, very tough. It was very, very hard. That's the kind of punishment we get if you get pregnant. If you're alone when you're pregnant then you have to take care of the kids yourself. Even if your mom is living with you, you have to take care of the kid yourself.*

[NFG2, Atua, aged 23]

Atua felt ostracised in the family so that their relationship broke down and ultimately she and her child moved out to live independently when Atua was 16. She remains estranged from her family.

Lisha also became pregnant at age 16, as she describes below:

*L: When I found that I was pregnant, I was so scared. But the guy was very supportive and said yeah yeah, I would be there all the way. But I knew my dad would kill me so I was really scared. But at the end of the day, I did an appointment with the GP. And my GP was like a family GP and she had said if I want I could tell him for you. So she called my dad for an appointment. I was there and she told my dad. Oh my God, I was like coming to my face, I couldn't ... I was totally blank I didn't know what he would do. But then we were outside he is not going to do anything. But when we get home, what is he going to do? That was my fear.*

*I: That was your fear. So what stage were you when you went to the doctor?*

*L: I was, like, only, like, three months.*

(Lisha, Muslim, aged 22)

Lisha's school put her in contact with a family support service and offered a home-schooling service during the late stages of her pregnancy and for a couple of months following the birth of her first child. Prior to being contacted by the support worker, Lisha had no knowledge of the Irish SRH system or awareness of what support would be available to her during a crisis pregnancy:

*I: And before that did you have any knowledge of any support services at that stage?*

*L: No, I didn't because, ehhh, I didn't know. I didn't know there was even social worker or anything like that. I didn't know of anything. I was like 'Oh my God, how am I going to feed the baby?' Because my dad was like a strict religious person.*

(Lisha, Muslim aged 22)

Lisha argued that as her father was so authoritarian and opposed to non-marital pregnancy, this made access to support services particularly important to her:

*I: Yeah. It is really strong that you've been able to make it work out your own way.*

*L: Yeah, yes. But if I didn't have the support - The support starts with the home-school liaison and to [support service]. I didn't know what I would have done if I didn't get the support and I'm still getting it right now. Now I'm in college - because I didn't do my Leaving Certificate because I went to Nigeria. I missed out on that. Now, I've done one year. I have one more year to go. Every thing is going OK. [Support service] is still there for me. They are paying for the kids at the crèche. They pay for the summer, as well, in the crèche and during the time I'm in school. I'm really in a good state that I can afford. I still take social money, but I have so matured, [my support worker] taught me to save, how to do everything. I don't think I will be anywhere if I wasn't with [support service].*

(Lisha, Nigerian/Muslim, aged 22)

The accounts of the women in the study group who had experienced a crisis pregnancy, while not representative of their communities, illustrate when young migrant women are not knowledgeable about crisis pregnancy support services they then are more isolated and reliant on their parents in the event of crisis pregnancy. Meanwhile, as we noted earlier, young daughters becoming pregnant in migrant families can create particular conditions for that pregnancy to be perceived as a crisis. More traditional or authoritarian perspectives on sex, pregnancy and young motherhood may prevail, so that young migrant women are specifically in need of the kinds of supports CPSS provide. Disseminating information regarding the availability of CPSS and disseminating messages regarding the importance of supporting young women with a crisis pregnancy to the migrant communities, both directed at young women and also their parents, would be important initiatives in this regard. Such initiatives could help to ensure that the progress made in supporting women in crisis pregnancy in the Irish context in recent years can be extended to our new communities also.

### 5.7 Overview of negotiating sexual risks

A range of perspectives on 'safe sex' was evident in the study and perspectives were often related to the contexts in which these young migrants came to Ireland. Among the study group, the notion of safe sex encompassed avoiding parental discovery of sexual activity, using contraception for protection against pregnancy, protecting against sexually transmitted infections (STIs), secure, trusting or positive relationships versus casual, unequal or conflictual relationships, both partners being tested for STIs and having the capacity to assert consent or dissent to sexual acts proposed by a partner.

The findings of this study showed complex reasons for risk-taking and highlighted many forms it can take. Some young women engaged in sexual behaviour that was 'risky' without being aware of the risk due to low levels of sex education. Others engaged in risk-taking in the form of not protecting themselves against pregnancy in order to minimize the risk of parental discovery. Finally, it was interesting to note how intentions and practices regarding celibacy featured in this study to a much greater extent than the issue featured in research with the Irish indigenous population where there is an acceptance that sexual experimentation is part of the life-stages of young adulthood. In particular young Muslim women, young Nigerian women who describe their parents as 'traditional' and young Chinese women did refer to celibacy as a strong part of their worldview.

Risk-taking featured in a number of ways in this research including risk-taking for intimacy where young women described seeking out intimacy at an early age which would develop quickly into sexual relationships without the girls having the knowledge and capacity necessary to address pregnancy or STI prevention. In discussing the role of men in addressing sexual risk, young women in this study concurred with findings of other studies reporting they often encountered male resistance to condom use. The sexual double standard discussed previously wherein responsibility for maintaining morality, avoiding pregnancy and so on is vested in young women seems to have the effect within



intimate sexual encounters that young males can abdicate responsibility and leave female partners feeling pressurised to engage in sexual risk-taking. Meanwhile behind such recourse to these discourses of male sexual prowess there also seemed to be evidence that both young men and young women may not practise safe-sex out of lack of knowledge and confidence regarding how to do so.

Experiences of unprotected sex were disclosed by over half of the participants, and were associated with risk-taking for intimacy, pressure from sexual partners, and women's lack of sexual knowledge and self-esteem. There was evidence of pressure on young women to have sex before they were ready to do so. As observed in Murphy-Lawless et al. (2004), sex education needs to counter this pressure on young women to be sexually open and available to men on men's terms. Programmes supporting migrant women's knowledge, confidence and self-esteem in their understanding of their sexuality are essential, in parallel with initiatives to secure migrant women's socio-economic independence and capacity for self-determination.

As regards knowledge of sexual and reproductive health services in Ireland and in particular crisis pregnancy support services (CPSS), the study found low levels of both familiarity and connectedness with services among migrant women. One issue arising relates to the 'localised' terminology of 'crisis pregnancy', which is very particular and requires local 'tacit knowledge' to understand the shared meanings that have attached to the term over time. There was evidence of confusion as to the legal status of abortion and how to access information about services overseas. Meanwhile participants made some references to a perception that medical abortion, in the form of 'the abortion pill', is obtainable in Ireland. While not representative, the accounts of the women in the study group of experiencing crisis pregnancy illustrated that as young migrant women seem to have low levels of knowledge about CPSS they are more isolated and reliant on personal networks - particularly parents - in the event of crisis pregnancy. Meanwhile, migration can create particular conditions for pregnancy among young unmarried daughters to be perceived as a crisis. Extending dissemination of information regarding the availability of CPSS and messages regarding the importance of supporting young women with a crisis pregnancy to migrant and newcomer communities would be an important initiative to ensure that the progress made in supporting women in crisis pregnancy in the Irish context in recent years can be extended to our new communities also.

## 6.0 Motherhood in a new country

### 6.1 Introduction

This chapter discusses the views and experiences of women in our study group to becoming or on becoming a mother in Ireland. The strong influence of participants' cultural backgrounds was evident in their exploration of notions of motherhood, as well as issues related to the practical and emotional aspects involved in becoming a mother. These elements featured throughout their accounts of their expectations of motherhood, the 'right circumstances for motherhood', pressure to have children, childrearing, and challenges in becoming a mother. We see women's agency in beginning to challenge traditional cultural norms and carving out their own notions of motherhood in a new country, which were shaped by Irish cultural values and norms. This was not easy, and women discussed their views on the context in which they did this, and the various constraints they encountered and/or envisaged relating to financial issues, and balancing mothering with the other dimensions in their lives, such as education, and work. Of our study group, 25 women were mothers: five Chinese, nine Polish, six Nigerian, and five Muslim women.

### 6.2 Notions of motherhood

In this section, we will explore the meanings women attached to motherhood. According to Zofia, in Poland, national and religious discourses emphasised the role of mother as one of selfless devotion to the upbringing of her children. Women, for example, can be disapproved of for sending their children to crèche. A mother that does this does not fit with the idealised notion of Polish motherhood, one in which the mother is central to the hearth and home, and whose principal function is to selflessly nurture all her children. Zofia contrasted this with the approach she observed in Ireland, which she considered to be more open and understanding:

*Church is still very influential. But apart from it, it is well seen that a woman after giving birth to her children stays at home and raises her kids up to their third birthday, the end of story ... And the crèche is the biggest drama and tragedy. And here is easier. My friends who have given their children to crèches are super happy, they see how great their kids can develop among their peers. I think that emotionally we are much behind.*

(Zofia, Polish, aged 29)

Zofia saw the church in Poland as having continued authority and influence in the private sphere in relation to notions of motherhood, and on the standards one should maintain to fulfil the role of 'good mother'. As she keeps abreast of social change and opinion in Poland through internet forums and articles, she contrasted thinking there with the attitude she considers pervades in Ireland:

*I feel that in Poland women who decide to send their kids to crèche and come back to work are not seen in positive light still. This may be because of stereotypical thinking but also because maybe of the attitude in religion, the role of a woman as a source of hearth and home is very much supported by the church. Church is still very influential.*  
(Zofia, Polish, aged 29)

The impact of culture was also evident from the participants in Nigerian focus group NFG2 who discussed the highly differentiated treatment and expectations of males and females with regard to parenting:

*E: You can be a professor, a lawyer - whatever degree you have - and you still have to go back to the kitchen. That's part of - the kitchen is where you have to be. 'Cause, like, when you get married you should be serving your husband and not the other way around. When you have kids, you'll be in the kitchen preparing food for the kids' dinner, lunch, breakfast, whatever, and other things for the kids, like washing the clothes. So that is the main role for the wife, women. So that is the main role.*

*A: They aren't expecting anything from the boys. They know that a boy is going to get married to a woman and they expect the women to know everything in the house. For the men, they just go to work and provide the money.*

*E: Just provide for the family.*

*A: That's wrong. I think the both parts should know everything that's going on. Like the house, everything should be 50/50. Yeah, 50/50 - not 100% and the man doesn't know anything. It's very bad. That idea is very, very bad.*

*I: And what about parenting? Does the father get involved in that or what?*

*A: I think out of 100% of African men - Nigeria, where I come from - out of the 100% of them, only 20% of them knows about taking care of their kids. The other 80% expect the women to do everything.*

(NFG2, Esosa and Atua, aged 18-23)

Many of the participants strongly rejected gender-differentiated roles and expectations. Yet when they later discussed their aspirations regarding relationships and motherhood, they adhered to fairly normative gender roles.

Almost all of the women envisaged that they would become mothers at some point in their lives either in the near future or when they were older, contrasting with the findings in Murphy-Lawless (2004), where some of the Irish women aged 18-30 were beginning to question whether they wanted to have children at all.

### **6.3 Expectations of motherhood and 'right circumstances' for motherhood**

Recent Irish research exploring attitudes to family formation and using a nationally representative sample of 1,404 men and women (aged 20 – 49) found that the most important considerations in the decision to have a child were related to psychological factors, namely, having a suitable partner and the quality of the relationship with one's

partner. After these, economic considerations featured strongly, such as having a job, one's housing situation, and being able to afford childcare (Fine-Davis, 2011).

In our study women themselves introduced discussion on the 'right circumstances' in which to become a mother. Similar to Irish research, a strong theme emerging from women across the four groups was the requirement to be financially secure before having children. In contrast, for the majority of women marriage was seen as a precondition to having children, and for most women it was a cultural imperative; the quality of the relationship with one's partner was less emphasised. The section below presents women's perspectives on the 'right circumstances' for having a baby, and their expectations of motherhood.

Changying, who participated in a friendship-pair interview, stated that she would like to plan the life stages of marriage, pregnancy and motherhood so that they would occur sequentially and at the correct stages in her life; she would thereby avoid an unplanned pregnancy and/or pregnancy outside of marriage:

*I have to first know how to support myself and also me and boyfriend should be in a stable relationship or marriage.*

(Changying, Chinese, aged 22)

Chinese Li also commented that she would like to be married first, to be financially stable before having a child, and not to be dependent on her parents for support:

*I think both of us should have a job and we have salary. We can raise that baby because until now I still get some money from my parents. I don't want my parents to raise me and also raise my baby. And yeah, we get married. So that's enough I think.*

...

*I think it's better to get married before you have the baby, yeah. Because if you didn't get married and you give birth to the baby, people will always gossip about you and you will have a lot of pressures.*

(Li, Chinese, aged 25)

Shu also highlighted the importance for her of being financially stable before having children. Ling, meanwhile, emphasised that having a minimum level of economic security was sufficient, and if she was to become pregnant now she would continue with the pregnancy as she was relatively secure in being married and working part-time:

*I don't mind even though we're work, I just graduated in 2009 and we just started our lives together as a family, but back then I used to think I'd have this much money in my account before I have a baby and now I think it's a silly idea because I've seen friends ... all of a sudden she fell pregnant and they decided to have this baby ... The baby is gorgeous and their life didn't get worse! So I think having a baby just completes the family. But I think the only thing holding me back is the pain you're going to suffer...*

(Ling, Chinese, aged 23)

The majority of the participants in the Nigerian group placed a high value on motherhood and most considered marriage and financial security as the ideal situation for having children (although this contrasted sharply with the circumstances of most of those in the sample who already had children). Below, Atua discusses motherhood as a priority which for her supersedes career ambitions:

*We do think about it. But even when you're a professional lawyer or doctor you still will come back having that child and you're still gonna come back to the kitchen. So after you go to school and finish uni or something - if the job comes first then that's good. If it's marriage that comes first, then that's fine. For me, I wouldn't be waiting until I get a job or going into my career or anything. But I can still do that.*

(NFG2, Atua, aged 23)

Atua went on to note that attaining a third-level education would improve one's chances of meeting a more appropriate partner (someone mature, dependable, and professional).

While other Nigerian participants placed more emphasis on education and employment, almost all saw themselves as having children at a relatively young age, putting their mothering responsibilities ahead of their careers for at least a few years while their children were young.

The Irish Central Statistics Office (CSO) Vital Statistics birth data for 2010 (CSO, 2011) showed that the average age of mothers was 31.5 years for births registered in 2010. The average age of mothers of Irish nationality was 31.9 years, while mothers of accession-state nationality had the lowest average age at maternity at 28.6 years (CSO, 2011).

Women in our study group shared their views on the ideal age at which to become pregnant. Most participants reported that they would like to have their first child before the age of thirty, while Chinese participants said that their parents in general would prefer if that age was closer to twenty-five. One Chinese participant considered that for her the cut-off age for having a baby was thirty-five, as after that age, she believed there was a strong chance that a baby would be born with an intellectual disability.

Shu, Yuan, Ling and Nuying have been living in Ireland for three years. Shu, Yuan and Nuying were single when they were interviewed, and Ling was in a relationship. Their narratives demonstrate a changing attitude towards motherhood compared to the other Chinese participants in that they considered delaying having children, in order to pursue career and lifestyle pathways first. The influence on them of living, studying and working in a new and different culture was implicit in their responses. Shu was unusual amongst the Chinese participants in that her intention was to become pregnant around the age of thirty-five, as she had already spent time studying and had plans to travel and visit many places before settling down and having children. She prioritised other dimensions of her life besides motherhood; for example, making time for herself, and undertaking voluntary work:

*I will have baby around 35 years old. I will settle down after I have baby. I don't want to be a full-time mother either. I will probably put 80% efforts at home and use the rest to do things I am interested in, like volunteering, some voluntary work. And when my child gets older, I want to do my own things.*

(Shu, Chinese, aged 23)

Similarly, Yuan had recently relaxed her attitude towards marriage and pregnancy and was planning to allow herself some time to think about doing other things before settling down:

*So yeah, I don't, I used to think that I had to get married at the age of 26 and have a baby at the age of 28, yeah [laughs] and have a very stable family by the age of 30 and then I could think of doing something else ... I am more relaxed now. Whoever is going to be my husband, I don't think too much anymore.*

(Yuan, Chinese, aged 24)

Nuying, meanwhile, commented that she would not get married before the age of thirty just for the sake of being married, and that if she had not met the right man at this stage in her life, she would wait longer.

Ling's original life plan was to get married at the age of 23 and have her first child at the age of 24, but going abroad to study changed that plan. Ling intended to have two children in the future, and to wait until she was able to support herself and her child before doing that.

Polish participants were asked about their desire for motherhood and their ideal age to have children. Many women automatically assumed that they would have children following marriage. For example, when Julianna was asked when she would like to become a mother she responded that that would be '*of course, after marriage*'. There was a perception that Irish women tended to marry at older ages compared to women in Poland and that living in Irish society would impact on their choices in this domain. When Ruta was asked about the influence of Irish values and norms on her attitudes and behaviour compared to living in her home country, she highlighted the effects of Irish social and cultural mores on her thoughts in relation to marriage and motherhood:

*Oh definitely! I'd say I'd probably already be a mom or get married if I was still down there. Even my granddad was like, 'You're gonna have a baby soon and a husband' and I'm like, 'NO I'm not, leave me alone' and my grandmother was like, 'YES.' That's the way to think going against my grandfather! So it was very good!*

(Ruta, Polish, aged 19)

A number of the Polish women expressed a desire to have children but did not feel mature enough or 'mentally ready' to do so. Like her Chinese counterparts, Ruta felt

that education and life experiences were more important to her at this stage in her life. Meanwhile, Justyna emphasised the importance of educational attainment before becoming a mother: the fact that she has attained her Leaving Certificate examination, would, she felt, make it easier for her to cope with an unplanned pregnancy and prospective motherhood: *My world would fall down but I'd manage.* (Justyna, Polish, aged 19)

All of the Muslim participants saw motherhood as ideally taking place within the context of a Muslim marriage. (Although an exception was Suliati, in that she unsuccessfully tried for children with her former partner and they were not married.) The other ideal conditions for motherhood were financial stability and security. Early motherhood was not considered desirable, but overall motherhood was seen in a positive light.

Marjana was the only participant across the entire sample who saw herself possibly not having children. She is 18 years of age, of Algerian origin, and has been living in this country for the past 10 years. Yet she did not reject motherhood outright; rather she saw marriage and motherhood as less likely due to her other aspirations and priorities. Although she doesn't completely rule it out, Marjana is not personally interested in marriage and places a high value on her independence:

*I: And about [...] marriage - what would be your ideal age of getting married do you think?*

*M: Haha. Em, marriage isn't a thing for me, really. I personally do not want to get married. But if it ever did happen I would be quite old. I like to live my life, and I'm not saying that I can't live it when I'm married to a person, but I like my independence. I, like, prefer my own company anyways. So I have set goals for myself to do alone with no-one else. So I'd like to do them and that's just a personal thing for me that I have to do to triumph.*

(Marjana, Muslim, aged 18)

While Marjana did not prioritise marriage or motherhood in her future ambitions, marriage and motherhood were integral to Jamila's future expectations. Jamila, who is Ugandan, had escaped an enforced, restrictive and burdensome form of motherhood but she anticipated motherhood in future, within a Muslim marriage. Jamila's sister was forced into a polygamous marriage by her parents when she was 19, for economic reasons. She escaped the same fate by migrating and expressed her relief to have avoided a forced marriage and the likelihood of a large number of children:

*J: I didn't go through it, because at that age...*

*I: 16?*

*J: At that age, marriage...*

*I: Your life would be over?*

*J: Over! I'd be having six kids maybe. Hah.*

(Jamila, Muslim, aged 20)

Jamila discussed the ideal circumstances for motherhood, including personal attributes of maturity (age, 'personal development'), 'readiness', relationship factors (marriage, suitable partner, familial support) and external/circumstantial factors (financial status). Jamila saw motherhood as both demanding and pleasurable. Similarly, Marjana described motherhood as both taxing and rewarding:

*I: And what is your attitude towards motherhood, and attitudes towards being a mother?*

*M: I respect people who have kids, I think it's the most beautiful thing a woman could ever do, is have a child. It's an experience and you're literally spending the rest of your life... No matter if until you're eighteen or until the rest of your life, they're gonna be home, they're gonna be calling you like, 'Mum, I need this', and you're always gonna be there for them. So I highly respect mothers for doing what they do because I think the best and most rewarding job is being a mother.*

[Marjana, Muslim, aged 18]

Marjana explored her expectations of motherhood, recognising the sacrifices a mother needs to make, as well as balancing the multiple dimensions of her life, which could be made all the more difficult if a woman did not have the help of her partner/husband:

*I: Yeah. And do you think motherhood is a difficult job or is it something you think you can manage?*

*M: Difficult. I think it's a difficult job. It's going to be hard. As much as a husband's going to be involved in it, it's not going to be the same way as a mother. Like, when you're about to have a child you have to give up so much. Because if you're working and get pregnant you kind of give up your job. And you've spent so many years in college and finding this job, and getting your degree and sitting so many exams and the stress of it. A woman would be like, 'I'm happy to give it up', which is what a woman would do. There's always the going back to work, going back to the routine, which is going to be so hard for them, you know. So there are hardships and there are also great aspects of it as well. But that's just part of motherhood - it's not just all bliss twenty-four-seven, 'cause that's just impossible.*

[Marjana, Muslim, aged 18]

Iram, who is also of Algerian origin, discussed her maternal desires and referenced the discourses of 'readiness' and 'maturity'; for her this readiness and maturity would be in her early twenties and within marriage:

*I: What makes you think you are ready to be a -*

*Ir: I can say everyone, every woman that's matured want to have their own family, want a child who can say 'This is my mum'. As you said to other woman, you want someone who can call you 'Mum'. So obviously, you want to know how to be a mum, how it feels to be a mum, how your mum suffered with you. You want to know all that so you want*



*to have your own child as well. So I'm ready to do that, I'm really, really ready to push the buggy [Laughter]. Ahh, I'm ready, seriously.*

*I: And you are also ambitious? How do you think those two things can work together?*

*Ir: Maybe I will stay with my child. I will be quiet - not really quiet, I won't go out much. I will be there for my child and my husband and the family. I won't be this ambitious with a child because it won't be good for me, to my marriage at all. I think it will be a change for me when I have a child.*

*I: How do you think he'll behave, then, when you have a child? [Laughter]*

*Ir: I don't know.*

*I: Do you expect him to stay more at home and take care of the child?*

*Ir: I really don't mind staying full-time at home and care for the child. It's a blessing having children, it is. I have to be proud being there, you know. I know my husband will be there for the child. My mum and dad will be there for the child as well. If I have to go to college or work, I know there will be people there who can help me with my child. [Iram, Muslim, aged 20]*

The majority of participants in the Nigerian and Muslim groups (both those who were already mothers and those who weren't) were more circumspect about motherhood and acknowledged the positives and negatives. They were aware of the far greater responsabilisation of mothers with regard to parenting, and saw motherhood as entailing challenges and requiring support.

#### 6.4 Pressure to have children

Many of the Polish women spoke about the pressure they experienced from their family and extended family to get married and to have children. Traditional marriage and family values were considered to have a continuing influence on women's attitudes in Ireland. Meanwhile the impact of living in Irish society, where the culture was perceived as being more liberal and less restrictive, could produce feelings of internal conflict and disjuncture. Katarzyna, who is engaged to be married, spoke of the enormous pressure to get married and start a family:

*And it is very depressing to hear it all the time. Now I am with my fiancé and we are planning a wedding, but I keep hearing from my mum that I should start taking folic acid to get ready for pregnancy.*

...

*It's like that every time we talk on Skype - that she wouldn't talk about everyday stuff: wedding preparations, but about what I should do, which doctor to visit etc.*

[Katarzyna, Polish, aged 27]

Aniela concurred with Katarzyna in feeling pressurised from family members to become pregnant. The day after hearing that her younger sister was pregnant, she described a sub-text in her conversations with family members, a clear message wanting to know when her time to become pregnant would come:

*The day after [hearing about her sister's pregnancy] everybody was calling me and wishing happy birthday, and every time I heard the wishes I also heard them asking, 'So when are you going to have children?' I am in a relationship, but not even engaged, we don't plan children yet as I consider it much too early for me. This is my choice and I spoke with my dad saying to him that it is not a race. I don't feel like having children yet.*

[Aniela, Polish, aged 28]

Again, we see Aniela's agency in being able to withstand the pressure from home and to trust herself in her decision-making about prospective motherhood. Aniela did not experience any pressure from her Irish boyfriend's family, and she felt that they were more respectful of her choices. Meanwhile, Weronika spoke about the pressure to marry her then boyfriend. Even though she lived with her husband prior to their marriage, her mother considered that at the time there were only two options available to her, either to get married, or to break off the relationship. Weronika contrasted this with the Irish situation, as she perceived it, where the order is reversed, with couples living together and having children, and only getting married after these stages:

*I actually stopped going to Poland because it becomes annoying for me to hear about my friends. They are put up as an example of good living. They are married with a house, children, good job, good car. And the question is what do I have? And I keep saying that I am happy travelling, studying, etc. The fact that I don't have a house is a blessing for me for now as I can always pack my bags and go to my husband once a child is born.*

*I think that in Poland there is a huge need of permanent things, stability, constant house, job. They don't understand us that we have a different point of view, that being here six years now we want to move out again. So what then? ... I am always asked.*

[Weronika, Polish, aged 30]

Polish Aniela, aged 28 years, also recalled her grandmother urging her to talk to her boyfriend to encourage him to propose marriage to her, so that she could settle down and have children. She was aged 24 at the time, and her grandmother felt that she might lose this opportunity, and thus 'be left on the shelf'.

The issue of motherhood as an expectation and the pressure on women to enter motherhood under 'appropriate' circumstances was raised by some of the Nigerian women. One woman in NFG1 explained the different pressures women are subjected to associated with pregnancy and motherhood, be they single or married:

*You said the issue about fertility. I don't know if it is the same here as it would be in Nigeria but I think it is such a big issue, like. Ok. First of all you have the young girls, 'Don't get pregnant, don't get pregnant, wait till you get married' - 'Till you get married*

*- Oh God, if you don't get pregnant!' [All laugh] Now that's another issue. It's such a big problem, like, 'What's wrong with you? We will find your husband another wife'. You have to give him children like once you get - At a wedding ceremony in Nigeria there is a prayer that this time next year we carry baby - that's the kind of prayers. So you already have that pressure like, 'Oh God, what if am not fertile?' That you can't give him a child, you know, so that's another issue where women are put into this system where if they are married and not able to have kids at a certain time, a certain time frame, it is a problem.*

(NFG1, Omorose, aged 20-29)

Meanwhile, Marjana perceived her family's interest in this topic as gentle persuasion, curiosity and interest, rather than as any form of pressure on her:

*I: And would there be pressure on you to have kids straight into the marriage or...?  
M: Yeah, I'd kind of have my aunties, old aunties, at home. And they'd kind of look at me and they'd be like - five weeks into marriage - 'Are you not pregnant yet?' 'Is there something wrong with you?' Haha. But I'm not gonna be, like, you know, women's rights and all that sort of stuff. I'd just be like, 'Erm yeah', 'cause they grew up in that generation so I respect them. So I'd be like, 'No Aunty, but hopefully one day I will', and all that kind of stuff. But I wouldn't say pressure as such, but you would get the little comments, but that's normal.*

(Marjana, Muslim, aged 18)

## 6.5 Parenting in Ireland

This section explores the role of grandparents in childrearing and parenting issues raised by women who were mothers.

### 6.5.1 Role of grandparents in childrearing

The strong and involved role that participants' mothers see themselves playing when their daughters give birth was evident from Katarzyna's account of her sister giving birth in Ireland. Her mother, feeling unable to help and powerless, wanted to ensure that that experience did not occur again in relation to Katarzyna:

*She was really helpless and in that despair; she came to me asking me to promise her that I will be giving birth to my child in Poland. Promise me that you will not do it to me ... There is pressure - I feel it enormously.*

(Katarzyna, Polish, aged 27)

Meanwhile, Polish Ewa described feeling bombarded with advice after giving birth to her son, and felt she was being tested in terms of her own resolve and level of assertiveness to withstand all the advice from her family and neighbours about caring for her baby. She felt that she lacked the supports that a new mother needs, which would allow her to gain enough confidence to stand over her own parenting approach and skills. Another Polish

participant, Danuta, who has a two-and-a-half year old, said that she dealt with this by putting her midwife's advice up as being the best standard, so as to 'close off my mum's advice'.

In China it is expected that grandparents will take care of a new born baby. There are two main factors that facilitate grandparents adopting child-rearing roles in China. First, the number of children in any family will be a maximum of two, because of the 'one-child policy', thereby reducing the burden of childcare on grandparents generally. Second, as Chinese women tend to get married and give birth at younger ages, grandparents will be younger and therefore more likely to be comfortable taking on a childrearing role. Li's parents would not approve of her having a baby in Ireland, as their role in parenting her child would be severely diminished:

*L: Actually, no, because you know nowadays, such like my generation, we are all only child, most of us are only child in the family and if I give birth to a baby, there will be four parents to look after him or her, so we don't need the childcare.*

*I: So usually the grandparents look after the baby?*

*L: Yeah, the grandparents always look after the baby. If you don't let them look after, they will be angry with you.*

*I: Ok. So it is expected that way.*

*L: Yes. They really expect it about that.*

...

*I don't think my parents will allow me to give birth to a baby here because they think just me with my husband, we can't deal with so many problems, and they really want to look at this baby and they can take care about him or her and they will think you should go back to China and we can take care both of you.*

(Li, Chinese, aged 25)

If she married an Irish man, then she imagined her parents would have to move to Ireland to help her care for the baby. In China there are certain customs and traditions associated with giving birth and the care of a new born baby and new mothers are perceived as needing the guidance and support of the older generation in handling these new experiences:

*Because you know in China, if you give birth to a baby, it's very important for you to have a rest. You can't touch the cold water or something like that. There are a lot of rules and you need to eat something not so spicy and eat some things more with vitamins or something like that. So they will always think you can't, you can't deal with so many problems so ... So they will worry about, worry about that and they will come to Ireland. [Laughs.]*

(Li, Chinese, aged 25)

Another reason for the increased level of involvement by grandparents in Chinese culture is that it is believed that women should not move for the first two weeks after giving birth. Mei, too, pointed out that grandparents in China are always involved in raising the children of the next generation. In terms of her own future childcare options, she does not intend to be a full-time mother, and so she would either arrange for her mother to come to Ireland to look after the baby, or pay for the costs involved in sending the child to a crèche. Mei was completely unaware of the costs of childcare here, and commented that if she was in China it would be much easier, as her mother works in a crèche there.

In contrast to the level of support and involvement sought by Polish and Chinese grandparents, Nigerian Atua's experience of a crisis pregnancy brought out her mother's anger as well as her withholding of support for her daughter when Atua's baby was born. Atua was brought to a crisis pregnancy counselling service by her mother. The option of abortion was ruled out, and during the counselling her mother agreed to support Atua in caring for the child. However, when the child was born Atua's mother's support was not forthcoming. Atua's relationship with her mother broke down completely and she left home with her baby at age sixteen and came under the care of the HSE.

Atua's account illustrates how one consequence of extra-marital pregnancy/motherhood for young women is complete responsabilisation for parenting their children. A few of the Nigerian participants who had experienced extra-marital pregnancy had been supported by their partners and/or by their parents and wider families, but others experienced some form of abandonment and rejection. As Oni put it:

*That's the kind of punishment we get if you get pregnant. If you're alone when you're pregnant then you have to take care of the kids yourself. Even if your mom is living with you, you have to take care of the kid yourself.*

(NFG2, Oni, aged 18)

There was very little discussion of the role of fathers as co-parents by participants in the Nigerian group. In their discussion of their relationships with their own parents, their mothers were the primary reference point – there was little mention of fathers, and many of the participants' fathers were not involved in their upbringing (in fact, there was more mention of grandmothers).

### **6.5.2 Different approach to parenting**

A number of women discussed issues related to parenting their own children and the kind of sex education they would like their children to have. These views were grounded in their cultural background and upbringing. Polish Malina (aged 27) who has a two-and-a-half year old boy expressed concerns about rearing her son in the Irish culture, which she perceived as having very open attitudes to educating young children in sexual mores. She talks about having to prepare her son for when he goes to crèche here for these differences; for example, she observed that there were communal toilets for boys and girls in one school:

*When I was [in a Montessori school] I experienced that the boy went to the toilet and was peeing with the door open while the girl was very close by in the next cabin. The kids do not necessarily have their pants on ... The sexual education here, maybe doesn't frighten me but maybe because I was raised differently, I am not 100% sure if I should overwhelm my child, educate him in such a young age.*  
 (Malina, Polish, aged 27)

Several of the Nigerian and Muslim participants spoke of their desire to parent differently to the way they themselves had been parented. This was particularly the case where they had experienced conflictual relationships with, or harsh treatment from their parents, as was the case for Suliati (who had a difficult relationship with her 'tough' mother). Suliati was subjected to FGM at the age of five, and a 'virginity test' by her mother some years later. She left home aged 16:

*I: What difference would you bring to parenting compared to the type you had?  
 S: I would train my children differently. Here children are taught everything about sexuality from primary school. So children know all they need to know. I've started English classes now so I can communicate with my children. I will teach them all they need to know from the onset to minimise likely mistakes. I will never mutilate my children because of the pain and the after-effect of it.  
 I: Mhm. Yes, it's true. It's no good at all.  
 S: More so, it's illegal in Ireland and can attract imprisonment. Some of my friends believe it's good to have it done but I always talk them out of it. FGM has affected my life negatively; I have a feeling of incompleteness, so I'll never do such to my children.*  
 (Suliati, Muslim, aged 26)

However, even many of the participants who had had overall positive relationships with their parents felt that they would treat the matter of sex education differently in parenting their own children. Nkoyo (Nigerian group) became a mother under very difficult family circumstances before coming to Ireland and this has shaped how she wants to raise her own children:

*I: How was it for you when you had your baby and the process of pregnancy? Did your parents help out?  
 N: Heaven knows that if I had known before my mother found out I could have done a lot of things to get rid of the pregnancy because of the shame, the trauma associated with getting pregnant in my society. Hmm, hmm, hmm... [Respondent sighs] My mother insulted me! My father beat me up. My uncle abused me. [Pause] My sister made fun of me. I was shattered and felt like killing myself and dying. But death did not come. I myself was ashamed of myself and that was the way it was for me. When I had my baby, my brothers called her a bastard to my face. I will never forget that statement. Luckily for me I got a visa to Ireland and left. Since then I have been really happy.*

*I: How is motherhood now for you?*

*N: It is the joy of every parent when my baby laughs. My heart is full of joy. She means everything to me. She washed away my pain. She is a gift to me a blessing in disguise. [Brief pause] I'm very happy I'm in Ireland because my view of life has changed, and emm, I see things differently now. The kind of upbringing I am giving my child right now is very different from what my parents had given me.*

*I: In what way is it different?*

*N: I will give my daughter a free hand - trust her to make the decisions. Very different from what my parents gave me. I listen to her and impart knowledge into her, and indirectly I have been telling her about life, and by God's grace she will know more about sex than I did. And to my ability she will be truly prepared to face life better than I did, so she is able to learn from my own mistakes.*

*(Nkoyo, Nigerian, aged 30)*

## **6.6 Challenges in becoming a mother**

Some of the women shared their perspectives of the different pressures motherhood can bring. These pressures related to general challenges for women, trying to balance a mothering role with earning a living, as well as cultural pressures supporting gender-differentiated roles, which place the responsibility for childrearing solely on women. The outcome of these pressures in some cases was stress, depression, loneliness and isolation. Chinese Ling gave consideration to the practical and emotional challenges that she foresaw would arise for her on becoming a mother:

*And then I don't know what kind of job I'll be in at that time and might not get paid maternity leave and I have to think about what am I gonna do when I'm not working: how to support my family? And also talking about the mental change for being a mother. I think it's important you receive support of services, consultation before and after.*

*(Ling, Chinese, aged 23)*

A number of women in our study observed the impact of young motherhood on migrant women, the realities of which put them off considering motherhood themselves. Ling spoke about her cousin's wife who suffered from post-natal depression when she and her husband were living in England. Ling described another friend of hers living in Dublin who also had post-natal depression. She highlighted the loneliness that women can feel following the birth of a child, and the importance of having social supports to alleviate the isolation:

*L: So she said if there was some kind of service like that she can talk to someone it would be much better because she feels quite isolated 'cause she's here in Dublin as well. She finds it useful just to talk to moms and so I think...*

*I: And would she have visited any clinics in Dublin, or...?*

*L: No. I don't think so ... just mother groupings, but not clinics. Not anything professional.*

(Ling, Chinese, aged 23)

Similarly, Yuan recalled the difficulties faced by a friend of hers who is working full time and who is a new mother, highlighting the loneliness and isolation a new mother can feel when she is unsupported in that role. Yuan felt that if her friend was at home in China, her situation would be very different as her parents could take on a greater role in looking after her baby:

*Y: I used to think having a baby was an easy thing. I actually wanted to have a baby, but what she's been telling me is quite negative. She can't hang out with us because she has to go back to take care of her baby.*

*I: She feels very isolated?*

*Y: Yeah, yeah, yeah. I would think that it shouldn't be like this.*

*I: Is she a single parent?*

*Y: No, she is with her husband but they both work full-time.*

*I: Yeah, yeah. So who is taking care of her baby while she is at work? Does she send her baby to creche?*

*Y: I am not sure. I think she sends her baby to creche in the day time.*

*I: She picks her baby up from the creche after work?*

*Y: Yeah, yeah.*

*I: She only has one child?*

*Y: Yeah, just one.*

*I: So it sounds very difficult to you?*

*Y: Yeah. They thought their parents could take care of the baby before but their parents are in China. So I think it's quite difficult for her.*

*I: Yeah. So when you plan to have child, you would probably go back home?*

*Y: Yeah, most likely. Again, you can't say for sure about what is going to happen in your life so I'll have to wait and see.*

(Yuan, Chinese, aged 24)

Julianna, a Polish student in college, had always felt that she would get married and have children at a young age, but after seeing her friends become mothers and the efforts they invested in child-rearing, she changed her mind and decided to postpone this life stage until she was older. Equally, Jamila, a Ugandan woman from the Muslim group, was aware of the demands a new baby can make on a mother's mental and physical well-being from observing her friend cope with new motherhood on her own:

*J: If you're alone it's very difficult. 'Cause I tell you, my housemate - she got depressed. You could see that she had depression because it's something new to her. The social workers didn't come visit her; they came once but never again, and I think that was something that they should do. Social workers should come, especially to women who*



*are their first time to have a baby*

*I: And they don't have the support either of a husband?*

*J: The fact that I'm there - I help her a bit. But I can't help all the time because I have my own life. But I think it's hard when you're alone.*

(Jamila, Muslim, aged 20)

## 6.7 Supports for motherhood

Some of the women discussed financial and other supports available to women when they become pregnant. Jiao was aware that in Ireland, a woman could receive maternity benefit if she has paid tax. Li, meanwhile, had scant information about maternity supports for women in this country. The following quote demonstrates Li's surprise at the supports provided for mothers, as well as the differences between the Irish and Chinese approaches to motherhood:

*L: And I think em, you know, to have a baby is totally different from in China and here. I never heard about a woman, they need to have after birth, do you need kind of em a holiday or something like that?*

*I: Yeah you have maternity leave from work.*

*L: You still have. How long?*

*I: Yes, six months.*

*L: Six months [shocked]?*

(Li, Chinese, aged 25)

Li favoured the Irish system, and described the unfairness of the attitudes towards pregnancy and motherhood held by some Chinese employers:

*L: I think this is much better: this is better than China. Because in China we just have one month and this one month is if you have a very fixed work, fixed job you can have. If you just work in some small companies, maybe they don't give you.*

*I: So the companies can choose if you can have it or not?*

*L: Of course this is illegal! You should have, you should have. But some of the companies they will just try to find out some excuse and they will fire you before you give birth to the baby. So you'd have no choice. And, and we [sighs] don't have that kind of long period with pay - we just have one month with salary and after that you still have to, em, you know. Maybe one month is not enough for you, so you still need to ask for leave and you will be, you will be reduced in your salary because of that.*

(Li, Chinese, aged 25)

Yuan, who is working full-time in an IT company, was aware that she was entitled to maternity leave, but was not aware of the particular conditions of eligibility for maternity benefit. Participants in the first Chinese focus group who were mothers were quite positive about the mother and baby group they attended through the health centre and appreciated the ability to share information related to the health of their babies with Irish

women and women from other countries. Xia found the attendance of the nurse at this group to be very beneficial.

Both Klara, who has a one-year-old daughter and who is pregnant with her second child, and Krystna, who participated in the Cork focus group, felt that the socio-economic conditions in Ireland were more favourable for raising children than they were in Poland. The Child Benefit payment was seen as adequate to cover the cost of baby-related expenses such as clothing, nappies, baby wipes, and milk. Both women stated that if they were planning on having children/more children, they would prefer to do so in Ireland. Equally Karina, who was also based in Cork, thought that it would be possible to parent alone in Ireland but not in Poland because of the supports provided through the Irish social welfare system.

### 6.8 Overview of motherhood

Almost all of the women in this research saw marriage as the first step and a precondition to having children. Recent Irish research exploring attitudes to family formation and using a nationally representative sample of 1,404 men and women (aged 20 – 49) demonstrated strong support for marriage as an institution, but cohabitation was widely accepted and seen as a step in a progression towards marriage. A high proportion of the sample (84%) believed it was better to live with someone before marrying them and this was partly explained by the fact that religious reasons for marriage are less important to people nowadays (Fine-Davis, 2011). This was not the case for many women in our sample, who were more likely to experience pressure from family and extended family members to get married and have children.

The issue of lone motherhood and the pressure on women to enter motherhood under 'appropriate' circumstances was raised by many women in our study group. Polish women experienced feelings of conflict and disjuncture trying to reconcile traditional family values and norms with their own changing attitudes, which were developed here and were influenced by what they perceived as more open and relaxed Irish cultural norms.

Ideal circumstances for motherhood were discussed by participants, including personal attributes of maturity (age, 'personal development'), 'readiness', relationship factors (marriage, suitable partner, familial support) and external/circumstantial factors (financial status). Almost all of the women foresaw marriage and motherhood in their future and the majority felt that the right circumstances for motherhood were marriage, and financial security. Views varied on the ideal age for motherhood, but in general, women planned to have their first baby before the age of thirty, in contrast to the average childbearing age of thirty-one of their Irish contemporaries. There were some exceptions to this viewpoint, and some women expressed their desire to focus on education, travel, and employment plans first and delay having children until their mid-thirties. Implicit in these narratives was the impact more liberal Irish cultural norms had on their aspirations for motherhood.

While participants expressed their views on the ideal circumstances for motherhood, the reality differed considerably for some of the women who already had children. A number of women had become pregnant at a young age, were not married, were very isolated, and had little support from their partners and/or wider families. Cultural norms and pressures also led to the withholding of support, women feeling a sense of shame, and, in some cases, experiences of abandonment and rejection.

The majority of participants in the Nigerian and Muslim groups (both those who were already mothers and those who weren't) acknowledged the positives and negatives of motherhood. They were aware of the far greater responsabilisation of mothers with regard to parenting, and saw motherhood as entailing challenges and requiring support.

Women spoke about the strong and involved role their own mothers expected to play in the rearing of their children. Some Polish women experienced this as overly intrusive and sought ways of lessening their mothers' involvement, while some Chinese women regretted not having their own mothers here with them to take on a childcare role and to advise them on all aspects of childrearing. Meanwhile, withholding of all forms of assistance and support by their mothers was perceived as punishment and rejection by two women who were young and unmarried when they had their children.

Some of the women shared their perspectives of the different pressures and challenges motherhood can bring, including balancing the mothering role with earning a living, as well as cultural pressures supporting gender-differentiated roles, which place the responsibility for childrearing solely on women. The outcome of these pressures in some cases was stress, loneliness and isolation.

A key concern arising was migrant women's capacity to interpret and establish their entitlements to ante-natal care, maternity benefit, maternity leave, protection in employment during maternity and the myriad of supports available to support women during pregnancy and early motherhood in Ireland. As Kennedy and Murphy-Lawless (2002) reported in relation to the maternity-care needs of refugee and asylum-seeking women in Ireland, women encounter difficult circumstances as they engage with a system of maternity care unused to such complex needs, amidst a general policy climate of uncertainty and even hostility towards asylum seekers. It seems that such uncertainty is encountered by many migrant women of diverse legal status seeking to establish entitlement to maternity care needs when newcomers to Ireland.

## **7.0 Sexual and reproductive health services**

### **7.1 Introduction**

This chapter discusses women's accounts of their knowledge and experience of sexual and reproductive health services in Ireland, and their access to such services. Expectations women held of services are discussed. The discussion takes account of how the expectations of women who migrated to Ireland in adulthood are shaped by the services the women had available to them in their country of origin. Practices of accessing sexual and reproductive health services transnationally are described, including reasons for doing so, means of doing so and the implications raised by this dual care. Overall, we identified distinct stances towards the Irish healthcare system (and the sexual and reproductive health services therein) between the four groups in this study. There were also distinct patterns of service usage in the different groups. Findings are presented first under thematic headings and then are explicated out to draw together the distinct issues for each of the study groups.

### **7.2 Barriers to accessing sexual and reproductive health (SRH) services in Ireland**

Knowledge and experience of SRH services, and access to them, are discussed within the framework of barriers encountered by women in this study group. The barriers that emerged from these women's accounts in accessing SRH services in Ireland were related to the following factors:

- Impact of legal status on access to health services
- Knowledge about sexual and reproductive health services
- Language and communication
- Issues related to accessing SRH services through primary health care
- Cost as a barrier to accessing SRH services
- Impact of cultural silences and sense of shame

### **7.3 Impact of legal status on access to health services: Case of Chinese students**

A newcomer's legal status has been noted in research from other countries as a key factor determining access to and use of health services (Flipper, 2009; HSE, 2008 and Gushulak and Mac Pherson, 2004). This was a key feature in our study too. Within our study group some women were second-generation migrants, other women had been granted refugee status in their own right or with their families, others were economic migrants from within the EU or without the EU, while others were here on short-term student visas. The variation of grounds on which women were here made for variation in their rights and access to services. Almost all of the Polish, Muslim, and Nigerian women in our study were living in Ireland for three years or more, while nine of the Chinese participants were living here for less than three years.

The legal basis on which many Chinese women are in Ireland precluded them from accessing public health services. Young Chinese women in Ireland to study English or

pursue third-level qualifications at Irish universities and colleges explained they had to have private health insurance in place in order to secure their visa. However, many did not see this as giving them access to health services, but rather a condition to be satisfied to gain entry to Ireland. This seems a lost opportunity both for women to access services but also for health insurance providers to inform women of health service provision in Ireland. Depending on the college women attended, some provided student health services, with varying procedures for access and entitlement.

Ling is a young Chinese woman who came to Ireland on a student visa, a basis on which many young Chinese are currently in Ireland. Her depiction of her knowledge of primary health care in Ireland provides an insight into the level of engagement this significantly sized group of young migrant women living in Ireland have with health services here generally. Ling had been in Ireland for three years but was very uninformed about the primary care system:

*L: I actually don't know much about how to see a doctor here. I didn't know what GP was. I only heard people talking about GP. I actually still don't know what GP is. Are they doctors?*

*I: They are. They are general practitioners. They would cover general health problems and they would also put you in contact with specialists if necessary. You will have to make an appointment with your GP and you will have to pay something like 50 euro to see the GP and it doesn't include other costs. So you've never been to a GP during the three years?*

*L: No.*

*I: Have you ever been to a pharmacy?*

*L: I went there with a friend of mine but it wasn't for myself. I have never been there for myself as far as I can remember.*

(Ling, Chinese, aged 23)

Li, also a student, said that if she needed contraception, she would go to a pharmacy:

*I: Have you attended doctor at all in Ireland?*

*Li: No, I never.*

*I: Yeah. So you don't have that - access to a doctor?*

*Li: Yes.*

*I: Yeah, so your first thought would be go to a pharmacy?*

*Li: That's my choice.*

*I: Yeah, and what would your method of contraception be that you would think of?*

*Li: Em, the pill, the contraception pill and condom I think.*

(Li, Chinese, aged 25)

Throughout the accounts of the Chinese women the issue of not having entitlement to services was a key barrier to becoming informed of the health system and options for

support in the event of a health issue or crisis arising. Not having a sense of entitlement precluded women from informing themselves of how the Irish health system worked. There were some women in the study whose migration status was irregular and/or who had friends in this position. The accounts of these women provided an insight into the mind-set that can develop among irregular migrants who avoid contacting any official services for fear of what this might mean for them. Mei described how she knew of Chinese women living illegally in Ireland, who had given birth at home because they were afraid to attend a hospital due to their illegal status. Mei felt that people who are in this vulnerable situation will be reluctant to speak out about it, but that they are the ones most in need of this kind of support and information. Jiao recounted that some irregular status migrants will seek access to A & E departments rather than GPs where they can receive medical attention but 'without [the hospital] asking many questions' (Jiao, Chinese, aged 18).

#### 7.4 Knowledge about sexual and reproductive health services

In general, knowledge about sexual and reproductive health services within the broader Irish health system amongst the participants was low. Given the previous discussion this low level of knowledge about services was not unexpected; poor knowledge was particularly noticeable amongst the Chinese participants. An illustration of this low level of knowledge was Yuan's case. She has been paying medical insurance through her employer, who deducted a contribution from her salary towards the cost of health insurance. She has been living in Ireland for a year, and has no awareness of any health services available here, including sexual health clinics. Yuan recently started working for a company full time, who arranged her working visa and her medical insurance. She was unaware of either the Irish health system, or of how her medical insurance operated. She attributed joint responsibility for this to herself for not being motivated to find out about it and to her employer for not being effective in informing employees about the medical health insurance scheme they were contributing to:

*I: You are working in the company full time, right? Do you have your own private medical insurance or it's paid for by your company?*

*Y: My company pays for the insurance.*

*I: The medical insurance?*

*Y: Yeah. But I don't know anything about the insurance system here. I only know, when I was signing the contract, they told me a lot of things.*

*I: But you weren't aware of...*

*Y: I didn't think too much. They already agreed to apply for the Green Card for me so I didn't think too much and I signed the contract. I was provided salaries and immigration status so no matter what else they were providing, I didn't care.*

*I: So that's not ... it didn't matter that much if they provided you medical insurance or not back then?*

*Y: That's right. I didn't think too much.*

*I: Yeah, yeah. So now do you know, do you have a GP?*

*Y: I don't. All I know is that my company takes a small amount of my salary every*

*month for that ... They think it's the common sense and they don't tell you much about it. Besides, I think I am still young and I shouldn't have any big problems so I don't pay much attention to it.*

(Yuan, Chinese, aged 24)

Only one Chinese woman had attended any specialist women's health clinics for sexual health services; Yuan attended the Irish Family Planning Association (IFPA) to find out information about contraception options. Yuan highlighted the fact that even though one might be in close networks with Irish people themselves, this would not necessarily mean that a person would get the information they required. Yuan's flatmate, who has been living in Ireland for seven years, told Yuan that she had some sexual health concerns and wanted to see a doctor, but did not know who to go to, or where to find out information about where she should go. She was also concerned about the cost of care. Yuan explained that despite the woman having an Irish boyfriend, she did not receive the information she sought, as he dismissed the concerns she had:

*Her [Irish] boyfriend is a doctor. She asked her boyfriend what she should do and he didn't seem to care. Her boyfriend would tell her that she thinks too much. I think some things ... girls know their own bodies and they can feel something is not right. Guys they don't seem to care.*

(Yuan, Chinese, aged 24)

Many women had no awareness whatsoever of crisis pregnancy services. Shufen, who worked in a university, was aware of notices informing about services for women with an unplanned pregnancy. However, she considered these were services targeted at students, and did not see them as being relevant to her. Chinese women in their later twenties who were here with spouses and having children had participated in public maternity care services, including the GP combined-care scheme and this had represented their first engagement with SRH services in Ireland. Shu's account depicts the barriers to accessing services for a young migrant woman arriving in Ireland unfamiliar with the health system or the language:

*And about the Irish system: When I first came here, I didn't know anything about the Irish health system. I didn't even know how to see a doctor and how to get medicine. Because it's completely different here. You have to make an appointment with the GP and sometimes, I didn't know back then, sometimes you wanted to find, when I first came here, maybe I couldn't express myself well, my English. And you didn't know which doctor to go for. But after I got to know more, probably because people around me, because I am from [region in China], there are many people from [my region] here.*

(Shu, Chinese, aged 23)

As Shu described, connecting with networks of friends from one's own home country or region who have been here for some time is a principal source of information on health

services. It is interesting to note that it was through maternity care that some newcomer women began to connect with Irish health services.

Shu's account describes how for her word of mouth among her network of Chinese friends was the key source of information about accessing health services in Ireland. However, not all women had access to such networks and they were left without information. For example, the following exchange between the Chinese peer researcher and Yuan who, as discussed above, has been living here for three years, demonstrates Yuan's lack of knowledge in this area and her sense that the Irish system of regulating contraception is very onerous:

*I: Do you have any other questions?*

*Y: Any other questions. Oh, some, contraception, I don't even know where I can go to get different contraception products?*

*I: You mean contraception products like...*

*Y: Like what kind of pills and condoms, things like that.*

*I: You don't know where to get those things?*

*Y: Yeah, yeah.*

*I: Those contraception products?*

*Y: Yeah, yeah ... I know a lot of the contraception products are brought over from China. Because we don't know where to get them here.*

*I: And you can actually get pills from some Chinese website?*

*Y: Yeah, so I am just wondering if there are some special stores where you can get them.*

*I: The pills, you can actually get condoms in almost every pharmacy and they are quite easy to get. Or you go to shops like Spar - they would have them over the counter. About pills, you have to go to your doctor, your GP, to get a prescription and the prescription is valid for six months. The doctor will have to check if you can use the pills.*

*Y: Isn't there too much work?*

*I: Well I think it's OK but you can only buy those pills with the prescription from your GP. That's how you can get pills here. Buying condoms is pretty much the same as it is back home.*

(Yuan, Chinese, aged 24)

In Chinese Focus Group 2 (CFG2), comprising students aged 23-24, there was a generally low level of awareness of how to access contraception other than condoms. Jia commented that condoms are available in pharmacies in China, but they are not as visibly on display as they are here in Ireland. The focus group participants were also aware that you could buy condoms from vending machines in public places, such as toilets at college or the cinema. Huifen added that she received condoms in a bag during orientation day in college. She thought that it was a good policy to promote condoms to young men and women in this way, as it would help them to understand the important message of safe



sex. Apart from Nuying, who was aware of a pharmacy on O'Connell Street which could provide emergency contraception, the other members of the focus group were not aware of how to access any other form of contraception other than condoms. Jia added that if she wanted to access emergency contraception she would go to a hospital, as it is perceived as being a safe place, and it would be what she would do if still living in China.

### 7.5 Language and communication

The issue of language as a barrier to using services was highlighted by Muslim woman Marjana, who argued that improving linguistic and communicative competencies amongst service providers in order to enhance the quality of care was essential for migrant women:

*M: Yeah, definitely. Language - never mind culture - it has gotta be language problem. I honestly think doctors and nurses need to be bilingual or trilingual, whatever, 'cause literally language is the key. Some women, say for example a Muslim woman speaks Arabic, comes into a clinic and no one understands her. She might have a thick accent where they might not even understand her English. They're going to need more foreign people. From what I've gathered, foreign people feel more comfortable with foreign people because they're basically in a foreign country, so they're going to understand each other. So maybe if there are more foreign people or else a person that speaks a few languages I think, or even another language. It will always be helpful because...*

*I: They can relate to each other more.*

*M: Yeah. But if an Irish nurse spoke Arabic it would make things a lot easier, because a woman could explain herself properly. If they don't speak it then the nurse will be baffled, the patient is going to be baffled, and nothing will get done! There's not enough in the health sector in Ireland for any bilingual speakers. They don't accommodate for people with different languages or cultures, which I think they should do, because they need to move on with the times. Maybe look into training nurses with languages. Maybe putting it as a module in universities that all nurses must speak another language. I don't see why they can do that in secondary schools but can't do it throughout college.*

(Marjana, Muslim, aged 18)

Nkoyo, who described herself as very shy, also identified the existence of communication barriers due to women lacking the confidence to discuss SRH issues with their GP. She felt that Nigerian women would have particular difficulty in discussing issues relating to sexual health. She added that she could not access a GP locally and had to travel to a larger town in order to access health services:

*I: Do you feel you have access to contraception?*

*N: Sure. Em, they need a good family planning service where people can go to when they need help with regards to sexual health. I feel they do not really have that in Ireland. It might not be something you feel comfortable about talking to your GP. I feel like Nigerian women find it very difficult to express themselves, especially when*

*it comes to a sensitive topic such as sexual health. I have to travel to [the large town] to see my GP. I could not find one to register with locally so my daughter and I have to travel for everything.*

(Nkoyo, Nigerian, aged 30)

Meanwhile, Beena, a Somali woman who participated in MFG2, wondered if the reason she did not receive an adequate explanation for her health concerns was due to (her perception) of her insufficient language skills. She was at a loss to understand why she did not receive adequate treatment here for her sexual health concerns, and attributed this in the first instance to language and communication issues for migrant women:

*B: Already I went to my GP, go to hospital, come back again, I didn't get an appointment, phone them and they say, 'We don't see your file here what is your number?' So the thing I'm thinking is that the person can't speak English and the person can't get help forever so you'll have to suffer from that.*

*I: You have good English and can understand.*

*B: I can speak good English and can understand everything but I don't see help from that. 'Cause I go to the GP, go to the doctor, you'll get an appointment, when I go there I don't get good explanation.*

(MFG2, Beena, aged 32)

## 7.6 Issues related to accessing SRH through primary healthcare

GPs were identified by some participants as the first point of contact with/referral to SRH services, particularly by participants with medical cards.

### 7.6.1 Cost as a barrier to accessing SRH services

Chinese young women Jiao and Changying both stated that the cost of attending a GP in Ireland is prohibitive, which can act as a barrier to accessing the contraceptive pill. Students attending private colleges described how they paid medical insurance along with their college fees and this covered the cost of attending a GP. However, not all colleges had an on-site medical service, and most of the smaller language schools did not provide this service. Neither young woman had used the medical service available to them, while both agreed that it would be too expensive for them to attend a GP privately outside of the service provided by their college. Shu also considered that it was too expensive to see a GP here, particularly when the fee does not include the prescription charge:

*S: I think it's too expensive to see a GP here. If I could handle it myself, I wouldn't go to a GP. I bring medicine from home. So I would check the symptoms first and then google them on the internet. If it's not very serious, I won't go to the GP. Because the health system here, I think, even it seems that many services are free, but...*

*I: But they are only for Irish nationals or foreign nationals with long-term residency status?*

*S: That's right. And how to say, there is one thing in particular about the system*

*which is not good is that you spend 50, 60 euro to see a GP, which doesn't include the expenses for sorting out the problem.*

[Shu, Chinese, aged 23]

Other Chinese women concurred with Shu, and it appeared that a general attitude existed among many young Chinese in Ireland that they would not attend a GP unless it was absolutely necessary. The GP service was perceived as being too expensive and they felt that entailing long waiting times at the surgery and for appointments.

*Why don't they make normal pills more accessible to women and they don't need a prescription from the GP? ... Yeah, that's what I think. Unless their current policy is to largely increase the population so people don't need to care about contraception use. But I don't think this is the case. There are so many foreigners here and I think Ireland's population is ok. I think they shouldn't be so restrictive on the normal pills. Like you said, it's a protection method. I think if I have to pay 50 euro in order to protect myself, I would choose another way. This is how I see it.*

[Ling, Chinese, aged 23]

As well as being dissuaded by the cost of GP services, women's impression of the GP service was that it was cumbersome to attend due to the appointment system, as Mei described:

*M: Yeah, no information actually; I don't know how to do. You know, erm, I think here, if I feel not well, I go to see GP, it have to spend a long time. I have to...*

*I: Wait?*

*M: Yeah, wait.*

*I: Queue.*

*M: Yeah queue and to order the time with GP [meaning to make an appointment].*

[Mei, Chinese, aged 29]

Chinese women who would be liable to pay for consultations and prescriptions described getting contraception from home or the internet to use while in Ireland, leaving them without medical support in the event of an issue arising for them.

Both Muslim women Lisha and Suliya, whose legal status has allowed them access medical card services, demonstrated the value of a medical card in facilitating access to sexual health services. Lisha from the Muslim group described being informed about how to access sexual and reproductive health services by her support worker, who had advised her to ask her GP about choice of contraception. Her GP referred her to a specialist family planning clinic, which she was pleased to discover was covered by her medical card:

*I: And what about the family planning clinics that are just for contraception provision. Have you heard of those?*

*L: Yes. Is it those clinic where you get contraception?*

*I: Yes.*

*L: Yes. There is one in O'Connell Street. That's where I got mine done.*

*I: Yeah. Did you know about those?*

*L: Yes. No, not until I had the second baby that [support worker] said to me that you had to get contraception. Then I went to my GP to get the full details and she now gave me the numbers of places that I can get it done free with my medical card. I thought you can get it done at the GP until she told me. I didn't know about that. It is not expensive if you have the medical card. Even if you don't, the price is OK to be safe.*

*(Lisha, Muslim, aged 22)*

Suliat's account demonstrated that when cost was eliminated women were very happy to attend for a consultation and receive contraception through a prescription system:

*S: In Nigeria the health system is not free. You must have money to access it. That's one of the things that impressed me where medical cards are given to those who cannot afford to pay. The other thing is that you need prescription to buy medicines here.*

*I: Is it different in Nigeria?*

*S: Yes. If a doctor prescribes a medicine for me for an ailment and there's a reoccurrence of it, I would just go to the chemist and buy same medicine instead of going back to the doctor.*

*I: Would you get contraception easily in Nigeria?*

*S: Yes, but you have to pay, whereas condoms are given free here. I think it's better in Ireland in some areas. Like it is good that you get a prescription before you buy your medicine rather than self-medicate. I will also say that doctors in Nigeria are very good and that's why you have some of them working here.*

*(Suliat, Muslim, aged 26)*

The most reported barrier to accessing contraception amongst all participants was expense/affordability. Bisi and Chinua, who both had spent time studying in the UK, noted that contraception and STI/sexual health check-ups were easily accessible and provided free of charge to students there. They found sexual health services in Ireland to be of a lower standard with regard to cost and accessibility than the UK. Bisi, in particular, mentioned the insufficient provision of affordable emergency contraception. However they compared Ireland favourably to Nigeria with regards to health service provision, and in particular maternity and childcare services. For these young migrant women cost of accessing contraception functioned as a barrier in a particular way because their independent economic situation was precarious, often due to their legal status.

### **7.6.2 Impact of cultural silences and sense of shame**

Where women were attending GP services, this did not always mean they used their GP for sexual and reproductive healthcare. Cultural silences and sense of shame in relation

to sexuality inhibited asking a GP about sexual health services. Nigerian Nkoyo, who lives in a rural area, cited her GP as her only option for accessing sexual and reproductive health services and considered this did not adequately address the cultural sensitivities that sexual health raised for women sharing her cultural background:

*They [Nigerian women] need a good family planning service where people can go to when they need help with regards to sexual health ... I feel they do not really have that in Ireland; it might not be something you feel comfortable about talking to your GP. I feel like Nigerian women find it very difficult to express themselves, especially when it comes to a sensitive topic such as sexual health.*

[Nkoyo, Nigerian, aged 30]

Chinese Shufen echoed this view and spoke of feeling shame when having to ask for information relating to sexual health services. She said she would rather ask her mother in China for information. She attributed these feelings of shame to Chinese women's cultural background and upbringing, as they are not normally comfortable talking about these topics:

*S: Just, just feel from the culture background we grow up so, we not normally talk about sexual... This kind of topic, or... It's just really hard when you want to open your mouth and ask for somebody. It's become very, very shameful.*

*I: Because it's not usually talked about?*

*S: No, no, no, not usually talked about. Maybe with some close friends, we will mention one or two sentences.*

*I: So even with friends it's not generally a topic of a conversation that's easy?*

*S: With some friends, we have similar experience, then maybe we can have a few words after, they can give your some suggestion.*

[Shufen, Chinese, aged 32]

Shufen had begun attending a GP for combined care while pregnant; during post-natal care her GP initiated a discussion about contraception, which Shufen was surprised by:

*I was surprised my GP she just, you know, I didn't ask her, but she automatically told me, saying something so, oh you're breast feeding, and then you could, well, you could do, and then you know you couldn't, you won't get pregnant again because you keep on breast feeding so it's OK. And then she said you can use some [spermicidal] 'jelly' or something.*

[Shufen, Chinese, aged 32]

Young Nigerian women emphasised confidentiality and accessibility of services independent of parents as a huge concern for young women due to the taboos against extra-marital sex and pregnancy. They stressed that any doubts regarding confidentiality are likely to deter them from availing of services. Bisi recalled that a friend refused to go

to her GP for emergency contraception as she feared that the bill would be sent to her home address where her mother would see it.

### 7.7 Cultural approaches to medicine

Another source of reticence in using Irish health services expressed by Chinese women was based on cultural approaches to medicine and a preference for the Chinese medical philosophy over the western. Ying, who is married and living here for three years, stressed that she would have more faith in the Chinese approach to medicine compared to the western approach, as the Chinese approach aims to cure a person from the inside:

*Y: But to be honest my family are very proud of traditional Chinese treatment like herbs, so I'd say if it happened to me I'd go back home, 'cause here the way of thinking is quite different.*

*I: What do you mean by that?*

*Y: Like if you're sick they'll try to cure you from the inside, but the western medicine cures you from the outside that you don't have the syndromes but the thing is still inside you ... So this is the problem I have with doctors here or whoever was going to provide me the service.*

(Ying, Chinese, aged 25)

Thus both cultural and structural barriers featured in the barriers Chinese women cited in accessing GP care. Rather the community strives to be self-reliant through self-diagnosis and management of health issues using a combination of medicines brought from home in bulk or bought over the counter. Two young women in a friendship-pair interview explained:

*C: Yeah. I didn't like going to see doctors at home, let alone here. It's quite expensive here.*

*J: And you will have to make an appointment. It's quite troublesome. I was injured while I was ironing a shirt. I was planning to go to the doctor. But a Chinese friend told me that I had to make an appointment and it was going to cost me a lot so I decided to get some medicine myself. That left a really big scar on my arm. If I went to a doctor it probably wouldn't leave a scar.*

(Jiao, Chinese, aged 18, and Changying, Chinese, aged 22)

Reluctance to attend a GP among the Chinese group is indicative of a general lack of connection between the group and the Irish health services. This has the effect of young Chinese women being uninformed about how to access contraceptive services.

### 7.8 Impact of pre-migration experiences

Discussion in the introduction referred to how women's pre-migration experiences can shape their post-migration service needs. Among our study group, Muslim woman Jamila had prior experiences of sexual violence before arriving in Ireland. While she was within

the asylum-seeking process as an unaccompanied minor she was put in contact with support services and a GP with whom she has now established a relationship of trust. She highlighted how important this was to her and described a positive relationship with her GP, who is aware of her background. This was important to Jamila, as she found it difficult to speak about her past experiences. She was uncertain whether she could have negotiated such service access without supports:

*J: My GP, even her, herself - when I first came here I got a body - with all the things I went through, I got a full body check-up, like medical check-up. Because I was always sick so they thought maybe I was pregnant or something. It felt different because I really went through a lot before I came here - I was abused and all that. And I came in here and they had to do all that.*

*I: Physical medical check-up.*

*J: They did things to me that was new to me. But at the end I'm just finding out now that they did that all for my own health and for my own safety and everything. I was taken to different clinics.*

[Jamila, Muslim, aged 20]

## 7.9 Transnational service use

Among some women in the study group their time living in Ireland was intended to be short. They had come here to study or work but retained very strong connections to their home country. They returned frequently, particularly Polish women. Even Chinese women - for whom distance and cost of returning home is much greater - talked of returning home at least once a year and while there stocking up on supplies of contraception and over-the-counter medicines:

*Y: I felt awkward to go get the contraception so I would go back home once a year and because condoms were cheaper back home I'd...*

*I: Stock up?*

*Y: Yeah!*

[Ying, Chinese, aged 25]

For example, Chinese Mei, who used condoms as contraception with her husband, described having to take emergency contraception on a number of occasions, after a condom had broken during sexual intercourse. When this happened, Mei did not access emergency contraception in Ireland, but instead used pills she had brought over from China on a previous visit. Like a number of other Chinese women, Mei has very little knowledge about accessing contraception in Ireland. If she needed to, she reported that she would go to a pharmacy for information.

Chinese Ling's perspective illustrates how unclear women are about access to services here - her automatic position is to consider returning home for care:

*I: So for young Chinese girls here, like yourself, for example, if you ever had problems, if you ever had any gynaecology issues, would you choose to go back home or would you go to a doctor here? What would you do?*

*L: If it ever happened to me, I would choose to go back home. I don't really know how the system works here. Until some girls I know who had babies, I knew that they provided free antenatal checks, something like this; I didn't know anything at the beginning. I thought those free checks were only provided to Irish women but they are actually for everyone. I didn't know that at the beginning. Is there any requirement in terms of age or something?*

(Ling, Chinese, aged 23)

Polish Agata who had a medical card described how she was refused contraception when she moved to a new locality and attended a new GP. She was critical of the length of time it took to change GPs and to switch her medical card. Lack of knowledge of the full range of services meant she was unaware of sexual-health-specific services where she might have found alternative care.

As well as returning home for medical consultations or supplies, women described 'transnational' forms of accessing sexual and reproductive health advice, information and contraception. This included calling home to ask for advice and information from mother, siblings or friends, asking for supplies to be posted or ordering supplies through the internet. There were some references to accessing medical supplies either directly through the internet or through other sources. As seen already, young Chinese women avoided attending a GP due to cost. Instead the first resort when a medical issue arose was to attempt to self-diagnose the problem using internet resources and try to manage it without professional advice:

*I think it's too expensive to see a GP here. If I could handle it myself, I wouldn't go to a GP. I bring medicine from home. So I would check the symptoms first and then google them on the internet. If it's not very serious, I won't go to the GP.*

(Shu, Chinese, aged 23)

Polish women talked of a range of ways in which transnational use of sexual and reproductive health care featured for them. For some this was because they preferred to continue to receive care and treatment from a familiar and trusted service, delivered through their first language. For example, Julita came to Ireland three and a half years ago, shortly after having left school and having a baby in Poland. She described having a poor understanding of Irish services. Furthermore, she was not entitled to a medical card as she was not considered habitually resident<sup>16</sup> in Ireland, thus raising cost as a barrier.

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<sup>16</sup> The Habitual Residence Condition (HRC) is a qualifying condition for social welfare payments which was introduced on 1 May 2004 in response to EU enlargement. All persons seeking means-tested social welfare payments and Child Benefit after that date have been required to satisfy this condition. There are five criteria used by the Department of Social Protection to determine whether a person satisfies the habitual residence condition. These are:

1. The length and continuity of living in the State or another country
2. The length and reasons for any absence from the State
3. The nature and pattern of the person's employment
4. The person's main centre of interest
5. The future intentions of the person applying for the social welfare scheme



Julita explained her response to her sexual and reproductive healthcare needs:

*J: No, I was always visiting doctors in Poland. When I was on holidays I was trying to organize some time to visit a doctor if I had to have a smear test and to get checked. There's a language barrier here in Ireland, so I couldn't go because I just couldn't get the information I'm looking for.*

*I: And that way suits you?*

*J: Hmm...I prefer to wait a while and go to a Polish gynaecologist than here. I know I should really go for a visit now, because I have cervical erosion and it's large. And I really should start treatment, so I'm waiting till I go to Poland to do something with that.*

*I: So last time you were in Poland you got diagnosed?*

*J: No, these problems started when I was pregnant. Last time I was in Poland I did a smear test and the doctor said we have to do something, but it wasn't that urgent. But that was a year ago.*

*I: A cervical erosion is a common problem of many women, isn't it?*

*J: Yeah, mine is large. Well, smear test was OK, but you know it is a cancer risk. I don't have the chance to go to the doctor here, because I don't have a medical card. This is a problem for me.*

*I: So maybe you should apply for one?*

*J: I should, but from the other hand I'm not habitually resident so I'm not entitled to a medical card. That would be so handy if I could just go to the doctor, not wait. I don't know when I'll go to Poland and how this disease is going to develop since then.*

[Julita, Polish, aged 23]

Another reason for women engaging in transnational use of SRH services is because of differences in the structure of provision in Ireland as compared with their country of origin. A striking feature of Polish women's accounts was the expectation that all sexual health matters would be dealt with by a gynaecologist rather than by a general practitioner within the primary healthcare system, as happens in Ireland. A number of Polish women expressed worries that their care was being handled by a GP rather than a gynaecologist:

*She was just a GP. This is what I find very strange in Ireland: the same doctor deals with my children – she's great with them, by the way – she's treating all kinds of diseases. Friends who cannot have children are visiting her and I don't get it why she won't send them to a specialist. She also deals with depression. In Poland you visit a general practitioner and you tell him what is your problem and he refers you to a specialist. Here it's only GP! ... Seriously, I think I will just collect my money and I'll be just going for private visits to a specialist to get accurate treatment.*

[Agata, Polish, aged 29]

In a group discussion Klara and Krystyna highlighted their lack of faith in the competency of a GP to provide care: post-natal care in the case of Klara, and antenatal care for Krystyna in the initial stages of pregnancy:

*Kl: Once we did a scan in [Polish Medical Centre] and it was grand. What I don't like here is after-birth check-up on mother and child. GP checks up on stitches. What does GP know about stitches?! I'd expect a gynaecologist instead.*

*K: Or when a pregnancy begins you go to GP, not to a gynaecologist. When can you go to the hospital?*

*Kl: You can go to the hospital after 12 weeks - before this period pregnancy doesn't exist for them.*

*I: What do you mean?*

*Kl: Miscarriages happen very often. Well you can go for a private visit.*

*I: And in Poland?*

*K: You can go to a hospital as soon as you find out you're pregnant and they will run all the tests etc.*

*Kl: I had my first check-up at 14 weeks. Before that I had a pregnancy test and a blood test at the GP.*

(Klara, Polish, aged 19 and Krystyna, Polish, aged 21)

Referring to a broader cultural difference, Dominika felt that Polish health professionals are more distant and authoritative, and that perhaps this inspires more confidence in Polish women, as they are used to professionals who behave in this manner:

*I think that it is what we see as the position of doctors, medical staff etc. I think that there was some research done in Poland and that doctors don't greet us or reply hello if we say good morning to them. So in Poland doctors' position is very authoritative; doctors are used to being treated as half-gods. It's also communistic, when priest, doctors, and teachers were huge authorities and everybody had to listen to them. I don't know what is the historical background in Ireland, probably they didn't have those implications.*

(Dominika, Polish, aged 29)

Two young professional women interviewed together were a striking example of transnational service users. When Krystyna and Klara were asked by the peer researcher their preference in accessing sexual and reproductive health services, they both said that their first preference would be to attend a Polish doctor in Poland, their second preference was an Irish doctor in Ireland, and their third preference was a Polish doctor in Ireland. Krystyna gives the reasons for these choices, namely that there is no communication barrier with a Polish doctor in Poland, the healthcare system is familiar, it's cheaper, and she can trust her doctor. Krystyna is continuing to pay health insurance in Poland, thereby maintaining a link with home and giving herself the option of availing of dual systems of healthcare:

*K: Polish doctor in Poland – no communication barrier, he’s someone you trust because your mum is visiting him too. In Poland it’s a different healthcare system. It doesn’t cost you a penny. Even if you choose a private visit to make it faster it’s not even ten euro for a smear test.*

*I: Even if you live in Ireland it’s free in Poland?*

*K: I’m regularly paying for insurance in Poland. And in second place we have an Irish doctor in Ireland. I’ve been there once with my backbone problems. Sick leave, medicines, referral for massages - very nice. No communication barrier; well, maybe I won’t answer, but at least I will understand everything. And in third place is a Polish doctor in Ireland – my gynaecologist as an example.*

*[Krystyna, Polish, aged 21]*

This was also the case in relation to maternity services. Polish women generally understood they had access to Irish maternity care services but many were critical of what they perceived as lower standards of care in the Irish approach. Women argued that Polish doctors were more thorough and more cautious, so that they felt safer with the level of care given to a woman during pregnancy:

*Polish doctors do more scans during pregnancy and also gynaecological examination. I think that it becomes a clue for Polish girls if everything is fine, and it’s not practised in Ireland. I am happy that my pregnancy went without complications, but I don’t know if it would have been possible to early diagnose any problems here in the Irish system. I would trust polish doctors more in that matter.*

*[Julianna, Polish, aged 19]*

Zofia described Polish women’s needs and experiences of maternity care in Ireland. She believed that women can focus on themselves a great deal during pregnancy, and have a tendency to worry. Therefore, they need to be reassured that everything is proceeding as normal. In contrast, she perceived the Irish approach as being more relaxed, where the attitude is that pregnancy and childbirth are natural processes in a woman’s life, and thus intervention occurs only when it is necessary:

*I think that in Poland we are very much focused on ourselves [women in pregnancy]. We are used to going to the doctor with every pain, every worry and uncertainty. Here everything is left to the natural flow, and it’s more natural, but I think that the women who are coming here from other cultures can feel a little bit more lost here, as they don’t get as much attention as they would get being in Poland ... I can’t be sure because I wasn’t pregnant in Poland but that’s what I am observing, and also from talking to my friends being pregnant as I am. I don’t know if attention is a good word, it’s rather running from doctor to doctor and being in their hands during pregnancy. I also don’t think that those visits are that much focused on the woman, so I don’t know if it’s a real attention, but it gives an impression of bigger safety. So when I go to the doctor every month and have a scan done, and some examination I feel more under*

*control, especially in those first months of pregnancy. I think it's important. Here I felt very lost, uninformed. I didn't know what was going on with me. I wanted to have a scan done immediately, but it occurred that the first scan is after first three months of pregnancy.*

[Zofia, Polish, aged 29]

Similar to Zofia, others thought that the Polish maternity healthcare system overly medicalised pregnancy and childbirth:

*When I first came here to Ireland I was thinking that this is how pregnancy medical care should look like. I was thinking that Polish way is too much medicalised ... That there is too much rumour around pregnancy in Poland. I think that if there are no obstacles the pregnancy should be led by a midwife, as doctors have a tendency to implement more fears, which are not good at that time.*

[Beata, Polish, aged 30]

*Service here is really super. Pregnancy is treated as something normal. In Poland pregnancy is treated as a sickness. In Poland a pregnant woman in the fifth month is sent on sickness leave. Here if you feel OK you can work till the end of pregnancy.*

[Malina, Polish, aged 27]

As the accounts above show, women's decisions about using Irish or transnational health services often related to personal preferences and perceptions of quality. However, for women who did use Irish maternity-care services this functioned as a critical means through which they became established with Irish primary care services, including GPs. Women whose migration status entitled them to access the health services included women on a work visa or women accompanying spouses here on a work visa.

Women interviewed in this group who had given birth in Ireland spoke of their experiences of maternity services, including how they accessed information and supports on sexual health services through this source. All women in the study who had had children in Ireland had used the combined care service of their local GP, combined with visits to their local hospital for ante-natal care. The Public Health Nurse was commended by a number of new Chinese mothers, including Lan, who availed of contraception advice from her nurse. The nurse advised Lan on natural family planning methods, namely the Billings method, which was her method of choice. Xia mentioned that she had got a booklet about services at her local mother-and-toddler group. The booklet included listings of crisis pregnancy services and so she was aware that there were services available, but she had never used any of them. These examples illustrate again how maternity-related services connect women with sexual health services more generally.

### 7.10 Overview of sexual and reproductive health services

A key feature throughout this chapter are the distinctive stances towards and patterns of use of Irish health services - including sexual and reproductive health services - our four study groups described.

Again, the conditions under which women are living in Ireland framed their engagement with the health services. Young Muslim women were mostly second-generation migrants and thus integrated into the Irish health system through their families. Many women in the Nigerian study group were here with their families and had established their relationship and access to services through their families, as opposed to in their own right. Meanwhile, there was a small number of women who were in Ireland independently and were entitled to a medical card, under the General Medical Card scheme. Having a medical card appeared to make services, contraceptive supplies and knowledge of SRH more accessible for women

For those whose medical card entitlement was based on a family entitlement, the key issues in accessing SRH related to confidentiality and accessibility of services independent of parents, due to the taboos around extra-marital sex and pregnancy. Women from both the Nigerian and Muslim group referred to how cultural silences and a sense of shame in relation to sexuality prevented them from asking a GP about sexual health services. There were some concerns regarding the existence of communication barriers due to lack of multi-lingual competency among doctors and nurses in the Irish health care system, as well as women lacking the confidence to discuss SRH issues with their GP.

By contrast, women in both the Chinese and Polish groups were more likely to be in Ireland independently and were a more transient group in the sense that moving on or returning home was more amenable to women in this group than to women in the Nigerian or Muslim groups. Reflecting the very different legal status and entitlements accruing to each group, each group demonstrated a very distinct stance toward the Irish health services as well as distinct patterns of usage of services while at the same time demonstrating commonalities in their engagement in 'transnational' health service usage.

Young Chinese women in our study group were here either studying on a work visa, on an accompanying spouse visa, or they had irregular migration status. All of these categories of migration left them very circumscribed in their entitlements to Irish health services. The stance of young Chinese women to Irish health services generally observed in this research was characterised by a feeling firstly of being at a life-stage where health issues were not a feature and therefore entitlement to health services were of marginal concern. Meanwhile Chinese women were aware that they had to have private health insurance in place as a condition of their visa and that they were therefore within the private stream of the Irish health service. However, Chinese women in our study group tended to consider

the Irish primary care system as hard to access for a number of reasons. First, many did not see the health insurance they arranged as giving them access to health services, but rather a condition to be satisfied to gain entry to Ireland. Based on anecdotal assessment of the primary healthcare service, women tended to hold the view that attending a GP entails long waiting times to arrange an appointment, queuing in waiting rooms and a prohibitively expensive fee that does not include the prescription charge. There was some reticence expressed towards using Irish health services based on cultural approaches to medicine and a preference for Chinese medical philosophy over Western approaches. These factors converged so that young Chinese women's health service usage patterns tended to entail being self-reliant through self-diagnosis and management of health issues using a combination of medicines brought from home in bulk or bought over the counter. This entailed returning home and buying contraceptives in bulk, asking someone in China to post contraception, ordering contraceptives over the internet or acquiring contraception from someone in one's own network outside of the health service. Central to the effect of this from the perspective of this study was how not having entitlement to services operates as a key barrier to *becoming informed* of the various elements of health services. Given the reliance of health policy makers and providers on primary healthcare as a point of contact and information for specialist areas within the service, it is no surprise to hear that a group who are outside this system remain uninformed of specialist services such as sexual and reproductive healthcare services or crisis pregnancy counselling and support services.

Polish women, in turn, tended to return home frequently and retained very strong connections to their home country, including their health service providers in Poland. The issue of the transnational use of sexual and reproductive healthcare featured most among the Polish study group. Polish women frequently reported opting to attend Polish health services in Poland or alternatively opting to attend a Polish doctor privately in Ireland. Transnational use of services also included obtaining medical supplies including contraceptives in Poland for use when in Ireland. Various reasons were given for using Polish services. Cost was a feature - returning to Poland was often calculated to result in cheaper medical care and contraception than using the Irish system. Another reason for not using Irish services was that some women preferred to receive care and treatment from a familiar and trusted service delivered through their first language. Polish women also engaged in transnational use of SRH services because of differences in the structure of provision in Ireland as compared with their home country. A striking feature of Polish women's accounts was the expectation that all sexual health matters would be dealt with by a gynaecologist, rather than by a general practitioner within the primary health care system as in the Irish case. A number of Polish women expressed worries that their care was being handled by a GP rather than a gynaecologist. Referring to a broader cultural difference, there were also some who felt that Polish health professionals were more distant and authoritative, and that inspires more confidence. Polish women generally understood they had access to Irish maternity care services but many were critical of what they perceived as lower standards of care in the Irish approach. Women

argued that Polish doctors were more thorough and more cautious, so that they felt safer with the level of care given to a woman during pregnancy. This was not unanimous, however, and some Polish women opted for the Irish system, believing that the Polish maternity healthcare system overly medicalised pregnancy and childbirth.

Overall, then, there were clear and distinct patterns in how women from the different groups viewed and accessed the Irish healthcare system. Legal status was an important factor in determining use of Irish services, but other factors, such as cultural preferences, also featured. There is no doubt that those with the lowest levels of access and use of services, such as the Chinese women in our study, risk experiencing health-related problems arising from a lack of connection with primary healthcare, including crisis pregnancy, which in the long-term are costly both for the woman herself and for services.

## 8.0 Quality and cultural competency in sexual and reproductive health services

### 8.1 Introduction

This chapter concentrates on women's views on the quality of sexual and reproductive health services. The chapter describes perceptions and experiences of how culturally sensitive services encountered by the women interviewed presented. Expectations of how services could be more culturally appropriate to women's needs are discussed, including cultural awareness and sensitivity among staff. Finally ways of informing newcomers about SRH services are explored. Firstly the emergence of ethnic-specific health services in the Irish context and women's experiences and views on using such services are described.

### 8.2 Accessing ethnic-specific services

As mentioned in the previous chapter, ethnic-specific professional services - including medical services - are often a feature of newcomer communities in their new country. In the Irish context Polish medical centres are now a feature of the medical services landscape in larger urban centres where there is a concentration of Polish residents.

Polish women living in the vicinity of Cork and Dublin city described how Polish-specific private health clinics, run by Polish medical staff licensed to work in Ireland, were in operation. Among the study sample, women living in Cork had less access to Polish services than women living in Dublin. The services provided by the Polish-specific clinics were culturally much closer to the services women were used to in Poland. A number of women favoured using both systems. As seen in the last chapter, there were differing views on whether the Polish or Irish approach to sexual and reproductive healthcare was better.

One reason Polish women gave for using private Polish antenatal services in Ireland was because of pressure they came under from family and friends in Poland who felt the Polish management of pregnancy was of a higher standard:

*And also pressure coming from our mums, friends asking if I did this, that and that in particular moments in pregnancy: if I had scans done, saw the baby... My friend [in Poland] was pregnant when I was – her due date was two weeks later. She was under Polish doctor's care, so she had the scans done on every visit. I had few extra scans, but also she had some medication prescribed, and was advised to do a smear test. So I really was thinking that maybe I was neglecting my child, and that probably I was right to do that smear test as she did (it happened that she had to take some medication after it). So I did that smear test to prove to myself that I am a good mum and that I take good care of my unborn child.*

(Aniela, Polish, aged 28)



*Yes, I had also never attended Polish doctors here in Ireland, but once I got pregnant I felt enormous pressure, that my friend is doing things her way, that she has a trustworthy doctor ... So I went to the Polish doctor, but looking back I regret this decision. I wasn't happy with the doctor, I was more happy with the care that I was under in the maternity hospital. I consider labour, how I was minded by doctors and midwives as a very pleasant time.*

[Danuta, Polish, aged 23]

Weronika challenged the need for such a parallel system, having used both. She was concerned that Polish clinics might be benefitting from women's lack of understanding and knowledge of Irish maternity services, and in fact, contributing to their fears and anxieties about the standards of care in the Irish system:

*Plus I think that, I am grateful for Polish clinics here in Dublin. I sometimes go there as well, but I have a sense that - especially during pregnancy - women are a bit exploited there, the fact that they are fearful leaves space for doctors to prescribe unnecessary tests. Every month a visit - €80, scan, another €80 plus some tests for hormones, toxoplasmosis, etc. and the bill is €350, but do we need it all? I don't think so. I didn't need them. I think that if there is some problem, there will be some symptoms of it. I feel that Polish clinics are using that fear that women have; this two-way thinking that we are in Ireland, but we will have things done in the Polish way.*

[Weronika, Polish, aged 30]

Weronika was of the opinion that Polish women need to learn to adapt to the Irish system and should not avail of dual systems of care. She explained the Polish way of thinking:

*I think that lots of women are doing well. I decided to follow the Irish system in maternity care. I think that we cannot bring that dichotomy in coming to Irish and Polish doctors. You cannot trust any doctors then. So I saw following the Irish system as my best option, but among many of my friends it doesn't function like that. For the sense of security they need to attend Polish clinics here in Ireland, as they think that two scans during pregnancy is not enough. I don't know. I think it's Polish thinking. I admit that once in pregnancy I visited a Polish doctor in Poland, and he actually put that seed of anxiety in me. He was against the system here and I disliked it a lot.*

[Weronika, Polish, aged 30]

Klara's experience, however, illustrates the confusion that can arise when a migrant woman's healthcare involves using multiple services, in this case services in Poland, ethnic-specific services in Ireland and standard Irish healthcare services. Klara attended health services when on visits home for scheduled health checks because of familiarity with and trust in the system, as well as the fact that it was cheaper to visit a doctor in Poland. When a smear check result in Poland was queried she was asked to have a repeat check, and she attended a Polish clinic in Ireland. However, she found the systems were not compatible:

*I did a smear test in Poland. I came back to Ireland and my doctor rung me to do a re-test 'cause he wasn't happy with the results. So I went to [Polish Medical Centre] to visit a gynaecologist. I took the previous results done in Poland with me. She got confused and couldn't read these results because it's a different methodology. But it was funny for me that a Polish doctor in Ireland couldn't interpret Polish smear test results. I was like: Who the hell is she? A doctor or a nurse?! So every time I'm in Poland (I'm visiting Poland three, four times a year) I'm visiting a doctor, doing blood tests, all kinds of tests. It's cheaper in Poland. I have my doctors there, they know me. Nothing can surprise me.*

[Klara, Polish, aged 19]

Chinese Ying is married and has been living in Ireland for three years. She described knowing of some non-medical doctors<sup>17</sup> providing services here, who some members of her network attend instead of the formal healthcare system. Ying used the term 'backstreet doctors'; this discussion was not in reference to abortion where such a term is more commonly used but was intended here more generally to refer to non-medical doctors:

*Y: And also I heard there are some backstreet doctors.*

*I: Sorry?*

*Y: Backstreet doctors. So I can't imagine that. It's quite tough and I mean for me it's kind of awkward that we don't want to pay for medical insurance and we're not qualified for a medical card. So we just thought we're better to take care of ourselves and not get sick. But we always try to sort it out by ourselves or inside the Chinese community.*

[Ying, Chinese, aged 25]

Muslim women considered the merits of having a shared (minority) religious/cultural identity between service users and service providers in their focus group discussion. While the women had earlier noted the benefit of migrant/ethnic minority healthcare staff as having a possibly broader range of cultural knowledge or an enhanced predisposition to responding to cultural needs, on the other hand they would not necessarily see it as beneficial to be treated by a member of their own community. It is noteworthy that the Muslim women in the focus group unanimously agreed that they did not require or desire a doctor with a shared cultural/religious background. Indeed, some of the women would be uncomfortable with a doctor who was a member of their community:

*I: And would you try to seek out a Muslim doctor?*

*All respondents: No.*

*A: Not necessarily.*

*N: I prefer not.*

*I: Why?*

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<sup>17</sup> This refers to the provision of medical services without a licence issued by the regulatory medical body of the country.

*N: Maybe because in Ireland we all know each other. So you'd prefer to go to someone you don't know.*

*I: So there's a chance you'd know ... The community is smaller, like?*

*C: Our community is really small. Like, we're a big minority, but we'd know, say, someone from Galway or Cork or whatever.*

*A: And it's like, 'Oh, isn't that the daughter - if the daughter - Oh yes, she had a leg problem.' [Laughs]*

*I: Oh. So is it a private, confidentiality problem?*

*F: It's not necessarily that they're not gonna be confidential, but just for yourself.*

*C: It's kind of awkward, really.*

*I: They're bound by rules of confidentiality to not discuss your issues?*

*A: They may say, 'Oh, I saw your granddaughter yesterday.'*

*C: 'And she had this problem...' [Laughs]*

*N: Even when you're in the room with him, it's like, 'Oh your dad does this, and your mom does that, and I seen your brother...'*

*C: And 'Oh your sister got married.' Ha ha, that's how it goes. 'Cause we are small. (Aadila, Nasrin, Cala, Fiza and Shireen, MFG1, aged 18-25)*

### 8.3 Quality of sexual and reproductive health services

A key difference between the Polish and Irish healthcare systems identified by some of the participants was that in Ireland general practitioners can deliver sexual and reproductive healthcare, whereas in Poland all such healthcare is delivered by a gynaecologist. The delivery of SRH services by GPs was criticised by some of the Polish participants. Women who had attended for sexual and reproductive healthcare in Ireland also made comments on their experiences of Irish services:

*She was just a GP. This is what I find very strange in Ireland: the same doctor deals with my children – she's great with them, by the way – she's treating all kinds of diseases. Friends who cannot have children are visiting her and I don't get it why she won't send them to a specialist. She also deals with depression. In Poland you visit a general practitioner and you tell him what is your problem and he refers you to a specialist. Here it's only GP! ... Seriously, I think I will just collect my money and I'll be just going for private visits to a specialist to get accurate treatment.*

[Agata, Polish, aged 29]

Jamila, a young Muslim woman who came to Ireland as an unaccompanied minor through the asylum system, described how she had been prescribed a hormonal contraceptive by her GP despite the fact that she was not sexually active at that time. She had been referred to the GP while in the asylum process. She was unhappy with the side-effects of the hormonal contraceptive and was critical of her GP, who she felt was motivated by a strong concern to ensure she avoided pregnancy. Jamila felt that the GP had neglected to fully inform her about her care, failed to offer her choice and did not address concerns she had regarding its side-effects:

*J: Yeah, my case. Because the GP told me that the implant was the best for me, but it wasn't. It didn't even - I just kept on bleeding.*

*I: And did you find the GP good in terms of advising you about these matters?*

*J: Yes, somehow it was good, but somehow they should advise us more to tell us what is going to happen - like, if this happens, this should happen. They should tell us more and tell us how most things work. And sometimes you're only taking it because they tell you to take it.*

*I: And did you ask them about contraception?*

*J: No. I got the information as soon as I got here. So that's the information they kind of give to avoid pregnancy. 'Cause the GP obviously encourages you to go on contraceptives. Most of my friends have gotten the same thing when they went to the GP - their GP always encourages them to take...*

*I: Is this when you go into a country as an asylum seeker and you have to go through all the medical check-ups?*

*J: Even now. Despite coming here and seeking asylum and everything. As a young woman, if you go there complaining about your tummy, the first thing they think about is pregnancy test. So even if I'm not feeling well, the first thing that comes to mind is a pregnancy test.*

*I: Oh really? And you may not even be having sex.*

*J: Yeah, you won't even be having sex but you're not feeling well. And the first thing she does is take a test.*

*I: Yeah. And would you not tell her 'I'm not having sex, so I don't think it's possible?'*

*J: Yeah, but she'd still say, 'Yeah, let's just check'. Ha ha.*

*I: And why do you think that is?*

*J: I dunno. Maybe it's a procedure.*

(Jamila, Muslim, aged 20)

Jamila was dissatisfied with the level of information and consultation she received and felt that women should be educated about the potential side-effects of contraception and supported in making fully-informed decisions, rather than being expected to passively follow medical advice. She felt that the advice given to her was inappropriate and indicated that there may be a disproportionate medical concern with or focus on pregnancy/contraception in respect of young women.

#### **8.4 Expectations of cultural sensitivities among Irish SRH providers**

While some of the issues raised above could be seen in the context of 'cultural sensitivities', wider issues of comparative health systems were central also. More specific cultural sensitivities arose for Muslim members of the study group particularly in relation to understandings of Islam in the Irish health system whose origins are in a western, Christian tradition. Overall, the Muslim participants in this research did not have high expectations that service providers would have an awareness of religious or cultural characteristics or requirements. None of the women in the Muslim group employed the language of 'rights' when talking about the accommodation of cultural difference. Most,

as Iram remarks below, would be pleasantly surprised to encounter service providers with knowledge of Islamic values or cultural practices. When asked if she expected medical staff to know about her religion or cultural background Iram replied:

*Well, obviously it would be nice, but I don't think it's something that goes and something big. I don't think that they do know a lot about the religion and all that stuff, but it would be nice to see.*

(Iram, Muslim, aged 20)

The extract below from a focus group with eight Muslim women aged between 18 and 25 discusses a range of experiences and themes associated with SRH service provision in Ireland. The topics touched on in this conversation include intercultural competence on the part of service providers, cultural expectations, requirements, stereotypes and assumptions and issues of shared identity, trust and confidentiality. When the interviewer instigates the discussion of service provision, Shireen recounts two instances in which she experienced overt misunderstanding by health professionals in the maternity services. In the first instance the doctor treating Shireen suggested that the practice of wearing a headscarf contributed to her miscarrying. This suggestion is understood by Shireen and the rest of the group as being an expression of the doctor's personal prejudice rather than having any basis in medical or scientific reality:

*I: And how did you find the maternity services, ante-natal services and did you find them culturally appropriate? Anything in particular you want to point out?*

*S: I had a miscarriage before I had her and I went in for the scan to see if any part of the baby was left. And I was basically told 'No, you have to pass out the baby', and was told to take off my hijab [head scarf]. 'The reason why you had a miscarriage was because you weren't getting enough sunlight.' I was completely shocked! Like, I just walked out of the room. [Upset] ... She then told me to go home and take off the hijab and get some sunlight. And I just walked out of the room.*

*I: Were you angry at that time?*

*S: Yeah. I just walked out of the room, 'cause I was really upset. And when I was pregnant with [my daughter] I was wearing my hijab in the hospital around the ward. And a nurse came over to me and said 'Take that hijab off. Your husband isn't here and you don't need it here. Why are you following that religion? You're Irish, you don't have to do that.'*

(Muslim FG1, Shireen, aged 25)

The second incident, where Shireen was instructed to remove her headscarf by a maternity-ward nurse, is suggestive of two distinct prejudices on the part of the nurse. One is the questioning of the legitimacy of Shireen's religious/cultural identity, as she is an Irish convert to Islam. The other is the implied understanding that the wearing of the hijab is an expression of Muslim women as subservient and submissive. This assumption is a source of frustration for the group, which they further discussed and challenged later in the conversation.

Another source of frustration identified by Shireen was the cultural assumptions or expectations around the appropriate age for motherhood, as expressed by another doctor, which she felt de-legitimised her pregnancy. Shireen was unhappy to be viewed as 'a teenage pregnancy' and emphasised her married status:

*S: Yes, really, really. And when I fell pregnant and had my son and he was sick in hospital and a doctor comes over to me and goes, 'Oh, 19 and pregnant.' And I was like, 'I'm married, I'm not like a teenage pregnancy.'*

*I: Oh. So you felt that he was saying you're a young one coming in pregnant?*

*S: Yeah. And when I was going home the doctor comes over to me and goes 'Next time, don't forget to use contraception, and what kind of contraception are you going to use?' And just demanding how I'm gonna...*

*I: Why was he saying that to you?*

*S: I don't know to be honest. He was just a paediatrician looking after my son who was really sick when he was born. And he just came down to me and turns around and says that to me. And I just go, 'I'm gonna discuss that with my husband.' He was trying to say I'm not allowed to get pregnant at 19.*

*I: Why do you think he said that?*

*S: I don't know.*

*C: I think it depends on the people.*

*S: It's pretty prejudiced.*

*N: Some people think that because you're married you're forced to have children. Oh yeah, because you're Muslim and wearing a scarf then that means you're forced.*

*S: Under your husband's control.*

*I: Do you get that attitude a lot?*

*B: Yeah.*

*F: Yeah, people do believe that you're oppressed.*

*I: Because you're Muslim?*

*B: And they think husbands have complete control over the marriage. But they don't understand that it's actually equal rights between women and men.*

*C: And they don't think – Like, they think when we say we both got equal rights, they think we're just saying that to cover up for something. Oppression and all.*

[MFG 1, Shireen, Cala, Nasrin, Batool, Fiza, aged 18-25]

The women in the group were clearly frustrated with the prevalent stereotypes of Muslim women as passive and suppressed. They saw these stereotypes as completely at variance with the reality of their lives, but they were at a loss as to how to challenge these views because they found themselves not being believed. Some Muslim women in our study felt that Irish health service providers portrayed them as completely powerless. At the same time they felt disempowered by those personnel from presenting any alternative perspective on their own situations or identities.

However, the women in the group also had positive stories to tell about service provision in the Irish SRH context. Cala recalled that her mother was treated respectfully by maternity hospital staff by being asked about her preference for a female or male doctor:

*C: OK. Look, for Muslim women they prefer to have a female doctor and they totally respected that. And my mom, when she was pregnant with my little sister she was having a caesarean. And they asked, 'What doctor would you prefer?' and she said, 'Well if there's a female then I'd prefer that, but if not...' And they respected that. And there wasn't a female at the time, but there was only a Pakistani doctor. He was supervising but wasn't actually there, but he was supervising the nurses. So they respected the fact that she wanted a female.*

*N: But any other woman of a different religion could have said that.*

*C: Yeah, I know. But I mean, they know especially with Muslims.*

*I: So you think they have that awareness that Muslim women actually want to see a female doctor?*

*N: Yeah. Some respect it and some don't.*

[MFG1, Cala, Nasrin, aged 18-25]

Based on the discussion above, it seems that the actual provision of a female doctor is less of an issue than the expression of sensitivity to cultural requirements. Cala seemed to be satisfied with the staff actually consulting her mother as to her preference for a male or female doctor, viewing this as expression of respect and a perfectly adequate effort at cultural sensitivity. Below, Aadila related a similar story of being asked about her preference regarding the gender of the doctor who would treat her labour. While a female doctor attended her first, it subsequently became necessary for a male doctor to treat her. Aadila's husband was upset that she was examined by the male gynaecologist. Aadila lauds this doctor for handling the situation so well by patiently engaging her husband in conversation to distract him from the stress of the birth complications:

*A: See when I was having my daughter I went to [hospital]. And basically both our heart rates dropped. Like my daughter was very low. And it was around 12 o'clock at night on [date]. They told me we needed a doctor and asked whether I want a male or a female and I said, 'Female, if possible.' So I had to wait five minutes, but because her heart rate was dropping this woman came in and started with medical terms and said, 'Sorry, we have to get the other doctor.' The other one was more experienced and he knew how to handle the situation better. And this man comes in, and my husband is like, 'Oh my God,' and he holds my legs and goes, 'Why do you want to be a gynaecologist? Do you want to sit down and look at women all day..?'*

*I: Who was that?*

*A: My husband. Ah, he's usually level-headed but I think he just had a really rough day and I was not easy. And the guy was so respectful. He was like, 'Oh, where are you from? I'm from Nigeria. There are lot of Muslims there in Nigeria and Christians.' And he was doing what he had to do, but looking at my husband, then doing what he had to*

*do. So respectful. And he was covering what he didn't need. And then he goes, 'Here's your baby.' He was so respectful. And my husband apologised to him later on, just saying like, 'Sorry. You know, like, I'm not used to this,' and all that. Once they know, and I think if they are culturally sensitive, then they will do their best to accommodate. Like, he was the only one at that time that could do that. But the female doctor wasn't able to do it, for whatever reason. But she came and she saw and she couldn't conquer. So they had to bring him in.*

(MFG1, Aadila, Fiza, aged 18-25)

In the dialogue below, Aadila considered the role and attitude of minorities, in this case Muslims, in intercultural interactions. She advocated a measured and flexible rather than demanding or uncompromising approach in making culturally-specific requests of service providers. She saw this manner as more likely to result in compliance with the request:

*I: And how do they become more culturally sensitive?*

*A: Just by knowing about it and becoming more aware.*

*I: Aware how?*

*A: Like if there are a lot of Muslim women coming and saying 'Look, could we require this...' And also if the Muslim women are accommodating and polite in their request, and not saying, 'I can't have a man doctor', and being all pushy like that.*

*F: But I think doctors, in general, are the most culturally sensitive - doctors and nurses. Because they see the most - Like, there are a lot of foreign doctors in Ireland. There's a lot of mingling and you see a lot of different people. So I do think they are the most culturally sensitive profession.*

*A: True, but it depends on our request. Like, if we are quite possessive and want and want and need because my religion says - So they kind of get sick of it and are like, 'Look we're under-staff [ed] and we've had enough, so we need to do what we just need to do and that's it.' But if you're polite about it, then they would, like me, go out of their way.*

(MFG1, Aadila and Fiza, aged 18-25)

However, Aadila then went on to relate another experience in which she received brusque treatment by a maternity-ward nurse who treated her as disruptive due to her requirement for privacy while breastfeeding, despite her efforts to accommodate the needs of the other inhabitants of the ward:

*A: The nurse I was with after the birth had a problem. The only bed that was left was near the window. And there were two jaundice babies. And she told me to keep the curtain open, and I did. But she said, 'When you want to breastfeed and take off your scarf, close the curtain but let one of us know so we can move the jaundice babies elsewhere.' So I was doing that and at one point she just flipped. And I was like, 'Look, I have an idea. Why don't I swap with the woman over there who has the jaundice baby? I'm more than happy to go to that side of the room and swap beds. Just get someone*



*to change the sheets and I'll move.' But they didn't even have enough staff to change the sheets. When I was giving birth to my daughter there were patients all over the corridor. There were beds here and there [gesturing to illustrate], and there were beds outside the beds. Do you know what I'm saying? Like it was really, really full. But what they should have done is, if you have a woman in a scarf and jaundice babies - move her to the corner and re-do her bed and put me in that corner.*

*C: Sorry, what's a jaundice baby?*

*A: A baby with yellow skin. And they need the sunlight. So that's why they needed to be at the window.*

*I: And you think she should know the knowledge that you needed privacy?*

*A: No, we told her that. But they accommodated that by giving me a corner. But they gave me the window corner. But what she should have done was, OK, so that woman is coming in in the wheelchair, and that's there, and so put you there over night and switch you over the next morning.*

[Aadila and Cala, MFG1, aged 18-25]

From Aadila's perspective the issue could easily have been resolved to the satisfaction of all relevant parties. She identified the conflict as a symptom of an over-stretched, under-resourced healthcare system. She stressed that she would not have inordinate/unreasonable expectations of prior cultural knowledge or familiarity, pointing out that simple solutions can be found to accommodate the needs of everyone involved if individuals have the capacity to work together. However, Aadila's experience is indicative of the fact that a system which is facing overcrowding and under-staffing has the potential to undermine the intercultural capacity of service providers:

*I: But my question is, had she or did she have the knowledge on your need for privacy or is it your responsibility to say it?*

*A: She did at the beginning. No, she didn't know about it, so I had to tell her.*

*I: Would you have liked her to know it without you telling her?*

*A: It would be nice but you don't expect them to. Do you know what I'm saying? It's not what they're taught in medical school. They're just taught what to do. So it depends on how many patients she had with the same issue as me. For me, I couldn't walk around the room without my headscarf, so to breastfeed was a problem. And there were fathers coming in and out, so I needed the curtains to be closed. That way, it's a compromise and everyone doing their thing. She kind of did get fed up of me closing the curtains. But I did tell her I'll be closing them, and they'd move the baby elsewhere, and they just snapped.*

*I: What do the rest of ye think about that? How much responsibility has the medical staff, medical practitioners to be culturally - to have some knowledge and sensitivity?*

*C: From their side, they should know the different cultures and the different requests by people 'cause people aren't the same. As from the people's side, they should know how to go about asking them. Say it nicely and then...*

*F: Yeah, not be rude about it.*

*I: So a little bit of give and take, as she said earlier.*

*A: Ultimately, I think it's a patient's responsibility to put their requests forward.*

*Because [Hospital] is fantastic but it's crowded - so many women. [Hospital] has about nine, ten labours a day and the wards and all jammed and full. But as a patient you have the responsibility to make that request. If they know that, and if they're familiar with these requests from past patients asking for those requests, then it's easily accommodated.*

(MFG1, Aadila, Cala and Fiza, aged 18-25)

As with Aadila's positive experience with the Nigerian male gynaecologist, Kalila's contribution to the discussion (below) demonstrates how having multi-cultural staff in any health setting brings knowledge and understandings. This should be viewed as a valuable resource as strategies such as the National Intercultural Health Strategy are being implemented:

*I: Anyone else have any thoughts about that?*

*K: My [family member] is a midwife and Muslim, so she wears the scarf. She had, with other Muslim families and patients, they either had issues or demands that she found surprising herself as a Muslim. So she was quite aware that if another midwife was there at the time they would have found it even more confusing. But she understood it from her point of view.*

*I: What kind of things would that be?*

*K: There was one - I think it was some African woman. She had been circumcised and it had been very difficult for her to give birth. And [family member] understood this, but she knew if another midwife was there, then she wouldn't have understood it like [family member] did.*

*I: Ireland is changing as you know and there are many people from different backgrounds and beliefs. So is having somebody from that background in the services good?*

*K: I think there should be more.*

*C: Even hospitals have halal food now. Because they know Muslims can't have certain foods, so they ask.*

*N: But other people who aren't Muslim, like Christian, white and blond, yet they can't eat a certain food.*

*C: But the fact that they're still aware. Any Irish person walking you wouldn't know, let's say, if they don't eat pork. We wouldn't know they don't eat it. But say a Muslim, they know they wouldn't be eating pork. Do you know what I mean? So they know what you can't have and they respect that as well.*

*F: And I think in the medical profession, they do have a bit of knowledge as to cultural beliefs. Like I was taught, Jehovah witnesses, don't give them blood transfusions. And you know, there are things about Islam. So there is some knowledge there.*

(MFG1, Kalila, Cala, Nasrin and Fiza, aged 18-25)

Aadila pointed out that while she may have a preference for a female doctor this is not a rigid requirement. The doctor's gender is less relevant than their professional competence and their skills in putting a patient at ease:

*See, when I'm looking for a doctor I would prefer to go to a female. But if they're not available and I need a doctor then I'm open to see a male doctor. But that's because there are female doctors available. Like, when I was seventeen I had a stomach problem and the only gastrologist in that whole area was a male. And I had to go see him and he was very lovely, very respectful, quite funny as well. But, like, I had to see somebody.*

[Aadila, MFG1, aged 18-25]

The sentiments of the Muslim women in the focus group were echoed by Jamila, a young Muslim woman who took part in an individual interview. Jamila also emphasised the need to balance expectations of a culturally-aware practitioner with the responsibility on the service user to recognise the intercultural context:

*J: I think just making them understand - it's not about religion here, it's about your health, it's about you. Let's put religion aside, because we all believe in God, and God knows what we're going through. So you just making them understand and put religion aside and think of your health and life.*

*I: So you don't think they need to have an understanding of religion?*

*J: Even the different - like the social workers and the GPs should have a bit of knowledge about the Islamic religion, because most people who are really staunch Muslims take things very personally, even if it's not meant to be taken personally. So I think if you talk to them in the right way and make them understand that this is this and maybe that can help.*

*I: But as you were saying, someone who is caring as well is going to be very important.*

*J: Yeah, someone who is caring and very easy to talk to. Because some people who are really not so nice and you just look at them and you don't want to open your mouth. I'm not going to say anything.*

[Jamila, Muslim, aged 20]

While she perceived a background awareness of religious/cultural characteristics/traditions as beneficial, Jamila considered that a patient, open and caring attitude were of greater significance in shaping the interaction between service providers and service users. This same point was made by participants in the Muslim focus group, who agreed that inter-cultural competence entailed being respectful and receptive, rather than having in-depth knowledge of specific cultural traits or traditions. It was also noted that stress on service providers (due to inadequate staffing levels, high levels of demand, insufficient resources) can be detrimental to the provision of culturally sensitive services.

Among Muslim women in study, both in the focus group and individual interviews, there was strong consensus that service providers should have a basic level of knowledge about the cultural values or practices of the major world religions or large minority groups, and there was a minority view that service providers should be able to communicate in other languages:

*M: They need to be, if they're dealing with a foreign person, they need to know a little...*

*I: A bit about the background or...?*

*M: Yeah, kind of. Like know where the person is coming from and stuff. Like, for example, if a patient comes in and she is a Muslim and she wears the scarf, and the nurse talks to her and she finds out that she's from Libya and is Muslim - It would be nice for that nurse to know that she's not going to take her scarf off in front of a male doctor, so maybe she can get her a female doctor. It's nice to have that extra bit of information to make a patient feel comfortable.*

*I: And would you think it would be essential for them to understand the religion when dealing with patients?*

*M: Yeah. I think it is important in every - it should be Judaism, Christianity, Islam - every religion there is. And they need to be, they need to know about it so they don't say something or do something that will offend a person.*

*I: And would that have a negative impact on the person visiting the GP or the clinic?*

*M: Yeah, they would never come back to a hospital again.*

(Marjana, Muslim, aged 18)

Here, Marjana highlighted the very significant implications of failing to cater for religious/cultural minorities in health service provision. The trust and confidence of service users is vital to maximising access and beneficial health outcomes. Demonstrating respect for cultural difference is an important element in building such confidence among service users from different cultures. Service providers should endeavour to accommodate key cultural values and practices where feasible and appropriate. Marjana also raised concerns about the long-term exclusion and disenfranchisement of migrants and religious/cultural minorities in Ireland:

*I: Do you think the people from Muslim backgrounds would appreciate their voices being heard? And that improvements in the services wanting to be provided?*

*M: Definitely. A lot of them complain that nothing is being done, so now that there is something being done and they see that their voice is - If you're not going to listen to their opinion, they're then going to think that they're still outsiders, they're still foreign people even if they have Irish citizenship. And that's not the message you want to be sending out - a negative one. But if they see that their voice is being heard, then they're gonna feel that they are a part of the Irish community and Irish society and that the Irish people and Ireland have welcomed them, so they can give an opinion, honestly.*

(Marjana, Muslim, aged 18)

Marjana felt that improved awareness of and responsiveness to cultural difference could promote integration, a more cohesive society and more inclusive citizenship.

In summary, participants displayed a balanced and pragmatic approach in their expectations of cultural competence amongst Irish sexual and reproductive health providers. They did not employ the language of 'rights' when talking about accommodation of cultural difference. The women in our study were conscious of not seeming to be overly demanding and expressed appreciation for service providers who made efforts to accommodate difference. Women also disclosed accounts of prejudice, and behaviour grounded in prevalent stereotypes of Muslim women as passive and suppressed, which they universally criticised. At the same time, there was agreement that inter-cultural competence entailed being respectful and receptive, rather than having in-depth knowledge of specific cultural traits or traditions. It was considered that the additional cultural knowledge or understanding that migrant or ethnic minority staff members could bring to the healthcare setting should be exploited as a valuable resource.

### 8.5 Informing newcomers about health services

Chinese women expressed a strong need for information on the system of primary care in Ireland. Yuan who still felt uninformed after three years living in Ireland proposed that an initiative to inform newcomers on the Irish health system was needed:

*I: So how did you get to know how the Irish system worked?*

*Y: I actually don't know very much about it. My flatmate has been here for seven years.*

*I: Chinese?*

*Y: Yeah, Chinese. After I moved into the apartment and she has a foreign boyfriend, so she has told me some things. But I don't know how exactly it works... I actually hope that there is a lesson available about the Irish system and how it works.*

...

*Y: I'd like to suggest that there should be a place where we can learn about the whole thing, about what you can do, about contraception use...*

*I: About the choice of contraception.*

*Y: Yeah, about everything. I hope there is a place or a lesson which can teach us those things.*

(Yuan, Chinese, aged 24)

While some women referred to sourcing contraception abroad, either online or during visits home, Chinese participant Mei stated her preference would be to attend sexual and reproductive health services here in Ireland. She proposed that the best way to target the information to young Chinese women living in Ireland would be through Chinese language websites, such as 0086.ie. Ling, another Chinese woman suggested that information should be translated into Chinese, and widespread circulation of this information would be a very useful supplement to targeted information, in, for example, Chinese newspapers such as the Sun Emerald, or Ireland Chinese News, as well as in specialist supermarkets:

*L: Chinese newspaper, not everyone reads it. I would read a page or two but very rarely. I think the best way, they don't necessarily have to put up information in Chinese shops... shops like Spar, Centra, not matter Chinese people or people from other countries would pay attention to it. I think it would catch more attention. Those shops in the city centre, they have a lot of customers.*

*I: Do you think it would be easier to catch your attention if the information is in Chinese?*

*L: I think so, yeah... If the information is in English, I would wonder what it means, I would have to look up the terms in the dictionary to check the meaning. I think I would probably just leave it.*

(Ling, Chinese, aged 23)

Li, meanwhile, considered that the best place to pass on this information to Chinese women was in the pharmacy, arguing that pharmacies are the only point of contact with Irish health services for many young Chinese students like her:

*I: And what type of advertisements do you think would reach somebody like you as a visiting scholar?*

*L: I think in pharmacy. I think that's the best way, yeah. We don't have GP, so no other organisations can give us the advertisements and advice. If I need some advice, maybe they, if they don't, the pharmacy can tell me and I can go to that kind of organisation directly.*

(Li, Chinese, aged 25)

Chinese women also emphasised the importance of word of mouth and informal means of dissemination of information amongst their community:

*L: I think it's better if they can state it clearly on the leaflets. If they are very vague about it, I don't think it would work.*

*I: Yeah, yeah. So they should make it very clear who are entitled to these services and how much exactly do those services charge.*

*L: And how to say, many Chinese people here, we always get information from word of mouth. Like you're now doing this research, you can tell your friends about this project. You can tell people in this way that the services are for everybody and they are good for the women's health. So by passing around the information through word of mouth, a lot of people would get the information... I think that is quite good. The Chinese community is not very big here. So I think if you tell some girls or some girls who have received the services already, they would definitely tell their friends and everyone would know it in the short time.*

(Ling, Chinese, aged 23)

Crucially, Yuan pointed out the importance of cultural understandings and differences in expectations and knowledge depending on attitudes to sexuality among their culture of

origin. In her opinion, the best time and place to reach Chinese young people with health information is when they are attending college. She remembered her time in university in China, where information was provided on posters on campus. The peer researcher explored this further with her, questioning whether she was aware of any posters or information when she was in university here. She found an explanation for not paying attention to information in her college here by suggesting that Chinese people have a lower baseline of sex education and knowledge to begin with, and therefore, some of the materials that are available may not reach women, as they might not be able to relate to them:

*I: I think they do have some posters in the colleges but you probably..*

*Y: I probably didn't pay attention.*

*I: Or it probably didn't attract your attention. So you think they can improve in terms of..*

*Y: I am thinking maybe it's because people from home have less knowledge than people from here. We probably know those things later than they do, people at the same age.*

(Yuan, Chinese, aged 24)

Polish women described their need for information to assist them in adapting to the Irish health system and to reassure them that best practice in healthcare exists here:

*That if someone sees that there is an immigrant women coming from outside of the system, we should be informed about how system works and why is that. That we cannot take for granted things that are obvious for Irish.*

(Beata, Polish, aged 30)

*We should probably be given things in writing and quite detailed information.*

(Katarzyna, Polish, aged 27)

*We really need to be informed on why scans [during pregnancy] are done here that rarely, why the system works here as it works ... I discovered that it is not a necessity to be examined and have those scans, but my thinking was unpopular. I didn't have knowledge to support it against what Polish norms are.*

(Danuta, Polish, aged 23)

Dominika recommended using leaflets to educate Polish women. She felt that Irish doctors were unfairly criticised by the Polish community when the reason was more to do with different approaches to healthcare across the two countries. Finally, young Muslim woman Jamila suggested the wide distribution of multilingual written resources on SRH issues to young people in their places of study, work, and residence.

*Like, in schools, especially secondary schools, they should give out leaflets and things like that for girls to have more knowledge about things. And the different organisation[s] should be very welcoming when someone comes in with a problem and they should have that care when someone comes. Because people go through a lot and they need - they're vulnerable. So I think giving leaflets to different schools. And like hostels - they have asylum seekers - them hostels, have people to go in and talk to people from different nationalities and they won't know about those things. So I think that would be a good thing to be done.*

(Jamila, Muslim, aged 20)

Jamila proposed that the provision of information leaflets should be supplemented or complemented by the provision of education - through SRH classes throughout secondary school and continuing into adulthood. She noted that immigrants would have little knowledge of the Irish sociocultural context and service provision landscape, and may have missed out on school-based SRH education both in Ireland and in their country of origin:

*I think it's an area that we immigrants - not only religious things - but we immigrants, it's an area that we need to be educated on. Because from where we come from much things aren't there and no-one has the time to educate us about this. So I think it's a very good thing to do the research, and maybe as years go on immigrants will have more information, more services and where to go. If I get an unwanted pregnancy I can go here, and if I need support on something I can go here. So most of us don't know. Like, I can get the information 'cause I have social workers and I can call them and ask them, but other people don't have that connection to ask 'Where can I go for this?' So I think it's a very worthwhile thing to do for immigrant people here.*

(Jamila, Muslim, aged 20)

As Jamila observed and was noted by others in the study, once women have established an initial connection with the system, they are in a better situation to access services in future, as and when needed. However, migrants who have had no prior contact with health or social services might find it hard to learn where to go or who to make contact with when a SRH issue arises.

## 8.6 Overview of quality and cultural competency in health services

Women in our study group continued to access ethnic-specific medical services in Ireland, despite having lived here for varying periods of time over three years. This was a feature of Polish women's experiences in Dublin and, to a lesser extent, in Cork. Reasons for using private Polish antenatal services here were related to pressure exerted from family and friends in Poland, who felt that the Polish management of pregnancy was of a higher standard. There was also evidence of women availing of dual systems of health care. Chinese women in our study also accessed ethnic-specific services, and there were reports of non-medical doctors<sup>18</sup> providing services in Ireland, which members of one

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<sup>18</sup> This refers to the provision of medical services without the necessary licence issued by the regulatory medical body of the country.



woman's network attended, instead of the formal healthcare system. Muslim women considered this issue and agreed that they did not require or desire a doctor with a shared cultural/religious background. As seen in the last chapter, though, the value of having staff members from a shared cultural/religious background in a healthcare setting, such as hospital or clinic was emphasised by some Muslim women.

Issues about the quality of sexual and reproductive health services were raised by some women; dissatisfaction with aspects of ante-natal care being delivered by a general practitioner rather than a gynaecologist was one issue, experienced by some Polish women. Another issue was a young migrant woman's complaint that her GP prescribed a form of contraception to her, even though she was not sexually active, due to a disproportionate emphasis on preventing pregnancy.

Muslim women discussed their expectations of cultural sensitivities amongst Irish SRH providers and displayed a balanced approach in these expectations. They did not employ the language of 'rights' when talking about accommodation of cultural difference and were conscious of not seeming to be overly demanding; instead they expressed appreciation for service providers who made efforts to accommodate difference.

Women also disclosed accounts of prejudice, and behaviour grounded in prevalent stereotypes of Muslim women as passive and suppressed, which they universally criticised. At the same time, they agreed that inter-cultural competence entailed being respectful and receptive, rather than having in-depth knowledge of specific cultural traits or traditions. For example, provision of a female doctor is less of an issue than the expression of sensitivity to and respect for cultural requirements. In general, women tended to advocate a measured and flexible rather than a demanding or uncompromising approach in making culturally-specific requests of service providers. One woman recognised through her own experience that a health system which is facing overcrowding and understaffing is likely to undermine the intercultural capacity of service providers. It was considered that the additional cultural knowledge or understanding that migrant or ethnic minority staff members brought to the healthcare setting was a valuable resource. This can be drawn on in the implementation of the National Intercultural Health Strategy which would address many issues raised here.

Once a migrant woman has had an initial connection with SRH services, she can more easily access services in the future, as and when needed. However, migrants who have had no prior contact with health or social services may have no knowledge about where to go, or who to make contact with when a SRH issue arises. Information needs highlighted by participants included Chinese women's need for more information on the system of primary care here. They considered the best way to target information to them was through specific Chinese language websites, pharmacies, posters in shops and by word of mouth. Also Polish women highlighted the need for education on the benefits of the Irish approach to ante-natal care.

In order to develop SRH materials that will meet the needs of women from diverse ethnic and cultural backgrounds it is necessary to understand these backgrounds, particularly the expectations and knowledge of services that stem from different cultural attitudes to sexuality. Creating pathways to enhance opportunities for an initial connection and raising awareness among staff to ensure initial contacts are optimised are critical features in promoting migrant women's use of Irish sexual and reproductive health services.

## 9.0 Conclusions and recommendations

### 9.1 Introduction

In presenting our findings on migrant women's SRH care needs we are mindful of how sexual and reproductive practices and health issues as well as service needs and utilisation experiences vary depending on a myriad of issues. These issues include length of time living in Ireland, age, country of origin, ethnicity, faith, legal status and indeed the conditions and reasons under which women are in Ireland. Equally it is important to bear in mind that among newcomer communities in Ireland there are high levels of diversity in the ethnic, cultural and religious origins of migrant and minority ethnic women, and this was reflected even in our relatively small study group, constituted by members of three nationalities and one faith group. We need also to understand that, even within an ethnic and/or national group family/community values can vary considerably; for example, depending on whether the woman grew up in a rural or urban region. Our methodology therefore involved identifying individual perceptions, attitudes and experiences of women across the themes of our inquiry. Differences between first- and second-generation immigrants emerged, which added another layer of diversity to our analysis of migrant and indigenous women's experiences. However, within the study, not surprisingly, legal status emerged as a key factor in determining women's access to services; the implications of legal status on service use intensified for undocumented migrant workers.

The approach taken in this study entailed focusing on four communities within the overall migrant and minority ethnic community in Ireland – Chinese, Nigerian, Polish and Muslim. In-depth, qualitative interviews were conducted with eighty-one women aged between eighteen and thirty years from each community to draw out detailed accounts of their experiences, views and needs in relation to sexual and reproductive health. Such an approach generates a rich and detailed picture of the particularities and specificities of risk, care and support needs of the group that policy makers and services need to be cognisant of and address in the context of a more culturally diverse as well as transient population. Migration and transition to a new cultural environment bring challenges for individual young women seeking to live out healthy and fulfilling sexual lives, as well as for policy makers and service providers, whose purpose and remit it is to provide them with the capacity and resources to do so. Overall, our research participants and key contacts within migrant communities welcomed the research and being consulted in this way. They were enthusiastic in their suggestions and recommendations for change, which they felt needed to be underpinned by improved awareness and responsiveness to cultural difference in order to promote integration, a more cohesive society and a more inclusive citizenship.

The participants in this study developed their sexual identities in the context of changing and oftentimes conflicting cultural influences and messages – from their families, formal education, peers and media, particularly post migration. The findings of this study correspond with many other studies of the meaning of heterosexuality in Western

contexts wherein sexuality is gendered, double standards are attributed to male and female sexual activity and power is asymmetrically distributed in favour of men. This illustrates the relevance of such analysis to multi-cultural populations. These meanings were found within the Irish context with specific cultural nuances in research by Hyde and Howlett, (2004), Murphy-Lawless et al., (2004 and 2006) and Mayock et al., (2007). Women in our study came from diverse cultural contexts. Living in Ireland, these women were negotiating their sexual and reproductive lives and well-being in the context of identified meanings of westernised sexuality. These young women did not tend to reject or question such a construction of female sexuality. Rather, there was evidence that some women at least accepted them as normal. There were also some references to an emerging culture of conceding to them, through, for example, recourse to hymen reconstruction cited by Chinese women. Some of the women described close control and monitoring of female sexual behaviour by parents and communities; however, for those young migrant women who were in Ireland independently, the distance from this kind of parental and community monitoring created new opportunities and also pressures to have sexual relations. Our findings suggest that young migrant women, when negotiating their place in Ireland as a new home, may experience conflict between the values transmitted to them from home, their sexual feelings and practices and their willingness or preparedness to recognise themselves as sexual, sexually active and at risk of pregnancy or sexually transmitted infections. This represents a particular set of challenges to Irish sexual and reproductive health services who seek to promote the sexual well-being of young migrant women.

Participants' experiences of formal sex education in the school context in their countries of origin tended to be seen as inadequate in preparing them for what they perceived to be a more permissive sexual culture prevailing in Ireland. Many participants did not have the opportunity to receive sex education in the formal education system in Ireland. Therefore informal sources - particularly media and peers - became an important source of information about sexuality for young women newcomers to Ireland. The chasm between silence regarding sexuality within trusted family circles and the highly permissive and explicit messages in popular media produced confusion for women about how to negotiate safe and fulfilling sexual relationships. There was a heavy reliance on multi-media, particularly the internet, and peers as sources of information, advice and support in relation to sexual development, sexual health issues, accessing services, negotiating social mores and prohibitions, embarking on relationships and making choices around fertility and safe sex. Overall, a common theme emerged of reticence amongst parents and teachers with regard to discussing matters of sexuality; for example, Nigerian participants described how communicating on the topic of sexuality had to be negotiated cautiously because of the danger of implicating oneself in inappropriate or 'wayward' behaviours. A consequence of such mixed messages and varied levels of openness across the domains of home, community, school and media is that it can give rise to young women coming to fear their bodies, feeling a lack of control over their own sexuality and reproductive capacity and encountering hugely conflicting expectations between the varying discourses of sexuality they have encountered. Participants related

mixed experiences with regards to accessing information on SRH services in Ireland, ranging from the very positive to the extremely negative. Services discussed included contraception, abortion, maternity and gynaecological services, crisis pregnancy counselling and social support services. Overall, though, across the four groups, knowledge and information was poor, and experiences of accessing services limited, in comparison to young Irish women in the same age group. Women's need for sexual health services was clear. Despite coming from cultural and family settings where female sexuality is heavily regulated and controlled outside of marital relationships, young women nonetheless described being sexually active and engaging in sexual risk-taking regarding both pregnancy and STIs.

The main barriers women across the four groups experienced in accessing and participating in sexual and reproductive health services were influenced by women's cultural and religious backgrounds, their pre-migration experiences, and in particular their legal status here in Ireland. Issues of particular salience were: the impact of cultural silences and shame, women's transnational use of services and how this created conditions for sexual risk-taking and using ethnic-based services alongside Irish health services and the implications this has for their SRH care. There were clear and distinct patterns between the groups in terms of women's engagement with the Irish healthcare system as well as the patterns of usage of healthcare either in Ireland or on a transnational basis. References to traditional practices such as female genital mutilation or testing for virginity featured in the study, as well as practices such as hymen reconstruction. This demonstrates the importance of sexual and reproductive health services in Ireland becoming aware and knowledgeable of particular global sexual and reproductive health issues.

## 9.2 Recommendations

A key recommendation from this study is the need to support staff to deliver culturally competent services. This is a pillar of the HSE National Intercultural Health Strategy (NIHS) 2007-2012 and the relevant recommendation contained therein. The NIHS has strong relevance to this study's findings. The NIHS recommends:

*A whole organisational approach to work with a diverse population will be actively championed to develop a culture and ethos that supports interculturalism. This approach should be multistakeholder and encompass advancing equality as a principle of service commissioning and planning, equality of opportunity, proactively managing diversity, addressing discrimination and racism, and promoting an approach that is responsive to the range of cultures and religions of service users.*

(HSE, 2008, 107)

### 9.2.1 Increasing cultural sensitivities and partnership in sex education

Informal sources such as media and peers were easily accessed sources of information for young migrant women in the same way that they are for young Irish women, but these

sources subjected teenage girls to increasing sexualisation at younger ages, giving young women a sexualised language in a vacuum, without the corresponding knowledge, and understanding of sexuality and awareness of making healthier choices. Indeed this needs to be addressed with reference to both young women and men, as Mayock and Howlett (2007) highlighted.

Initiatives to reach migrant and newcomer communities with existing materials, key among them being the 'b4udecide' campaign, would be beneficial. Developing the b4udecide campaign to have greater multi-cultural presence and relevance on both the web-site platform as well as in printed materials, combined with a targeted awareness-raising programme to reach migrant and new communities with these messages, is a key recommendation of this study.

- The development of multi-cultural awareness materials for parents within this framework is necessary, highlighting the importance of acceptance and support. Information regarding the availability of CPSS and messages highlighting the importance of supporting young women with a crisis pregnancy should be disseminated to migrant communities; these messages should be targeted particularly to young women and their parents.
- This is considered to be an important initiative to ensure that the progress made in supporting women in crisis pregnancy in the Irish context in recent years can be extended to our new communities also. An openness and sensitivity to cultural diversity needs to underpin the delivery of all SPHE/RSE programmes, such as the TRUST resource and the 'b4udecide' programme, in school, community and youth work settings. Multi-cultural awareness should be a part of all teacher and youthwork training in this area.
- Finally there is scope for the CPP, health services, and educational services to create links with migrant rights organisations developing out of the consultation process engaged in during this research. An effective initiative to strive to target migrant rights organisations with key resources so as to up-skill staff members of MROs in providing sex education for young migrants is recommended. Migrant rights organisations should be provided with RSE training by the National Youth Council of Ireland (NYCI) and other bodies working with community based organisations; the NYCI and other such organisations should strive to include the needs of new communities in their policy and practice.

Specific issues to consider in developing multi-cultural sexuality education programmes include:

- Varying cultural practices and norms regarding extra-marital pregnancy, STIs, sexual abuse, safe sex and contraception, being aware of how both cultural silences on these themes as well as more foundational issues such as bodily awareness and reproductive biology, while at the same time acknowledging different cultural values.

- In terms of sex education, meeting the needs of young migrant and minority ethnic women means avoiding the development of 'them-and-us' attitudes in relation to the majority Irish and migrant and ethnic communities. The teaching of sex education needs to focus on the commonalities and the need for all children to negotiate safer sexual lives for adulthood. Secondly, the need for comprehensive information about the sexual and reproductive body for migrant and minority ethnic women in the context of this information not being provided by parents was highlighted by participants as well as a focus on the empowerment of young women and building their confidence and self-esteem.
- Hyde and Howlett's (2004, 97) recommendation that sex education materials should be underpinned by an egalitarian sexual discourse aimed at dissolving deeply engrained gender codes through means such as strategies for consciousness-raising about the way in which gender codes operate in intimate encounters or, young women being equipped with negotiating skills to enable them to maintain the boundaries with which they are comfortable and the confidence to insist on safer sex.
- The view of women in this study group that sex education can be more successful if it is delivered in a creative way by people who young women can relate to, and who use language that is open, informative and youth focused, and if it is interesting and relevant to them.

### **9.2.2 Building information and access to SRH for young migrant women**

Providing information on contraceptive choices to women in Ireland entails recognising the level of translation and transmission of not just English language materials but also local understandings so as to reach migrants living here in order that both messages promoting and protective of sexual health as well as information on sexual and reproductive health services can become fully accessible to newcomer communities. While efforts have been made in this regard, such as development by the CPP and Treoir of multi-lingual materials, implementation of such an initiative at national level is challenging for individual agencies.

- We recommend that the language used in public communications programmes be accessibility proofed to assess the reliance on 'tacit' localised references and to assess its capacity to reach new communities. Again, recommendations within the NIHS 2007-2012 set out clear principles for interpretation and translation that can be useful here.
- In particular we recommend that both the 'Think Contraception' and 'Positive Options' campaigns be developed further with reference to multi-cultural content and dissemination.
- In addition, the translation and targeted dissemination of materials within the Positive Options campaign would address the expressed need for information regarding maternity care, benefits, protection in employment and early motherhood supports.

- Liaison with the HSE, again within the framework of the National Intercultural Health Strategy, regarding initiatives to inform migrants of how the primary healthcare system works would be beneficial, given the importance of this route for accessing information regarding SRH care. Within HSE East Cairde have particularly focused on promoting access to primary healthcare among migrant and newcomer communities and their initiatives could be examined for learning in this regard.
- If representative research supports the findings in this study regarding the very low engagement of Chinese women with primary healthcare in Ireland, consideration should be given to undertaking an initiative with private health insurance providers to provide all migrant clients with information to increase uptake of services by these women. Information should be provided about primary healthcare services at a minimum but ideally also about sexual health and crisis pregnancy counselling and support services.

Women in the study made specific recommendations regarding effective dissemination to their communities. These demonstrate the extent to which public communications programmes need to incorporate targeted components for specific communities:

- Chinese women suggested the best ways of targeting information to them included putting up information on Chinese websites, such as 0086.ie, widespread circulation of information in Chinese newspapers and supermarkets, and placing posters in pharmacies translated into Mandarin.
- The Polish community also highlighted key outlets particularly newspapers and related web-sites e.g. Polski Express, Forum Polonia.
- Lack of adequate language skills was identified by Chinese and Polish participants as a barrier to consulting with GPs or specialist sexual health clinics. Consideration could be given to liaison with English language schools to ensure that the content of language lessons for migrants will include language they likely will need to talk about their medical, sexual and reproductive health needs.
- The CPP should consider an initiative in partnership with other programmes within the HSE as well as other agencies including National Employment Rights Authority to disseminate information to migrant women in employment as well as in other situations regarding entitlements to maternity benefit, leave and employment protection.

### **9.2.3 Quality and cultural competence of sexual and reproductive health services**

As stated above, an overarching issue in the report is the importance of supporting staff in delivering culturally competent services. This is a pillar of the HSE National Intercultural Health Strategy (NIHS) 2007-2012 and the relevant recommendation contained therein has strong relevance to this study's findings. The NIHS states that a whole organisational approach to work with a diverse population will be actively championed to develop a culture and ethos that supports interculturalism. This approach should be multistakeholder and encompass advancing equality as a principle of service



commissioning and planning, equality of opportunity, proactively managing diversity, addressing discrimination and racism, and promoting an approach that is responsive to the range of cultures and religions of service users (HSE, 2008, 107). Recommendations below refer to findings regarding women's accounts of how sexual and reproductive health services in particular could be more multi-culturally sensitive yet at the same time have wider application than just the SRH service domain.

- Health practitioners should be mindful to avoid a 'them-and-us' attitude and should instead strive to develop an inclusive perspective that still allows for difference. Women considered that health professionals demonstrating a manner of respect and receptiveness towards cultural, ethnic or faith specificities of new communities would be adequate, rather than having an in-depth knowledge of specific cultural traits or traditions.
- While a background awareness of religious/cultural characteristics/traditions was seen as beneficial, it was considered that a patient, open and caring attitude was of greater significance in shaping the interaction between service providers and service users.
- Linguistic, communicative competencies and multi-cultural understanding would be greatly enhanced by the advancement of the recommendations within the NIHS 2007-2012 for promoting greater culturally diversity and awareness within their human resources remit.
- The issue of female genital mutilation (FGM) featured in this study, and the account of the woman who survived this practice described in the report highlights the importance of the current initiative to implement legislation making the practice illegal to perform here or making it an offence to remove a young girl from the State for the purposes of performing FGM upon her. The legislation also has implications for service delivery and needs to be accompanied by a process of awareness-raising among the general population as well as developing further such work already commenced with health service providers in maternity and other sexual and reproductive health settings.

#### **9.2.4 Further issues and further research**

- Further quantitative and representative research is required to assess the degree to which findings in this study are generalisable to the broader populations of the groups studied here.
- This study focused only on issues for young migrant women aged 18-30. Similar research is required with additional non-Irish national groups not included in this study, as well as with non-Irish national men and non-Irish national women aged 30 and over.
- As many young migrant women acquire the nationality of the country they live in or are born in, they can disappear from statistics, and in particular, health statistics. Ethnicity as well as nationality needs to be captured to allow for the

specificity of minority ethnic groups' needs to be adequately captured. While the Health Information and Quality Authority is the authority best placed to mainstream attention to ethnic diversity in health service data-collection systems, the format for including 'ethnicity' as a category in recent Census questionnaires is a useful reference model here.

- Ethnicity and cultural diversity should be retained as a key 'variable' in the design of future studies in this area by the CPP, as in the model of the recent ICCP 2010 study.

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## APPENDIX 1

**Table A1: Estimated migration by sex and nationality, 2006 – 2011**

Sex/Year ending April	Emigrants			Immigrants			Net Migration
	EU12 <sup>19</sup>	Rest of World	Total	EU12	Rest of World	Total	
Males							
2006	1,000	9,300	10,300	30,500	11,600	42,100	31,800
2007	4,300	11,500	15,800	28,300	13,400	41,700	25,900
2008	6,000	13,300	19,300	15,200	10,900	26,100	6,800
2009	14,900	11,800	26,700	6,300	9,700	16,000	-10,700
2010	9,000	15,100	24,100	3,100	5,600	8,700	-15,400
2011	4,500	15,000	19,500	3,900	8,100	12,000	-7,500
Females							
2006	1,400	6,600	8,000	18,800	11,800	30,600	22,600
2007	2,700	7,500	10,200	23,800	12,300	36,100	25,900
2008	3,000	6,500	9,500	17,900	11,500	29,400	19,900
2009	8,000	8,300	16,300	6,800	7,800	14,600	-1700
2010	4,900	8,100	13,000	2,900	5,200	8,100	-4,900
2011	5,300	15,100	20,400	4,300	8,100	12,400	-8000

Source: [www.cso.ie](http://www.cso.ie)

<sup>19</sup> EU12: defined as the 10 accession countries who joined the EU on 1 May 2004. (i.e. Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia, Slovenia) and includes the 2 new accession states who joined the EU on 1 January 2007 (i.e. Bulgaria and Romania)

## APPENDIX 2

Table A2: Different categories of immigration stamps

Stamp	Category	2007	2008	2009
1	Issued to non-EEA nationals who have an employment permit or business permission.	31,472	32,040	23,417
1A	Issued to non-EEA nationals permitted to remain in Ireland for the purpose of full time training with a named body until a specified date. Other employment is not allowed.	-	66	887
2	Issued to non-EEA national students who are permitted to work under certain conditions.	36,019	41,156	41,639
2A	Issued to non-EEA national students who are not permitted to work.	3,701	3,850	3,879
3	Issued to non-EEA nationals who are not permitted to work.	17,220	17,480	17,554
4	Issued to people who are permitted to work without needing an employment permit or business permission: Non-EU EEA nationals; Spouses and dependants of Irish and EEA nationals; People who have permission to remain on the basis of parentage of an Irish child; Convention and Programme refugees; People granted leave to remain; Non-EEA nationals on intra-company transfer; Temporary registered doctors; Non-EEA nationals who have working visas or work authorisations.	63,748	63,794	70,803
4EU FAM	Issued to non-EEA national family members of EU citizens who have exercised their right to move to and live in Ireland under the European Communities (Free Movement of Persons) Regulations 2006. People holding this stamp are permitted to work without needing an employment permit or business permission, and they can apply for a residence card under the 2006 Regulations.	1,660	3,727	5,208
5	Issued to non-EEA nationals who have lived in Ireland for at least eight years and who have been permitted by the Minister for Justice, Equality and Law Reform to remain in Ireland without condition as to time. Holders of this stamp do not need an employment permit or business permission in order to work.	149	218	548
6	Can be placed on the foreign passport of an Irish citizen who has dual citizenship, and who wants their entitlement to remain in Ireland to be endorsed on their foreign passport.	17	26	61
Un-recorded		1,260	1,985	2,391
A		6	2	
B		1	-	
Total		155,253	164,344	166,387

Source: Department of Justice, Equality and Law Reform, as presented in Joyce (2010)



## APPENDIX 3

Table A3 Nationalities included in research

Nationality	Size and age of population	Marital status	Labour force participation	Geographical location	Ethnic and cultural background
Polish	Total: 63,276 -22,988 women  -15-24 years: 8,139 -25-44 years: 11,588	67% of women were single and 28% were married	Over 84% of Poles at work in 2006, predominantly in the lower socio-economic groups Women mainly employed in shops, hotels and restaurants More than a quarter had third-level qualifications at degree level or higher; a third of Polish women had degrees in business, law, and social science	-Dublin city and suburbs -Other cities suburbs -Naas, Co. Kildare -Killarney, Co. Kerry -Swords, Co. Dublin	93% Catholic
Nigerian	Total: 16,300 -8,929 women  -15-24 years: 975 -25-44 years: 5,675 Only 15% of Nigerians in their 20s	42% of women were single and 49% were married	30% in work in 2006 Top occupations were: care assistants and attendants, security guards, sales assistants, and doctors 41% had completed a degree or higher level qualification	96% living in urban locations -Dublin city and suburbs Other cities and suburbs -Dundalk, Co. Louth -Drogheda, Co. Louth -Swords, Co. Dublin	26% Catholic 19% Apostolic or Pentecostal
Chinese	Total: 11,161 -5,143 women  -15-24 years: 2,088 -25-44 years: 2,599	67% of women were single and 30% were married	43% of Chinese community were studying and 42% were in work Majority worked in the hotel and restaurant industry Occupations: chefs and cooks, sales assistants, and waiters and waitresses	2/3 of Chinese living in Dublin city and suburbs Other cities and their suburbs -Bray, Co. Wicklow -Drogheda, Co. Louth -Athlone, Co. Westmeath	80% 'no religion' 6% Buddhist

Source: www.cso.ie

**APPENDIX 4****Table A4 Total dataset****Interviews with Nigerian community of women**

<b>Pseudonyms</b>	<b>Type of interview</b>	<b>Details</b>	<b>Group</b>	<b>Language of interview</b>
NFG1 – Isoke, Omorose, Kinah, Damilola, Urbi, Taiwo, Dayo	Focus group x 7 participants	Students aged 20-23, 25-30, lone mothers, employees	Nigerian	English
NFG2 – Atua, Oni, Esosa	Focus group x 3 participants	Students aged 23, 18, 23	Nigerian	English
NFG3 – Fola, Yetunde, Raki, Mairo, Asibi, Oseye	Focus group x 6 participants	Students, aged between 18 and 20	Nigerian	English
NFP1 – Nimma and Asa	Friendship pair	Aged 20 and 23, both third-level students in Dublin and Dundalk. Living with parents and siblings	Nigerian	English
NP1 - Nkoyo	PILOT One-to-one	30, lone mother, 7 years in Ireland, not employed	Nigerian	Yoruba
NOT02 - Bisi	One-to-one	25, post-graduate student. Living with family	Nigerian	English
NOT03 - Ivie	One-to-one	19, student, living with family, been in Ireland 7 years	Nigerian	English
NOT04 - Damilola	One-to-one	29, lone parent, living in Ireland 4 years, Muslim, unemployed	Nigerian	Yoruba-English
NOT05 - Chinua	One-to-one	25, lone mother, unemployed, graduate, came to Ireland with family as a child	Nigerian	English

**Interviews with Chinese community of women**

Pseudonyms	Type of interview	Details	Group	Language of interview
CFG1 - Shufen Liping Lan Xia Minmin	Focus group x 5 participants	Women aged between 26 – 32, all married with children; living in Ireland between 5 and 7 years	Chinese	Chinese and English
CFG2 – Jia Huifen Lijuan Meifeng Qingzhao Yanmei Mingxia Nuying	Focus group x 8 participants	Young women aged between 23 – 24 attending Irish colleges; five were single, and 3 were in relationships; 3 were living in Ireland for 3 years, and the other 5 women were living in Ireland for 3 months	Chinese	Chinese and English
COT01 - Li	One-to-one	25, Studying; single; living in Ireland for 1 year	Chinese	English
COT02 - Mei	One-to-one	29, married, student; living in Ireland for 11 months	Chinese	English
COT03 - Shu	One-to-one	23, p/t student, working p/t; single; living in Ireland for 3 years	Chinese	Chinese
COT04 - Ying	One-to-one	25, Married to Irish man, working; living in Ireland for 3 years	Chinese	English
CFP1 – Jiao and Changying	Friendship pair	18, student, working f/t in sibling's business; single  22, f/t student, working p/t, studying and living in Midlands; in a relationship. Both women were living in Ireland for a year and a half	Chinese	Chinese
COT05 - Yuan	One-to-one	24, f/t employed; single; living in Ireland for 3 years	Chinese	Chinese
COT06 - Ling	One-to-one	23, f/t student working p/t in catering; in a relationship; living in Ireland for 3 years	Chinese	Chinese

**Interviews with Polish community of women**

Pseudonyms	Type of interview	Details	Group	Language of interview
PFG1 – Beata Aniela Danuta Julianna Katarzyna Dominika Ewa	Focus group x 8 participants	Age group, 19, 23, 27, 28, 29, 30, 30 7 in a relationship; 1 engaged, women were living in Ireland for over 3 years	Polish	Polish
PFG2 – Krystyna Klara	Focus group x 2 participants	Aged 19, 21; both in a relationship; both living in Ireland for over 3 years	Polish	Polish
POT01 - Julita	One-to-one	Single, 23, unemployed, 4-year-old son, lone mother; in Ireland over 3 years	Polish	Polish
POT02 - Justyna	One-to-one	Single, 19 years old, employed, retail sector, returning to college; in Ireland for 5 years	Polish	Polish
POT03 - Karina	One-to-one	In a relationship, 24 years old; Unemployed, planning to study; in Ireland for 4 years	Polish	Polish
POT04 - Malina	One-to-one	27, Married, working in catering; 2-year-old boy; in Ireland for 4 years	Polish	Polish
POT05 - Weronika	One-to-one	30, Single, Higher education; unemployed; 5-year-old daughter; living in Ireland for 6 years	Polish	Polish
POT06 - Zofia	One-to-one	29, Married, pregnant; living in Ireland for 5 years	Polish	Polish
POT07 - Ruta	One-to-one	19, student in a relationship; living in Ireland for 6 years	Polish	English
POT08 - Martyna	One-to-one	30, Single; living in Ireland for 3 years	Polish	English
POT09 - Agata	One-to-one	29, Married, 2 children under 8 years; self-employed; living in Ireland for 6 years	Polish	Polish

**Interviews with Muslim community of women**

Pseudonyms	Type of interview	Details	Group	Language of interview
MFG1 Shireen Kalila Fiza Maali Batool Cala Nasrin Aadila	Focus group x 8 participants	Women's age range from 17 to 25 years. All were single apart from two women. One woman had 2 children, aged 5 and 18 months and another had one child, aged 1 and a half	Muslim/ ICCI	English
MFG2 Sofia - Nigerian Tabalah - Somalian Beena - Nigerian Parveen - Somalian	Focus group x 4 participants	2 Nigerian women in their mid-twenties both married with 2 children; 2 women from Somalia	Muslim women	English and Somalian
MOT01 - Jamila	One-to-one	20, student, single, came to Ireland when she was 16, as an asylum seeker and now has refugee status	Muslim/ E Africa	English
MOT02 - Nyla	One-to-one	20, student, in Ireland with family, attended school in Ireland, recently married an Irish man	Muslim/ W Africa	English
MOT03 - Marjana	One-to-one	18 years, single, her family moved from N Africa when she was 8 years old	Muslim/ N Africa	English
MOT04 - Iram	One-to-one	20 years, single, her family moved here from UK when she was 7 years old	Muslim/ N Africa/ Irish	English
NP2 - Suliat	Pilot One-to-one	26, gone through FGM, Muslim, living alone, unemployed	Nigerian	Yoruba
NOT01 - Lisha	One-to-one	22, lone mother of 2 living independently in Dublin	Nigerian/ Muslim	English





