Hamburg University of Applied Sciences
FACULTY OF LIFE SCIENCES

MASTER OF PUBLIC HEALTH DEGREE

A Case Study about *"The Benefits and Challenges of Health Promotion and Awareness Programme "REFUGIUM" for Refugees Living in Camps in Hamburg, Germany".*

MASTER THESIS

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Abstract

Background: More than 1 million refugees immigrated into Germany 2015-2016. To address the complex gaps between accessing proper health services or preventive interventions adequate for their needs and living situations in the new host country; health interventions based on innovative peer-led idea were required. Peer-to-peer health awareness programme REFUGIUM was set up to meet the health needs of refugees regarding prevention in temporary accommodation settings, aiming to activate refugee's health resources to cope with the living conditions in Germany. In 2016, 35 refugees (9 women - 27 men) attended 6-session facilitator training and participated in programme development.

Objectives: This research aims to describe the experiences of REFUGIUM first generation peer facilitators to assess and analyze benefits gained and challenges of the programme. This research gives recommendations and an overview on the ways of conducting health interventions for refugees in camps and health burdens they face in Germany.

Methods: Data was collected in 12-month participatory observation and 8 in-depth interviews with participants, 4 women and 4 men aged 19-63 from 5 different countries in Arabic and English. Qualitative content analysis identified benefits and challenges of peer-facilitator-training and collaborative research using intrinsic case study approach.

Results: 4 categories and 11 codes were developed and associated with the health intervention. Refugees in Hamburg were not aware about other similar health interventions. The followed methods in approaching refugees in camps were successful and faced challenges in motivating women due to cultural differences and resource obstacles in having separate workshops for them. Participants felt ownership of the programme, its content, relevance and culture appropriateness. They felt for the first time in Germany that they could talk freely about health burdens in camps without fear of getting transferred and, accepted as knowledgeable and resourceful. Participants felt they could be useful instead of just receiving charity. Peer-facilitators gained different health knowledge, psychological benefits and built new social networks from participating, and expressed different challenges and suggestions. Mental health, daily-hygiene, and health care system including entitlements to health services were identified as the most important types of information needed for refugees. Different organizational challenges were faced mainly due to limitations of resources

Outlook: This study gave refugees in Hamburg a voice to reveal their experiences, health needs and burdens. Participation in peer facilitator training and participatory action research empower refugees to integrate into host country and improve their mental health. Urgent mental support and better living conditions in refugee camps are required. Various and precise recommendations on conducting such interventions in developed countries as Germany were revealed, but still there is need for more future research.

Table of Contents

TABLE OF CONTENTS

Acknowledgment 1
Abstract 2
Table of Contents 3
List of Figures 5
List of Abbreviations 6
1. Introduction 7
1.1. Health Awareness Programme for Refugees at Department of Health Sciences (HAW Hamburg) and Study Rationale 10
1.2. Aim of the Study and Research Question 11
1.3. Thesis Structure 12
2. Theoretical Background: 13
2.1. The Declaration of Alma-Ata and the Ottawa Charter for Health Promotion 13
2.2. Health Promotion and Education for Refugees 14
2.3. Peer-education and Health Awareness 15
2.4. Access to Health Care Services in Germany 15
2.5. The REFUGIUM Programme 17
2.5.1. Case Background 17
2.5.2. Location 18
2.5.3. Peer Facilitator Training Time Schedule 19
2.5.4. Participants 20
2.5.5. Flyers and Manuals 25
3. Methodology 26
3.1 Rationale for Qualitative Research Approach 26
3.2 Case Study Approach 27
3.3 Data Collection 29
3.3.1 Interviews with participants from peer-facilitators 29
3.3.2 Observation 34
3.3.3 Data Management 35
3.4. Data Analysis 35
3.5 Ethical Considerations 36

3.6 Role of the Researcher and Self-Reflexivity 36
4. Results and Findings 39
4.1. Approaching Refugees 41
4.1.1. Health Awareness for Refugees 41
4.1.2. Approaching Methods and getting Participants 42
4.1.3. Women’s Representation in REFUGIUM 45
4.2. Taking part in the REFUGIUM Programme 49
4.2.1. The Idea of the Peer to Peer Approach 50
4.2.2. Essence of the Experience 52
4.3. Topics and Materials 56
4.3.1. Relevance of Topics 57
4.3.2. Knowledge and Information 61
4.3.3. Conduction of Peer-Facilitator Trainings 63
4.3.4. Materials 65
4.4. Challenges of Living as a Refugee 66
4.4.1. Health Challenges 67
4.4.2. Psycho-social Health Aspects 72
4.5. Organizational Aspects 73
4.6. A Day within the case of REFUGIUM 77
5. Discussion 80
5.1. Discussion of Methodology 80
5.2. Discussion of Study Results 81
5.2.1 Announcing for Health Intervention Programme 81
5.2.2 Experiencing the Health Awareness Programme “REFUGIUM” 82
5.2.3 Refugees and Health Competences 84
5.2.4 Refugees and Health Challenges 88
6. Conclusion and Recommendations 90
7. References 92
8. Appendices 98

List of Figures

Figure 1: Development of annual Asylum applications in Germany since 1995

Figure 2: Main countries of asylum claims in 2016

Figure 3: Asylum applications by age groups and gender in 2016

Figure 4: Hierarchy of the REFUGIUM programme

Figure 5: Peer Facilitators at the core of REFUGIUM

Figure 6: Analytic steps for case study

Figure 7: Categories and codes analysis tree

Figure 8: REFUGIUM's objectives and goals

List of Abbreviations

BAMF Bundesamt für Migration und Flüchtlinge (Federal Office for Migration and Refugees)

BVPG Bundesvereinigung Prävention und Gesundheitsförderung (Federal Association for Prevention and Health Promotion)

CBPR Community-based participatory research

ECRE European Council on Refugees and Exiles

HAW Hamburg University of Applied Sciences

NGOs Non-governmental organizations

PFT Peer facilitator training

REFUGIUM "Rat mit Erfahrung: Flucht Und Gesundheit, Information Und Multiplikation" (Experienced Advice: Refuge and Health, Information and Peer-Facilitation)

SDH Social determinants of health

TTT Train the trainer

UNCHR United Nations High Commissioner of Refugees

UNRWA United Nations Relief and Works Agency for Palestine Refugees in the Near East

WHO World Health Organization

1. Introduction

Many parts of our world are currently suffering from instability due to different reasons; wars, natural disasters, economic crises and political oppression. This instability has made millions of people escape from disaster areas seeking safety for themselves and their families; since 2015 more people are taking refuge worldwide than ever after World War II. The term "refugee" was clearly defined by the *1951 Geneva Convention* as someone who has been forced to flee his or her country escaping from war zone or natural disaster. The convention stated that refugees have the right to flee their countries because of "well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group" (ECRE, n.d.; USA for UNHCR, 2016).

Worldwide; there are 65 million men, women and children displaced from their homes, meaning that one in every 113 humans on our planet is either an asylum-seeker, a refugee or internally displaced (UNHCR Global Trends, 2015a). The number of refugees of concern to the United Nations High Commissioner of Refugees (UNHCR) has reached its peak and highest level in 20 years by mid-2015 reaching around 15 million refugees. Furthermore, around 5 million refugees are registered under the supervision of the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), which was established in 1949 to take care of displaced Palestinians. From the 15 million refugees of UNHCR concern around the world; 4.1 million are in Sub-Saharan Africa which are considered the highest number, followed by 3.8 million in Asia and the Pacific, 3.5 million in Europe, 3.0 million in the Middle East and North Africa, and 753,000 in the Americas (UNHCR Refugee Figures, 2016b).

The year 2015 resulted in new global records in regard to refugees' and asylum-seekers' demography; Lebanon is now the number one host country for refugees worldwide with a ratio of 183 refugees for every 1000 inhabitants and Germany has received almost half a million asylum claims and listed top reception country that year (UNHCR Global Trends, 2015a). Many Syrians along with other vulnerable nationalities facing conflicts and wars, e.g. from Afghanistan, Kongo, Somalia, Eritrea, South Sudan and North Nigeria have found their way to Europe via the Mediterranean. Since the first of January 2015, more than one million

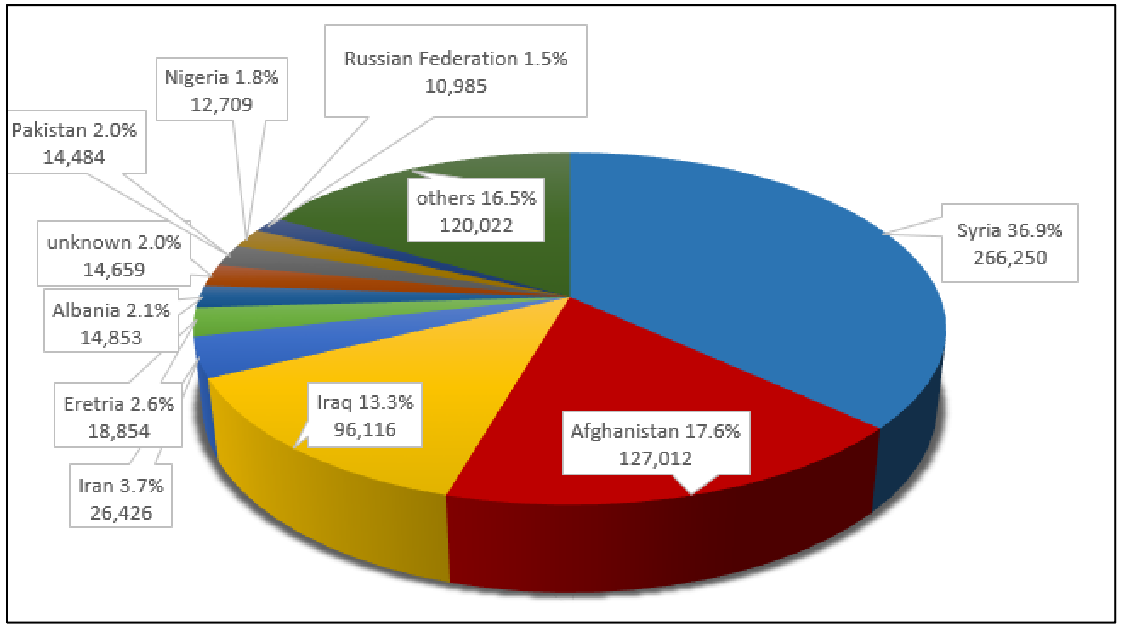
refugees have crossed the Mediterranean Sea from Turkey reaching Greece (UNHCR, 2016c; UNHCR Global Trends, 2015a), and many took the more dangerous route from Libya to Italy.

Germany has been one of the main European host countries for refugees and asylum-seekers for a long time, especially after the fall of the Iron Curtain in 1989 to mid-1990s with record of around 722.000 asylum claims in 2016 (figure1). Claims derived from different countries as shown in figure 2 with Syria on top with 266.000 claims, then Afghanistan 127.000, Iraq 96.000, Iran, Eretria, Albania, Pakistan and others (BAMF, 2016, p. 8).

Year	Asylum Applications			Year	Asylum Applications		
	Total	Initial	Following		Total	Initial	Following
1995	166,951	127,937	39,014	2006	30,100	21,029	9,071
1996	149,193	116,367	32,826	2007	30,303	19,164	11,139
1997	151,700	104,353	47,347	2008	28,015	22,085	5,933
1998	143,429	98,644	44,785	2009	33,033	27,649	5,384
1999	138,319	95,113	43,206	2010	48,589	41,332	7,257
2000	117,648	78,564	39,084	2011	53,347	45,741	7,606
2001	118,306	88,287	30,019	2012	77,651	64,539	13,112
2002	91,471	71,127	20,344	2013	127,023	109,580	17,443
2003	67,848	50,563	17,285	2014	202,834	173,072	29,762
2004	50,152	35,607	14,545	2015	476,649	441,899	34,750
2005	42,908	28,914	13,994	2016	745,545	722,370	23,175

Figure 1: Development of annual Asylum applications in Germany since 1995 with total number of 722.370 initial applications in 2016 (BAMF, 2016, p. 4)

Figure 2: Main countries of asylum claims in 2016, clockwise; Syria, Afghanistan, Iraq, Iran, Eretria, Albania, unknown, Pakistan, Nigeria, Russian Federation, and others(BAMF, 2016, p. 8).



In regard to age groups and gender, It is also important to reveal that around 74% of the refugees immigrated to Germany in 2016 were under 30 years of age with almost 65% men and 35% women (BAMF, 2016, p. 7).

Age Groups	Percentage of Male Applicants	Percentage of Female Applicants
below 4 years	51.6%	49.4%
4 - below 6 years	53.1%	46.9%
6 - below 11 years	54.0%	46.0%
11 - below 16 years	62.2%	37.8%
16 - below 18 years	50.3%	19.7%
18 - below 25 years	76.0%	24.0%
25 - below 30 years	70.9%	29.1%
30 - below 35 years	65.8%	34.2%
35 - below 40 years	64.0%	36.0%
40 - below 45 years	63.0%	37.0%
45 - below 50 years	61.2%	39.8%
50 - below 55 years	57.1%	42.9%
55 - below 60 years	54.5%	45.5%
60 - below 65 years	52.9%	47.1%
65 years and older	45.8%	54.2%
Total	**65.7%**	**34.3%**

Figure 3: Asylum applications by age groups and gender in 2016 (BAMF, 2016, p. 7).

The World Health Organization (WHO) revealed that during population movements and mass fleeing; refugees and migrants are exposed to many serious risks of psychological disorders, increasing vulnerability to communicable and non-communicable diseases, poor hygienic conditions, nutritional disorders, hypo- and hyperthermia, drug abuse, different forms of violence, sexual abuse and many other health risks (WHO Europe, 2016). Furthermore, maintaining health of refugees even in Germany with its high-quality health services cannot be achieved by the health care system alone. Social determinants of health (SDH) including social security, education, physical environment, housing, social networking, gender, along with tackling cultural and language barriers and access to health care services have significant impact on the health of new immigrants and refugees (WHO n.d.; WHO Europe, 2016). Considering both migrants' benefits and Germany's interest as a host country; it is important to ensure the preparedness, availability, proper and rapid access to health services, not only for treatment but also for the prevention of spreading diseases (WHO Europe, 2016).

After reaching Germany; refugees experienced the positive aspects of feeling safe and secure. They received accommodation, nutrition, basic health care, strong volunteer support and, cultural integration classes were offered to learn the language. But also negative experiences were made which included living in mass-shelters, dependency, inactivity, bureaucracy and long waiting times in the asylum process, fear of deportation, stigmatization, victimization and being unfamiliar with the language, the cultural structure and the health care system, with limited access to language courses and health services depending on legal status.

From that point, it was and still is highly important to provide the newcomers with information regarding their health, health care system in general, and health issues that they might face during their stay in Germany. That was the main reason for setting-up health awareness and prevention programmes for refugees in different parts of Germany, among them the REFUGIUM programme in Hamburg.

Refugees' health related resources and risks can be phased over three periods; before fleeing, during migration and after reaching Germany. Before fleeing and while staying in their home countries; they had to cope with known risks and many had resources of balanced diet, physical activity, adequate hygiene, familiarity with mental stressors and had developed adequate coping strategies, they were familiar with the health care system and had their own social network of family and friends.

1.1. Health Awareness Programme for Refugees at Department of Health Sciences (HAW Hamburg) and Study Rationale

REFUGIUM is the Latin word for refuge or hideaway; the programme's name is the German acronym for "Rat mit Erfahrung: Flucht Und Gesundheit, Information Und Multiplikation" (Experienced Advice: Refuge and Health, Information and Peer-Facilitation).

The health awareness peer-to-peer programme was meant to disseminate health information for refugees through interactive and participatory workshops. Materials in form of thematic flyers and manuals covering important health issues were developed in 8 languages to support the workshops. Refugees were trained as peer-facilitators at the university to conduct health workshops and were supposed to pass their knowledge and health information to family

members and friends living in the same refugee accommodations. The workshop topics developed in 2015 were; the German local health care system, daily hygiene, mental health, nutrition and physical activity, and in 2016 oral health in Germany was added. The first generation of 35 peer-facilitators was trained on the first five topics in 5 train the trainer (TTT) workshops, from April to June 2016.

The programme's main objectives are to activate health resources of refugees; allowing them to maintain and regain their health, and cope with the new living conditions in Germany on the one hand and, to empower them to serve and be useful to the community, thus facilitating integration into life in the new host country on the other hand.

This master thesis critically assesses the REFUGIUM programme's first implementation conducted from April to June, 2016 during my internship at the department of Health Sciences from March to July 2016. My main tasks as an intern were to manage and coordinate the REFUGIUM programme and develop the oral health topic.

1.2. Aim of the Study and Research Question

The primary aim of this study is to assess and analyze the gained benefits and challenges of the REFUGIUM programme. Through analyzing the experiences of peer-facilitators who participated in the programme and direct observations of the researcher throughout the 2016 intervention period; outcomes from different perspectives will be detailed and, gained information and recommendations on effective ways of conducting health interventions for vulnerable communities such as refugees will be developed. The second aim is to identify health related challenges and issues facing refugees in their accommodations and entitlements for accessing health services in Hamburg, Germany.

The principal research question is: What are the benefits and challenges of the health awareness intervention REFUGIUM?

1.3. Thesis Structure

This thesis is structured in six chapters. After this introduction, the second chapter provides an insight into theoretical background of refugee health and will introduce the reader to the case. The third chapter will present the methodology of the case study. The results will be detailed in chapter four, subsequently chapter five will discuss the findings and results. The final chapter will give recommendations for future programme's practice and the study limitations critically and for future evaluations and research, and closes with short conclusion.

2. Theoretical Background:

2.1. The Declaration of Alma-Ata and the Ottawa Charter for Health Promotion

Health promotion has been acknowledged internationally for decades. Health and access to health services are both unarguable human rights (UN, 1948), and from the fact that a good state of health is a human right too; The Alma-Ata Declaration on Primary Health in 1978 stated that; “health is complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector” and urged “the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world” (WHO Alma-Ata, 1978a).

As a response to the growing potentials of the new public health movement all around the world and to build on the progress achieved through the Alma-Ata Declaration on Primary Health, the first International Conference on Health Promotion was held in Ottawa, Canada during the late 1986 with a clear objective declared in the meeting’s charter to achieve“Health for All” by the year 2000 and beyond (WHO The Ottawa Charter, 1986b).

The Ottawa Charter came to define Health Promotion as “the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.” The Charter identified the prerequisites, fundamental conditions and resources for health; peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. The Charter also explained the way Health Promotion achieves its targets through advocating good health, enabling all people to reach their highest

potential through achieving equity in health and mediating all these prerequisites through governmental and non-governmental health stakeholders and within the different levels of society (WHO The Ottawa Charter, 1986b).

Thus, health promotion and prevention have been recognized as important strategies towards health for all people by WHO and the world community which defined health promotion in general, its origin, usage, and applicability. Many health awareness interventions targeting different populations, vulnerable groups, genders or communities within developing and developed countries are conducted to promote health according to WHO standards.

2.2. Health Promotion and Education for Refugees

Providing health services to refugees cannot be limited to treating diseases or healing wounds. During the 61st World Health Assembly held in Geneva, 2008; the member states committed themselves to ensure access to health promotion, disease prevention and care for migrants (WHO WHA61; 2008c). But managing health issues and providing health services for around one million refugees who entered Germany during 2015 (Mediendienst, 2016) was not an easy mission. It challenged the host country, weighed load to more burdens to the health care system in the future.

The immigration of refugees and asylum-seekers to Germany went through many twists and turns during the year 2015; politically, economically and socially. The health needs of about one million newcomers had to be covered by the German health care system, which is usually well prepared against disease outbreaks and well equipped with good surveillance and reporting systems against imported infections, non-communicable diseases (NCDs), and even diseases seen rarely within Europe (WHO Europe, 2016).

Creating health promotion and awareness programmes for refugees is beneficial in developing their knowledge of home treatment for simple conditions and improve refugees' health care seeking behavior which can lead eventually in some improvements in their health status and reductions in the burden to the health care system (Doocy, Lyles, Akhu-Zaheya, Burton, & Burnham, 2016). Additionally, health promotion could be useful in emphasizing the positive aspects of health assessments like screening, vaccination, detection and treatment of

infectious diseases and results in promoting healthy productive life for the newcomers (Semenza et al., 2016) which is indeed beneficial for the host country, in this case Germany.

2.3. Peer-education and Health Awareness

Essential health and mental care are vital for refugees in the new host country, but in addition to the language and cultural barriers that burdens them to access the proper service and sensible interventions, the notions of mental health treatment or prevention are foreign to the refugee community (Im & Rosenberg, 2016). In the study by Im & Rosenberg, many health experts spoke out the importance of health awareness interventions for refugees and new immigrants but innovative and new ideas for such programmes are needed to address the complex gaps in health for these vulnerable communities, such as peer-based health education (ibidem).

Peer-based interventions utilize people sharing mutual beliefs, ethnicity, language, religion, and other common aspects to "change health behaviors and increase positive health outcomes among members of their own community", demonstrating effectiveness when used with cultural minority populations and internationally conducted interventions (Im & Rosenberg, 2016; Petosa & Smith, 2014). Further, it is important to involve the target population from refugees and new immigrants in designing, implementing and evaluation of the intervention, and that would not be possible without the role of "cultural mediators" or peer-facilitators from the targeted community for effective actions and communication (Semenza et al., 2016).

2.4. Access to Health Care Services in Germany

Although the World Health Organization (WHO) is promoting for Universal Health Coverage (WHO, 2013d), there are still differences in accessing health care services, not only between low and high-income countries, but the gap exists within the economical levels of the society within countries and even rich countries (Marmot, 2015).

In the European Union, refugees are usually owed protection from their first country of registration for asylum, and this protection includes access to health services. During the asylum determination stage and in practice, these rights might be deprived as some

governments, even in the European Union, tend to differentiate between asylum-seekers whose claims for refuge are in process and refugees whose claims have been already accepted and therefore, a distinction in accessing welfare and health services is established (Bradby et al., 2015a, p. 1).

In addition to the language and cultural access barriers that face refugees and asylum-seekers (Razum & Bozorgmehr, 2016), in some European countries including Germany, they face legal restrictions in accessing health care services, despite the values of universality and equity (Norredam, 2006). Germany has been ranked 23rd out of 38 countries due to the restrictions facing refugees and undocumented immigrants in accessing health care services in the Migrant Integration Policy Index (MIPEX) comparing health care entitlements, access policies and health services offered in responsive to immigrants' needs and mechanisms for change across European countries and the United States, Canada, Australia and New Zealand (Razum & Bozorgmehr, 2016).

Germany has established inequalities in entitlements to health care and after the fall of the iron certain and the arrival of large numbers of refugees and asylum seekers in the 1990s (Razum & Bozorgmehr, 2016). In Germany, the entitlements to accessing services and receiving medical care for asylum seekers are detailed in the Asylum Seekers' Benefits Act (Asylbewerbsleistungsgesetz, AsylbLG); a national law that limited the access to health care services. Health care services according to sections 4 and 6 AsylbLG are limited to; emergency conditions, women's care during pregnancy, childbirth, and childhood vaccination and other "indicated preventive measures" for the first 15 months of their stay in Germany (Bozorgmehr & Razum, 2015).

In addition, bureaucratic restrictions exclude them from treatment so, refugees are excluded from membership in statutory health insurance during their first 15 months in Germany or before if their asylum claim has been decided positively. Some federal states such as Bremen, Hamburg and Berlin acted against the restricted entitlements and reduced bureaucratic barriers by introducing the electronic health card (EHC) for asylum-seekers in cooperation with a statutory health insurance. In other federal states like in Bavaria, any refugee or asylum-

seeker who wants to receive health care, is conditional upon showing a paper health voucher. This health care voucher entitles its holder to health services for limited time. To obtain this voucher, the refugee or the asylum-seeker must make a personal request or even several requests to different welfare agencies. This bureaucratic procedure might be repeated every time before visiting a health service provider and depends on the interpersonal skills of the applicant in negotiation, communication, and speaking out the needs and is subjected to the local authorities' judgment and the bureaucratic regulations of the Laender or community government (Bozorgmehr, Schneider, & Joos, 2015; Bozorgmehr & Razum, 2015).

After a waiting period defined by (Bozorgmehr & Razum, 2015) as the "waiting time" which might last for months or years; refugees and asylum-seekers are entitled to unrestricted health insurance membership, allowing their regular access to health care services and other welfare benefits. Refugees unable to claim asylum as well as undocumented labor migrants who do not or cannot declare themselves to the local authorities, either fearing from detection or deportation, are not entitled to any health care services other than emergency treatment (Bradby et al., 2015, p. 1).

2.5. The REFUGIUM Programme

This chapter gives a full description of the case, the REFUGIUM programme will be detailed including; background of the case, location and time schedule, and finally a full presentation of the participants from organizational team, bachelor students joined as TTTs, and peer-facilitators from refugees and volunteers who took part in the programme.

2.5.1. Case Background

The REFUGIUM programme is basically a health awareness intervention using community-based participatory research (CBPR) and peer-led intervention to promote refugee health and well-being, empowering refugees to maintain and regain their health during resettlement in Hamburg city, Germany (Faerber, Kama, & Aboelyazeid, 2016). The programme is devoted to build a network comprised of members from the refugee community recently resettled in the city of Hamburg; living in refugees' initial reception centers and temporary accommodations;

interested and willing to be peer-facilitators by passing the information and educating their peers refugees about different health topics.

The programme started with five topics most relevant to primary prevention; health care in Germany and Hamburg, day-to-day hygiene, mental health, nutrition and physical activity. The topics were chosen and developed according to the priority needs of refugees in their new accommodations. They were identified through research of students of health sciences with a background as refugees and asylum-seekers, focusing on strengthen refugees' resources and empowers them to maintain and regain their physical and mental health and overcome barriers and challenges.

The preparation for the programme started in March 2015 with the planning of a health sciences project by Prof. Dr. Christine Faerber and Nita Kama, who had recently graduated from university with a bachelor thesis on health resources of refugees (Kama, 2015). In September 2015, a class of 25 university students and 2 guest students with a status of current asylum-seekers started the development of drafts of the topics' flyers and manuals.

The final flyers were developed during the peer-facilitators' training period from April to June 2016 by another group of 12 health sciences students. The process of finalizing the manuals lasted until June 2017 and involved two bachelor courses on "Evaluation in Health Sciences" (Winter Term 2016/17 and Summer Term 2017) and two further generations of peer facilitators trained during that period. The flyers and manuals are translated and printed in 8 languages; German, English, Albanian, Arabic, Bulgarian, Dari/Farsi, Russian, and Turkish and, peer facilitator trainings were conducted in all languages but in Bulgarian.

2.5.2. Location

The REFUGIUM training of the first generation of peer-facilitators was conducted at the Hamburg University of Applied Sciences, faculty of Life Sciences in Bergedorf Campus which is situated around 20 minutes from the city center by local train (S-Bahn). The Life Sciences campus which is 5-10 minutes walking distance from Bergedorf train station, is one of the four faculties in the university with around 4,000 students, 70 professors and more than 100 lecturers (HAW Hamburg, Facts & Figures, 2016).

Bergedorf which means the “Mountain Village” could be considered a city of its own at a higher altitude compared to Hamburg city center. The approximately 120.000 inhabitants (Statistikamt Nord, 2015) are proud of having everything, from shopping centres to small open markets or museums, so that they do not usually visit Hamburg’s city center although it is not far away, and in reverse many Hamburgians feel they are leaving their city if they drive out to Bergedorf.

2.5.3. Peer Facilitator Training Time Schedule

The peer-facilitator training was conducted from April to June 2016 (see REFUGIUM plan in tables 1 and 2). The first session in April was an information session, followed by 5 training sessions every Monday over 5 weeks, and then a final graduation session in which certificates of participation were rewarded. Each session took 3 hours and half from 4 pm to 7:30 pm.

PFT session	Activity
April 25th	Information session and setting groups per language preferences.
May 2nd	German health care system covered to all peer-facilitators
May 9th	Peer-facilitators were divided into 3 language groups; Arabic, Dari/Farsi and English. 2 topics were conducted during the training session.
May 23rd	2 topics were covered during the session in each language group. During the last 30 minutes; the peer- facilitators were trained to perform a presentation and how to conduct an intervention using the given materials.
May 30th	Each peer-facilitator presented a part of the topic of his/her own choice to their peers and HAW students using the flyer and manual.
June 6th	Graduation session and certificates were handed out to participants.
June 13th	Additional voluntary visit to two different refugee accommodations in Hamburg, where the trained peer-facilitators along with the help of students and scientists conducted interventions.

Table 1: Peer Facilitator Trainings Schedule

The peer-facilitator trainings were conducted in Arabic, Dari/Farsi, English, Russian and Turkish in 3 parallel sessions in several classrooms within the campus. At the beginning of each workshop, all participants were seated together in one big classroom, the schedule of the day was presented in German and English and then translated to Arabic, Dari/Farsi, Russian and

sometimes Turkish when needed. Albanian and Bulgarian were offered, but no refugees requiring these language skills participated. The information session and the health care in Germany topic were conducted in this way, in all other workshops the participants were divided in groups according to their language preference and the workshops were held in different classrooms, sometimes bilingually.

March	April	May	June
Setting plan for the peer-facilitator trainings Preparation of material Make students familiar with topics, information and manuals	Prepare materials and peer-facilitator trainings Developing flyers and manuals Invite participants (recruitment) Information session 25th of April	Workshops on the 2nd, 9th, 23rd, 30th of May. Finalize flyers information with facilitators. Finalizing flyers for printing (layout, translation, proofreading in 8 languages)	Graduation session and certificates, June 6th. Visit to 2 refugee accommodations, conduct 4 topics actual intervention on June 13th in Osterade and Wiesendamm.

Table 2: REFUGIUM plan

2.5.4. Participants

Lecturers and Organizational Team Members

The programme was developed under the guidance of Dr. Christine Faerber, professor and head of health sciences department at HAW Hamburg. She planned the module “Refuge and Health” in spring 2015. Her idea was to advance from research in preliminary work conducted by students with a background as refugee immigrants on experiences, health problems and resources into a practical intervention approach during the winter semester in 2015/2016, so that bachelor students would get a real-life field experience. As professor Faerber was leading the programme, she had the highest load of responsibilities from coordinating with the many stakeholders involved, for e.g., establishments interested in sponsoring the programme either with funds or materials, non-profit organizations (NGOs) through which many interested refugees heard about and joined the programme, lecturing some of the topics in German and

sometimes in English followed by translations from the interpreters in the different languages and finally delegating other tasks to the team members and giving students the opportunity to get committed and feel responsible for this new experience.

Nita Kama; graduated as a bachelor of health sciences from the HAW Hamburg in 2015, she is originally from Albania, and arrived to Germany when she was 9 years old with her family as refugees during the Yugoslavian war in the 1990s. Her family after many years of waiting received the asylum status. She is now a legal citizen of Germany; she went to school and university in Hamburg. Nita Kama had always been concerned about refugee health since she had gone through that difficult experience and was especially in refugees' health resources and wrote her bachelor thesis about "Resilience of former refugee children living in Germany from Kosovo - A retrospective study of the personal and social protective factors" (Kama, 2015). Nita Kama was a lecturer in the programme; who from September 2015 on together with Profe. Faerber, students and, current refugees had developed the programme and, educating the facilitators from refugees about the topics and the loads of information about health. She was very important as a role model and an influencer for the refugee audience from women, men and especially youth listening to her personal story. Her words gave them hope that they could overcome whatever happened to them, pass the bad experiences they were currently struggling with and look forward to new beginnings and "make it" in Germany.

As the researcher of this study and member of the organizational team; my role in the programme, how I joined and self-reflexivity will be detailed later in the methodology chapter.

Student Trainers

The Health Science's bachelor students in the module "Refuge and Health" took part in this programme as topic trainers. 11 students (9 women – 2 men). Three guest students with asylum-seeker status have participated in the development of the programme in this initial phase. Allaeldin Hassan from Sudan supported the programme during the preparation phase in 2015; he gave information about living conditions in refugee accommodations and the health needs there. Sami Ojo also supported the programme during the preparation phase in 2015 with his information inputs and was additionally actively supporting the English-speaking

peer-facilitator training group from April to June 2016. The third guest student was Zeinab Behroozian from Afghanistan who attended the module "Refuge and Health" which started in March 2016, she participated in developing the mental health topic along with her team and was translating from English to Farsi during the peer-facilitator trainings from April to June, 2016.

The student trainers chose the topic of their interest and were divided accordingly:

Health Care System	Daily Hygiene	Mental Health	Nutrition	Physical Activity
1 student trainer and 1 member from organizational team	3 student trainers	2 student trainers and 1 refugee guest student	2 student trainers	2 student trainers

Table 3: Student trainers divided over the topics

During March and April 2016, students underwent extensive training regarding their topics to enable them to instruct the peer-facilitators. In addition to getting trained on the content information, good presentation methods and handling workshop techniques; they were also informed about the cultural sensitivities and communication issues that they needed to be aware of when getting in contact with refugees.

Their task was to summarize the information for their topics in the simplest and most relevant, informative form so that participants from peer-facilitators understand the information and pass it on to their peers afterwards in an uncomplicated and qualified.

The student trainers conducted the interventions to the different peer-facilitator's language based groups and they had to finalize with them the flyers and manuals after guiding the workshops discussing all information and its relevance, and adjusting all language amendments needed in a participatory approach.

Peer-Facilitators

The participants of the training programme became REFUGIUM peer-facilitators. They were trained and educated on the health topics of REFUGIUM and then learned to pass the information in their own languages on to their peer refugees in different accommodation settings in and around Hamburg. During invitation and recruitment phase, refugees, both

women and men, 18 years of age and older living in either primary or secondary refugee accommodations or other types of accommodation settings in Hamburg were approached.

Approaching methods

Facilitators were invited to join the programme using different strategies; printed invitation leaflets in 8 languages including an introduction of the programme, objectives, schedule and plan of the programme, benefits from participation, and contact information were detailed. The invitation was handed out all over Hamburg in refugee accommodation settings and German language schools where refugees get their integration classes and at different universities' campuses (see Appendix A).

Social Management of many refugee accommodations, public health administrators and NGOs working with refugees on many levels were contacted via; emails, phone calls, or post mail through which the programme was introduced, its benefits and enquiring help by inviting interested and tempted refugees and other volunteers to join the programme. Students' activated private networks, HAW press office released information to the press and the Hamburg Social Ministry posted it on its homepage.

Presenting the peer-facilitators

The initial number of refugees interested in the programme on the first introductory session was 59 participants (18 women – 41 men) between 18 – 63 years of age. 36 (9 women – 27 men) completed all the workshops and received their certificates.

The majority of participants came from Syria and Afghanistan, other nationalities were represented in lower numbers coming from Iraq, Iran, Eritrea, Nigeria, Egypt and Ukraine. Participants had different professional backgrounds and educational levels starting from school students, service workers, musicians, university students and academics, engineers, pharmacists, bankers, dentists, physicians and on the other hand several were even illiterate. From the 36 peer-facilitators who completed the programme; 34 had arrived to Germany as refugees during the period between 2014 - early 2016 and were staying in either primary or secondary refugee accommodations in Hamburg. The other two participants worked as volunteers in secondary accommodations and helping refugees on different levels.

Farsi/Dari group (included 1 Russian speaking peer-facilitator)	Arabic group	English group
15 peer-facilitators	13 peer-facilitators	8 peer-facilitators

Table 4: Workshop groups and Peer-facilitators by language

REFUGIUM's Stakeholders

The programme had to deal with different internal and external stakeholders which included; the university press office who helped us in the announcement of the programme. The university campus cafeteria MENSA which provided crockery and cutlery for free. Social managements of the refugee accommodations supported the programme by motivating many refugees to attend the peer-facilitator training. An illustrator with a bachelor in health sciences sketched all explanatory drawings on the flyers using her own immigrant experience and her professional knowledge to provide informative, gender and culturally sensitive visualizations. A graphic designer hired to design the flyers in all 8 languages in HAW corporate design. Former and current students with Farsi mother tongue supported translations during trainings. Buhck Foundation sponsored the print, and Prof. Dr. York Zoellner supported the graphic design. The Patriotic Society of 1765 suported the fundraising process.

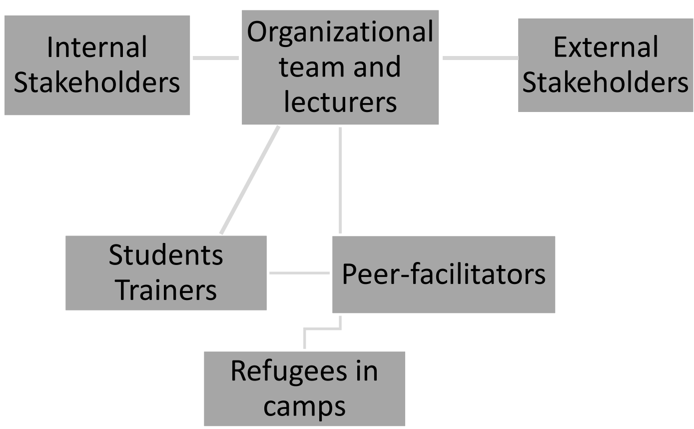


Figure 4: Hierarchy of the REFUGIUM programme.

2.5.5. Flyers and Manuals

The initial flyers for each topic which had been developed during the winter term 2015/16 were improved in a collaborative process with refuges who participated in the peer-facilitator training in May 2016. Peer-facilitators were involved in the development of the final version of flyers, after discussing all information and its relevance with their student and scientific trainers during the workshops, giving their comments, making suggestions and providing language adjustments. Finally, in June 2016 the flyers were set for printing; two versions were produced; a PDF for online publication and more refined version for paper print.

Also, facilitator sheets or topic's manual to guide the peer-facilitators when they are conducting workshops in refugee accommodations were developed further in participatory collaborative process. All manuals were designed to have 5 horizontal sections and 5 vertical phases for each topic. Horizontally, each manual provided; a time plan, objectives, content input, methods of conduction, and materials needed for each workshop phase. Vertically, the process of the workshop was covered welcome and suitable introduction of participants and topic, information, activity, take-home message and farewell part (see appendix B).

The Intervention and peer-facilitator trainings can be simplified in the following figure;

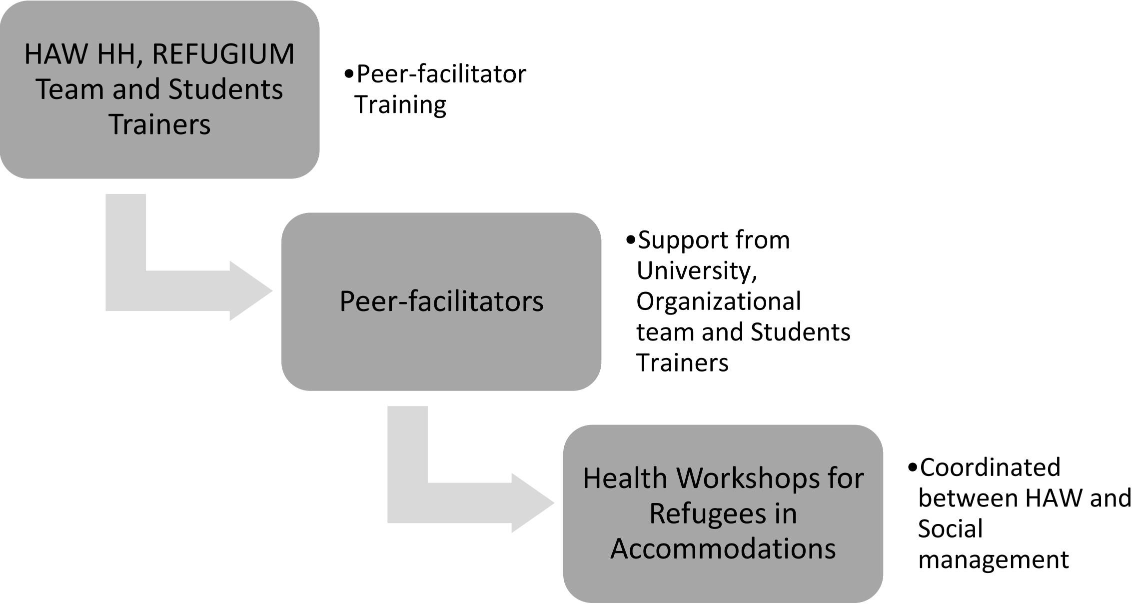


Figure 5: Peer Facilitators at the Core of REFUGIUM

3. Methodology

In this chapter the case study approach that was chosen and applied for this project will be outlined. At the beginning, the rationale for choosing a qualitative approach, and case study as research method will be discussed. Following that, an insight to the different sources of data and data collection will be detailed, including face-to-face interviews with peer facilitators participated in the REFUGIUM programme, with respective interview guidelines and procedures, the sampling process, as well as direct observations by the researcher. Furthermore, the data analysis process will be described. Finally, ethical considerations and the role of the researcher in the field will be discussed.

3.1 Rationale for Qualitative Research Approach

The qualitative study design was chosen to be the desired methodology in this research due to its explorative character that makes it distinctive when a group or a population needs to be studied especially when the variables that need to be identified are difficult to be measured and most importantly when silenced voices need to be heard (Creswell, 2013 p.48). Additionally, qualitative research method was adequate because the potential sample size of peer facilitators educated in the REFUGIUM programme in 2016 was 35, so it was decided to collect in-depth data. Interviewing the peer-facilitators gives a voice to refugees arriving to Hamburg, Germany after a long and hard journey for survival. Talking to them directly and empowering this vulnerable group to share their stories and experiences allows the researcher to get a complex and detailed understanding of the health issues they are facing since arriving to the host country (ibid, p. 48).

The qualitative inquiry and its interpretive frameworks and methods allow the researcher to study the case in its “natural settings” which is the key to focus on meanings and the essence of the experience, bringing it directly from the people and the real world to scientific analysis which will help in giving recommendations for practice at the end of this research rather than measuring, calculating and analyzing statistics which do not fit the problem (Creswell, 2013, p. 44, 48; Denzin & Lincoln, 2011, p. 3).

Qualitative methods also allow the researcher to be the key instrument of the research making it flexible to show his/her own reflexivity, observe behaviors, study documents and interview participants using own instruments like open-ended questions without relying on questionnaires or instruments developed by other researchers (Creswell, 2013, p. 45). This was described and feasible because the researcher had built a good relationship with the peer facilitators in the REFUGIUM programme during the facilitator training in the summer term of 2016, could gain their trust, and was active in the programme for a whole year, so extensive experience in the field was given.

Another distinctive characteristic for qualitative research that made this research rely on it, is the multiple methods and forms of data sources that could be used; interviews, casual conversations, direct observations, recordings, field notes and memos, making the complex world of refugee health visible and turning it into a series of representations rather than relying on one source of data which would provide only a limited perspective (Creswell, 2013, p. 45; Denzin & Lincoln, 2011, p. 3).

This comprehensive research process and diversity of data sources is what I was in need for to transfer the experience that I had witnessed into a research that could formulate hypotheses and give recommendations to researchers who want to study this area in the future and who are concerned about refugee health and effective health promotion programmes.

3.2 Case Study Approach

The case study approach was chosen to develop an in-depth understanding of the CBPR based intervention dealing with refugee health, to explore the issues and problems accompanied, and using the REFUGIUM programme which is a case within real-life as a specific case for illustration (Creswell, 2013, p. 97). According to Yin (2014, p. 12), a “case study is preferred when examining contemporary events” which have been seen throughout the programme. A case study and historians’ repertoire rely on the same techniques, but the former adds on two more sources of data not usually used by historians which are; direct observations of the

events being studied and interviewing the persons involved in them, in addition to the variety of evidence-documents and artifacts that can be used in a case study (ibid, p. 12).

Before summing up the outlines defining the case study approach, it is important to consider that some researchers as Stake (2005) do not consider case study research as a methodology and rather a choice of what to be studied "(i.e., a case within a *bounded system,* bounded by time and place)", while other researchers present it as "a strategy of inquiry, a methodology or a comprehensive research strategy" and according to Creswell (2013); it is viewed as a methodology: " a type of design in qualitative research that may be an object of study, as well as a product of the inquiry" (Creswell, 2013, p. 97).

The rationale of choosing the case study approach is that it has its own place among other approaches in conducting evaluations. According to the U.S. Government Accountability Office (1990), case study has at least four different applications and among them "is to describe an intervention and the real-world context in which it occurred" (Yin, 2014, p. 19) which is certainly applicable for this research. As "there is no standard format for reporting case study research" (Merriam, 1988, p. 193), it allows for the researcher to explicate and display the lived experience with few boundaries.

Creswells sums up the characteristics defining the case study approach (2013, p 97);

"Case study research is a qualitative approach in which the investigator explores a real-life, contemporary bounded system (a *case*) or a multiple bounded systems (*cases*) over time, through detailed, in-depth data collection involving *multiple sources of information* (e.g., observations, interviews, audiovisual material, and documents and reports), and reports a *case description* and *case themes*. The unit of analysis in the case study might be multiple cases (a *multisite* study) or a single case (a *within-site* study)".

Identification of a specific case is the first step in beginning a case study research, which might be an individual, a small group, an organization, a relationship, a decision process, a community or a specific project as in the case (Creswell, 2013, p. 98) of the REFUGIUM programme, is a progressed real-life case bounded by specific time and place which are key parameters defining it as a case to be studied (ibid; p. 98).

Among the three types of case study, the *intrinsic case study* design focusing on the case itself was considered for this research; allowing the evaluation of a programme, presenting and illustrating a unique and unusual health awareness intervention for refugees in Hamburg and giving a full detailed description of that case study and its analytic procedures (Creswell, 2013, p. 100).

3.3 Data Collection

Case study allows the use of different sources of data in order "to build an in-depth picture of the case" (Creswell, 2013, p. 162) as for this part of the study; sources of data used in order to answer the main question along with detailing and displaying the themes around the REFUGIUM programme case. Some sources of data and evidence for case study that was recommended by Yin (2014), p. 12; interviews and direct observation were used in this study research.

The data was collected over an 8-month period, from April to November 2016, during the researcher's internship in the programme. The following parts reveal the interviews with peer-facilitators in the form of open ended questions, direct observation of the events and participants as a member of the organizational team and one of the lecturers and interpreters during the programme.

3.3.1 Interviews with participants from peer-facilitators

As a widely used procedure in qualitative studies for data collection; face-to-face interviews with a number of peer-facilitators were determined as a main source of data for this research in the form of open-ended questions (Creswell, 2013, p. 163, 164).

Sampling

Cases or individuals to be selected within a case study should preferably be unique and unusual. For that purpose and in regard to the main research question of this study to be answered through diversified representation from the peer-facilitators, a maximum variation sampling strategy was applied (ibid; p. 156).

The maximum variation sampling approach allows the researcher to determine and select participants that are quite different based on criteria which are important to the study (Creswell, 2013, p. 157).

In order to maximize differences; participants from peer-facilitators were selected from the main list of attendees based on four criteria; their gender, age, regional background and educational levels. Gender was important as women were less represented compared to men. Stratifying participants according to age and gender together ensures priorities and demands differences between them. Educational levels and country of origin were part of selection criteria, as it was assumed that both could impact the way participants benefit from the experience of becoming a peer facilitator and participating actively in the programme ending up in reflecting different findings and perspectives.

Recruitment Procedure

After refining the list of participants according to the inclusion criteria, 9 peer-facilitators were contacted through personal mobile phone calls as they had been requested to leave their contacts, age, country of origin and educational level during the workshops.

As the participants knew me as one of the lecturers and interpreters in the programme, I tried not to pressure them during the phone call so they would not feel that they must just meet me for the interviews or would do me a favor, also to avoid any bias from the beginning. I reminded them about myself and after greetings, informed them about my research topic and then I asked if they could tell me about their experience, what was good, what kind of challenges they faced and if they had problems with my recording the interview confirming that the questions would not get out of the REFUGIUM programme topic and will be kept anonymous and that a consent for ethical purposes will be conducted for both interviewees and interviewer.

The interviews took place in 3 different locations upon agreeing with the participants; 3 interviews took place in the Central Library which is a 5-minute walk from Hamburg's main station; one focus group with 2 participants, was conducted in quiet and isolated reading rooms which avoided any kind of distractions and the other interview was done in the open

hall as the female interviewee did not seem to like the idea of staying in one room alone with me, a male researcher. Three other interviews were done in the Hamburg City Library which is also quite central and has some good calm spots that were good for the interviews. The last interview took place in one of the coffee shops around the central station following the interviewee's request.

As mentioned earlier, 9 interviews with peer-facilitators were planned; and only 8 were conducted as one woman could not be reached on the scheduled interview day, although she was very interested to participate. Her criteria would have been important to the sample with its distinctiveness; she is 38 years old coming from Syria and arrived to Germany alone after her husband was trapped in Istanbul. She is illiterate and was living in an initial reception centre only for women and she had told me before that she was suffering from some psychological especially because she could not sleep well at her accommodation due to the noises of children, she had visited a therapist several times but did not help her much in her own perception.

The final sample of 8 peer-facilitators; 4 women and 4 men represents the countries of Syria, Afghanistan, Egypt and Iraq. Ages ranged from 19 to 63 years. Up to the time of the interviews; only one was entitled the asylum status, 5 were still waiting for it as refugees in "waiting time" and these 6 had been staying in Germany from 9 – 13 months, mostly in Hamburg and living in either initial or secondary temporary refugee accommodation settings. The two participants of the focus group were German high school pupils of Arabic origin whom their families had brought to Germany as refugees years ago as children, they both were volunteering in different refugee camps. The interviewees came from different rural or urban backgrounds; farming villages, small cities and capitals. Further, different educational levels; school students, university student, teacher, professional musician and a dentist. Table 5 lists all details about the sample are stated; age, gender, legal status, languages spoken, profession and the duration of living in Germany, and gives the interviewees suitable pseudonyms.

Id	Name	Gender	Age	Legal status	Country of origin	Duration in Germany	Profession	Languages
1	Fatma	F	33	Refugee	Afghanistan	9 months	IT specialist	Dari MT*/ English
2	Nada	F	20	German Citizen/ Former refugee	Iraq	6 years	School Student	Arabic MT/ German
3	Dina	F	19	German Citizen/ Former refugee	Egypt	9 years	School Student	Arabic MT/ German
4	Ahmed	M	25	Refugee	Syria	13 months	Master student	Arabic MT/ English
5	Haidar	M	46	Refugee	Syria	13 months	Dentist	Arabic MT/ German/ English
6	Shiar	M	36	Asylee	Syria	12 months	Teacher	Arabic MT
7	Asmaa	F	19	Refugee	Afghanistan	10 months	School Student	Dari MT/ English/ German
8	Hussein	M	63	Refugee	Iraq	13 months	Musician	Arabic MT/ English/ Turkish

MT* = Mother Tongue

Table 5: Sample description and characteristics

Interview guideline

At the beginning and while formulating the questions, the interview guideline was first developed as a form of 20 questions and then was refined to a 2-page form of 10 semi structured open-ended questions phrased in an understandable way and allowing the interviewees to open up and talk freely, in addition to probing questions to be asked when needed if the participants were hesitant to speak or share their ideas during interviews (Creswell, 2013, p. 164).

The questions were divided into three main parts

- Benefits of REFUGIUM programme
- Accommodation Settings and Health Conditions
- Challenges during the programme and other health issues

Additional pages; contained the socio-demographic information and the informed consent form (see appendix C and D).

Interview procedure

All interviews were conducted during October and November 2016. In the beginning it was thought to be more advantageous if the interviews would conducted in focus groups as the interaction between the interviewees would result in more and a better quality of information and help avoid any hesitance and discreet attitude (Creswell, 2013, p. 164), but there was a problem in gathering all or some of the interviewees together as they were attending either language schools or some different courses and only one focus group interview was done.

After arriving to the location of the interview, the interviewer started with welcome greetings and offered tea or coffee from the location's cafeteria for refreshment purposes as all interviews were done during the afternoon when participants had finished their courses. We started with some small talk to catch up and also to make the interview partners feel relaxed and comfortable then, I handed out the informed consent form, explained the research purposes, and data protection and asked them to give written informed consent (Creswell, 2013, p. 166).

Furthermore, I explained the interview procedure; with every interviewee, I asked if it is problematic to audio-record the interviews and there was no single refusal, I showed them that I was going to ask these number of questions and the interview would probably not exceed one hour (ibid; 166). Some of them asked me if they could look at the questions before we start and I agreed. Another participant told me "I totally trust you and you know that, but I do not want to tell my story again", and I asked "which story?" and he answered; "About fleeing from my country and coming here and so on...". So I assured him not to worry and there would not be any personal questions and he could look at the questions to avoid any nervousness and we started afterwards.

The interviews lasted between 26 – 52 minutes and they were all audio recorded. Only afterwards I took out the socio-demographic form to fill it out, this was intentionally planned to make interviewees feel more comfortable at the beginning of the interview and avoid any

impression that the following interview would be personal. Five interviews were done in Arabic, as I was keen that the interview partners could talk freely and express their ideas in their own mother tongues. The other two interviews were done in English as I cannot speak Dari or Farsi, and the interview partner from Afghanistan were speaking excellent English.

Some interviewees seemed to be tense at the beginning, I did not like to interrupt them trying to be a good listener (Yin, 2014, p. 74), but on one incidence, the participant seemed not to be that open and I think even that he noticed it, so he asked me, “shall I talk and say everything?”, I said absolutely, you are free to say anything, criticize with no worries and I added that you will even feel better if you speak in your own dialect as he was trying to talk in my own one and I think from that point he was really open to talk and was freely enjoying giving his opinion and speaking out his ideas like other participants did and all interviewees were thanked for participating at the end of the interview.

3.3.2 Observation

Observation is a key tool when it comes to data collection in qualitative research (Creswell, 2013, p. 166). As I was engaged in the REFUGIUM programme and participated in its activities for a year, far away from being a passive observer, rather acting as a “*participant observer*” giving me the opportunity to get inside views, interact with refugees on a regular basis and get more of subjective data.

Observation of physical settings of the programme, participants along with their interactions and reactions to the activities and topics and even my own reactions and behaviors were carefully watched to help answering the research questions of this study (Creswell, 2013, pp. 166, 167 & Yin, 2014, p. 115). From the time that I had been officially engaged into the programme, I started taking notes directly after the PFT sessions in order not to forget about what happened during the trainings. I was also keen on writing down all interesting incidences happening either during the normal office hours, correspondence emails or phone calls while communicating with our stake holders or during my casual small talk with the peer facilitators.

3.3.3 Data Management

The face-to-face interviews with the peer-facilitators were audio recorded, saved to my personal computer and to an external hard desk as backup files (Creswell, 2013, p. 175). All interviews were manually transcribed from digital recording to word files and the records were deleted afterwards to keep anonymity. The original meaning, intent and ideas of the interviewees were reflected while transcribing. The Arabic interviews were transcribed into English language and few grammatical and syntax corrections were made to the English interviews in order to be easier for the reader to understand their meanings. The anonymity of the participants was protected as they were given pseudonyms, also names of the accommodation settings where they lived were replaced with different ones (ibid; p. 175). All interviews were given an identification (ID) number from 1-8 following the sequence of conduction.

Second main source of data in the form of researcher's memos on observation or the documents from the programme were manually saved and archived.

3.4. Data Analysis

In order to know the benefits, challenges and the impact of the case study of the REFUGIUM programme, the data was analyzed following Stake (1995) in his book "The Art of Case Study Research" that was simplified and modified by (Creswell, 2013, pp. 199 & 200). As a first step when analyzing a case study and as a modification to Stake's analytical steps, Creswell (2013, page 200) recommended the full and detailed description of the case and its aspects and that was described in the background part. Second step as shown in figure 6 was to develop the themes from the data collected using categorical aggregation to reflect a meaningful picture of the issues. The saved word file transcriptions were categorized and analyzed using the MAXQDA software programme.

The following step was the direct interpretation of the researcher in order to clarify or give a deeper insight into issues and instances along with the observations from participating in the REFUGIUM programme. Finally, and as a fourth step, naturalistic generalizations were

developed from the analyzed data in order to give recommendations to other researchers who would be interested in conducting programmes like REFUGIUM in the future.

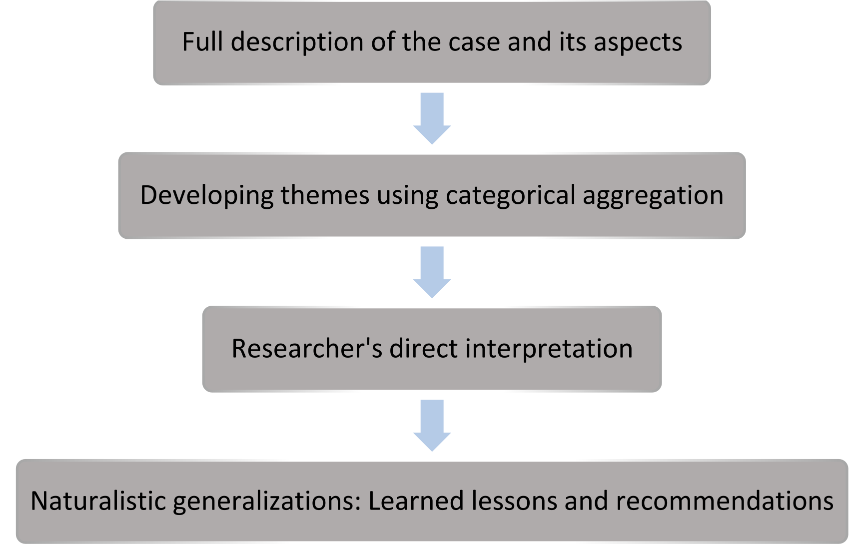


Figure 6: Analytic steps for case study (Creswell, 2013, pp. 190 & 191)

3.5 Ethical Considerations

Before the conduction of the interviews, an overview about the study research and its objectives was explained to the interviewees. The same information was also stated in the informed consent form that was obtained for confidentiality purposes. The informed consent was written in three languages; English, German and Arabic (Creswell, 2013, p. 166).

It was also confirmed that no personal information would be published and names would stay anonymous as it might be sensitive for them as refugees and not to endanger them by any means and that all recorded interviews will be deleted after the transcription process.

3.6 Role of the Researcher and Self-Reflexivity

I was partially involved as a volunteer during the winter term 2015/2016 into the very first semester of development of the REFUGIUM programme in the project seminar "Refuge and Health". Since I come from a Middle-Eastern country and I know some cultural sensitivities, I could help in identifying relevant information and as an interpreter translating from Arabic to English and vice versa during two workshops conducted in January 2016 when refugees were invited to share their opinions and give input regarding the programme.

By the beginning of 2016, after some volunteering work in refugee emergency camps in Hamburg, helping with translations some families and individuals there and seeing the situation in the accommodations, I wanted to help more effectively and structurally and not just by showing empathy and providing individual support. I wanted to use my specialty as a dentist, my experience in research and as volunteer with multinational organizations. An appointment with Prof. Faerber was arranged to speak out some ideas that I had to support the awareness programme and an internship was agreed on. From March 1st 2016 I was involved officially in REFUGIUM and managed it for the period to July 2016 as an intern at the Health Sciences department. My tasks were; the coordination between different stakeholders, planning workshops, data management, translation to and from Arabic during the workshops, developing the dental health awareness topic and its flyer, manual and material, and other organizational arrangements and responsibilities.

During the first weeks of my internship, I got the idea to write about this real-life experience and to reflect it in the form of a story or a case study in its scientific meaning but the topic of the benefits and challenges came at a later point.

I had a mixed feeling about everything; I was emotionally feeling empathy towards the refugees which I could not show during the workshops and at the same time; I was feeling motivated and responsible to teach them something useful and felt happy seeing them enjoying coming and going, engaging in the programme and being part in enhancing their mood.

I believe that refugees and I got along together well; I was keen to go to each participant; greet and welcome her/him at the beginning of every workshop. I showed them that they could trust me and they can ask about anything they need. I got in contact with almost everyone from the peer-facilitators; Arabic, Dari/Farsi and other speakers; I got many questions about what I do at the university, how I came here and if I could help some of them to join the university in the future. I was also keen to show them that I was not only speaking one of their languages, but I was aware of their cultures and sensitivities especially when talking to women participants or during the holy month of Ramadan.

During the workshops, I was motivating both women and men to speak out their opinions, I wanted to encourage them and make them feel welcome in all possible ways. Many of the refugees asked for my personal cellphone number and I gave it to them and some had contacted me and I met some of them many times occasionally in the city.

Aside from the PFT workshops; I had a great opportunity being invited on behalf of the organizational team to the annual conference of the Federal Association for Prevention and Health Promotion (BVPG), June 2016 in Dusseldorf. The conference title was “Refuge and health - integration through competence development”, and I was there to give a presentation about REFUGIUM and share our experiences with the participants from different organizations, the ministry of health, and others concerned about the case of refugees and their integration in the German culture regarding health.

The participants were very excited about the work done and achievements of REFUGIUM, I received a lot of questions and enquiries during the discussion time after the presentation and by the end of the conference. Further, the presentor of one health organization related to the ministry of health in Germany asked for my permission to use REFUGIUM’s flyers, which were available during the conference, for their health intervention for refugees in Frankfurt city and asked for our cooperation, which appreciated the work and efforts put into the programme, and more so, the results.

4. Results and Findings

In this chapter, results of the analyzed data from the 7 interviews with the 8 peer-facilitators are presented in 4 main categories and revealed in 332 significant statements coded in 11 codes. Analyzed data of each code are then followed by the interpretation of the researcher and contrasted with direct observations in order to describe the benefits and challenges of the health awareness programme "REFUGIUM". The categories and codes are presented in the category tree (figure 7). Additionally, organizational aspects and challenges faced by the organizational team that could not be detailed in the background chapter will be described. Finally, a detailed description of the activities, physical settings and observations over one workshop day within the programme allowing the reader to get a full picture of the procedures of the peer-facilitator training.

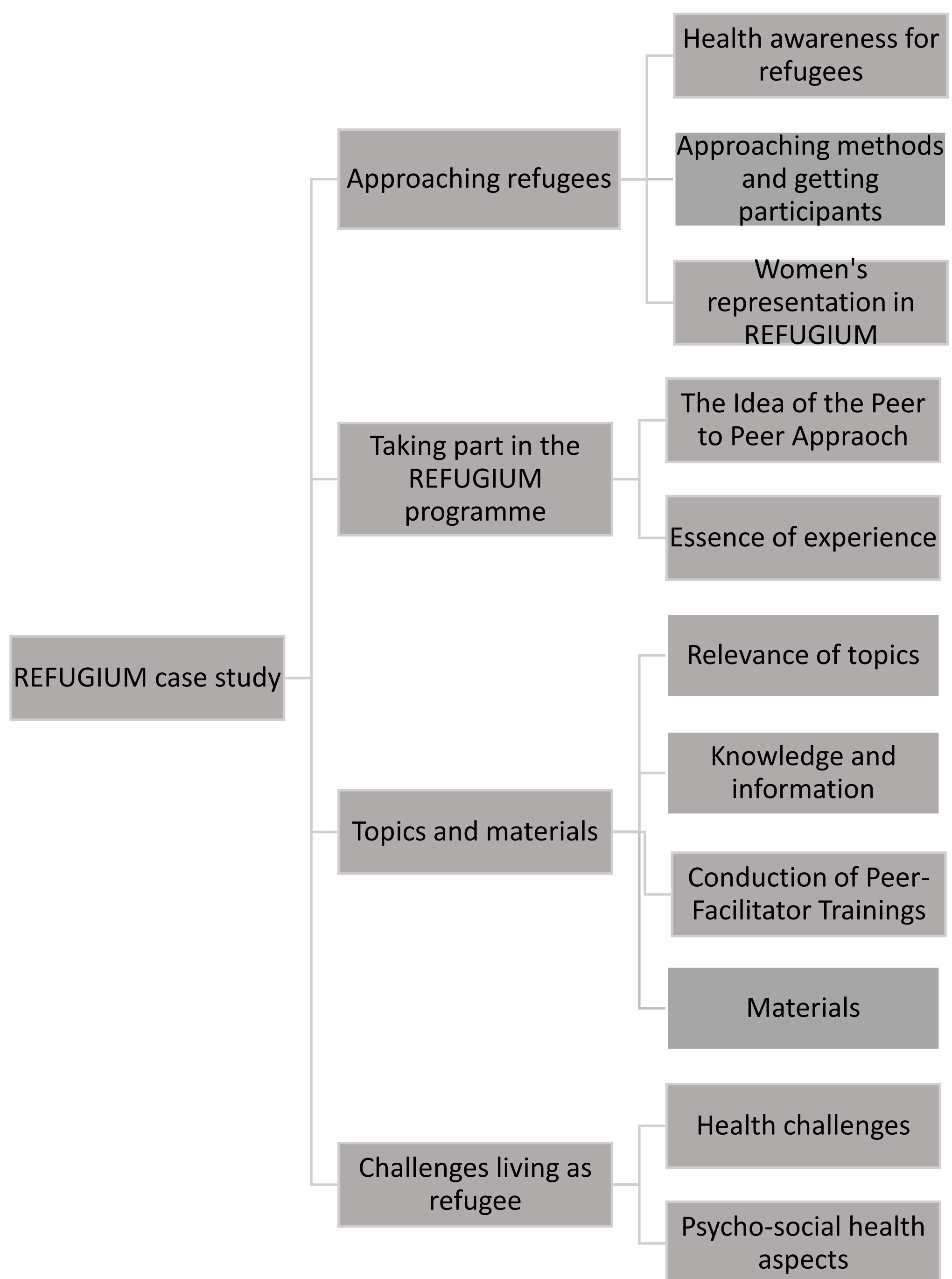


Figure 7: Categories and codes analysis tree

4.1. Approaching Refugees

The first category *Approaching Refugees* gives a description of how refugees in initial reception centers, temporary accommodations and other settings were reached and and received invitations to take part in the REFUGIUM programme and if there were other similar programmes that they had heard about. Three categories were developed which are considered important as they could provide valuable information about challenges that might face researchers and social workers interested in conducting similar programmes for refugees or other vulnerable groups in the field of public health.

Category:	Code:
Approaching refugees	1. Health awareness for refugees 2. Approaching methods and getting participants 3. Women's representation in REFUGIUM

Table 6: Approaching refugees

4.1.1. Health Awareness for Refugees

This code was put here to clarify if there were any similar programmes concerned about refugee health in accommodation settings in Hamburg, especially because we claimed "REFUGIUM" to be unique and almost alone in that area in the city regarding its objectives and method of conduction. In this code, I am not talking about the idea or the methods of conducting the programme, this will come later in a separate code but rather if other health programmes were known to refugees in Hamburg.

During the peak of the refugee immigration into Germany in 2015 and early 2016, large numbers of announcements for volunteering, donations and integration language courses and activities were everywhere in town but nothing was seen for refugee health, so I asked the peer-facilitators if they had heard about similar programmes elsewhere.

All of the 8 interviewees told me that they had not heard or seen any other announcements talking about health awareness. Dina who was volunteering in a secondary accommodation for families in Hamburg for one year and came herself as a refugee almost 9 years ago before she became a German citizen told me that "nobody actually took care of this topic before, and

of refugees' health" (Dina, 4 – 5). Shiar also told me "no, I did not know or hear about any other similar programmes about refugees' health but I have heard about other programmes helping refugees in integration and others offering German language classes" (Shiar, 5 -5). There was another programme about sexual health, not targeting refugees only but also involving other vulnerable groups from workers in Hamburg or that was what Asmaa told me who was really shy to continue talking about that other programme and wanted to change the subject telling me "yes, but in a way different, the other programme here in Hamburg is about personal and sexual health for both women and men but I do not want to speak about it now [..laughs and shyness], it is about women's health" (Asmaa, 5 – 6).

I am not saying that we are the only ones concerned with refugees' health promotion and awareness in Hamburg, but at least we are one of very few initiatives and was even more convinced about this unique position of REFUGIUM when I attended two conferences in a row about refuge and health in Dusseldorf and another one in Hamburg city in autumn 2016. It was very obvious that all official and non-official organizations in Hamburg were mainly concerned about announcing for integration in the form of German language classes or cooking workshops for women but it was rarely seen a flyer, brochure or any kind of announcements talking about refugees' health awareness and how to take care of one's own health in the new host country. For sure health professionals might know or have heard about these kinds of programmes targeting refugees but about the published ones that a refugee in a camp or other accommodation setting might get in contact with, none was identified by the refugees I talked to.

4.1.2. Approaching Methods and getting Participants

In my opinion this was the hardest phase of the programme because here you are not going to the refugees' camps or their accommodation settings and conduct the workshops there, but you are inviting people who suffered very hard and face current critical situations to the university to participate in a comprehensive training about health. It was a very challenging to invite refugees from many different aspects; first of all, they are the ones coming to you and not the opposite, so there must be a very good reason for them to come and it must be beneficial and interesting at the same time. Second; it is a long way from Hamburg city center

to Bergedorf, for sure there are some accommodation settings in Bergedorf area but the majority are in the center. Third; these people suffered in their home countries, while fleeing, and even after arriving to Germany, so why should they trust the invitations and come attend the sessions?

As a result for our activities and methods that we followed in inviting peer-facilitators (see background chapter, REFUGIUM case study, peer-facilitators invitation methods), 55 attendees showed up on the first introductory session after handing out around 500 invitation flyers in 9 different languages and a lot of contacting procedures with many different organizations to invite people.

During my interviews, I asked the participants about how did they hear about us and the programme and what would be the best approach in their opinion to invite more peer-facilitators from refugees to actively participate in the programme. Fatma who was also a guest student at the university told me that she knew about the programme from one of the lecturers at the university and for her opinion about the best way of approaching refugees, she said

> “unfortunately, the social management doesn’t cooperate with these kinds of programmes, usually they are busy with their stuff and work, they could give good help, like providing the sessions or asking the parents and talk to them because usually they are in contact with each other but they don’t cooperate. I think it is very good if we can have refugees with same nationality to transfer information” (Fatma, 88 - 89)

and then I asked about how to reach the vulnerable groups and pass them the information, she said “if you go to the doctors in the camps as they have a list of how many people are asking for therapists or psychologists for example” (Fatma, 90 - 91). Dina and Nada said that they heard about the programme from their coordinator in the volunteering association that they work for and they also said that in order to get more refugees to participate in the programme, Dina was not that convinced about only inviting the refugees and the programme should have been involving social managements of the refugees camps and accommodation settings

> “it would have been very meaningful if the programme was introduced to the social management in the camps or the people dealing with refugees, as refugees who participated can only use the information themselves or maximum they can tell some of their friends or family members but it won’t reach the big numbers in the camps and apparently, the majority will lose the opportunity to get the information. It was good to involve and invite the refugees from their settings but also the social management or volunteers working with them should have been included in that invitation” (Dina, 48 -49)

Ahmed, Haidar and Shiar live in three different camps and they saw the flyer invitation on the information board at the social management office in their camps and through that they contacted us and participated. Haidar was very enthusiastic about announcing the programme in primary and emergency camps as the new refugees arriving there are in deep need of the information and agreed with Shiar in his opinion who said

> “I think for the continuity of the programme, it is always good to keep hanging the brochures and flyers in the social management rooms or dining rooms and make some introductory videos of the past sessions or videos inviting the new facilitators from refugees motivating them to participate” (Shiar,45-45)

Asmaa and Hussein who also live in different camps near the city center told me that the social workers in the camp gave them the invitations and they nearly had the same opinion about the way to approach more refugees to attend the sessions, Asmaa said

> “we need more people to attend the sessions of the programme, we need also official communication between the university and different organizations to help and support; social management, BAMF and the city of Hamburg in order to reach more refugees”, she continued “we wanted to conduct an intervention in my camp, from 400 people living there only 20 or 25 attended the intervention. Also, giving the flyers with the information in it will not be that effective, it will be just another book or advertisement in his or her backpack, I think if we conducted introductory sessions about the programme, that would be useful” (Asmaa 39 – 46)

Also Hussein confirmed not only about more involvement of the social management but also “you should contact the company responsible for managing all camps and introduce the programme and its goals to them in order to involve more people and make it more effective. if you just left a paper or a flyer, not everyone will know about it and not everyone will go to the management’s office and see the flyer, that is the problem” (Hussein 40 – 41). He also

wanted to target children more by saying "If you visited the camps once in a month, played with the children and taught them, it would be even better, teaching children would be more beneficial and easier than making adults change" (Hussein 60).

Most of the peer-facilitators asked about more involvement of the social management in camps. Aside from that, we did not want to have large numbers to attend because the quality of the workshops will definitely be impacted, I believe that the 36 health facilitators that we ended up with was fairly enough to conduct a good quality of peer-facilitator training compatible with our resources at that time which also included collaborative programme refinement.

4.1.3. Women's Representation in REFUGIUM

Cultural and gender sensitivity played a major role while preparing for this programme and throughout its conduction period and especially women's perspectives were focused. As the majority of refugees during that period in 2015 and early 2016 came from Syria which is a near-eastern country and Afghanistan which is a middle-eastern country, cultural gender issues were reflected on our programme as the majority of participants came from these two countries.

The number of female refugees who applied and showed up during the first introductory session was around 30% from the total n=59 participants; 18 women and 41 men which was a satisfactory female representation for us as organizers, we expected higher drop out rates as we considered how hard it could be for women to participate in a mixed programme like ours. That was even clearer when I first went to record the attendees' data and contact details during the introductory session; almost every woman came with either her husband, sibling or a relative sitting beside her, I knew that because they were answering me "you can contact me through my husband's or my brother's number" that I had just written down. Only 5 women out of the 18 had come alone; two refugees from Syria and Asmaa; refugee from Afghanistan and; Dina and Nada, the German volunteers with refugee near-eastern origins.

As we ended up with 9 women, the percentage decreased to 25% of the peer-facilitators, we wanted to know the reasons behind that and I asked the interviewees about what could be

hindering women in refugee communities from participating in our health awareness programme that could be beneficial for them and their families together? And the second part of my question was how can we encourage women to take part in these programmes and what could be the measures that we could take in the future in order to achieve a good representation of women?

Men	Women with partners	Women alone	Women with children
27	2	5	2

Table 7: Gender representation

Fatma was very upset and emotional when she talked about the women's issue especially for those who come from her country Afghanistan. She told me that "among the refugees when you go, you see that even women who have free time, they are not interested to do anything, not interested to learn the language, not interested to join any kind of programmes", "and now everything is ready here for women and they can plan for their future, for 2 years or 3 years after this and work for it, but when they don't have any plan, they don't have any dream, even they don't like to learn the language after some years, I have seen people after 7 years of living here, they don't learn the language, it's a big problem, like they don't need it, why should they have to learn it, there is no hope, there is nothing for it." (Fatma, 38 & 103).

She continued and stated some reasons about why women from her country would not participate in such programmes

> "In Afghanistan, women are second-class citizens and even within their families. In my country, they are treated as a second-class gender, they didn't have the right to dream, they didn't have the right to plan for themselves, all the time their plans are dependent on their men. Ok, the husband says what is the job or what should they do and for every activity, and now they have the possibility to think for their future, for their jobs, for everything they wanted to do but they don't have any idea about it, now they have everything but they cannot use it, they say what is the need for it, or I prefer to stay or may be my husband says something. You know that, they don't have the motivation anymore" (Fatma, 103).

The second reason that Fatma stated was that "they don't know their rights, it's a problem that men know something, that is why they forbid the women to go out and to be in the

community, to be not in the picture, to not understand, not to study, not to get educated" (Fatma, 110). She was also clear when she said that she invited some friends who came with their children and those mothers could not continue the programme as their husbands refused to take care of the children during the next sessions. (Fatma, 112)

Nada also told me that women with children might find it difficult to attend, in addition to that, in Arabic cultures which she works with, a woman tends to "isolate herself from the surrounding culture outside her family zone and she might say that, it is better if my husband participated instead [laughs]. I see that often but it is very wrong" (Nada, 69). She suggested to "have nursery services for their children during the workshop's time, that would be a positive thing, also if it was during the morning time while their children are in schools or if you made sessions only for women but if you say it is for both men and women, no, there is a high possibility that they might not come" (Nada, 71).

Dina was against the idea that because they are refugees, so they are conservative and women should not be participating but it is rather a whole culture thing;

> "look we work mostly with refugees coming from Arabic cultures and they have a lot of things in common, it is not because they are refugees, no, even at my home, it is the same restrictions applied on me, even if I am well educated or I know the culture and living here for almost 9 years with my family, [laughs]. Arabs are mostly the same when it comes to restrictions around women" (Dina, 73).

Ahmed, our peer-facilitator from Syria told me that one of the reasons that keep women away from participating is that

> "In our culture, a man doesn't like his woman to be better, more knowledgeable or to have more information than him. So he starts telling her; your mission is to cook or take care of your children and house, you don't need to go and participate in such programmes and waste the time that your family needs you. Stupid excuses in my opinion.
>
> We have traditions which say that women are not allowed to go and come alone and needs her man always beside her, and as the man doesn't want to go then she must obey his rules and stay at home. Most of the time, men don't accept their women to be outgoing by saying that they are a conservative family and cannot let their women or daughters participate in activities with foreign men" (Ahmed, 75).

He was specific regarding physical activity that women in camps should take care about and paid attention to an amendment that we did to an illustration for a woman doing sports with shorts on the topic's flyer;

> "Some families do not accept that their daughters or partners from women play sports or run or even ride the bike, they come from a culture that doesn't accept seeing a woman moving or they think like that. Even on the flyer, the girl running in the picture, I think you changed it, right?
>
> - Yes we had to cover her legs.
>
> I see it is normal to have her with shorts, but some people don't" (Ahmed, 75).

In a participatory process the image was changed, in respect of conservative cultural backgrounds, nobody should feel insulted in anyway because of the illustration. We also thought that if some men might think that we are pushing their female family members to wear shorts and it might be a reason not to allow them to participate.

Further, Hussein during the interview told me, "you remember when we visited that camp near Bergedorf, you saw how women could not do the sports moves in front of men, you know yourself as a Muslim the strict traditions within our communities, it is difficult to bypass or ignore these cultural sensitivities affecting women" (Hussein, 53)

Shiar was convinced that there is nothing cultural that does not allow women to participate but it is rather a personal decision and he agreed with Haidar's suggestion to make separate groups for women which would be motivating for them to attend as "the cultures of most refugees tend to have separated and unmixed meet-ups for men and women" (Haidar, 66). That suggestion was against Asmaa's opinion who told me "I think it would have been boring if there were only sessions for women and only for men, I think mixed groups was ok" (Asmaa, 53).

Separate groups for women were very difficult to establish at that time, we did not have the resources especially regarding language competences, but it is a future goal to establish some peer-facilitator trainings for women. The co-educative approach could also be seen as a new opportunity for both men and women to integrate more in the community of the new host country and indirectly inform them that in education in Germany there is no separation between the genders.

During one of our visits to the camps, I was accompanied by 4 female bachelor students in my group and there was a mid-30s man from the refugees there who wanted to attend the workshop we were doing and I invited him to enter the room and after he saw the young women there, he refused to enter and told me outside; “I cannot attend, I am not used to that and I will not feel comfortable” although there were other men attending, so it is not only about women refusing to attend workshops with men but sometimes it happens the opposite way. Therefore, workshops in refugee accommodations should be offered both in a co-educative way, and also for women and men only.

Offering childcare during our PFT time would have been very beneficial, because few mothers came with their children and it was not comfortable at all for both the mothers and other attendees, sometimes the children were crying or playing and it distracted all people in the room. Some of the mothers were embarrassed because of that and it might be a reason for not showing up again during the following sessions. The childcare suggestion is considered in our future developing plan of REFUGIUM and will be applied to the peer-facilitator trainings and workshops in accommodations.

4.2. Taking part in the REFUGIUM Programme

The second category *Taking part in the REFUGIUM programme* describes the impression about the peer-to-peer idea of the programme and involving the refugees as health facilitators not only as receivers for information. Also, the experience itself that the peer-facilitators went through, and the benefits and challenges they experienced throughout the programme period.

Category:	Code:
Taking part in the REFUGIUM programme	1. The idea of the peer to peer approach 2. Essence of the experience

Table 8: Taking part in the REFUGIUM programme

4.2.1. The Idea of the Peer to Peer Approach

As member of the organizational team, I wanted to know how our programme's attendees received the idea of peer-facilitation, what was their impression of the concept and if they became active in educating or advising other refugees in their accommodation settings?

Fatma was excited about the idea; "I think the idea was very good to disseminate the information through the people and to other groups but the only thing is that you have to know the language and in their community" (Fatma, 85), but she also suggested; "you have to spend more time with the refugees or the facilitators and make them ready, because you know, if they don't fully understand or are not really interested in the topic, they will not pass the information" (Fatma, 95). About passing the information, Fatma told me that sometimes she does that and advises her neighbors when needed, but usually they know about it (Fatma, 85).

Ahmed also liked the idea and I asked him about the reasons for that;

> "Because they know the existing problems and their roots, for example, if you are there and you told your neighbor in the camp that I was attending that session and we should do that thing in that way for the sake of our health, they might listen to you. Also it is very nice if you convinced him/her using the same language or coming from the same culture, he would be listening to you, it is not just about telling someone information" (Ahmed, 58)

He also tried to pass the information to some of his neighbors but "most of the time they ignore it, it is all about your own beliefs" (Ahmed, 51).

Asmaa was excited on the one hand; "I think it was a really nice idea, the programme taught us a lot of information and wanted to involve us more in real life by helping others in our camps, I really liked the idea (Asmaa, 44). On the other hand, she found that passing the information to her peers in the camp was challenging;

> "Yes, I tried but it is not easy, it was really difficult. They have so many problems, I can't fix their problems but I told some people, I said we should do that and that but some people listen and most of them don't, it's a personal willingness and I can't do anything to that" (Asmaa, 42).

When I asked Haidar if he tried to pass the information to others in his camp, he replied proudly;

> "Yes, for sure, now almost everybody in the camp knows that I attended some sessions about health and I have some information about the health care system, what to do if they get sick? how to visit a doctor? how to get a medication from the pharmacy?... etc." (Haidar, 45)

Shiar found that passing the information to his peers in the camps is very challenging because "the problem they do not listen that much, they just say that they know. But I did help some people with the information and I am happy about that" (Shiar, 39).

Dina and Nada were not really convinced about the idea and they both wanted to involve the social management or health professionals to do the awareness and teaching the refugees better than the peer-to-peer idea;

> "The idea is not bad but it would have been more efficient if health specialists or professionals in that area dealing with refugees were involved and then they teach the refugees. You can teach the refugees, some of them will pass the information to their families or friends but a lot of them will not" (Nada, 55), "but what is more important is talking to the social management in the camps, as they have the power to change the situation" (Nada, 46).

Dina added on that;

> "Look, every camp has its own social management office, they have all lists of the residents, they give orders to people and so. If the social management were involved and got the knowledge and the programme's information, they would pass it to the whole camp and to all people, better than depending on refugees" (Dina, 57).

The idea of REFUGIUM programme was not only about giving health awareness information but in addition to that, we wanted to achieve other goals. First, getting refugees out of the camp and the pressured atmosphere there and change their routines that might be boring, come to the university meet new people from both the refugee community and students, have a look at university life in Germany and how things work. Second, give them the opportunity to talk freely about their health issues and the health challenges they face at their accommodations. Third, involving them in an interesting way in developing the material during that phase of the programme to empower ownership, making them feel the programme is their own thing and help us to make the information easily understandable even if health is not the top priority of refugees attending workshops in accommodations. Last but

not least, allowing refugees to pass the information to their peers makes them feel they are doing something useful to their community. This impacts their mood positively. Fourth, of course, the peer-to-peer opportunity has the huge benefit of passing the information in the same language and through people coming from the same culture and sharing the same experience to refugees in accommodations.

Figure 8: REFUGIUM's objectives and goals

4.2.2. Essence of the Experience

This code summarizes the experiences the first generation of peer-facilitators went through; presenting the positive and negative aspects, the benefits and challenges they have faced.

> "Everything was told during the sessions and all topics were relevant to the situation that we live in as refugees. The refugees really need information, need people and experts to talk with, they have been staying for long times in very stressful conditions and dreadful mental situations with nothing to do all every day except staying in your room, going to the dining room and coming back to your room" (Hussein, 15).

I asked Fatma who joined the programme just a few months after arriving to Germany about her experience during REFUGIUM; “It was very nice experience, as first experience of being in Germany because I was new and as a refugee was passing through a lot of difficulties and living in such condition, bad conditions in the camps, it was good experience to go out for some hours to be with some educated people for positive energy or in a good environment, working or talking with them” (Fatma, 7). She commented on participating in this programme about refugee health; “it is not my field of work or study but I wanted to know what’s going on there” (Fatma, 9).

Actually, she did not mention a lot of health benefits or new knowledge that she gained except for “with my friends when I talk to them, for example I advise them to go to the psychologists, because I have seen that how they want to hide themselves from others or family” from the signs of mental disorders taught in that topic. “About hygiene things I think there wasn’t something new but for me, the healthcare system and mental health; they were useful and new for me and I saw many cases that I could tell them yes, that is a mental problem or help them to make an appointment” (Fatma, 77 – 78). She was more keen on telling me the extracurricular benefits that she gained;

> “I met other refugees who are in the next step of asylum cases or who have found their ways into Germany and already settled here, it was just a new hope for me and I was wondering if I can settle here or I would not like it”, also “I found some friends there, some contacts, from HAW, I got introduced to some new people and they are big help after that and I was introduced to some refugees who already started working and studying here and it is like a good sign for me that may be that we can settle here and we can find our way in a way, yeah it had a good impression for me” (Fatma, 9 and 17).

For her the timing was a challenge; “one thing was the time, till I arrived back to my room, it was around 10 pm, it was too late for me” (Fatma, 94).

Dina also did not get a lot of new health knowledge but the programme made her implicit knowledge explicit and thus empowered her;

> “The programme was very useful, a lot of information was already known to me but was somehow more deep and taught me how to analyze some cases, how to better deal with the refugees. We were depending on our own experiences before, now we know from where can we get help for refugees and

> if they wanted to get out of the camp, what shall we do to make their lives better. Also, the other topics were important but the most important that the programme allowed them to get out of the camp's atmosphere and for sure it kind of improved their mental state and mood" (Dina, 7 and 16).

Ahmed also started telling me about his experience by saying "I got new information, how the system works when trying to visit a doctor, the health insurance system. I met new people and exchanged contacts and that was a really important and positive thing for me". He was interested in the mental health topic "it was well and nicely covered, different from the usual way as the refugees started to tell how did they pass the hard times and shared their positive experiences rather than telling stories that could affect them negatively" (Ahmed, 12 and 28).

Dina was not satisfied about the location of the workshops; "it was very far away, was in Bergedorf and out of the city, it was school time and I went into trouble because I wasn't attending school. Regarding the same issue, Haidar mentioned that it took him almost an hour or more to reach the university, "but I had no problem also as I was enjoying coming and attending" (Haidar, 12).

From the challenges that Dina has revealed that; "the period of the workshops was short; there was a lot of information and the short period did not allow the team to cover it all" (Dina, 62-64). Ahmed also stated that the period of the workshop was not enough to discuss everything; "we really needed a time of 30 to 60 minutes more for each session, we were in a rush at the end of the session, a lot of information and discussion that needed a little bit more time" (Ahmed, 66).

As Ahmed was telling me about the challenges that he and other participants faced during the programme's period, there was some that we actually did not pay much attention to;

> "The time of the workshops during the day was somehow inconvenient for most of us, as most of the refugees have the 9-hour transportation ticket and it is not allowed to use between 4 - 6pm during the afternoon and the sessions started at 4pm, so we had to buy extra tickets". Also "most of the refugees have language schools to attend, either during the morning times or evenings and sometimes twice daily and it was always during the workshop times" (Ahmed, 65 and 79).

Haidar was very passionate while telling me about his experience in REFUGIUM;

> “The experience was really good. For me, the most important thing was the psychological part, for most of my life time, I have been always a giver person, but since I arrived here in Germany, I changed to a recipient person, everyone is trying to help me and I felt very useless and that depressed me a lot. But after participating in the programme, my mood was boosted again and I had a chance for helping others and do some useful things. Since I participated, I tried to give back some of the merits to the people who need help. It motivated me so much and gave me the opportunity to pay back the German community which was generous to me. The difference between my mood and mental state before and after participating is really huge, it really went better and I am really happy that I have participated, that was the personal aspect” (Haidar, 6-7).

Asmaa with the help of some of the participants from students had conducted a workshop to 20 residents at her camp after attending REFUGIUM. She said that social management, university and even the city of Hamburg should support these kinds of activities to be always ongoing and help as many refugees as possible (Asmaa 22-23). She also felt happy about the certificate that she got after attending the programme;

> “Besides helping other participants from refugees with information, I got a certificate that I have done this workshop and I can proudly say that I got it after attending the REFUGIUM programme and I did so and so, it was really helpful when I tried to apply for an internship in different companies, it is really helpful here” (Asmaa, 13-14).

Hussein spotted a different benefit that he gained from attending; “look, most of the information was already known to most of the people but knowing the reasons behind, following the tips given in addition to the information was the most advantageous and the whole atmosphere was really interesting and kept me coming to all sessions. I made good relationships with many people there and we even talk and go out sometimes from both the students and other participants.” (Hussein, 7, 11 & 13).

Hussein ended the interview with warm thanks and said; “It gave us a new opportunity and new hope” (Hussein, 39) and continued;

> “What was amazing and appreciated; the certificate that I got, you know that I took it with me to the court during my asylum registration and the judge was very happy. He told me that he appreciates me helping and being useful to other refugees. I am really thankful and grateful for that” (Hussein, 62).

Going through experiences of the participants; benefits were mostly not related to health information; getting new hopes and powers as Fatma and others said, making new friends and getting into contact with other refugees, students and university members, getting out of the camps and the pressured atmosphere, and the opportunity to talk about their problems freely. The majority of the facilitators attended this programme are not health experts but some were curious to know what is going on, some wanted to come and change their routine by getting out of the camp, some wanted to get the information and help others. Among the many reasons that I heard or observed when I communicated with the attendees of the peer-facilitator training that some came because they were sick and needed the information, some even thought that they could get treated at the university and others needed some guidance to join the university as students.

Reasons of attending differ from person to person and that is why their experiences differ too. It is difficult to know everyone's reason from coming to the programme and their gained benefits but I have seen how passionate and active those 36 persons who finished the first generation of peer-facilitator training were during the group discussions, their inputs and tips if some information or the way it was addressed was not suitable for the refugees' community. They felt in the position of experts, treated as equals and as people with a potential. I believe they had a lot of latent energy because of the long stay and the time consumed in their camps, that energy was observed during every session of the programme.

4.3. Topics and Materials

The third category *Topics and Materials* comprises the particular stage of the participatory development of the material and information of the programme including the topics and their relevance to the situation in refugee accommodations. It covers new information and knowledge peer-facilitators gained from participating and the way and methods of conducting and, the materials used during peer-facilitator training and the workshops in accommodations.

Category:	Code:
Topics and Materials	1. Relevance of topics 2. Knowledge and Information 3. Conduction of peer-facilitator trainings 4. Materials

Table 9: Topics and Materials

4.3.1. Relevance of Topics

Overall, the topics of this programme were meant to cover almost all basic dimensions of health promotion (nutrition, physical activity, mental health) and specific issues refugees face (hygiene, regional health care and oral health). During the PFT and 4 months later during the interviews, the participants were most interested in three topics, hygiene, mental health and health care system in Germany, while the other two topics; nutrition and physical activity, were difficult due to several reasons.

Relevance of Hygiene topic

Day-to-day hygiene is the most critical topic for the new living conditions in mass shelters and I was surprised during the interviews that almost all of the 8 interviewees chose it as the topic of priority and not mental health regardless the loads of pressures that they had been and still were experiencing because of the living conditions and uncertainty about the future. The thing about this topic that everyone can take care of his/her hygiene in normal conditions, and even if personal hygiene is not the best normally will not affect anybody else. But in a camp, your personal hygiene is impacted by many other people from different countries with different backgrounds, having different habits, who are sharing the same room or living area, and facilities like sinks, showers or toilets and later in secondary temporary accommodations the kitchen, then it is important to pay attention to hygiene very carefully.

Nada was telling me about her camp that she works at;

> “for my camp, the most important thing is the day-to-day hygiene and cleanliness of the place, the refugees should get aware of that. The place is really dirty and for sure it affects their mental health and mood” (Nada, 43).

Another issue about the hygiene topic was raised by both Haidar and Hussein who were telling me that the problem is that many of the new coming refugees do not know how to use the facilities in the camps especially the toilet seats and paper that differ from toilets or water based toilet hygiene in their homeland settings, so it is not a matter of different cleanness standards but rather ignorance of using the facilities and failure of adaptation. Also during the trainings, the topic of molds and how to handle that hygiene issue was covered.

> "What we really need to do in the camps is to teach the refugees how to use the toilet facilities and how to keep them clean" (Hussein, 64).

Still from my personal observation, overcrowding is a major issue, making hygiene a very important public health issue in camps.

Relevance of Mental Health Topic

Mental health is one of the most important topics reported, it was mentioned second by peer facilitators especially after the programme was conducted. It is a very sensitive topic not just because refugees are suffering from current and past trauma, but because mental health is considered a taboo in the cultures of their homelands. Fatma, who comes from Afghanistan, stated; "Afghan people do not have experience with psychologists and don't know about mental health" (Fatma, 35). Bute she underscored the importance;

> "This is the most important problem nowadays in the camps for refugees, they face psychological problems rather than physical problems. Mental health, it is very important because you know, in Asia, it is a shame to talk about it. In my country, there is no doctor as a psychologist even to go to, and they are not professionals, there are some doctors or some nurses who have received some short trainings or workshops and now they are serving us, but this is not enough, they are not professionals, so it is a new thing in my country" (Fatma, 33-34).

Ahmed pointed out stigma connected to "craziness";

> "I believe that mental health as a topic is really important in our case as refugees but it is very difficult to apply it or to start opening that topic in camps, as refugees are somehow allergic to the term mental health itself, they think that if somebody is suffering a mental problem then he or she is crazy" (Ahmed 26).

To Hussein, lack of privacy, long duration of life in "temporal" emergency camps and other mental stressors are reasons for the topic's inclusion into REFUGIUM;

> "The majority are suffering from mental issues, someday a man took his bed out of the container in the outer area as an objection against his situation in the camp, crying, screaming and shouting while the social workers were watching him claiming that he had been staying for one whole year in the same room with his wife and his four children and he could never have any personal time with his wife" (Hussein, 33).

Relevance of Regional Health Care Topic

Peer facilitators held health care in Germany to be third important, as it is a complicated topic for all people who are moving to Germany, not only for refugees. This topic was developed in the programme to guide participants through the system, inform them about procedures to do when getting sick, their health care services entitlements and other useful information regarding access to care. That session in the PFT was one of the most active sessions, a lot of questions were asked by participants who seemed to have been waiting for answers for a long time or had suffered from illnesses before and had not known what to do.

> "What I have figured out that, the health care system was really important, I have seen the participants during the workshop, they were really interested as they had no idea or little information about that topic specifically" (Nada, 16).

When I asked Dina "what was really important for you to hear about in order to help other refugees in the settings?', she answered;

> "The health care system in Germany, how, where, what they are entitled to and what not while the other topics like hygiene, nutrition, physical activity are existing or known anywhere or in any country" (Dina, 17-18).

Haidar observed many refugees wanted to know more about the health care system;

> "A lot of refugees who newly arrive to Germany, they have no idea what to do and how to get a health service if they are sick or suffering from a health issue, and I really got a lot of information from the REFUGIUM programme about the issue and now I am helping a lot of them with this information" (Haidar, 8).

Relevance of Physical Activity

The physical activity topic was very fun during the sessions and all participants enjoyed its way of conduction and were very interested and attentive. In my opinion it was a very important topic but the conditions in camps, stress with asylum documents and legal status make many refugees ignore it and of course lifestyle and environmental factors play a big role here. That is why it was as stressful as important for students with refugee background to make refugees aware of the topic's benefits in relieving stress and support mental and physical health. During my interviews, this specific topic was not mentioned so much except for the gender issues, as women do not usually do sports in front of men. Fatma considered the topic to be less relevant; "all the people around the world they do sports and you know they are not small kids; they know how to take care of themselves" (Fatma, 33).

For physical activity, it was important to explain its psychological benefits in addition to its other benefits from having fun, laughing, enjoying the session, opening up unclear competences and empowerment, which was also valuable for women who lack any form of physical activity; team building in PFT.

Relevance of Nutrition

The information was perceived as good and even new to many participants and they appreciated diet recommendations, but they felt they could not apply this information because in initial reception centers they are not allowed to choose their diet or cook for themselves and their families. The main issue about this topic was; "we cannot do anything about nutrition because nowadays we are still in primary camps and they are cooking something and if you like it or not, you have to eat" (Fatma, 79- 80) and Shiar told me "my fellow refugees either eat outside or even they do not eat at all if they don't have the money" (Shiar, 32-33). During the sessions, I had always asked about the participants' feedback, I noted down one mother's arguments about nutrition and she was very emotional to the extent that I thought she was going to cry telling me; "my son does not like the food there and he is always asking me to cook something, he even goes into rebellion sometimes and stops eating". Ahmed also commented on the topic's relevance;

> "It was good but it is inapplicable for us, as in the camps with their fixed nutritional system, we are not allowed to cook and the food is served to us, you cannot choose what do you want to eat, but fortunately they serve fruits and vegetable and dairy products, somehow not bad, but to live a healthy nutritional life in the camp is very difficult" (Ahmed, 19).

The nutrition topic was good in guiding them to choose the type food they eat at their accommodation, and of course cooking your own food is important and might have a psychological effect on them in not accepting this topic that much. Nutrition topic is important as many refugees suffer in initial reception centers from malnutrition; many complained about food quality, taste and lack of variety.

It is true that the peer-facilitators did not perceive all topics with the same level of importance, but I believe that all topics were relevant to the refugees in their accommodation settings and for the programme as a whole, and that relevance was also important to build trust.

4.3.2. Knowledge and Information

There was a lot of relevant information in each topic but we were keen to keep the level of this information very basic but relevant to newcomers, neither advanced nor sophisticated so that everyone regardless of their educational level can understand, benefit from the content and of course interact in the group work without feeling isolated.

> "I was expecting that the programme would have been more advanced, more difficult or at a higher level of information, I don't know why, especially when I read the invitation flyer. I think the quality of information was really good but also simple and not complicated" (Nada, 13).

Mental Health

Everyone was searching for the information of interest from the 5 topics; Fatma was keen on knowing more about mental health and its signs of sickness;

> "Now I know how we should implement it again but you know it was like a big gap there because all the people were new, we should have focused more on mental health because you know it is a new thing and most people do not hear about it or don't take it serious" (Fatma, 33).

The information and knowledge part within the mental health topic were simple but important; starting with a simple definition of mental health and the mental issues refugees might face in Germany, stigma and taboo (it is nothing to be ashamed of if you speak about

it) signs of sickness and different reactions from one person to another, and finally, resources, prevention and options of treatment in Germany.

Hygiene

Hussein liked the information about “kitchen, room hygiene, good ventilation, dental, and overall hygiene” (Hussein, 19) and he wanted even to know more about it as he thinks it is the main issue in his camp.

Nada was keen to know more about hygiene to elevate it at the refugee camp where she volunteered at as she found the health care system “is not really an issue, they know it and if they don’t, they ask us or the social management or even their network” (Nada, 44). Haidar had an opposing opinion from Nada’s regarding the health care system topic;

> “A lot of refugees who newly arrive to Germany, they have no idea what to do and how to get a health service if they are sick or suffering from a health issue, and I really got a lot of information from the REFUGIUM programme about that issue and now I am helping a lot of them with this information” (Haidar, 8).

The hygiene part included information and tips about taking care of the body from head to specific information for women’s and men’s hygiene, kitchen hygiene, toilets, and room hygiene.

Health Care System

Even Dina who has been living in Germany for 9 years was interested in knowing more about the health care system as “we had an idea about most of the information about sports and nutrition, it is the core of our duties when we go and work with the refugees in camps” (Dina, 51) but for the health care system;

> “I did not have a good knowledge about [health care for refugees, OA.] before, specifically for the refugees, I only knew what can I do when I am sick or where can I go, but for refugees, that was really new for me as they have another system to follow. Also, it was good to hear about the preventive visits for kids and youth, what are their rights regarding health and what are they are entitled to” (Dina, 52).

Health care system in Germany is not an easy topic, full of information that needs to be clarified and that is why we were very keen on simplifying it and addressing information about what to do when refugees get sick, where to go, explaining different types of health insurance

documents and how to get them, entitlements to health services, prophylactic check-up visits for children, and many other useful information that does not only give knowledge about the complicated system, but also allows them to know their rights in having good health, and avoid worries that they would not get treated when they get ill.

Nutrition

They knew about the daily portions that they should get from the different types of food, which foods should be avoided or consumed sparingly, how much sugar is in soft drinks and how to read nutritional information on food packages and identify proportion of fat in fast food.

Physical Activity

Physical activity also had some interesting information; why it is important to do sports for physical and mental health, dimensions of sports (strength, coordination, relaxation, stamina and flexibility), recommendations about minimum time that adults should devote during the week to physical activity, ties open to refugees and where to find them in Hamburg.

As the peer-facilitators had to present a workshop or a part of it about their topic of interest by the end of the programme, some of them did their presentation about physical activity and nutrition topics, so I assume that the information there was useful for the attendees. It was clear that peer facilitators felt competent to master these topics and that was important aspect of low-threshold empowerment. The good thing about the information part in our programme is that the refugees themselves were part in developing it; they participated in identifying the important points and issues within each topic and judged individually or in group discussions chose what was most relevant for them and suiting their situation in accommodation settings

4.3.3. Conduction of Peer-Facilitator Trainings

Throughout the programme, we were keen to conduct both, the PFT and the peer-to-peer health workshops in accommodations in interactive and interesting ways; we did not want to make the attendees feel that we are the experts and they are lacking knowledge but rather that they are the experts of their own situation and resourceful persons. We preferred the

sessions to be participatory rather than having an active instructor and a passive receiving audience. To keep the attendees in an active mode, we always set the groups in "round table" or "open circle" discussion form and always started each topic and subtopic with questions that ask for participants' experiences, motivating and activating them to participate. This way of instructing opened many discussions, allowed the attendees to re-explore their competences and resources, and in each discussion, the instructors would contribute evidence based scientific information in a very simple and clear form.

Participants appreciated PFT-atmosphere and didactics;

> "I think the interactive way of conducting the sessions was really positive and made us receive the information smoothly. In our countries, the way of giving information is only telling or presenting it but what I like here is that the participants also contribute, discuss and say their opinion about the information that they would receive at the end, so they never forget it. Also, the fun and the enjoyment during the session time" (Haidar, 17).

> "It was very nice to work with other people, they were conducted and managed very well like many people, different languages, different topics, it was well managed" (Fatma, 15 & 19).

Shiar commented on that by saying; "I think the discussions were really good and active within our group and it was very interesting although some people were not convinced by my opinion [laughter]" (Shiar, 14).

I believe that the most challenging thing while conducting the PFT sessions was time; it was very tight to ask questions, discussions, give information and do some activities like washing hands in the proper way during the hygiene workshop, or do the practical exercises in the physical activity workshop.

> "The time of the workshops was somehow short, we needed more time for the topics" (Shiar, 50).

> "Also, the period of the workshops was short; there was a lot of information and the short period did not allow the team to cover it all" (Dina, 63).

The good thing about the given information is that; it was always supported by reasons about why should or shouldn't we be applying that information, or substitutions for unhealthy habits that people might be practicing, or what and how the right behavior should be practiced. The

relevant, acceptable and understandable information had been boiled down to essentials by the participants in a participatory process that was never with blaming or scholarly tone, but always in exchange and developing solutions and strategies together.

4.3.4. Materials

During all workshops, we used two main types of materials; a topic flyer and a manual for facilitating workshops and, in addition some topic required specific material and illustrations for activities.

Flyer Development

The first draft of the flyer was provided during the sessions and each PFT language group during summer term 2016; Farsi, Arabic and English groups had to give their input about the information; whether relevant or not to the living situation in camps or if they had further ideas and suggestions about the topic, language mistakes and adjustments.

The final flyers were planned to be finalized, printed and handed out during the last session of the programme but we had to change some illustrations that were redone by Natalia Yaremenko; artist and health scientist who came to Germany from an eastern European country. Natalia had changed the cover drawing on the physical activity flyer as it illustrated a woman running with shorts as mentioned before and to avoid cultural misunderstandings, it was preferable to redraw it while wearing leggings, thus being less revealing.

Additionally, we faced some technical problems with the contracted graphic designer who did not have supportive applications for the Arabic and Dari/Farsi languages, therefore; the process of designing, proofreading and corrections took longer than expected.

I thought that attending and proceeding the programme till the end without getting the main inscribed source of information for the peer-facilitators would be a challenging aspect for them especially if they wanted to pass the information to their family, friend or neighbors in the accommodation settings, so I asked during the interviews if that was the case or not and if they have received the final printed version of the flyers.

> “They are printed!? [laughter], I thought they are still in process. If we could have them on time, they could have had something in hand to have an idea about what are you going to talk about before the sessions or they are ready about what are you going to discuss and have some idea” (Fatma, 96 – 99).

Asmaa had another opinion; “no, I think it was not a problem that the final ones were not there, because we already participated in developing the flyers and the information was in my mind, I think it was fine” (Asmaa, 50). Also, Hussein was agreeing with that opinion; “for me it was not a challenge, I got the information here in my head, wasn’t problematic at all” (Hussein, 48).

Manual Development

The manual which is the second main resource that should be guiding anyone from the instructors, students or peer-facilitators willing to conduct workshops on the topics. These manuals included the time in minutes for each activity and sub-topic, all questions used for initiating interactions and discussions, and the way of handling and conducting the workshop.

Conducting the sessions to people from different backgrounds, feeling pressured and suffering many health and social issues was challenging for us as a team. It made us very meticulous about what to say, which topics to avoid that might provoke some bad memories or re-traumatization, taught us to be very patient, calm, friendly and finally to be strictly resource oriented and positive. I believe we left a good impression on the attendees from the way we handled the peer-facilitator training. The process showed that the draft manuals had been too complex, too difficult and confusing, so they had to be improved decisively. The process which only was started during the first generation PFT and continued during winter term 2016/17 and summer term 2017 and required evaluations of workshops conducted in camps.

4.4. Challenges of Living as a Refugee

The fourth category *Challenges Living as Refugee* gives us an overview on the health challenges that might face the refugees living in Germany and more specifically in Hamburg. Additionally, other social and living challenges will be presented within the miscellaneous part of this category which might indirectly affect and impact refugees’ health with mental and psychological pressures.

Category:	Code:
Challenges Living as Refugee	1. Health Challenges 2. Psycho-social Health

Table 9: Challenges Living as Refugee

4.4.1. Health Challenges

Being a refugee and new to Germany might be challenging when it comes to maintaining your health in the new host country either because of the unfamiliarity with the health care system's differences from the refugee's home country or because of exclusion from many health services. Other aspects might play a role too; bureaucracy, long waiting times and language barriers. REFUGIUM was meant to help with the basic health information, self-maintaining and regaining of health after migration, but as we are researching this critical topic, we wanted to know other difficulties and put hands on the health challenges that refugees face which will be useful while developing the programme and for future research.

In this code Health Challenges, I wanted to hear from the peer-facilitators themselves about their daily experiences while trying to maintain their health; I asked them if it is difficult to stay healthy in camps, if they can see health differences between refugees living in camps or other accommodation settings and people living in real apartments, and if they saw a general health issue affecting specific groups like children, women or elderly people;

> "In REFUGIUM you are focusing on basic things of health, that is ok physically, you can take care of yourself, it is not possible sometimes" (Fatma, 26).

Health issues related to living conditions in accommodations

Fatma who has repeated "it is not fair" many times referring to the living conditions in her own camp, suffered from noise;

> "Nowadays I have seen some changes in myself, really, I cannot tolerate or I am really sensitive to the noise, really cannot tolerate it, actually it's uh… Usually 2 or 3 times per week, I am going to the social management that it is very noisy that you have to do something"(Fatma, 28).

Asmaa and Hussein talked about lack of privacy where they live in refugees' camps;

> “The other thing is about privacy; we don’t have separate rooms, almost no privacy at all and it is stressful also if you have precious things that you care about and your mind is always thinking when you leave the camp that someone might steal them” (Asmaa, 31).

Living conditions in the camps had something to do with the challenges peer facilitators are facing every day;

> “I have no idea about others but about me, it affects me. I am just losing my patience there, it is not a good place for living, again, lots of noise and you don’t have privacy, you can’t manage your time, like, you must stay awake until all the people sleep, you have to wake up when all the people wake up” (Fatma, 43).

Ahmed focused on the chronically ill and disabled who suffer from the rigid camp regimen;

> “Some refugees who suffer from chronic diseases who cannot cope with the living conditions in camps and they go and ask for a transfer to another camp, but this procedure might take months until the documents are collected and a place in the destination camp is available and then other different procedures. Also for some refugees with physical disabilities who are not able to go to the dining area, they miss most their meals as you are not allowed to eat outside that area” (Ahmed, 46).

Furthermore, he was doubting that he can live a healthy life in the camp even after attending the programme;

> “The bad thing is that you cannot apply all the information or tips from those topics in the camps or the settings where refugees live. For example, when I was in the emergency camp, there was more than 30 people from the same 8 container block using 1 or 2 toilets, so it was always dirty and was always left like that. Sometimes you cannot even find warm water for days and the people stay without showering until it is back or the problem is fixed” (Ahmed, 14 & 24).

Haidar referred to the different backgrounds of the refugees sharing the facilities and how can that impact the living conditions and refugees’ health in camps;

> “Regarding the cultural backgrounds and traditions. For e.g. when it comes to the toilets, here it is a seat, in our countries, mostly as a land-hole, and some of the refugees do not know how to use the toilets here and the hygiene gets terrible with that. There should be someone teaching them that they should sit on the toilet seat and use it properly” (Haidar, 37).

I was wondering if the peer-facilitators see that there are health differences between refugees living in camps and other people living in normal situation in their own accommodation settings, Nada replied to that, stating the hygiene problem;

> "Yes, I think there are health differences, because the people living in their own houses care more about hygiene, I don't know, may be because they want to live in a clean place but the refugees in their camps, they do not care that much about the hygiene as they think they are going to stay there temporarily. I don't really know, but I think there is a big difference" (Nada, 37).

Mental issues

When I asked if they can see a common health problem at their camps, Fatma referred to mental health issues;

> "Many people after living in the camps, they are referred to the psychologist or the therapist and these people are increasing day by day because the situation they had already; they have experienced trauma, but now the situation of living here is more difficult, getting more difficult day by day but I don't know, taking too much time and it is affecting them" (Fatma, 29).

Shiar spoke about the common mental state disturbances and pressure in his camp;

> "Also, regarding mental health, I would say that we are suffering from a lot of pressures and stresses due to many reasons, large numbers living together in a small area, long waiting times, you feel useless because you are doing nothing, bureaucracy, life instability, non-privacy and boredom" (Shiar, 30).

Asmaa talked about limitations in receiving psychological support;

> "It is not easy to find people who can help you with your mental health, for e.g. if you want to go and visit a psychology doctor; then you need from 3 to 6 months on a waiting list until you are able to visit him" (Asmaa, 18).

From the challenges that Dina has witnessed while volunteering at one of the family camps;

> "They are also not allowed to get or buy any furniture and it makes them feel that they are going to stay there for a short period. Some of them can get out of the camp to their own house or flat eventually and others stay for longer time. A lot of them now are suffering mentally from that issue, they feel that they are only guests for a short period, it is not their homes nor they can't go out, they are not allowed to work and that affects them negatively too" (Dina, 40).

Access to Health Services

Haidar talked about bureaucracy and long waiting times affecting refugees' mental state;

> "Very difficult, waiting for long times is very hard and it feels like the time is endless especially if you are not allowed to do anything or work or other things. I would say that the refugees in camps are suffering from mental exhaustion and high load of stresses but I would not call it mental or psychological problem, and that is common in the camp" (Haidar, 35).

Fatma referred to the difficulties that she faces in maintaining her own health;

> "After 9 months of living in Germany, I just find out that it is very difficult to get sick here, if you get sick, you should know for some months before, because the doctors don't have time, you have to make appointments, you have to be very urgent to go to hospital or so, and you know lots of limitations for refugees as well for the insurance, if they have of course" (Fatma, 22).

And she continued speaking about the limitations in accessing some health services;

> "They just have very basic services, they can get harmed, for e.g., when they go to the dentist; the doctor says, I just take out your teeth not repair it, this is your AOK card limitations. As a refugee, you should wait, I don't know but when you are sick, you have pain and they say uh., ok take it out and many people after they have their teeth removed, they don't receive antibiotics and for 1 or 2 weeks in the camps, they have pain" (Fatma 56).

She also told me about how refugees in camps might bounce over the system's procedures if they want to see a specialist;

> "There are all the time ways to skip; sometimes you cannot wait for some months when you have pain. Usually based on the system you have to wait but all you have to know (predict) few months before or may be each 6 month you get appointments for all doctors that you might be needing them.
>
> - So you do that?
>
> [Laughter], no not actually
>
> - But you have seen people doing that?
>
> Some people say, yes I will be sick and I need it and you have to wait for 2 months. [Laughter], I just learned that, uh I cannot go through the system, it takes too much time, actually it is useless time (Fatma, 76).

Additionally, Haidar opened that issue about limitations in receiving dental treatments;

> "Yes, for dental health, a lot of refugees are suffering from dental issues but they are either not entitled or the AOK health insurance card does not cover the dental services and it is very expensive here in Germany. This is a common and current complaint from refugees" (Haidar, 68).

Ahmed did not see any limitations in accessing health services but rather the procedure is long;

> "I don't think so; the only thing is in the bureaucracy and the long waiting times. That is very difficult, you need to wait for long times for your health insurance card, may be for months, it is very difficult. In camps if you suffer from a health problem, you wait till you visit the camp's doctor and the waiting time varies here, might take a week or more" (Ahmed, 18 & 44).

For Shiar, it was both dental and dermatological services limitation "for example dental issues, a lot of us have issues that we can't afford unfortunately, I hope my teeth stay good because I will not be able to get them treated. Also for dermatological issues, most of the issues are considered esthetical and not health issues, so they are not covered too" (Shiar, 58).

Mothers and infants' health issues

Another interesting topic was opened by Haidar who wished for more family and social support activities, and awareness about violence against women and children in camps;

> "For the mental and psychological part, some of the refugees are coming from backgrounds where it is allowed to hit children or act in a violent way against women, and these issues can be seen in the camps" (Haidar, 33).

Ahmed told me about some cases he has seen in the camp;

> "Some mothers only knew that their newborn babies are allergic to breast milk just after delivery and it gets complicated afterwards, and the social management try to help by ordering the alternatives but everything takes time and those mothers might not have money to avoid waiting or keep their babies waiting, but eventually nothing to do except waiting for the babies' milk to arrive after 2 or 3 days" (Ahmed 22).

To keep yourself healthy in a refugee camp or other form of refugee accommodation setting might be difficult as the peer-facilitators mentioned; a lot of people share limited number of facilities from toilets and bathrooms making it dirty most of the time and affecting the hygiene

in addition to personal habits like smoking from people sharing bedrooms together that might impact cohabitants' health. Nutritional aspect also might be difficult as you cannot control your own diet if you get served food from the camp only. These are decisive differences in health between refugees living in camps and people living in normal accommodation settings.

It was obvious that refugees living in camps especially those initial reception centers as a big industrial hall or large container settlements suffer from a lot of pressure. Additionally, limitations to accessing health services are might be critical to some of the refugees; long waiting times to get appointments with physiologists and therapists, adding on the language barriers that result in more stress and pressure.

Another common limitation is getting dental services and treatments. I have always been asked from refugees about what to do in case their teeth need dental treatments especially after they knew that I am a dentist by profession, they started to ask intensively. Dental treatments and services represent a huge limitation for refugees as they are excluded from these services for the first 15 months almost entirely, and not covered by health insurance except for emergency case which usually ends up by extracting the tooth for young people. During one of the conferences, I also asked a guest speaker from the German ministry of health about that subject and she told me it is a very difficult issue as it is a vicious circle, dentists do not want to do treatments other than very simple ones or tooth extraction as the health insurance companies might not cover the expenses, she continued that they are trying to fix it with the health care providers and insurance companies but it is a fund's problem and it might take long time.

4.4.2. Psycho-social Health Aspects

In this part I will be presenting different issues that refugees in Hamburg might face and could be directly or indirectly impacting their health in various ways. During my interviews with the peer-facilitators, everyone answered questions differently, trying to give their opinions and tell about their experiences which pointed out some challenges and difficulties either experiencing themselves or witnessing around them and in a way or another wanted to tell me about it during this opportunity to talk.

The difficult situation being a refugee had some negative effects regarding the vague future;

> "For me, I just lost one important thing, I lost my dreams by coming to Germany, it is, uh… to be honest, I just, uh, when I lost my dreams, … I had lots of plans for myself in my country, all plans about education, about jobs, I don't know about the living, were planned according to the situation in my home town and my country, but now in this situation, everything changed" (Fatma, 24).

Fatma was very emotional when she started talking about her 13 years old son who fled with her and now living together in the camp. She started to share her worries and fears about him due to the living conditions and people's attitude inside the camp which is impacting him;

> "I tried a lot to for example to save my son to take a distance from some issues, but nowadays in the camp I cannot control it, because all the people are talking about these issues, there is no limitations, like these are children and these are adults, they are involved all together. He was very interested to go school when we came to Germany and he was dedicated or something but nowadays with this type of education in camps, he just loses the interest, they are not teaching, they are not doing anything, he prefers to go sleep, so he doesn't like to go to school" (Fatma, 49 & 60).

Dina was worried about undocumented refugees and workers in Hamburg but she was uncomfortable to ask during the sessions about the ways of treating them without harm and fear of deportation.

4.5. Organizational Aspects

During this part, I will be speaking out the different organizational arrangements and the challenges faced during the conduction of REFUGIUM.

The organizational team has faced many challenges within the different levels of REFUGIUM's structure and throughout the whole period of the programme. We were able to overcome many challenges during the conduction of PFTs of the second and third generations of the programme in winter and spring 2017 and working hard to figure out solutions for many difficulties which we had not taken into consideration while planning for this intervention.

Materials

Starting from the preparatory phase in winter term in September 2015, until the end of the first-generation trainings in June 2016; most of our efforts were concentrated on finalizing the

flyers and manuals. The organizational team along with the students were most of the time busy perfecting the information to be put in the thematic materials, translations, illustrations, discussing and adjusting some of the information again with the peer-facilitators, searching for a graphic designer who took more time until printing the flyers. That hectic and long-phase procedure consumed a lot of energy, effort and time and resulted in different drawbacks. For the organizational team; it made us concentrate on this one aspect and thus many other aspects were not anticipated, ending up in other challenges.

Stakeholders

These included communication challenges between the team and the social management of the refugee accommodations. We wanted to involve social management more in our programme as we needed to conduct many workshops along with the new peer-facilitators on one hand. On the other hand, the peer-facilitators demanded the involvement of social management in the programme through inviting them to the workshops as they wanted their support afterwards in enhancing the conditions or in educating other refugees in camps. Peer-facilitators were saying that "many of them do not listen to us but they do listen to social management"; "we cannot change people" and "they say we know the information, we don't need it" and similar statements.

We were struggling throughout the period from March to June 2016 in getting either meeting with different accommodation managers or get in contact through emails or phone calls. Most of the time there was no response from their side or when it happened and they agreed to have a workshop; we had to learn that they did not prepare any rooms for us or even did not make the effort to announce or hand out our brochures of invitations to refugees living there.

Fortunately, we were able to overcome that issue partially during the following PFT second and third generations in summer term 2017 as we had a plan to communicate directly with the organization in control of the primary and secondary reception accommodations and with the local public health authorities in Hamburg who facilitate our communications and workshops we currently conduct in the refugee accommodations since spring 2017.

Print and Online Material

Apart from the social management, we faced also challenges regarding our time plan while working with our hired graphic designer who was assigned to finalize all the flyers and make it ready for printing. It took him more time than planned to finish the work due to the unavailability of some computer programmes and unfortunately we could not hire another one due to budget limitations and we thought as a team that it might take even longer to start from the beginning.

We needed the flyers to make sure that everyone received the same quality of information, and to support peer facilitators in conducting workshops in camps. Additionally, we would as a university to be of service to the community and make our results public during the emergency situation in 2015/16.

Peer-facilitators

Peer-facilitators of the first generation had participated in developing REFUGIUM which resulted in their ownership of the programme. They felt that they have done something very useful to themselves and for their community. Around 9 of the peer-facilitators after the end of the PFT workshops of this first generation were still engaged in the programme and accompanied the organizational team in different events, conferences and supported REFUGIUM during many visits to refugee camps and in the conduction of workshops at those accommodations.

This kind of commitment and responsibility towards REFUGIUM and its objectives that peer-facilitators showed during and after the first generation PFT workshops were unexpected for us as organizational team. I believe that without this enthusiasm of the peer-facilitators in REFUGIUM and even if the programme was perfectly planned theoretically, having the best instructors and materials; it be would not be that successful without its participants, their commitment, and eagerness. Therefore, for the better assessment of this health intervention programme, its benefits and challenges, and for its development in the future, it was seen that involving peer-facilitators in this research was a must and could not be ignored.

It was expected that this level of ownership will be missing and would not be seen during the second and third generation PFTs. Therefore, it was planned to motivate the new through involving their seniors from the first generation. Milad; a Farsi/Dari speaker who is a refugee from Iran and Mohamed; an Arabic speaking refugee from Syria who both speak perfect English too. They both engaged themselves into REFUGIUM, conduct workshops and do translations too for both the new peer-facilitators or during the workshops visits in different refugee camps. Additionally, and as an extra form of motivation and commitment; the new peer-facilitators are obliged to participate in at least two visits to refugee accommodations where workshops are conducted; have a different and new experience and to finally receive their certificates of participation.

Students Trainers

On the student trainer level, the challenges were seen from a different perspective; we were wishing as an organizational team that a good relationship would develop between peer-facilitators from refugees and trainers from university students so that they are both more engaged into the programme and a relationship would develop that does not end with ending the PFTs.

As organizational team, we were motivating the students to support the refugees from peer-facilitators to make them feel welcome to the new community in Germany either by going out with them, inviting them to events or doing some language exchange meetings from time to time. It happened couple of times that students celebrated one of the peer-facilitators' birthday and went out another time. But, usually students were busy in his/her life either studying or working and we could not force or do more pressure on the students or make them feel that it is a must do.

It was good to see and hear from the peer-facilitators afterwards that they are still in contact with some of the students and they meet from time to time. I believe that it is a good way for the students to learn the acceptance of the new immigrants and for the refugees to engage and integrate. Some of the students in the course feedback stated that they had prejudices before the course, and they all feedbacked how important the experience of working with refugees in this empowering way which had also empowered them as students.

4.6. A Day within the case of REFUGIUM

In order to harmonize and visualize the experience for the readers, feel the time and place (Creswell, 2013, p. 236), describing a whole day within the case of the REFUGIUM programme would transfer that experience and make the reader develop a real-life picture of the programme.

The first session of the PFT was conducted on Monday, the 2nd of May 2016. It was a sunny day during spring time in Hamburg, the weather was nice and daylight periods during that time were long. I started my office hours at 10 am during that morning and started planning the day. On Friday the 29th of April, I had reminded the participants who took part in the information session on the 25th of April that our first workshop would be on Monday from 4 pm – 7:30 pm. I had sent emails, mobile messages and made phone calls depending on the contact information of each participant. Also, on the first workshop day, I did the same as I was somehow worried that they forget on one hand and on the other hand to make them feel that we are keen on having them at our sessions.

Many tasks were waiting for the whole team during that day; we had to make sure that all materials for the workshop were printed and ready. On the first day, we planned to conduct the topic *Health Care System in Germany* for all participants, so we printed out the first draft of that flyer in German, English, Arabic, Dari/Farsi, Russian and Turkish as these were the languages of refugees present during the information session. In addition, I prepared other material like the topic's poster.

Moreover, the university campus as a location allowed us to easily access the facilities there and gave us the opportunity to show some generosity in offering a small snack buffet in cooperation with the Mensa, the university cafeteria which provided cups and glasses. We served water, tea, coffee, fruits, and nuts for refreshment purposes during the long period of the workshop and thus wanted to give the participants at least a little something back for their time and effort.

Around 20 minutes before the session, some of the students were prepared to wait for the participants at the train station with signs of the programme name written in different

languages to make it easier for them to find the university. Also, signs were placed on campus to show the way to the workshop room as the building is not the easiest one in finding your destination.

The main room we used for the workshops, can hold up to 70 attendees, the sun was entering the room at the third floor through the big windows allowing a nice view over green Bergedorf. We were waiting for the refugees when they entered the room, welcoming them and inviting them to have some tea or coffee from the buffet and then get seated on the nice wooden chairs at nice tables to start the session.

At that time, one of the team members was usually moving around to check the names of the attendees, or adding them to the list if they were attending for the first time; information included name, family name, gender, age, address, mobile number or email, profession or latest education. Some of the attendees refused to give their contacts preferring to give only their names and I remember one man saying "no need for my mobile number, don't worry I will be coming next week", but I can understand the way he acted as I have also heard later that some gave fake names to remain anonymous.

We started the workshop at 4:30 pm, this was the only session all participants attended together and not were divided into language groups. We shortly introduced ourselves again to the newcomers. Prof. Faerber was the presenter in German and English language and following direct translations were done by language interpreters who were standing beside her; one guest student for Dari/Farsi, two students for Russian and Turkish, and myself for Arabic. That workshop took about two hours due to multilingual presentation and many questions. Questions were answered at the end as some were related to the topic and some were more personal issues regarding health services. The attendees were very interested in that topic because information regarding attendees' needs of their entitlements and system procedures was different from their home countries and new to them.

We took a break for 15 minutes, and we as a team took the chance to start some small talk with the attendees, some of them started asking team members and myself about their future opportunities to join the university. I received many questions about what I was doing at the

university and how I had come to Germany, some were curious to know if I was a refugee too. We resumed the workshop and promised them to answer their questions at the end of the session.

We were done at around 7 pm and kept around 30 minutes for questions, but before that, we handed out the flyers and asked them to look through them till next session and try to help us in finding spelling mistakes or wordings that needed adjustment and asked whether information was relevant and acceptable. Furthermore, we handed out a document called "tip doc" which can be printed for public usage from the website of The Federal Center for Health Education (BZgA/tip doc, n.d.). It is a document that refugees and asylees can take during to appointments with physicians or hospitals allowing them to express their medical status in the form of choices in their own languages in correspondence to German language especially if they do not have a language interpreter accompanying them. Tip doc is available in more than 20 different languages.

After 7 pm we answered the questions raised by participants either about the information in the workshop or regarding the programme and participation. Finally, the organizational team, bachelor students, volunteering interpreters stood up and thanked the attendees for coming and participating in the programme, saying goodbye and that we would like to welcome them the following week.

5. Discussion

5.1. Discussion of Methodology

Choosing the case study method allowed describing the REFUGIUM programme effectively and reflected the overall picture and aspects before and during the programme's conduction. Although the case study method allows the usage of different data sources; only two sources were used; interviews with participants from peer-facilitators including refugees and volunteers working in camps, and the researcher's direct observation during conducting the programme in a CBPR approach. Correspondence communication from emails and other sources of documents written in German language were not used due to my language limitations. Language limitations were also seen during my interviews with refugees coming from Afghanistan; sometimes it was difficult for them to express in English language.

The sample of interviewees was diverse by including both genders from different backgrounds, cultures, and educational levels. However, obstacles in reaching more peer-facilitators from refugees limited a more diverse sample and had consumed a lot of time at the early stages of this research.

Participatory observation and the extensive time spent in the field had provided a deep insight about the issue and built trust between the researcher and participants. However, this might had shaped some form of bias and limited my scope of sight in observing other important issues. Additionally, this prolonged time was very hectic and complicated at some point, especially if many cultural and gender sensitivities need to be taken into consideration.

Ultimately, there was concerns about bias during the interviews from being the interviewer and one of the instructors during the programme, but it turned out that the interviewed peer-facilitators trusted me as the researcher and instead of appraising; they talked freely about their concerns, criticized and suggested improvements of the programme in the future.

5.2. Discussion of Study Results

In this case study, benefits and challenges of the REFUGIUM programme were described in the context of real-life experiences presented through two different points of views; peer-facilitators from the refugee community, who participated in the programme, and my own perspective as participant observer from the organizing team. The peer-facilitators described their experiences, benefits that they gained from attending the programme, challenges they faced throughout the programme's period and finally the overall health and living issues that they had to deal with on daily basis while living in refugee camps. As a researcher, I took a more interpretive attitude, summarizing and categorizing the interviewees' opinions, relating organizational decisions, activities and objectives, in addition to the challenges the team faced throughout the conduction of the programme.

5.2.1 Announcing for Health Intervention Programme

The conduction of a broad primary health promotion and prevention programme in Hamburg or an industrialized country like Germany is not new but it is not an easy task. For refugees in camps; most of the time they hear about German language classes for integration, cooking classes for women, etc., but it was new for them to hear about a programme concerned with their health.

The conduction of the programme was a challenge itself, as REFUGIUM is one of the very few health awareness programmes targeting refugees in their accommodation settings. No other programme was known to the participants; this was beneficial when we started approaching refugees and announcing REFUGIUM. The approaching methods were effective in getting quite a good number of participants interested in the programme by inviting refugees in camps and through different organizations, and were developed after the programme reached only few numbers of attendees in January 2015.

The first generation PFT in summer of 2016 was the first conduction of the programme in which we had to overcome many struggles, especially language and cultural barriers which might act as one of the main hindrances in establishing social capital and suitable health resources within refugees' community (Im & Rosenberg, 2016; Nawyn, Gjokaj, Agbényiga, &

Grace, 2012). We used different recruitment measures; students and volunteers who in German or English, visited camps and invited refugees through word of mouth. The organizational team printed invitation leaflets in 9 different languages and sent electronic versions to social management in refugee accommodations. That way of approaching refugees resulted in 59 attendees on the first day during the information session on April 25th 2016 (cf. Chapter 2.4.2).

Another main challenge was identified, which is the women's representation. The final number of women attending was only 9 which is representing 25% only of the attendees who completed the programme (cf. Chapter 4.1.3). However, since most women who reached Germany as refugees in 2016 were below 18 years old, the initial number of peer-facilitators from women 30% (18 of n=59) was a satisfactory representation when compared to the average percentage of women from the total number of refugees above 18 years of age (cf. Chapter 1.1). Depending on the resources, either financial and/or human; suggestions like providing childcare service during the workshop period, motivational reimbursements and planning gender segregated PFTs which might have hindered some women and some men to attend the programme. To increase their overall number of participants, these issues were put into consideration during the further development of the programme's second and third generation PFTs.

5.2.2 Experiencing the Health Awareness Programme "REFUGIUM"

The peer-facilitators' experiences were very positive when it comes to getting new opportunities for social integration in Hamburg other than just German language classes. REFUGIUM increases refugees' social network by contact with university and its members, and meetings with new people having the same backgrounds and passing through the similar experience. Participants had the opportunity to talk about their health issues, exchange knowledge and take part in the programme's developing process to match with their different interests, cultural backgrounds and their expectations. All that in addition to having the opportunity to be useful to their communities and help their families, friends and peers in their camps, boosted and enhanced their mood and mental state.

The community-based participatory research (CBPR) approach was used in conducting the REFUGIUM programme for educating refugees on one hand and activating their role in serving their community on the other hand by passing health information to their peers in accommodation settings. There are many benefits of this peer-based model in developing social capital; broadening social networks, increasing their responsibility towards their community and unity; capacity building and leadership; developing their network and access to get effective help when needed; allowing the facilitation of awareness and efforts for living a healthy life through peer support (Im & Rosenberg, 2016). This verifies the strong relationship between social capital and health promotion within the refugee community and its influences for healthy integration and contribution in the new culture (Deuchar, 2011; Im & Rosenberg, 2016). Peer-facilitators stated many of the above-mentioned benefits during interviews (cf. Chapter 4.2.2). In addition, I could observe and interviews reported peer-facilitators' boosted mood, gaining of self-confidence, and they appreciated escaping the boredom of camp life.

Although peer-facilitators liked the social empowerment idea by helping other refugees in increasing health competences, some of the interviewees found it very challenging to facilitate health workshops in refugee accommodations alone. They wanted to involve social management and other social workers in camps to attend REFUGIUM programme with them and help them passing information side by side to refugees in camps. That is why we believe that this programme should try to actively involve key actors or gatekeepers in the refugee community or other vulnerable groups in need of such interventions, like Haidar the dentist. Residents in his camp respected him being an active refugee, helping with translations, guiding his peers in many ways about the healthcare system his PFT in REFUGIUM. Such social influencers within the refugee communities should be targeted more actively for such interventions. Gatekeepers like Haidar and Asmaa who organized a workshop at her camp helped the programme organizers in reaching more refugees in camps much more actively than some social managements did when we tried to visit camps and conduct workshops there.

It was and still is one of our main challenges to organize workshops in camps due to many reasons; bureaucracy, lack of fast decisions from camp management, lack of good and effective communication, extra load of work on the social management that they prefer to avoid in organizing a place for the workshop and effectively inviting refugees to attend sessions. That is why we decided to deal directly with the main organization controlling refugee camps in Hamburg; facilitating better communication and faster actions when we need to conduct workshops there (cf. Chapter 4.5).

Other challenges were perceived; the distance from the city center to the university in Bergedorf where the university is located was too long, it took more than one hour for some of them to reach the PFT. There were no reimbursements for the extra transportation tickets that they paid to come to the university, and most of peer facilitators had language classes during the PFT workshop time and some of them had to either skip their language classes or not continuing the programme. All this needed a lot of effort from the refugees and effective time management. These challenges were put into consideration while preparing for PFT of the second and third generations of REFUGIUM peer-facilitators.

5.2.3 Refugees and Health Competences

The REFUGIUM's topics were chosen in fact in relevance to the refugees' needs identified during many preparatory workshops involving former and current refugees, health experts, social workers, and after having a clear picture on the living situation in refugees' accommodation settings in Hamburg (cf. Chapter 2.4). Migration to a new culture can could be considered as a risk factor for many health problems; mental health issues such as depression, anxiety disorder and post-traumatic stress disorder (PTSD) (Fazel, Wheeler, & Danesh, 2005; Marshall, 2005), and devastated health (Im & Rosenberg, 2016). Other health issues that could be induced due to migration are diabetes (Kinzie et al., 2008; Petosa & Smith, 2014) and obesity (Yun et al., 2012) which need nutrition and physical activity awareness. The health care system in Germany was planned to be a main topic within the programme not only because it might be different from the ones in refugees' home countries or somehow complex, but also it is difficult to navigate the system due to cultural and language barriers the refugee community faces in various settings (Pumariega, Rothe, & Pumariega, 2005).

The information level was kept very basic to be received and passed easily from and to other refugees. Many gained knowledge regarding health promotion outcomes, but challenges were also identified for each topic.

In the hygiene topic, peer-facilitators learned about diseases and serious hygiene issues that might affect them due to the mass number of people living together, sharing facilities; lice, bedbugs, cockroaches, rats, scabies and mold occurred and they learned how to avoid those issues, kitchen and toilet hygiene, gender specific hygiene, and importance of airing their bedrooms. Challenges were also expressed in the interviews, refugees demanded a strong involvement of the social management and their attendance in the programme side by side with the refugees to hear their problems and induce an improvement of the hygienic situation in accommodation settings **(key 1 finding)**. Adding on that, the demand of educating new refugees arriving to camp on using the facilities especially toilets and bathrooms properly to adapt quickly and not to be burden to the other residents living there **(key 2 finding)**.

The nutrition topic as mentioned before was useful in pointing out recommendations and nutrition facts, type and amount of foods or drinks that refugees should be consuming or avoiding. They learned about the relevance of vegetables, fruit and unsweetened beverages. They also learned to avoid industrialized snacks such as chips and to use oil sparingly, they learned that soft drinks contain large amounts of sugar that is unhealthy for their bodies. Regarding controlling their diets in camps; they received good information about how many portions of vegetables, fruits and other food types their bodies should daily intake, but as they said it is challenging to apply that in camps as they are not allowed to bring or cook their own food which put some psychological pressures and affected their overall mood. They very much missed fresh and self-made food and taste of home, and nutrition impacted their mental health significantly in a negative way. They wished for a better compliant from social management regarding the caterers, since food did not meet their need and they, had to live on it for months, even years, with effects of malnutrition or diarrhea. Therefore, here caterer or social management participation would be helpful, too **(key 3 finding)**.

Physical activity was not a new topic for many of the attendees but the information about the five dimensions of physical activity; endurance, relaxation, coordination, mobility and strength were indeed new to the majority. Recommendations about the importance of regular exercise and outdoor activities (Im & Rosenberg, 2016) was new to them, they benefited from this regarding physical activity especially in groups and sports places in Hamburg having special offers for refugees. Many different exercises were shown and explained in the physical activity flyer which helps them do physical activity at home or in the open areas and parks to overcome the challenge of not having a sports room or area in their accommodation settings. Gender specific challenges were raised as some women did not have the chance to do any kind of sports before in their home countries and many were not allowed to do sports in front of men.

Mental health was indeed the most interesting topic in REFUGIUM, not only through my observatory point of view from witnessing the interactive discussions between the attendees during the workshop, but also that was expressed by the peer-facilitators during the interviews. I believe that the attendees have successfully crossed the barrier that is not allowing them to talk about their mental problems which is considered as a taboo to most of their communities **(key 4 finding)** and people suffering mental illnesses could be easily stigmatized back in their home countries (Ciftci, Jones, & Corrigan, 2013). During the workshop, peer-facilitators learned about the definition of mental health and that they need not be ashamed or afraid of talking about their mental problems. They got an idea about stressors they might face while living in Germany, the signs of recognizing mental illnesses in a very simple way and what to do if they saw some of those signs on themselves, family members, or friends. Furthermore, they learned about their competences in avoiding mental issues represented in family, friends, religion, music, sports as primary prevention, self-help groups as secondary prevention and were advised to go for counseling and professional treatment if needed.

The peer-facilitators issued some challenges regarding mental health especially about the living conditions in the camps and the high load of pressure they face every day after arriving to Germany; bureaucracy, long waiting times before knowing their final status from asylum or getting deported, working and education dis-allowance, fear from future, recalling bad

memories from their home countries or during migration (cf. Chapter 4.3.1). Their main issue about mental health was the stigmatization from their own community and neighbors in their accommodation settings preventing them from speaking their issues out and for those who visited the psychologists; they face very long waiting times and language barriers preventing them from expressing their concerns and issues they face properly. REFUGIUM provided effective primary prevention to participants.

The health care system in Germany was a totally new topic also for the attendees; getting an idea about their legal rights and entitlements in receiving health services in Germany, steps for visiting the general practitioner, specialist or hospital in emergencies. Importance of checkup visits for pregnant women and new mothers, children, and youth. Health services that are totally covered by health insurance and others which need some out-of-pocket co-payments. Challenges for that topics were as follows; bureaucracy and long waiting times which drove some of refugees to burden health service providers with appointments regarding fake health issues in a period of 2 or 3 months in advance just to avoid long waiting times if they get ill in the near future. Concerns were refugees still waiting for health insurance and undocumented refugees and how would they could receive the health service they needed.

A common issue that was raised by the attendees during the interviews was the workshops' period. They suggested allowing more time for the workshops; giving more space for discussions, comfortable conduction and explanation of all information especially for mental health and health care system workshops. Another issue for some of the participants was regarding the delay of the final printed flyers and the challenges we faced from changing some illustrations to cope with the cultural sensitives of the refugees' community and then another delay from the graphic designer side due to the unavailability of some applications needed for printing all languages which consumed more time and money.

These community-based workshops were conducted in an interactive and participatory way allowing attendees to openly discuss sensitive topics such as mental issues, health concerns and matters they share within their community (Im & Rosenberg, 2016). Some of the

programme's topics were new to the participants and some reinforced their existing health knowledge or competences resulting in positive health promotion outcomes such as knowledge, awareness, skills, networking and further development of competences (ibid, 2016) expressed by peer-facilitators during the interviews. These main objectives from the REFUGIUM programme were met by the first generation of the PFT (cf. Chapters 4.2.2 & 4.3.2).

5.2.4 Refugees and Health Challenges

REFUGIUM programme is an adequate measure to raise health awareness among refugees in their accommodation settings through enriching their existing knowledge and adding new general health information relevant to their current situation. Many health promotion outcomes and benefits were reported but still the existing refugees' living situation and conditions are very difficult to change, and act as a burden on refugees' health.

Health challenges regarding accommodation settings expressed during the interviews and observed personally during visits to some camps in Hamburg were e.g. large number of people, reaching sometimes more than 800 refugees living under one roof with just bed sheets separating them; bureaucracy; long waiting times; vague future and fear from deportation; ongoing day and night noise accompanied by many sleepless nights; lack of privacy; hygiene problems due to sharing facilities and lack of enough toilets, showers, disinfectants, soap, water, etc.; dis-allowance of cooking and education. Bad hygiene conditions led to vermin like rats, lice or bed bugs and diseases like scabies or diarrhea. Such conditions resulted in many psychological and mental pressures as some interviewees expressed; bad mood, depression, and conflicts, sometimes resulting in aggression and violence (cf. Chapters 4.4.1 & 4.4.2).

There was no specific group from refugees suffering from a common health problem as reported during the interviews except for refugees with some chronic diseases and handicapped as the living situation and facilities in camps are not well prepared to accommodate their health conditions and they keep suffering for a long period until they get transferred to another more convenient living place (cf. Chapter 4.4.1).

Germany issued many formal barriers and legal restrictions regarding refugees access and entitlements to healthcare services (Langlois, Haines, Tomson, & Ghaffar, 2016; Rechel, 2011).

As expressed during the interviews, and in addition to the cultural and language barriers, lack of interpreters while visiting doctors, unfamiliarity with the health care system; refugees receive deficient level of treatment and health services, even after 15 months compared to residents having the same health insurance card from the same insurance company. This bias and inequity was perceived by the peer-facilitators for e.g. at dental offices where refugees are only entitled to emergency treatment resulting most of the time in the extraction of the defected tooth and leaving no other options to maintain natural teeth for youth and adults (cf. Chapter 4.4.1).

6. Conclusion and Recommendations

Refugees face a lot of threats and difficulties before and during fleeing their homes, and many burdens after arriving to the host country. Health burdens facing asylum-seekers in Germany are more complex than getting primary or emergency treatments when needed. The findings of this study have contributed in sharing the daily health burdens facing refugees living in refugee camps in Hamburg, Germany. Further, it has defined the overlooked complex gaps between accessing health services, preventive health, language and cultural barriers hindering refugees from living a healthy life and the efforts made through different awareness interventions in addressing those gaps.

This study has given refugees a voice to reveal their experiences and needs from participating in health interventions. Various and precise recommendations on conducting such interventions for vulnerable communities in developed countries such as Germany were revealed. In addition to the good planning and information content of health promotion programmes, the keys of success of interventions targeting vulnerable groups and communities depend on paying attention to details such as cultural and gender sensitivities, overcoming language barriers, involving reliable and trusted gate keepers from the targeted groups, and having sufficient financial and human resources.

The key findings of this research have shown important aspects specific to the REFUGIUM programme and could also be beneficial when applied to other similar interventions. Key 1; the need of strong communication between the different stakeholders for better outcomes, e.g. motivating the social management in camps to get more involved into the programme and start changing the living situation into a better one. Key 2; paying more attention to cultural differences and working on overcoming the gaps, e.g. giving orientation sessions to the newly coming refugees arriving to camps on using the facilities such as toilets and bathrooms for better hygiene matters. Key 3, decreasing indirect psychological pressures affecting refugees which might not be noticeable unless getting in contact with the target group and hearing them, e.g. enhancing the nutrition quality and giving refugees the opportunity to cook their own food which have put a lot of pressures on them, especially

mothers and children who are missing the taste of home. Key 4, capacity and trust building, e.g. encouraging refugees and allowing them to talk about their sensitive issues such as mental health which can enhance their overall mood and start engaging into the new community of the host country.

As observed while participating in REFUGIUM, being engaged with refugees for the last year of my life and concerned about their health; urgent mental support and better living conditions in refugee camps are required. Supportive, empowering and innovative ideas for better refugees' integration into German culture are needed which was in a way or another provided by REFUGIUM and if these interventions should be implemented at larger scale.

Ultimately, public awareness regarding the case of refugees and asylum-seekers, their rights according to international human rights laws and legislations in living good and healthy life and not as second or third class citizens should be addressed.

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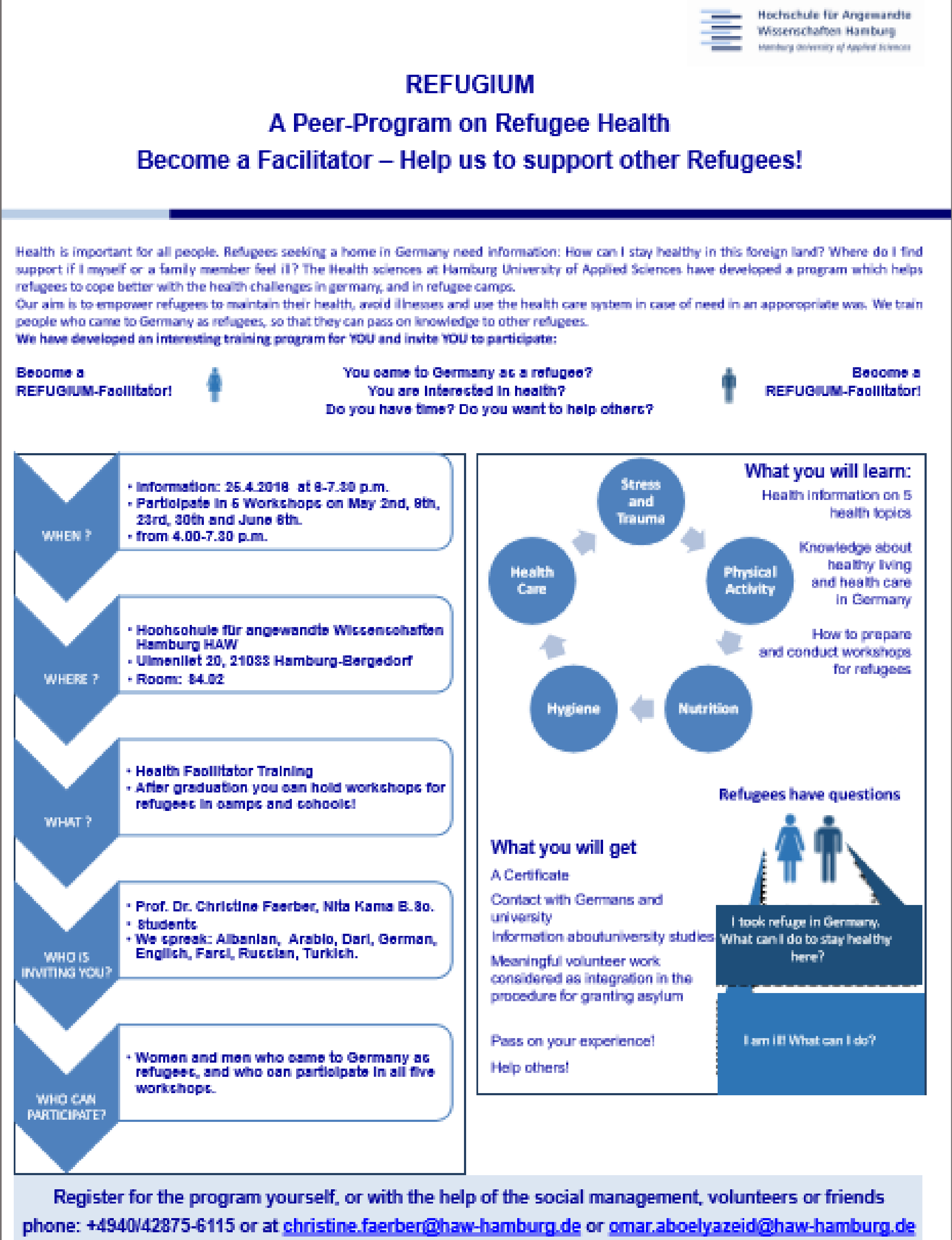
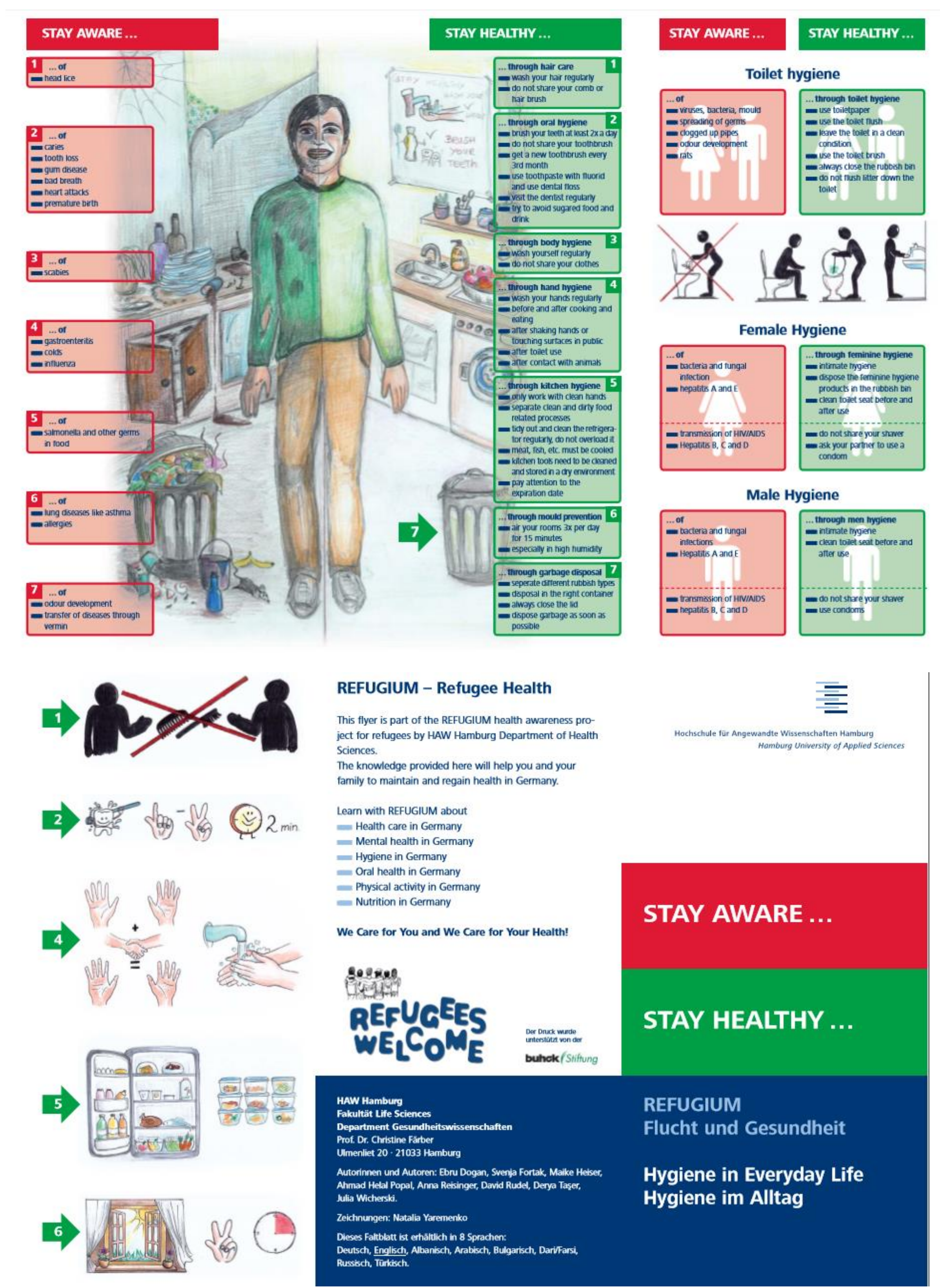
8. Appendices

Appendix A: Invitation leaflet



Appendix B: Hygiene Flyer and Nutrition Manual



STAY AWARE ...

1 ... of
- head lice

2 ... of
- caries
- tooth loss
- gum disease
- bad breath
- heart attacks
- premature birth

3 ... of
- scabies

4 ... of
- gastroenteritis
- colds
- influenza

5 ... of
- salmonella and other germs in food

6 ... of
- lung diseases like asthma
- allergies

7 ... of
- odour development
- transfer of diseases through vermin

STAY HEALTHY ...

1 ... through hair care
- wash your hair regularly
- do not share your comb or hair brush

2 ... through oral hygiene
- brush your teeth at least 2x a day
- do not share your toothbrush
- get a new toothbrush every 3rd month
- use toothpaste with fluorid and use dental floss
- visit the dentist regularly
- try to avoid sugared food and drink

3 ... through body hygiene
- wash yourself regularly
- do not share your clothes

4 ... through hand hygiene
- wash your hands regularly
- before and after cooking and eating
- after shaking hands or touching surfaces in public
- after toilet use
- after contact with animals

5 ... through kitchen hygiene
- only work with clean hands
- separate clean and dirty food related processes
- tidy out and clean the refrigerator regularly, do not overload it
- meat, fish, etc. must be cooled
- kitchen tools need to be cleaned and stored in a dry environment
- pay attention to the expiration date

6 ... through mould prevention
- air your rooms 3x per day for 15 minutes
- especially in high humidity

7 ... through garbage disposal
- seperate different rubbish types
- disposal in the right container
- always close the lid
- dispose garbage as soon as possible

STAY AWARE ... STAY HEALTHY ...

Toilet hygiene

... of
- viruses, bacteria, mould
- spreading of germs
- clogged up pipes
- odour development
- rats

... through toilet hygiene
- use toiletpaper
- use the toilet flush
- leave the toilet in a clean condition
- use the toilet brush
- always close the rubbish bin
- do not flush litter down the toilet

Female Hygiene

... of
- bacteria and fungal infection
- hepatitis A and E
- transmission of HIV/AIDS
- Hepatitis B, C and D

... through feminine hygiene
- intimate hygiene
- dispose the feminine hygiene products in the rubbish bin
- clean toilet seat before and after use
- do not share your shaver
- ask your partner to use a condom

Male Hygiene

... of
- bacteria and fungal infections
- Hepatitis A and E
- transmission of HIV/AIDS
- hepatitis B, C and D

... through men hygiene
- intimate hygiene
- clean toilet seat before and after use
- do not share your shaver
- use condoms

REFUGIUM – Refugee Health

This flyer is part of the REFUGIUM health awareness project for refugees by HAW Hamburg Department of Health Sciences.
The knowledge provided here will help you and your family to maintain and regain health in Germany.

Learn with REFUGIUM about
- Health care in Germany
- Mental health in Germany
- Hygiene in Germany
- Oral health in Germany
- Physical activity in Germany
- Nutrition in Germany

We Care for You and We Care for Your Health!

REFUGEES WELCOME

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Hamburg University of Applied Sciences

STAY AWARE ...

STAY HEALTHY ...

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Dieses Faltblatt ist erhältlich in 8 Sprachen:
Deutsch, Englisch, Albanisch, Arabisch, Bulgarisch, Dari/Farsi, Russisch, Türkisch.

REFUGIUM
Flucht und Gesundheit

Hygiene in Everyday Life
Hygiene im Alltag

Time (Min)	Targets	Content	Methods	Media/ Materials
	Arrival	Participants write name tag (crepe tape, felt pen) Arrange chairs in a circle		Crepe tape + 2 felt pens
10	**Welcome Introduction** Participants and facilitator introduce themselves Goal of workshop is communicated	✓ Fruit basket: participants choose a fruit. ✓ Question: why did you choose this particular fruit? ✓ Participants introduce themselves: name, country of origin, and explain their choice of fruit. Facilitator introduces the goal of the workshop: healthy nutrition	Introduction with practical elements (fruit)	Fruit
25	**Information** Exchange experiences on nutrition. Eating behaviour in Germany/ recommendations.	Facilitator asks questions about nutrition: ✓ What did healthy nutrition mean in home country? ✓ What do you think is important for healthy nutrition? **Activity:** Participants judge the healthiness of their current nutrition on scale (put stickers on scale). Question: Why did you put your sticker here? Question: What do you like or dislike about nutrition in Germany? ➢ If refugees complain about food in camp, tell them it is their right to complain to the management. Take down complaint and communicate it to management. **Input:** Present nutrition recommendations (circle) in Germany: daily recommendations for 7 groups of food: ✓ 1,5-3 liters of water/unsweetened drink ✓ Vegetables and fruit: 5 portions a day, 1 portion=1 handful ✓ Plenty of cereals and potatoes ✓ dairy products daily ✓ meat and eggs in moderation, fish 1-2x a week ✓ use sugar, salt and fat sparingly	Activity Input Discussion	40x stickers DGE-nutritional circle Nutritional scale Grocery pictures

		✓ use sugar, salt and fat sparingly **Activity:** Participants relate pictures of food from their home countries to food groups. ✓ Mind that some refugees, especially children, may be malnurished. In this case recommend meat and fat.		
25	**Information** Interesting knowledge about sugar and fat	**Activity:** Participants estimate sugar content of various drinks with the help of sugar cubes. Facilitator gives proper number and recommends to avoid sugared drink and sweets **Activity:** Participants estimate fat in fast food/convenience food. Facilitator shows nutrition facts on packages: e.g. on pizza, chips and gives advice to avoid fast food/convenience food and demonstrates the amount of fat.	Activity Input Discussion	1 sugar cube = 3g 1g fat = 1ml Oil **Beverage 1l** – **Lump sugar** Cola – 36 Concentrated apple juice – 33 Ice tee – 24 Less concentrated apple juice (apple spritzer) – 20 Mineral water – 0
10	**Take home message**	Summary Distribution of flyer Take Home Message: use the variety of food! 5 per day for fruit and vegetables! Eating healthy improves your health and wellbeing.	Flyer	Flyer
	Farewell	Giving thanks and saying goodbye.		

Appendix C: Interview Guideline

Informed Consent and Data Privacy Form

Dear Sir/Madam …..,

I would like to thank you for participating in this Master thesis's in–depth interview titled *"Benefits and Challenges of Health Promotion and Awareness Programme "REFUGIUM" for Refugees Living in Camps in Hamburg, Germany".*

With this agreement, you allow the Hamburg University of Applied Sciences (HAW-Hamburg) to use the interview materials in the context of this research. It will be used only for these purposes and remain anonymous.

1. Participation is totally on voluntary basis.

2. The interviewee has the right of not answering any questions when feels so.

3. There will be no physical or any other form of harm.

4. The interview is part of a Master thesis. The data from the interview will be completely or partially transcribed into a written form. The recorded interview will be deleted immediately afterwards.

5. Your data will be anonymous and will not be given out to any party

(Conclusions about individual persons will not be possible. Names and addresses are not collected.)

……..   ....

Interviewee   Interviewer

Datum: __ __ / __ __ / __ __ __ __

Both parties receive a copy of this agreement document.

Socio – demographics' Biography

Interview No.: __ __ **Date:** __ __ / __ __ / __ __ __ __

Duration: __ __ Hrs __ __ Mins __ __ Secs

1. Gender: _______________

2. Age: ___ ___ years old

3. Nationality/ Country of origin? _____________________________

4. Duration of living in Germany? ___ ___ Years ___ ___ Months

   And in Hamburg? ___ ___ Years ___ ___ Months

5. Type of legal status:

   - Refugee (waiting for asylum)
   - Asylum entitlement (Refuge accepted)
   - Other________________________________ Specify: _________________________
   - I do not know
   - I do not want to answer

6. Highest level of education reached: ______________________________________

7. Profession: ____

Questionnaire for Interviews with REFUGIUM's Facilitators from Refugees and Other Participants

I. Benefits of REFUGIUM:

1. **How did you hear about REFUGIUM?**
   Probes:
   - Flyers / Internet / Friends or Social Management
   - Did you hear or did you know about other similar programmes?

2. **Can you tell me about your experience in REFUGIUM and benefits from attending?**
   Probes:
   - Why was it interesting for you to participate?
   - What were your expectations?
   - How did you find going to HAW for workshops?
   - Any benefits other than health information/knowledge?

3. The workshops' topics of REFUGIUM were: Health care system in Germany, hygiene, physical activity, nutrition and mental health.
   What is your opinion about the topics and the way they were conducted?
   Probes:
   - Relevant or not?
   - What do you think was missing?
   - What did you want to hear about more?

II. Accommodation Settings and Health Conditions

4. **Where did you live during the conduction of REFUGIUM? And now?**
   Probes:
   - Camp shelter
   - Container in camp…etc

5. **How do you feel about the overall living conditions and health situation in refugees' accommodation settings?**
   Probes:
   - Do they affect refugees' health living there?
   - Is there any common or serious health conditions facing refugees or specific groups (children, women, men) in their accommodations? Examples
   - Do you see any health differences between refugees and rest of population?

6. **How could REFUGIUM impact that?**

Probes:

- How useful could be the information to refugees with different backgrounds and educational levels? Applicable or not?
- Did you try applying your gained knowledge to improve any of the conditions?
- Tell me more? How? Or why not?

III. Challenges accompanied REFUGIUM

7. You know the idea of REFUGIUM is to pass health awareness information from refugees/facilitators to other refugees in their accommodations.
   Can you tell me your opinion about it?
   Probes:
   - What would be the best approach to reach refugees in camps?
   - What could be the challenges to reach vulnerable groups with it?

8. **Tell me about the challenges you have experienced during the programme.**
   Probes:
   - Language and cultural barriers
   - Time of seminars, period during the day.
   - Transportation or distance
   - Did you get the flyers and other materials to conduct workshops? Yes/No and effects?

9. **Is there any cultural barrier within the refugees' communities that hinder women from participating with men in such programmmes?**
   Probes:
   - Why there weren't many of women?
   - Tell me more? How? Examples
   - Any suggestions, extra special workshops just for them or childcare?

10. **Are there any health issues, difficulties in accessing health services or health related conditions affecting refugees in their accommodation settings that you want to speak about?**