HEALTH ISSUES OF MINORITY WOMEN LIVING IN WESTERN EUROPE

WORLD HEALTH ORGANIZATION
Regional Office for Europe
COPENHAGEN
TARGET 8

HEALTH OF WOMEN

By the year 2000, there should be sustained and continuing improvement in the health of all women.
HEALTH ISSUES OF MINORITY WOMEN LIVING IN WESTERN EUROPE

Report on a WHO Meeting

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ABSTRACT

The WHO Regional Office for Europe hosted a meeting on health issues of minority women in western Europe, attended by participants from Denmark, Italy, Norway, Sweden, Switzerland and the United Kingdom. The participants discussed a wide range of subjects, such as: the number of immigrants in western Europe, pregnancy and birth issues, female genital mutilation, mental health, experience with providing health care for immigrant women and sexual health, including approaches to HIV/AIDS prevention among ethnic minorities. All participants felt that, regardless of social or economic status, equity in health care and the social inclusion of members of minority groups, especially women, are vital to the wellbeing of a community. The participants made recommendations to such bodies as the Regional Office, governments and health services. Another meeting is planned for 1999, at which it is hoped that WHO, European Member States, the International Organization for Migration, the European Union and a group of medical professionals and immigration experts will form a strong network to follow up and monitor these issues.

KEYWORDS

MIGRATION
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INTRODUCTION

Women’s health has been seen as a growing priority for WHO, central governments, city institutions and health care providers for the past few years. The WHO Regional Office for Europe therefore organized a working group on the health issues of minority women in western Europe, building on a network first established in 1991 at a WHO workshop in Vienna for women from the countries of central and eastern Europe. This reflects WHO’s recognition of the widening health gap between the eastern and western halves of the region and commitment to equity. In 1994, each Member State was asked to nominate a focal point for women and health, which will embrace and extend the elements of initiatives such as the Ottawa Charter and health for all.

Women and girls suffer disproportionately from the consequences of war, civil unrest, poor health care and random violence. The difficulty of changing cultural practices puts girls and women at a permanent disadvantage throughout their lives because divisions of rights and roles are deeply rooted in the relevant culture and have been internalized by both men and women. Protection of women is often defined in terms of male ideologies and interests without specific reference to women’s needs. As a result, in emergency situations women and female children are given less consideration. Migration, urbanization and the cash economy have accentuated the disadvantages of female inequality and have reinforced coercive and exploitative patterns of relations between the sexes. This in turn has put
women at a higher health risk, especially migrant women who are generally prone to psychological problems partly as a result of the precarious conditions under which they started their journey for survival.

Power relationships are linked with economic inequalities, which means that minority women in western Europe have difficulties in acquiring the necessities for a healthy life.

To speak of poverty is to speak of inequality. This has been closely associated with gender and race. The phrase “feminization of poverty” describes the situation where the majority of women, whether employed or unemployed, women cannot escape poverty or the danger of being catapulted into it. Many women depend on the income of the man they live with for their class and status, and lose their position and their lifestyle when their relationship ends. Women in employment are often kept poor because of low wages, being paid less than their male counterparts for the same job. This situation is worse for migrant professionals who are often working in jobs for which they are overqualified. Race, too, is a significant source of inequality and poverty. Minorities, especially women, are prejudged, relegated to the background, underestimated and not given the same opportunities to succeed in a job.

Two particular difficulties in women’s daily lives can lead to stress and mental health problems which typically manifest themselves as anxiety and depression. These are:

- *cultural devaluation*, where women find it difficult to develop a positive mental attitude in a society that defines them as inferior, and
• *social expectations*, which require women to take responsibility for multiple roles in the management of everyday life (domestic, caring for others, work), which is often cited by women as a source of tiredness and stress.

In addition, psychological problems among immigrants are often not understood by host countries, and training is required to avoid misdiagnosis.

**Scope and purpose**

This meeting, by bringing together representatives of ministries of health, nongovernmental organizations (NGOs) and representatives of minority groups, pursues the following scope and purpose:

• to formulate recommendations and guidelines for the development of appropriate health service and health education strategies to meet the needs of minority women;

• to identify further operational research needs on the health status of and health services for minority women (plus databases on existing informational material);

• to compile experiences of national authorities and NGOs with successful and unsuccessful interventions in health information and services;

• to identify areas of greatest need (e.g. antenatal care, family planning, prevention of sexually transmitted diseases, adolescent girls);

• to draw up recommendations to WHO and to Member States as to further strategies to improve the health of women in minority groups
**BRIEF OVERVIEW OF PRESENTATIONS**

**Minority women and migration of syndromes: the case of mental health and risks of misdiagnosis** *(Dr Natale Losi, International Organization for Medical Services)*

The aim of Dr Losi’s project is to inform governments of the nature of the difficulties suffered by migrant women in relation to mental health, and to inform and train local health professionals in diagnosing depression so as to reduce the rate of misdiagnosis and subsequently reduce health costs. Dr Losi reiterated that migration has rapidly increased during the last century due to wars, famine and other natural or man-made disasters, as well as for economic reasons. These migrants often face severe problems in dealing with the practical and psychological difficulties encountered in the new settlement situation. Even though women are generally more traumatized by the vacuum created by this new settlement, this is not perceived as an important variable for psychiatric diagnosis. A high number of women are mistreated because of misdiagnosis. The most common mistreatment consists of long-term use of antidepressants. The prevalence of illness/disease varied from one ethnic group to another and, according to a WHO scientific study, women suffer from depression at almost twice the rate of men.

**Female genital mutilation (FGM)** *(Mrs Efua Dorkenoo, WHO headquarters, Mrs Rahmat Mohammed, Foundation for Women’s Health, Research and Development – FORWARD)*

Female genital mutilation (FGM) is the single most extreme, violent and painful practice causing physical, psychological and emotional problems and even the death of girls and women in some societies. FGM comprises all procedures involving partial
or total removal of the external genitalia or other injury to the female genital organs, whether for cultural or other non-therapeutic reasons. FGM has been associated with serious complications such as haemorrhage, severe pain, urinary retention, tetanus and other infections including HIV, pelvic infections, infertility, obstructed labour and depression. FGM has also been linked to gender inequalities and is a reflection of the discrimination and violence practised against girls and women in both public and private life.

As a consequence of migration, this harmful practice is no longer confined to the 26 sub-Saharan African countries where it has been prevalent for centuries. Migrants from these countries seek to continue with this practice within the western countries where legislation prohibits it. According to a statement by the Medical Women’s International Association in 1994, 85–114 million girls and women throughout the world are the victims of the traditional practice of FGM. Each year 2 million girls are at risk.

According to Dr T. Turmen of WHO headquarters, there is a technical difference between male and female genital mutilation. The removal of the clitoral prepuce (female circumcision) is equivalent to male circumcision, and constitutes less than 1% of all female genital mutilations. In young girls this procedure is extremely difficult to perform. In over 95% of cases the clitoris, the labia minora and (in some cases) the labia majora are excised and the vulva sewn up. The biological equivalent in the male would be partial to almost two-thirds removal of the male sexual organ, including in some cases removal of tissue from the scrotum followed by stitching up the remaining tissue. Dr Dorkenoo and Mrs Rahmat Mohammet (FORWARD) also presented several reasons
for FGM based on their experiences in working at grass-roots level on government and policy issues. It is not known where or when the tradition originated but in most cases the practice is to control women’s sexuality. Other reasons given are to do with hygiene, psychosexuality, culture, religion and aesthetics. FORWARD has played a major role in bringing the practice of FGM into the open in the United Kingdom. It is also working to promote women’s health in other parts of the world.

WHO has recognized that the genital mutilation of girls and women represents a serious health hazard for them and reinforces the inequality suffered by women in their communities. WHO has consistently recommended that governments adopt clear national policies to abolish FGM and intensify educational programmes to inform the public about FGM. Steps are being taken internationally to eradicate FGM, such as the programme of action of the International Conference on Population and Development. The platform for action of the Fourth World Conference on Women also included a section on the girl child and urged governments and international organizations to develop policies and programmes to eliminate all forms of discrimination against the girl child, including FGM.

**Pregnancy and birth in minority groups in Denmark: focus on Somali women** (*Mrs Lisbet Nybro, Danish midwife*)

Mrs Lisbet Nybro a midwife at Frederiksberg Hospital, Denmark, shared her experience of working with Somali women living in Denmark. She pointed out that FGM is not a subject that is easily dealt with by many Europeans. However, with the influx of refugees, especially from Somalia where 98% of women are infibulated, they have no choice but to begin to deal with the trauma of
this harmful and unnecessary tradition. Ms Nybro explained that her goal is to show proper handling of the infibulated tissue and health education during pregnancy as a means of bringing about changes of attitude towards female circumcision. Experience has shown that health education about the female anatomy provided by a midwife during pregnancy and the effects of female genital circumcision might prevent many mothers from passing on the tradition.

Working with these women requires positive, unconditional regard and empathy because it is not their fault that their savage custom requires FGM. Patients in this category prefer to visit the same health worker, one with whom they feel comfortable. It is therefore recommended that these women continue to see the nurse or midwife who is familiar with their predicament so that they can develop a rapport. This helps to enhance the relationship before the health worker can raise sensitive questions such as: if you have a girl child, will she be infibulated? After your dein-fibulation, will you want to be stitched up again? The responses to the above questions differ among these Somali women: some believe that infibulation helps to prevent diseases. Ms Nybro explained that she respects their opinions and takes the time to explain the consequences of infibulation such as infertility due to infections or blood clots.

**Female genital mutilation as a problem in western countries: focus on Somali women in Denmark** *(Dr Vibeke Jørgensen, Danish Medical Women’s Association)*

Dr Jørgensen pointed out that several countries have specific laws against FGM, such as the United Kingdom (1982) and Norway (1995), but Denmark has no specific law. However,
doctors have been prohibited from performing FGM since 1981 and it has been forbidden under the penal code of the Danish Medical Association since 1992.

Due to the influx of Somali women, the Danish Medical Association is training many health professionals in the handling of FGM cases. Somali women are informed as soon as they arrive in Denmark that FGM is illegal. The Danish Medical Association has also involved the Ministry of Justice in dealing with parents who take their daughters to other countries to be circumcised. It is recommended that fathers should also be involved in education against FGM by informing them of its terrible implications.

**Health needs of minority women living in Italy** *(Dr Lucia Spada, UICEMP, Genoa)*

Health care for migrants is an important issue in the Italian welfare system. However, when the first immigrants from low-income countries arrived in Italy, they found that without a permanent visa they could not get access to the medical services. This was a constant theme of the multi-ethnic association founded in 1993 to struggle for the right to health care. This led to the founding of the multi-ethnic clinic in inner Genoa, where some hospitals were providing special services for migrants.

**Some experiences with providing health care for immigrant women: a case from Norway** *(Dr Berit Austveg, Norwegian Board of Health)*

In 1975 the health commissioner of Oslo had founded a health service for immigrants. Apart from the double objective of providing health care to people who could not benefit from the ordinary services owing to cultural and language barriers, and in-
creasing competence in health care across cultural boundaries, this was also geared to the provision of health care to immigrant women because they had more problems in getting health care and they preferred female doctors. Unfortunately, this clinic was closed in 1988 because of political differences, but other psychosocial clinics focusing on traumatized refugees have opened over the last 15 years.

Some of the lessons learned include the fact that cultural issues in medicine are real and should be considered before some of these patients can be properly treated. Language issues must be dealt with; for instance, some immigrants may label illnesses such as diabetic pelvic pain in women as “exotic” and will therefore resort to some form of magic cures. In dealing with these immigrants, unexpected challenges such as racism, power relations and superstitious beliefs often arise and should not be underestimated. Care should also be taken to avoid misdiagnosis and labelling of these patients.

**Sexual health work in a multicultural society: strategies for minority women in the Healthy Cities Network**
(Ms Margareta Ackerhans, AIDS/HIV Coordinator, Department of Public Health, Gothenberg, Sweden)

Immigration of refugees has been on the increase in the twentieth century, especially from Asia and Africa due in part to war and difficult economic situations in their countries of origin. These migrants include people seeking asylum to improve their life situation, education, better jobs, etc. Unfortunately their culture, languages and lifestyles differ greatly from those of their host countries. The traumatic experiences, (sometimes) chronic diseases or other distress suffered by immigrants pose a
major challenge to the receiving countries in terms of health and social care. Efforts are being made in Sweden to address these issues; one example is the healthy city project in Gothenburg. The aim of this project is to strengthen local HIV/AIDS work and to exchange knowledge, experience and good practice such as devising standards in testing and counselling. This project also takes into account cultural and ethnic diversity and the political and economic situation of the communities. Several methods are used for information dissemination which are relevant to the communities involved.

**DISCUSSION AND RECOMMENDATIONS**

Participants from six countries of the European Region (Denmark, Italy, Norway, Sweden, Switzerland and the United Kingdom), along with health professionals and representatives of NGOs such as FORWARD, came together to discuss the health needs of women belonging to minorities living in western Europe. The discussion and recommendations focused mainly on the health needs of immigrant women living in these countries. It was decided that the recommendations should be limited to these groups.

**Preamble**

1. Everyone has the right to health and wellbeing, as laid down in the global and regional health for all document.

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1 Written contributions were submitted by France, Germany and Portugal.
2. Governments of Member States and multilateral health organizations should focus on reducing differences in health status between geographical areas and socioeconomic groups.

3. All services provided must be based on respect for the human rights, dignity, integrity and individual choice of the person seeking health care.

4. The social inclusion of minorities is essential for the well-being of a complete community.

5. The decisions of national and local governments with respect to these groups should be based on the principles of equity and compassion.

6. Access to health and health information services must be provided to all groups in society without discrimination.

7. In all countries there is evidence of growing inequity in health care affecting particularly weaker socioeconomic groups, including migrants.

8. The memorandum of understanding between WHO and the International Organization for Migration, which is being prepared at present, may form the basis for joint implementation of the recommendations below.
Recommendations

To WHO

- WHO should assist Member States in research, data collection and monitoring of progress as well as provide comparison between countries and identification of best practices.

- WHO should strengthen its normative role with respect to equity in health care.

- The work of WHO networks such as Healthy Cities in connection with the health of migrants should be strengthened.

- A larger meeting on this topic should be held in 1999 involving WHO Member States, the International Organization for Migration, the European Union, the European Commission, the International Federation of Gynaecology and Obstetrics, representatives of national medical and paramedical associations and representatives of minority groups, national medical associations, nurse/midwife associations and refugee institutions and lawyers with experience in immigration law. Funds for this meeting should be raised by the participating institutions. If possible, the meeting should be hosted by the European Commission.

- A strong network for follow-up and monitoring of these issues should involve the above-mentioned organizations as well as cities/communities with large immigrant populations, policy-makers, politicians, NGOs, pressure groups, social workers and educators.
To governments

- National and community resources should be allocated to provide the necessary services within the public health structures.
- Sensitization to cultural differences (and to explicit and implicit racism) and the specific needs of migrant women should be included in the training curricula of universities for health professionals and nurse-midwifery schools as well as postgraduate training.
- Research on health needs of the target groups should be enhanced.
- Services should be organized accessibly and without cultural, racial or class barriers.
- Health service provision should particularly take into account the trauma of migration and the changes in community structure encountered by migrant women as a contributing factor to disease and ill health.
- Services should be sensitive to gender relations within the communities concerned.
- Every effort should be made to facilitate legally the professional work of health professionals belonging to migrant communities in the host country.
- In order to ensure that newly developed services respond to the real needs of women belonging to minority groups, it is essential that these women are included in the planning and conceptualization phase: it is not sufficient to plan services only with the leaders of minority groups, who are usually
men and may not be concerned about health issues specific to women.

The meeting commended the General Medical Council of the United Kingdom for putting the issue of racial inequality within the National Health Service high on its agenda and recommended that other countries follow this example.

**Specific health problems to be addressed by health services**

In line with the recommendations of the International Conference on Population and Development in Cairo and the recommendations of the Women’s Summit in Beijing, health services should use the life-cycle approach to the health needs of women, taking into consideration the needs of migrants at different times in their lives. In particular, the following areas of concern have been identified by the countries participating in this meeting.

*Health services*

- Health services should address reproductive and sexual health and rights and obstetric care.
- Female genital mutilation, although a sub-topic of reproductive health, should be considered not only as a health issue but as a human rights issue. Health services, education services and legislation should be directed towards eliminating FGM and other harmful practices in a culturally sensitive way. European Member States should develop a policy against FGM. Cooperation between countries on legislation to prevent loopholes is recommended.
• Services should be provided to deal with complications resulting from FGM.

• Health services should address mental health needs, in particular depression resulting from uprooting and the trauma of migration and isolation within a host community.

• Health services should address ill health related to changing patterns of nutrition, e.g. malnutrition, obesity, diabetes, anaemia and hypertension as well as genetic conditions and blood dyscrasias such as sickle cell anaemia.

• Health services should provide information on and treatment of infectious diseases such as tuberculosis, HIV/AIDS and sexually transmitted diseases as well as address irrational fears of infections and myths related to these diseases.

• Health services should be sensitized to recognizing when women have been forced into prostitution and provide help and information about social and legal services to which they can turn.

• Health services should also offer counselling and rehabilitation for refugee or immigrant victims of torture and domestic violence.

• Interpreters/cultural mediators working in health and health information services should be trained in the specific terminology, especially with respect to sensitive issues around sexuality and gender.

Health information and education

• Care should be taken that health information and educational materials on the priority health areas defined above
are developed in a culturally and linguistically appropriate way.

- Not all women belonging to migrant communities are literate, and therefore other forms of disseminating information such as films, plays, dance, music and posters should be explored. The imagery used must be appropriate. In order to ensure that the materials produced are understood by the target groups, pre-testing is essential before large-scale dissemination.

- The important role of community-based organizations in raising awareness in the migrant community should be recognized and supported financially and structurally by the public sector.

- Community-based organizations should be given information on how to mobilize resources to meet their needs.

- Professional members of the communities should be involved in the provision of health services and health education as well as planning the training of other health workers.

**Access to health care**

- Members of the immigrant communities should be covered for health care.

- Migrant communities must be informed of their rights within the social security systems of the host countries as well as given practical information such as the location of clinics and governmental and nongovernmental services.

- Contrary to the belief that providing additional and specific services will be costly to the public sector, it is probably more cost–effective to invest in appropriate health promo-
tion and disease prevention services than to cope with the costs arising from untreated and unrecognized disease, pregnancy complications, etc.

**Follow-up**
A general memorandum of understanding is being prepared between the International Organization for Migration and WHO. The meeting recommended that the above issues should be addressed in the framework of this memorandum.
Annex 1

BACKGROUND DOCUMENTS


Annex 2

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