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ASPECTS OF FAMILY PLANNING AND MIGRATION

Report on two surveys

by

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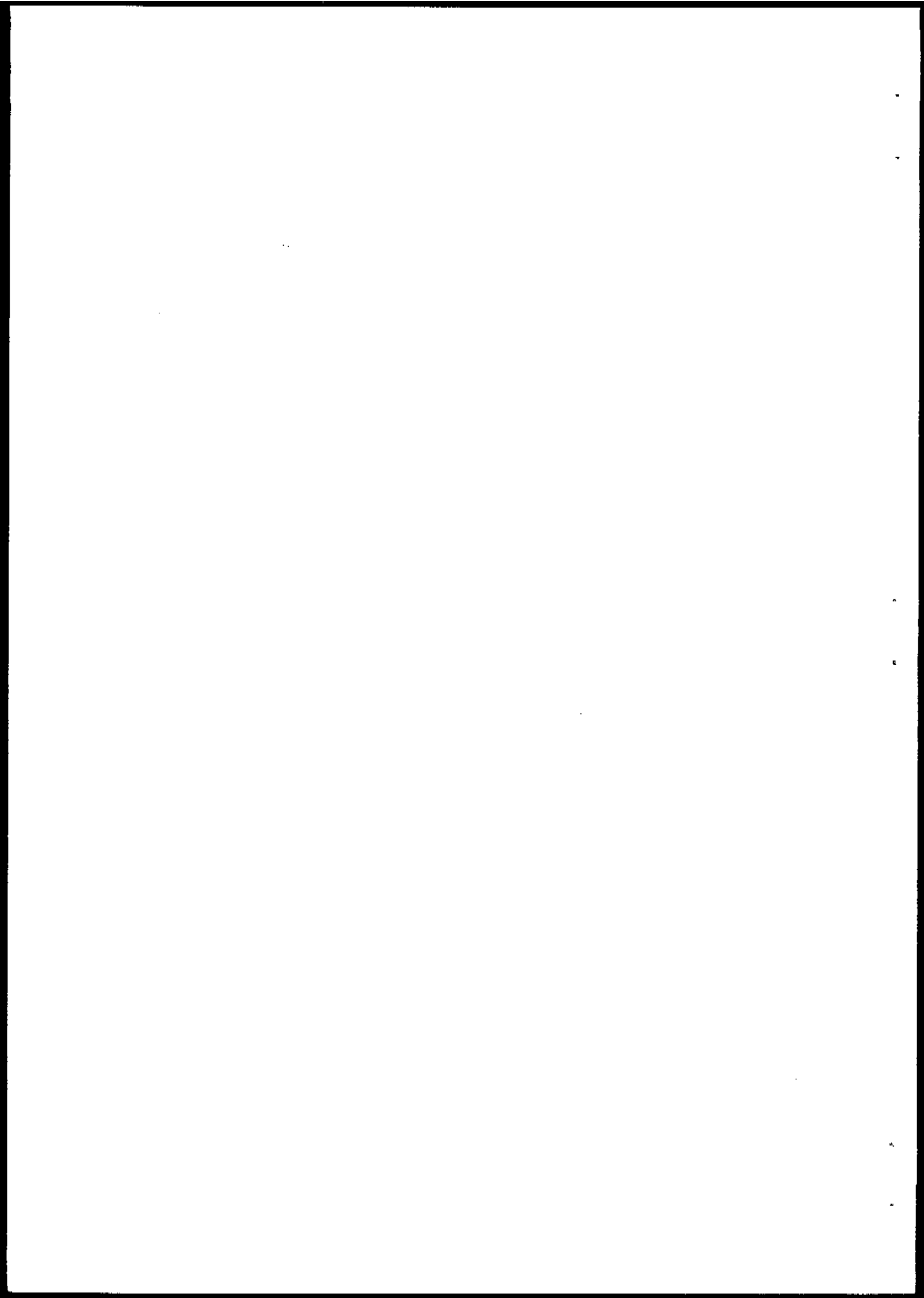
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Note

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1. Introduction

At a time when many European countries are concerned about their low birth rates and are engaged in political discussion about ways to increase them, it seems appropriate to say a few words about the general concept of family planning, which is also one of the underlying themes of our study.

In a situation of growing unemployment, there is increasing hostility towards migrants in several European countries. Arguments on the lines of "there are too many of them" are by no means uncommon. In fact, the whole question of migrants and family planning has become a highly sensitive political issue.

As far as this report is concerned, we should like to express support for a concept of family planning that respects the right of women and men to decide by themselves when they wish to have children and how many. The task of the family planning worker is thus to guarantee that right for both nationals and migrants.

Realizing that little is known about the needs of migrants in relation to family planning and sexuality, it was hoped that the two surveys would shed some light on the subject, not in terms of merely identifying another group at risk but of generating ideas on how to improve the health services so that they also benefit migrants.

The task has not been easy. Studies in this field are not only few in number but also have some conceptual shortcomings.

According to a research group at the Institute for Social Medicine of the University of the Ruhr in Bochum,^a it is wrong to speak of the health problems of migrants. The group believes that there are no such problems per se, and that this generalization ignores the differences between nationalities and between the various migrant groups.

After studying more than 300 publications on the health of migrants, mainly in German, the group has concluded that the main shortcoming of the studies is that they take no account of the key question of whether there really is a difference between the health of nationals and of migrants. Sociomedical and other problems are often termed migrant-specific, although it is by no means certain that this is the case.

A suitable approach must be developed to research on migrant health. At present, it seems to oscillate between two poles: health problems are analysed from either a cultural or a social perspective. Both viewpoints have some validity and some limitations. Both fail to recognize that we cannot distinguish the specific problems of migrants from general social problems as long as we have no comparative information on the health of nationals and migrants.

In short, we can say that we do not have too much on which to base political, social or health programmes for migrants. This situation might seem a critical limitation at first sight. Yet at the same time it can be viewed in a positive light. Whenever we consider the findings of migrant-specific research, we should simply ask ourselves: are these findings really different from those relating to nationals? To what extent are they truly migrant-specific?

This report describes a study undertaken at the request of Ms Wadad Haddad, Regional Officer for Family Planning at the WHO Regional Office for Europe. The introduction is followed by a brief review of the history of migration in Europe and an analysis of the interrelationship of migration and fertility, with reference to migration as a process and to changes in the home countries of the migrants. The question of the impact of migration upon family planning patterns is then taken up and the two surveys that view family planning from different perspectives are described. The first survey, dealing with the attitudes of migrant women to family planning, was carried out in Belgium, and the second, analysing the experience of "failed" family planning practice, in the Federal Republic of Germany. The first survey was organized in collaboration with Martine Dal, who conducted the interviews, and the second with Christine Holste, who carried out the research and assisted in preparing the report. The following chapter on services describes and reconsiders the present approaches to health services for migrants. The potential and limitations of extramural resources such as domiciliary services and women's groups are reviewed, and the needs of migrant men with regard to family planning are examined from the perspective of the specific family structure of migrants. Finally, the report presents a number of conclusions and recommendations which are addressed mainly to health professionals who actually work with migrants.

^a Land, Hövelmann, Neumann & Dietzel-Papakyriakou. Gesundheit und medizinische Versorgung ausländischer Arbeiterfamilien - Ein Literaturbericht. Bochum, Studienverlag Dr N. Brockmeyer, 1982.

2. History of migration in Europe

Throughout the history of mankind, people have migrated for a variety of reasons, whether economic, political or religious. Hence, migration is not a new phenomenon, but it takes different forms at different places and times.

Migration was already taking place in Europe before the Second World War, but the pace accelerated subsequently and especially after 1960 in a situation of economic expansion, and soon the process became structured.

Two important waves of migration can be noted: the first, from Italy and Spain and subsequently Portugal and Greece, started in 1945 while the second, from North Africa (Morocco, Algeria, Tunisia), Yugoslavia and Turkey, goes back to 1961.

The new migrants joined earlier groups who had come from eastern Europe and the former colonies of sub-Saharan Africa, Asia and the West Indies and settled mainly in France, the Netherlands and the United Kingdom.

Table 1 shows the extent of migration to western Europe.

Table 1. Migration in western Europe

Country	Total population in 1982 ^a	Foreign residents in 1982 ^b
Belgium	9 848 000 ^c	885 720
France	54 219 000	3 680 100
Federal Republic of Germany	61 638 000	4 667 000 -
Luxembourg	366 000 ^c	95 789 ^c
Netherlands	14 286 000 ^c	537 571
Sweden	8 327 000	405 475 ^d
United Kingdom	55 742 000 ^c	2 137 000

^a Digest of health statistics in Europe. Copenhagen, WHO Regional Office for Europe, 1984.

^b Eurostat, Demographic statistics, 1984.

^c Eurostat, Demographic statistics, 1981.

^d Folkmängd 1983, Swedish official statistics, 1984.

This has been a massive population movement involving between 12 million and 15 million people, not counting illegal migrants. Initially, the migrants usually arrived on their own and were later joined by their families.

Originally, the recruitment of foreign workers was based on the assumption that they would stay for only a limited time and then go back to their countries. However, this did not happen; after a few years the migrants did not wish to return and became established in the host country. For example, in 1983, nearly 35% of migrants in the Federal Republic of Germany had been there for 10-15 years and almost 20% for more than 15 years.

Since the early 1970s, attempts have been made to prevent a "flooding" of the national labour markets, when the consequences of the economic crisis began to be felt, but they have not been very successful. Moreover, the halting of the recruitment of foreign labour in the Federal Republic, for example, has contributed to the trend of migrants prolonging their stay.

It may be said that migrants have more or less become a fixture in Europe over the last 20 years and their presence is now a definite social phenomenon.^a As compared with migration in

^a Demain les immigrés. La Revue Nouvelle, No. 9. Brussels, Casterman, 1980.

the 1960s, however, today's migrants are far more affected by unemployment, and in fact their situation is becoming critical in the face of growing joblessness among nationals.

3. Migration and fertility

The apparently high fertility of migrants has been the subject of numerous discussions and theories, and it now seems from a closer analysis of the birth rates among migrants in the different host countries that significant changes are taking place in this respect.

3.1 The process of migration

Over the years, the number of births to foreign women in the Federal Republic have been declining, and the rate is now approaching that of the German population. The only notable difference at present is between German and Turkish women, but this situation is also changing.

According to the German National Office of Statistics (Statistisches Bundesamt), the average number of children born to 100 German women is 140. For 100 Turkish women, the average fell from 428 in 1975 to 357 in 1980. There have also been significant changes in the rates for other migrant women in the Federal Republic, as shown by Table 2.

Table 2. Average number of children per 100 women

Nationality	Average number of children per 100 women in 1975	Average number of children per 100 women in 1980
Greek	276	168
Italian	223	192
Portuguese	215	153
Spanish	180	140
Yugoslav	195	175

Source: BIB Mitteilungen 2, Wiesbaden, 1982.

It should be noted that an average of 210 children per 100 women is needed to maintain a stable population.

There are numerous reasons for the decrease in the birth rates. First, we have to bear in mind that migration is a process, a dynamic phenomenon in space and time. It involves a displacement from one place to another and in addition, because the home country and the host country differ so greatly, this change is not only spatial: the perception of time is also altered.

Furthermore, migration involves a comparison between the value system of the home country and that of the host country. Thus, it is also a learning process in which the individual migrant must decide how far he or she is prepared to adopt new values and behaviours, e.g. the fertility behaviour of the host country.

Migration is an economic experience with a considerable impact on family and partner relationships. One concept that is characteristic of migrants is that of "double life planning", which means simultaneously saving money for the future of one's children and preparing for life in the home country after the working life. Migrants, however, very quickly realize how costly it is to live with this concept; their plans are upset by economic crises and growing unemployment, which force them to rethink their goals, particularly in terms of reducing the desired family size.

Finally, migration is a socialization process, especially for many women who for the first time in their lives are confronted by the world of industry. The growing employment of migrant women is changing their traditional image related to motherhood and opening the way to new role alternatives.

It is important to stress that these factors which underlie the changes in the fertility of migrants not only evolve but are also closely interrelated at different levels.

3.2 Changes in the home country

Migrants do not arrive in the host country without a background. Their home countries are undergoing enormous changes. Hence, their fertility behaviour has to be examined dialectically, taking into account the modernization that is taking place in their countries and the effects of migration on their lives.

So far, we have assumed that there is a clear difference between the family patterns of the host and the home countries. While the extended family is the dominant pattern in the latter, the situation is gradually changing, especially in expanding urban centres and even in the countryside. This is true especially of young people, who are influenced by the mass media, through which they are brought into contact with other cultural values. They are starting to regard the couple as an affective and no longer essentially functional entity. Similarly, the life plans of both individuals and couples are no longer always bound up with the destinies of the extended family.

4. Family planning and migration

Attitudes to family planning are influenced by several factors:

- economic: prevailing mode of production (agriculture, industry), economic role of the family;
- social: social role of the family, status of women and children, religion, spatial organization (rural or urban environment), the availability of contraception and abortion;
- health: infant mortality;
- individual: life plans for oneself and one's children, power relationships within the couple, dreams, aspirations, love.

Migration affects this process not as a factor in itself but rather as a modifying influence. Migrants are presented with two social concepts of procreation, which differ significantly in most cases.

As far as European migration is concerned, whether national or international, we know that the home societies value the extended family, which plays an essential role in a largely rural economy, whereas in the far more industrialized host societies, the prevailing structure is the nuclear family, which is the only type of family organization possible in an urban environment. However, it is not only these two concepts of the nuclear versus the extended family that are opposed but also two different processes of family formation. Whereas in many European countries the birth of the first child is increasingly delayed, young migrant couples prefer to have children during the first years of marriage.

Different processes of family formation require different approaches to family planning. The western European woman must use contraception if she wishes to delay the birth of her first child, while the young married migrant woman who wants children right away has no need to. Hence, the absence of family planning among migrant women may be the result of a rational choice at a certain stage of their lives and not the reflection of an inability to plan. Thus, a knowledge of different models of family formation is of great importance for health workers in the host countries.

The shift of values and attitudes from one model to the other is a slow process since it involves firmly ingrained social concepts relating to the family, sexuality and procreation. Aspirations and practices are influenced by an interplay of traditional versus new values and the attraction of Western culture versus the weight of tradition and an attachment to the original culture. Studies have shown that as a rule "second-generation" migrants wish to have smaller families than their parents.

Decisions concerning family planning are made at three levels:

- the acceptance of family planning;
- the choice of a method;
- the practice of that method.

At each stage, the elements mentioned above come into play, interact dynamically and achieve a fragile balance.

There is a direct relation between the degree of acceptance of the western European family pattern and:

- the tendency to practise family planning and/or birth spacing;
- the steps taken to obtain information on modern contraceptive methods;
- the use of such methods.

The transition from one model to another does not take place without difficulties, hesitations and changes of mind. It is in fact associated with a sense of betrayal of one's origins.

The transition also changes the power structure within the couple, since it is the woman who is responsible for the use of modern contraceptive methods and this no longer allows any control over her sexuality.

The main obstacle to the acceptance of contraception is the contradiction between the rational need to plan and the irrationality of sexual desire. This applies both to migrants and to nationals. All women and all couples must come to terms with this contradiction in their own way, in accordance with their personal experience within the context of their family background.

5. Surveys

5.1 Survey on family planning among Moroccan migrant women in Belgium

This survey was conducted among Moroccan women attending a family planning clinic in Brussels.

5.1.1 Objectives

The survey had as its back-drop the activities of a family planning clinic in a working-class district of Brussels, with a large population of migrants of mainly Moroccan and Turkish origin.

First, we gave the women an opportunity to talk about themselves during individual interviews conducted on the basis of a "response pattern".

The interviews provided material for an analysis which seemed very worthwhile in spite of being qualitative rather than quantitative.

Then we made a critical assessment of the work of the family planning clinic so as to ascertain in particular its receptiveness to the dynamics noted in the interviews.

Finally, the ideas generated by the interviews and our analysis of a particular medical, psychological and social experience led us to question the concept of needs and the services that should be available.

5.1.2 Area

(a) The Josaphat district

Brussels is divided into 19 communes, each forming a heterogeneous entity, and some attracting migrants. In the Schaerbeek commune, to which the Josaphat district belongs, 33.3% of the population (19.8% in 1970) are migrants, including 30% from Morocco. In the Josaphat district itself, 70% of the population are migrants. The age distributions of the national and migrant populations show marked differences. The latter have much higher birth rates, and in the commune as a whole one boy or girl in two of under 15 years is a migrant.

(b) The Josaphat family planning clinic

In 1975, three general practitioners set up a health and family planning centre (Groupe Santé Josaphat) in a working-class district of Brussels where many migrant families from Morocco and Turkey had settled.

The gynaecological service gradually expanded owing to increasing demand. The general practitioners moved into other premises nearby, and the centre itself became the Josaphat family planning clinic (Planning Josaphat).

The initial team of staff has grown to meet the rising needs and now comprises:

- two gynaecologists;
- one social nurse;
- two physiotherapists;
- one social worker;
- one psychologist;
- one lawyer.

All are women, and the social worker is of Moroccan origin.

The activities of the clinic include reception, medical assistance, individual counselling (social and psychological problems), legal advice, health education groups, gymnastics groups.

The clinic has established contacts with other health resources in the area: hospitals, maternal and child health centres, general practitioners, mental health centres, associations of migrant women, schools.

5.1.3 Methodology

The survey was carried out from June 1982 to May 1983, with the help of a sociologist, who had previous experience with migrant families and conducted the interviews.

(a) Sampling method

All the medical files of the Moroccan patients were made available for the survey. We first selected 100 files of patients whose last visit had taken place less than a year ago and then reduced this number to 30.

The approach proved to be difficult because of cultural barriers, which themselves would be a subject for study, and hence additional steps were necessary.

We interviewed patients from the Josaphat clinic, following their delivery, and at a maternity clinic (Clinique César De Paepé) where one of the team gynaecologists was working. The dialogue between women who had attended the clinic and others who knew only the hospital, as well as a comparative analysis of both situations, proved very useful.

We also had an opportunity to carry out a group survey of five Moroccan women who were attending a social improvement course organized by an association of migrant women (Le Piment). The teacher, who was herself Moroccan, was interviewed first, and she was then able to enlist the cooperation of the other women in the survey.

Our sample was composed as follows:

- 23 women interviewed at the Josaphat clinic;
- 5 women interviewed at the maternity clinic;
- 5 women interviewed as a group through the association of migrant women.

Thus, 33 women were interviewed and 33 statements of experiences were obtained.

(b) Survey procedure

We used a direct, verbal approach. Repeated contacts were necessary in some cases before the patient accepted the idea of the survey. Staff from the Josaphat clinic often acted as mediators between patients and the sociologist in order to overcome prejudices and fears relating to sociological surveys.

Some women, although fluent in French, used the excuse of language difficulties to avoid being interviewed alone and said they wished to be assisted by their husbands. We tried - often successfully - to convince them of the importance of a personal contact and stressed the anonymous nature of such surveys. Other women, however, were anxious from the outset to avoid any participation by their husband or another member of their family.

The assistance of an interpreter was never needed, nor wanted. Almost all the interviews took place at the clinic, in a special room, in a quiet and friendly atmosphere. In a few cases, they were carried out at the patients' homes for convenience, particularly where pregnant women requiring complete rest were concerned, but in any case always on a one-to-one basis.

At the maternity clinic, the initial contact was made easier by the fact that the interview took place after the delivery: the patients were proud to talk about their experience, felt more secure with other women around them in the ward and were eager to discuss matters in which they were deeply involved. On the other hand, the interviews were shorter and were often interrupted by nursing activities.

(c) Sample population

Age

15-19 years	2
20-24 years	9
25-29 years	16
30-35 years	6
	<u>33</u>

Marital status

Married	28
Separated	1
Unmarried	2
Widowed	2
	<u>33</u>

Education

Primary school	10
Secondary school	8 (middle)
	3 (full secondary)
Higher	5
None	2
Unknown	5
	<u>33</u>

Occupation

Student	2
Working outside	8
Unemployed	13
Housewife	10
	<u>33</u>

Among the eight women working outside, six had a higher education: one secretary, one nurse, two social workers, one chemist, one actress.

Occupation of mother and father

In nine cases, both parents were still living in Morocco. Among the others, all were living in Belgium:

Father

Factory worker	9
Salaried employee	1
Unemployed	9
Pensioned	4
Sick or disabled	2
Unknown	8
	<u>33</u>

Mother

Housewife	23
Disabled	1
Deceased	1
Unknown	8
	<u>33</u>

Origin of both parents

Rural	10
Urban	18
Unspecified	5
	<u>33</u>

Age on arrival in Belgium

0-5 years	3
6-10 years	7
11-15 years	9
16-20 years	4
Over 20 years	5
Unknown	5
	<u>33</u>

Composition of the family on arrival in Belgium

In most cases, the father came on his own and, when he was in a position to do so, arranged for his wife and children to migrate about a year later. Other children were then born in Belgium.

Housing

Couple	17
Couple with family	8
Unmarried, living with the family	2
Living alone (with children)	2 (widowed)
Unknown	4
	<u>33</u>

The housing arrangements are linked to the problem of "space", which we will return to subsequently.

The subject was discussed spontaneously by most respondents. It may be postulated that the choice with regard to housing (for a couple or family) is an indicator of the degree of autonomy and the attitude to the traditional way of life.

5.1.4 Results

In the light of the interviews, we tried to identify factors which influence contraceptive choice and practice, to determine attitudes to sex education and to assess the effect of migration on those attitudes.

The outstanding impression which emerges from all the statements is of the image the women have and project: they see themselves as a point at which different forces converge; they do not define themselves as individuals, as separate entities.

The migrant woman has to find an equilibrium between the different models available to her. The effort she has to make to assess the models, whether this results in their rejection or an attempt to adjust to them, is too difficult and demands too much energy for her to establish her identity through an individual life plan. She is faced with a choice: either she remains isolated, locks herself off, defends the traditional way of life, withdraws into herself and loses contact not only with the outside world but also with her own children, or she adjusts gradually, in a continuing effort, often at the price of conflict with her family or her husband.

All the statements were pervaded by such contradictions, which each woman perceives in her own way, and they cannot be better exemplified than in the individual's attitudes to family planning and sex education.

A more detailed analysis of the data led us to classify the respondents into three groups:

- those who attended the family planning clinic;
- through them, in the background, their mothers;
- those who attended a hospital.

The significance to be attached to this classification is, of course, relative. The criterion on which it is based (as emerged from the statements) is the concept of space, of an extensive communication network from the sociological standpoint which serves as an important indicator for a behaviour, for a "way of being".

In our study, this criterion was found to underlie the approaches to the family planning issue, which is essentially cultural and only secondarily medical (where women seek information, the use they make of it, etc.).

(a) Characteristics of women attending the Josaphat clinic

The women were young (aged between 20 years and 30 years) and had in common the fact that they had extensive contacts with Belgian society:

- they were born in Belgium or arrived very young and therefore spent most of their school years there;
- some came more recently, but their family environment was particularly favourable;
- they had a strong personality which enabled them to challenge their families or husbands (under whose authority or protection they were always placed); or
- their husband was very receptive and wanted to help them to fulfil themselves.

In any case, all this had led to a better understanding, a deeper awareness of the "space" in which they lived and a better integration into Belgian society.

They had generally learnt about the family planning clinic from friends and decided to come back because they were received in a friendly way, were given detailed information and were able to discuss their problems freely.

At the same time, constant reference was made to the maternal image in the women's statements. This appeared to be a very important factor in the formation of their personality.

An obvious tendency to reduce the family size can be observed from one generation to another: the women in the sample (and their husbands) desired three or four children, although their mothers wanted an average of six or seven.

That attitude towards fertility seemed to be more compatible with the women's desire to be no longer confined at home like their mothers and to lead a professional life.

At the same time, the economic situation had prompted them to limit the number of their children, particularly as they often expressed the wish to give each of their children a better chance of reaching a higher social status. The pill and the intrauterine device (IUD) are the only methods used, in most cases in turn.

The pill was regarded by all respondents as the most effective method and was correctly used. However, numerous references were made to side effects, thus explaining a certain resistance - which remained quite strong.

It is clear that this resistance was not due to a lack of understanding, nor to a lack of information in the case of the women we interviewed at the family planning clinic, but to conflicting feelings: desire and refusal to procreate, traditional value placed on fertility, and questioning of the status of women. Complaints about the pill (headache, fatigue, dizziness) were in some cases the expression of a profound distress related to the imagined effects of the drug: sterility, break with the mother ...

The IUD was well tolerated and incurred no criticism once the idea of a "foreign body" had been accepted and once the fear of damage to the reproductive organs had been overcome.

The method of injection of medroxyprogesterone every three months was known but not used because it causes weight gain and stops menstruation, both of which conditions are equated with menopause and sterility. The women stated that this was the most common method in use by their mothers, but as a means of preventing further births rather than spacing them.

Mechanical devices (diaphragm, cervical cap) were not popular as they require manipulation of the genital organs, which was not acceptable to the women.

We tried to determine where the information had been obtained, whether it was considered adequate, and who chose the contraceptive method (the woman, the husband or both). We also questioned the women about the role of religion. This did not appear to be a factor in itself. Religion was used as an argument to restore a lost sense of rational thinking or to justify a particular attitude, e.g. fear of sterility, contraception, sexuality. On the other hand, transgressions of religious rules did not pose any difficulty when the couple were in agreement, e.g. about using a contraceptive method: "We have to, there's no alternative." All the respondents complained about the paucity of their sexual education, which was sketchy and often inaccurate and was gained from friends or older sisters, i.e. women of the same generation. Often the mother was explicitly excluded, since she was not very well informed herself. She was frequently blamed for being too strict and for depriving her daughter of information. As a rule, the respondents did not have confidence in their mother in this matter. With regard to the impact of migration on this generation gap, it seems that the relationship between mother and daughter seems to be the same in Morocco. There, as in the host countries, the younger women demand better sex education and regard the sexual harmony of the couple as an important element in its equilibrium. The respondents also wanted to establish a dialogue with their children and to give them some sex education, and they looked to the school for help in that respect.

(b) Characteristics of mothers

In most cases, a picture of the mother emerged from the statements of the daughter. In nearly all the cases, the mother plays the traditional role assigned to her in a Moslem culture. She stays at home with other women, her contact with the outside world is very limited, she does not learn the language of the host country and she rejects its customs.

Her attitude towards family planning is governed by the factors which continue to influence women of the same age who still live in the home country: low socioeconomic level, low status of women, high value placed on fertility, high infant mortality. Her life consists of a continuous involvement in pregnancies and deliveries and is devoted to the upbringing of young children. She receives no sex education.

However, older women achieve a higher status once they have given evidence of their fertility. Age, while depriving them of the reproductive power, confers on them a new authority and a freedom of speech and behaviour, which younger women do not enjoy.

Migration has, of course, a negative impact, since it disturbs this balance. For women, it means a loss of the covert power based on the complex relationships which grow up between households and streets in the traditional urban setting. They lose their authority over their children and the family.

(c) Characteristics of women attending a hospital

These women form another group who, although they were of the same age as those attending the Josaphat clinic, had a very different attitude:

- in many cases, they had come to Belgium more recently;
- they had more children;
- they were very isolated.

In towns where they rarely went anywhere alone, they followed specific routes between different points which formed a circumscribed area: the home, the hospital, government offices (local council, labour exchange), the school, the grocery store.

A correlation can be seen between a number of variables: limited space/reduced contacts, difficulty of integration/traditional behaviour/no knowledge of contraceptive methods, no family planning, no sex education, early and successive pregnancies, and a large number of children - all of which reinforce the women's isolation.

When the women were faced with a health problem, they took the most immediate, simplest decision: they went to hospital. They knew of no alternative. We interviewed only a small number of women in this situation, but it would be worthwhile to hear more about them since they are unquestionably the group in the greatest need of help in their efforts to adapt.

5.2 Survey on abortion among Turkish migrant women

5.2.1 Introductory remarks

For effective family planning counselling, attention must also be paid to the influence of social factors on sexuality, pregnancy and abortion. Behind language barriers, we often find differences in approaches to health problems, different types of family relationship and the "double life planning" that is characteristic of migrants. Thus, family planning, pregnancy and abortion take place within this dual context and in another health and family culture.

The purpose of the small survey on abortion among Turkish migrant women, carried out in Berlin (West) in 1982, was to find answers to the following questions:

- (1) What is the cause of unplanned pregnancies among Turkish women and which of them end in abortion?
- (2) How do Turkish women cope with the legal aspects of abortion and how helpful is obligatory abortion counselling?
- (3) What is the attitude of Turkish women to abortion and what use do they make of the health services in this situation?
- (4) Would it be possible to use the experience of abortion to sensitize this group of women to family planning?

The survey consisted of an analysis of the medical statistics of 29 Turkish migrant women admitted to a public hospital in an area with a large migrant population in Berlin (West).

At the same time, the counselling situation in which the data were collected was evaluated. As the German abortion law requires that women seeking abortion undergo obligatory abortion counselling, it was felt that, by observing and analysing the counselling, we could gain insight into the complex causes of an unplanned pregnancy and the process of decision leading to an abortion.

This kind of research was necessarily limited as the abortion counselling is obligatory. Therefore, in addition to the 29 women at the hospital, we interviewed 12 women at their homes on a voluntary basis.

The study also compared data on German abortion clients attending the hospital with those relating to the Turkish women. Although the German women were from a slightly different socioeconomic background, it was felt that a prudent comparison could be made.

5.2.2 Characteristics of German and Turkish abortion clients

First of all, an age difference was apparent. The majority of the Turkish women were between 30 years and 34 years, while most of the German women were much younger (21% between 16 years and 19 years). The second and third largest age groups were those of 30-34 years (19%) and 40-44 years (19%).

Table 3. Age of German and Turkish clients

Age group (years)	Number of German women	Number of Turkish women
16-19	10 (21%)	-
20-24	5 (10%)	4 (14%)
25-29	6 (12%)	6 (21%)
30-34	9 (19%)	11 (38%)
35-39	7 (15%)	5 (17%)
40-44	9 (19%)	2 (7%)
45-49	2 (4%)	1 (3%)
Total	48 (100%)	29 (100%)

The most striking difference between the German and Turkish abortion clients was in their family status.

Among the German group, almost as many women were single (35%) as married (44%). The situation was different with the Turkish women; almost all were married (93%), which indicates that their sexual experience was far more likely to take place within marriage than in any other form of relationship.

Table 4. Family status of German and Turkish clients

Family status	Number of German women	Number of Turkish women
Single	17 (35%)	1 (3.5%)
Married	21 (44%)	27 (93%)
Divorced, separated, widowed, etc.	10 (21%)	1 (3.5%)
Total	48 (100%)	29 (100%)

The difference in the numbers of children born to German and Turkish women is a reflection of different lifestyles and cultural attitudes to children. However, as we have already shown, migration changes the reproductive behaviour of migrants. Most migrants have increasingly adapted their fertility behaviour to that of the German population. The Turkish migrants are an exception in this respect, but their fertility is also decreasing. Among the Turkish abortion clients, there were two main groups:

- women with 1-2 children (31%);
- women with 3-4 children (38%).

Table 5. Number of children of German and Turkish clients

Number of children	Number of German women	Number of Turkish women
0	20 (42%)	2 (7%)
1-2	25 (52%)	9 (31%)
3-4	3 (6%)	11 (38%)
5-6	-	5 (17%)
7-8	-	2 (7%)
Total	48 (100%)	29 (100%)

Looking at the average age of children of German and Turkish women seeking an abortion, both similarities and differences can be found. In both groups, the majority of women had children aged between 5 years and 9 years. However, while German women with older children also sought abortions fairly often, the rate was much lower among Turkish women.

Table 6. Average age of children of German and Turkish clients

Average age of children	Number of German women	Number of Turkish women
0-4	3 (11%)	7 (26%)
5-9	8 (29%)	11 (41%)
10-14	6 (21%)	3 (11%)
15-19	6 (21%)	1 (4%)
20-24	2 (7%)	1 (4%)
No data	3 (11%)	4 (15%)
Total	28 (100%)	27 (100%)

Last but not least, the numbers of miscarriages and stillbirths give some information about the health status of German and Turkish women. The rates were much higher among the latter. One known but not systematically researched fact is that, during pregnancy, Turkish migrant women do not make sufficient use of the preventive health measures offered to them.

Table 7. Number of miscarriages and stillbirths among German and Turkish clients

Number of miscarriages and stillbirths	Number of German women	Number of Turkish women
0	42 (88%)	21 (73%)
1	2 (4%)	3 (10%)
2	1 (2%)	3 (10%)
3	-	-
No data	3 (6%)	2 (7%)
Total	48 (100%)	29 (100%)

5.2.3 Health problems and counselling

Health problems and insufficient counselling are often factors contributing to unwanted pregnancy.

The idea that family planning must be seen as a discontinuous rather than life-long process has gained ground in recent publications.^a This view is confirmed by the behaviour patterns of female migrants, although such attitudes are not exclusive to them.

The extraordinary pressure placed on female migrants, due to their living and working conditions, contributes to discontinuity in their family planning. The majority of the Turkish women who were interviewed within six months after an abortion had previously taken the pill for some years (very few used only traditional methods). Yet a number of them complained of serious health problems, as in the following case: "I always used to work in the fields until the last

^a Summarized in: Oeter, K. & Wilken, M. Psychosoziale Entstehungsbedingungen unerwünschter Schwangerschaften. Berlin (West)/Stuttgart/Köln/Mainz, Bundesminister für Jugend, Familie und Gesundheit, 1981, p. 317 (Schriftenreihe des Bundesministers).

week of pregnancy. I also had a lot to do in the house. But there one is much more preoccupied with oneself than with other things. I listen to my inner self much more there than I did at home. Here I have so many physical problems which I didn't have there. Sometimes I have pains from head to foot ..."

Clearly, the subjective complaints of the women had increased since migration and were often a consequence of their multiple responsibilities (housework, paid work, side jobs) as well as legal and social insecurity bringing additional anxieties. All the respondents were employed, most since migration.^a Often, the women complained of headaches, depression, constant malaise ("a feeling of emptiness, as if I didn't belong to myself"). In cases where the symptoms persisted or got worse, they were interpreted as side effects of the pill, which was then naturally abandoned, meaning that the women had not really understood the doctor's instructions. In many cases, they returned to the methods they knew, which we tend to consider "unreliable", e.g. coitus interruptus.^b The fact that they did not see a doctor after stopping the pill is indicative of their confidence in traditional forms of birth control.

Probably, as long as the traditional methods appear to be sufficiently reliable ("it worked for 1-1/2 years"), the women will consider it less necessary to resort to modern methods such as the pill or the IUD. Occasionally, misleading information is given to the doctor with regard to an unwanted pregnancy, either out of fear of discriminatory remarks or because the woman's existing knowledge about birth control methods is simply not communicated to the doctor.

Doctors are also responsible for unwanted pregnancies, as is borne out by recent literature on German women who have abortions.^c We can confirm that this also applies to Turkish migrants. Women who have been given insufficient directions for taking the pill and who cannot read the instructions written in Turkish develop their own approach and take the pill as they wish. The range of ways in which the pill can be taken as a result of inadequate information is astonishing, and cases are even known of the husband taking the pill in place of his wife.

Whether or not a foreign woman decides to follow her doctor's advice thus depends on the amount of time he (or she) devotes to advising her and on his social empathy. In the final analysis, he has to know how far his advice is being followed and whether it is attuned to his patient's health and cultural beliefs and economic possibilities.

5.2.4 Conflicts surrounding pregnancy

As the family-oriented value system has by no means lost its validity for the Turkish migrants in the Federal Republic, one can assume that the decision for abortion is normally conflict-ridden. On the one hand, the women's stories revealed culture-mediated family models which had been reactivated and were now influencing the decision-making process between the partners. On the other hand, such models may break down in face of the tensions encountered in the host country.

The point of reference may be the family ("I told my husband, if we can raise two children, we can also raise three"); the proof of fertility ("I told him, I'm not able to have a son, and neither is he; it's not all my fault if we can't have sons"); the sex of the children according to previous experience ("I only have boys anyway and the next one would also have been a boy"); or the preferred demarcation between generations ("I and my daughter-in-law would have had children at almost the same time; that's impossible"). It is, of course, not possible to explain why an abortion is sought without knowledge of the client's value system.

^a At the time of the interviews, five women were employed in a factory, three in a cleaning firm, one had just been laid off and one was working as a gardener.

^b With regard to coitus interruptus, Langley has pointed out that the Pearl Formula is not the only measure of the reliability of this method. For about 50% of males, coitus interruptus can be considered reliable if practised successfully for 5-10 years. See Langley, L.L. Contraception. Pennsylvania, Dowden, Hutchinson & Ross, 1973, p. 13.

^c Materialien zum Bericht der Kommission zur Auswertung der Erfahrungen mit dem reformierten Paragraph 218 StGB, Bd. 92/3. Berlin (West)/Stuttgart/Köln/Mainz, Bundesminister für Jugend, Familie und Gesundheit, 1982, p. 27-28 (Schriftenreihe des Bundesministers).

Table 8. Number of previous pregnancies of German and Turkish clients

Number of pregnancies	Number of German women	Number of Turkish women
0	18 (38%)	1 (3%)
1	3 (6%)	1 (3%)
2	19 (40%)	2 (7%)
3	4 (8%)	8 (28%)
4	2 (4%)	3 (10%)
5	-	5 (17%)
6	-	3 (10%)
7	-	3 (10%)
8	-	2 (7%)
No data	2 (4%)	1 (3%)
Total	48 (100%)	29 (100%)

It is also striking that the decision to abort was taken only after the woman had given birth to several children and the family had reached a certain size ("I'm now 33 years old and have been pregnant six times; I thought that was enough"). At the national level, the same is true of German women seeking abortions, in that most already have one or two children. Among the Turkish women questioned, the motivation of retroactive family planning was sometimes evident. Such decisions are, of course, strongly influenced by the perception of circumstances and the problems expected with the arrival of another child.

The spectrum of problems faced by the individual migrant families was surprisingly similar. Financial difficulties (loans, hire purchase, financing of a house built in Turkey), financial support of relatives, care of children of preschool age, the need for the additional wages of the wife which might be lost in the case of a pregnancy, and inadequacy of living space^a are problems which arise, often simultaneously, and become the determining factors in the decision. A problem at the heart of many conflict-ridden pregnancies, which engenders guilt feelings, is the fact that parents often have to let some of their children grow up in Turkey simply because they are not in a position to care for them in the host country. Less than half of the families of the interviewees had managed to bring all their children with them. In such cases, abortion seemed the only solution ("It's much worse to give birth to children and then send them to Turkey").

In contrast to German clients, both partners had usually participated in the decision.^b Where they had worked out an arrangement that fitted in with their future plans, it was possible to reach an agreement on this question. The decision is always controversial if there is disagreement over the wish for another child.

In general, female friends, neighbours and colleagues from work were also involved, particularly with regard to practical arrangements, e.g. selection of doctor, hospital, etc. ("Mihriban, she said, maybe it will be a girl. One can depend only on girls. One can't expect anything from sons later on"). They hardly ever seemed to have a direct influence on the actual decision to seek an abortion, but one cannot overestimate the help they give in coping with the decision emotionally.

^a See: Materialien zum Bericht.

^b Materialien zum Bericht indicates that 47% of German women take the decision alone (41% in the case of married women). In the total sample (N = 388) questioned, one woman in three had taken the decision alone.

5.2.5 Medical confirmation of pregnancy

As noted above, foreign women are poorly informed about the legal prerequisites for abortion.^a This deficiency, along with their minimal knowledge of German can be disadvantageous for them when making use of the official channels.

Table 9. Occupation of German and Turkish clients seeking an abortion

Occupation	Number of German women	Number of Turkish women
Salaried employee	5 (10%)	-
Lower-echelon employee	22 (46%)	8 (28%)
Apprentice, trainee, student	9 (19%)	-
Housewife	8 (17%)	7 (24%)
Manual worker	2 (4%)	11 (28%)
Unemployed	2 (4%)	3 (10%)
Total	48 (100%)	29 (100%)

The first doctor consulted therefore plays a key role as he has the function of "paving the way". If he assists the patient by sending her to a "Sozialberatungsstelle"^b or to a hospital, she will be able to pass through the remaining channels without too much delay.

In this situation, the women said they preferred to see a doctor they could trust, one whose attitude towards abortion was known. Occasionally they had obtained addresses from female friends to be treated, for example, by a "woman doctor who does abortions with an injection", as if in search of a miracle treatment which turned out to be illusory. When they saw a doctor, they were usually quite sure they were pregnant and wanted a medical check-up. At that stage, they had usually made up their minds about having an abortion.^c In the cases we learned of, the reaction of the doctor seems to have been neutral. Neither did he offer short-term social aid, nor did he try to influence the patient through moral arguments, whether positive or negative.

The doctors seldom referred their foreign patients to a "Sozialberatungsstelle".^d As a rule, the Turkish women seem to have been satisfied with their medical treatment. They did not expect advice so much as an acceptance of their decision. According to our survey, it did not take the Turkish women longer than German women to state their intentions.

^a See also: Ausländerinnen in Hamburg. Gesundheitswissen und Gesundheitsverhalten. Hamburg, 1981, pp. 80ff.

^b A social advisory agency specific to Berlin (West).

^c According to the replies to the questionnaire (N = 380) in the previously mentioned report, 85% of the German women had made a preliminary decision (see: Materialien zum Bericht, Bd. 92/3, 1982, pp. 43 and 163).

^d Regarding conditions under which doctors may carry out social counselling along with the confirmation of pregnancy, see: Die Anerkennung von Ärzten als Berater. Bundestag: Wahlperiode 8/3630 (31.1.80), 1980, p. 30. (Drucksache des Deutschen Bundestages).

Table 10. Number of previous abortions of German and Turkish clients seeking an abortion

Number of abortions	Number of German women	Number of Turkish women
0	35 (73%)	13 (45%)
1	8 (17%)	9 (31%)
2	2 (4%)	3 (10%)
3	-	2 (7%)
4	-	-
5	-	1 (3.5%)
No data	3 (6%)	1 (3.5%)
Total	48 (100%)	29 (100%)

5.2.6 Hospitalization

Many foreign patients are referred to hospital by the doctor who confirmed the pregnancy. However, they may also be referred by the social agency they last visited. The women we interviewed all went to the hospital in their district and almost half of them knew the hospital from prior deliveries. Those who had good experiences during their previous hospital stay were less afraid, but even those who did not know the hospital or who had received negative reports of it from friends still went there because of its proximity.

It is striking that the women never allowed themselves any time to think the matter over before contacting the clinic. As soon as they received the authorization on social grounds, they called up the hospital and asked for admission, obviously in the hope that the "last hurdle" was now behind them: "Finally I got in, at ten in the morning. I had taken all my things along, thinking they would keep me there. The nurse downstairs had recorded everything, telephone number, address, everything. Then more and more Turkish women arrived. It got very crowded."

The patients were not only afraid of the anaesthetic and the operation; they were also intimidated by the hospital bureaucracy with its complicated system of controls, reports and records. Solidarity between patients is one way of dealing with the situation and regaining a sense of calm and is the norm among migrant women: "After a while, other Turkish women arrived. We were all afraid and talked a lot - about earlier pregnancies, abortions and also sterilization. Some wanted to be sterilized, as they felt they could not stand any more."

Where hospitals do not employ interpreters, the patients consider it necessary to bring along a family member to translate for them - a sometimes unreasonable demand under the circumstances: "She (the eldest daughter) came into the hospital with me and stayed with me. When I came out of the doctor's office she said: 'Mummy, I think there's a baby in your tummy and you want it taken out.' I said: 'Yes, that's right.' Then she was quiet."

The long waiting period between registration and admission is often a problem.^a On the one hand, it increases stress before the operation; on the other, medical records show a higher rate of complications between the eighth and twelfth weeks of pregnancy. In retrospect, the patients were generally relieved that the operation was carried out under narcosis ("I couldn't believe it was over") and in most cases they were satisfied with the care they got from the nurses. They also appreciated the fact that their eating habits were respected. Finally, it is a sad truth borne out by doctor's observations that German women receive far less attention from their families than Turkish women, although abortion is certainly no less of a taboo in Turkey than in the Federal Republic.

^a Two thirds of the patients who were interviewed had to wait for between one and 14 days, which seems a longer delay than normal. According to the Materialien zum Bericht, 33.8% of patients waited one to three days, 35.5% four to eight days and only 9.3% for longer (see: Materialien zum Bericht, Bd. 92/3, 1982, p. 85).

5.2.7 Introduction of birth control following the operation

Women who have undergone an abortion are under strong social pressure to return to normal life after the operation. This pressure seems to be particularly strong in underprivileged groups. Turkish women, for example, try to leave the hospital as soon as possible in order to resume their family responsibilities, e.g. when they have small children and no one to look after them. Once they are out, they often return to their work immediately for fear that their absence might arouse suspicion among co-workers or cause them to lose their jobs - a fear which often turns out to be justified.

It goes without saying that health problems are often the result of such demands.

Some of the postoperational complications reported by the women are horrifying: "This abortion was terrible. I think I would rather have ten children than go through it again. Three days after the abortion I went home - after signing a discharge form. When I left the hospital, they told me I was leaving at my own risk and that if anything happened they would not be responsible. That was Saturday. On Monday I went back to work. Then it started: I haemorrhaged for three months. Sometimes it was so strong that I couldn't stand up. Everything under me was soaked with blood. I felt weak and barely conscious, and had constant abdominal pain. But I knew it would be over eventually and then suddenly after three months, from one day to the next, the bleeding stopped."

The rate of postoperational complications is very difficult to determine because many women are reluctant to return to the same hospital and hence the records do not allow a reliable assessment. Furthermore, psychological effects, such as vaginismus, indicating a disruption within a relationship, are often not perceived as the women rarely seek counselling for such reasons; they prefer to talk about such problems with other women in their social group.

What changes in attitudes to family planning occur after an abortion? Abortion is not necessarily, as one might like to imagine, a good opportunity to learn about modern methods of contraception; in any case, these will always be promoted by industry.

It seems that discontinuity in family planning is a fact we have to live with - that is, if we do not want to make our psychosexual needs conform to a rigid pattern.

Despite the emotional reaction of the interviewees reflected in the clear response of "Never again", whereby abortion is seen as a "once in a lifetime" emergency solution, different attitudes certainly emerge with time.

Families in which the decision for abortion was taken by mutual agreement have an easier time with the question of subsequent birth control. Women enmeshed in controversial or ambivalent decisions are at a greater risk of undesired pregnancy (women with postoperational complications do not necessarily belong to this group). For them, problems that existed before the abortion, such as difficulty in taking a decision, insufficient counselling by the doctor, inner ambivalences, unfavourable circumstances, burdensome household responsibilities and physical and psychological barriers to contacting a doctor, all contribute to prolonging the risk.

In other words, abortion is a favourable factor in modifying family planning behaviour under certain conditions. A great many other factors are also involved. This applies particularly to the desire for another child.

6. Services for migrants

6.1 Introductory remarks

Despite the growing criticism about traditional health care institutions, it is still to doctors and hospitals that most people turn when they have a health problem and not to other health care providers. This also applies to migrants.

One study in Brussels, for instance, found that the foreign community normally attended some institutions rather than others, their choice being based on the criteria of geographical proximity and the public status of the institution: "Apart from the concentration in some institutions, some services like paediatrics, gynaecology and obstetrics are attended by a larger proportion of foreigners. This is due to the relatively larger numbers of children and women of child-bearing age, to the high fertility of some ethnic groups like Turkish and Moroccan women, and to the difficulty in relying on other members of the family to look after children when the mother is ..

employed, since the extended family still lives in the home country in most cases; and there is no adequate infrastructure to fill this gap. It must also be recognized that hospitals have done nothing to remedy this situation either."^a

Grottian^b has reported on another aspect of the use of health services by migrants. Preliminary results of an ongoing research project on the health and living conditions of Turkish migrant women showed that all 80 women questioned were or had been under medical treatment. Originally, it was assumed that migrant women who worked outside the home would tend to seek more specialized services because they had more social contacts and access to information. Surprisingly, all 80 women, irrespective of age, duration of stay, education, rural or urban background or density of doctors in the area, had in fact attended general health care institutions.

6.2 Hospitals

The private or state hospital is the symbol of modern western medicine. Its use of technology is impressive. It is accessible at any time (on-call services). Any condition, however serious, can be treated. Yet in many cases there are no proper arrangements for reception of the patients. Doctors have little time for their patients, who neither receive nor are allowed to give explanations. Successive examinations are often carried out by different staff.

These conditions do not promote the development of a stable doctor-patient relationship. Of course, there are exceptions; some services have made special efforts to improve their reception arrangements and give greater access to the health care personnel, while others employ official interpreters.

6.3 Family planning clinics

As migrants gain experience of the new country, their attitudes change and their approach becomes more diversified; they attend different institutions, depending on their complaints (illness) and expectations (what they think the institution can do). They may, for instance, attend specialized centres (family planning, antenatal or infant clinics), which are smaller and where the reception is more friendly and personal, or go to a private surgery. They go to hospital only in an emergency or when the examination requires sophisticated equipment.

This approach calls for greater integration in the local community. It implies that the migrant family knows where to go, that it is familiar with the neighbourhood and commune, and that it has given thought to the need to make appointments.

The family must be sufficiently self-confident to break out of the refuge of anonymity and establish a relationship with health workers that is no longer purely functional. This choice also implies calling the omnipotence of medical technology into question.

A study by Marques-Balsa/Martoms-Boudru showed a significant difference in this respect between the now well-established Spanish and Italian communities and the more recent Moroccan and Turkish migrants.

Finally, there is yet another approach which is sometimes taken simultaneously: when hospital treatment has proved ineffective, some migrants turn to traditional medicine, which is practised in all large European cities.

Let us now examine in detail the results of the Josaphat family planning clinic survey with regard to the attitudes of clients to the health services.

What did they find at the clinic?

- A warm, friendly atmosphere.
- Information about the problems they may have, and ways of solving them.
- An opportunity to ask questions, and time to give their views.

^a Marques-Balsa, C. & Martins-Boudru, F. Besoins et aspirations des familles étrangères établies en Belgique, Vol. 2. Brussels, Services du Premier Ministre, 1978 (Programmation de la politique scientifique).

^b Grottian, G. Einige Aspekte zu Gesundheit und Lebensverhältnissen türkischer Frauen in Berlin (West). In: Geiger & Hamburger, ed. Krankheit in der Fremde. Berlin (West), Express Edition, 1984, p. 42 (Materialien zur Gesundheitsarbeit).

What brought them to the clinic?

- Hearsay information.
- A favourable report by a sister or friend.
- A clear, deliberate choice, which was as much a rejection of the hospital as a decision in favour of the centre (in the case of women with higher education).
- Advice by a local general practitioner.
- Knowledge gained from an information meeting.

What led them to seek assistance?

- Pregnancy, contraception, gynaecological check-up (younger women).
- Specific problems (older women).

How did they regard the hospital?

- 21 women out of 23 took a negative view.
- 2 women felt more secure at hospital than at the clinic.

The women gave different explanations for their rejection of the hospital:

- the premises are less hospitable;
- the reception is often cold and impersonal;
- they have to wait a long time;
- they do not understand what the doctors say;
- too many blood samples are taken;
- they are examined by several doctors;
- the doctors do not listen to them.

However, they still go to hospital occasionally: "I would feel lost anywhere else; I know the place as I often go there with my children; you can go there at any time and even if you have to wait, you'll still get treatment."

Thus, the rejection of hospital results from a lack of communication with the personnel, mutual incomprehension, and a feeling of humiliation.

One woman said about her delivery: "I had the impression of being quite alone, no one around me said anything, I felt less pain when I gave birth in Morocco."

The women's wishes

Although the women were satisfied with the services given by the clinic, they would have liked the reassurance of arrangements for rapid and direct transfer from the clinic to the hospital if necessary for delivery, miscarriage or surgery, (at the clinic, the gynaecologist and the physiotherapists were responsible for liaison with the hospital).

6.4 Counselling with an interpreter

6.4.1 Official interpreters

Migrants frequently live and work in countries whose language they did not speak before their arrival.

Language barriers are a major obstacle to integration of migrants, especially in countries with very few specialized services for them.

Inability to speak the language of the host country may also be a health risk in itself, since it not only hinders access to health services but makes it impossible to obtain necessary information.

Health care institutions deal with the language difficulties of migrants in different ways. They may ignore them, try to get round them by hiring foreign health professionals, or work with interpreters.

The employment of official interpreters, however, may itself give rise to problems. The form and content of counselling interviews necessarily change. The traditional professional/client relationship is broadened by the participation of a third person who has to effect the communication between the other two.

Experience has shown that for work with interpreters to be effective, they must not only possess medical and psychosocial skills but also be allowed to take part in the counselling process. This implies a change from a purely technical role to one of "cultural mediator".

Health professionals sometimes mention difficulties in working with interpreters. In this respect, mention may be made of the "power relationship", which is an aspect that is often overlooked in considering work with interpreters. If it is not taken into account, the counselling may not achieve its purpose, which is to improve communication and the wellbeing of the client.

Interpreters also have their criticisms of working with national counsellors. They have to follow instructions and are seldom allowed to contribute to the counselling in a personal way. They find this unacceptable as they often feel closer to their own people than to the national counsellor.

What matters is that the institutions of the host country should discuss and define the nature of migrant counselling and the cultural mediation role of the interpreter. The national counsellor and the interpreter are by no means equal partners. To start with, the interpreter is in most cases required to transmit the counsellor's instructions. The counsellor earns more than the interpreter and has access to the training provided by the institution. Finally, the counsellor has a higher professional status and income and better training and, ultimately, is in the home environment.

The objective inequality between the counsellor and the interpreter places the latter's criticisms in a different light. Each partner has a different perception of his/her role, and if they are unable to solve the conflict they engage in a "power game". The power of the interpreter derives from knowledge of the language and "complicity" with the clients. Conflicts are more likely to arise when roles are not clearly defined, and in any case the victim is always the client.

The client caught up in this triangular situation has to cope with different forms of authority. During the counselling process she is confronted by:

- the socially and institutionally based power relationship between the national and the migrant population, which is to the detriment of the latter;
- the power relationship between the counsellor and the interpreter, which aggravates the existing imbalance;
- the power of the majority culture, which leads the migrant to place less value on his/her own culture.

Migrant clients must also be able to speak to others about their personal problems, which is something they are not accustomed to. Different cultures have different ways of dealing with intimate matters. In the West, socialization often generates a need for bilateral interaction (as with the concept of the mother-child dyad in psychoanalysis). In the triangular counselling situation, this may provoke a conflict between the two professionals and the client, who endeavour to win over one or the other. In the power game, there is an inequality between the two professionals on the one hand and between them and the client on the other. The counsellor has a higher professional status than the interpreter, while it is the client who is seeking the support of both. Whoever of the three has the stronger need for dyadic interaction will try to influence the situation to his/her own advantage.

The three levels of communication involved - implying different perceptions, meanings and feelings - complicate matters still further. One of the most important and difficult tasks for the interpreter is to mediate between the counsellor and the client at the level both of language and of nonverbal communication.

There is no doubt that contacts are easier and more effective when two people are sitting face to face in a situation of dialogue.

If we wish to define the objectives and content of migrant counselling as well as the respective roles of the counsellor and the interpreter, we must accept that:

- there is a more or less concealed power relationship in any migrant work;
- the role of the interpreter is to a large extent determined by the institutions of the host country;
- it is not possible for migrants themselves to participate in this process effectively, as a basis of equality does not exist.

To gain a better understanding of what constitutes "good" migrant counselling, we should consider the respective motivations of counsellors and interpreters. Why does the counsellor want to work with migrants? Why does the interpreter want to effect cultural mediation? The key question is: what do we understand as normal behaviour in this intercultural process?

Counselling with interpreters is a complicated procedure calling for a high level of competence on the part of both professionals. In view of the difficulties involved, there is no doubt that counselling by a counsellor from the home country of the migrant client is always preferable to the unequal and professionally and socially hierarchical triangular situation of counsellor, interpreter and client.

Working with interpreters may be effective in dealing with serious problems, but it does not encourage migrants to overcome the language barriers with which they have to contend in addition to socioeconomic barriers.

6.4.2 "Spontaneous interpreters"

The presence of an official interpreter can have some disadvantages. The interpreter is a person whom the client does not necessarily know, but who comes from the same country and sometimes from the same region. His/her presence may discourage the client from expressing personal feelings and aspirations if this is not customary in that particular culture. Also, a client may not always be able to place the interpreter socially, and this can cause problems of trust.

Moreover, the presence of the interpreter does not encourage the client to break through her reserve in order to explain what she wants: she has to express herself through somebody else.

Migrants often come to the clinic with interpreters they have chosen themselves: children, other members of the family or friends. We refer to them as "spontaneous interpreters".

The spontaneous interpreter can help the client to express herself more freely but sometimes can also be an obstacle. Migrant women often find it difficult and may even be ashamed to talk about family planning and sexuality in front of their children or to be examined with their husbands present. Health personnel should give encouragement to spontaneous interpreters, while bearing in mind the potential difficulties.

6.5 Extramural approaches

6.5.1 Domiciliary services

Domiciliary services are a long established practice in the health system, especially in such areas as care of the elderly. Domiciliary family planning services were first tested in the United Kingdom among Asian migrants.

Elphis Christopher, a doctor with great experience of domiciliary family planning services for migrant women of different nationalities in London, suggested in her book Sexuality and birth control in social and community work (1980) that this approach is acceptable for providing advice to women who are too embarrassed and modest to attend a clinic or go to a general practitioner.^a

Domiciliary services must be distinguished from "community-based distribution" (CBD) programmes which have mainly been set up in developing countries. They are designed to reach as many women as possible by distributing contraceptive methods at home. Counselling in the broader sense, i.e. not only about contraception but also about psychosexual problems, is of secondary importance in these programmes.

^a Freedman, P. Family planning services for ethnic minorities in the United Kingdom. In: Migrants and planned parenthood. London, IPPF Europe, 1984, p. 51.

A project on domiciliary services for migrant women in Berlin (West),^a aimed at counselling small groups of women in the home on family planning, pregnancy, partnership and sexuality, has explored the potential and limitations of this approach. From the findings to date, it seems that the only way to reach a group of migrant women is to designate a "key person" among the group who will agree to invite the other women, the national counsellor and the interpreter to her home. In this situation, it is essential that the counselling team accept their position as guests.

The project has also shown that the needs for family planning and abortion counselling are not the first concern for the women. Health workers must be prepared to address problems of accommodation and employment which have much higher priority.

The ideal situation would be if a migrant woman who is able to deal with medical as well as social problems could carry out the home visits. Nevertheless, they can be done quite acceptably by a national counsellor together with an interpreter; this approach is more realistic. The interpreters in the Berlin (West) project, for instance, do not only translate but also assist in the counselling. Counsellors must have many years of experience of working with migrants, being either social workers with a knowledge of the medical aspects of family planning or physicians with sufficient competence in social work. It is not necessary to be a high-level specialist. What is much more important is to be able to guide migrant women through the maze of family planning clinics, doctors' surgeries, social welfare agencies, government departments, etc.

Home visits require a great deal of time and energy, but they do make it possible to take account of the conditions in which the clients work and live as well as the interaction between the family members. Provided the domiciliary service is based on voluntary participation, it can be an effective complement to the work of a family planning clinic.

Although domiciliary services are appreciated by migrant women, they nevertheless pose an ethical problem. They represent an intrusion into family life, and it is significant that no thought has ever been given to extending them to middle-class women. Health and social workers seem to assess the need for privacy according to social class, i.e. the lower the class, the lower the professional barrier to intrusion.

6.5.2 Women's groups

What emerges from numerous contacts with migrant women is their need/wish for self-expression and information. Their traditional family network has been destroyed by migration to some extent, and they need to find a substitute for it.

Migrant women often live withdrawn from society in a world of their own, a woman's world in which, like other women, they are responsible for the health and wellbeing of the family. Migration changes the daily life of migrant women, particularly in that their expertise in health matters and traditional practices is constantly being called in question and devalued by the health system of the host country.

Everywhere there are migrant associations that organize cultural activities, language courses or health education groups. In these settings of self-expression and communication, the women learn to assert their identity as women, as mothers and as workers.

If a migrant woman is to be in a position to make a decision on family planning which corresponds to her real wishes, she must be well informed and have access to a place where she can think and express herself in an atmosphere free from prejudice and fear.

It is important to know the places where group activities are carried out in one's district and the sections of the community they are directed to. Health workers and teachers should work hand in hand with the groups and give them technical support.

The following are examples of group activities:

- a Moroccan young women's group in Brussels, in which they feel secure and are able to discuss their problems freely and try to solve them together;

^a Dietzmann, B. et al. Familienplanungsberatung bei türkischen Frauen in ihrer Wohnung. Jahresbericht 1981 zum Modellprojekt Familienplanungsberatung bei Ausländern. Frankfurt-am-Main, PRO FAMILIA Bundesverband, 1981.

- groups set up by migrant associations to provide health education and social training for the unemployed, in conjunction with family planning clinics;
- "open house" sessions at family planning clinics where migrant women can take their children and meet other women.

6.6 Needs of migrant men

The traditional image of the helpless migrant woman goes together with that of the authoritarian husband who is only interested in proving his virility. Both surveys gave contradicting pictures of the behaviour of migrant men in relation to family planning and abortion. Some accompany their wives to the clinic and support them in their decision-making, as shown in the Berlin (West) survey. If there is dialogue between the two partners, the choice of a contraceptive method is much less of a problem. On the other hand, there is also evidence that migrant women feel uncomfortable in the presence of their husbands, possibly seeing this as a form of social control.

Migration changes not only women, but also men. The men realize that they are no longer the sole providers of the family income. Their status is diminished. Their self-image as men is called into question, their relationship with their wives and children is altered.

Health services should also give migrant men an opportunity to express their wishes and needs concerning family planning. As the process of individualization of the family has not gone so far in certain migrant groups as in western European societies, it is important that the health services help migrant clients to solve their problems within the family context. For this reason, partner and family counselling can be useful.

Last but not least, the situation of migrant men is not so different from that of the men in the host countries. Their choice of contraceptive methods is limited and both will be affected by future changes in sex roles.

7. Conclusions and recommendations

In this part of our report, we shall refer to the findings of the surveys in Belgium and the Federal Republic of Germany and to our general analysis of the migrant situation. We hope our recommendations will be a source of support and inspiration, especially to those health workers who actually deal with migrants, frequently without adequate funds, training and institutional support, e.g. in overcoming language difficulties.

7.1 General conclusions

First of all, migration is not a new phenomenon. Throughout history people have migrated for various reasons, whether social, economic or political. Migration will continue, and health services must therefore be prepared to continue working with migrants. Programmes, too, should take this multinational dimension into account from the outset.

At a time of great demographic change in Europe (low birth rates, increases in the proportion of the elderly, etc.), we have to be concerned about the political aspect of the migrant issue, especially where family planning and sexuality are concerned.

Instead of categorizing migrants in terms of shortcomings, we should recognize that they carry with them the potential of their own rapidly changing societies and bear in mind that they differ not only from one group to another but also individually.

"The first problem of the migrant is insecurity, stemming from discrimination, legislation biased towards the native, language inability, etc. Most migrant groups tend to be economically and socially disadvantaged; their basic needs are not fulfilled. Hence family planning is not a high priority. Much migrant work often deals with the consequences of their basic insecurity. Personnel working with migrants should be aware of their limitations in imparting information, but should also realize that other needs outside the scope of family planning might be expressed."^a

^a Migrants and planned parenthood. London, IPPF Europe, 1984, p. 88.

Migrant work is a complicated process as it strongly influences one's cultural identity. Originally it was "merely performed". Now it is admitted that there has often been a tendency to try to achieve maximum safety margins in migrant work: no aspect should be neglected, no mistakes made. This overprotective approach, in the tradition of health and social work, leads the professional to view the client's problems in terms of helplessness and dependency, and to respond in terms of welfare. This search for security is, however, no more than a reflection of one's own predicament and need for certainties. Only one thing seems to be certain - the foreign has to be brought under control.

The search for security is also manifested at the theoretical level. A vast amount has been written on migrants in an attempt to cover the subject exhaustively. Migrants have been documented, studied and frequently reduced to stereotypes. This profusion of literature stems, among other things, from our own cultural insecurity and the fact that social issues are now fashionable. However, one key element of control is missing: the migrants themselves. Studies on migrants are rarely seen by migrants. Yet this control is essential in order to prevent clichés from being accepted as the "truth", which is then taken as an unchallenged basis for work with migrants.

The clichés include:

- that of the helpless, isolated, ill informed migrant woman, coming from an underdeveloped region and unable to read or write;
- that of the greater frequency of disease among migrants.

Working with migrants heightens our practical as well as theoretical awareness and leads us to question our own cultural identity. There is, however, a danger in trying to adjust totally to an alien culture, to understand fully, to "overadapt". Uncritical adoption of another's culture results in the loss of one's own identity.

The field of migrant study and work has been invaded by specialists on housing and migration, health and migration, women and migration, etc., and this fragmentation makes it impossible to take a holistic view of the problem.

There is certainly a need to promote:

- comparative research on migrants' needs in relation to family planning and sexuality;
- training for all the professionals involved;
- the provision of larger numbers of more adequate and accessible services for migrants, which take due account of their life situation;
- better cooperation among the different health care providers (doctors, hospitals, family planning clinics);
- greater social and economic security for migrants, so that they are able to have the number of children they want.

7.2 Research

The following research is needed:

- comparative studies on health, family planning and sexuality among migrant women and women in the host countries;
- research on the causes of the apparently larger number of miscarriages among migrant women, as well as complications during delivery and after abortion;
- research on the somatic and sociocultural aspects of the side effects of the pill among migrant women;
- surveys on migrant women's perceptions and experiences of the western health system in specific situations, such as delivery, miscarriage, abortion and surgery;
- studies on the attitudes of health personnel working with migrant women and men;

- research on generation conflicts within migrant families in relation to family planning and sexuality;
- surveys on different groups of migrant men and their needs in relation to family planning and sexuality.

7.3 Training

All health personnel providing family planning services need training to enable them to deal with questions of sexuality, fertility regulation, sex roles, partnership, and the socioeconomic context of family planning. Family planning counsellors working with migrants should receive additional training which takes account of the fact that they have to cope with language difficulties, unfamiliar family planning practice, and other health values. The confrontation between different cultures often gives rise to a sense of insecurity, and it is therefore essential that health personnel examine their attitudes towards their own and foreign cultures.

The training should also enable the counsellors to live and work with different cultures rather than trying to harmonize them at any cost.

As national health personnel will continue to work with interpreters, the training should take account of the difficulties involved in a triangular counselling situation and cover such aspects as:

- the function and role of the interpreter in the communication process;
- different models of working with interpreters (technical, cultural mediation and advocacy);
- attitudes of health professionals towards a third person in the counselling process;
- the dynamics of a culturally differentiated three-person counselling situation;
- the status of the interpreter in the counselling process.

It is advisable to train national counsellors and interpreters first separately, then together. The separate training should focus on the specific professional functions, and the joint preparation on cooperation and communication between the counsellor, the interpreter and the client.

Family planning services should offer short courses on the sociocultural aspects of family planning and sexuality to general practitioners, gynaecologists, nurses, social workers and teachers.

In the training, migration should be seen as a dynamic process in which the migrants change and new risk groups emerge, e.g. illegal migrants.

7.4 Information - education - communication (IEC) material

Both surveys showed a lack of information on certain aspects of family planning. When producing IEC material to make good this deficit, it must be borne in mind that in some migrant groups the proportion of illiterates remains higher than among nationals, and hence different types of material are required.

IEC material, either written or audiovisual, should be developed on:

- the main aspects of fertility regulation;
- the different institutions offering family planning services, e.g. in the form of a guide;
- the legal aspects of family planning in the host country;
- family planning counselling: what can be asked and expected of health personnel.

Use should also be made of the existing media resources for migrants, such as television and radio programmes, and magazines.

Family planning associations in the migrants' home countries may serve as an initial source of IEC material which can be used until the services in the host country have developed their own material, e.g. on the legal aspects of family planning (abortion, sterilization, etc.).

The production and translation of IEC material for migrants should be a joint undertaking by representatives of national services and migrant groups.

7.5 Services

- (1) The process of migration evolves in different stages, and it is assumed that migrants' attitudes towards health care alter accordingly. In some cases, migrant-specific services may be appropriate, but normally an integrated health system should be established, providing care to both nationals and migrants.
- (2) The form of health services is generally decided by the host country, and hence they do not take sufficient account of the health needs of migrants. It is necessary to involve representatives of all the ethnic groups in the country in the decision-making.
- (3) Health services are less accessible to migrants because of language barriers, segregation in housing and schooling, "over-occupation" (two or three jobs at the same time) and different health values.

Health services should be made more accessible by:

- employing more official interpreters;
 - instructing national personnel in the basic terminology of family planning, in the language of the migrant clients;
 - reorganizing counselling services into communication and information settings where migrants as well as nationals can familiarize themselves with the health care system through audiovisual material and personal information;
 - arranging flexible opening hours that take account of the working and life situation of migrants;
 - making health care financially accessible.
- (4) Ideally, the health services should employ personnel from the home countries of the migrants. However, as this is rarely the case, health services should have interpreters available whenever necessary and the latter should be trained in counselling work if they have the ability and so wish.

District or regional interpretation services should be established to provide interpreters to institutions that are unable to arrange their own service.
 - (5) Sometimes migrants choose their own interpreters, such as the husband or a child. These "spontaneous interpreters" can give considerable subjective support to the client while at the same time inhibiting her from expressing herself. Health personnel should not reject the participation of these spontaneous interpreters but must be aware of its possible impact on the family relationship.
 - (6) Health services should offer both migrant and national clients a choice of male or female personnel.
 - (7) It may be useful to develop extramural activities in certain cases, e.g.:
 - domiciliary services;
 - health education;
 - information sessions at migrant cultural centres.

Participation in such activities should be completely voluntary.

The formation of women's groups should be encouraged. Health personnel should give them technical assistance if requested, but they must remain informal and independent.

- (8) There should be easy and direct communication between different institutions, such as hospitals, family planning clinics, antenatal clinics and social welfare agencies, since health may not always be the first priority for clients. At the local level, representatives of the institutions could arrange regular meetings.

7.6 First contact with new clients

Health workers dealing with migrant clients for the first time should bear the following points in mind.

- They are not alone in encountering difficulties and being handicapped by a lack of information. Much work is being done in this field. They do not need to start from scratch. They only have to identify the existing expertise and information.
- The first experts to consult on these questions are the migrants themselves. It is important to listen to them and call on their assistance if necessary.
- The local medical association can supply the names of registered foreign doctors if one is required.
- In countries with large numbers of migrants, trade unions usually have migrant representatives who can be contacted.
- The generally numerous migrant associations can give assistance in contacting migrant communities, in improving knowledge of their languages and cultures, and in supplying interpreters.
- Universities can be asked about the results of migrant research.
- Finally, information material may be obtained from family planning associations in the host or the migrants' home countries.

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