Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma
MEM-TP

ADDITIONAL MODULE 2:

SPECIFIC HEALTH CONCERNS

Unit 4: Sexual and Reproductive Health

Guidelines

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Migrants & Ethnic Minorities Training Packages

Funded by the European Union in the framework of the EU Health Programme (2008-2013) in the frame of a service contract with the Consumer, Health, Agriculture and Food Executive Agency (Chafea) acting under the mandate from the European Commission. The content of this report represents the views of the Andalusian School of Public Health (EASP) and is its sole responsibility; it can in no way be taken to reflect the views of the European Commission and/or Chafea or any other body in the European Union. The European Commission and/or Chafea do not guarantee the accuracy of the data included in this report, nor do they accept responsibility for any use made by third parties thereof.

Additional Module 2: Specific Health Concerns
Unit 4: Sexual and Reproductive Health

1. Objectives and Methods

Time	Objectives	Activities	Sources
5 minutes	Explain the objectives of the Unit.	Explanation of the objectives	Projector, laptop, screen.
30 minutes	• To explain the general patterns of sexual and reproductive health in migrant and ethnic minority population, among them the Roma. • To inform about the epidemiology of sexual and reproductive health of migrants and ethnic minorities, among them the Roma, in Europe and how EU institution could address these problems.	Presentation "Sexual and Reproductive Health" and questions	Projector, laptop, screen.
20 minutes	To apply the acquired knowledge to clinical practice.	En small groups: • Identification of experiences related to one of the topics of the four Units. In the plenary: • Representation of the small group results and discussion	Blackboard, paper, markers

2. Presentation

Slide 1: Title page

Slide 2: Summary

Slide 3: According to Wold Health Organization[1], sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Slide 4: Compared with the general EU population, extra-EU migrant and Roma women[2] [3] have less access to family planning and contraception and a lower uptake of gynecological health care, are more at risk of unplanned pregnancies, attend fewer and later antenatal care visits and, have poorer pregnancy outcomes (notably more induced abortions and complications except for lower birth weight, for which current findings differ between the migrant group, generation and EU host country) and have higher infant and maternal mortality rates[4].

Slide 5: This can be caused both by premigration factors such as the level of education or cultural issues, and by the difficulty of obtaining access to services or information, etc... Also this can be caused for difficulties in our environment as lack of information about contraception or barriers to access to family planning, employment services.

Slide 6: It is important to control some factors in every contact with a women with migrant history[5]:

- Countries of origin and last stay
- Countries that individuals come across of encountered
- Duration of the stay in the country
- Housing characteristics and cohabitants
- Most frequent communicable diseases among migrant population (TB, STIs, HBV y C, HIV)
- Stress factors
- Activity and employment status
- Vaccination status (Vaccination record)
- Exhaustive Obstetric History
- Gynaecological history of STIs, EIP
- Family planning
- Access to cancer screening

Slide 7-8: However, not all perinatal care indicators are worse than those of European people. As a consequence, the so called epidemiological paradox[6] occurs, as there are indicators such as birth weight that exceed those of people born in Europe[7]. Infants of North African migrants

[1] Wold Health Organization. Defining sexual health. Report of a technical consultation on sexual health, 28-31 January 2002, Geneva.

[2] Keygnaert I, Guieu A, Ooms G, Vettenburg N, Temmerman M, Roelens K. Sexual and reproductive health of migrants: does the EU care? Health Policy [Internet]. Elsevier Ireland Ltd; 2014; 114(2-3): 215-25.

[3] De Graaf JP, Steegers E a P, Bonsel GJ. Inequalities in perinatal and maternal health. Curr Opin Obstet Gynecol [Internet]. 2013 Apr; 25(2): 98-108.

[4] Keygnaert I, Guieu A, Ooms G, Vettenburg N, Temmerman M, Roelens K. Sexual and reproductive health of migrants: does the EU care? Health Policy [Internet]. Elsevier Ireland Ltd; 2014; 114(2-3): 215–25.

[5] Carballo, M. Female migrants, Reproductive Health, HIV/AIDS & The Rights of Women. UNFPA-IOM Expert Group meeting New York, Mai 2006.

[6] Keygnaert I, Guieu A, Ooms G, Vettenburg N, Temmerman M, Roelens K. Sexual and reproductive health of migrants: does the EU care? Health Policy [Internet]. Elsevier Ireland Ltd; 2014; 114(2-3): 215–25.

[7] Gagnon a J, Zimbeck M, Zeitlin J, Alexander S, Blondel B, Buitendijk S, et al. Migration to western industrialised countries and perinatal health: a systematic review. Soc Sci Med [Internet]. 2009 Sep; 69(6): 934–46.

are reported to have higher birthweights than their Belgian counterparts. Asian, North African and sub-Saharan African migrants were at greater risk of feto-infant mortality than 'majority' receiving populations, and Asian and sub-Saharan African migrants at greater risk of preterm birth

Slide 9-10: Among the problems in sexual and reproductive health, there is the low use of services dedicated to the promotion of health prevention in migrant women, in particular, screening programs for breast and cervical cancer. The review study in Spain[8], identify that African women were 0.36. Eastern European 0.40, Western European, American and Canadian 0.60, and Central and South American 0.64 times less likely to undergo a mammogram compared with the general population of Spain. In regard to cervical cancer screening, Eastern European women were 0.38, African 0.47, and Western European, American and Canadian 0.61 times less likely to undergo cervical smears. These associations were independent of age, socioeconomic condition, health status and health insurance coverage. Other study of Holland[9] says that the attendance of Dutch women at breast cancer screening in 2007–2008 was high (83%). The attendance rates of migrant women originating from Africa, Asia or Latin America (63%), such as Turkish women (62%) and especially Moroccan women (54%), were significantly lower (Vermeer and col. 2009). This lower utilization of services can be caused by linguistic barriers or information but also by cultural differences in relation to the understanding of health and disease[10].

Slide 11: This refers to all procedures that involve partial or total removal of the female external genitalia or other injury to the female genital organs for cultural and other non-therapeutic reasons[11]. The World Health Organization (WHO) estimates that approximately 100 to 140 million women worldwide have been subjected to FGM. FGM has been documented in 28 countries in Africa and in a few countries in Asia and the Middle East.

Slide 12: There are three types of female genital mutilation[11]:

- **Type 1:** partial or total removal of the clitoris and/or the prepuce (clitoridectomy)
- **Type 2:** partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora
- **Type 3:** Narrowing the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora with or without excision of the clitoris (infibulations)

Slide 13: The FMG[12] have a **Immediate risks (**severe pain, haemorrhage, tetanus and other infections, septicaemia or even death) and **risks in the longer term (r**ecurrent urinary tract infections and pelvic infections, difficulty with voiding or menstruating, difficulties with childbirth due, fistulas, sexual sensitivity reduced, painful in sexual relations, behavioural

[8] Sanz-Barbero, B; Regidor, E; Galindo, S. Impact of geographic origin on gynecological cancer screening in Spain. *Rev. Saúde Pública*[online]. 2011, 45(6): 1019-26 .

[9] Lasch, V; Maschewsky- Schneider, U.; Sonntag, U. Equity in Access to Health Promotion, Treatment and Care for All European Women. The European Women´s health Network (EWHNET). 2010.

[10] Saadi A, Bond B, Percac-Lima S. Perspectives on preventive health care and barriers to breast cancer screening among Iraqi women refugees. J Immigr Minor Health [Internet]. 2012 Aug [cited 2014 Dec 6]; 14(4): 633-9.

[11] World Health Organization. Eliminating Female genital mutilation: An interagency statement OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO. Geneva: World Health Organization, 2008. Available from: http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf

[12] Female Genital Mutilation: Caring for patients and safeguarding children. Guidance from the British Medical Association. 2011.

disturbances and feelings of incompleteness, anxiety and depression, and suffer chronic irritability, frigidity, marital conflicts, or even psychosis)

Slide 14: The fear of stigmatisation within the host society cultural norms in regards to the integrity and rights of girls' and women's bodies as well as the overt perceptions that FMG is a deviant practice that requires criminalisation has been documented as inadvertently limit women and men from accessing needed quality health services. The practice of FMG at times, understood as a form of gender-based violence, may result in unjustifiable consequences among girls and women; yet, these practices are culturally engrained traditions with complex meanings calling for ethically and culturally sensitive health and social service provision. A culturally competent, gender and ethically sensitive approach is argued for to ensure the provision of quality ethical care for migrant families in host countries. Socio-cultural determinants such as ethnicity, migration, sex and gender need to be accounted for as integral to the social construction of FGC[13].

Slide 15: Any discussion of the reproductive health of Roma people must take into account the practice of forced sterilisation of Roma women, prevalent in some countries, and its possible effect on present day help seeking behaviour. A study of the sexual culture of Roma women in Bulgaria found that only 61% used contraception regularly, abortions were more common than in the majority population— 2.41 abortions per woman, with 33% of women having had more than three—and that Roma women had their first pregnancy earlier[14].

Slide 16: Sexual Reproductive Health interventions should stem from a holistic and positive approach and also address SH promotion in adolescents, women without children, men, elderly, LGBT and MSWs. A move away from vertical programmes is central to this approach, towards broader-based programmes that involve the integration of sexual health services with reproductive health services and broader systems of provision. In an effort to promote sexual health effectively, reaching men and vulnerable people (individuals and groups) and implementing both broad-based and targeted community education initiatives are likely to be significant. This document[15] offers a framework for programming for sexual health. It describes the historical processes underlying our evolving understanding of sexual health, and discusses why sexual health is becoming an issue of sexuality and why the promotion of sexual health is of critical importance in the reproductive health field.

Slide 17: Thank and question

Slide 18: References

4. Activity

Slide 16-18: Activity

[13] Vissandjée B, Denetto S, Migliardi P, Proctor J. Female Genital Cutting (FGC) and the ethics of care: community engagement and cultural sensitivity at the interface of migration experiences. BMC Int Health Hum Rights [Internet]. 2014 Jan; 14:13.

[14] Hajio S, Mckee M. The health of the Roma people: a review of the published literature. J Epidemiol Community Heal. 2000;54:864–9. Available from: http://www.ncbi.nlm.nih.gov/pubmed/11027202

[15] Wold Health Organization. Developing sexual health programmes. A framework for action. WHO. 2010. Available from: http://whqlibdoc.who.int/hq/2010/WHO_RHR_HRP_10.22_eng.pdf?ua=1

a) The class is divided into four groups.
b) Each group deals with one of the units of the module (which consists of Chronic diseases, Communicable diseases, Mental Health and Sexual and Reproductive health).
c) In each of the groups the members have to discuss their experiences in clinical practice according to the subject that is assigned to them. It is about sharing experiences they have considered interesting or difficult, critical incidents, experiences, etc ... in an intercultural practice.
d) Each group will have to choose one of the experiences set out by the group members.
e) Finally, the chosen experience has to be presented to the class * answering the following questions:
    f) Why do you consider this experience to be interesting?
    g) Which parts of your actions, or those of your colleagues, would you change? Do you think there are things that could be improved?
    h) Which things do you think have been done well?

*For the presentation, all kinds of materials can be used: board, flipchart … It can be developed through a spoken, theatrical, or even graphic performance.

Slide 19: Thank you and questions

Slide 20-21: References

4. Readings

Recommended readings

Wold Health Organization. Developing sexual health programmes. A framework for action. WHO. 2010. Available from:
http://whqlibdoc.who.int/hq/2010/WHO_RHR_HRP_10.22_eng.pdf?ua=1

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http://www.bma.org.uk/images/FGMJuly06_tcm41146715.pdf#sthash.QIF4PqaH.dpuf

Complementary readings

Lasch, V; Maschewsky- Schneider, U.; Sonntag, U. Equity in Access to Health Promotion, Treatment and Care for All European Women. The European Women´s health Network (EWHNET). 2010. Available from: http://www.uni-kassel.de/upress/online/frei/978-3-89958-740-1.volltext.frei.pdf

Hajio S, Mckee M. The health of the Roma people: a review of the published literature. J Epidemiol Community Heal. 2000;54:864–9. Available from:
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Mora, L. Gender, reproductive rights and international migration. -EAT/UNFPA. 2006. Available from: http://www.cepal.org/celade/noticias/paginas/6/27116/moral.pdf

Lasch, V; Maschewsky- Schneider, U.; Sonntag, U. Equity in Access to Health Promotion, Treatment and Care for All European Women. The European Women´s health Network (EWHNET). 2010. Available from: http://www.uni-kassel.de/upress/online/frei/978-3-89958-740-1.volltext.frei.pdf

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http://www.ncbi.nlm.nih.gov/pubmed/21901446

World Health Organization. Eliminating Female genital mutilation: An interagency statement OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO. Geneva: World Health Organization, 2008. Available from:
http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf

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http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=4012131&tool=pmcentrez&rendertype=abstract