SEXUAL AND REPRODUCTIVE HEALTH AND WELL-BEING OF AFRICAN MIGRANT WOMEN IN THE MIDWEST OF IRELAND

Exploring Experiences of Access to and Knowledge of Supportive Services

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By

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AUGUST 2024

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We would like to thank the Family Planning Service, Dr Negin Reyhani, Doras, and Northside Family resource centre for their support of this project. We also thank our community colleagues and the Migrant Forum for supporting this survey.

Our gratitude and thanks to those who participated in the survey and attended the education sessions. Their feedback and responses were helpful in developing the context within this report. We hope their voices are respectfully and accurately represented in this report. The GOSHH team's educational PowerPoints used in the education sessions are included in this report as information materials in the appendix. We hope they are useful resources.

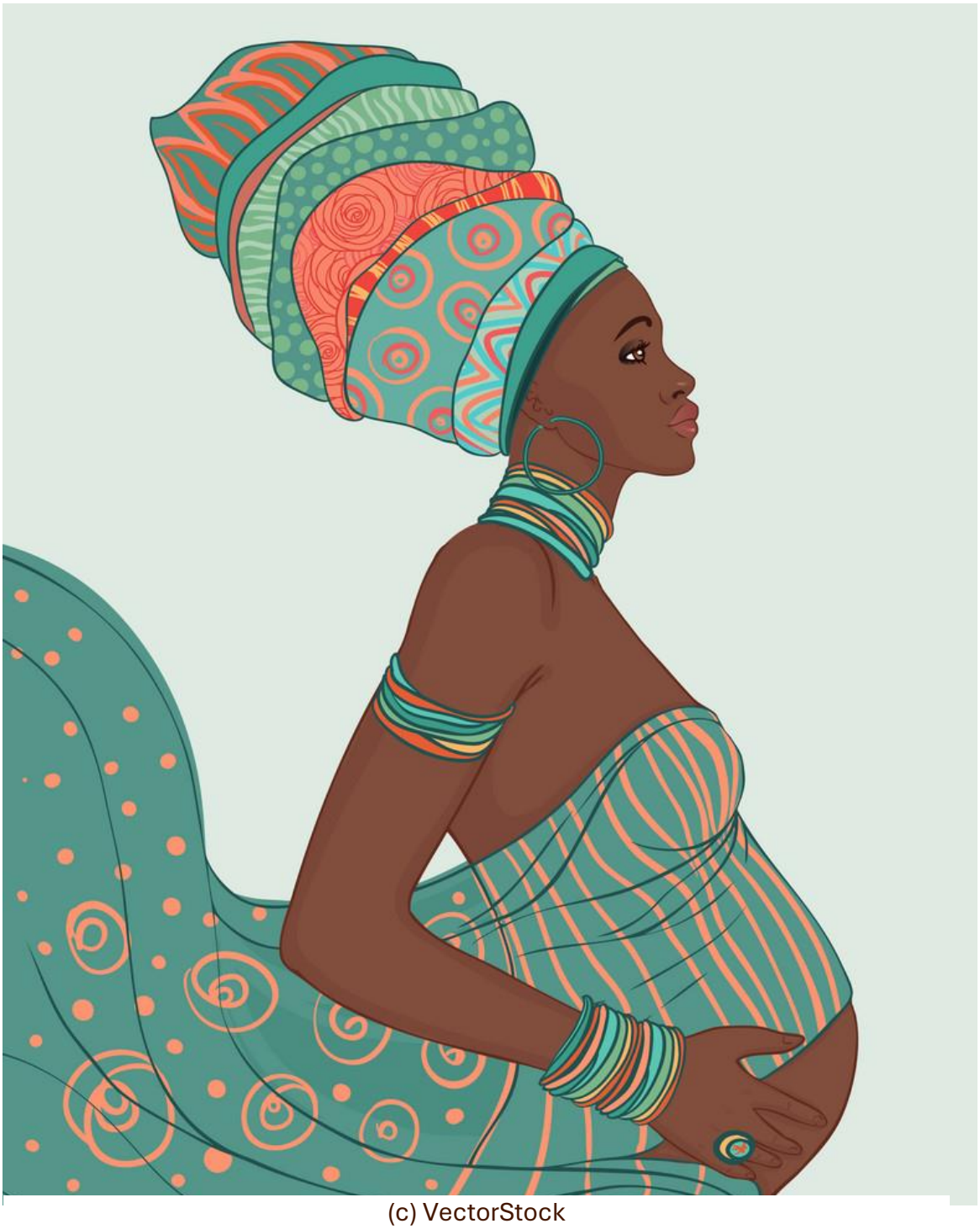
The project team thank Joshua Biggs and Michael Corcoran for their contribution to the development of the visual media component of this project. The sexual health and well-being promotional video and audio/visual material produced for this project will be available on both GOSHH Ireland and MMCN Ireland websites. The video will also be available to access via YouTube and Instagram. For further information please access this report via both MMCN and GOSHH websites.

MMCN - Who we are:

This network consists of a distinctive group of highly skilled individuals of all backgrounds and nationalities, committed to social justice and fostering positive experiences amongst all local communities in the Midwest of Ireland. We are seeking to promote the experiences, shared values, and cultures of diverse communities via engagement with local groups, organisations, and agencies. We aim to achieve this through partnerships and contribute to community building and well-being of migrant communities in the Midwest of Ireland. Our approach is to work collaboratively through projects, initiatives, and campaigns by articulating migration stories, through education, challenging 'myths' about migrants and infusing the local social landscape with our unique cultural heritages and community values that promotes belonging. Visit: mmcnireland.com

GOSHH – About this service:

This is a service that provides an environment where the mental, emotional, physical, and social well-being of everyone is promoted and sexual rights are respected, protected, and fulfilled. GOSHH focus on the promotion of equality and wellbeing of all with a positive and respectful approach to sexual orientation and gender diversity. Our work starts with a human rights base and progresses within an equality framework, according to the Equal Status Act 2000-2004. Visit: [GOSHH Ireland – GOSHH Ireland CLG]



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FOREWORD

Ms. Verena Tarpey
CEO, GOSHH Ireland

IT gives me great pleasure to introduce this piece of work on behalf of Midwest Migrant Community Network and GOSHH. This report takes us on a journey charting the experiences of migrant women and their views on accessing sexual and reproductive health services in Ireland. Sexual Health is essential for lifelong wellbeing with the biological, social, mental and emotional factors all intertwined within that.

Within our 'Western Constructs', we often fail to recognise distinct barriers for those who come from culturally diverse populations where sexual healthcare is not always prioritised. This report examines these barriers, and the personal stories bring a human perspective to the findings. A lack of knowledge, personal beliefs and Interpersonal challenges in relationships were highlighted. Coupled with this, these women experienced societal challenges such as a cycle of taboo and stigma in addressing these important topics. Despite the challenges, there is also hope for the future. We can use the recommendations to campaign for the need to provide more education to migrant women and to apply culturally congruent approaches to support them in their quest for accessing these essential services.

I want to thank Santhi Corcoran and the Midwest Migrant Community Network for conducting this valuable piece of research with GOSHH. Finally, I want to pay tribute to the migrant women who took part. They shared their intimate stories, insights, fears and hopes for the future enabling us to give a voice to those who are not as empowered.

EXECUTIVE SUMMARY

Ms. Santhi Corcoran
Chair, MMCN Ireland

HEALTH services and community health programmes have a key role to play in the health and well-being of Migrant, Refugee and Asylum-Seeking communities. Within this context the need for knowledgeable, culturally aware, welcoming, and supportive service provision is vital for the experience of those from migrant communities when seeking help and attending services.

This is particularly crucial in healthcare areas that may be seen as sensitive and carry stigma within their communities and culture. Women within migrant communities often provide the role of care givers to their children and family members as well. As newcomers, migrants often find navigating the different systems and services in Ireland confusing and complicated especially if language is a barrier.

Therefore, useful information, education, signposting, and provision of sympathetic, compassionate, and helpful pathways to access health services is important for their continued good health and well-being.

This report was instigated in response to concerns of members of the Midwest Migrant Community Network (MMCN) about the needs of migrant women from the standpoint of sexual and reproductive health. This project was a collaborative initiative with GOSHH Ireland who equally shared our concerns.

It was agreed that women and girls from communities where conversations were not taking place on issues around sexual and reproductive health, are at risk of misinformation or lack knowledge on how to seek help for symptoms that may

indicate the need for medication or treatment. This could adversely affect their long-term reproductive and general health. We, therefore, specifically focused on women within our local region – the Midwest of Ireland - in this project. We also focused on African women as we felt there were issues of stigma and taboo that may be worth exploring with them and could be the cause of difficulties, or barriers to help-seeking when in need.

Therefore, this project applied a broad perspective to the information we gathered from exploring their knowledge of sexual and reproductive health and the stigma, shame and taboos in their culture or communities around these topics. We also looked at their experiences of accessing sexual and reproductive health services. This was managed via three formats; a survey, interactive and engaged education sessions and the gathering of personal stories provided by African migrant women. Participants in these sessions indicated the need for a more culturally aware service provision for those attending Sexual Health Clinics, particularly for those with HIV positive status. They recommended that access to services with culturally congruent and aware staff would improve their experience of sexual and reproductive health care. They felt more education sessions should be provided to women and girls to empower their knowledge and understanding of sexual and reproductive health. They further advocated that better training of clinical staff was required, and a person-centred approach applied to clients. Namely to develop an understanding of complex cultural issues, stigma, and taboos that women navigate in their communities and how shame is reinforced to prevent communication of need and help-seeking.

The work that we have conducted hopefully provides food for thought on an area of health that is quite often poorly discussed within some cultures and communities. Key recommendations are provided at the end of this report and together with the poignant stories of the women who bravely shared their experiences, we hope, will instigate new conversations, dialogue, and collaborations to improve sexual and reproductive health services for migrant women in the Midwest of Ireland.

CONTENTS

PREAMBLE

This project's focus was to explore issues around sexual and reproductive health of African migrant women. We focused specifically on access to services, and experiences of service use. We further explored shame, stigma, taboos and lack of communication and information within their communities on issues of sexual health, sexuality and reproductive health.

Sexual Health Strategy in Ireland:

The National Sexual Health Strategy 2015 – 2020 is a strategic framework for the sexual health and wellbeing of the Irish population and was launched in October 2015. The link for the document is provided here:

e5a5ac26eb22405aaf6538656564690a.pdf (assets.gov.ie)

The three key goals of the strategy are to ensure that:

- everyone has access to appropriate sexual health education and information
- high quality sexual health services are available and affordable
- good quality data is available to guide the service

***This strategy was reviewed in January 2023.**

The review document link is provided here:www.gov.ie/pdf/?file=https://assets.gov.ie/248743/fb604c71-d193-4dfe-af87-eac4594479f2.pdf#page=null

In its concluding statement the review report recommends that:

> *'There is now a requirement for the NSHS 2023 – 2030 to demonstrate a commitment to, and take the required actions to make progress towards, the WHO 2030 goal to end STIs as a public health concern and prioritise action towards reducing health inequalities and delivering equity of access to services. The new strategy will benefit from greater collaborative working between sectors, agencies, and disciplines, and may be further strengthened by providing a strong community focus that may, in turn, improve the reach of messaging and services. The development of an explicit and evidence-led Model of Care for sexual health may provide a robust framework for the further development of accessible, effective, and efficient services, and set the vision for services in the future. A series of 32 indicative recommendations is provided in this review, but further highly relevant and valuable contributions from stakeholders will influence the goals, priorities, and actions of the next strategy, notably the key actions proposed by the SHCPP as part of the stakeholder consultation exercise'* **(Dept. of Health 2023)**

INTRODUCTION TO PROJECT

This was a small-scale project that explored the experiences of African migrant women regarding access to sexual and reproductive healthcare in the Midwest of Ireland. It was agreed by the project team that the experiences of African migrant women captured in this report should provide the template for further exploration of the experiences of migrant women from other communities. Our perspective was supported by our colleagues in GOSHH (Gender Orientation, Sexual Health, HIV) who felt more information, advice and sign posting of services around sexual and reproductive health should be provided to migrant women to promote their health and well-being.

The project plan consisted of three steps:

1. To survey African migrant women regarding their experiences in accessing services associated with sexual and reproductive health.
2. To gather their personal stories that they wished to share of their experiences in accessing these services in Ireland.
3. Provide information and education to enhance migrant women's knowledge about services and empower women in their self-care around sexual and reproductive health.

The project planned to target women who had arrived from the Sub-Saharan region of Africa, who due to their cultural taboos and stigmas and lack of information in their own country are often unable to discuss sexual and reproductive health issues openly. Further to this, lack of access to technology and internet compounds the poor information available on sexual and reproductive health in their own country creating misinformation. To compound this, there was the possibility that they may feel uncomfortable or lack confidence in accessing or engaging with sexual or reproductive health services in Ireland. The project aim was to explore this and to provide sign posting and information that could help them maintain their health and well-being.

The aim of the project:

To collaborate with displaced women and migrant women from Sub-Saharan Africa, to support their understanding of and access to information on sexual and reproductive health.

The objective:

To provide knowledge of services via, up to date information, sign posting, and having conversations around the areas of taboos, shame and stigma associated with sexual and reproductive health.

To provide these via education sessions designed around four key topics:

1. **Sexual Health**
2. **Reproductive Health and Family planning**
3. **Women's Health**
4. **HIV**

During these education and information sessions we had conversations that enabled us to gather personal perspectives and statements that further highlighted the experiences and needs of migrant women in supporting their sexual and reproductive health. It provided us with the opportunity to have healthy conversations on topics seen as too sensitive to discuss in their communities or within their cultures. We also addressed and discussed topics, experiences and presentations of sexual and gender identities that would be associated with stigma and shame.

We approached these conversations with sensitivity and provided a safe space for women where they could express themselves comfortably, ask questions and feel secure in their conversations. This we hope will contribute to open and honest conversations between women, mothers and daughters, improving their communication around sensitive topics and breaking the cycle of stigma, taboo, and shame. This approach is rooted in supporting women by applying a simple but effective methodology of guided conversation when discussing sensitive subjects and topics.

Methodology:

The participants were all residents of the Midwest of Ireland. They were recruited via several networks and sources in the community. We applied three methods to collect data and information that would address the project aims and provide the narratives for this report. These were:

1. An online survey created through Google forms and circulated to migrant networks in the Midwest of Ireland via email, social media and WhatsApp. The survey was created by GOSHH in collaboration with MMCN.
2. We gathered information, with the consent and permission of the participants, during education sessions. This was via guided conversations and through feedback and evaluations post education sessions to learn more of their needs.
3. Personal stories of their experiences in accessing sexual or reproductive health services were collated from five women who volunteered their stories – *see Page 17.*

Participants:

A total of 45 migrant women participated in this research project. 19 women participated in the online survey. 21 women attended the education sessions in person and 5 women independent of this shared their personal stories.

Recruitment of participants was conducted via:

- **Word of mouth**
- **MMCN website**
- **Posters**
- **Contacts within community organisations**
- **Member of MMCN who already works in the field of sexual and reproductive health.**
- **Gender Orientation Sexual Health HIV (GOSHH) outreach and newsletters**
- **Migrant Forum**
- **Social Media**

Ethical Standards:

All information was collected within strict ethical guidelines. Confidentiality, and the anonymity of participants was respected and protected. Consent and GDPR guidelines were adhered to. Only those who were 18 years of age and above and could consent independently were recruited for the survey and this applied equally to the education sessions and personal stories shared. Those participating engaged voluntarily and were given the option of withdrawing from the survey, personal stories, or education sessions at any point of the process. Interpreters were also offered if required.

Consent and Anonymity:

All those approached for participation in this project whether through the survey or personal stories, were assured of confidentiality and anonymity. Their consent was requested and gained for participation. They were assured of their right to withdraw their consent at any point of participation or post-participation. The project applied the principles of the Singapore Statement on Research Integrity to the process of survey design, data collated, education sessions and personal stories **(**WCRI 21-24 July 2010**).** These statements are grounded in the 'principles of honesty in all aspects of research, accountability in the conduct of research, professional courtesy, and fairness in working with others and good stewardship of research on behalf of others' (WCRI 21 – 24 July 2010). These principles guided both the integrity of our work, and the ethical considerations applied. Further to this we ensured that the education sessions were created as 'safe spaces' to enable discussion and queries that may be uncomfortable, sensitive, and personal to all women who participated.

Timeline of the project:

- Funding was approved in July 2023
- The project planning commenced in November 2023
- Survey began in January 2024 and ended in May 2024
- Education sessions were delivered from March 2024 to May 2024
- The project and report were completed in August 2024

We further organised and developed a health promotion video that will provide information on sexual health services provided by GOSHH, Ireland. This will be

accessible to the public via YouTube, and the websites of MMCN and GOSHH from September 2024.

Participating agencies and services for the education sessions were:

- **GOSHH – Sexual Health and HIV education and awareness sessions**
- **Family Planning services – Women's reproductive health education and signposting**
- **General practitioner – Women's health and well-being**

Working group – Project delivery:

A working group of current MMCN committee members and the GOSHH team formed to establish a project plan and ensure the management and delivery of this project. This was the core group that developed and delivered this project up to the launch of the final report.

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PROJECT GROUNDING

Theoretical Framework

This research project was anchored on the Theory of Change. Theory of Change can be seen as an "on-going process of discussion-based analysis and learning that produces powerful insights to support programme design, strategy, implementation, evaluation and impact assessment, communicated through diagrams and narratives which are updated at regular intervals" (Vogel 2012, p.5). This provided a good framework for this project for all parties involved, in its planning, development, review, learning and impact.

Therefore, the theory of change has been an appropriate tool and framework for the project design, data, feedback and information collection, review of findings and the delivery of training. It enabled the project team to apply the on-going processes of design, strategy, implementation, evaluation, and discussion-based analysis to produce the insights we now present in this report.

Literature Review

Studies on sexual and reproductive health of African migrant women in Ireland are not plentiful. We therefore reviewed work conducted abroad and what was currently available in Ireland. Literature from key databases such as Google Scholar, PubMed, government reports and online health research were used to review relevant and current information about migrant health, focusing specifically on sexual and reproductive health.

The studies reviewed indicated that migrants were generally healthier on arrival in their new countries of residence. However, the longer migrants stayed in a host country, the more their health deteriorated due to living standards, working conditions, and adoption of risky health behaviour (Sserwanja and Kawuki 2020). In their examination of public health challenges faced by migrants and the approaches that host countries can adopt to improve migrant health, they discovered that communicable diseases, non-communicable diseases (NCDs), mental health and social problems, contributed significantly to the morbidity of new migrants in host countries (ibid). Additionally, migrants were less likely to access or fully benefit from the healthcare system in their host countries, because of various challenges such as language barrier, denial of access based on the lack of documentation – (being undocumented), and negative healthcare provider attitudes (Sserwanja and Kawuki 2020).

Furthermore, Dune et al. (2021) conducted a study of sexual and reproductive health of 1.5 generation migrants in Australia. The term 1.5

generation migrants is applied to people who migrated as children to host countries. The study was aimed at investigating the role of culture and religion on sexual and reproductive health indicators and help-seeking amongst 1.5 generation migrants. It involved 111 participants who completed an online survey. Dune et al. (2021) found that there was no significant difference between ethnocultural groups or levels of cultural connectedness in relation to sexual and reproductive health help-seeking attitudes.

The researchers, however, noted that participants who reported as having 'no religion' were more likely to seek help with sexual and reproductive health matters. Results further showed that, while cultural norms of migrants' country of origin can remain strong, religion had more impact on how 1.5 generation migrants sought help for sexual and reproductive health issues.

Ussher et al. (2017) explored sexual and reproductive health of migrant and refugee women in Australia and Canada. The cross-country qualitative study was aimed at examining how recent migrant and refugee women in Sydney and Vancouver experienced and understood sexual and reproductive health. 169 women from various migrant and refugee communities were recruited for the study. The communities from which the participants were drawn included among others, Sudan, South Sudan, Somalia, India, and Afghanistan. The majority (66%) of the women were Muslim, 20% were Christian, 2% were from other religions, and 5% were non-religious. Over 50% of the participants were married and only 23% were single.

Their findings were presented thematically. Areas explored included menstruation, contraception, sexual knowledge, use of sexual health services, and preference of sexual health information and support (Ussher et al. 2017). In relation to menstruation, the researchers found that most young women concealed their first period and did not discuss it with anyone because of shame. They described the whole experience as "isolating," "shocking" and "frightening." They noted that migrant and refugee women did not know the function of menstruation as it was not discussed in their families. More so, from a cultural and religious perspective, menstruating women were considered unclean (ibid).

Additionally, Ussher et al. (2017) found that the use of contraception among Muslim women was forbidden and highly problematic within their community. All unmarried women were forbidden from contraception knowledge and use. Meanwhile, married women needed the agreement of their husband to use contraception. Although some married women used contraceptive pills, they expressed concern over the side effects of the pills such as headaches and weight gain. These effects deterred the women from using the pills. Finally, most participants in the study had undergone abortion before and after migration. However, discussing abortion with

others was a “taboo,” hence it was conducted in secret (ibid).

Moving to sexual knowledge and communication, Ussher et al. (2017) discovered that unmarried women were not allowed to discuss sex. Sex and intimacy were only acceptable within married heterosexual relationships. Therefore, most participants had limited sexual knowledge. Even within marriage, however, open communication about sex was uncommon. Women who openly discussed sex were seen as “bad vulgar women (ibid).” Results further showed that women were embarrassed to express their sexual desire within marriage. Most of them believed the focus of sex was on male pleasure and childbearing. Thus, most married women felt they did not have the right to say no to their husbands (Ussher et al. 2017).

It was noted across all the cultural groups involved in the study, that women were expected to be virgins on their wedding night. Infibulation and FGM (female genital mutilation) were used to ensure virginity before marriage among Sudanese and Somali participants. A woman who was not circumcised was considered “not a virgin,” and traditionally was not marriageable. However, migrant women who were circumcised experienced severe pain on sexual intercourse and problems with childbirth. They also became indifferent to sex due to the pain, which prevented them from feeling pleasure (Ussher et al. 2017).

The study found that the use of sexual health services by migrant and refugee women in Australia and Canada was low (ibid). The women could not, for example, screen for sexually transmitted infections (STIs) and cervical cancer because of shame. Even if they knew about the services, the women were too shy or embarrassed to use them. Consequently, the women preferred private sexual health resources and services. They also relied on cultural remedies for sexual infections, and left it in the hands of God, and not in those of professional healthcare providers. Additionally, most of the women faced financial barriers to accessing sexual and reproductive healthcare.

In Ireland, Conlon, O’Connor and Ni’Chathain (2011) conducted a study on the sexual and reproductive health of migrant women, investigating their attitudes to fertility, sexual health, and motherhood. Their study, which was commissioned by the Health Service Executive (HSE) Crisis Pregnancy Programme was designed to help build a multi-cultural competency in crisis pregnancy and sexual health services in Ireland. The qualitative study involved 81 migrant women aged between 18 and 30 years. The women were recruited from four target communities: Polish, Chinese, Nigerian and Muslim.

Findings show that migrant women practiced transnational use of sexual and reproductive services. Also, sexual morality was found to be a girl’s responsibility placed on her by family and society. Premarital sex was

forbidden, especially in Muslim communities. Participants linked loss of virginity to loss of value in dowry or monetary terms on marriage. They also viewed early pregnancy as a risk for life chances or advancement. They associated both premarital sex and early pregnancy with shame, fear, and guilt.

In addition, Conlon, O'Connor and Ni'Chathain (2011) found that migration created conditions for risk taking and crisis pregnancy. This was due to new opportunities for sexual activity, especially for young women who arrived in their new home alone. The researchers also established that cultural practices, such as female genital mutilation and hymen reconstruction, impacted the provision of sexual health services to women. These procedures are not provided or endorsed in Irish healthcare and clinicians may not be familiar with and knowledgeable of how to manage the sexual or reproductive healthcare of women who have had these procedures. They emphasized the need for Irish health service providers to take these cultural practices into consideration when dealing with migrant women.

Finally, Conlon, O'Connor and Ni'Chathain (2011) established that few migrant women used sexual and reproductive health services in Ireland due to lack of information of the services available, and the costs thereof. Most women instead maintained a strong connection with their home countries, where they returned frequently to access medical supplies and treatment. Participants noted that transnational use of sexual and reproductive health services was cost effective. It also allowed them to access services in their first language and was part of continuing care and treatment from a familiar and trusted service.

Endler et al. (2020) published an article on the subject matter titled "Sexual and Reproductive Health and Rights of Refugee and Migrant Women: Gynaecologists' and Obstetricians' Responsibilities." The article discussed the violations of sexual and reproductive health rights, particularly in relevance to the refugee and migrant reality. The article was premised on target 3.7 of the United Nations Sustainable Development Goals (SDG), which advocates for universal access to sexual and reproductive healthcare services.

Endler et al. (2020) gave context specific examples of denial of health services to vulnerable groups, including lack of dignity as a barrier to care, the vulnerability of adolescents, child marriage, weaponized rape, gender-based violence, and sexual trafficking. They presented case studies from Argentina, Lebanon, and Iraq in their article. The authors also examined the rights frameworks and models that are being used in response to sexual and reproductive health crises. They called on obstetricians and gynaecologists to act as individual providers, to protect women's health and rights in warzones and low-income countries.

Conclusion

In the project delivered by MMCN and GOSHH we encountered several of the findings of the studies presented in this literature review. These emerged via the survey, conversations in our education sessions and within the personal stories submitted by women. The women who participated in our project discussed the taboos, stigmas and shame associated with sexual health and reproductive issues within their communities. They highlighted the lack of information about services and sites, access to products and constraints within their culture or partnership/relationships in accessing help for better sexual health and well-being. The following sections in this report provide:

- ✓ **Analysis from the survey conducted.**
- ✓ **The personal stories of African women in navigating sexual health services, and their experiences of maintaining their sexual and reproductive health.**
- ✓ **Feedback and evaluations from the education sessions and further commentary from discussions and conversations during the sessions.**
- ✓ **Our reflections and recommendations.**
- ✓ **Proposed suggestions for future projects.**

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SURVEY FINDINGS

a) Demographics

A total of 19 women from Sub-Saharan Africa completed our survey between January and May 2024. Most participants (representing 53%) were aged between 26 and 35 years as shown in *Figure 1* below.

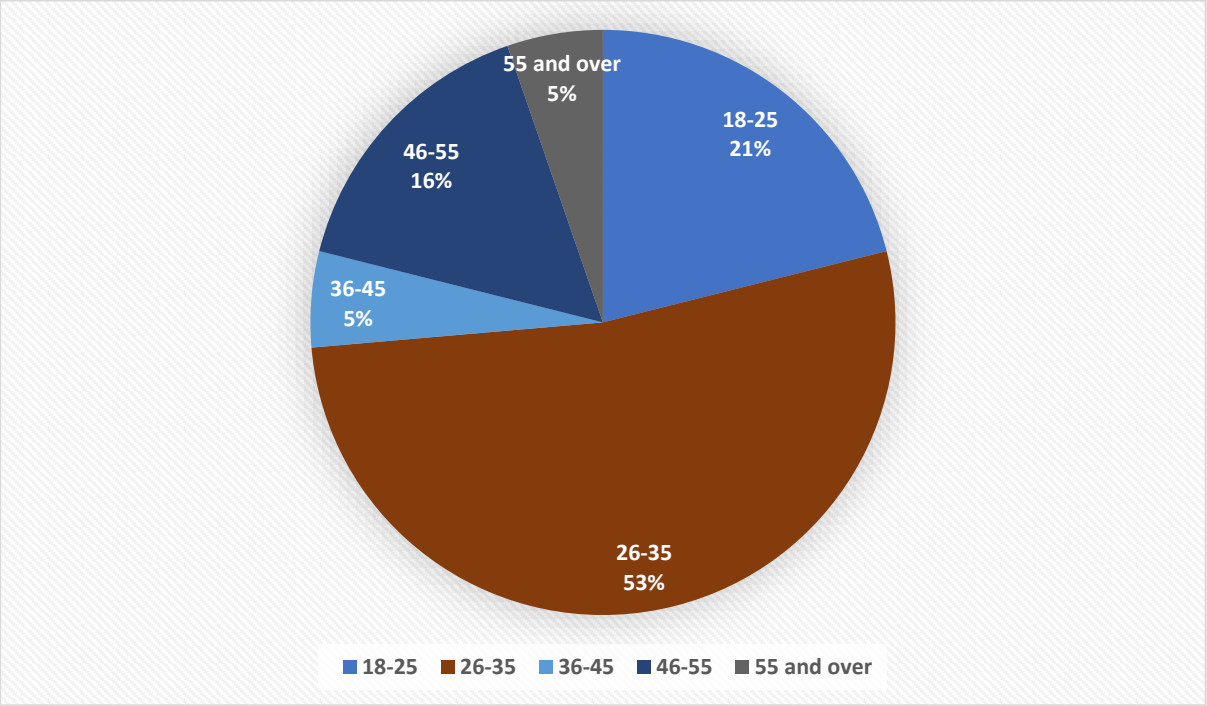

Figure 1: *Age*

Figure 2 (below) illustrates that most of the participants migrated from Nigeria (37%) and Zimbabwe (16%).

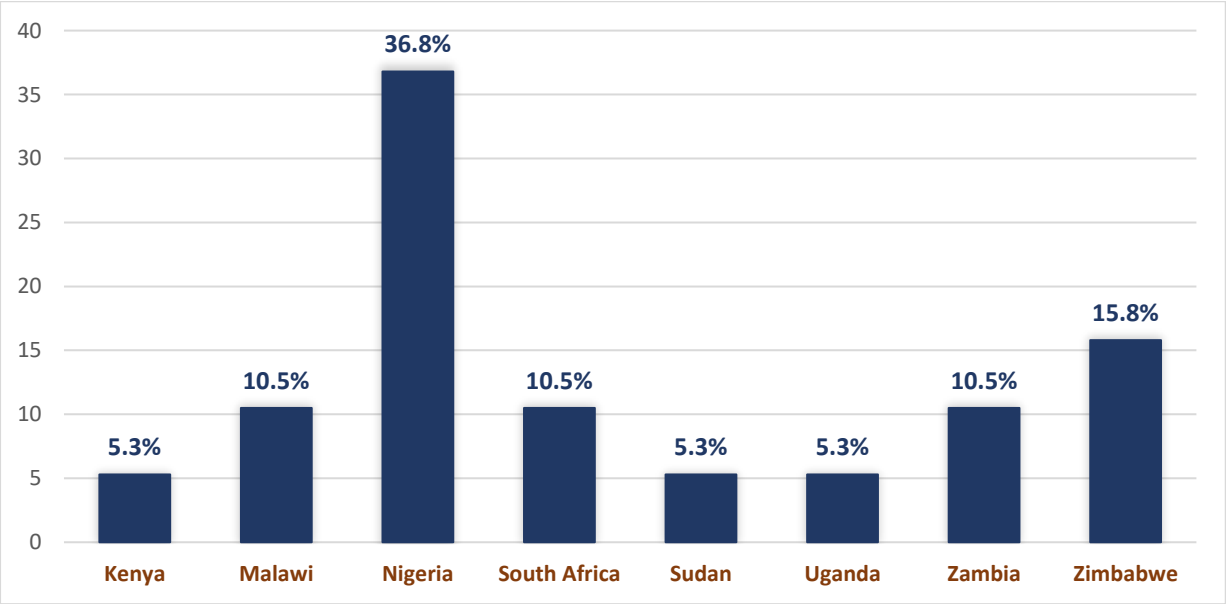

Figure 2: *Country of Origin*

b) Access to Sexual and Reproductive Health Services

Most of the African migrant women surveyed had accessed sexual and reproductive health services at University Hospital Limerick (UHL) – see *Figure 3* below. The women visited the hospital for STI screening and contraception coil removal.

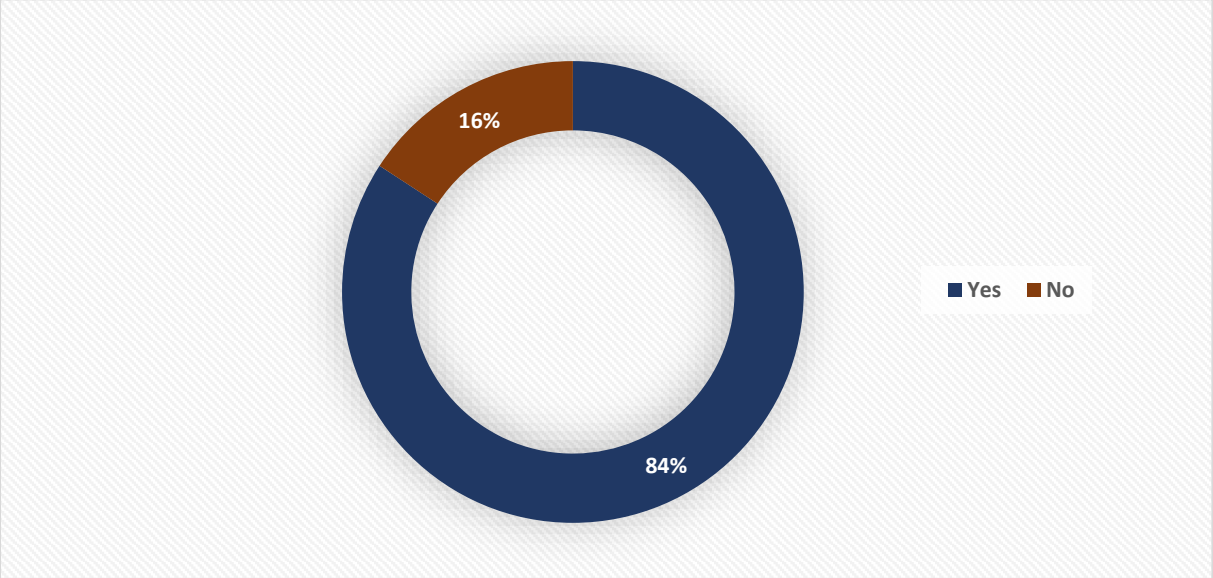

Figure 3: *Visit to UHL*

However, those who did not visit UHL (representing 16%) cited cultural barriers, costs, difficulty of access, and inconsistencies within the service as reasons for not accessing sexual and reproductive health service at their local public hospital.

Meanwhile, most participants (89%) in the survey had attended the maternity hospital and had accessed antenatal services in Limerick as shown in *Figure 4* below. Some of the main services the women accessed related to childbirth and routine cervical checks.

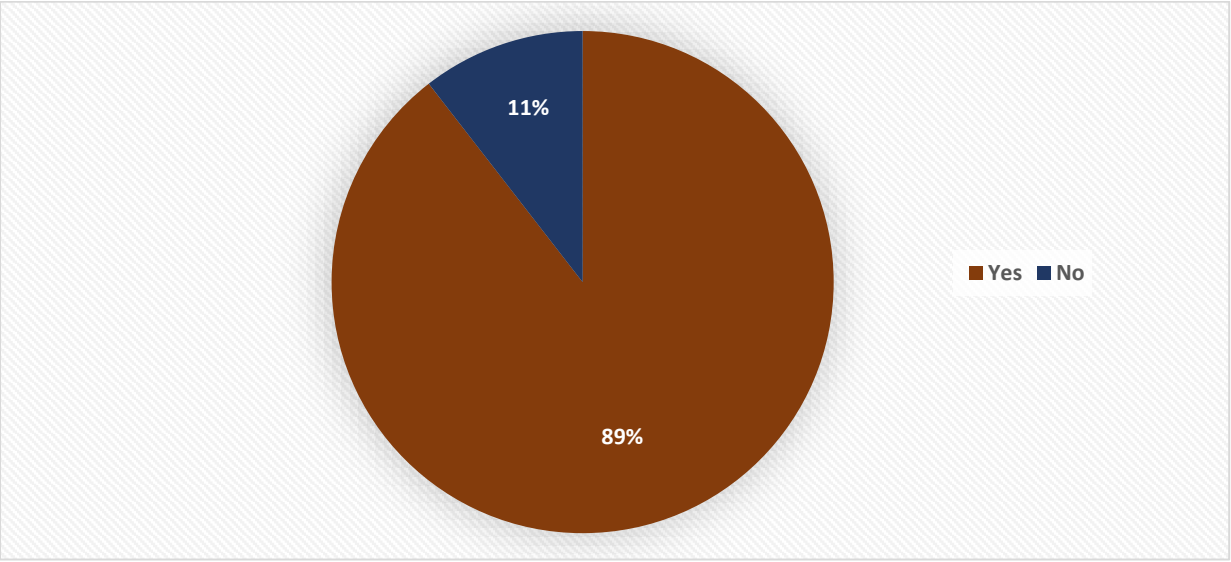

Figure 4: *Access to Maternity and Antenatal Services in Limerick*

Most of the migrant women surveyed (representing 63%) were aware of GOSHH (Gender Orientation Sexual Health HIV) services as illustrated in *Figure 5* below. Those who were unaware expressed interest in learning more about the services offered by GOSHH.

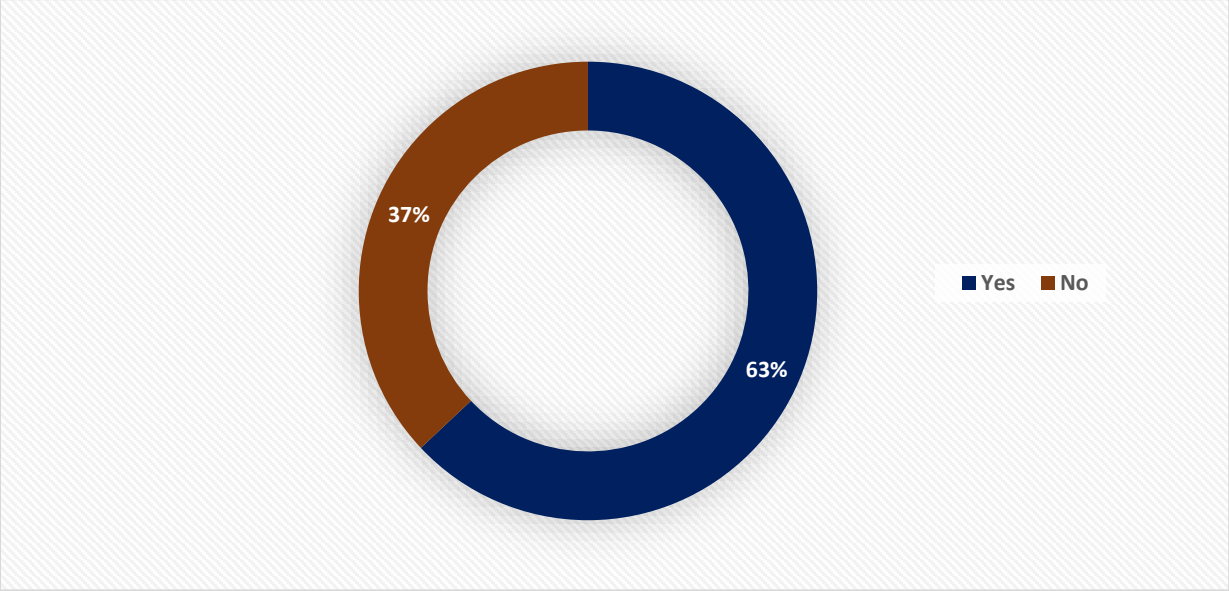

Figure 5: *Knowledge of GOSHH Services*

Most of them described their experience of accessing reproductive health services as good particularly in maternity health services – see *Figure 6* below. Experience of sexual health services was not as positive. This was described in the personal stories provided by participants.

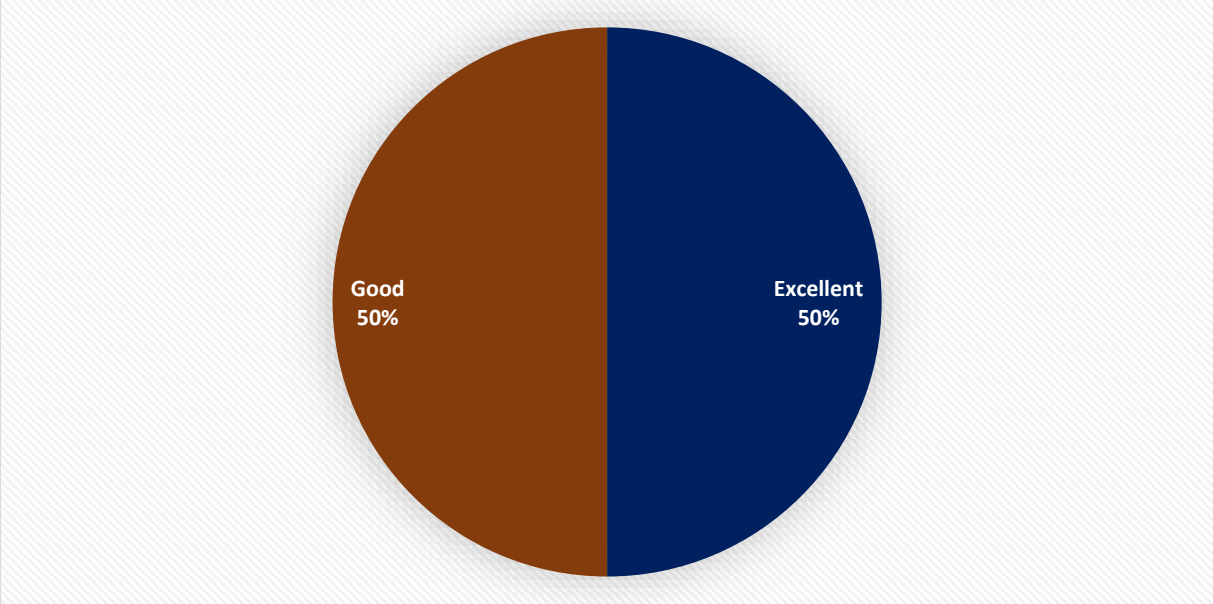

Figure 6: *Experience with Maternity Services in Limerick*

Table 1 (below) illustrates the main factors that prevent most African migrant women from accessing sexual and reproductive health services in the Midwest of Ireland.

Most women gave other barriers such as barrenness. Other participants cited language, culture, faith, and relationship/partners as some of the hindering factors.

Table 1: *Factors Hindering Access to Sexual Health*

Factor	Frequency
Faith	5%
Culture	10%
Language	15%
Literacy	3%
Cost	5%
Relationship/Partner	18%
Other (e.g. barrenness)	44%

c) Access to Family Planning Services

Participants in the survey met their family planning needs through various means as shown in *Figure 7* below.

However, some of them (representing 32%) did not have access to family planning services.

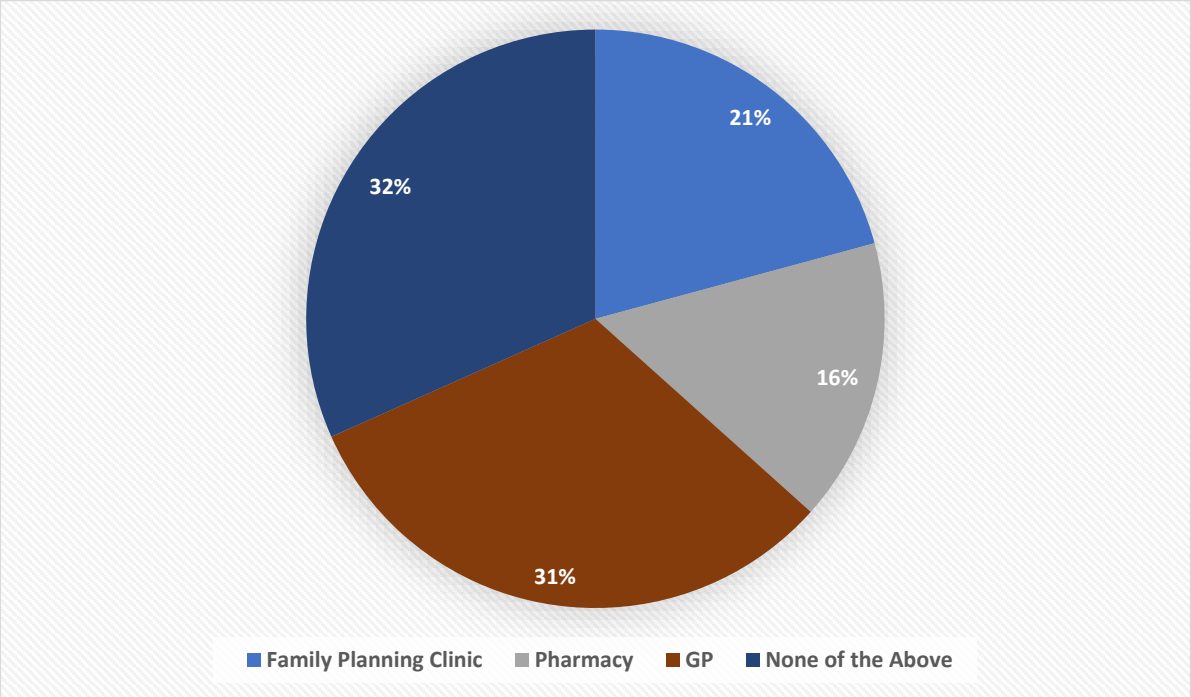

Figure 7: *Sources of Family Planning*

A majority of the participants (representing 68%) reported having a General Practitioner (or GP) – see *Figure 8* below. Those without a GP (representing 32%) attributed their fate to GPs being fully booked, the inability to find a GP, challenges in booking an appointment, and the lack of time to register.

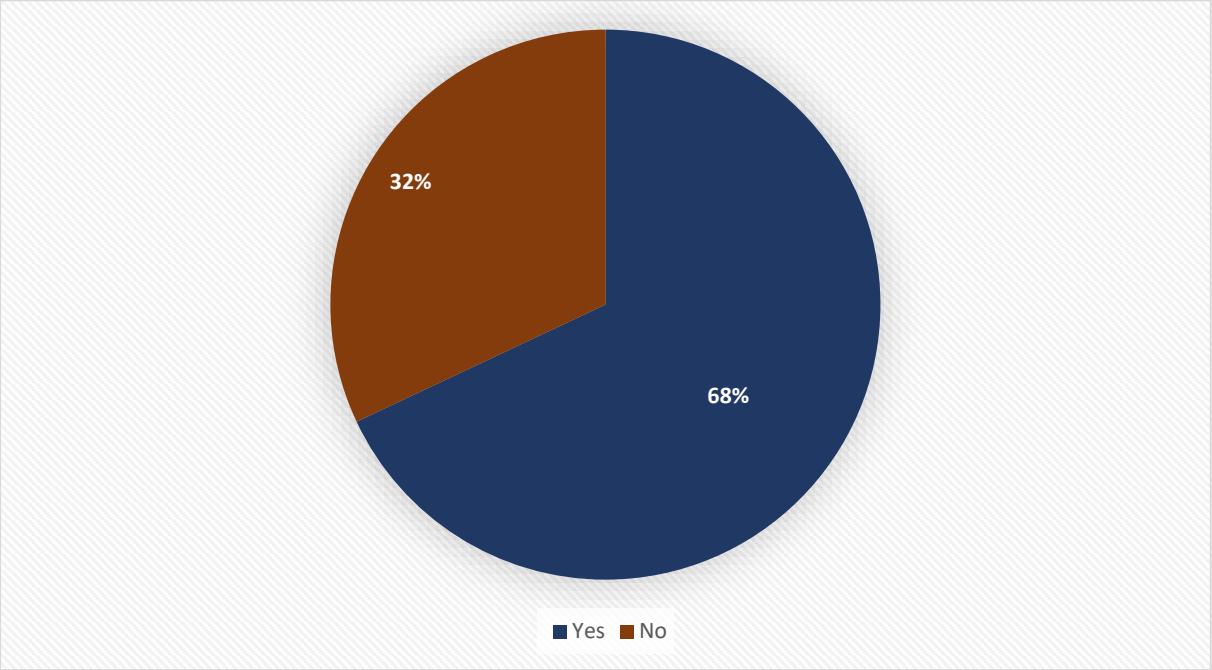

Figure 8: *Having a GP*

Key Take Away

- ✓ These findings highlight significant barriers and gaps in access to sexual and reproductive health services among African migrant women in the Midwest of Ireland, underscoring the need for more culturally sensitive, accessible, and consistent healthcare services.

d) Attitude towards Sexual and Reproductive Health

The findings reveal that many areas of reproductive health are considered difficult or taboo topics within various families, communities, and cultures. Abortion is particularly sensitive due to widespread anti-abortion messaging, and there is a need to educate migrants about their rights and access to services. General discussions about sex, including sex outside of marriage, HIV (Human Immunodeficiency Virus), STIs (Sexually Transmitted Infections), and PrEP (Pre- Exposure Prophylaxis), are often avoided.

Amongst young people topics such as contraceptives, masturbation, gender orientation, same-gender relationships and difficulties with sex are rarely discussed, leading to a reliance on peers for advice rather than risking judgment from elders. Most reproductive health

struggles are not openly shared due to feelings of shame, and discussions about sexual or reproductive organs are often confined to professional settings to avoid stigma and gossip.

e) Attitude towards Family Planning

Form our survey, we found that the use of contraceptives by young people is discouraged due to beliefs about future fertility complications. Additionally, young girls often lack early education about sex, leading to experimentation and teenage pregnancies.

Cultural traditions and religious beliefs further inhibit discussions about abortion and family planning. In the communities surveyed, there is a general difficulty in sharing health-related issues, and carrying condoms or deciding not to have children can lead to judgment and assumptions about one's sexual activity.

Key Take Aways

- ✓ Cultural and community norms typically discourage any open sexual health discussions, with topics like abortion, termination of pregnancy, and female genital mutilation (FGM) being particularly challenging to address.
- ✓ Overall, these findings highlight significant barriers to open discussions and education about sexual and reproductive health.
- ✓ We find this concerning as the conversations and support young people should gain from their elders, particularly mothers, is not possible due to parent's own lack of knowledge about factual and helpful information.
- ✓ Added to this the stigma, shame and taboos surroundings sexual and reproductive health and sexual and gender identity prevents honest and sympathetic conversations that will prevent misinformation and support help seeking.

***The poster (next page) was used in publicising the survey and recruiting participants. The survey was conducted online and accessible via links provided at the end of the poster. The survey was conducted in English.**

Public Health Survey

Title: Sexual and Reproductive health and well-being of migrant women in the Midwest of Ireland: Exploring experiences of access to and knowledge of supportive services.

SURVEY INFORMATION

This project aims to explore issues around sexual and reproductive health of African migrant women, focusing on access to services, experiences of service use, shame, stigma and lack of communication and information within their communities. Funding for this project is provided via the International Protection Integration Fund, by The Department of Justice, Ireland. This survey is only for African migrant women who are 18 years and older. Please adhere to this guidance.

Project coordinators:
This project is a collaboration between Midwest Migrant Community Network (MMCN) HOME | MMCN (mmcnireland.com)
and Gender Orientation, Sexual Health HIV (GOSHH) GOSHH Ireland – GOSHH Ireland CLG.

Survey Links

https://forms.gle/H3ebdADdmubr1sdQ6

PERSONAL STORIES

The following stories capture the lived experiences of migrant women from Sub Saharan Africa, who are now resident in the Midwest of Ireland. The first-person narratives are based around the women's sexual and reproductive health and wellbeing experiences. The stories were collected through face-to-face interviews and email. All the names of the women in the case studies were pseudonymised to protect their identity in line with our commitment to anonymity and confidentiality. The five women in this section tell their stories from their individual experiences and perspectives. We have presented these stories verbatim.

DINEO's Story – PrEP to the Rescue?

I AM a 41-year-old married woman from South Africa. I have two small children, and I work in Ireland. I have been married to my husband for 15 years. He is a good father to our children; he spoils them. Him and I are a different story. He has cheated on me a couple of times, and I don't trust him anymore. I have caught him with text messages from different women, and when I confront him, he has denied, gotten angry with me and became abusive.

We came to Ireland two years ago, and before leaving South Africa, he was the same, having loads of different girlfriends. For me to protect myself from contracting HIV, I started taking Pre-Exposure Prophylaxis (or PrEP). He does not know that I have been taking this medication to prevent HIV. I hid them and I would not want him to know. I have told him to use condoms when together, but he refuses and threatens to send me back home. I am scared of not continuing to take the tablets here in Ireland for I feel he might contract HIV and give it to me. I want to live a healthy, happy life. I want to get some education and get a better job one day.

I tried getting PrEP when I arrived in Dublin, where we stayed for a few months, but was told I cannot because it is only given to gay men. I have not tried to ask for it since, and I cannot afford to buy. I am yet to ask here in Limerick for I thought the rules are the same for all hospitals in Ireland. When I went to the hospital in Dublin, I felt dismissed, especially after mentioning that I was married.

"Today, I still do not have PrEP."

The one I brought from South Africa finished a long time ago. What I do is, after having sex with my husband, I immediately go to the bathroom and wash myself to remove everything. He is not happy when I do that and becomes abusive.

KATLEGO's Story – Living with HIV in Ireland

I AM a 27-year-old single mother from South Africa. Both my baby girl and I are living with HIV. When I came to Ireland, I brought enough medication for the two of us to last three months, thinking that by then, I would be sorted with my paperwork. I only got my medical card about four months ago. I

stayed a few months without medication and my condition started deteriorating. I started losing my mind and I was tired all the time. When I got my medical card, I went to the hospital to let them know I wanted to get medication. I was sent to Dublin to the children's hospital because they do not treat babies in the Midwest. My baby was eventually referred to Crumlin Hospital.

At the beginning, there was no help as I did not know that I could go and register to get medication anytime.

"There was no information of medical services upon arrival in Ireland."

Only when I got my medical card did I know that I could have accessed medication a long while ago. I was very sick when I got back to taking medication again. It is just that I am renting accommodation and sharing with others, and it is always hard to hide medication especially for the baby because we use one fridge. I must lie and say the medicine is folic acid. I have a bottle of Gaviscon that I pour the baby's medication into, and I have labelled that so no one should touch. It is challenging.

FARAI's Story – In "The Corridor of Doom"

I AM a 35-year-old woman from Zimbabwe living with HIV. I was diagnosed here in Ireland. I have not disclosed my status to other people, except my immediate family, all because my children are still young, and I don't want them bullied in school. They are too young to defend or stand up for themselves. I was put on medication after two weeks of my diagnosis. Medication for HIV is readily available here in Ireland, no need for any documentation for one to access medication.

However, information on how the health system works in Ireland is not readily available. For example, I was not informed that my access to the Infectious Disease Department was only for six months; then I was to transfer back to my GP thereafter. I had formed a bond with the consultant at the ID clinic and thought that was where I was going to be going for continued treatment. I felt safe and comfortable there knowing they already knew my status and were not going to discriminate against me. All the staff at the clinic were nice people, hardworking and understanding.

As a person living with HIV, I feel they know that people living with HIV will not carry placards outside marching for change because, well, as a black woman, I don't want to expose myself due to stigma, and I don't want my children to be discriminated. Because there is shame associated with HIV, I keep quiet and persevere.

Patients attending the clinic have now given the corridor we sit waiting for consultation a name: "The Corridor of Doom." The most unpleasant corridor I walk once every six months.

"The anxiety when I think of going to the clinic is so high that my blood pressure is always high."

I sometimes wish I had cancer or was a diabetic, perhaps things would have been different. I am not courageous

enough to approach management and let them know how hard it is to relive one's HIV diagnosis to a different consultant every six months when I go for a review. As for me, I dread that appointment day.

BISOLA's Story – No Help in Sight

I AM a mother from Nigeria, who once faced a challenge after my daughter, Bisola, who was well over 20 years, began experiencing issues with her menstrual cycle. I was concerned about my daughter's health, so I decided to consult our GP, an older male doctor. The GP suggested putting Bisola on "family planning" pills as a solution. However, my daughter and I were not comfortable with this recommendation. We felt that the GP's suggestion was a superficial fix without a thorough investigation into the underlying cause of the problem. Determined to find a more comprehensive solution, we sought a second opinion.

Our next stop was a new GP, a female doctor who listened attentively to our concerns. The female GP recognised the seriousness of my daughter's symptoms, recommended a scan, and referred us to a specialist for further examination. I was present alongside Bisola for all the GP visits to provide support and advocate for my daughter's health. After a long wait of 3 to 4 months, the day finally arrived for the scan results. Unfortunately, I could not accompany my daughter to receive the results.

The diagnosis was fibroids, but the experience with the consultant was far from reassuring. The consultant, seemingly in a hurry, delivered the news with little empathy or explanation. My daughter felt dismissed and unsupported. The consultant stated that the fibroids were not large enough to require surgery and ended the appointment abruptly. Feeling frustrated and unheard, Bisola left the clinic with a negative impression of the healthcare system in Ireland.

> "To make matters worse, we never heard back from the female GP for a follow-up."

When we reached out, we discovered that the consultant had never communicated the results to the GP, and the scan results had somehow been lost in transit. The GP suggested undergoing new scans, which was disheartening after our lengthy and stressful journey. I was disillusioned by this entire experience. Thereafter, I decided that any future medical treatments or procedures for my family would be overseen in Nigeria, where I felt we might receive more attentive and compassionate health care. This decision was fueled by a desire to ensure that my family received the best possible medical support, free from the frustrating experiences we had faced in Ireland.

THANDIWE's Story – Sex Education at Home

I AM Thandiwe, originally from Ghana. I come from a Catholic background where discussions about sexual health are notably sparse. Even as far back as secondary school, my friends were uncomfortable discussing sexual health matters with adults. This is also

attributed to the broader cultural reticence to address these issues openly. However, despite the general lack of dialogue about sex in our community, we had a unique family dynamic at home.

My mother, a health professional, regularly conducted workshops and talks on sexual and reproductive health. This fostered an openness in our household, allowing me to ask questions about sex freely, and in turn, get accurate information. My mother's approachable nature made her a reliable source of knowledge and comfort on sexual health matters.

Since I had accurate information about sex from home, and I was comfortable about discussing it....

"..... I became a resource for my friends at school and in our community."

I often found myself correcting misconceptions and providing reliable information on sexually transmitted infections (STIs) and HIV to others. This role highlighted the prevalent misinformation among young people and the critical need for better sexual health education. There is a need for increased educational sessions that directly target young people and migrant women in Ireland to address misinformation and reduce potential health risks. That's my story.

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EDUCATION SESSIONS

The project in conjunction with the survey ran 6 education sessions. The topics included Sexual Health and Well-Being, Reproductive Health, Contraception and Family Planning, Women's Health, and HIV awareness. The education sessions were conducted in a local venue within a supportive environment. The sessions were framed as educational, informative and awareness raising events. All migrant women were given the opportunity to attend, and the education sessions were not only for migrant women from Africa.

One session was with those who work with young people from diverse communities. The aim was to inform, empower and equip women with a good understanding of sexual health matters and best reproductive health practices. The sessions also provided sign posting to the numerous services that can be of help and support to women in protecting and caring for their sexual and reproductive health.

It was hoped that this may prompt women to share the information gained with their peers, those they work or socialise with and family members including their daughters. All education sessions were run by GOSHH (Gender Orientation, Sexual Health, HIV service), local Family Planning Service and a Limerick based GP (General Practitioner).

Poster of education sessions conducted in Limerick – March 2024.

Feedback on the education sessions was significantly positive. The participants comments are noted below. 21 participants attended the events in total. Most of the sessions were kept to small numbers to enable discussions on matters and topics seen as sensitive.

Although advertising of these events was across several platforms and networks it was still noted that some participants mentioned that women in their communities may have felt uncomfortable attending educational events that featured topics that were located within areas of stigma and taboo in some of their cultures. This was a

point of discussion in the sessions, and we explored together - trainers, project coordinators and participants - the ways in which to address these issues for better participation in future education sessions.

Trainers Erica, Ayushi and Roisin

It was also noted in conversation with other agencies that participation and attendance in events pertaining to sexual and reproductive health with migrant women was often low.

Education sessions and events on sexual health and HIV were not well-attended generally by migrant women and may be contributing to poor information and understanding of what is available for them to protect their health and well-being. We have summarised these discussions and key points raised by attendees on the issues explored as supplementary comments to the feedback on their education experience.

STI Poster *©HSE*

NOTEWORTHY

***** We have specifically chosen to not provide photographs of the education sessions participants. It was agreed due to the sensitive nature of the training and topics explored that those in attendance may not be comfortable with sharing their images. We respected their right to anonymity in this instance. The images provided are of the trainers from GOSHH and work done in the education sessions.

Feedback and Evaluations from Education Sessions

We appraised the feedback and evaluations from the six education sessions. We then focused on four key questions across the four education areas. All returned feedback were positive, and participants rated the education sessions as excellent unanimously. The venue and services provided were also rated as excellent. Presented below are recurring feedback and comments from the four key questions in the evaluation questionnaire.

a) What motivated you to attend?

"I wanted to know more about women's health."
"I felt the session was invaluable and I had a lot to learn."
"Because it was specifically for women."
"I am very concerned about my well-being."
"I think sexual health education is important, and I want to share this with my peers."
"I want the information and knowledge to take better care of myself."
"The topics are very relevant for me."
"The opportunity to learn."
"To become better informed and empower myself."
"I needed up to date information and wanted to engage with other immigrant women."

b) What did you hope to learn?

"I want to learn how sexual education is addressed in Ireland."
"Technical information with real scenarios helped me to understand better."
"How to address these topics with my peers and others."
"Reinforced things I knew, and I also learned new things."
"To get myself protected and learn about contraception."
"Where to go for women's health, well-being and support."
"Gain more knowledge and information for my health and well-being."
"Gain health advice and guidance."
"How to take care of my sexual health and be able to talk to different women who are in similar situations."
"Learn about contraception and learn more about prevention – protecting myself."
"Learning about preventing infections and protecting my reproductive health."
"I attended with different expectations, but this was very informative – I am grateful for the opportunity."

c) Has this education session provided you with poor, adequate, good, or excellent information?

Overall, all participants agreed that the education sessions were excellent. Some participants provided further reasons for their evaluation.

"I did not realize about consent – this was helpful."
"The information provided was excellent."
"This was an excellent opportunity to learn and be informed."
"I wish I could take you to my country to share this information."
"This was very informative and the discussion as well."

d) Would you be interested in attending future events?

All participants said that they would attend future events or training programmes.

"Yes, I would like to know more."
"I would also be interested in any online events/training."
"I would like to be updated with information."
"Please do more sessions."
"I would be interested in volunteering at GOSHH."

Comments From Discussions During Education Sessions

We collated comments and discussion on stigma, taboo, cultural and community perceptions of the topics presented. The participants discussed issues that may be uncomfortable or have the perception of being difficult topics of conversation. The comments are from several women and not necessarily representative of or generalisable to all migrant women and girls. These are presented as narratives from the discussions conducted during these specific education sessions.

How do we learn about sex and women's health?

The participants identified their older sisters, mothers, cousins, and teachers as those who informed and advised them about women's sexual and reproductive health. One participant was a teacher who had taught her female pupils sexual health in her country of origin. She admitted that it was not always in the curriculum in her country, and she had been proactive in educating her students so that they were better informed about the facts of sexual and reproductive health than she had been when younger.

Some women discussed that within Islamic culture they did not discuss sexual or women's health openly. There was what they termed 'gender separation' in conversations about intimate, sexuality based and

reproductive health conversations. These were taboo topics and there were few conversations within families and certainly not across gender such as mother to son or between male and female members in general.

Menopause

This was an area of women's health that many of the women who attended these sessions commented on. It was a topic that was not discussed in their families or between mothers and daughters. Menopause is seen in some cultures and communities as an aging process. There was poor information on managing symptoms and the topic is considered a taboo in some communities. Women are socialised to put themselves last according to some participants and did not necessarily have strong body autonomy.

Period Dignity and Attitudes to Women

Women discussed the start of menstruation, and the cultural traditions involved in the acknowledgment of maturity in young girls. The celebration of womanhood they felt should include advice, information, and the debunking of taboos around menstruation. This may not be conversations young girls from some cultural communities have with mothers or grandmothers. Some discussed FGM as a fear and concern and were glad it was not allowed in Ireland. Periods are often seen as unclean and those menstruating are separated in some cultures from the family during periods. This is again applied when women have given birth, and their unclean status does not allow their participation in religious practices and spaces.

Sexuality

Attitudes to sex, sexuality and conversations about the topic is difficult to navigate in some conservative cultures and deeply religious communities according to some participants. These were identified as the topic that would be considered taboo in many communities. Attitudes varied depending on whether they were from rural or urban populations and the type of education that they or their families had. However, there was still taboos and stigma attached to those seen as different. There were pressures to fit into stereotypes and conform to gender roles and identity.

Hidden Sexuality

Some women talked about hidden sexuality as a norm with both men and women in their communities. Being non-binary or a member of the LGBTQ+ community was not acceptable in some of their cultures and faiths. They spoke of harmful consequences in their countries if people came out as gay, lesbian, or transgender. Those in relationships or presenting as LGBTQ+ faced both stigma with their families and communities and feeling a sense of shame. Often it was a hidden and unacknowledged status. The passing of legislation in some of their home countries against LGBTQ+ communities was of concern, and they felt Ireland was a safe haven in comparison.

Their lives in Ireland would provide access to information through other mediums such as schools. Participants discussed the need for young girls and boys to be well informed and educated on reproductive health, sexuality, consent, relationships and for any taboos and stigmas to be addressed. They wanted a different and positive approach to their daughter's experience of womanhood than they had experienced.

Contraception and Women's Health

The participants found the advice and information provided by the Family Planning Service and the GP on women's health extremely helpful. The information on service provision and where to access services, the signposting of services, was considered useful. The Family Planning Service reported visits from women accessing their services post-education sessions which was a positive outcome.

The GP session with a female GP was welcomed by the participants. The GP focused on women's health issues and provided not just information but focused also on their rights to services. This was welcomed by the attendees as some were not familiar with the services in Limerick or their rights in terms of access. They also had the opportunity to discuss any concerns, needs or queries with a clinician who is a woman, which they identified as helpful.

FGM (Female Genital Mutilation)

This was an area that some women felt was important in the education of reproductive health workers, nurses, midwives, and doctors in Ireland. There was concern that the understanding of what it is and the diverse ways it is conducted and presents could be confusing to health workers involved in women's health in Ireland. Training they felt was crucial to the delivery of diligent care to those women who have had FGM and present at local hospitals or clinics for ante-natal care, childbirth, smear tests or if they develop infections.

There was a discussion on the rights of women and the perception of what FGM is and why it is conducted. Often it is conducted due to the insistence of their families and not by choice. It is seen as a way of preventing female sexual pleasure. The trainers highlighted to the groups they worked with that FGM is not conducted in Ireland. Some women mentioned that families can sometimes travel to their home countries or where they can access this practice for their daughters.

Sexual Rights and Consent

Sexual rights, sexuality and gender are seen as cultural, social, and political issues in some communities. According to some participants, husbands and fathers are the patriarchs and the person to consult in these matters in some cultures and they had control over the information and services that women could access. Attending the education sessions we provided, would not

necessarily be endorsed by husbands and fathers in some communities.

HIV

During the workshops, there was a notable openness among the women when discussing HIV, although a lack of awareness on the topic was evident. We engaged in a highly interactive session that highlighted their existing knowledge about HIV. Several women shared feedback that such open discussions are rare in their communities, where shame, stigma, and anxiety prevail, primarily due to the limited information available. Despite the lack of awareness, the women were eager to learn more about HIV and the services available in Ireland for its prevention and treatment. When we discussed the U=U (Undetectable = Untransmittable) message, they strongly advocated for its dissemination within their communities. They emphasised the ongoing need for education to destigmatise the virus and better inform people about HIV.

Discrimination

Conversations around discrimination and misrepresentation of culture and practices by some communities was another area that was raised by some of the participants. There was a lack of awareness they felt among health workers on the experiences of migrant women and the daily biases that they navigated in accessing health and social care services.

Homelessness And Migrant Women

There was a growing number of migrant women who are now homeless in Ireland. The recent census data indicates almost one in four (23%) of the homeless population had non-Irish citizenship compared with 12% of the State population (Census 2022).

A support worker who works with migrant women who are homeless asked for more training and information for workers in the field. She felt that whilst women in these circumstances may not attend these education sessions, empowering community workers may enable them to provide information and advice to the homeless migrant women they work with.

Migrant Women in Rural Communities

Although these migrant population numbers may be lower than in cities and suburbs, it was raised as a concern as there are fewer services that are easy to access and fewer members of similar cultural communities. This provides less opportunities for women to access and ask other more established migrant women for advice and local information. Having support groups and services, mobile services attached to local health services, clinics, or primary care provision, was seen as a possible helpful approach.

Trainer Reflections (GOSHH)

During the sexual health and HIV workshops, the facilitators engaged participants in open discussions about their knowledge, awareness, and the sexual health education they received in their home countries. This dialogue revealed several critical insights.

The participants shared personal stories and anecdotes about their experiences growing up, which highlighted a significant gap in sexual health education. Many of them recounted that the education they received was minimal, often limited to basic biological information, and lacked comprehensive discussions on safe sex practices, consent, or the prevention and treatment of HIV and other sexually transmitted infections. This gap was attributed to cultural taboos surrounding the topic. In many African countries, sexual health, particularly topics related to HIV, is not openly discussed within families or communities. This cultural silence stems from deep-seated traditions and religious beliefs that view open discussions about sex as inappropriate or shameful.

Despite these traditionally imposed taboos, the women in our workshops were notably open and willing to engage in conversations about sexual health and HIV. This openness indicates a readiness to learn and a desire to break away from the stigmas imposed by their cultural backgrounds. They expressed a strong interest in gaining accurate information and clarifying misconceptions they had held for years. For many, this workshop was one of the first opportunities they had to openly discuss these critical issues without fear of judgment or reprisal.

A recurrent theme in the discussions was the profound stigma associated with HIV and other STIs in their home countries. Participants highlighted that individuals diagnosed with HIV often face severe social ostracism. People with HIV are frequently disassociated from society, with friends, family members, and even healthcare providers shunning them. This social isolation is compounded by widespread

misinformation and fear, leading to a lack of support systems for those affected. The stigma extends to perceptions of morality, where individuals with HIV are often unjustly blamed for their condition and viewed as having engaged in morally questionable behaviour.

In addition to the stigma, many participants were unaware of the treatments and healthcare services available to them in Ireland. While effective treatments for HIV and other STIs are readily available, the lack of awareness among migrant women about their entitlements and how to access these services is a significant barrier. This suggests a need for more comprehensive education and outreach efforts to ensure that migrant women can fully utilise the healthcare resources available to them. Many expressed surprise and relief upon learning about the support and treatments they could access, underscoring the importance of disseminating this information more broadly within migrant communities. The workshops sparked the idea of organising similar workshops for migrant men as it was evident that the men in their communities influenced their decision to access sexual health services in one way or the other.

These reflections highlight the critical need for culturally sensitive education and the importance of addressing both the stigma and the knowledge gaps that exist within migrant communities. Providing accurate information upon their arrival to Ireland and fostering an environment where open dialogue is encouraged are crucial steps in improving the sexual health and overall well-being of migrant women. By understanding and addressing the unique challenges they face, we can help empower migrant women and men to make informed decisions about their health and advocate for themselves and their communities.

Key Take Aways

The evaluations identified several key points including:

- ✓ The need for education sessions on sexual and reproductive health for migrant women and girls.
- ✓ The signposting of services for newcomer women to enable access to services.
- ✓ Although all attendees understood English and were able to communicate well in the language there were concerns that we did not have the opportunity to provide these sessions to women who had language needs. That may be a consideration for future work with the support of identified communities and appropriate interpreters.
- ✓ Discussing and addressing taboos and stigmas was a useful exercise in the education and awareness raising process.
- ✓ Learning about cultural and faith practices of migrant women in terms of health and well-being is important for health, and social care workers.

RECOMMENDATIONS

The project identified five key areas for development:

1. **Providing education sessions**
There is a need to provide education sessions on sexual, reproductive health and self-care to migrant women. The provision of information, advice and guidance on topics that may be taboo in their own culture or community can help them navigate independently services available in Ireland. This includes contraception access and information.

2. **Consulting migrant women and providing culturally congruent services**
The experiences of migrant women in accessing the above services must improve and they should be consulted on service provision. Sexual and reproductive health services must apply culturally congruent approaches to support migrant women's access to services and promote positive experiences of service provision.

3. **Collaborative working**
There is a need for collaborative working with agencies and organisations who can sympathetically and successfully deliver accessible services and support. This may be a particularly useful approach for women in rural communities.

4. **Supporting women in rural communities**
Women in rural communities may not have access to or have contacts locally with women in their cultural communities who may help them during key developments in their lives such as pregnancy, post-natal period, menopause, or miscarriage. Providing links and developing support groups can be beneficial to newcomer women.

5. **Developing safe social spaces**
There is a need to establish safe social spaces where communities can come together to host events and social gatherings. Such spaces also help in tackling social isolation, particularly among minority groups, thereby improving their mental and social well-being. These would serve as hubs for community building, support networks, information provision, training and cultural exchange.

Current provision from Sexual Health Services in the Midwest of Ireland

The sexual health services within University Hospital Limerick:

The STI/STD (Sexually Transmitted Infections/Sexually Transmitted Disease) service provides testing, treatment and vaccination service. PrEP (Pre exposure prophylaxis) and PEP (Post-exposure prophylaxis) service is also available. A nurse led clinic is available for patients requesting a STI screen. Referrals and appointments are available to all patients. This can be both GP and self-referrals. Those accessing services can attend via appointments or walk-in.

Current Provision From GOSHH

*GOSHH provides several services. These include testing, counselling and education sessions on sexual health, gender identity, and sexuality. GOSHH is a non-clinical, supportive, and welcoming environment that is free from judgment. This atmosphere is crucial in encouraging individuals to seek help, participate in discussions, and utilize available services without fear of stigma or discrimination.

Education services are also provided to community groups, colleges, schools and organisations as requested. A social space is provided in support of social networking for LGBTQ+ community members. This is crucial in providing a supportive space and for access to sexual health information, and signposting to various other organisations.

Furthermore, GOSHH continue to develop and offer culturally sensitive educational programmes that address both the stigma and knowledge gaps within migrant communities about sexual health and sexuality. These programmes will be designed with input from community members to ensure they are relevant to and respectful of cultural differences. The main topic of discussion will include sexual health, HIV prevention and treatment, and navigating the healthcare system in Ireland.

Future Project Suggestions

a) Project on sexual health and migrant men

It is recommended that MMCN and GOSHH undertake a similar project focused on migrant men and compare the results with those from the women's workshops. This comparative analysis could reveal unique challenges and perspectives specific to migrant men, helping to tailor support services more effectively. Understanding the different experiences and needs of men and women can lead to more comprehensive and inclusive programmes.

b) Project on education addressing healthy personal relationships

During an exercise on healthy and unhealthy personal relationships, women attending the education sessions discussed controlling, and non-supportive behaviours exhibited by men. This highlights a critical area for intervention. GOSHH should consider developing a project focused on educating both men and women about healthy relationship dynamics. Such initiatives could include workshops, counselling sessions, and support groups aimed at fostering mutual respect, communication, and support within relationships. By implementing these recommendations, GOSHH can build on the success of the recent workshops and further support the health and well-being of migrant communities. These steps will help create a more inclusive, informed, and supportive environment for all individuals accessing GOSHH's services and the provision of better sexual health care in the Midwest of Ireland.

CONCLUSION

This project was helpful and informative in several ways. The project coordinators and trainers identified the need for further education and awareness raising regarding sexual health amongst migrant communities. There is also a need to increase awareness amongst migrant communities about the treatments and healthcare services available to them. More funding to deliver workshops around the Mid-West region is needed. Collaborations with local healthcare providers and community leaders could enhance the reach and effectiveness of these campaigns. Joint working could further enhance the services delivered both within hospital and community services. Furthermore, addressing taboos, stigmas, and shame about sexual health and sexual identities and the need to promote healthy sexual relationships was a common thread that ran through all the discussions within the education sessions. Education approaches as applied in this project can be an example of promoting understanding of healthier sexual relationships and better understanding of sexual and gender identities within migrant communities.

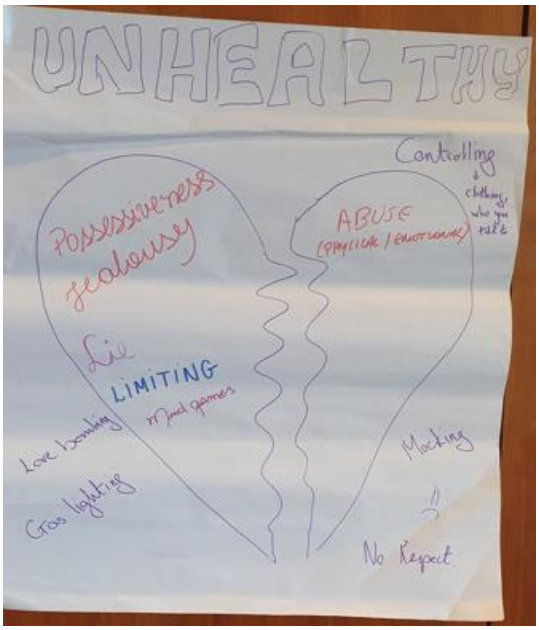
There is a need to ensure that all sexual and reproductive health staff and clinicians are aware of certain cultural practices such as FGM and the implications for sexual and reproductive health. Some participants within the education sessions of this project were concerned that there may not be extensive training provided on this topic within clinical services. Promotion of well-being is not merely about physical health but if addressed holistically should include sexual health, sexuality and information that enables both help seeking and support. This can also promote positive mental health and enable healthy conversations about topics that can be difficult and sensitive to both adults and young people. We hope this project begins the dialogue to promote a holistic and culturally congruent approach to sexual and reproductive health and well-being that benefits all communities in the Midwest of Ireland.

APPENDIX

Training Exercise: Healthy V Unhealthy Relationships

Before starting the exercise, we engaged in a discussion about relationships, posing the following questions to the group:

1. Why is it important to have positive relationships in our lives?
2. Why is it essential for children and young people to be educated about healthy relationships?



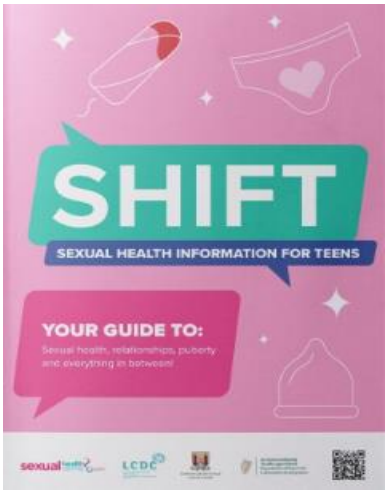
We next watched a short film **'Don't Disappear'** which tells the story of Jamie and Emma, beginning with their seemingly loving early relationship and progressing to the emergence of coercive and controlling behaviours.

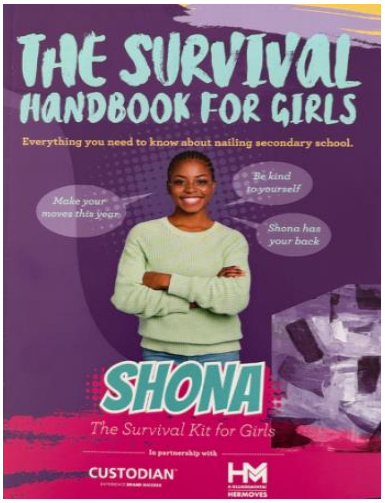
To spark a discussion about relationships, the facilitator posed the following questions:

1. What forms of abuse are evident?
2. What are the signs of an unhealthy relationship?

HSE & GOSHH Resources:


How to put on a condom
Man2Man.ie
hi
Healthy Ireland
sexualwellbeing.ie


SHIFT
SEXUAL HEALTH INFORMATION FOR TEENS
YOUR GUIDE TO:


THE SURVIVAL HANDBOOK FOR GIRLS
Everything you need to know about nailing secondary school.
Be kind to yourself
Make your moves this year.
Shona has your back
SHONA
The Survival Kit for Girls
CUSTODIAN


Free Home STI Testing
SH:24


HIV PEP
Post Exposure Prophylaxis
Take Action Start PEP
man2man.ie/hivpep
72
HRS

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