



HEALING THE WOUNDS OF WAR

Narratives of Women from Armed Conflict

March 2016





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Wezesha would like to acknowledge the financial support provided by
HSE- National Social Inclusion Office

Published by Wezesha

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Acknowledgements

This project was made possible through generous grants from the Health Service Executive National Social Inclusion Office. We would like to thank Diane Nurse and colleagues for their interest in this project. Wezesha would like to thank the 115 women from eight counties in Ireland who agreed to participate in focus group discussions. We would also like to thank Laois County Council that generously provided venue for focus group free of charge, Karen McHugh and Hannah Culkin of Doras Lumni for their help in mobilizing the women and supporting the focus group meeting in Laois, Ini Inga from Love for Care for People for mobilizing the women in Cork and organizing the venue, Toluwani Akaehomen for helping with the meeting in Kilkenny and all other individual women who helped or provided support for holding meetings in Waterford, Galway, Monaghan, Dublin and Mosney. We really appreciate your time and help.

Wezesha would also like to thank board members in particular Egide Dhala for his guidance and support during the time of the research, volunteers, and interns, especially Neegan Aghassibake and Fiona McCarthy from Dallas University USA for helping with this project, and all other volunteers who have been supporting the work of Wezesha since 2010. Finally we would like to thank Susan McKay for editing this report.

To all the migrant women who participated in this research, may your resilience and continuous persistence drive you to better futures and may you live to realize your full potential.

Executive Summary

In January 2015 Ireland launched its second National Action Plan on Women, Peace and Security 2015-2018 and committed under its third pillar to support the relief, recovery and rehabilitation of women affected by conflict on the island of Ireland, including women who have migrated to Ireland from conflict affected areas.

The HSE National Intercultural Health Strategy 2007-2012 also recognises that ethnic minorities have specific health needs and that appropriate intervention must be implemented to improve equality in health access and management. The health and wellbeing of refugee women coming from armed conflict zones can be identified within the framework of this strategy.

In March 2015, Wezesha launched a five year strategic plan that proposes under its third pillar to work on migration and development, involving the empowerment of African Diaspora, in particular women from armed conflict living in Ireland. Wezesha believes that by supporting the rehabilitation and integration of these women, they will be able to reconcile with issues arising from the conflicts that affected their lives, and thus negotiate a better life in Ireland.

The most recent statistics collected by the Central Statistics Office estimate that around 300,000 migrant women currently reside in Ireland¹. General trends indicate that a good number of those would have come from armed conflict zones and that there has been a recent rise in the number of applications coming from Syria². From 2000 up to 1 June 2015 1,198 vulnerable persons from 27 different countries, including Iraq and Syria, have been resettled in Ireland and 40 additional persons have been relocated from Malta³. The International Organization for Migration (IOM) estimates that more than **920,000** migrants arrived in Europe by sea between January and November 2015, thus creating an appalling refugee crisis in Europe. Member States are struggling with refugee resettlement. In 2015 Ireland committed to resettle 100 refugees from Syria and 120 in 2016.

The health and wellbeing of many refugee women, especially those who have come to Ireland under the resettlement programme, have been affected by conflict in their country of origin as well as in refugee camps in other countries where most of them lived for years before arriving in Ireland.

To establish the needs of these women, Wezesha set up 9 focus group discussions with one hundred and fifteen women in eight counties. It emerged that the majority of the women are living on the margin of the society; they are struggling with their past experience of trauma – especially women who experienced rape, loss of families and properties and they have lost self-esteem and self-worth. They are faced with challenges while trying to access health services due to language barriers. There is a lack of both accessible information and cultural competence among frontline services and healthcare professionals who have not received appropriate training in this sensitive area of work. The women reported that they feel isolated and have been consistently victims of racism and discrimination in Ireland. Some have poor literacy level and there is high risk of poverty. Despite these challenges most women expressed their gratitude and feeling of safety and security while living here in Ireland. Programme refugee women, in particular newly arrived Syrian women, highlighted and acknowledged the support given by the Office for the Promotion of Migrant Integration and by the support worker from an NGO. They highlighted that health services in Ireland are much better resourced and that doctors' approach toward them as people coming from conflict has been good.

The present report is a narrative of experiences of women from armed conflict - the first time such stories have been recorded.

Key recommendations:

- Training on cultural competence should be delivered to all front line and healthcare professionals in order to provide culturally appropriate services to women from war torn countries and armed conflict. This would include developing strategies of dealing with culturally sensitive health related issues that are viewed to be stigmatizing, such as mental health. Extra cautions should be taken, in particular the approach and the way healthcare professionals and front line services engage and deal with complex or gender specific issues that pertain to women from armed conflict.
- Community peer-led programmes should be established. This should be done by identifying and engaging migrants who have settled and integrated well in the Irish society. Such Community peer-led support programmes would act as a link between migrant women and service providers. They would also provide support, information and mentoring.
- Social inclusion strategies should be put in place to ensure that women from armed conflict are integrated in the society and that their social, economic and cultural needs are fully met.
- Information and cultural orientation should be provided to women from armed conflict in an accessible manner, using a language or a methodology that facilitate an easy learning and understanding.
- Support to access employment and work placement: Government should roll out already existing support for employment model – Employment for People from Immigrant Communities (EPIC) Nationwide.

1 CSO 2011.

2 ORAC 2013.

3 www.integration.ie



Glossary

Asylum seeker

An asylum seeker is a person who seeks to be recognised as a refugee under the terms of the 1951 Convention relating to the Status of Refugees as defined in Section 2 of the Refugee Act 1996, as amended. Under Section 2 of the Act, 1996, the legal definition of a refugee is a person who, "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his or her nationality and is unable or, owing to such fear, is unwilling to avail himself or herself of the protection of that country; or who, not having a nationality and being outside the country of his or her former habitual residence, is unable or, owing to such fear, is unwilling to return to it"

Refugee

A refugee is a person who fulfils the requirements of the definition of a refugee under the terms of the Geneva Convention relating to the status of refugees as defined in the Refugee Act, 1996, as amended and is granted refugee status.

Programme refugee

A programme refugee is a person who has been invited to Ireland under a Government decision in response to a humanitarian request, usually from the United Nations High Commissioner for Refugees (UNHCR), either for the purposes of temporary protection or resettlement.

Leave to remain

A person who does not fully meet the requirements of the definition of refugee under the terms of the Geneva Convention relating to the status of refugees as defined in the Refugee Act, 1996, may be granted leave to remain in the State for humanitarian or other compelling reasons. Leave to remain may also be granted to non-EU nationals who have been refused a declaration as a refugee.

Trauma

Trauma is an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives⁴.

4 www.apa.org/topics/trauma/

I. Introduction

1.1 Migration and Refugee Women

Although information on the international migration patterns of women is notoriously hard to pin down due to varying studies and statistics, it is generally accepted that women comprise about half of total global migrants, and they and their dependents make up the majority of global refugees. This group is well-documented to be more prone to trafficking as well as to various forms of physical, sexual, and psychological violence in their countries of origin, in transit and in their countries of destination. Coming from armed conflict zones increases this vulnerability exponentially, due to the higher incidences of violence in countries of origin and the trauma that such violence brings.

Women from armed conflict zones have specific issues due to both their previous experiences of violence and their heightened risk for continued trauma⁵. Many of these conflict areas present a high risk of Female Genital Mutilation (FGM), high rates of HIV/AIDS and other gender-specific issues that often follow these women to their countries of refuge. The higher vulnerability of this group also increases the likelihood of continued abuse and exploitation within their destination countries.

Global recognition of these problems as significant barriers to the health and wellbeing of refugee women has grown in recent years. The United Nations passed several resolutions in 2013 aimed at committing more resources to ending gender-based violence in conflict areas and giving more support to the women affected by it, and the European Commission on Humanitarian and Civil Protection – the humanitarian aid branch of the EU – also donated 71% of its annual budget to projects designed to help refugees as well as internally displaced persons⁶. However, the World is currently facing the worst refugee crisis since World War II, with an estimated 50 million people being forcibly displaced from their homes as of June 2015⁷. Continued conflicts in areas such as Syria and the Democratic Republic of Congo largely account for this staggering rise, and many industrialized countries have already committed to accepting more refugees from these war zones.

Now, more than ever, it is crucial to have structures in place in destination countries to protect and support this vulnerable group of refugees. As conflicts in the world worsen and the number of people seeking asylum rises, the risk of ill-health for migrant women from conflict zones escalates. Thus, it is important to engage in dialogue with these groups to construct a more accurate picture of the barriers that women face in recovering from their trauma and adjusting to a new life. This is not only to help them, but to provide support structures for the next influx of vulnerable women.

1.2 Migration and Feminization: The Irish Context

The most recent statistics collected by the Central Statistics Office estimate that around 300,000 migrant women currently reside in Ireland. General trends indicate that a good number of those would have come from armed conflict zones since a significant proportion of refugee women originate from these areas as evidenced by the high number of refugee applications from conflict-affected countries such as Nigeria, DR Congo and Zimbabwe received by the Office of the Refugee Applications Commissioner in 2013, and the recent rising number of applications from Syria.

Apart from asylum seekers landing in on its shore, Ireland has committed to resettle refugees under the UNHCR program, mostly people who have escaped from wars and conflicts in their countries and settled in UNHCR refugee camps in neighboring countries. From 2000 up to 1 June 2015 1,198 vulnerable persons from 27 different countries, including Iraq and Syria, have been resettled in Ireland and 40 additional persons have been relocated from Malta. Refugees have been resettled in 25 different communities throughout Ireland – Kilkenny, Carlow, Cavan, Monaghan town and Carrickmacross, Carrick-on-Shannon, Roscommon, Sligo, Ballina and Castlebar, Ennis, Limerick, Tralee, Cork, Thurles, Portlaoise, Tullamore, Waterford, Naas, Arklow and Mullingar - and in the four Dublin Local Authority areas.

Such a trend, as relatively new to the history of Ireland, may impact on its political and social landscape as to provoke a structural adjustment since it has been forcibly shifted from a homogenous to a multicultural society. With regard to the social inclusion, health and wellbeing of migrant women specifically, there are unexplored facets of the lives of women from armed conflict zones that need to be addressed⁸; also gender related issues on refugee women's health are so significant, especially on their reproductive and psychological health and require particular attention.

5 Human Security Report 2012.

6 ECHO Factsheet 2015.

7 Amnesty International Report 2015.

8 McGuinness 2013.



Research indicates that a significant number of refugee women who eventually arrive in Ireland have been victims of sexual abuse⁹. In 2012, 92% of asylum seekers and refugees who contacted one Rape Crisis Centre somewhere in Ireland were women, as compared to just 8% of men. And 93% of those who contacted that same RCC were from conflict-affected African States, with 23% of that population coming from the Democratic Republic of Congo or the Republic of Congo, 13% from Zimbabwe, and 12% from Nigeria¹⁰. Thus, the rates of sexual violence among African asylum seekers and refugees are higher than any other region of origin, raising the need for assistance to asylum seeking and refugee women from known conflict areas.

1.3 Refugee Women and Health

In Ireland, the management of healthcare for refugee women is primarily through government funded public services, with a number of NGOs funded to deliver specific services. However, while the women have the right to those vital health services, barriers in accessing them still remain a challenge for many, thus increasing the level of risk and leaving them vulnerable. Such issues have been also identified in other countries that accept women refugees, including the United Kingdom and Australia¹¹.

In Ireland the HSE through the implementation of the National Intercultural Health Strategy has been addressing such challenges by engaging and supporting organisations working directly with refugees and ethnic minorities in general, and establishing an ethnic identifier for the utilization of health services. Furthermore, through the Office for the Promotion of Migrant Integration, Ireland has mainstreamed a model of integration for refugees under the resettlement programme in which service providers directly meet the needs of the new arrivals. The Resettlement team works at a local level through the City/County Development Boards which have a coordinating role in relation to social inclusion.

Asylum seeking and refugee women have indeed particular issues that need to be addressed. In relation to gender based violence for example, it has been noticed that women who victims of sexual assault often do not report it, yet this may have health implications. Among the asylum seekers and refugees who sought assistance from a Rape Crisis Centre in Ireland, 11% said they reported their assault to the police, 5% to some other formal authority, while 84% stated that they never reported their sexual assault to a formal authority at all¹². While in part this arises as a result of cultural conditioning, it may also be related to the fear of the authority or to the anticipated distress of not being believed or taken seriously.

Sexual violence, primarily directed at women and girls, is currently well recognized as a practice during armed conflict and wars around the world. Gender-based violence impacts on their health not just psychologically, but reproductively as well. Rape and other forms of sexual violence and exploitation have resulted in a higher overall occurrence in sexually-transmitted infections such as HIV/AIDS amongst women. Women are further disadvantaged because they are more vulnerable to sexually-transmitted infections simply due to their physiology¹³. Women from armed conflict zones, especially from African countries such as DR Congo, Sudan, and Nigeria as mentioned earlier, are much more likely to experience rape and other forms of sexual violence than women from non-conflict areas (Human Security Report 2012).

Many female refugees hail from countries with a high risk of Female Genital Mutilation (FGM) practice. FGM-affected women often require specialized healthcare. Also Country of Origin (COI) information is needed for providers in order to tailor the healthcare given to each woman with crucial cultural sensitivity and avoid re-traumatization¹⁴. According to AkiDWA 2013 statistics on FGM, there are at least 3,780 women living in Ireland who have undergone FGM. A specialised clinic was established and opened in May 2014 at IFPA Everywoman Centre which is financially supported by HSE National Social Inclusion Office and provides free comprehensive physical and psychological care to women who have undergone FGM.

9 Clarke 2015.

10 RCNI 2014.

11 Bartolomei 2014

12 UNPFA 2002.

14 UNHCR 2013.

II. Women from Armed Conflict Living in Ireland

Migrant women have specific needs and vulnerabilities caused by armed conflict or other situations of violence. These needs must be addressed more effectively. Armed conflict and violence take a heavy toll on women's lives in different parts of the world. Not only do women suffer from the direct consequences of war and armed violence (rape, physical abuse and injuries, death), they are also indirectly affected by displacement, loss of relatives and the trauma associated with witnessing acts of violence. It is critical to establish existing needs and develop support mechanisms for migrant women from armed conflicts living in Ireland in order to help them cater for their families and integrate fully into the society.

The HSE Intercultural Health Strategy recognizes that ethnic minorities have specific health needs and that appropriate intervention must be supported to improve equality in health access and management¹⁵. It was stated for example that the expansion of initiatives such as the peer-led health information program formerly operated by Spirasi should be supported across a range of settings. Furthermore, following the rollout of ethnic identifiers, research should be undertaken around aspects of prevalence and management of specific conditions disproportionately affecting minority ethnic communities. Women in particular have been identified as a specific group that deserves more attention and care due to the double discrimination experienced by them as a result of their gender and ethnicity which has an impact on all aspects of their lives, including health.

Ireland's second National Action Plan on Women, Peace and Security 2015-2018 engages the Nation to increase coherence in its activities in the area of the relief, recovery and rehabilitation of women affected by conflict on the island of Ireland, including women who have migrated to Ireland from conflict affected areas¹⁶.

Background to Research

Established in 2010, Wezesha, Swahili for 'empower', is an African Diaspora led development organisation. Wezesha aim is to support, promote and empower African women and children who have been affected or are likely to be affected by conflict, war, violence and poverty. With a vision of enabling the African women and children to live in peace, with dignity, be in good health, and have access to essential resources, Wezesha strives to support and promote human rights for this vulnerable population in order to achieve their full participation in an equal and just society. The organisation works in collaboration with local groups and other organizations through partnership in order to raise awareness and end sexual and gender-based violence and improve people's livelihoods and wellbeing.

In March 2015 Wezesha launched a five year strategic plan that outlines under its third pillar to work on migration and development which would involve the empowerment of the African Diaspora, in particular women from armed conflict zones. Wezesha believes that by supporting the rehabilitation and integration of these women, they will be able to reconcile with issues of conflicts that affected their lives and thus negotiate a better life in Ireland.

In May 2015 Wezesha submitted a funding proposal to the HSE Social Inclusion Office to undertake a Community Dialogue and Needs Assessment on Health and Social Needs for the Rehabilitation and Social Inclusion of Women from Armed Conflict living in Ireland. The research was carried out by Salome Mbugua, a community leader and activist with Feminist Participatory Action Research (FPAR) skills.

Research Methodology

The process of undertaking the project was designed and agreed between the HSE and Wezesha in mid-July. Desk research commenced and a questionnaire was developed. Through sampling, eight counties covering four provinces in Ireland were identified with key direct provision centres for asylum seekers run by the Reception and Integration Agency as well as 3 regions of resettlement for refugees supported by the Office for the Promotion of Migrant Integration.

Initial Contacts were made with groups and individuals living in these counties. Introductory visits were paid before actual focus group discussions to some of the groups which helped to prepare the participants and enable the facilitator to become familiar with the conditions of the women. Nine focus group discussions with one hundred and fifteen women were held in eight counties: Meath, Laois, Cork, Monaghan, Dublin, Galway, Kilkenny and Waterford. Each session took two and half to three hours maximum.

¹⁵ NHIS 2007-2012

¹⁶ Ireland 2nd NAP 2015-2018



Participants of three groups out of the eight were programme refugees from Syria, Democratic Republic of Congo and Sudan. Participants of four groups were women from direct provision centres for asylum seekers. Two groups had a mixture of women with different immigration status - Refugee, Naturalized Irish citizen and Leave to remain. Meetings were held in accommodation centres, community halls, hotels and church halls. Apart from programme refugees coming particularly from specific countries, all the other groups were comprised of women from different continents and nationalities, mainly Africa and Asia.

Qualitative research methods were used in collecting information. These face to face and focus group discussions provide invaluable information to feminist research as they position women's stories at the centre of the study, allowing for rich examination of these stories within their larger gendered social context. At the beginning of each session women were asked to give their consent and confidentiality was guaranteed by the facilitator. Notes of women's stories were taken but names of the women are not included in the quotes in order to retain their confidentiality.

Interviews and focus groups established the rapport needed between the researcher and the women participants to share their stories. The group interview structure provided an interactive approach, yielding rich data and discussion stimulated by narrative, varying positions and opinions as well as shared experiences.

This research document is a narrative of experience as provided by migrant women from armed conflict countries now living in Ireland through focus group discussions under the following areas:

- 2.1 Protection and Security**
- 2.2 Health/Access to Health Services/Family & Children Education Issues**
- 2.3 Coping Mechanism and Livelihood**
- 2.4 Co-existence with the Local Host Community**

2.1 Protection and Security

Knowing whether or not women from armed conflict zones are feeling protected and secure in Ireland can help to determine and gauge their health and wellbeing needs. It enables the health authorities to plan for intervention and improve the management and accessibility of services available to them.

The large majority of women participating in the focus group discussion highlighted that they feel safe and secure in Ireland. However, for most of them, this was in the context of comparison with the situation of conflict and war in their country of origin and its impact on them. When recalling their difficult experience during war, they expressed their continued struggle to heal: *"We have come from far with many issues; some of us have been raped and are still suffering from it. After leaving our country, we were settled in a refugee camp in Tanzania following many days of walking through the bush; many families did not make it to the camp including some of our relatives. Some families gave in their young daughters for money to help them move. It was sad and emotional, seeing girls being sold to become wives. Also in the refugee camp there were lots of violence against us, outbreak of disease and a lot of rape for women leading to crisis and unwanted pregnancy. We stayed in the refugee camp for 13 years before getting here to Ireland. Even though we feel safe and secure here, our memories and past experience continue to haunt us."*

Women spoke of a range of issues from protection and security to non-physical forms of violence. However, they expressed their continuous struggle in life despite living here in Ireland, a place free from conflict, war or physical danger. This is because they are bearing 'another hidden war' within their own bodies and minds. Their lives are full of emotional battles and the inability to fit, adapt and settle in the new environment interacts damagingly with this daily reality.

"Living here now we are still struggling with trauma and experience of our past. Even though we have been granted houses and social welfare money our lives remain the same, we are not able to move beyond the impact of the war, we can hardly communicate in English, we do not engage with the rest of the community or go out, we feel they do not understand the harsh and difficult life we have gone through. We feel ignored and nobody that we can approach for help; the government brought us here but after two years all those who were supporting us disappeared; we are people who have been so much affected physically and mentally in a new land, we cannot find work to help us move out of house or keep ourselves busy, it's so hard living in the house the whole year and with no meaningful resources. We have left war there but have found another one here"

Furthermore, women from armed conflict zones pointed that feeling secure here is simply an illusion since they still feel they are still living in war as their relatives are still being victimized by on-going war and conflicts in their country of origin. They live with worries and it is difficult for them to leave behind their traumatic experience that they would have wished to forget about. This is especially damaging because of the inability to resettle in a new life style that would bring independent living and thus build self-esteem and confidence. They are not able to access paid employment and secure income that will allow them to assist their relatives in countries of origin who have been struggling with difficult situations from which participants in the focus groups had themselves got away.

"I am safe compared to the conditions in which I was before. I don't even sometimes want to think about it, my life was full of drama, surrounded by war. My husband was even brought to the hospital together with dead people, surrounded by blood, until later on it was found that he was still alive... However, I feel challenged here: coping with life is not easy; accessing services is a nightmare. The education provided is just limited to Basic English which does not allow us to move on effectively with life. We feel very limited... We are not facilitated for recovery from our trauma... Though we don't have war here, we are still in war since our people are still affected by war and this is affecting us too... It is hard for us to support our relatives who are left behind and still struggling. We are not able to get jobs here, we are discriminated against, not in peace, we are not happy"

Women also spoke about the insecurity they face in their communities, how they are being followed and stalked by men in cars positioning themselves for sexual favors, how the lack of access to employment and poverty issues have pushed some women into prostitution, especially those living under the direct provision system: "Sexual harassment and stalking by Irish men have been a reality though very humiliating, especially when we are walking with our children. This has created fear and a feeling of insecurity, it's dangerous and scaring".

The use of substances such as alcohol and drugs is a major threatening reality for many women with children living in direct provision centres. They expressed their concern at having to witness children being exposed in the selling of drugs, children having to witness parents drinking heavily while being also exposed to behaviors that are quite damaging. Women also feel intimidated by single men and many of them have experienced sexual harassment in the centre.

It is important to note that in 2014 the Reception and Integration Agency, in addition to regulations that prohibit and prevent abuses in accommodation centres, produced a policy document on sexual and gender based violence to protect the residents.

"The accommodation centre system is very insecure; it has made many people lose their self-worth and has destroyed many people's health. Children have lost the sense of normal living and belonging, they have become completely institutionalized. The system is harmful for children and has bad impact for families; children are being exposed to many bad behaviors and are in danger of living in communal system with people that they don't know... Issues of trauma and conflict have never been discussed, many women don't want to talk about rape and the impact it has had on them... There is danger here in this centre with all these young men that are on drug, I fear if any woman or girl is caught by force, I experienced it and it's such a bad thing, I would not wish to hear it has happened to anyone"

Women in the asylum process reported on how they are living in fear of deportation. The uncertainty of the future impacts negatively on their daily life and leads to poor health: not able to eat, isolation, and depression. They witnessed how their friends were brutally taken by the police in the presence of their own children and explained how this has affected their children who continuously ask when will be their turn: "I cried loudly when I saw the Gardaí taking my neighbour away, the Gardaí shouted to me 'close your door!'. Since that time, my son cries everyday fearing that we will be taken too. We live in fear, fear of the unknown, uncertainty on what will happen tomorrow, having to face deportation probably".

Women consistently reported on attitudes and incidents of racism and discrimination. They feel that they are victims of both on a day to day basis, including from the police who do not take into account any form of complaint they make to them. This makes them feel very insecure. Additionally, the lack of trust for the host community and the authorities put them further into isolation that results to poor health: "I was pushed by an Irish woman while I was pregnant saying to me: go back to your country!"... "A pregnant woman was arguing over the social welfare claim. They called the Gardaí to deal with the issue, but the Gardaí did not listen to the woman and treated her very badly. Few weeks later she lost her pregnancy after developing a depressive condition".

It emerged from general discussion with women who have come from armed conflict zones, whether they are program refugees or asylum seekers in direct provision centres, that the majority of them are happy to be in Ireland where they all enjoy peace and security. Bombings are absent, rape from soldiers and militia is no longer there, feeling protected from violence from men in the community. However, they all raised serious concern over the welcoming and treatment by both the host community and state agencies that do not facilitate their transitional move to a well secured life. Because they fail to integrate in Ireland, although they have been 'resettled', they are not able to establish new life patterns and they readily navigate back to their former traumatic experience that they revive on a day to day basis. They all stated how they are constantly sick, taking any sort of medicine, especially pain killers, and how they have even become a burden to primary healthcare providers who seem to think that they only want to be sick.



2.2 Health/Access to Health Services/Family & Children Education Issues

Women participating in focus groups expressed concerns in relation to their health and family issues that include challenges in accessing services, stress related to managing family, language barriers and negative perceptions and attitude from front line services, healthcare professionals and the host community.

General Health Issues

In general women reported that the majority of them have poor health conditions which they relate to their traumatic experiences in their country of origin and that have been aggravated by the living conditions here in Ireland. They stressed that: Physically, they haven't had good health conditions since they have been in Ireland, suffering from constant headaches, sinusitis and body pain. They complain that healthcare professionals do not understand them and thus interventions are ineffective.

"I have had fibroids for the past 4 years, going constantly to hospital. All my legs are swollen; my tummy is full as if I am pregnant. In the hospital, I was told that I was going to undergo surgery immediately, but surprisingly I was left without care until very late in the night and just to be told that I should go home. They obliged me to go back home and just to take pain killers".

"I have constantly a pain on one side of my body, constant headache... all the time the GP gives me just pain killers, the hospital always sends me back home saying that I am fine, yet I am suffering"... "I constantly suffer with sinusitis but the GP is not helpful, he just prescribes a spray and this is bothering me very much. Every single night I can't sleep, I have headache and pain in my throat".

"Most of us come to this country very healthy but our lives change just within a short time: the weather, the food, negative and cold attitude from the host community, lack of ability to know your rights and stand for those rights, the system and environment in general, we have a long way to be treated equally or with respect, especially as black women we face a lot of barriers and resistance; it's like we do not count or even exist. I never heard the word stress or depression before in my country; I came to hear those words here. These issues are normally not there because the community deals with issues affecting them differently. Even for mental health, mad and crazy people are treated with passion, they are part of the community too but here due to stress and life in limbo many of us have become different people, we get angry, always screaming and agitated, those who have serious mental breakdown do not accept it since they do not want to be labeled as mad, the doctors are also giving prescription that can damage our health. One day I went to see my GP and even without examining me he said that I am depressed, that life in the centre has made me depressed, he wrote me a prescription but I didn't take those medicines, I prayed and prayed, I was not going to accept these things that the doctor was telling me".

Psychologically, most women reported how the traumatic experience from war and conflict has been affecting their lives, causing stress and depression. Lack of cultural understanding by healthcare professionals has been a real issue and they feel that this aggravates further their health conditions.

A woman from an armed conflict country and who has lived in a direct provision centre in Ireland for ten years spoke with emotion how her life has been completely destroyed:

"I feel all alone, no one understand where I am coming from, I lost my family and everything during the war, I have grown without a family member, I still hear the scream and shakes every time I remember what I went through... moving on with life is difficult; I keep getting sick, I can't find peace... What can I do? It's not my country... We are suffering all this because of our leaders (from our country)... we should not have come here".

"Some of us have witnessed a lot of violence and have been affected by the war. In Kivu we had to hide in the bush for years, I am not even able to talk in-depth of what happened to me, no one here in this country understands the trouble and problems that I have gone through, I am just lucky to be here and safe but what I have seen and gone through is still haunting me".

Women also reported that most of them end up going to the GP but feel that GPs are not giving them time to explain or explore their health problems. Some have even become mentally ill and need real psychiatric attention but they are relating it to traditional beliefs, some have developed memory loss. Others are in denial of stress or mental health based on the fact that culturally the community always stigmatizes people with mental health.

It has been felt from discussing with women during focus groups that conflict related trauma has never been disclosed as many of them do not want to talk about rape and the impact it has had on them. A woman explained how she feels uncomfortable to discuss the rape she experienced for fear of stigma and shame; she has not discussed this with her doctor but she lives on medication. She feels that her life is in limbo and living in the accommodation centre has made everything worse, even her health condition: *"sometime I just find myself speaking loudly to no one, I scream for nothing".* The same woman also said that this has impacted on her sleeping patterns and seeing so many single men around makes her very uncomfortable.

Clearly there is a denial of mental health by refugee women due to their cultural beliefs, and moreover acknowledging rape victimization remains a taboo as it may lead to a social marginalization that no one is ready to accept. Women have even expressed how they are fearful of speaking with their doctor about their past experience of trauma, depression and stress saying that once it is entered into hospital records it will impact on their possibility of accessing jobs in the future. They indicated that all they want is to move on with their lives. Women are not always aware of available services to them.

The impact of war and conflict has certainly been very negative on women's mental health and wellbeing. Syrian women, for example, reported on how all the families have been struggling with feelings of loss and separation from other family members and loved ones; some mentioned how they are still haunted by the sounds of objects... One woman narrated: *"When they arrived in our town, they locked 49 people in a room and killed them; only a child came out alive. I still hold these memories and will never forget them until I die"*.

Similarly, an African woman, a programme refugee who escaped from war and conflict in her country of origin related how her health condition and of others have not been good:

"I have been having headache and its even getting worse; I cannot forget what I saw. My husband and brother were killed in my presence. I still hear the noise of the bullets; I am not able to sleep at night. The doctor has prescribed me medicine many times but these medicines are not working. Members of the family left behind are also struggling, the war and conflict is still there, my people continue to suffer, I can never be at peace, every day we receive news, all bad news, sometimes they want us to send them money, to help with food, but we don't have that money. I am very sad even though I am here I am not happy, my heart is not here, I am sad, sick and completely lost, my health is not good".

Syrian women asserted that the ongoing impact on them of the conflict in their country of origin has affected their ability to plan for the future. They can't cope with the separation of families, some living still in Syria and others in Jordan. Others reported about their families being resettled to other parts of Europe and that they are not allowed to visit them due to temporary restrictions on travel. Violence, war and conflict have affected their sleeping patterns and some said that they are not even able to sleep at all.

Women said that the focus group was the first occasion for them to talk about the impact of war as a group. However, each and everyone talks about it when they meet. They also fear to talk about it in presence of the children due to the horrifying nature of what is happening and how that can impact on the children.

Like other resettled refugees, refugee women from Syria feel that most doctors are aware of their stress and trauma but are unable to do anything for them, that they are restricted, probably because of the language barrier and the lack of cultural competence.

With regard to women living in direct provision centres, stress has been a major issue for all the women and it is aggravated by life in the centre: *"it's difficult to live this kind of life, eating same food, having no privacy for years"*. Many women are on depression and migraine tablets. The stress has developed further and caused physical health problems to some of the women; one woman reported that she had a stroke due to stress and now living with migraine everyday: *"my face gets swollen; I do not know what is happening in my body"*.

Reproductive Health Issues

Beside the general physical and mental health conditions that refugee women from armed conflict countries have been subjected to, it was important to explore how this has related to their reproductive health as women and the implication on their family lives as mothers.

"Women fleeing conflict or natural disaster – often already precarious because of women's poverty or low social status – are further threatened by severe living conditions and, in general, the complete absence of either immediate or longer-term reproductive health services. Displaced women and girls are also especially vulnerable to sexual violence, including rape as a weapon of war and sexual abuse and exploitation. All of these conditions contribute to a heightened risk of unwanted pregnancy and botched abortion, HIV and other STIs, and high-risk, life-threatening pregnancies and childbirth".

All refugee women who have been resettled in Ireland traveled from refugee camps in neighboring countries before coming to Ireland. As mentioned above, some refugee women reported on how they have been subjected to inhuman treatment while in refugee camps, including rape and other forms of violence that have had an impact on their reproductive health.

Some women mentioned that they know of migrant women who continue to struggle with STDs, including HIV and other health related issues without revealing them in order to avoid shame, stigma and also because of lack of accessible information and support.

"We have limited information on how to access healthcare services, in particular on reproductive health such as smear test and morning after pills."

Focus group participants reported on how they have not been happy with doctors putting them on long-term contraceptive, such as Mirena. They feel that doctors do that because they don't want them to get more children; they feel they should give them information on all available contraceptives and their side effects too for them to choose which ones are better. Some women have been put on Norplant and found it difficult to have it removed if they are not comfortable. They were also not aware of the fact that it would cost them €50 to remove it, an amount of money that they would not have. Three women spoke about how they have been having vaginal bleeding and one reported that she was put on a second contraceptive drug and she was therefore on two different drugs which she did not find right and that this did not even ease her bleeding either.



As stated, traumatic experience from war, conflict, poverty and resultant stress affect both refugee seeking women and those who have been resettled from overseas refugee camps. Four out of fifteen women in one focus group reported on how they had a miscarriage as a result of a combination of ill-health conditions: continued several headaches, lack of appetite, lack of good diet, high blood pressure, isolation and boredom, lack of family support, lack of physical exercise, lack of proper hygiene, negligence by healthcare professionals.

"As women we have to buy our sanitary towel and, when pregnant, be able to buy fruits or any other thing that one may need; it is very stressful when there is no means of earning income that will help us to maintain ourselves and have a living style of our choice".

"I lost my baby just because I was given an overdose of anesthesia by negligence and all I was told was sorry".

While aware of their past situation, refugee women tend to move on with their lives and avoid recalling their difficult experiences. Even though they may not be able to relate their issues of reproductive health to the traumatic experience from war and conflicts directly, they all complain of health issues that are symptomatic of their dramatic life stories that certainly impact on their reproductive health. Referring on the four women who had a miscarriage and on other similar cases, women asserted that such incidents are certainly related to the refugee situation, i.e. not only from the living condition here in Ireland but also from past traumatic experience that forced them to seek refuge.

Access to Healthcare Services

All the women participating in the interview reported on how they were able to access GP services with the medical card provided by HSE of which they cited as a great help. One group of Syrian women felt that their GP had been prepared of their arrival and were very happy with his welcoming approach: *"My GP is very good, he listens to me when I go to him with a problem, it was hard to get a doctor in Jordan, here the doctor is kind and very helpful"*. Some of the women spoke about challenges that prevent them from receiving appropriate healthcare interventions. Language and the lack of cultural competence among healthcare professionals remain the big barriers. This was highlighted throughout conversations with the women. Below are some of the issues underlined by focus group participants:

"We are unable to communicate with the community and are not able to express ourselves while accessing services". Women who came as program refugees from Syria, for example, reported that there is only a young woman within the community who has been translating for all the families; she is the only one translating for them when attending appointments in hospitals, schools or other services which, she said, is very overwhelming. This is certainly not a good practice and in principle a professional translation should be provided.

Women believe maternity hospitals should understand that they are coming from different backgrounds and beliefs where there is no remedy to pain relief during child birth. Not a cultural prohibition as such, but a practice they are not used to. They feel there is a lack of understanding and empathy when they decline the use of such remedies. Women also believe that there is a lack of knowledge and understanding on gender specific harm that they have gone through, such as rape, FGM and other forms of violence.

"I was told of epidural as a pain relief at the maternity but I feared the side effect very much, I never heard about it before as we do not have such a thing in my country, we go through labor without any relief".

They raised concern about the access to circumcision for their boy children: it has been difficult for parents to obtain a GP's agreement for the circumcision as many doctors do not accept such cultural practice. Women indicated that based on religious and cultural beliefs, once a baby boy is born he should be circumcised from birth to maximum 6 months; yet here they are told it can only happen when the child is 3 years old which they find to be conflicting with their culture and thus adding stress to families; they also lack information on where to access such services.

"We are very upset as we can't obtain circumcision for our male children, yet medically it's not a problem. We are being neglected."

Some women raised concerns on GPs being unable to give them time and attention when they attend clinics: *"Even before you tell him your problem he concludes that you have stress and depression because you are living in the direct provision centre"*.

One woman reported on how she was sent to a mental health hospital and was prescribed tablets for two years that she did not take simply because she believed that the doctor just decided to send her to mental health hospital from the first instance without examining her circumstances or listening to her. She has been stressed since, shouting constantly.

Women highlighted negligence issue by the healthcare professionals. They asserted that they are getting wrong diagnosis on their health issues:

"When I went to my GP with bloating problem he asked me to fast; my body is now changing and I can feel the changes but the GP keeps dismissing me; he told me just to exercise".

Women from one direct provision centre mentioned that their GP would not take blood pressure or do any test on them and that they are worried about the assumptions made about their health. They felt that the GP has no keen interest in their health and wellbeing.

"We do experience a lack of listening and empathy from the GP... Now I fear to go to see the GP as he does not believe me being sick".

"I had a lot of pain, nurses thought I was pretending, I was screaming with pain, the doctor then said I should have antibiotic through drip. They inserted needle on my hand, the pain was so strong, my hand was getting sore, I removed the needle, the nurses were not good or cooperative at all, a new doctor was called, his approach made me feel much better, he indicated that the drip had been put wrongly and he rectified it. The doctors and nurse's attitude and approach towards patient in distress should be that one of empathy and understanding, the nurse ignoring me made me feel so much alone and not wanted at all".

Women tend to be more confident with female GPs, especially Muslim women. In one of the direct provision centres they highlighted that there was only one male GP for over 500 hundred residents. They also pointed that there is a discriminatory attitude by the healthcare providers: *"our health is affected by the lack of equality that we are experiencing every day, we feel being discriminated because of being asylum seekers. We are looked at as less human being".*

"Once you enter to see him it's like if he is in a hurry and he wants to finish with you very quickly. Even without checking you he writes a prescription. When I went to my GP that morning he said to me: you asylum seekers, you are too much, our country is going back because of you".

One woman reported on how she was bitterly disappointed by her GP when she was told: *"You Africans have a lot of diseases that we do not know, go and Google".*

Family and Children Education Issues

The majority of women who participated in the discussions expressed deep concerns about the future of their children and said that this was also affecting their health and wellbeing.

It is interesting to note how the welfare and education of their children is important to the women. It is through the success of their children that they expect to recover from lost hope for their own lives. They were happy that their children are able to go to school (primary and secondary school) free of charge. However, most of them expressed serious concerns about discrimination and marginalization to which their children are subjected and how this is causing more stress on them.

Women living in direct provision centres, in particular, reported on how their children in schools are being labeled as 'refugees', called names, being isolated and sometimes even fought by other children, that some of their children have now been performing poorly as a result of the bullying.

"Our children are frustrated and are becoming violent... my teenage boy who is epileptic is being called names by Irish children in school and as he reacted violently to bullying, was blamed by school authorities who could see only violence coming from him. Despite his health condition that I explained to the school and how this impacts on his behavior, the authorities did not even want to understand and kept blaming my child instead of dealing with the issue in a fair manner. Now as a consequence, his health condition has worsened (constant seizure), poor performance in school (failing to achieve the leaving cert). This has affected me deeply; I am not able to sleep and now I suffer from high blood pressure, going constantly to the GP"

"I have been here for nine and half years. Three of my children are born here, the one I came with was nine and now an adult, they are tired, tired of living with the asylum label, they are restricted in life, this has impacted seriously on my children; they cry a lot, they are tired of this life... As a mother I am tired of dealing with demands, with only 19.10 per week I cannot meet the demands of all my children, my children are not involved in any extra curriculum activity even when they so much want to join, it is impossible. This has been impacting seriously on my health. I have been on tablets for five years now, these medications are reacting on me, I am not the same anymore, my body has expanded, I feel tired and struggling with blood pressure".

Some teachers are not sensitive vis-à-vis of children of asylum seekers and fail to understand the life style and circumstances of their parents while living with them in direct provision centres: *"My son came home very agitated and said that the teacher was explaining in the class about the economic crisis in Ireland saying that asylum seekers in the country are one of the causes for this crisis. Other children knew that my son live in the asylum accommodation centre and was therefore an asylum seeker. He was very verbally abused. I had to go to the school to address the situation with the principle; this is not good for any one at all; it reinforces stereo types and put our children in danger, children don't want to go to school most of the times, it's like you are pushing them every morning to go, their experience has not been good".*

Having to deal with parenting issues is certainly not easy. Most of the women are parenting alone and lack support from immediate family members, they are isolated and have no access to social network. Women living in direct provision centres find it much harder as they have limited means that would allow them to cater for their children properly:

"Our children are not participating in many activities since we can't afford... Our children are only able to cope with school and life style at the accommodation centre until they are around ten years but once they become teenagers, it is then difficult for them to settle and perform well in school. This increases stress and depression in us... I deprive myself from anything to make my children happy; sometimes I just cover myself and cry; it is hard living in these conditions".

Women expressed concerns about children being taken into State care due to lack of cultural understanding. One woman volunteering as a family support worker gave an example of a family whose child was put into care due to lack of communication and cultural understanding. The child had reported to the teacher that the father had touched his private parts and the teacher immediately alerted social workers who took the child from his parents. It was not explained to the parents why the child was taken



from them until 3 years later. Apparently the boy had undergone circumcision and the father was checking to find out if he had recovered from the wound which is culturally appropriate. This had caused family stress and the family has been separated with their child for what they felt was a misunderstanding.

Inability to afford childcare costs can also prevent parents from engaging in activities or services that are vital to them:

"I missed three appointments for a serious operation because I had nobody to leave my children with, and now my health condition is worsening".

It appears clearly that the health and wellbeing of women coming from war and conflict backgrounds are complicated by a network of issues. Since children play an important role in their lives, not seeing them enjoying their rights like other children in the community aggravates their health condition and their ability to move on in life.

2.3 Coping Mechanisms and Livelihoods

Coping mechanisms and social life in local communities play a determining role in relation to women's health. During focus group discussions, women expressed freely how the lack of employment and participation in the local community has impacted on their health and wellbeing.

Even though most of the women who participated in focus group discussion have the right to work, almost all of them have been unable to access work. They all depend on social protection allowance that helps them meet their basic needs. However, most of them mentioned that they are always stressed with demand for support from extended family members in country of origin that they are unable to meet.

Lack of ability to provide for their children or to plan for their life while trying to manage on a low allowance of 19.10 euros per week for women seeking asylum has pushed many of them to turn to somehow inappropriate survival mechanisms, including prostitution and other unregulated employment, causing more health problems to the women. Women also spoke of how they keep their children indoors to prevent stress caused by their demands.

"I cry a lot every day to see myself not able to meet the needs of my children. When we go out they cry for ice-cream and kids stuff but I cannot afford".

Other coping strategies include reducing eating pattern, not buying clothes in order to save money that will allow them to meet demands that are more important to them: *"We buy the cheapest food and products to keep going. We are just resilient but very much struggling".*

Programme refugee women highlighted that they are struggling to keep up with demands from their extended families. They said that house rent is high and normally takes most of their weekly allowance, leaving them with very little for all other basic needs. The clothing allowance has been a problem. A family with four children indicated how they could only afford uniforms for two children with the money granted for four children, and so the other two children had to do without uniforms for a year. They highlighted the need for the Department of Social Protection to review and examine the needs of each family since poverty is really affecting their health and wellbeing. One woman explained how her family had to live without gas for a week in winter season.

It should be noted that refugees receive the same social benefit as citizens. However while the social welfare allowance provided is enough to meet most of their basic needs here in Ireland, they suffer for the fact that they are financially limited to extend support to other family members left in countries of origin.

Some women have managed to set up small businesses such as selling beauty products, braiding hair, others have undertaken volunteering jobs within the community and majority are engaged in English, computer classes and social care training with hope of accessing employment in the future.

2.4 Co-existence with the Local Host Community

Being part of the local community remains a challenging issue for refugee women and the experience of isolation is a factor not to be neglected when managing their health and wellbeing. Women expressed the following concerns in regard to their social inclusion in their local communities. They highlighted that people from local communities are not willing to engage with them, even to understand and empathize with their situation. Others are not able to understand their circumstances: *"We are idle most of the time, we just wake up, sleep, we do not go out and only engage among ourselves the four programme refugee families that were brought here, we don't see ourselves advancing or moving on in life, we are still living in war but a different war. To move forward we need information, jobs, learn English, be part of the community".*

"Here the Irish people do not want to engage with us. Even when we go to the church, they only and always ask us if we are from Nigeria. It's like the government brought us here and dumped us after two years, yet we are a long way to come into terms with our experience and impact of war on us. The social welfare allowances we receive is not enough, it would have been better if we had jobs; we need to be facilitated to access work. We would like to become independent. We have skills and talents, yet we can't do anything. Our lives have been wasted and our children's lives are going to be the same. We are here forgotten, neglected completely, isolated; we will continue to grow old and become useless in a land that we feel we do not belong".

"We were well supported when we newly arrived here but then we felt abandoned. Nobody can assist us properly. There is Theresa, an Irish woman who tries to help but she is alone and limited".

Being unable to find paid jobs, women tend to seek voluntary work. However, they find it difficult to be provided with such opportunities or when they succeed to get one, they feel they are being exploited. Most of the volunteer jobs that they get last only for very limited time and do not even allow them to move to paid employment. In 2007 the Department of Justice supported a project to assist Migrant in accessing employment – Employment for People from the Immigrant Community (EPIC), which is still funded by the Office for the Promotion of Migrant Integration and managed by Business in the Community Ireland (BITCI) operates only in Dublin and therefore not accessible to the women. However a call was made by BITC in 2013 for Government to roll out the programme nationally. This is a good model that has been in operation in the last eight years that can be of great support to this vulnerable group among other migrants.

For those living in direct provision centres, it is even harder; they feel completely excluded from the rest of the society, including neighboring communities: *"We are called names: "Nigerians black, go back to your country".* The women are mainly confined to stay in their rooms in the accommodation centre, quite isolated and inaccessible, making it difficult to reach out to the community or engage on any community activities.

Women find the transition from direct provision to living in the community difficult. After getting residency, they have difficulties in finding private accommodation; landlords do not accept rent allowance and others are reluctant to rent their houses to people who depend on rent allowance.

"I have been looking for a house in the last five months, no one wants to give us their houses to rent, and some people have said that the landlords are not comfortable renting to people from the asylum accommodation centres saying 'they will not be able to take care of the house'. This is really causing us more stress".

Women feel socially disconnected. They indicated that they are discriminated against and that the community does not want to give them a chance to help, get out of boredom and be useful to the society.

"We keep to ourselves, no one wants us around, you get that feeling when you get out there, the attitude, even when you attend meetings or gatherings it is like you are not there presently, you feel that you are being ignored." One of the young women who participated in the group and had finished her leaving cert two years ago explained how it has been difficult to have Irish friends: *"All my friends were Africans or from other EU countries, the Irish girls just want to ignore you, even when you say something in the class or in the group it is like you are wrong and don't know anything. With Polish and Slovakian girls for example you feel more fitting".* Some of the women explained how they felt assumed and ignored by some Irish people that they would have been involved with in church projects: *"when the project finished the women did not want to engage with us any more, even when we met in the church, I tried talking to one of them but she quickly assumed and ignored me. Since then I don't even feel like going to the church, it's really hard here".*

"We are not invited for community activities; sometimes we go out to see but it is hard engaging, some of the families have experienced anti-social behavior, abuse and attack within their residences, children are verbally racially abused, eggs thrown into our houses. All services, volunteer positions and opportunities are by white people; we have no hope of getting opportunities and our children are suffering too, urgent intervention is needed".

The lack of English language and communication skills has prevented the majority of the women from engaging with the rest of the society. Some women have problems with their children having catholic religion classes imposed on them. One Muslim woman said that they have tried to discuss the issue but their children have still been asked to do the sign of the cross.

Syrian program refugee women said they are happy that they are able to access halal food locally and are facilitated in many ways by the support worker assigned to them. *"She has been very helpful to us, I don't know how we would have survived without her, she supports us with all our needs and in connecting us with the community, we are very happy to have her."* They were however worried about the support worker role coming to an end. The support worker was only assigned for six months but this time was indicated not to be enough based on the needs of people who have gone through very traumatic experiences and the fact that even after six months they are not settled at any level.

The women felt that Irish people knows they are refugees but they do not think that they understand war and conflict going on in their countries and how that has impacted on them.

Living for a long time in isolation in a direct provision centre prevents women from developing social connections with the indigenous community and can be damaging when one leaves the centre to move into private accommodation within the local community. The women gave an example of a woman in one county who, after getting residency, left the accommodation centre for a private house in the community but was always coming back to the centre for socializing and to be with the people in the place that she only knew after living there for over 8 years. Later on, that woman was found dead in her room: *"she was mentally ill even though she was not hostile nor aggressive towards anyone, she had no friends out there, she kept coming here and was later on restricted from visiting; they even called the Gardaí to remove her one day and just few weeks later she was found dead in her room. Nobody cared about her; she was ten days dead before she was found".*



III. Conclusion

Discourses on women from armed conflict zones highlight how their traumatic experiences expose them to vulnerability. They are subjected to complex health issues that deserve care and specific intervention. This is confirmed by the stories of women who participated in focus groups. They expressed freely and with confidence, being in a safe environment during the discussions, how their health and wellbeing have been compromised by not only the traumatic experience of war and their journey to Ireland, but also by the inability to recover the personal integrity due to the social environment they are living in and the negative attitudes directed at them by the host community and service providers. Most of the women highlighted the importance of the discussion and found it to be a great way of expressing themselves and speaking out for the first time. They highlighted the challenge of not being able to communicate in English or express themselves, and how not being culturally understood by front line services and healthcare professionals impact negatively on their health and wellbeing. However, programme refugee women strongly acknowledged the support they have received from the Office for the Promotion of Migrants Integration and the welcome by few local community groups and individuals as well as positive attitude of some healthcare providers.

Overall, discussions with the women revealed that refugee and asylum seeking women from war and conflict zones often have multiple unmet health and social needs before, during and after resettlement; access to health services has been hampered – mainly by language barriers for service users and lack of cultural competence by front line services and health care professionals. Lack of proper support, isolation, racism, discrimination and access to information remain a huge challenge. State agencies, including the HSE, the Office for the Promotion of Migrant Integration and the Reception and Integration Agency have been supporting the social inclusion and integration of these groups through different measures. Though the process is slow and difficult, it must be acknowledged progress is being made.

While these findings are rich and useful, views, perceptions and experiences are those of the women who were interviewed. It is important to note that despite the challenges outlined in this report, women expressed determination and hope for a better life in Ireland.

This needs analysis aims to bring a new understanding of the experiences of women from war and conflict zones living Ireland and brings suggestions that should be considered while planning for service intervention. Throughout the four main aspects that covered this research it has been noted that in general women from armed conflict have been struggling to recover from wounds of war. There is much that can be done to help them – providing basic safety is not enough.

IV. Recommendations

1. Training on cultural competence should be delivered to all front line and healthcare professionals in order to provide culturally appropriate services to women from war torn countries and armed conflict. This includes developing strategies of dealing with culturally sensitive health related issues that are viewed to be stigmatizing, such as mental health. Extra cautions should be taken, in particular the approach and the way healthcare professionals and front line services engage and deal with complex or gender specific issues that pertain to women from armed conflict.
2. Community peer-led programmes should be established. This should be done by identifying and engaging migrants who have settled and integrated well in the Irish society. Such Community peer-led support programmes would act as a link between migrant women and service providers. They would also provide support, information and mentoring.
3. Social inclusion strategies should be put in place to ensure that women from armed conflict are integrated in the society and their social, economic and cultural needs are fully met.
4. Information and cultural orientation should be provided to women from armed conflict in an accessible manner, using a language or a methodology that facilitate an easy learning and understanding.
5. Support to access employment and work placement. Government to roll out already existing support for employment model – Employment for People from Immigrant Communities (EPIC) Nationwide.
6. Awareness of war and the impact of conflict on women should be raised countrywide. This will generate empathy within the Irish society and will help people understand the true reality of women who have come to Ireland from armed conflict and torn war countries.
7. Integration initiatives should be established. Women from armed conflict participating in the focus groups expressed the need and interest to link up and have a meaningful engagement with Irish indigenous women in order to share their experiences, similarities and differences; they pointed that this could be one way of facilitating mutual understanding and acceptance as part of their healing process.
8. Investigation on drug use and abuse in accommodation Centres for asylum seekers should be done as matter of urgency. Provision must be made to safeguard children from exposure to those harmful and other unacceptable behaviors.
9. Single males should not be accommodated in women and family accommodation Centres; specific centers should be established for women with mental health or major health related issues.
10. Provision should be made for collection of data that would inform interventions , such as ethnic identifier as part of ethnic equality monitoring



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Appendix: Research Questionnaire

FOCUS GROUP DISCUSSION

Questionnaire on Need Assessments and Dialogue with migrant women from armed conflict zones

1. Protection/security

- a. Do you feel safe in Ireland?
- b. What are the dangers that you experience in Ireland?
- c. What is the source of the danger?
- d. Do you feel that your physical safety and security are at risk?
- e. Are you aware of any incidents that have threatened migrant women?
- f. If you face a protection or security problem, where do you go? Who do you call?
- g. What do you worry about with regards to your family? Do you think that migrant women are more exposed to danger than men?
- h. Which are the possible dangers? Do you think that migrant women are scared more than men?

2. Access to education/health/services

- a. What are the experiences of your children in school? How does this affect you?
- b. Are you afraid of sending your children to school?
- c. What types of health problems are most widespread among migrant women in the community?
- d. How do you think the issues of violence against women are dealt with in Ireland?
- e. Would you say the needs of women that have come from armed conflict zone are met, what would you see as the issues to be addressed for women from armed conflict zones
- f. How do you find health services in Ireland in particular for migrant women?
- g. What are the health challenges that are there in the provision? Are there gaps?

3. Coping mechanisms and livelihood

- a. What are the main sources of income for migrant women?
- b. What are the main jobs that migrant women have access to?
- c. Are there some groups that can better have access to labour market?
- d. Is it easy for migrant women to rent a house?
- e. What are the main difficulties that migrants find in having access to housing?

4. Co-existence with the local host community

1. Do migrant women in general have relations with the host community?
2. How are in your opinion these relations?
3. Do you think migrant women live in the same areas?
4. Do you think that living in the same area would facilitate the relations with the host community?
5. How is, in your opinion, the awareness of the local community regarding migrant women especially women from armed conflict zones?
6. What do you think the local community could do to help the migrant women more?
7. What do you think the migrant community should do to ensure inclusion and intervention on issues affecting them?
8. Are there social/recreational spaces where the migrant community meets?
9. How do you relate with your Irish neighbourhood?
10. Are you involved in any group/network with Irish community? Involvement in children school, community activities, etc

Unmet Needs

Which are the most urgent health and social unmet needs that need to be addressed?



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