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## Diversity in sexual health: Problems and dilemmas

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### ABSTRACT

The increase in migrant populations in western Europe has led to specific problems and dilemmas in the area of sexual and reproductive health and service provision. In general, these problems and dilemmas can be divided into four categories: (1) epidemiology of diseases and risk factors; (2) psychosocial and cultural aspects; (3) communication; and (4) moral and ethical dilemmas.

Regarding epidemiology, there is an increased prevalence in migrant groups of unwanted pregnancy and abortion, HIV/STDs, and sexual violence. Effective contraceptive use is hampered by knowledge deficits, uncertain living conditions, ambivalence regarding the use of contraceptives, and problems accessing (information on) contraception. Psychosocial and cultural aspects relate to the norms and attitudes individuals and groups have regarding the family, social relationships, sexuality, and gender. These norms and attitudes have an impact on the sexual and reproductive choices people make and the possibilities and restrictions they feel in this respect. Problems in communication concern not only language but also communication styles, the way patients present their problems, and the expectations they have from the service provider. Communication problems inevitably lead to a lower quality of care. Moral and ethical dilemmas arise where cultures collide, for example regarding sexuality education and virginity problems. Two examples of practical situations in which migrant patients ask for help with sexual or reproductive health problems will be described.

### INTRODUCTION

In all western European countries, the percentage of immigrants in the population is growing. This is specifically visible in the large cities, where sometimes 25–40% of inhabitants are immigrants. The growing diversity of the population leads to specific problems and dilemmas in the area of sexual and reproductive health and service provision. In this article, these problems and dilemmas are illustrated with examples from the Netherlands.

Diversity means more than ‘coming from different countries’. Specific groups differ with respect to their cultural background, religion, migration history, degree of acculturation, present living conditions, educational level, and legal status. Each of these factors can have an impact on the sexual and reproductive status of the men and women involved. Immigrants come from different regions and countries, some have already been in western Europe for two or three generations, while others are more recent and less well

integrated in society. Refugees and asylum-seekers have specific problems, living in uncertain conditions and sometimes being traumatized before or during their flight.

## PROBLEMS AND DILEMMAS

In general, the problems and dilemmas around sexual and reproductive health can be divided into four categories: (1) epidemiology of diseases and risk factors in specific populations; (2) psychosocial and cultural aspects; (3) communication; and (4) moral and ethical dilemmas.

### Epidemiology of diseases and risk factors in specific populations

Regarding epidemiology, there is an increased prevalence in migrant groups of unwanted pregnancy and abortion, HIV/STDs, and sexual violence. In the Netherlands, the abortion rates for immigrant women are four to 13 times higher than for Dutch-born women[1][2] (see Table 1).

#### [TABLE 1]

The main reason for this difference is ineffective contraceptive behavior. Effective contraceptive use is hampered by several factors[3]. Knowledge deficits regarding the Dutch language, contraceptive methods, or the female body have a negative impact on the quality of contraceptive use. In particular, many common mistakes in the use of the contraceptive pill are the result of lacking or incomplete knowledge. Health care providers should therefore take extra time during a consultation to explain in detail how the contraceptive pill should be used and, if necessary, make use of specially developed brochures in foreign languages or a translator to make sure the instruction is understood. Another factor negatively influencing the quality of contraceptive behavior is ambivalence regarding sexuality and the use of contraceptives. Sexuality before marriage is forbidden for Islamic girls, which makes it virtually impossible to plan for it and buy or use contraceptives in advance. In Caribbean and African cultures, fertility and motherhood are highly regarded, which can influence the motivation to use contraceptives.

Partner relationship factors also influence contraceptive behavior. For example, some Caribbean women, whose sexual relationships can be characterized as infrequent ('visiting relationships'), take the pill only when they have sex, or they stop using the pill as soon as their partner(s) leave. Inequality in a partner relationship (because of financial dependence or traditional norms regarding gender and sexuality) negatively influence the negotiation process between partners over contraceptive use.

Uncertain living conditions are especially relevant for refugees and asylum-seekers. Most of their energy is concentrated on primary living aspects, and the future is insecure.

The last aspect that negatively influences contraceptive use are problems accessing information on contraception or contraception itself. Some women are not aware of how the health system works, they might be afraid to go to a doctor and talk openly about sexuality with them, or they may not have the money to pay for contraceptives. Some may be unable to read or write, and do not speak the language of the country in which they are living. For these reasons, they might not use contraceptives or might rely on more traditional methods.

These factors have an impact not only on the quality of contraceptive behavior but also on the quality of prevention from HIV/AIDS and STDs. Condom use and negotiating safe sex practices are more difficult to put into practice for most immigrant men and women, and prevention campaigns seem to have less impact on them. In the Netherlands, the percentage of new HIV diagnoses concerning migrants is continuously rising[4], mostly because the percentage of Dutch-born men and women is diminishing (see Table 2).

#### [TABLE 2]

The incidence of gonorrhoea and *Chlamydia trachomatis* in the Caribbean population is also rising[4], which is due to a combination of their sexual lifestyle and ineffective or absent condom use.

With regard to epidemiology, sexual violence is the most difficult topic. Few studies dare to address this issue, and even then, the figures might be an under-representation of the actual situation. Studies with refugees and asylum-seekers show high percentages of sexual violence: 22% of minor refugee girls have

had a sexual-violence experience[5]. It is not known whether this experience happened before, during, or after the flight from their home country.

### **Psychosocial and cultural aspects**

The second category that causes problems and dilemmas is conflicting psychosocial and cultural aspects. These aspects relate to the norms and attitudes individuals and groups have regarding the family, social relationships, sexuality, and gender. These norms and attitudes have an impact on the sexual and reproductive choices people make, and the possibilities and restrictions they feel in this respect. In this article, two examples will be described: the impact of norms and values regarding virginity and regarding homosexuality.

In theory, sexual abstinence until marriage is equally important for Islamic girls as it is for Islamic boys. In practice, however, there is a double standard. Girls have to guard their virginity, while boys are allowed to be sexually active. Though virginity at marriage is crucial for Islamic girls, growing up in a western, sexually liberal culture makes it sometimes very difficult to comply with this norm.

In a survey study on youth sexuality[6], around 10% of 12–19-year-old Turkish and Moroccan girls were reported to have had sexual intercourse. In the older age groups, the percentages may be even higher. While some of the girls are pressured or forced to have sex, most have sexual contact voluntarily. They feel and act in a similar way to their Dutch peers, but when they grow older, and the age of marriage is nearing, they start to feel less confident. Three quarters of sexually active Islamic girls develop problems in dealing with sexuality and virginity[7]. They experience a dilemma between the traditional Islamic norms and values regarding sexuality, and the more permissive Dutch norms and values. This dilemma may eventually result in many different requests for help from service providers, from information and a need for reassurance on the one hand to requests for ‘virginity certificates’ or even hymen reconstructions on the other (see Table 3).

### **[TABLE 3]**

The second example concerns homosexuality. There are differences in the definition and meaning of homosexuality in Islamic tradition and in western cultures[8]. In western cultures, homosexual behavior is defined as having sex with someone from the same gender as one's own. In Islamic cultures, however, there is a distinct difference between the partner who penetrates and the partner who receives. While the first is considered an active male, who does not lose his honour in the homosexual contact, the other is regarded as the passive, ‘female’ homosexual. For the latter, it is very shameful if his behavior becomes publicly known; this gives the ‘active’ partner more power and makes the ‘passive’ partner more vulnerable to abuse and humiliation. Furthermore, Islamic tradition requires living according to the rules of the Koran, which, among others, means marrying and having children. Whereas in western cultures, where individual choice and freedom are central themes, a homosexual lifestyle can be a good and acceptable alternative to married life, in Islamic cultures this means denouncing one's holy task as a man and rejecting the values of one's community.

Knowing the different definitions and meanings of homosexuality is important for western service providers, when confronted with problems in this respect. These problems can vary from identity and relationship problems to threats and violence from the community, and trauma resulting from such experiences.

### **Communication**

It is obvious that diversity can pose difficulties for adequate service provision, not only because the client and provider may have different norms and values regarding sexuality, or because sexual topics can have a different meaning in different cultures, but also because of communication problems. These problems concern not only language but also communication styles, the way patients present their problems, and the expectations they have from the service provider. Communication is one of the most significant factors in the perceived quality of care[9].

Language problems can be addressed by using professional interpreters/translators, either in person or by telephone. Service providers may also use specially made health or sexuality-education materials.

Communication styles may differ in the degree of openness and explicitness, especially in the area of sexuality. Furthermore, patients and providers may have a different 'clinical reality', different views on illness and health[10]. This also impacts on the way patients present their problems and their expectations of the service providers.

### **Moral and ethical dilemmas**

Moral and ethical dilemmas arise where cultures collide. Sexuality education in primary and secondary schools and some forms of health care provision, such as hymen reconstructions, can lead to problems and dilemmas for all concerned.

Sexuality education in primary and secondary education runs counter to the wishes and beliefs of many Islamic parents. Can they exclude their children from it, should the boys and the girls be divided, or should school sex education be abandoned at all? In western cultures, sexuality education is generally regarded as a common good, an acquisition of the 1960s and 1970s. But the open and explicit ways in which children and adolescents learn and talk about sexuality may be problematic for people from other cultures. Dividing boys from girls during sexuality education might be an option, but eventually it is desirable for boys and girls to learn to communicate with each other.

Virginity problems are another topic where an individual gynecologist or a department should address the ethical decision: Will we perform hymen reconstructions, thus contributing to the double standard that allows premarital sex for boys but not for girls, and to the myth of bleeding at first intercourse?

## **CASES OF MIGRANT PATIENTS WITH SEXUAL OR REPRODUCTIVE HEALTH PROBLEMS**

### **Virginity**

A Moroccan father accompanies his 17-year-old daughter, Fatima, to a female gynecologist. He is very concerned about the 'western' way in which she behaves and is afraid that she has had sexual intercourse with her 20-year-old boyfriend. He asks the gynecologist to do a physical examination to establish whether the girl is still a virgin.

The gynecologist can react to this request in several ways. She might refuse to do such an examination altogether, because she does not want to function as a 'controlling' instrument with respect to virginity or because she thinks such an examination has little reliability. She might also want to talk with the girl separately, to establish what the girl wants herself. She has to determine who her patient is (father or daughter) and what action is in the best interests of her patient. If the gynecologist consents to doing an examination, she might also decide to just 'declare' the girl a virgin, regardless of her actual sexual experience. Whatever the gynecologist does, she has to consider the consequences of her actions. She also has to choose a reaction that is in line with her personal and professional integrity.

### **Unwanted pregnancy**

A 32-year-old single Caribbean woman presents herself at an abortion clinic. She is 9 weeks pregnant and wants a termination of this pregnancy. She is the mother of three children (10, 6, and 4 years old). In the past 2 years, she has been to the clinic two times before for terminating an unplanned and unwanted pregnancy. Each time, the doctor has discussed with her future contraceptive behavior, but this does not seem to have had much influence on her actual behavior.

The doctor might feel frustration and even anger towards this woman. Nevertheless, he has to act professionally and provide her with optimal quality of care. Therefore, refusing the abortion cannot be an option. Prevention of future unwanted pregnancies should be the main focus of attention. More specifically, why did the previous counselling not have any effect on her behavior? One answer might be that the counselling was not tailored enough to the specific needs and situation of this patient. Communication with the woman about contraception should target the result (what method will she use in the future?), but also the problems, myths, questions, and difficulties regarding the use of contraceptive methods should be discussed.

## CONCLUSION

Diversity in western European societies leads to specific problems and dilemmas in the area of sexual and reproductive health and service provision. In general, these problems and dilemmas concern the epidemiology of unwanted pregnancy and abortion, HIV/AIDS and other sexually transmitted diseases, sexual violence, risk factors, psychosocial and cultural aspects, communication, and moral and ethical dilemmas.

These differences in sexual and reproductive health should be a concern to service providers, but also young immigrant girls and boys themselves face ethical problems and moral questions, as do their parents. Also, policy makers who have to make up general rules and regulations should cope with this diversity. Trying to find solutions to sexual health problems and dilemmas is therefore a general responsibility for all persons and organizations involved.

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## TABLES

Table 1 Abortion rates per 1000 women (15–44 years) in the Netherlands (2002/2003)

	2002	2003
Dutch-born	4.5	3.6
Surinam	25.9	31.4
Dutch Antilles	30.4	45.4
Turkey	9.2	14.5
Morocco	13.3	17.6

Table 2 Percentage of immigrants with new HIV diagnoses

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1982	9%
1991	20%
1997	29%
2000	40%

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Table 3 Virginitv problems

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Knowledge deficits  
Insecurity as to whether or not still virgin  
Requests for virginitv certificate  
Requests for hymen reconstruction  
(Loyalty) conflicts with parents/family  
Fear for wedding night  
Doubt as to whether to tell future husband  
Sexual problems  
Questions related to 'magic'

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