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"Exploring the sexual and reproductive health of refugee women in Hamburg, Germany"

Master thesis

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Abstract

In Germany, the number of refugee girls and women has increased dramatically over the past years. More than half a million girls and women applied for asylum in between 2012 and 2016 (Worbs & Baraulina, 2017, p. 3). In comparison to the general population, refugee women are at higher risk of several health issues because of their migration history. They have an additional burden due to different aspects of reproductive health like pregnancy complications and childbearing (Gagnon et al., 2002, p. 6). Especially, women who get married in their early ages, have little formal education on sexual and reproductive health. Due to inadequate sexual and reproductive health knowledge, they face problems like unwanted pregnancies, sexually transmitted infections, maternal death and sexual violence (Ivanova et al., 2018, p. 1, 2). Refugee women also have poorer infant and pregnancy health outcomes than other women (Gagnon et al. 2002, p. 14). But, there are only a few researches done in this sector. Therefore, it is important to explore the needs of refugee women so that the health promotion program like REFUGIUM can fulfill their needs in promoting sexual and reproductive health. Thus, this paper aims to explore the sexual and reproductive health needs of refugee women in Germany.

A qualitative case study is conducted with refugee women in Germany originating from different religious and cultural backgrounds. Within a qualitative method, 2 focus groups, 7 face-to-face interviews and 5 observations in different refugee accommodations in Hamburg were conducted. The collected data were then analyzed and presented in the results. The findings of this study show refugee women's pre- and post-migration experiences, less consciousness regarding sexual and reproductive health, lack of understanding about available health services in Germany and difficulties in accessing health services. This deeply impacts refugee woman's sexual and reproductive health and shows the need for health promotion and awareness programs. A health promotion program like REFUGIUM can provide sexual and reproductive health education for refugee women through research oriented workshops.

Keywords:

Women's health, Refugee women, Sexual and reproductive health, REFUGIUM program

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List of Abbreviations

AIDA	Asylum Information Database
AIDS	Acquired immune deficiency syndrome
BAMF	Bundesamtfür Migration und Flüchtlinge (Federal Office for Migration and Refugees
BZgA	Bundeszentralefür gesundheitliche Aufklärung
ECRE	European Council on Refugees and Exiles
HAW	Hamburg University of Applied Sciences
HIV	Human immunodeficiency virus
MCWH	Multicultural Centre For Women's Health
NGOs	Non-governmental organizations
REFUGIUM	Rat mit Erfahrung: Flucht Und Gesundheit, Information Und Multiplikation (Experienced Advice: Refuge and Health, Information and Peer-Facilitation)
RHTAC	The Refugee Health Technical Assistance Centre
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
UNHCR	The United Nations Refugee Agency
WHO	World Health Organization

1 Introduction

Germany is one of the European countries that received the highest number of refugees for the last years (Sönmez et al., 2017). In the year 2017, around 1.7 million people seeking protection were registered in the Central Register of Foreigners (AZR) (Statistisches Bundesamt (Destatis), 2019). The majority of the people that claimed asylum in Germany are from Syria, Afghanistan, Iraq and Iran. Among refugees, women and children constitute the most vulnerable groups from war and conflicts (Sönmez et al., 2017). The number of refugee girls and women has also increased dramatically over the past years. There were more than half a million girls and women who applied for asylum in Germany between 2012 and 2016. Most of the refugee girls and women are in the reproductive age (Worbs & Baraulina, 2017, p. 4).

A systematic review of refugee women's reproductive health show that resettled women are at higher risk than others for several harmful reproductive health outcomes because of their migration experience (Gagnon et al., 2002, p. 6). Refugee women experienced many problems in their home country, during their migration and in the host country (World Future Council, 2016, p. 4). Especially, women and girls are exposed to sexual and gender-based violence, such as rape, sexual exploitation and abuse, sexual harassment, psychological violence, trafficking, early and forced marriage, transactional sex and domestic violence (Kurmeyer, Abels, & Merkle, 2017, p.5). This gender-based violence, including forced marriage is one of the reasons for migration for some refugee women (World Future Council, 2016, p. 4). Further on, female refugees have an additional burden due to different aspects of reproductive health like pregnancy complications, childbearing, which places them in a particularly disadvantaged position (Gagnon et al., 2002, p. 6). Especially, women who get married in their early age have little formal education on SRH (Crossland et al., 2015, p. 397). Due to low SRH knowledge, they have to face problems like unwanted pregnancies, sexually transmitted infections, maternal death and sexual violence (Ivanova et al., 2018, p. 2). Refugee women have also poorer infant and pregnancy health outcomes than other women (Gagnon et al., 2002, p. 14).

All these health-related problems, including gender-specific traumatization and the child care responsibility of married women, language barrier, woman's changing role within the traditional family context and loss of social support hinder refugee women to get access to medical care in the host country (Charite, 2017). These kinds of pre- and post-resettlement factors can have profound effects on women's reproductive health. Further on, only a few types of researches have been done in the field of SRH care for refugee women with a focus on the provision of family planning, SRH and maternity care (Mengesha et al., 2017). Thus, there is need of health promotion programs, which helps refugee women to benefit and live a better life than they were able to do before.

1 Introduction

REFUGIUM program in Hamburg is one of the health promotion and awareness programs, which aim to promote refugee health by providing them knowledge of healthy lifestyle and information on access to health services. REFUGIUM program is offering different health workshops in refugee accommodations in cooperation with other organizations. To improve the sexual and reproductive health of refugee women, REFUGIUM program aims to develop a women's health workshop (REFUGIUM program). Before the development of women's health workshop for refugees, their SRH issues and needs, and existing level of knowledge and their understanding should be explored. Thus, this paper aims to study such needs, which should further help REFUGIUM program to develop a women's health workshop focusing on SRH. Therefore, the research question is "What are the sexual and reproductive health needs of refugee women living in Germany?"

Answering this question involves several steps. At first, some data regarding refugee women in Germany are presented. Following it, sexual and reproductive health is described briefly including some aspects such as pregnancy, family planning, contraceptive, STI, sexual and gender-based violence. After that, refugee women's SRH problems are presented based on literature research. Further on, a brief description of SRH services in Germany and the health promotion and awareness programs, i.e. Zanzu and REFUGIUM program are also introduced. This gives an overview of the sexual and reproductive health of the refugee women in Germany. Then each step of the applied method for the research is described. It starts with choosing a qualitative case study design and the development of the interview guide. The data collection process involves the recruitment of participants, conducting a focus group and face-to-face interviews based on a semi-structured interview guide. The data analysis process includes transcriptions and content analysis. During the research process, ethical aspects were also considered and a self-reflexivity is also provided. Finally, the obtained data are interpreted and portrayed in results. Following that, a summary of findings, some limitation of the results and applied method are also discussed. At last, some recommendations are given to REFUGIUM program to conduct a women's health workshop. There is a general recommendation for conducting a women's health workshop and specific recommendations which provide relevant SRH information as a content for women's health workshop.

This paper explores refugee women's perception towards health, their health conscious and health-related behaviors. It discusses their specific SRH issues such as early marriage, the problems during menstruation, difficulties during pregnancy, low awareness about STI, and contraception, high risk for sexual violence etc. The paper also explores the reason behind poor sexual and reproductive health knowledge among refugee women. It also illustrates refugee women's awareness of health services in Germany, as well as their utilization of health services in their home country. The results also present the barriers such as a communication barrier,

gender aspects, the difference in health care systems, poor living conditions, lack of social and financial support, stress factors, etc.

In this way, the paper presents different SRH issues that refugee women are experiencing and emphasizes the need for public health intervention to promote their health as well as minimize negative impacts on family and the economy. The results of this study will certainly help REFUGIUM program to develop women's health workshop modules. Further on, the finding from this study could also help policymakers, educators and health care providers in promoting the sexual and reproductive health of refugee women.

2 Sexual and reproductive health of refugee women in Germany

This chapter provides insight into the relevance of the topic by presenting some key facts about refugee women in Germany, a description about sexual and reproductive health (SRH) and refugee women's SRH problems. It also provides information on different health services that Germany is offering concerning SRH. Along with it, there is also a brief description of health promotion and awareness program like Zanzu and REFUGIUM.

2.1 Refugee women in Germany

In recent years, Europe has encountered a refugee crisis due to continuing conflicts, war and human rights violations in many countries. This has resulted in the displacement of millions of people, who seek refuge in different countries (Entre Nous, WHO & UNFPA, 2016, p. 26). European countries are currently the main recipient of immigrants as refugees. Among them, Germany has become a popular destination for many refugees. There were more than 1 million people who have migrated Germany since 2015 (BAMF, 2016). The immigrated refugees are distributed in different regions of Germany. The figure1 shows the distribution of refugees in different region of Germany.

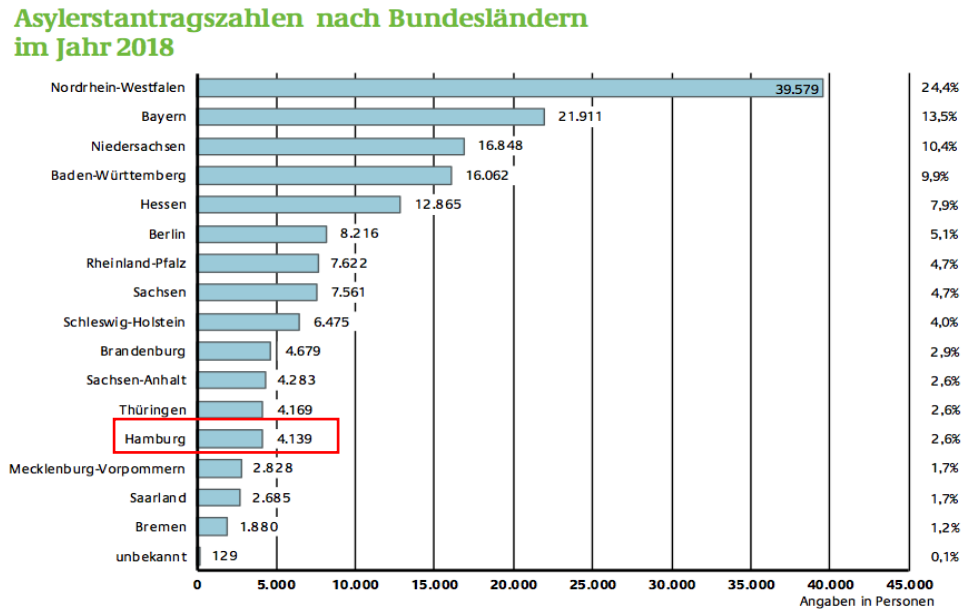


Figure 1 Number of asylum application in different regions of Germany in 2018
(Source: BAMF, 2018)

In 2018, Nordrhein-Westfalen and Bayern have the highest number of asylum application. In Hamburg, there were 9.700 asylum applications in the year 2016 and 4.139 asylum applications in the year 2018 as shown in figure 1 (BAMF, 2019).

According to the current data from BAMF 2019, the majority of these refugees originates from Syria, Iraq, Nigeria, Iran, Afghanistan, etc. The chart below (Figure 2) illustrates the top ten countries of origin of asylum applicants in Germany in 2018 (Worbs & Baraulina, 2017, p. 1). In comparison to the male refugees, there are less female refugees who applied for asylum. However, the number of refugee women has increased dramatically from 2012 to 2016 (Table 1). There were more than 500,000 girls and women who applied for asylum in Germany between 2012 and 2016 (BAMF, 2017). Regarding age group of female refugees, most of the refugee women are in young age, i.e. more than 40%of female refugees were under 18 years old, 38% were aged 18 to 35 and lived with their families. This indicates that most of the women are in reproductive age (Worbs & Baraulina, 2017, p. 4).

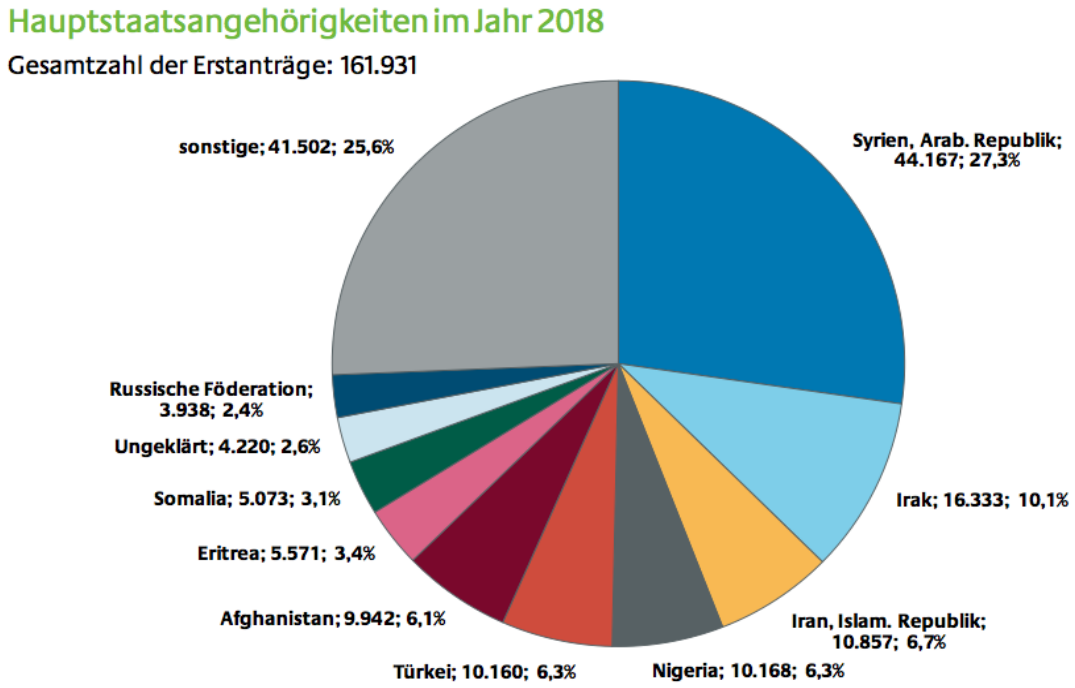


Figure 2 Origin of Refugees in Germany
(Source: BAMP, 2018)

Table 1 Female asylum applicants and cumulated percentage of women by country of origin from 2012 to 2016.

Country of origin	2012	2013	2014	2015	2016	Total 2012-2016	Cumulated percentage of women, 2012-2016
All countries	24,670	40,109	57,891	136,315	247,804	506,789	33,5%
	including: TOP 10 countries						
Syria	2,348	4,075	11,419	41,527	96,817	156,186	32.4%
Afghanistan	2,447	2,282	2,740	8,459	40,379	56,307	30.8%
Iraq	2,502	1,859	2,261	8,675	37,051	52,348	37.2%
Iran	1,779	1,961	1,335	1,767	7,630	14,472	33.1%
Albania	107	534	3,432	21,339	6,102	31,514	40.4%
Eritrea	282	951	2,673	2,649	5,720	12,275	26.0%
Russian Federation	1,533	7,304	2,114	2,727	5,436	19,114	49.1%
Nigeria	418	848	1,619	1,856	4,582	9,323	37.8%
Somalia	404	1,015	1,486	1,476	3,282	7,663	30.0%
Serbia	4,212	5,661	8,342	8,188	3,113	29,516	49.0%

(Source: Worbs & Baraulina, 2017, p.3)

According to BAMP research, most of the refugee women have lower educational qualifications and less experience in paid employment in their home country (BAMF, 2017). In terms of religious structure in year 2016, there were 74.8% Muslims, 12.8% Christians and 8.0% Yazidis, which represents three most important groups (Worbs & Baraulina, 2017, p. 4).

Studies show that women refugees are less proficient in German than men. At nationwide integration courses refugee women's attendance is below average and they take long time to attend a course. Besides, in comparison to male refugees and other population groups, women refugee participation is significantly lower in employment sectors (Worbs & Baraulina, 2017, p. 1). Due to illiteracy, many refugee women have less opportunity in the employment sector and due to less language proficiency; they have to struggle hard to integrate in Germany (World Future Council, 2016). However, most of the refugees in young age are highly motivated to change their lives in the new country. They have strong intention to stay and work hard in Germany (Worbs & Baraulina, 2017, p. 2; Praia. Baraulina/Bitterwolf 2016: 47; Romiti et al. 2016: 46; Worbs et al. 2016: 177, 270f.).

As shown in the Figure 2, refugee women indicate a heterogeneous group as they come from different countries and have different migration experiences. They come from different social backgrounds, have different levels of education and therefore have varying expectations regarding life in Germany. Despite of these differences, there exist some common "trend findings" (Worbs & Baraulina, 2017, p. 12). They all are forced to migrate and leave their home country due to various reasons like war and persecution (The UN Refugee Agency, 2016). The reasons for leaving the own country, the potentially long hazardous journey from one country to another and the process of resettlement in a new country are some risk factors for refugees to suffer from a variety of health issues including sexual and reproductive health issues (RHTAC, 2011). Specially, refugee women are exposed to threatening condition like sexual harassments, isolation, physical torture etc. (Slobodin & Jong, 2015).

2.2 Sexual and reproductive health

According to World Health Organization (WHO) sexual and reproductive health (SRH) is defined as "*a state of complete physical, mental and social well-being in all matters relating to the reproductive system*" (WHO, 2018a). It implies that every individual is able to have a responsible, satisfying and safe sex life and they have the rights to make their own choices about their sexual and reproductive health (WHO, 2018c). In a comprehensive way, SRH refers to the ability to have a voluntary sexual relationship, fertility regulation, disease protection and treatment, and right for pregnancy support and delivery, abortion and post-abortion care and early child health (Blanc, 2001, p. 190).

However, health advocates from developing countries have the opinion that the globally used concept of reproductive health is not always applicable to all cultures as the concept of reproductive health is culturally constructed. It is a product of specific historical, ethical and legal transformations (Kaddour et al., 2005, p. 35). For example, the Reproductive Health Working Group (RHWG) which is comprised of researchers, particularly from Egypt, Lebanon, Palestine, Syria and Turkey defines reproductive health as ''*the ability of women to live through the reproductive years and beyond with reproductive choice, dignity, and successful childbearing, and to be free of gynecological disease and risk*'' (Kaddour et al., 2005, p. 35).

Nevertheless, SRH includes a wide range of aspects such as family planning, contraceptive, STI, post-abortion care, menopause, female genital mutilation, sexual and gender-based violence (Gagnon et al., 2002, p. 9). Another important subject area of SRH is maternal-health, which encompasses pre-pregnancy, antenatal, childbirth and after birth supports which has profound effect on mother and their child health (Commonwealth of Australia, 2010, p. 24). Furthermore, it is also concerned with issues like human rights related to sexual health, sexual pleasure, eroticism and sexual satisfaction, sexual dysfunction, and mental health related to sexual health (WHO, 2018c). Following paragraphs provides some important aspects of SRH such as family planning, contraceptive, pregnancy, STI and violence.

Family planning is an important aspect of SRH. Family planning enables individuals to make informed choices about their SRH (WHO, 2018e). It is the information, means and methods that allow individuals to decide if and when to have children (UNFPA, 2018). There are many benefits of family planning. Firstly, family planning allows individuals to attain their desired number of children and determine the spacing of pregnancies by contraceptive methods. Family planning can delay pregnancies in young women and thus decrease the risk of health problems and death from early childbearing. It prevents unintended pregnancies, mostly in case of older women who face increased risks related to pregnancy. By reducing rates of unintended pregnancies, it also

reduces the need for unsafe abortion (WHO, 2018e). Family planning also empowers women through efficient planning of their childbearing, education and employment (UNFPA, 2018).

Contraceptive is another major aspect of SRH. The use of the contraceptive method helps to prevent the transmission of HIV and other STI. Contraceptive helps in decreasing unwanted pregnancy and abortion (Entre Nous, WHO & UNFPA, 2016, p. 10). Due to lack of proper education, there are millions of women, especially in developing countries, who are not using any of these contraceptive methods. Mostly the adolescent girls from the age 15-19 died due to complications from pregnancy and childbirth (UNFPA, 2018). It has also consequences of neonatal mortality (WHO, 2019). SRH also deals with pregnancy related topics such as prenatal care which helps to identify possible risks for mother and child that can be reduced by providing appropriate medical, nutritional, and educational interventions. This helps further on to reduce the adverse pregnancy conditions and outcomes (WHO, 2018c). An abortion is another aspect of SRH. According to WHO statistic, there are around 25 million abortion cases in the world which are not safe (Narasimhan, 2018). An abortion is legal in most of the countries within certain circumstances, however different countries have different rules and regulations (BZgA, 2017b, p. 84).

Sexually transmitted infection (STI) is another important aspect of SRH. Worldwide, there are more than 30 different types of STI. Some common STI are chlamydia, syphilis, gonorrhea, hepatitis A, HIV and Aids (BZgA, 2018e). Among them, the prevalence of the most frequently occurring STIs like chlamydia and gonorrhea has increased in several European countries (Entre Nous, WHO & UNFPA, 2016, p. 13). The WHO world report states that there are around 1 million women and girls who acquired HIV, which illustrate huge gaps in access to basic services regarding STI (Narasimhan, 2018). Many STIs can have dreadful long-term consequences. The STIs like chlamydia and gonorrhea may lead to complications such as infertility, chronic illness and can also lead to life-threatening conditions in fetuses and newborn babies (WHO, 2018c). But most of the STI can be treated if it is diagnosed early (BZgA, 2018e).

Violence is one of the sensitive topics of SRH. In today's world, violence against women is perceived as a public problem (BZgA, 2018a). Violence can take the form of physical assault, sexual abuse, verbal abuse, psychological or emotional abuse, economic abuse, social abuse, and spiritual abuse (MCWH, 2009, p. 36). The gender-based violence and sexual violence has a multitude of negative effects on women's SRH. Results from almost 50 population-based surveys in worldwide show that between 10 and 67 % of women report being physically harmed by a male partner at some point of their lives excluding psychological or sexual abuse (Blanc, 2001, p. 195). This further on results to unwanted pregnancies leading to gynecological problems, pregnancy complications and miscarriages, unsafe abortions, rejection and harassment in their families, and

STI (Ivanova et al. 2018, p. 2, 8; Blanc, 2001, p. 195). In addition, it can adversely affect the mental and physical health of women and lead to post-traumatic stress disorder, anxiety and depression. Due to sexual violence women in some culture experienced social rejection, stigma, suicide or even murder by a family or community members (Entre Nous, WHO & UNFPA, 2016, p. 27).

The social determinants of health play a key role in SRH, which impacts the development of individuals, their families and communities' at large level (Entre Nous, WHO & UNFPA, 2016, p. 12). The factors like education, employment, income, social connection, safety and security, including freedom from violence have a huge effect on women SRH and their overall health outcomes and their access to health care services (Commonwealth of Australia, 2010, p. 26). For e.g. women who are socioeconomically disadvantaged suffer from poor health and have a high risk of having children with poor health (Commonwealth of Australia, 2010, p. 25). Indeed, poor SRH has the consequence of poor physical, psychological and social health and wellbeing of women and their families (Mengesha et al., 2017). According to WHO, this kind of SRH problems is responsible for one- third of health issues for women between the ages of 15 and 44 years (WHO, 2017a). Looking at wide range, poor SRH leads to increase morbidity and mortality, gender inequity, financial strain, and even decreasing national development and progress rate in a large scale (Crossland et al., 2015, p. 393).

To maintain the SRH of an individual, the sexual rights of all individuals must be respected, protected and fulfilled (WHO, 2018d; WHO, 2006a). In order to promote the sexual health of individuals, all individuals should get an education about sexuality and they should be aware about sexual health problems. The health sector of each community can play a significant role in assessment and in providing counseling and care on SRH (Alexander & Korenbrot, 1995). Therefore, all the women around the world should get equal access to information and services relating to sexual health, reproductive health, and safe sex practices, screening and maternal health for a better SRH (Commonwealth of Australia, 2010, p. 8).

2.3 Refugee's women sexual and reproductive health

Most of the refugee women currently living in Germany originate from Arab countries that have recently seen several conflicts and political upheavals. This not only caused death and disabilities, but disrupted the provision of health and education services too. These have also led to differential implications for SRH (DeJong et al., 2005, p. 50). The study on Syrian refugees has shown that women's health and specifically their SRH are disproportionately affected due to limited access to contraception, difficulties in accessing health care services, increasing gender-based violence, early marriage, lack of access to emergency obstetric care, etc. (Yasmine & Moughalian, 2016, p. 27). In addition to that, most of the married women experienced childbearing, parenting and domestic violence issues (MCWH, 2009, p. 38). The following paragraphs demonstrate major SRH issues among refugee women.

Sexual and reproductive health education

In most of the Arabic countries, sexual education is not really given a priority (Mengesha et al., 2017). To discuss the sexuality topic is even a taboo in the surrounding and public places in many Arabic countries (DeJong et al., 2005). The study about SRH situation of young people in the Arab states and Iran address that young people in Arab countries lack access to information. The education curricula in the school levels rarely include SRH topics and if they are included, the teachers are not prepared well or embarrassed to teach about SRH topics. Hence, some of the teachers even skip SRH topics. Neither, the parents being the first source of information discuss SRH with their young ones. Because of this, most of the younger generations people in Arab countries lack SRH education (DeJong et al., 2005, p. 52). Studies on refugee women reported that the majority of women lacks knowledge on different areas of SRH such as the body changes, pregnancy, information on HIV/AIDS, sexuality, abortion (Ivanova et al., 2018, p. 8). Further on, there is a huge gender disparity in social opportunities. More than half of Arab women lack literacy, and thus have lowest participation rate in the labor market (DeJong et al., 2005, p. 51). This largely influences on health awareness among women.

Family planning, contraception and STI

SRH is an important aspect of women's quality of life, but the utilization of family planning methods and STI prevention are lower among refugee women (Mengesha et al., 2017). Available evidence from UNFPA indicates that, the use of contraceptive methods in south-west Asian countries like Syria, Afghanistan, and Iraq are very low from where most of the refugees originated (UNFPA, 2018). The contraceptive prevalence rate in different countries can be seen in Figure 3 below. Looking at the worldwide statistics presented from WHO 2018, there are around 214 million women in reproductive age in developing countries who want to avoid pregnancy, but they are not using a modern contraceptive method (WHO, 2018b). Some possible reasons are social barriers in some culture, such as opposition by partners, families or

communities (Ivanova et al., 2018, p. 8). Lack of knowledge plays a big role, as women do not know what kind of contraceptive methods are available or having incorrect perceptions about the health risks of modern methods. There are also some logistical problems, such as difficulty in travelling to health facilities or supplies running out at health clinics, especially in developing and underdeveloped countries (UNFPA, 2018).

In comparison to adults, many adolescents were less aware of modern methods of contraception from the same group and culture (Ivanova et al., 2018, p. 5). There is also lack of proper services regarding contraceptives and family planning like a counseling center. Due to lack of knowledge about SRH and inadequate utilization of family planning methods among refugee women there is a high rate of morbidity and mortality cases in women via pregnancy-related complications (Ivanova et al. 2018, p. 9). Especially, women in younger age groups are at high risk. Their emotional immaturity and lack of negotiation skills put many young girls in vulnerable positions (Crossland, 2015, p. 394).

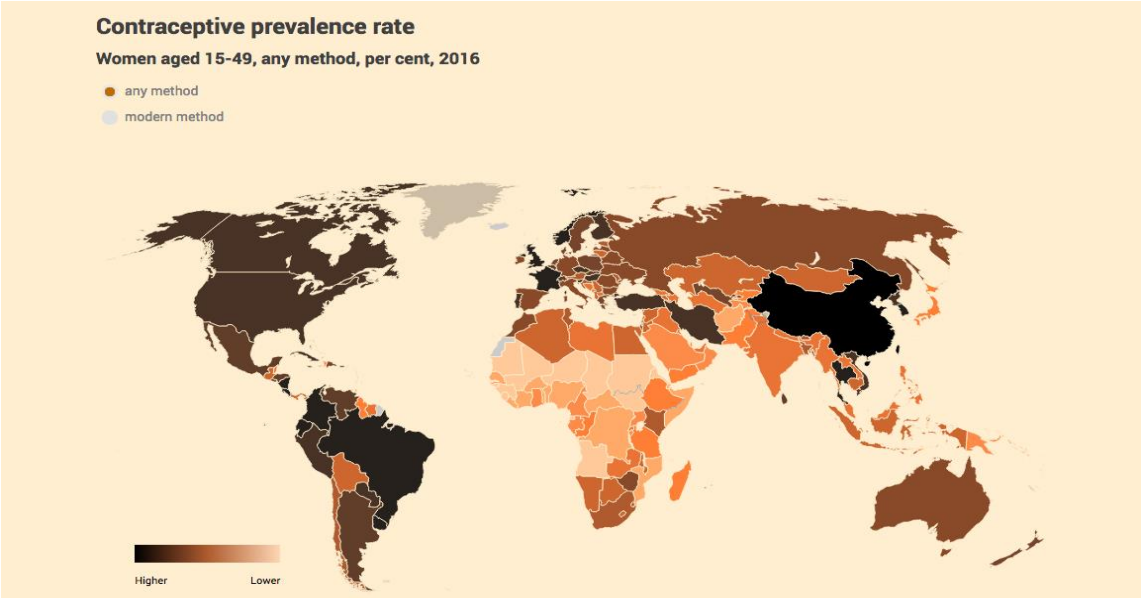


Figure 3 Contraceptive prevalence rate
(Source: UNFPA, 2018)

Regarding STI, a systematic review of the SRH knowledge among refugees demonstrated that the majority of refugees did not know any correct route of HIV transmission and effective means of avoiding HIV or other STI (Ivanova et al., 2018, p. 5). Particularly, young girls are more susceptible to STIs (Crossland, 2015, p. 394). Studies also showed enormous stigma and rights issues surrounding HIV in the Arab states (DeJong et al., 2005, p. 55).

Pregnancy and childbirth

According to WHO, adolescent girls, migrants and women with low socioeconomic status or education have a higher risk of adverse outcomes of pregnancy and birth (WHO, 2019). Most of the refugee women experience higher rates of unplanned pregnancy, obstetric complications and induced abortion than women in the host population (WHO, 2001). Globally looking, the complication in pregnancy and childbirth is one of the main causes of death for 15–19 years old girls (Entre Nous, WHO & UNFPA, 2016, p. 12). In some developing countries, most of the adolescent girls even lack access to SRH commodities like menstrual hygiene products (Ivanova et al., 2018, p. 9).

Furthermore, there are still many early marriage cases and high incidence of consanguineous marriages in many Arab countries. Particularly women are pressured to marry at an early age and after marriage, they are pressurized to reproduce children (DeJong et al., 2005, p. 52) which is further seen as a barrier to pursue education (Ivanova et al. 2018, p. 8). There is also a higher number of single women and the resurgence of forms of non-conventional marriage. However, there is a decline in polygamy in some Arab countries (DeJong et al., 2005, p. 52).

Sexual and gender-based violence

Refugee women have high risk of sexual violence in combination with physical, emotional or socioeconomic violence. A study in 2014 estimated that around 21% of women in 14 conflict countries reported experiencing sexual violence (Entre Nous, WHO & UNFPA, 2016, p. 26). Refugee women experience sexual violence not only in their country, but also on their journey and even after their arrival in Europe (Entre Nous, WHO & UNFPA, 2016, p. 26). During the journey, there are cases, where refugee women have been victims of violence from police and border guards, as well as smugglers, who are demanding high prices to facilitate entry to the EU (Keygnaert et al., 2012, p. 516). Some studies also address that refugee women are victims from transactions and commercial sex, which is also called as “survival sex” in exchange for goods, food, menstrual hygiene products and money or even in exchange for documents or transport to Europe. Even after arriving in a new country, women and girls living in refugee camps are experiencing violence as there is not enough security in camps (Entre Nous, WHO & UNFPA, 2016, p. 26).

Many studies demonstrated different forms of violence which refugee women have experienced such as rape, unwanted physical touching, sexual exploitation, commercial sex, early marriage and trafficking (Kurmeyer et al., 2017, p. 5; Multicultural Centre for Women’s Health, 2009, p. 36). Moreover, a systematic review of Ivanova et al. reported that refugee women are suffering from sexual exploitations and harassments by their family members and close relatives apart from

their partners which is quite difficult to assess as the victims may not be willing to open up to report such incidences (Ivanova et al., 2018, p. 9). This kind of violence results to a negative impact on women physical and mental health and their ability to access health services (MCWH, 2009, p. 36). The sexual abuse and violence have many other negative consequences such as maternal mortality, suicide because of unwanted pregnancy, high risk of STIs, neonatal morbidity due to transmission of STIs which are illustrated clearly in the diagram below (Garcia-Moreno & Stöckl, 2009).

This violence in refugee population is rooted in gender and power imbalances (MCWH, 2009, p. 36, 37). Usually, women have less power in a relationship which gives men greater sexual freedom and rights of sexual determination than women (Blanc, 2001, p. 190; Mason 1994, Riley 1997). In a family, gender-based power relations can also effect on the ability of partners to acquire information relevant to reproductive health, on their ability to make decisions related to their health, and on their ability to act to protect health or improve their health or health of those who depend upon them. Due to imbalance in power among men and women, most of the women can hardly negotiate about SRH concerns such as contraceptive use with their partners (Blanc, 2001, p. 190). Thus, this power relation has a direct causal link with violence or the threat of violence and it in turn influences the health of the women in many ways.

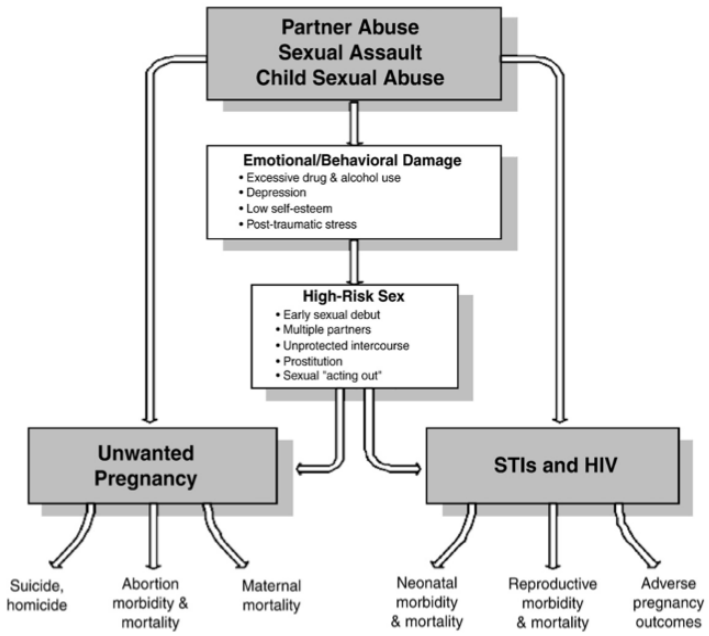


Figure 4 Consequences of partner abuse, sexual assault, and child sexual abuse (Source: Garcia-Moreno & Stöckl, 2009)

Barriers in accessing sexual and reproductive health service

There are numerous barriers which hinder refugee women to seek SRH services in the new country. Some of them are pre- and post-migration experience, lack of understanding about available services and difficulty navigating the health care system (Mengesha et al. 2017). As refugees came from different country and were grown up with different culture, it is hard for them to deal with sexuality and contraception in new countries (BZgA, 2017, p. 17). Along with this, most of the refugee women from Middle East Asia feel ashamed to visit gynecologist and to ask women health related questions (Charite, 2017).

Refugee women's health is also highly influenced by their relationship with the family. The study on refugee health shows that husbands or male member of the family has a big role in the family. Normally a man acts as decision making person. Also, in the context of SRH, husbands involved in family planning consultations and decision making for their wives (Mengesha et al., 2017). Therefore, men's lack of knowledge on SRH can affect women's health. For e.g. men's lack of knowledge of the contraceptives can affect the couple's choice of method (Blanc, 2001, p. 197). Further on, women are not supposed to be knowledgeable about sex and are expected to be passive in sexual matters. They feel uncomfortable in discussing sexual matters with their own partner and hence women communicate indirectly or nonverbally or partially with their partner (Blanc, 2001, p. 194).

Moreover, Muslim women prefer to undergo medical examination by the health professional who belongs to same gender. This culture even tends to continue after the resettlement in new countries like Germany, where they prefer to visit doctors from the same cultural and linguistic backgrounds as their own as this allows for better communication and longer consultation times (MCWH, 2010, p. 45). Communication barrier is another big problem for most of the refugee women, who cannot speak the native language. There is also a problem in finding a professional interpreter especially female interpreter. Women are very concerned about the gender of interpreters too. Some women take relatives as a professional interpreter as they feel uncomfortable to talk about the sensitive topics like sexual health in front of unknown people. The scarcity of health interpreters may cause frustration in some women, who are left with no choice but to use family members as interpreters (MCWH, 2010, p. 48, 49).

Further on, refugee women are not active in seeking health services and the utilization and experiences in accessing health services also vary among refugee women. According to a study conducted with refugee women in Australia, refugee women's experiences in accessing health care in their country of origin influenced their access and utilization of care after resettlement in the new place.These all cultural, educational, societal factors indicate that there is a dynamic interrelationship between women and their surroundings (Mengesha et al., 2017). Thus, it is very crucial to empower refugee women, to educate refugee women about SRH and to inform them personally about the available health services in their surroundings.

2.4 Sexual and reproductive health service in Germany

In Germany, there are different health care services regarding SRH such as gynecologist's service where women can get help if they have problems such as pain during menstruation and pregnancy issues. They also offer consultations and preventive examinations during pregnancy (BZgA, 2017, p. 11). There are also counseling services on abortion, STI, contraceptives, etc. Further on, gynecologists and urologists help with the problem related to sexual organs, prevention and sexuality (BZgA, 2017, p. 11). Some important SRH services in Germany are described in following paragraphs.

Pregnancy and childbirth services

In the context of pregnancy, there is available of different services during pregnancy, childbirth, for maternal care from clinic, midwives or gynecologist (BzgA, 2018). There are medical examinations on a regular basis to monitor the child's development and maternal health. This helps to detect risk and prevent from risks (BZgA, 2014). There are also pregnancy counseling centers that help women to get answers to their questions about sexuality, contraception, the desire to have children, etc. (Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, 2016; BZgA, 2017, p. 90). They also provide information about the possibilities of financial support if required. Especially, the Federal Foundation known as "Mother and Child- Protection of Unborn Life" support women with financial issues (Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, 2016).

There are also birth preparation courses conducted by midwives or physiotherapists, which aims to accompany women during pregnancy and to prepare them comprehensively for the birth. The course provides basic knowledge about pregnancy and childbirth and help pregnant women by sharing tips regarding childbirth, to take care of the newborn baby and about breastfeeding (BzgA, 2014). After the birth of a newborn, the newborn health and maternal health is regularly examined. The newborn gets a first pediatrician's examination, which is known as U-Untersuchung. Along with this, the pregnant mother also gets medical care and advisory support from midwives on breastfeeding, to recover from birth injuries, to live a new life with a new child (BZgA, 2016). There are also some other services like family-midwives (Familienhebammen) and family health and child nurses (Familien-Gesundheits- und Kinderkrankenpflegerinnen).They help women in difficult cases like if the newborn baby has some chronic diseases, or if parents are disabled. These all above mentioned services are funded by statutory health insurance in Germany (Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, 2016). The following table provides the list of services that are covered by statutory health insurance in Germany.

Table 2 Services provided by statutory health insurance during pregnancy and motherhood

Services provided by statutory health insurers during pregnancy and motherhood
- Medical check-ups - Doctor and midwife care - Midwife assistance - Help with medical, dressing and remedies - Birth in a hospital - Household care - Household help - Maternity benefit

(Source: Own representation according to: Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, 2016)

Services concerning contraception and STI

In Germany, there is availability of variety of contraceptives such as combined oral contraceptives (COCs) or pills, implants, monthly injectable or combined injectable contraceptives (CIC), combined contraceptive patch and combined contraceptive vaginal ring (CVR), intrauterine device (IUD)(copper-containing), male condoms, female condoms, male sterilization (vasectomy), female sterilization (tubal ligation) etc. (WHO, 2018e). Usually people have to pay for the contraceptive methods. But, there are some exceptional cases like the cost of medically prescribed contraceptives such as the pill, mini-pill, contraceptive patch, vaginal ring, three-month injection, hormone implant, spiral and emergency contraception etc. for the young women under 18 years are funded by statutory health insurance. But after getting 18 years old they have to make an additional payment (BZgA, 2017, p. 11). If people are not well informed about different contraceptives, they can get help from counseling services on contraceptive methods. The charge for counseling services is also covered by statutory health insurance. Moreover, each city and communities help women with low incomes to pay the costs of contraceptives (BZgA, 2017, p. 11).

The Federal Centre for Health Education (BZgA) has also been focusing on the prevention of STI, particularly HIV/AIDS. The campaign "Don't give AIDS a chance" is one of the best examples of successful health prevention campaign in Germany (BZgA, 2019). It is providing information on different STI and how individuals can prevent or where they can get help if they suffer from STI. They also offer telephone counselling and online counseling, which can be done anonymously (BZgA, 2019).

Support for victim of sexual and gender-based violence

Violence against women occurs across all cultures and strata (Blanc, 2001, p. 190). Even in the developed country like Germany, around 40% of women experience violence in their life. So, the Federal Family Minister of Germany made a helpline service called 'Violence against women' to help women who are victims of violence (BZgA, 2018). This helpline "Violence against women" is a nationwide counseling service for women. Women can call the number 08000 116 016 or contact via online. They offer direct service or online consultation anonymously in 17 different languages for women with and without migration background. They give advice and consultation on all forms of violence against women like domestic violence, mental, physical and sexual violence outside of relationships, stalking, mobbing, digital violence, forced marriage, sexual harassment in the workplace and in public places etc. They are available 24 hours a day and throughout the whole year (Bundesamt für Familie und zivilgesellschaftliche Aufgaben, 2018). Figure 5 below shows the logo of the helpline of violence against women.

Figure 5 Logo of the campaign “Violence against women”
(Source: Bundesamt für Familie und zivilgesellschaftliche Aufgaben, 2018)

These are some SRH services which are offered for the host citizenship as well for refugees and migrants in Germany.

2.5 Health promotion and awareness programs in Germany

In Germany, there are several organizations which are working in the field of SRH to address its importance and to raise awareness about the problems. Among several organizations, some of them are pro-families which offer counseling on sexuality, pregnancy or partnership (pro familia). There is Caritas Deutschland which provides counseling and advices on pregnancy (Caritas Deutschland), Diakonie Deutschland which supports women that are victims of sexual violence (Diakonie Deutschland, 2019). In the context of STI, there are Aids-Hilfe and CASA Blanca, which provides counseling. The Federal Centre for Health Education (BZgA) is working in cooperation with the Federal Ministry of Health in raising awareness program on overall SRH. They provide information on different areas such as pregnancy, STI, family planning and contraception, and even about screening of cancer etc. (BZgA, 2019). Currently, BZgA has developed an online website which provides key information on the topic SRH. This website is known as “Zanzu” which is described below in the upcoming paragraphs.

Moreover, there are some health promotion and awareness programs in Germany that are working in the area of SRH and especially for the refugee population (World Future Council, 2016, p. 4). Among them REFUGIUM program in Hamburg is one and it is also discussed in the following paragraphs.

2.5.1 Zanzu

Zanzu is a multilingual online portal which is developed by German Federal Centre for Health Education (BZgA) and Sensoa, the Flemish Expertise Centre for Sexual Health. This portal is available in Germany since February 2016 (World Future Council, 20, p. 24). Zanzu provides comprehensive information on SRH and rights in 13 different languages which are spoken by a majority of migrant and refugee groups such as English, Arabic, Farsi, Russian etc. (BZgA & Sensoa, 2019). This is an important element of Zanzu that migrant and refugee women living in Germany can get information regarding SRH in their own native language. The website is also intended to assist medical professionals in individual counseling sessions when there are language barriers (World Future Council, 20, p. 24). The SRH topics are divided into 6 main themes, i.e. Body, Family planning and pregnancy, infections, sexuality, relationships and feelings and rights and law (BZgA & Sensoa, 2019). These topics are shown in the very first page of the website a snapshot of which is shown below in the figure 6 below.

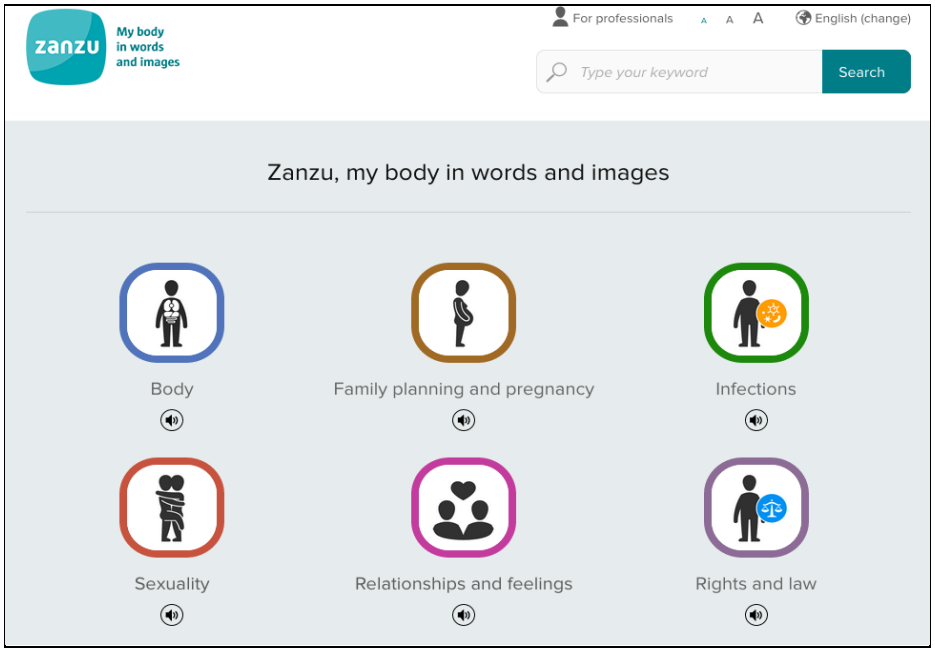


Figure 6 Six main themes of Zanzu
(Source: BZgA & Sensoa, 2019)

These six main topics are further divided into sub-topics. According to individual interest they can get information on different SRH education in the language in which they can understand. For each topic, it provides the important information illustrated by pictograms as shown in the figure 7 below. In addition to that, the website has a text-to-speech function, which allows the users to have each page read out if they have difficulties in reading. The website also includes a dictionary for most important terms such as STI connected to sexual health. These terms and its definition can be translated and read out (BZgA & Sensoa, 2019). Overall, the information is provided in a simple language.

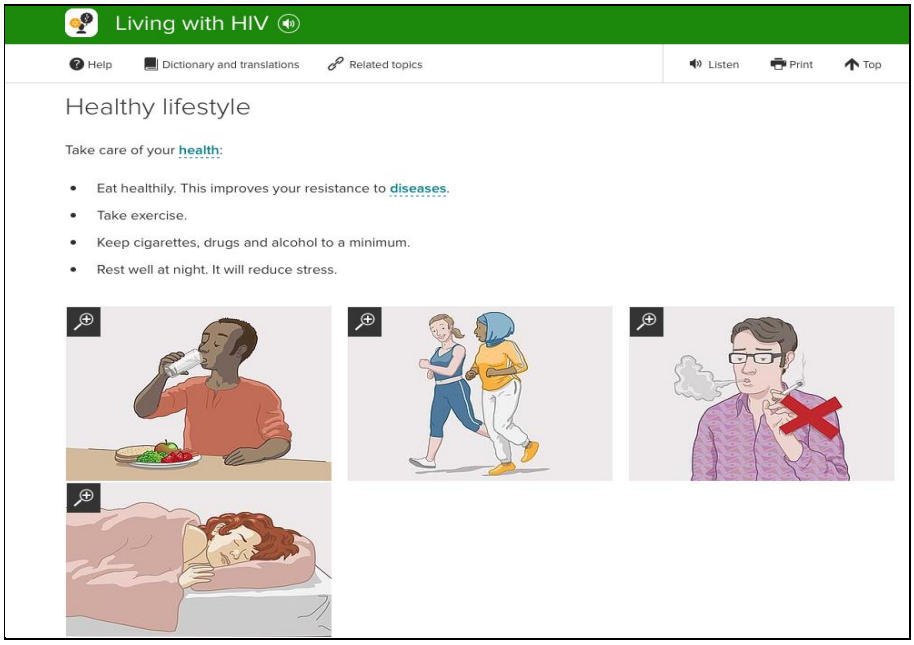


Figure 7 Zanzu information illustrated through pictograms
(Source: BZgA & Sensoa, 2019)

2.5.2 REFUGIUM program

REFUGIUM is a health promotion and awareness program, which helps refugees to gain knowledge of basic healthy living needs like nutrition, physical activity, hygiene, health care, etc. REFUGIUM stands for “Rat mit Erfahrung: Flucht und Gesundheit – Information und Multiplikation” (REFUGIUM). The program was developed by Late Prof. Dr. Christine Färber in the year 2015 at the HAW Hamburg together with the health scientist Nita Kama, HAW Life Science Department students and refugees. The aim of this program is to promote health awareness and improve knowledge and capability of refugees through training, active involvement and participation (REFUGIUM Flyer). Health trainings are provided in the form of workshops to interested participants. The trained people are also refugee health facilitators who are qualified to carry out interactive and activating themed health workshops for other refugees. These health facilitators further conduct health workshops in different refugee accommodations and in different settings like university, church etc. Thus, REFUGIUM works as a peer-to-peer approach so that an adequate number of target groups can gain knowledge about health. Furthermore, in REFUGIUM program the target group (refugees) is involved actively as peer health facilitator in the continuous development process of the program, hence it follows the participatory action research as researched cease to be objects and become partners in the whole process (Baum et al. 2006).

The REFUGIUM health workshops consist of six different topics; nutrition, physical activity, hygiene, oral health, mental health and health care in Hamburg as shown in the figure 8. For each topic, there are flyers and manuals available which help to guide peer health facilitators to conduct workshops. The flyers and manuals are available in eight different languages, i.e. German, English, Albanian, Arabic, Bulgarian, Dari / Farsi, Russian and Turkish. Depending on the participants, the workshops are conducted in their mother language, e.g. for Arabic speaking participants, the workshops are given in Arabic language. A health workshop takes normally 90 minutes. The health facilitator provides the information about the workshop orally.

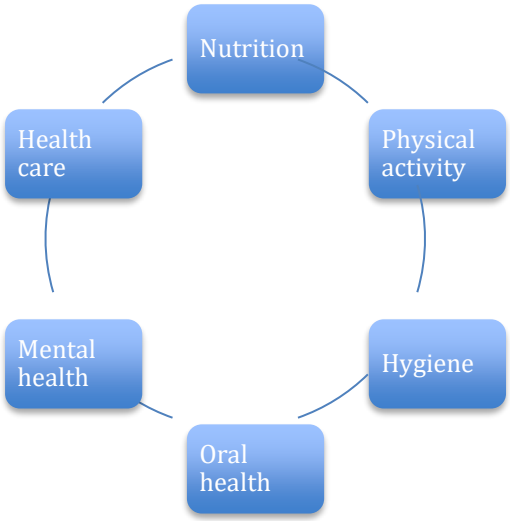


Figure 8 REFUGIUM health workshop topics
(Source: Own representation)

REFUGIUM program aims to enlarge the workshop topics, which are important and relevant for refugees. As there is very little done in the sector of refugee women's health, especially SRH, REFUGIUM aims to conduct workshops focusing on SRH. For this, REFUGIUM needs to develop a content, a manual i.e. workshops guide and flyers. The content of the workshop is SRH information based on the needs of refugee women, which will be gained from refugees. As REFUGIUM program work as peer to peer approach the needs of the refugees should be come from refugees. Their unspoken voices or unheard voices should be explored. Thus, refugee women were integrated in the development of a REFUGIUM workshop.

This paper presents the research study conducted with refugee women in the topic SRH. Through a qualitative study, refugee women were asked to share their understanding towards SRH, their issues and concerns and interest in SRH subjects. Based on their needs and problem, REFUGIUM program can prepare a workshop content, manual and flyers. Through women health workshop REFUGIUM program can provide SRH education to refugee women in Germany. Thus, this paper aims to explore the SRH needs of refugee women in Hamburg, Germany. Based on it, the research question of this study is formulated as **"What are sexual and reproductive**

health need of refugee women in Germany?" This study also aims to propose recommendations for conducting women's health workshop for REFUGIUM program. To fulfill these aims, some specific goals are made which are mentioned below:

- To develop semi- structured interview guide
- To contact refugee women and request for their participation in the research
- To collect data from refugee women through focus groups as well as face-to-face interviews (if focus groups do not meet the objectives)
- To conduct observations in different refugee camps and look what kind of SRH services are available
- To explore the perceptions of female refugees towards health and SRH
- To explore SRH issues and problems among refugee women
- To find out the gap in knowledge on SRH

Some of these specific goals are as well part of the research data collection procedure which will be further described in the method part of this paper in detail. Through these specific goals it is possible to identify and explore the SRH needs of refugee women in Germany, which in turn helps to achieve the main aim of this research.

3 Method

The following chapter outlines the applied research design that was chosen to examine the research questions. In the beginning, qualitative method as an appropriate method for this study is discussed. Following that, a developed interview guideline as a data collection instrument is described. The data collection procedures, which are implemented in this study such as focus groups, in-depth interview and observations are also presented. Subsequently, the data analysis strategies and self-reflexivity of the researcher during the research process will be illustrated. During the whole research process, ethical aspects were also considered which are mentioned in different phase of data collection and data analysis.

3.1 Qualitative approach

A qualitative study design was chosen to answer the research question as it helps in exploring, understanding, describing and identifying different issues within the phenomenon of interest (Lewis & Nicholls, 2014, p.51). According to Creswell (2013), a qualitative research is appropriate to use when the issues of an individual or group needs to be explored or there is need of complex, detailed understanding of the issues, which are hard to quantify and which cannot be observed directly (Creswell, 2013, p.65). Such issues can be sexual activity, drug addiction, childhood discipline, violence, death, etc. (Tracy, 2013, p.132). Qualitative study especially deals with the issues of gender, culture and marginalized groups such as refugee women (Creswell, 2013, p.51). Thus, qualitative approach is often used to open-up a new subject area and helps to explore unanticipated topics like refugee women's SRH (Lewis & Nicholls, 2014, p.47).

The qualitative approach allows examining people's experiences in detail by using a specific set of research method like in-depth interviews, focus group discussion, life histories, biographies, etc. The qualitative approach helps to identify issues from the perspective of study participants and understand the meanings and interpretations that they give to behavior, objects or events (Hennik, Hutter & Bailey, 2010, p.8). For example, to understand refugee women`s perception towards SRH, to know their health-related behavior, or to identify their social and cultural norms, which are affecting their access to health services. Hence, it is a method that helps to understand the knowledge and the behavior of individuals because it describes the world from the inner perspective, e.g. of the individuals who experience the problems (Flick, 2016, p. 28; Creswell, 2013, p. 44).

The following table illustrates the main features of qualitative research which shows its objectives and purpose. It also includes the data collection method, data analysis and outcome. While planning the qualitative research, along with these features, it is also important to anticipate and

consider ethical issues that might arise during several phases of the research process such as at the beginning of the study, during data collection, in data analysis, in reporting the data, and in publishing a study (Creswell, 2013, p.56, 57).

Table 3 Main features of qualitative research

	Qualitative research
Objectives	To gain a detailed understanding of underlying reasons, beliefs, motivation
Purpose	To understand why, how? What is the process? What are the influences or contexts?
Data	Data are words (textual data)
Study population	Small number of participants or interviewees Selected purposively (non-randomly)
Data collection	In-depth interviews, observation, group discussion
Analysis	Analysis is interpretive
Outcome	To develop an initial understanding to identify and explain behavior, beliefs or actions

(Source: Hennik, Hutter & Bailey, 2010, p.16)

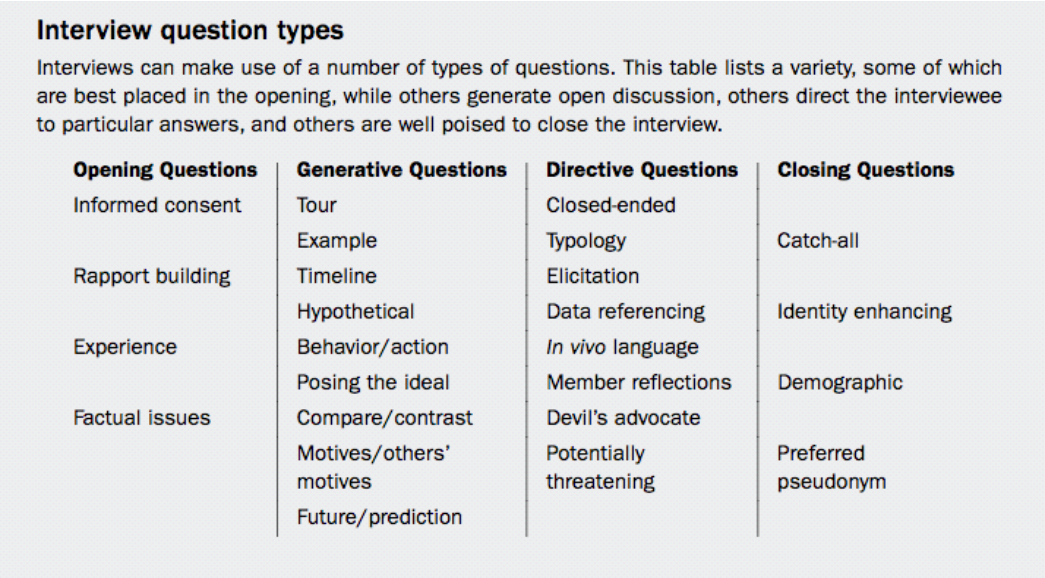
Within qualitative research, there are many different approaches, namely: Narrative Research, Phenomenology, Grounded Theory, Ethnography and Case Studies (Creswell, 2013, p.104). Among these approaches, this research follows the case study approach since case studies enable us to develop an in-depth description and analysis of a real-life case, or to explore an issue or problem using the case as a specific illustration (Creswell, 2013, p.97). In this research, the intent to choose a case study is to understand the SRH concern among refugee women who recently settled in Germany. In a case study, the case may be a concrete entity like an individual, a small group, an organization or even a community, a specific project etc. (Creswell, 2013, p.98). Case studies are also distinguished by the size of the bounded case, such as if it involves one individual it is a single case study and if it involves several individuals it is a collective case study (Creswell, 2013, p.99). In this research study, a collective case is chosen which focuses on SRH

issues of several refugee women. The intention to choose collective case study is to explore different perspectives on SRH issues from different cases. The cases are the female refugee women in reproductive age, who came to Germany recently and live in refugee accommodation. The issues are the SRH needs among refugee women.

3.2 Development of interview guide

As a data collection tool, a semi-structured interview guide was developed which will be used to conduct focus group and face-to-face interview. The interview guideline contains open-ended questionnaires as it helps in exploring the issues from the participant's perspective (Creswell, 2013, p.52). While developing the interview guide, some tips and tools for interview question types and its right placement provided by Tracy in the literature were considered which is shown in the Figure below.

According to the flow of the interview, there are four different types of questions, i.e. opening questions, generative questions, directive questions and closing questions. The interview can begin with the informed consent and asking participant experiences and factual issues. Then the questions related to behavior and motives were placed. After that follows the directive questions like Typology questions which help to organize the participants' knowledge into different types or categories. At the end, come the closing questions such as demographic questions (Tracy, 2013, p.146).



Interview question types

Interviews can make use of a number of types of questions. This table lists a variety, some of which are best placed in the opening, while others generate open discussion, others direct the interviewee to particular answers, and others are well poised to close the interview.

Opening Questions	Generative Questions	Directive Questions	Closing Questions
Informed consent	Tour	Closed-ended	
	Example	Typology	Catch-all
Rapport building	Timeline	Elicitation	
	Hypothetical	Data referencing	Identity enhancing
Experience	Behavior/action	*In vivo* language	
	Posing the ideal	Member reflections	Demographic
Factual issues	Compare/contrast	Devil's advocate	
	Motives/others' motives	Potentially threatening	Preferred pseudonym
	Future/prediction		

Figure 9 Interview question types
(Source: Tracy, 2013, p.146)

The developed interview guide for this study consists of 33 semi-structured and open-ended questions. The open-ended questions allowed the interviewees to open up and talk freely about

their views and experiences (Creswell, 2013, p.164; Flick, 2016, 221f). Furthermore, the sequence of the interview questions was taken into consideration. General questions, which were less sensitive, were put at the beginning of the interview so that the participants do not feel uncomfortable. Therefore, the first questions start with general background information about women in their home country to give impulse to the participants. More sensitive questions related to sexual health and violence were put after the general questions (Flick, 2016, p. 222 f.). Some questions also consist sub-questions. The socio-demographic questionnaires were put at the end so that interview participants do not hesitate to share their personal things like age, family status, etc. There are also some feedback questions at the end where participants have an opportunity to share their ideas and their interested subjects on SRH. Almost all the questions are formulated in a possible simple and clear way so that participants could easily understand it. While phrasing questions, the use of acronyms, abbreviations are also avoided (Tracy, 2013, p.144).

The developed interview guideline is shown below in the Appendix . The interview questions were divided into six main themes, which are shown below in the table:

Table 4 Main themes of interview guide

Main themes of interview guide
• Background information about women in own home country
• Current situation of refugee's women who are living in refugee accommodation
• Women's health in the perspective of refugee's women
• Reproductive and sexual health in the perspective of refugee's women
• Ideas gaining for conducting reproductive and sexual health workshop
• Socio-demographic Questionnaire

(Source: Own representation)

Pretest:

Before conducting the actual interviews, the questions from the interview guide had to be reviewed and tested. Many researchers recommend a pilot test to refine the interview questions and develop relevant lines of questions (Creswell, 2013, p.165). Pilot testing also helps to ensure the use of proper language comprehensible to women (Kaddour, Hafez & Zurayk, 2005, p. 37). Two sample face-to-face interviews were conducted with a questionnaire in order to check the time frame, the comprehensibility of the questions, the order of the questions, the meaning of the questions, the simplicity of the questions etc. One pre-test was conducted with a female member of REFUGIUM program. She had also a migration background and can understand the condition of refugee women living in Germany. However, she has been living in Germany for more than 2

years. The second pre-test was conducted with a woman from Nepal who came as a student to Germany. She is living in Germany for a few years and belongs to a migrant group. After the pre-test, the order of some questions was changed. Some questions were then formulated in a simple way and neutral way. Redundant questions were deleted after the pre-test or two questions were combined to one. Furthermore, some technical terms were changed into everyday words. In addition, the interview questions were formulated in a comprehensible and grammatically correct way. The revised and rearranged interview guide is shown in the Appendix B.

3.3 Data collection

The data collection on a qualitative study is the procedure of gathering data, which includes a series of interrelated activities such as gaining permissions, conducting a good sampling strategy, preparing equipment for recording both digitally and on paper, and anticipating ethical issues that may arise during data collection (Creswell, 2013, p.145). In this study, data collection procedure starts with access to target group, i.e. sampling and recruitment process. In qualitative approach, there are multiple data collection methods such as interviews, field notes, conversations, photographs, observation, etc. The researcher can even combine two or more methods, rather than relying on a single data source (Creswell, 2013, p. 44). For this study, it was planned only to conduct focus group at the beginning. But there were difficulties in finding appropriate time where all the participants could join. Therefore, after conducting 2 focus groups, 7 face-to-face interviews were conducted. Aside from that, an observation was also done in 5 different refugee accommodations.

3.3.1 Sampling and recruitment

Sampling is a necessary step in terms of choosing individual for study as a source for research data. It is not only finding people who are willing to talk on the topic SRH, it is also finding people who are prepared to share their time and stories (Tracy, 2013, p.134). This research follows the purposeful sampling, which means that the individuals for research are selected in a way that they can purposefully inform an understanding of the research problem and they fit into the parameters of the research questions, goals, and purposes (Creswell, 2013, p.156: Tracy, 2013, p.134). The target group of this study are refugee women living in different refugee's camps in Hamburg. Eligible in regarding our defined inclusion criteria are refugee women of reproductive age, i.e. aged between 15-59. Furthermore, the origin of target group should be from most common countries with greater number of refugees such as Syria, Afghanistan, Iraq, Iran, etc. In addition, either proper English or German language skills were considered. Religious background was not considered.

Further on, the snowball sampling method is also practiced to get more participants. The participants were asked to suggest a colleague, a friend, or a family member to take part in the

study, who fit into the same study's criteria (Tracy, 2013, p.156). In this collective case study diverse sample were selected such as single refugee women, married refugee women, refugee women from different origin and cultural background so that they can provide different perspectives on SRH concern.

Table 5 Inclusion criteria for the study

Inclusion criteria for the study
• Female refugee in reproductive age (women aged 15–59)
• Female refugee women living in Germany for 2-3 years
• Female refugee who are living in Hamburg in refugee accommodation
• Female refugee who can speak either English or Germany

(Source: Own representation)

As researcher being a part of REFUGIUM program, the researcher first contacted the female refugee participants of REFUGIUM program. Before contacting the female participants of REFUGIUM program, the permission was taken from Project coordinator (Professor Färber) to get contact data from female REFUGIUM participants. While accessing the target group of the study, it is important to disclose the purpose of the study to them (Creswell, 2013, p.57). Therefore, the contacted participants were at first informed orally about the purpose of the study in English or in German. The gatekeeper helped in translation in Arabic and Kurdish languages. Other REFUGIUM team member also helped in communication in Farsi.

During the study time frame, REFUGIUM had just completed its second-generation health facilitator training program. In 2nd generation health facilitator program, there were two groups, i.e. an Arabic group and a Farsi group. In the Arabic group, there were 4 female refugees and in the Farsi group, there were 5 female refugees. All the female refugees were contacted. At first, it was planned to conduct two focus groups, i.e. one focus group with an Arabic speaking female participant and one with Farsi speaking female participants. But, among four only two women from Arabic group showed up in the first focus group. From the Farsi group, none of the female refugee showed their interest to take part in this study.

After some months, REFUGIUM program conducted 3rd generation health facilitator training program, in which there were three women in the Arabic group and 3 women in a Russian group. None of the Russian women could speak either English or German. Thus, it couldn't meet the

sample criteria. Unfortunately, there were no female refugees in the Farsi group. Thus, a second focus group was conducted with two women from an Arabic group. Following that, REFUGIUM program conducted 4 ^{h} generation training program, where there was one female participant in Farsi group and 3 female participants in Arabic group. Among them, two face-to face interviews were conducted with two female participants, one woman belonged to Farsi group and other belonged to Arabic group.

As it was very hard to get participants for this study, another organization called "Patenschaftsproject of BergedorferVölkerverständigung" was contacted. From there, the researcher got to know some more women from Iran, Afghanistan, Syria and Pakistan. Among them a woman from Iran and one from Pakistan managed to take part in this study. The researcher also contacted 5th generation REFUGIUM participants. Only one of them took part in the study. Afterwards the researcher joined in the workshop, which was conducted in cooperation with Mut Café Afrika and Aids Hilfe Hamburg. From there, one woman from Iraq took part in the study. She further suggested her friend and another woman from Syria took part in the study. At the end, there were 11 refugee women who took part in the study.

3.3.2 Conducting focus-group

At the very beginning, only focus groups were planned to conduct. In the focus group the participants who have similar characters are put in one group. The first focus group was conducted with female refugees who speak the same language so that if one cannot speak fluently English or German, other participants could help in translation and interpretation. It was planned to conduct second focus group with Farsi speaking refugee women from Afghanistan. But none of the contacted women showed up for a focus group. Few months later another focus was conducted with women who spoke Arabic. In the first focus group, there were two participants (out of 4 agreed). In the second focus group, there were also two participants (out of 3 agreed).

Before conducting focus group, the location/ setting and the equipment for recording were prepared. It was made sure that the voices are audible, and the recording technology is functioning correctly. The questionnaire and some papers and pen were prepared for taking field notes. At first, the participants were greeted warmly. They were offered drinks and snacks. Participants were also asked about their health condition, their travel etc. so that they could feel more comfortable.

At the beginning, the participants were informed about the general purpose of the research, and the specific objectives for the day. Then they were given a consent form. The consent form includes the purpose of the study and the procedure to be used in data collection, the protection of confidentiality of the respondents, the signature of the participant (see Appendix C) (Creswell,

2013, p. 153). The informed consent was written in two languages: English and German. The consent form is written in a short and simple way so that participants can understand it easily. Moreover, the participants were not pressured to sign the consent form.

For conducting a focus group, the developed interview guide was used. During focus group, it was made sure that all the participants got equal opportunity to share their views and experiences. The participant's nonverbal communications during focus group were also noted in the field notes. Participants were not forced to answer all questions if they feel uncomfortable or hesitation. During the focus group, participants were not discriminated because of different culture, religion, gender and/or other differences. The researcher also tried to establish a supportive, respectful relationship without stereotyping and using labels so that participants do not have to face embarrassing moments.

Both focus groups took more time than planned. As most of the participants are not fluent in English or in German, they need more time to translate some words (sometimes using Google translator). The whole conversations during focus group were tape recorded for the data analysis process. At the end, the focus group participants were requested to keep the focus group conversations confidential. Lastly, all the participants were thanked for their time and participation.

Focus group setting:

To conduct a focus group, it is very important to find a quiet location, which is free from noise and any kind of distractions. For a focus group, there is need of extra room with chairs and desk. While conducting focus group, the confidentiality, the privacy of the participants should be respected from an ethical point of view (Webster, Lewis & Brown, 2014, p. 78). Therefore, both focus groups were planned to conduct in a closed room in the absence of any male member and outsiders. The group work room available in HAW Berliner Tor library have chairs and desks and the rooms are quiet, small and free from disturbance. Thus, the first focus group with two Arabic female refugees was conducted in a group work room at HAW Berliner Tor (see Appendix F). The second focus group with other female refugees was planned in the same room, but as the participants arrived late, half of the focus group was conducted in the group work room and the other half on a corner of the canteen. As it was conducted in the afternoon, there were only a few students in the canteen thus the surrounding area didn't have a lot of disturbance. However, as it had to move in between from the library group work room to canteen, it might have some impact on consistent communication flow. During the focus group, the researcher and participants sat in a round/circular position so that researcher could see all participants and it makes the communication easier.

3.3.3 Conducting face-to-face interview

As qualitative interviews elucidate subjectively lived experiences and viewpoints from the respondent's perspective (Tracy, 2013, p.132) seven face-to-face interviews were conducted with refugee women. As the participants could not manage to join in the focus groups which were conducted few weeks before, they were requested to choose their preferred time for the interviews. Therefore, it made easier to conduct face-to-face interviews with all 7 refugee women.

Likewise, in conducting focus group, the setting and required equipment for conducting an interview were prepared beforehand. While conducting interviews, participants were greeted nicely at first and thanked for their presence. Participants were also offered drinks and snacks and made comfortable. All the interviews begin with a briefing that includes a description of the interview's purpose, the amount of time that will be needed to complete and the plans for using the findings from the interview. Participants were informed that they have the right to refuse to answer any question which makes them uncomfortable. And they also have the right to stop their participation at any time without any consequences. They were made sure that participating this study will not put them at undue risk (Creswell, 2013, p.57). Then the informed consent was handed over to the participants. An adequate time (around 4-5 minutes) were provided to read over the inform consent form and ask questions if needed. While the interviewees are reading over the consent form some field notes about the nonverbal communication, the appearance of the interview such as looking nervous or, whether the interviewee arrived on time, when and where the interview occurred, where the interviewee chose to sit, and other interesting data that will not emerge in an audio recording were written down. One of the field notes taken during the interview is shown in Appendix E. This type of notes about nonverbal communication enhances the transcription (Tracy, 2013, p.161).

In comparison to the focus groups, the face-to face interviews were relaxed and pleasant. Participants were more open and were ready to share their experiences. Thus, face-to face interviews serve as an efficient method to "get to the heart of the matter" (Tracy, 2013, p.133). Beside this, it also provides opportunity to openly verify, refute, defend, or expand certain points (Tracy, 2013, p. 133.). During the interview, the researcher tried to create a logistically feasible and comfortable interaction to encourage an honest and engaging conversation. When participants were feeling uncomfortable about sharing their experiences, they were not forced to answer the questions. During the interview, the imbalanced power relation between researcher and the interviewee was also considered. Special attention was given when participants were being emotional or talking about emotional subject matters. At the end, interviewees were thanked and appreciated for their time and for sharing their experiences and opinions.

Interview setting:

As an interview setting the HAW Campus in Berliner Tor and HAW Library in Alexander street in Hamburg was chosen as it lies in the center of Hamburg and is not far away for the participants to reach there (compared to HAW Campus Bergedorf). Out of seven face-to face interviews, two were conducted in a closed room, i.e. group work room at Alexander street HAW library. Three interviews were conducted in the corner of the canteen at HAW Berliner Tor where there was presence of other students, but it was made sure that they could not hear the conversation. Rests of the two interviews were conducted in participants home because they had to look after their children. Thus, there was presence of participant's children, which is considerable in this case. But prior to conducting an interview, participants were asked for their permission to conduct an interview at their home as researcher needs to seek permission to conduct research on site (Creswell, 2013, p.57).

The settings of the interviews which were conducted in the canteen at HAW Berliner Tor were little bit noisy and disturbing from other students. Whereas the interview conducted in the group work room in library on Alexander Street was free from distractions. In the interviews conducted at home, it had to be stopped quite a few times due to children crying or coming to play with their mother. However, in all cases there was no presence of any third person except the children during interviews with married women. During the interview, the researcher and the interviewee sat in face-to-face position. In all the cases, there were required equipment for interviews like comfortable chairs and desk. Almost all the interviews were conducted in the afternoon (around 4 pm) as most of the participants had German language class in the morning.

3.3.4 Observation

Observation is one of the data collection methods in qualitative research, which helps the researcher to get a greater understanding of the phenomenon (Creswell, 2013, p. 166). Observation is based on research purpose and questions. Like interviewing, observation also includes a series of steps. At first, the site to be observed should be selected. Then the observation object should be determined, including the time frame and time duration for observation. The observation objects can be participants, activities, physical setting, interactions, conversation, etc. The observer should also determine the role of an observer such as observer as participant or non-participant. The observation protocol should be designed as a method for recording notes in the field. The observed objects are written down and at the end presented in which the researcher can also reflect own personal impression and ideas (Creswell, 2013, p. 166).

In this research, the main observation objects are physical setting, i.e. different refugee accommodations in Hamburg. The observation objects are available information on SRH services in refugee accommodations. Such information could be in the form of flyer, brochure, poster, etc. which are available in refugee camps. The observations took place in winter 2017, till 2018. Three Observations were done during the time when REFUGIUM program was offering health workshops in different refugee accommodations: Schnackenburgallee 81-83, Brookkehre 20, and in Harburger Poststraße 1. The other two observations were done in Schmiedekoppel29/30 and in August Kirchstraße 17. These two observations were conducted while visiting the camp for interviews with two refugee women who had children. In total, five observations were done to examine the health care facilities offered at the camps. The observed refugee accommodations are situated in different region in Hamburg. Following are the list of refugee accommodation, with its address (Table 6).

Table 6 Refugee accommodations where observations were conducted

No.	Name of the refugee camp	Region	Address
1.	FlüchtlingsunterkunftSchnackenburgallee	Altona	Schnackenburgallee 81-83 22525 Hamburg
2.	WohnunterkunftBrookkehre	Bergedorf	Brookkehre 18-20 21029 Hamburg
3.	ErstaufnahmeHarburgerPoststraße	Harburg	HarburgerPoststraße 1 21079 Hamburg
4.	ErstaufnahmestelleSchmiedekoppel	Eimsbüttel	Schmiedekoppel 29/30 22453 Hamburg
5.	Wohnunterkunft August-Kirch-Straße in Bahrenfeld	Bahrenfeld	August-Kirch-Straße 17 a 22525 Hamburg

(Source: Own representation)

During the observation in refugee accommodation the main focus was more to observe the facilities that are offered to refugees who are living there (Creswell 2013: 166) such as what kind of health care facilities especially regarding SRH services are available at that certain refugee accommodation? An observation protocol was made which include the name of refugee accommodation, date and time, as shown in Appendix D.

3.4 Data analysis

The data analysis in qualitative study involves several steps like organizing the data, conducting a preliminary read through of the database, coding and organizing themes, representing the data, and lastly forming an interpretation of them. Before that the audio recorded data are transcript. Ultimately, it also includes representing the data in the form of a discussion, table, charts, etc. These are the core elements of data analysis in qualitative study which will be discussed in upcoming paragraphs (Creswell, 2013, p.179, 180).

3.4.1 Transcription

The first step of data analysis is to organize the data, which means the audio recorded interviews and focus group data are organized in computer files and transcribed, which is one of the most important parts of transforming embodied interviews into usable data (Tracy, 2013, p. 177).There are numerous transcription rules in qualitative research such as transcription according to Ralf Bohnsack, Udo Kuckartz, etc. (Fuß & Karbach 2014, p.27). In this study, the collected data are transcribed according to Kuckartz. This means that every spoken word is literally transcribed, but not transmitted in a summary form. The dialects of the participants are not transcribed, but translated as precisely as possible into the general language. If there were long breaks in between the interview, they were marked by mentioning the brackets, which include dots. Incomprehensible words were identified by (unv.). Also, the individual pronunciation or vocalizations such as "Mhm, Na" etc. are not indicated in the transcript. The vocal expression of the interviewee supporting the statement like smiles or coughing are noted in brackets. Any kinds of disruptions during the interview are also noted in brackets stating the cause like (Telephone ringing). Incomplete sentences, wrong grammar etc. are corrected without changing the meaning of the sentences. The original meaning, intent and ideas of the interviewee were reflected while transcribing (Fuß & Karbach 2014, p.28).

To ensure anonymity, an individual name was assigned to each interviewee (Fuß & Karbach 2014, p.29). In this study, interviewees were also given a pseudonym like Nele, Zahra, Diva, etc. which are presented in the results. The researcher is named as “Anna” in the transcripts. Some interviews were conducted in half German language and half English language. The statements in German languages are translated into English for the analysis. After the completion of research, all recorded interviews will be deleted, and the transcript texts will not be utilized for other purposes.

3.4.2 Content analysis

For the analysis of verbal data, there are various qualitative content analyses available (Bortz & Döring 2006, p.31). The present research follows the traditional methods of qualitative content analysis according to Mayring, which dealt intensively with the formation of the category (Diekmann 2006, S.481). The core and central tool of content analysis is its system of categories, where every unit of analysis must be coded or allocated to one or more categories. These categories are understood as the operational definitions of variables (Kohlbacher, 2006, p.10).

In the content analysis, the transcripts were first read several times to get an overview of the data and sense of interview before breaking it into parts. The next step consists of describing, classifying and interpreting the data (Creswell, 2013, p.183, 184). The data collected in this study are analyzed inductively from particular to more general perspectives. These perspectives emerged from the data are named as codes or categories (Creswell, 2013, p.52). At first, the text data are reduced into smaller categories of information and then a label is assigned to it (Flick, 2006, p. 315). For that, meaningful text passages are identified and assigned to a category. That particular section of text is marked and stored in another document simultaneously. In this way, a long list of coded segments will be created from which emerge categories or themes (Kuckartz 1999, p. 90f.). Throughout the coding process, the constant comparative method will be used to compare the data applicable to each code and to modify code definitions to fit new data. This constant comparative method is circular, iterative, and reflexive (Tracy, 2016, p. 190).

After the formation of themes or categories from the codes, follows the process of organization of themes into larger units of abstraction to make sense of the data. This process is known as classification process and it helps further on interpretation of data. An interpretation involves abstracting out beyond the codes and themes to the larger meaning of the data to make sense of the data (Creswell, 2013, p.187). Thus, the researcher builds detailed descriptions, develop themes and provide an interpretation considering their own views or views of perspectives in literature (Creswell, 2013, p.183). The final phase of data analysis involves representing the data using narratives, tables, charts, etc. While presenting a result, the confidentiality, the privacy and anonymity of participants should be respected (Webster, Lewis & Brown, 2014, p. 78). Therefore, participants were given pseudonyms in presenting their statements in results (Creswell, 2013, p. 175). There will also be no such information published which will potentially harm participants in the present or future.

In this study, the categories are developed based on the interview guideline and specifically contents of the transcribed interviews (Flick, 2006, p. 315). The data analysis process in this research was purely inductive by which codes and themes were identified from the data and not

from another theory. After analyzing the dataset following main categories have emerged. The table below gives an overview about the main categories and the associated sub-themes.

Table 7 Main and sub categories emerged from content analysis

No.	Main Categories	Sub-Categories
1.	Perception towards health	• Understanding of health and women's health • Health consciousness • Health-related behaviors
2.	Perception towards SRH	• Understanding of SRH • Consciousness towards SRH
3.	Sexual and reproductive health knowledge	• Formal knowledge • Informal knowledge
4.	Sexual and reproductive health issues	• Menstruation • Early and forced marriage • Pregnancy and childbirth • Abortion • Family planning and contraceptives • Sexual transmitted diseases • Sexual and gender-based violence
5.	Awareness about health care services	• Healthcare services in refugee camp • Healthcare services in Germany • Health promotion and awareness program • Healthcare services in country of origin
6.	Barriers in accessing health services	• Communication • Gender aspects • Different health care system • Social and financial support • Culture and tradition • Living conditions in refugee accommodation • Stress factors
7.	Advice and suggestions for REFUGIUM workshop	• General suggestions for a workshop • Suggested SRH topics

(Source: Own representation)

3.5 Self-reflexivity

In the qualitative approach, the researchers can bring their own subjective influence on the research process particularly during data collection and interpretation. Thus, the researcher's background, position, or emotions are also integrated in the process of producing data (Hennik, Hutter & Bailey, 2010, p. 19). Therefore, it is important to acknowledge the researcher's subjectivity. Creswell also emphasized the importance of describing the researcher's perspective in qualitative research that contains information about conceptions of researcher self and those who are being researched (Creswell, 2013, p. 15-17). Research is created by the researcher and is not the reality. Therefore, the positioning of the researcher is crucial in order to understand how much is the influence of the researcher in the research process (Creswell, 2013, p.20).

A student doing a master's degree with the major in Health Sciences is involved as a researcher in this study. The researcher herself is a migrant from Nepal, who was grown up in different religious and cultural environment. So, the researcher can view the things from different perspectives. During the master 2nd semester, the researcher took part in the module "Advanced Qualitative Study design" from Prof. Färber where she got in contact with refugees taking part in REFUGIUM training program at HAW. At that time, she was involved in conducting a qualitative research study about risks and resources of refugee's mental health in Germany. For that, she along with her group members conducted a narrative interview with different refugees. Through that narrative research, she got to know about the critical living conditions of refugees, their terrible migration experiences, their health-related problems, etc. All these factors had inspired to discuss more on refugee's topic and to help them to stay healthy in their upcoming life in Germany.

According to the researcher's experiences as a foreigner in Germany, she was able to understand and research about refugees' challenges and obstacles in accessing health care services in new places as an outsider. The researcher being a female student with migration background had experienced similar difficulties in the beginning to access information and locations for healthcare services. Furthermore, she did her master internship in REFUGIUM program from February 2017 to July 2017. During her internship, she got close contact with lots of refugees. From them, she got to know that female refugee are bearing more health burden than male refugees as they have issues like pregnancy related complications, menstrual problems etc. These experiences added to her interest in work on this project directly related to SRH in refugee women.

In course of the research, it was easier for the researcher to connect as a migrant and get close as well as gain trust to conduct the whole research. On the other side, studying in a multi-cultural and diverse team throughout the master's program made her more culturally sensitive and very open to different perspectives and belief systems. In addition to that, internship and working in a

diverse team in REFUGIUM program improved her intercultural competence and communication skills. This tremendously helped her in conducting research, especially conducting interviews and focus groups with refugee women from different background. The researcher can also relate to some extent different perspectives and views of refugee women from their origin which further helps in the interpretation of their statements.

4. Results

In this chapter, the results of analyzed data from 2 focus groups, 7 face-to-face in-depth interviews are presented. Overall, seven main-categories have emerged from the data analysis. At first, the participant characteristics are described in detail. Afterward, the main categories and the associated sub-themes are described comprehensively. Each category and the according themes will be described consistent with the participant's experiences and opinions which also includes the statements of the participants. The statements of participants help in understanding about the perception of target group regarding different subjects related to SRH.

The description of main categories starts with the perception of refugee women towards overall health and then towards SRH. The consciousness of refugee women, their understanding of health, their health-related behavior, and understanding of SRH are presented under this section. After that, SRH knowledge among refugee women is explained. Then the SRH issues mentioned by participants are presented in detail. Further on, awareness about the health care services on SRH among refugee women is explored which present, the awareness about the health care service in Germany, in the refugee camp as well as in the country of origin. For more detail information regarding health care services offered in refugee accommodations, an observation was also conducted. The findings from 5 observations are also included in the results.

The barriers mentioned by participants which hinder them to get access to health care services in Germany are also presented in detail. At last, participant's suggestion for conducting women's health workshops are presented. In this way, refugee women's perception towards SRH, their SRH knowledge, SRH problems and issues and their awareness about health care services are analyzed. Along with these, factors that are affecting refugee women in getting access to health care services are also examined. These all together help in exploring the SRH needs of refugee.

4.1 Participants

Altogether, 11 refugee women participated in this study. There were 4 participants in the focus group and 7 participants in a face-to-face interview. All the participants in this study were female refugees, who live in Hamburg, Germany. During the study time frame, all the participants were living in different refugee accommodations in Hamburg. The age of the participants ranges from 24 to 45. The participants are originated from different nations. There were six participants from Syria, two from Iran, one from Pakistan, one from Iraq and one from Nigeria. Thus, the participants have different cultural background and speak different languages. The women from Syria and Iraq speak Arabic as their primary language. The participants from Iran speak Farsi as their mother language and a participant from Pakistan speaks Urdu as her primary language and a woman from Nigeria speak Igbo as her native language. All the participants could speak either

German or English, which made the communication during the interview and focus group quite easier. All the participants took part in the research process voluntarily and without any pressure.

Among 11 participants, there were four married women who have children and living with their family in the refugee accommodation. Among them, one woman from Nigeria is divorced and has three children. She is living in Germany with her two daughters in the refugee camp. The married woman from Iran (Lena) has two children. One of the married women from Syria (Diva) has a son and the other (Abba) has a son and a daughter. The four unmarried women (Nele, Celine, Zahra, and Usma) are living with their family in the camp. Whereas the three unmarried women (Mona, Ina, and Selli) are living in the camp, which is especially installed for female refugees.

Among 11 participants, 5 of them have graduated in their home country and want to study further and work in the same field in Germany. Most of the married women have a comparatively lower education level than the unmarried women. This indicates that most of the participants of this study are educated. Participants have been living in Germany since 1 to 2 years. All of them are learning German. Among 11 participants, 8 participants had participated in the REFUGIUM program and are familiar with different REFUGIUM workshops. The two participants who were contacted through the organization BergedorferVolkerverständingung did not know about the REFUGIUM program. One woman was contacted through participant contacts. She had heard about REFUGIUM but had not participated yet in the program. Some characteristics of the participants are presented in the table below:

Table 8 Sample characteristics of the study participants

No.	ID	Age	Nationality	Family status	Native language	Refugee accommodation
1	Nele	29	Syria	Single	Arabic	Accommodation for Family
2	Celine	26	Syria	Single	Arabic	Accommodation for Family
3	Mona	31	Iran	Single	Farsi	Accommodation for single women
4	Abba	40	Syria	Married	Arabic	Accommodation for family
5	Zahra	24	Pakistan	Single	Urdu	Living with family
6	Diva	35	Syria	Married	Arabic	In mixed accommodation
7	Usma	28	Syria	Single	Arabic	Accommodation for Family

8.	Selli	25	Syria	Single	Arabic	Accommodation for single women
9.	Lena	44	Iran	Married	Farsi	In mixed accommodation
10.	Bella	32	Nigeria	Divorced	Igbo	In mixed accommodation
11.	Ina	45	Iraq	Single	Arabic	Accommodation for single women

(Source: Own representation)

4.2 Perception towards health

Understanding of health and women's health

Health is understood in a different way from refugee women from different countries. The women from Syria, Pakistan and Nigeria understand good health as being free from diseases. However, the women from Iran and Iraq associate good health along with good looking or women having beautiful body and face. In this context Mona from Iran shared that:

"Women take care about their health. They always want to be fit, physically fit and look beautiful and charming. If they feel they are beautiful then they feel good. So, they give lots of time for making their hair, for make-up, for making nails. They also spend lots of money to be beautiful. Lots of women do plastic surgery, operation of their nose, operation of breast, making big or small as they wish. Actually, they do all kinds of operation" (Mona, 43-47).

Most of the participants of this study related women's health with care during pregnancy, hygiene, making body fit and fine, care during menstruation period, typical women's health problems. Some of them also linked women health as getting free from women diseases like breast cancer, ovarian cancer. One of the participants reported that:

"*I think the topic related to women's health are all about the personal hygiene, birth control, various female cancers like breast cancer, ovarian cancer, gynecological health problem, pregnancy issues and many more*" (Diva, 99-101)

Some participants also linked "age of the women" as one aspect of women's health, as women get older, she suffered from different problems like back pain, pain in shoulder, etc. Some participants also mentioned other factors affecting women's health like overweight and the problems arising due to overweight like high blood pressure, diabetes etc. There were also some typical women's problem such as hair loss, stress due to children which are related to women's health.

Health consciousness

Among refugee women from five different countries, women from Syria and Pakistan are less conscious about their health. Especially, the Syrian women who had succeeded to escape from the war in their home country and thus give more importance to save their life than to live a healthy life. Some women are even not in a mentally stable condition to think about their health as they had experienced horrible things in their home country due to war, and some of them are still in trauma being far away from their family members, relatives and being forced to leave their own home. In this context, one of the participants shared that:

"*I don't think women in our country care too much about their health. Well, talking in this generation, I mean now where we have no peace in our country. I know health is very important. But to survive is more important. You know I have seen many people in my life who struggle very hard to survive and to escape from the country. I have even seen people who died in the war. Those people's faces still come in my mind. I left my home. But my parents, my family and friends are there. I am here physically, but my mind is there. Whenever I hear bad news, I cannot sleep. I even do not have an appetite to eat something. So, I am not in the condition to take care of my health. I need time*" (Selli, 35-42).

According to the participants, the women who are still living in Syria or in Pakistan are much less conscious than the women who live in Germany because those women have to struggle almost every day for the basic things like safe drinking water, to survive in extreme heat especially in summer. These women lack knowledge of health. In contrast to these women, women from Iran, Nigeria, and Iraq showed a little bit more consciousness about their health. They give value of a healthy diet, being physically active, being mentally and socially fit.

The consciousness towards health is also influenced by education, economic condition, family status etc. Most of the refugee women who are educated showed more consciousness towards health than women with less education. They are conscious about healthy diet, physical exercise and consequences of stress as a mental health problem. One of the participants shared that:*"In Iraq, the women from the big city are well educated. They take care of their health. They do sport. They go to fitness*." (Ina, 24-26).

In contrast to these countries, women in Iran give more priority to their outlook and beauty than their health. Women are also ready to spend huge amount of money for their beauty than their health as one of the participants from Iran reported:

"*In Iran, women are not much conscious about their health, but they are conscious about their beauty. They do an operation like nose operation. But they do not care if they have broken teeth. Really, women spent a lot of things for makeup, for clothes. And women are happy when they*

have gold. They spent lots of money to buy gold jewelry. But if they have a stomach ache, they do not want to spend for that, I mean for health" (Lena, 125-129).

Comparing between married and unmarried women, the married women gave less priority to their health. The health of their family, especially their children's health is more important than their own health. In this context, Abba shared that *"usually the women, as I know they didn't care about their health. She cares about her children, her husband, her family more than for herself"* (Abba, 5-6).

According to the participants, most of the women in the refugee camp neglect their health because they have lots of resettlement issues, such as integrating in Germany, learning the language, uncertainty about their future etc. In concerned with this, Mona shared that:

"I don't think most of the women take care of their health. Most of the women in my camp are busy with mobiles. Some are busy in learning language, struggling to adjust here. Some women in my camp, even don't come out. I don't know why, but they just sit in their room. They do not do exercise. I don't understand them" (Mona, 87-90).

The refugees who have settled down for a long time in Germany are more conscious about their health than the women who are recently here in Germany. Celine reported that, "*I think, those women who came here as refugee, but are already here for a long time, they care about their health, about their family health. My elder sister, she is here for more than 5 years. She goes to fitness. She has joined yoga class. They visit the doctor regularly*" (Celine, 85-88).

However, participants have the view that women are more conscious towards health than men as reported by Diva. "*Both men and women have similar health problems. But women are much more conscious than men"* (Diva, 42-43).

Health-related behaviors

The participants of this study were living in different refugee accommodations during the study time. Six women were living in initial refugee accommodation where they are not allowed to cook food. Food is provided in the canteen. Among six women, who are living in the initial camp, all of them had reservations about the food. Even the food provided in the canteen is not good, they tried to intake more fruits and vegetables than meat. However, most of the refugee lack proper diet as most of them use to skip the lunch or dinner provided in the canteen. Therefore, one of the participants regularly takes vitamin tablets as supplementary, which are available at the drugstore.

The woman from Nigeria has a kitchen, which she must share with other refugees. She cares about her diet as she does not want to gain weight as she said, "*I am conscious of the weight. I don't want to be fat. I am conscious of what I eat, how I eat"* (Bella, 164-165).

The women from Iraq, Nigeria and Iran also know the importance of physical exercise. These women perform some kinds of exercises to maintain their health. For e.g. the women from Iraq had joined fitness and do regular exercise. In contrast to that, the women from Syria, Pakistan are not active in doing physical exercise. To this point, Celine from Syria reported that:

"(...) women are not so active in such things. They do not like to do exercises (laugh). They care too much about their family, their children, but not about their own health" (Celine, 134-136).

Refugee women are also passive in seeking health services. If they suffer from minor pain, then they try to treat themselves taking some medicines. They usually visit the doctor when they are seriously ill. As Bella reported: "*They are not really conscious about their health. When they get sick, then they go to the hospital. Only after getting sick, they become conscious, but not before"* (Bella, 80-81).

Most of the refugee women are not concerned with their health until they get some serious diseases or problem. However, there are also some women who give value to their health and engage them in something so that they can be mentally and physically fit as mentioned by Diva *"I try to be strong, I mean mentally strong. I don't want to sit like passive. I am most of the time busy with something*" (Diva, 105-106).

In this way, refugee women from different countries portrayed different concepts towards health and women's health.

4.3 Perception towards sexual and reproductive health

Understanding of sexual and reproductive health

Almost all participants except a woman from Nigeria were uncomfortable to talk about SRH as it is taken as a very sensitive topic in their culture. In the home countries of participants, i.e., Syria, Iran, Iraq, and Pakistan, it is not normal to talk about the topics which are related to SRH. Due to this, many participants hesitated to answer some questions regarding SRH. Even with hesitation, participants mentioned different subject areas related to SRH. Mostly the married women have a broad view on SRH and mentioned different aspects of SRH like pregnancy, care during childbirth, maternal health, problems that may arise during pregnancy. Regarding this, Abba shared that:

"(….) how women can take care of her body when she is in pregnancy. And also, after having a baby. Her body will be weak, and she needs a nutrient diet to be strong. She needs lots of vitamin and minerals to be strong. This is the most important thing for women to be conscious that she should take care of her body during pregnancy and also after giving birth to a child" (Abba, 164-168).

Some participants also mentioned topics like breastfeeding, childbearing. Most of the unmarried participants linked SRH with menstruation, pain during menstruation and female hygiene. Some other topics mentioned by refugee women are early and forced marriage and the complication in giving birth in early age or in late age, or consequence of giving birth to many children as shared by one of the participants: "*In our country, one woman gives birth to many children. I think that might also affect the women's health. My mom gave birth to 9 children and my uncle has 12 children. (....). For people in Syria, it is normal"* (Nele, 141-144).

Some participants also linked SRH with women's diseases such as cancer like breast cancer, ovary cancer. But there were also participants who have no idea about SRH at all.

Consciousness towards sexual and reproductive health

Among the participants, married women showed more consciousness about SRH than unmarried women, especially as married women have already dealt with some SRH issues such as pregnancy and childbirth. Whereas unmarried participants shared more on menstruation. One of the married participants shared about her own experience that she regularly visits the doctor and she was conscious about her diet during her pregnancy.

"*After I became pregnant, I visit her regularly and she gives advice on what to eat and what not to eat. And she also told me to do exercise so that my body gets active. Well, I know I should not do heavy exercise. I should practice some light exercise. My doctor told me that thing too."* (Abba, 284-287).

The married women from Iran was also conscious about SRH health consequences as she shared that: "*It is also important to do a check-up before women get pregnant. If she has some serious illness, then she might give birth to a baby with an illness* "(Mona, 123-124).

The woman from Nigeria was more conscious than other women. Bella from Nigeria shared that they are aware of family planning or birth control which can be clearer by her statement:

"*Lots of women are now being conscious about these things especially birth control. They do not want to have many children. Most of them have maximum 4 children. Now people are controlling their childbirth. Before, people have many children. Like my mum have eight children. We are 4 girls and 4 boys. But right now, it is no longer like that" (*Bella, 170-173).

According to the participants, most of the refugee women living in the camp do not care about their SRH. Participants shared that they have seen some pregnant women who regularly smoke and are not aware or conscious about its effect on theirs and unborn children health. Participants also do agree that most of them do not care about their SRH.

4.4 Sexual and reproductive health knowledge

The participants have the opinion that most of the refugee women have a very little knowledge on SRH. Therefore, they are not much conscious about their SRH. Related to this, Zahra shared that: *"I think women in accommodation or camp are not much conscious about their reproductive and sexual health because of lack of education"* (Zahra, 78-79).

The knowledge on SRH can be acquired through different ways, which can be divided as formal and informal education. Formal education indicates the knowledge that is gained through school and Universities. Informal education is the information obtained through other contacts/means such as from their sisters, mothers, friends, etc. which is described in following paragraphs.

Formal education

Six women in this study are grown up in Syria and they had completed their higher education in Syria. One participant came from Pakistan and did her study in Pakistan. One participant came from Iraq and had finished her undergraduate in Iraq. All these participants shared that they did not get adequate knowledge on SRH in their school in their country. There is the availability of books and articles regarding this topic, but the teacher hesitates to teach about these things. In this context, Nele shared that:

"In our country, we learn about reproductive and sexual health in 9th grade. And it was also only one lesson. Normally the teacher used to tell us about it very fast. And no one dares to ask questions about it. And if the teacher is a man then he will say that it is not so important. Our teacher told us that we should read it at home. He did not explain anything. And he also said that he will not ask questions from that part in the exam" (Nele, 203-207).

The participants from Pakistan and Iraq also reported that they were not enough informed and educated about SRH and its consequences on women's health in their school and higher schools.

In contrast to these countries, the participant of Iran and Nigeria reported that they were taught on different contents related to SRH like physiology, menstruation, pregnancy and contraceptives. A woman from Iran shared that, girls and boys are taught separately in school at her school time. Therefore, girls didn't hesitate to learn about those things. Besides this, women in Iran can also get information on SRH through a gynecologist.

"*In Iran, when I was in school, SRH was in the curriculum. We are taught about a woman's body, a man's body, how women get pregnant, I mean the changes in hormone and the development of the baby inside the mother's womb such things. I can't remember all but those things (….) and we were taught by a female teacher. At that time, boys and girls were taught separately so we did not feel hesitant"* (Lena, 153-157).

The statements of participants signify that women from Iran and Nigeria got a comparatively better education regarding SRH than women from Syria, Pakistan and Iraq.

Informal Education

In Syria, Iran, Iraq, and Pakistan, people usually do not talk about SRH related topics in public places. It is like a very private thing. People feel embarrassed to share their problems related to SRH. Some of them even hesitate to talk to their mothers. According to the statements of study participants, the main source of information regarding SRH is sisters, friends and cousins. Another source of information is neighbour, relatives, and people who are close to them. Regarding this Abba shared that:

"*When we have a problem, we get help from sisters, neighbors, other girls, friends who share about this girl's problem. Normally we also feel shy to talk about it with our mother. I normally talk with my cousins, sisters when I have a problem regarding menstruation, pain in stomach. They told me then that I have to drink a lot of tea. We should not do a lot of work during menstruation"* (Abba 54-58).

After marriage, women also share their problems related to SRH to their husband. Abba shared in this context that: "*I know my husband for 8 years. So, after all this year, I discovered that your husband is the only man to whom you can tell everything. You can share everything, your secrets in a very comfortable way. You can be sure that he will not say that thing to anybody. And he will help you without thinking too much. Well, he will take care of you. You can share everything. Women should let her share emotions with her man. If I did not tell him, then to whom should I tell and share my things. How should he know that I have pain, or I am suffering from a headache or I have pain in my arm?" (Abba, 112-118).*

Almost all participants mentioned internet as a big source of knowledge regarding SRH after their settlement in Germany. As participants could hardly share and ask regarding SRH to others, they search on the internet, especially in google if they want to know some information related to SRH as reported by Celine:

"*Here we usually search in Google. Before, we didn't have an insurance card and if I want to know something, I search it in Google"* (Celine, 178-179).

Thus, refugee women get SRH information through informal way, i.e. through the person who is close to them such as sister, husband, mother, and friend and an internet has become a major source of knowledge in Germany.

4.5 Sexual and reproductive health issues

4.5.1 Menstruation

For most of the participants, menstruation is an awkward condition. About more than half of the participants, especially the unmarried participants experienced a strong pain during menstruation. Some participants have lower abdominal pain, while some have back pain. Some participants had also experienced mood swings during their period. One of the Syrian participants shared that:

"*During my period, I have so strong pain in my stomach. And it happens for 3-4 days. Every month when I have my period, I just want to sit and lie in my bed. (….) till now I have not taken any medicine for pain. Sometimes I take paracetamol. Sometimes, it helps me and sometimes it does not help me. And you know, it is not only in my case. I know many girls in my friend's circle who have to bear pain during menstruation. And since I am here in Germany, I have an irregular period. Last year, after arriving here, I did not get a period for 2-3 months. I was just hoping that I am fine because I do not want to go to the doctor"* (Selli, 115-121).

Even though most of the participants suffer from acute pain during menstruation, they hesitate to visit the doctor as they are very embarrassed to talk about it and especially, with the male doctors. Participants also mentioned that they try to find another way to reduce the pain during menstruation. The participant from Syria and Iran shared that women usually drink a lot of tea during menstruation. They believe that tea helps in reducing pain during the period as Mona shared: *"During menstruation, we drink a lot of tea. In Iran, it is like a tradition that we drink a lot of tea, especially during menstruation. We believe that tea helps in reducing pain during menstruation*" (Mona, 24-26).

Another participant from Iran shared that she uses a hot bag during menstruation, which helps in reducing pain. Some participants also shared that they suffer from premenstrual syndrome like feeling tired, feeling irritated, mood changes, stress, anxiety, etc. In this context, one of the participants shared that:

"before menstruation and even during menstruation I feel some kind of tiredness. I get irritated with small things which do not suit me. I have like a kind of a headache and a bad mood. Oh, I get so angry and sometimes I feel like I am another person. I think, I even talk crudely with people. My mother tells me that, I usually have a bad mood before I get my monthly cycle. And I know she is saying the truth. But I can't change. What I do is, I try to remain calm and I usually stay at home. I didn't want to meet other people at that time" (Usma, 158-164).

In most of the Muslim countries, people normally do not talk about menstruation, so women tried to hide their problem especially with a male member of the family. Regarding this Celine shared that: "*we did not even talk about this openly. We could not talk about our menstruation in front of our father. Mothers use to tell us, but she does not give all information which we should know"* (Celine, 163-164).

Another participant from Syria added that women lack basic knowledge of menstruation, so she is left alone to handle the problem when she experiences it. Nelereported that, *"In our country, we get to know about menstruation, when we experience it but not before. If we know what happen before then, at least that girl has an idea what she should do, instead of crying"* (Nele, 158-160).

In contrast to this, women from Nigeria shared that they do not hesitate to talk about menstruation with other family members or neighbors, including a male member which she mentioned in her following statement: "*When I was having menstruation, the whole house will know that I am having menstruation. Because it is so painful, I used to cry so loudly*" (Bella, 96-97).

Use of menstrual hygienic products

Almost all the participants use sanitary pads as menstrual hygiene products in Germany. There were participants who also do not know about the tampons and other hygienic material before coming here in Germany. Women learn about the use of sanitary pads from their sister, and peers as Celine said.

"During my first menstruation, I even don't know how to use sanitation pad. I asked my elder sister. She told me how to use it correctly. She is like my teacher. She told me which foods are best to eat during menstruation and which are not good (*....)* (Celine, 172-175).

The participant also shared that the sanitary pads are generally expensive in their home country so it was hard to afford them. The participants from Iran also mentioned that girls could get sanitary pads without any charge in the schools if they get their period in school. (Mona, 26-27). The use of sanitary pads is also hardly communicated with the girls. Even mothers hesitated to talk about sanitary pads in front of her husband. Celine shared her experience like this:

"*You know when I was small around 5 or 6 years old, I didn't know about the use of sanitary pads. I used to see it in the market or an advertisement on TV. But no one told me what we do with sanitary pads at that time. I have no idea about that. Once I asked my mother in front of my father, what is that thing. For what purpose we use it. At that time, my mum just laughed and didn't tell me anything in front of my father. But after having menstruation, whenever there comes an advertisement of sanitary pads, I used to change the channel because most of the time, my father used to sit behind us. It is so funny. At the same time, it is embarrassing"* (Celine, 166-172).

4.5.2 Early and forced marriage

Early and forced marriage was another theme mentioned by participants from Syria, Iran, Iraq and Pakistan. According to society and cultural system, the refugee women got married at a different age. In Syria, Iraq and Iran, most of the girls from the big cities get married in mid or late 20. In rural areas, many girls get married at the age of 16 or even earlier. In Pakistan, most of the girls get married at an earlier age like 16 or 18. Also, in African country Nigeria, there is a trend of early marriage, especially in the east and west part of Nigeria, where girls get married at the age of 15 or 16.

One reason behind early marriage in Syria is due to war and conflicts. The family with daughter wants to protect their daughter through marriage. They think that their daughter could get protection from her husband and if the man is living outside the country, then it is easy for the women to migrate from their home country and stay safe. Due to this, some women are even forced to get married to someone. Abba from Syria shared like this:

"You know I think because of war, people start to think like they should give their daughters away so that her husband will take care of her. Most of the young men are travelling away from Syria and they think that if their daughter gets married someone, she can go away with her husband. And her husband will take care of her. Or if the man has been already outside, the parents hurry up to marry their daughter with that man so that she can go away from Syria". (Abba 41-46).

Another reason for early and forced marriage is due to a lack of education. The participant from Iraq mentioned that mostly the uneducated people get married at an early age in Iraq, which further make them difficult to continue their study.

"*Specially, the uneducated people they get married at an early age. There are girls who married at the age of 16 years old or 18 years old. You know the girl, who was with me in the workshop. She got married in 16 years old. She was studying in school when she got married. So, she could not finish her school level*" (Ina, 61-65).

Especially in Pakistan and some part of Syria, many people are still following the tradition of arranged marriage where the family selects a man for a woman. Some women are even forced to marry with the person. But in the city area, this trend of arranged marriage is changing. The women and men meet before they get married. Regarding this Zahra from Pakistan shared that:

"Everyone is free to choose his partner, but unfortunately, it is not common in my culture. Girls are mostly not allowed to choose her life partner without the permission or willingness of her parents. Maybe you know, in our culture, we follow the arrange marriage where parents search

life partner for us. And the girl and boy are even not allowed to meet before marriage" (Zahra, 119-123).

Along with arranged and forced marriage, there is also the tradition of polygamy in Iraq, where the man has the right to get married to more than one woman as reported by Ina:

"if a man wants to marry a woman and if parents are also satisfied than women get married with the man even women are not ready. And you know that there are some men who are already married, and they marry another woman. But that man should have enough money. He should afford a house for both wives. He should make both of them happy. There are also some men who are older, and they marry a very young girl. But these cases are now decreasing" (Ina, 259-264).

In opposite to Syria, Pakistan, and Iraq, the trend of forced marriage is decreasing in Nigeria and Iran. The participants from Iran and Iraq also shared that most of the women in their country are getting married at their later age in these days than in the past generation.

Consequence of early and forced marriage

Participants mentioned that women who got married at her early age get pregnant at an early and lack adequate knowledge of childbearing, breastfeeding and thus could not properly take care of their children. One participant shared this issue like this:

"Most of them, they do not know how to cook, how to take care of their baby. They are themselves like a baby and (….) and after 9 or 10 months, they get baby and they don't know how to take care of her baby" (Abba, 38-41).

Further on, some participants also shared that women give birth to many children when they get married at an early age. The participant from Nigeria also reported that women in Nigeria suffer from a disease where women cannot control their urinary tract.

"(…) a lot of girls suffer from a disease in which girl passed out urine without any control. I forget the medical name for it. After giving birth to a child, they cannot control their urinary tract because they are not mature enough to give birth to the baby. They are too young to get pregnant" (Bella, 64-68).

These are some problems mentioned by participants during the pregnancy and childbirth due to early and forced marriage.

4.5.3 Pregnancy and childbirth

All the married participants of this study indicated pregnancy and problems during pregnancy as an important subject concerning SRH. They also shared that they were more conscious of their health when they were pregnant. In their home country, they usually get get support and care from their family and relatives during pregnancy. Regarding this Lena shared that:

"*Me, personally, I was very much serious about my health when I was pregnant. My mother and grandmother took care of my health. My grandmother made special food for me when I was pregnant. It is a kind of food mixed with lots of nuts. And my mother told me that I should not eat a lot of beans such things. I also got tips from doctors what I should eat and what I should avoid during pregnancy" (*Lena, 145-149).

Among four married women with children, three of them had experienced many difficulties during their pregnancy. A woman from Nigeria with four children had even lost one of her children due to lack of proper care and diet and stress during her pregnancy. She had to stay for many days in the hospital as her body was very weak since she could not digest any food.

"The first three months were really terrible. I was very sick. I used to vomit after eating something. I can't eat for three months. I could not sleep well. I used to take just liquids. I can't swallow. I can't chew. Even I just take liquid, I vomited that. Anything I put in my mouth, after some minutes it comes out. I think after four months, I started eating gradually like a baby. I ate very little at that time. And the smell of food is different. Those foods which I like to eat before does not taste good to me. I can't eat them more. The taste is different in my mouth" (Bella, 220-226).

Further, she reported how she lost her child in Germany due to stress and lack of proper care.

"*I was pregnant when I was travelling from Nigeria to Germany. Those days are my worst time in my life. I divorced my ex-husband. I have a lot of stress. After arriving here in Germany, I did not get proper care. There was no one to care for my child and of me. There were times when I had no food to eat. Being pregnant, I worked as a dishwasher. I didn't know about the medical services at that time. It was so hard. Due to all these stresses, my baby boy died after his birth"* (Bella, 33-38).

Another participant reported over thinking as a major problem during her pregnancy. *"When I was pregnant for the first time, I used to think too much*" (Abba, 286).

The married participants mentioned that all of them had their child delivery in hospitals. However, participants also mentioned that in the remote areas in their country, women also give birth to their child at home. After the delivery of child, women normally get help and care from midwives,

relatives or neighbors. Some participants are also aware about medical and midwives' services during pregnancy and childbirth in Germany. But, participants also mentioned that refugee women who live in camp lack healthy diet during pregnancy as refugee camp does not offer special food for pregnant women.

The married woman from Iran also mentioned that some women in Iran have difficulties in giving birth to a child or they give birth to an unhealthy child which she illustrated in this way:

"*Nowadays, many women have a problem that they cannot give birth to a child or they bring an unhealthy child into the world. So many women are afraid about that. And nowadays there are many new diseases, which doctors also did not know well"* (Lena, 174-176).

In this way, women shared their pain, suffer and difficult experiences in relation to pregnancy and childbirth.

4.5.4 Abortion

The participants from the Middle East Islamic countries shared that abortion is normally not allowed after knowing that the baby is already there as Celine shared "*And in our country, we are not allowed to do abortion except in some serious cases. For example, one of my Aunt in Syria does not want to have a baby as she has already many children. But it was already too late. So that was her last baby"* (Celine, 258-260).

In Iraq too it is not legal to do an abortion, but some doctors perform it secretly. (normally it is not allowed, but some doctors do it illegally (Ina, 225)).

Also, in Iran, there are some cases when girls get pregnant before marriage and sometimes, they have to undergo an abortion, which is officially and from the religious point of view not allowed but many people do it secretly. Lena shared on this topic like this:

"*it is not allowed from religion, but people do it with a secret. When they notice that they are pregnant, then they go to women doctor and do it. There are also women who are against abortion. Women who are religious, who still follows an old tradition, they do not do abortion"* (Lena, 56-58).

However, there are also women who follow the old tradition and are religious and are against abortion.

In Pakistan, abortion is allowed only when pregnancy is severely affecting women's health. Regarding this, Zahra shared that: *"I think, abortion is also allowed, but under certain conditions for e.g. if pregnant women health is in danger due to pregnancy, then the women are permitted*

to do abortion. But she alone cannot take the decision. Both husband and wife should take the decision". (Zahra, 102-104). However, pregnant women could not take the decision alone if they want to do abortions.

4.5.5 Family planning and contraceptives

Among 11 participants, 7 participants are single and have not yet thought about family planning and contraceptives. Among the four married women, only two of mentioned they knew about family planning and contraceptives. The woman from Nigeria also reported that women in Nigeria are now more conscious regarding family planning.

"*Lots of women are now being conscious of these things. Especially birth control. They do not want to have many children. Most of them have maximum 4 children. Now people are controlling their childbirth. Before, people have many children. Like my mum have eight children. We are 4 girls and 4 boys. But right now, it is no longer like that*" (Bella, 171-174)

Also, in Iraq, women are now aware about family planning. In the past women used to have many children, but now they are reducing their childbirth as mentioned by Ina:

"In past, people in Iraq have a lot of children. For e.g. I have seven siblings. And one of my friends has 9 siblings. But now the people have fewer children. One of my sisters has 4 children and my brother has 3 children, another brother has 4 children. One of my sisters is engaged. She has not yet a child. My dad died early before 30 years old. If he was alive then we were more children" (Ina, 73-77).

According to participants, most of women in refugee camps are married and have comparatively more children than native citizen. One of the participants further stated that some couple intentionally wants to have many children as they get money from the government on behalf of their children.

"*you know there are some women who intentionally do not use contraceptive because they want to have more children so that they can get money from the government for their children. You know that in Germany if you have children you get Kinder geld from the government. So, they want to have more children. That's why they do not go to work. But I can't think of that. I want to work and earn money"* (Bella, 211-215).

The participant from Iran and Syria reported that the new generation couples are practicing family planning as they recognize that they need more money to grow a child and it also helps women to involve in the employment sector.

"In Iran, it is very expensive to grow up the children. If you have more children, then you need lots of money. So, people use contraceptives not to have a baby" (Mona, 137-138).

The participants from Syria, Iraq, Pakistan and Iran also shared that mostly the highly educated and wealthier people think about family planning and contraceptive use. One of the participants stated: "*You know, in our country, most of the rich people have only 2 or 3 children. And most of the poor people have more than 8 children. And later, they said it is hard to grow up many children"* (Celine, 147-148).

The married participants also shared about the involvement of a husband and wife in a decision-making role for family planning and contraceptive use. However, the couple should decide before having a baby in the mother's womb.

"*Well, I can decide that I don't want the baby but before being pregnant. After getting pregnant, I cannot say that I don't want this baby. I am not allowed to say I don't want a baby after having a test and when the baby is already there. It's a big mistake in our culture. Abortion is normally not allowed"* (Abba, 294-297).

Regarding contraceptives, all the participants stated that there are different methods available in their home country and uses of contraceptive are also acceptable in their culture and religion. Normally, people have to buy contraceptives for themselves However, in Nigeria, married women are not supposed to use contraceptives. *"Well, in Nigeria when you are married, you are not supposed to use any contraceptive. After marrying, if women say her husband to use a condom than the husband will say why did you marry me. Are you my girl friend? The husband does not want to use it. And it is very hard to negotiate on this topic*" (Bella, 184-187).

Like other SRH topics, people normally do not talk about contraceptive in the Middle East Islamic countries within the family and between siblings. Only husband and wife negotiate about the use of contraceptive. Many single women get to know about contraceptives only after marriage. Therefore, the unmarried participants have very little idea about contraceptive method. Some of them know only condom as a contraceptive method.

Among four married participants, only two of them have already dealt with contraceptives in their home country. They know about the contraceptives like a condom, injection of a drug, pills, spirals, etc. The married women from Iran shared that she had used a spiral and she finds it very effective. *"Yes, contraceptives are acceptable in our religion. I have used the spiral after giving birth to my second child. We can do that by a gynecologist. My mother also used a spiral. In my view, a condom is not so effective. But spiral is more effective, but it is expensive"* (Lena, 196-198).

Another participant from Syria shared that she had used some pills in Syria. But she had problems like unbalance in hormone as a side effect of that contraceptive method. Now, after settling down in Germany she is not using anymore. The participants further reported that many women don not use contraceptives because of its negative side effects such as weight gain or skin damage.

"*But most of the women are not using contraceptives because they think that they will be fat after using contraceptives"* (Bella, 177-179).

Concerning counseling center for family planning and contraceptive, none of the participants know about it in their home country as well as here in Germany. The participants were also asked if they know where they can get contraceptives. Most of them did not know where to get it and only a few mentioned that they can get contraceptives through a gynecologist.

4.5.6 Sexual transmitted infections

The participants from Syria, Pakistan, Iran and Iraq reported that they should not have a sexual relationship before marriage. Most of the participants think that this system prevents them from getting sexually transmitted diseases. Therefore, most of the women do not see STI as a huge problem, especially for the unmarried women.

The participants from Syria also shared that, most of the women and man should undergo a different health check-up before they get married. This helps men and women know about each other diseases and to prevent from STI as reported by Abba.

"*In Syria, before you get married, you have to go through a test or health checkups. They do a blood test. They test, how good is your health condition if he or she has some diseases. But they are not forced to do that. Normally, most of the people do that. The most important is that you should not have a relation before marriage. Before arranging papers for marrying, you should do some kind of health check-up and analysis" (*Abba, 329-333).

Among different STI, almost all the participants are well known about HIV and AIDS. But most of them are unaware of other STI such as Chlamydia, Syphilis, Gonorrhea etc. Most of the participants shared that they have learned about STI during their school life, but they did not get comprehensive information on it. The topic like STI is also taught only superficially in Pakistan, Iran, Iraq as well as in Syria.

The participant from Nigeria had graduated in Biochemistry and one woman from Syria had studied pharmacy. These women have more knowledge of STI than others. The women from Nigeria even knew close people who suffered from Gonorrhea. *"I know women who suffer from Gonorrhea. One of the friends of my husband had also this disease. My husband also has a*

urinary tract infection, I am not sure if it is STI" (Bella, 364-366).

The participant also mentioned that there are availability of a few health promotion and awareness programs on STI in Televisions in their home country. But none of the participants are aware of the counselling center about STI neither in their country nor in Germany.

4.5.7 Sexual and gender-based violence

All the participants do agree with the existence of sexual and gender-based violence in their home country or in their culture. Among the 11 participants who live in refugee camps in Hamburg, 6 of them had expressed their feeling of insecurity in living in refugee camps. They believe that there is a high risk of getting sexually abused inside the camps, especially at night when they have to go to the washroom. In most of the refugee camp, the toilets and bathrooms are outside the room and the bathrooms are open, i.e. there are only curtains instead of doors. Due to this, women always need someone to stay outside the bathroom for protection when they are taking a shower as reported by Celine:

"(...) The bathrooms are also not clean. The bathrooms are open. I mean there is no door in the bathroom, only a curtain. So, it's so uncomfortable to take a shower. One must stand outside the bathroom and look if someone enters there" (Celine, 10-12).

Further on the participant from Nigeria shared that she usually takes a shower at night when most of the people are already in their beds. "*whenever I take showers, I am afraid. As there are no doors, there are only curtains in the bathrooms. Even the men and women's bathrooms are separate, I am afraid that someone might enter and grab me. That's why I usually take shower at late at night, when most of the people are already in their bed*" (Bella, 383-386).

Nevertheless, there are also some participants who feel more secure inside the camp than outside because of the 24 hour security in the camp. Abba shared that:

"*Inside the camp, it is more secure. But outside the camp, it is very dangerous as on the other side of the road there is also another camp for single refugee men. Some of them are drunk at night and can do anything. And some are crazy and have a mental problem. So, I do not let my children play outside the camp. Even the securities told me that I should not let my children play outside*" (Abba, 365-369).

The participants find positive that most of the camps in Germany have 24 hours security. Three participants are living currently in the camp where only single women are permitted to live. In those camps, men are not allowed to enter inside the camp. Therefore, they feel safe in the camp. Regarding this Mona shared that: *"All women are alone. They are single women. We don't have*

women with children. Normally, men are not allowed to come inside our camp, except for a caretaker and securities. That is good for us. It is very safe" (Mona, 69-71).

Some of the participants reported that besides having security, they hear from people experiencing sexual abuse inside the camp. Some of them have even experienced unusual behavior of men like starring in an unusual way which makes them feel insecure when they are travelling alone. In this context Selli shared like this:

"I have not experienced so horrible thing. But I had experienced bad things. It was in the summertime, last year summer when I was returning to my room, I mean to my camp there were some men standing outside the camp and they were looking me from top to bottom and from bottom to top. It is so weird. It seems like they have seen a woman for the first time (….) they are not German, they are also a foreigner, like us but I have not seen them before. I walked from there so quickly as I can. After that, I have not seen them again" (Selli, 171-175).

Almost all the participants have heard about some kind of sexual abuse or sexual violence cases in their camps. Moreover, the participants shared that they hear sexual violence cases comparatively more in their home country than in Germany. The participant from Iran shared that in Iran, women are sexually abused in working place, in universities and the worse things are that some police officers are involved in doing such things who are actually there to protect public from crime. Furthermore, the women being the victim of sexual violence blame for her. Regarding this Mona reported that:

"In Iran, we are growing up with the ideology that if something bad happens then it's because of women mistake. For e.g., if women experience sexual harassment or something like this, then it's because of her. Police or Government says, women might have shown their hair to the boy, so it happens. So, many people believe in that. And many women do not dare to speak up. From our childhood, girls learn in that way that if they show their hairs then they will experience something bad. It's fully nonsense. A boy or man does something bad and people said it's the woman's fault" (Mona, 171-176).

Participants also shared that women being the victim of sexual violence have very bad consequences in some culture like in Pakistan and in Syria. Even the victims do not dare to complain about it at the police because they are afraid that the women might have to face many difficulties in the future.

Some participants expressed that living in Germany is much more secure than in their home country. In Syria, there are many sexual violence cases, which are under-reported. Related to this topic, Celine shared that: *"(....) there are some places in Syria or in Iraq, where ISS attack*

Yazidi people. And some Muslims man had raped Yazidi women. And in Iraq, there is one place, where ISS were selling Yazidi girls" (Celine, 387-389).

Regarding sexual and gender violence, the participants shared a lot of sexual violence cases, which they have heard about or experienced in their home country as well as after settling down in Germany. Most of the participants also shared that they feel safer in Germany than in their own country.

Domestic violence

The participants also shared their opinion on domestic violence due to which many women in Muslim countries have to suffer the adverse mental health problem. Participants shared that men are taken as superior and guardian in Muslim culture. Concerning this Celine said that: *"I have seen many Muslim men. They are so dominating. They think that he has the power and his wife should follow everything that he wants* (Celine, 392-393).

Another participant from Iran also mentioned unbalance power relation between husband and wife by illustrating one example*: "For e.g., my sister is younger than me, she is 28 years old and already married. She has one son and she always has to do that what her husband says. And in Iran, women cannot give divorce to her man, but a man can do that"* (Mona, 160-163).

This kind of unbalance power relation is mostly present in the old generation population. *"In Syria, it depends on the family. Mostly in the family with the older generation, women have to do what the man said. Women cannot speak up against their man. If a man wants to have sex, then it is more probable that women must do sex. But now, in new generations, it is not like that. Women can speak and say not to have sex if she is not interested"* (Celine, 322-32).

The participant from Nigeria was open to share that she was herself a victim of domestic violence (Bella).

In some regions, people, especially family member even were found to murder women in the name of honor when she broke any rules and regulation of the culture or religion. Even if women were victim of sexual violence, she suffers from its consequences and not the predator. In this context, Zahra shared that:

"Yes, people kill women, I mean their wife or daughter from their own family member when she breaks any rules or law. It happens in most of the remote area. Some people even feel proud after killing (Zahra, 129-131).

4.6 Awareness about sexual and reproductive health services

4.6.1 Health services in refugee camps

All the participants except one who lived in emergency shelter reported about the availability of general physician in a refugee camp. Some camps even have a special doctor for children. However, the participants reported that it is hard to get an appointment with a doctor in camp as they have to wait long for their turn. Regarding this, one of the participants shared that:

"*The doctor in the camp is also good, but she did not come regularly. Even it is written that every Monday there is the appointment and availability of doctor and doctor for children are also there for once in a week. But it is most of the time full or they take only a few children and we have to wait for a long time or search for another time"* (Abba, 214-217).

In some refugee accommodation, there are also midwives' services. Bella mentioned in her interview that: "*We have midwives, they come every Wednesday. If you have a problem, then you can talk to them. They will give advice then*" (Bella, 190-191).

In some refugee camp, they also offer yoga and meditation once a week, especially for refugee women. But, there is no information regarding family planning, STI, sexual violence and other topics related to SRH. One participant stated that: *"I have seen many flyers and information regarding healthy foods, sport, and mental health but not about sexual and reproductive health. There are programs like yoga course, women café such thing"* (Ina, 195-197).

The participants also reported that they were not informed about SRH services which are available in their surroundings as one of the participants shared that *"Normally in the canteen, there is an information board where they hang flyers and posters from different programs. But we have not seen any flyer related to reproductive and sexual health"* (Celine, 225 -226).

The findings from observation also present that there are available doctors and general physicians and special doctors for children in the observed refugee camps. Furthermore, it presents that some camp also offer counseling for mothers (Mutterberatung). In some camps, they also have midwives' services for pregnant women. However, there are not abundant services and information regarding SRH in refugee accommodations.

4.6.2 Health care services in Germany

The study participants are not well informed about different SRH services that are available in Germany. Most of the participants, mostly the unmarried group had not even sought for information regarding SRH such as family planning, contraceptives, sexual violence, etc. Hence, the unmarried women have not yet utilized any SRH services. The married participants know a little bit more about SRH and had also utilized the services like counseling for mother and

gynecologist services. One of the participants shared that she got good medical care in Germany when she was pregnant, and her child was ill.

"*When my second child was sick, they took me to the doctor who gave me service, medical service. They provide us doctor. When I was pregnant, I visited gynecologist. I also told her my history that I already lost my child*" (Bella, 317-319).

Among 11 women, only one married participant knew some counselling center for pregnant women, which gives advice on proper diet during pregnancy and negative effects of medicine during pregnancy. But the participant could not name the counselling center.

In Germany, there is help and support called as "Violence against women" (Gewaltgegen Frauen) which offers help for women who are victim of sexual and domestic violence. But none of the participants knew about this. If in case women experienced sexual abuse, then most of them said that they will go to the police for complaining. Few participants even don't know what they have to do if they experience sexual abuse in their life. Most of the participants expressed that they have more trust in a police officer in Germany than in their own country. Regarding this, Usma shared that: "*Yes, I think we can trust police here in Germany. It is not like in our country. The police do such bloody things like sexual harassment, rape"* (Usma, 210-211).

Participants were also asked about rights regarding sexuality. Almost all participants shared that they have not heard about this right before the interview. After explaining the rights regarding sexuality, participants meant to know these rights. Some participants shared that they are written in the paper, but people do not follow these rights in their country. *"Yes, I know these things, but I am not sure if people follow these rules"* (Diva, 198).

Nevertheless, most of the participants were interested to know about different SRH services which are available in Germany since they are going to stay in Germany as reported by Selli.

"*I don't know anything regarding this. But I would like to know. Because, if I am going to stay here in Germany, then I have to know that. In future, if I get married and get pregnant then I should know where to go for a check-up, where to go for childbirth, where I get care after giving birth to a child. All these things are important, but we do not know about it*" (Selli, 134-138).

4.6.3 Health promotion and awareness program

Among 10 participants, eight knew about the REFUGIUM health promotion program in Hamburg. Participants were also asked if they knew any other health promotion organizations. One of them knew about an organization like Caritas Hamburg which is working in the field of SRH. Two participants also mentioned about the health care services which is offered by the Church of that

community. Regarding this Nele shared that:

"There is also a doctors' service in the church, near our refugee camp. My mom also went there. The doctor in the church also said that she needs to have an operation. Her waist problem is getting worse. She is getting older, so it will be hard for her to do operation later" (Nele, 128-130).

Another participant from Nigeria got service and care from Adebar Hamburg in Bahrenfeld. From there, she got tips for breastfeeding, which she has reported in this way:

"And I also got help from Adebar. I was having a problem with my breastfeeding. My child has a problem with sucking milk. So, the doctor suggested me to visit Adebar in Bahrenfeld. The midwives there teach me how to breastfeed her. When my child was sucking well then I don't have to go there more" (Bella, 336-339).

A woman from Iraq also engages in different activities in different programs such as Frauen café in Aidshilfe Hamburg, Mut cafe, Refugium, and Roteskreuz. She shared that she got to know about SRH through Aidshilfe Hamburg. "*Day before yesterday, we had a lecture about sexual health in Aidshilfe in Hauptbahnhof"* (Ina, 177).

The participants of this study were shown Zanzu website from the BZgA. The website contains different SRH aspects such as women and man's body, family planning and pregnancy, infections, sexuality, relationships and feelings, and rights and law. These are the main topic which also includes sub-topics. Participants were asked if they knew about the online web site, where SRH were explained in different languages. None of the participants knew about the Zanzu website before. After knowing Zanzu, participants also gave some feedback. One of the feedbacks from a participant is mentioned below:

"*In my view, Zanzu is a very informative website, where everyone can get information about sexual life. The positive thing about this website is that the information is available in different languages. But the people who have no Internet cannot use this program"* (Zahra, 141-143).

Participants appreciate that Zanzu is providing a lot of helpful information in different languages. It is also easy to access as they can open the website in their smartphone. They liked that Zanzu website is designed in an understandable way, i.e. that they can have a glance in separate topics and to each topic there are subtopics. Due to lack of time, participants did not read all the information from Zanzu during the interview. But most of the participants were interested to read Zanzu information when they get time after the interview or focus groups were done.

There were participants who also knew about Diakonie, but they are not aware of the program for a refugee. About half of the participants knew some health programs while half of the participants are not aware of these programs except REFUGIUM.

4.6.4 Health services in the country of origin

The participants reported that there are only few SRH services in Syria, Pakistan, Iraq, and Iran. In comparison to these countries, Nigeria has more services on SRH. Many communities in Syria, Pakistan, and Iraq face severe limitations in their access to medical care and SRH services. Some participants even shared that most of the hospitals in remote areas are not hygienic. Therefore, they do not provide quality care as mentioned by Ina in her interview: "*We have a good hospital, but the condition of the hospital is not good. The hospitals are not clean, and, in some hospital, you can even see animals walking inside the hospital (laugh)"* (Ina, 45-47).

In Syria, many hospitals and health centers got destroyed due to war. Now, there are only a few hospitals in Syria. One of the participants mentioned in her interview that: *"we have now not so many hospitals. It is very sad to say. Before, there were either hospitals or health clinics almost everywhere in Syria"* (Usma, 69-70).

Besides hospitals and health centers, there were also some health promotion programs in Syria which are not running anymore.

Participants from Iraq, Pakistan and Iran mentioned there were a lot of good hospitals available which could provide quality care but they were expensive. There are clinics and hospitals where they can give birth to their baby and they provide quality care for mothers after giving birth. In Iran, they have midwives, gynecology services in hospitals or outside the hospitals. Women also get special care in case of miscarriage in Iran. However, the gynecologist is expensive than midwives. So many people prefer to go to midwives in Iran. "*We have hospitals, midwives and health center. And we have also gynecology. But you know gynecology is very expensive. So many people go to midwives. Midwives cost is not so expensive"* (Lena, 61-63).

Nevertheless, there is a common trend in all these countries that in rural areas, access to SRH services is difficult vs. say big cities like Damascus or Tehran.

None of the participants knew about the counseling centers for women regarding family planning, STI etc. in their home country. But in Nigeria, many hospitals are now offering a special course for pregnant women about childbearing, family planning, and contraceptives as there were high maternal and infant mortality rates in the past. In this context, Bella reported that: "*There are not so many cases about the child dead like before. Also, the maternal death cases are decreasing. We have still the cases like where the mother died, or a child died, but not so much like in the past. There are also miscarriage cases, but not so much"* (Bella, 75-78).

Regarding health promotion and awareness program, most of them shared that their country lacks health promotion and awareness program. In Iraq, however, there are different

organizations, which are working in the health sector, such Iraq Red Cross as mentioned by Ina: "*We have some organization like Iraq Red Cross, IFIC, ICIC such things but not so much. They have a lot of programs like they go to pregnant women and talk about what to do and what not. Like what should they eat"* (Ina, 91-94).

Excluding organizations that are offering health care services, there are lots of organizations in Syria, Iran, which help women to read and write who are not educated. There are organizations which provide swimming courses, nurse training course for women, or even training in doing makeup, and haircut. In this context, one Syrian participant reported this:

"*we have organizations (laugh) lot of organizations, but to learn like how to write for women who are not educated, how to swim, how to do make-up and to learn to do a professional haircut and dress up. Also, like training for women to become a nurse. I think this nurse training help women to become strong and to earn money. So, she can work in this field and can earn money. Even she can earn only a little money and can live with that. Yes, only this kind of organization*" (Abba, 88-93).

All the participants indicated hospitals as a main medical care provider in their home country. Some women from Syria got even emotional while talking about hospitals as they have seen many big hospitals which got destroyed due to war.

The entire participant shared that their country lacks good health care system and they have no universal health insurance coverage system like in Germany. Therefore, people have to pay from their own pocket, if they get any medical care. Participants also shared that many of them had not utilized any SRH services in their own country and therefore, they are not seeking any of these services in Germany too.

4.7 Barriers in accessing health services

There are different barriers, which are hindering refugee women in getting access SRH services in Germany. Some of the major ones are communication barrier, unfamiliar health care system, stress factors, poor living conditions in a refugee camp, social and financial support, etc. These factors, which are making refugee women difficult in getting access to health services are described in detail in the following paragraphs.

4.7.1 Communication

For all the participants the native language of the country, i.e. German language as one of the challenging factors in integrating and in seeking health care and other services. Almost all the participants could not speak German fluently at the time of the interview and focus group. About

more than half of the participants are joining language classes at the time. Some participants, especially married women with children have less German proficiency. Due to low language proficiency, they do not trust themselves to search doctors outside the camp. If in case they find a doctor outside the camp, they need a translator. And to find a translator is another big challenge for them. One of the participants shared her story while visiting the doctor like this: *"(….) the nurse and doctor don't speak good English and it was difficult for us. I visited doctor many times, but it is hard to tell everything*" (Abba, 217-218).

Further on participants reported that they hardly find doctors who speak their native language in Germany as reported by Abba*: "We tried to find doctors, a woman's doctor who speaks Arabic, but we couldn't find. We find a doctor who speaks English. But still, it is not your mother language. In other languages, it is hard to explain everything, so you summarize a lot of things. Also, some medical terms and medical things are not found in our mother language or I don't know that in English nor in German"* (Abba, 222-226).

Due to insufficient language skills, participants faced difficulties in sharing and explaining the problems to doctors or related person. At the same time, they are afraid that they will understand the wrong thing and get wrong advice or medicine. One of the participants expressed her feeling like this:

"*To be honest, now I am also afraid to visit a doctor because I cannot speak good German. And if I tell them something in broken German, they might understand the thing in another way. And the doctor might give me the wrong medicine. And it might again affect my health. My health condition might go worse. So, I don't want to take a risk"* (Selli, 103-106).

Moreover, due to low language skills, refugee women in the camp have few social contacts. Abba illustrates this problem like this:

"The first problem is language. People speak a different language and when people speak a different language, it makes us hard to communicate. And this camp is for the family so most of the family stay in their single room. And most of the time the man is also in the room. And we come from a different country, different culture, different city and we have different views and thinking. Sometimes it is very hard to see the people's behavior here" (Abba, 125-129).

The women not only have problem in communication with others but among own cultural groups as well since SRH is considered a taboo. Even within a family, women usually share their problems only with women as reported by Ina: *"Menstruation (….) No, such things we don't tell*

father or brother. They know somehow, but they pretend like they don't know about our problem and we pretend like we don't know that they know (laugh)" (Ina, 112-114).

Due to this communication problem, participants reported that they lack knowledge on SRH as Nelle said: "*In our culture, the married women should somehow know what they have to do with pregnancy and when they give birth to their child. We get this information from sisters, family members, relatives, and friends. But before marriage, you do not have to know about these things. It is also not good. Then after marriage, we have to know everything suddenly. Now, we are over 20 and we don't know anything about reproductive and sexual health*" (Nele, 190-195).

Participants also shared that they are ashamed to share their problems with others, including health workers. So, even if they suffer from pain and different diseases, they do not want to seek health care and their condition gets worse as reported by Usma: "*In the place where I came from, most of the women are ashamed of talking about personal health care. If there are any facilities available, they will not be using any of them. So, the conditions of women remain always the same"* (Usma, 80-82).

In contrast to Middle Eastern countries, women in Nigeria can freely share their problems with others including male members of the family. Bella from Nigeria reported that:

"*Yes, we share our problem with our family, especially with mother and with father. When I was having menstruation, the whole house will know that I am having menstruation. Because it is so painful, I used to cry so loudly. Even my dad felt very sad that he could not help me. We do not keep quiet. We share our problem*" (Bella, 95-98).

In this way, participants mentioned different kinds of problems which occurs due to low language skill and due to own culture belief system.

4.7.2 Gender aspects

In terms of gender aspects, participants shared that men and women have a different role within the family and in the community. Women are deprived of many social and public functions that men do. In many Islamic countries, women are not allowed to do certain things in public place like joggings, cycling, etc. "*Women in our country follow what their parents and husband said. They follow their words, not these rights*" (Usma, 199-200).

Within the family, the unmarried girls have a different role in their family. The unmarried girls live with their family till they get married. The unmarried women have the responsibility to take care of her parents and to help her mother in the household. The unmarried woman's decision in term of choosing a life partner is accepted, but the father has more decision-making power. The

parents should accept the man first. Only after that, women can get married to that certain person. In case of decision-making within a couple, generally, men are the one who takes a decision. Ina shared the problem that women in Iraq are facing*: "there are some cases, where women are forced to marry, and some women are forced to do sex. (…)"* (Ina, 253-254)

However, the educated women seem to have more decision make freedom than the uneducated women. Those educated women can speak up and share their opinion and views. In this context, Abba shared like this:

"*It depends on the person. I think, to have sexual intercourse, both men and women should agree first. And I think, if people are educated, then they won't do that. Most uneducated people act on those things. Some people force their wife to do that. Actually, there is law in Syria that if women are forced to do sex then she can complain about it to a lawyer and go to court. Unfortunately, lots of women do not know about it. They do not stand against these things"* (Abba, 350-354).

In Syria, women can even complain to the court, if she is forced to do sexual intercourse without her willingness. Unfortunately, most of the uneducated women, especially from older generations are not aware of this rule and have not so much power in decision making.

"Mostly in the family with the older generation, women have to do what the man said. Women cannot speak up against their man. If a man wants to have sex, then women can do nothing except than having sex. But now, in new generations, it is not like that. Women can speak and say not to have sex if she is not interested" (Celine, 324-327).

The gender of the doctor or any health care provider or an interpreter also plays a significant role among the refugee women's group. Mostly the women of Iran have shown very much concerned about the gender of the doctor. They prefer to go to a female doctor when they want to do health checkups as reported by Mona: "*If I find a female doctor, then I go to her. But sometimes, it is hard to find a female doctor, so I have to go to a male doctor. But I prefer to go to a female doctor"* (Mona, 38-39).

The women from Pakistan reported that women in Pakistan in conservative society are even more disadvantaged as they are not allowed to undergo medical treatment by others. Zahra shared in this context that:*"(....) they are not able to get proper medical attention. Women are not even allowed by others to undergo medical treatment or visit a doctor"* (Zahra, 27-28).

As refugee women have low language proficiency, most of them need support from professional Interpreter for performing different tasks. Women expressed the needs of professional Interpreter of the same gender while visiting the doctor in Germany because most of them feel uncomfortable

in translating in presence of an unknown male. And this can lead to miscommunication. Selli expressed her feelings like this:

"*In our refugee camp, we can also ask social management to arrange an interpreter while visiting the doctor. But the problem is, it is hard to find a female Interpreter. If you are suffering from a female problem, like menstruation, then think how we can describe it to a male interpreter and to that person whom we meet the first time. I personally cannot do it. I feel very shy to talk about my body parts in front of unknown male"* (Selli, 109-113).

4.7.3 Different health care system

The health care system in Germany is different in many ways from the health care system in Middle Eastern Islamic countries and Africa. Most of the participants find difficult to understand the health care system in Germany. In most of the countries, from where participants are originated, they go to hospitals, when they get injured or have some health problems. They are not used to undergo a regular health checkup by a general physician. In most of the countries, people do not have health insurance coverage. In case of Syria, Iran and Iraq only well educated, wealthy people and people who work for the government have insurance. People without insurance have to pay cash whenever they visit doctors or hospitals. Regarding this, Diva shared that: "*But we do not have an insurance card. Most of the rich people or who are employed, have insurance. Most of the people, who work for the government have also insurance. And when people do not have work or a job, they do not have insurance. Every time you visit a doctor, you have to pay*" (Diva, 71-74).

Participants further mentioned that health care service is very expensive in their home country due to which lot of people could not afford to get treatment or diagnosed. Regarding this Ina shared that:

"you know, if you want to do some check-up in a hospital, first you have to make payment. Only after payment, the doctor will perform diagnosis or the operation or such things. Even if the patient is going to die, first you must pay and then you will get treatment. There is no humanity. They treat people like an animal. No respect, no value. The hospitals run after money. It's all about money" (Ina, 49-53).

The participants from Syria, Iran, Pakistan also mentioned that they have to pay cash from their own pocket to get health services. Due to this, most of them seek health services only when they are seriously ill as reported by Nele: *"In our culture, if you are in normal condition, then you won't take care of your health. If something happens, and your health condition goes worse than only people start to take care about it"* (Nele, 188-189).

In the beginning of their resettlement, some participants did not have their health insurance card. Due to which, they could not visit doctors outside the camp. Even the refugee women can get medical service from the doctor available in the camp, the doctor in camp does not have required equipment's for the treatment and therefore suggest them to search doctor outside the camp. This further on leads refugee woman in frustration. In this context, one participant shared this:

"*my mum used to visit there. But they said that they cannot treat her there as it is not like clinics. They do not have equipment there to treat. Therefore, they suggested my mum to search a doctor outside the camp. Every time when my mom visits her, she said she should visit the doctor outside. The problem is, my mum does not have an insurance card till now. If we take her to doctor outside, then she needs insurance card, so we cannot take her to doctor outside the camp"* (Nele, 96-101).

For most of the participants, unfamiliar with the German health care system and lack of insurance card is a barrier in accessing proper health services at this initial stage of resettlement.

4.7.4 Social and financial support

Most of the participants feel isolated in the refugee accommodation as they do not have good social contacts. Thus, a lot could not communicate with their neighbors due to language barriers. Some of them experienced that they could not get immediate help as in their home country. As Bella shared her experiences in the interview:

"*When I was pregnant last time, I was here in Germany. And there was nobody to take care of me. I have to be strong. I have to take care of my girl. I have to take her to school. I have to cook food for her. And side-by-side, I have to take care of myself. I used to carry juice always in my bag. When I feel exhausted, then I had something with me to drink. I was struggling. Once when I was on the bus, I had a strong pain. Actually, I have to get out from the bus, but I could not. And no one was there to help me*" (Bella, 235-240).

In their home country, most of them live in a big family and if they need any help regarding their health problems, including SRH, they can ask their family members, relatives, and neighbors. In their countries of origin, women frequently visit each other. This interaction is vital as a source of support, as it allows community members to get attached to each other. The family who need help get support from neighbors and communities. Thus, most of the women are missing the tradition of sharing and supporting each other in the community. In this context, Abba shared that:

"In our country, we get help from neighbors and relatives. The neighbors and relatives live very near to each other. My uncle lives very near us. My cousins live very near us. We have a very

close bonding with our relatives, cousins, and neighbors. Our relatives, cousins, sibling helps in such condition. And we have friends. Most girls have a good friendship. So, when we have some problems, or pain in the body, we talk with friends. And my uncle's daughters, cousins are still like teachers for me. When we talk about such things, we talk in our circle. Till now, I share my things with them" (Abba, 64-70).

One of the reasons for poor social connection in the refugee camp is due to the refugee resettlement process. Many refugees are busy with learning the German language, arranging things for resettlement. That's why people normally do not have time to think of the next person. Bella clarified this statement like this: "*Everybody is busy here. Some are working. Some have language class. And most of them, they have their own problem. So, they don't come to help me. I have to do everything by myself"* (Bella, 243-245).

Some participants, particularly the married women are suffering from being far away from family and relatives and are worried about childcare if they get ill. "It's very hard to live alone or far away from family and relatives. Now I think, what will happen to my children when I am ill?" (Abba, 198-199).

Along with these, some refugee women also suffer from a financial problem. One of the participants shared that she had to struggle hard during her pregnancy to know about the medical service, to know the rules and regulation and as well as earn money because, at the initial stage, she was not aware that she could get financial support and help from German Government. So, she had to work hard during her pregnancy. "(…) *I don't have food to eat. If I get food, I gave it to my daughter. Me I was pregnant, but I could not eat because she has to eat. I have to sleep with an empty stomach. I called the father of my child and told the things. I asked him if he could send me some money. But you know what he said. It's not his problem. I said to him, I am pregnant with your child and I need to eat. He said I don't care if you are pregnant or not"* (Bella, 267-271).

Bella further reported that she worked as a dishwasher when she was pregnant so that she can earn some money and feed herself: *"When I got pregnant with my last child, I even worked in Reeperbahn as a dishwasher*" (Bella, 303-304).

4.7.5 Culture and tradition

In most of the Muslim countries like Syria, Iran, and Pakistan women are dominated and hindered from getting various services. Many women lack good education. There are certain rules and regulation for women such as in Iran, girls are not allowed to do sports in public place. This all demotivates women to involvement in public activities. One of the participants of Iran shared that:

"*there are also some disadvantages like I cannot go swimming in public places without covering my whole body (…). And the police and government control you all the time. You have the feeling like you are living in a big jail. There are certain rules and regulations, which you have to follow. But for boys it is good. They can go as they like"* (Mona, 9-13).

Even after settling down in Germany, some women from Syria, Pakistan or Iran still follow their own cultural system. This cultural system is linked with health-related behavior and women are active in doing physical activities like sports which is good for health.

The married women in Iran, Iraq, Syria, and Pakistan are not as independent as women in Europe. Most of the married women depend on their husband and family. Before seeking any health services, they have to communicate with their partner. One participant from Pakistan shared that some women must get permission from their family member before seeking any health care services or before performing medical care. In concerned in this context, Zahra reported that: *"Women are not even allowed by others to undergo medical treatment or visit a doctor"* (Zahra, 28).

There are also certain cultural things which influence women's health. For instance, in some cultural belief in Syria, it is not good to take showers when women have their menstruation cycle. Related to this, Celine shared that: *"But you know in our culture, people say that it is not good to take a shower during menstruation. It is not good when the warm blood flows out of the body and get mixed with cold water or something like that*" (Celine 51-53).

The African women from Nigeria also reported that there is some cultural belief which had established the wrong concept in people's mind. For e.g. in Nigeria, women who are fat or overweight are seen as better than women who are thin and slim. Fat women are seen as women with proper diet. This leads many women to gain weight to have a better image in the society.

4.7.6 Living conditions in refugee accommodation

All the participants mentioned about the unhygienic living condition in the refugee camps. Most of the participants have their own room, but they must share bathrooms and toilets with others. Normally only one toilet and bathroom is available for 25-30 people. Due to this, the toilets and bathrooms in the camps are not clean and hygienic as reported by Nele:

"*Well, we are 5 women in our family and our neighbor has also 5 girls. I think around 25 people. But sometimes there are some people from outside. I will say around with 30 people, we have to share toilets and bathroom"* (Nele, 19-21).

Participants further stated that people in the camp do not feel responsible to clean the toilets and bathroom after using it. There are some women who throw toilet papers and even sanitation pads on the floor. Regarding this Celine shared that:

"The biggest problem is toilet area. Even though there is sanitation bag available where women can throw their used menstruation pads, they do not use it well. Instead, they throw it on the floor or left as it is on the side. Sometimes there are also small blood spots on the floor. It is so disgusting. There are also some women in our camp who left their fallen hairs in the bathroom as it is. It's so disgusting" (Celine 12-17).

Because of unhygienic toilets and bathroom, one participant shared that she always takes cleaning paper with disinfection whenever she had to use the toilet (Ina, 15-17). Nevertheless, the participants of this study try to be healthy by following basic hygiene rules by taking shower regularly. But most of the participants have seen other refugee women in camp who are not utilizing the things in a hygienic way such as sharing razors. Related to this Celine also shared another incident:

"in the morning, one woman was shaving her armpit in the sink. And she just left the dirt as it is. We were brushing the teeth and it is so disgusting. Can you imagine that, how can we brush our teeth seeing that thing? For us, this is the biggest problem" (Celine, 37-39).

Another important reason for the poor living condition is a lack of proper food. The participants who are living in the initial refugee camp are not allowed to cook food as they have not their own kitchen in camps. They get food from the canteen. Most of the participants are not satisfied with the foods that are offered as they offer the same menu on a regular basis. Besides that, they usually offer such foods that are prepared for local environment, but not from the people from the Middle Eastern countries Related to this Abba shared that:

"*We always have the same food. I go only for breakfast and for dinner. For lunch, I don't like to go there because the food is always the same*" (Abba, 146-147).

Due to inadequate food intake, one participant from Syria regularly takes vitamin B tablets, which are available in the market.

Furthermore, in refugee camp it is not allowed to put Refrigerator in their room where they can put fresh fruits for them. Due to this, participants also lack healthy fruits "*We don't eat too much healthy food here because we don't have a fridge where we can put fresh fruits and meat here. And we are not allowed to cook*" (Abba, 184-185).

The participants are also not satisfied with the living conditions in the refugee camp. Foremost, they have to share their room with others. They have to adjust with other unknown people from other different culture. The environment in the refugee camp is normally noisy and some people are disrespectful to others. Related to this Ina shared her story like this:

"I have to share the room with others. My neighbor from Palestine, she used to smoke inside the room. And the smoke comes to my rooms also. I also complain about it, but she did not stop smoking. Then I shift to another room. And the women are very loud. I need peace sometimes, but there is no peace. Some women are crying. Some are talking so loudly. The women living in the camp do not respect or think about others. If they talk in telephone, they use to talk loudly. They don't think for others. And the problem is we are from a different country and we could not communicate well" (Ina, 121-127).

Some women have even problems with their neighbors. They could not make a good relationship with their neighbors. One of the participants had already fought several times with her neighbors.

"*Sometimes, the children from neighbor play in the corridor, in front of my room. They hit my door while playing. I am pretty sure that they are doing it intentionally. I almost beat her once when she was so crude. She was very crude. I asked the little girl, who told you to hit in my door? The little girl said that her big sister told her to do that. I asked her why she said to hit at the door of my room. Then she said that after I use the toilets, the toilet smells so bad. Then I said, you don't go to the toilet then. I even said to her that it is normal, and toilets do not smell like Gucci perfume. I said she, do your toilet smell like Gucci perfume? I really do not want to quarrel in such a nonsense thing"* (Bella, 139-145).

Most of the refugee camp does not have a big room where children can play in winter. A married participant with two children shared that whenever she allows her children to play outside, she gets complaints from her neighbor which she illustrated in this way:

"We were most of the time in the room and for children it is boring just to sit inside the room. And sometimes I let my children play outside, and my neighbors, they complain and tell me that they are making noise. They even called security. We really need a place to sit and to play, which we don't have" (Abba, 139-142)

Almost all the participants were unsatisfied with their unhygienic living condition. They all expressed their problem having a bad social connection with their neighbors and having difficulties to have proper food in the refugee camp.

4.7.7 Stress factors

Most of the refugee women are mentally and physically tired due to their long journey. Most of them had experienced terrible things in their life and journey to Germany. On the one hand, they had to leave their own home country due to war. Most of them are sad to be far away from own family, relatives, and friends. On the other hand, they must struggle hard for their resettlement. As Diva shared:

"*Some women are still traumatized with their long journey and what they have experienced in their life*" (Diva, 121-122).

Some women are afraid for their future. Mostly the women with children expressed their fear regarding their children's health. In addition to that, most of the refugees could not decide themselves where they want to live. The refugee center decides for them where to live, in which city, etc. Thus, they are fully depending on others due to which some of them are in frustration.

"*There are also women who get mentally and physically injured during their journey. They need rest. They need time to recover and the most difficult thing is that they cannot do their things themselves. They are depending on others, as they do not understand the German language. And they must do all that immigration office says*" (Diva, 127-130)

Another factor for stress is adjusting in a different society with a different culture. Most of them already got a cultural shock as there are vast differences Middle East and European Society.

"Most of the women are struggling to adjust in the new society. Most of the women need time to get into German culture. Some of them have got a cultural shock. Most of the women came from another culture where they are not used to see women working together with men, shaking hands. They need time to get into it. I don't think they are taking care of their health" (Usma, 123-126)

Except resettlement issues, refugee women have many more other issues in their life which makes them mentally in a stressed as one participant shared her stressful condition like this:

"At that time, I was very new here. I don't know where I could get medical care. I was stressed with my ex-husband. I am divorced now. He never accepted the child. He never accepted the pregnancy. I was in terrible condition. Unfortunately, the child died, which was a boy. So, it was a really bad time. Whenever I think about it, I feel really bad" (Bella, 249-253).

Other participants also expressed their stress and worries regarding the new beginning of their life in a new country. They are worried about the present condition of their country as well as their future regarding safe shelter, job opportunity, etc.

Some refugee women also shared that they are discriminated by other cultural groups. The woman from Africa expressed that her neighbors in a refugee camp discriminated her in a several ways because of color of her skin. On this subject, she shared her story like this:

"The problem is everywhere in refugee accommodation. There are people from Iraq, Iran, Afghanistan. And they do not like us. Even though we have the same status as a refugee, they hate us. They are really racist. You are in another country. They are providing us with shelter and taking care of us. We are in the same group. They also came as I do, but we black people are treated in a different way. They treat them like superior" (Bella, 152-156).

This kind of discrimination along with their own personal problems, health problems, traumatic experiences in their home country, during the journey and resettlement process in Germany are some stress factors for refugee women which make them difficult to get access to health services.

4.8. Advice and suggestions for women health workshop

The participants of this study were also asked for suggestions for conducting a women's health workshop by REFUGIUM program, which focuses on SRH. Participants gave several advices and commentaries for conducting SRH workshop.

4.8.1 General suggestions for a workshop

Participants provided some suggestions on conducting women's health workshops for REFUGIUM program. They mentioned that women's health workshop should be first conducted with the women participants of REFUGIUM program because they know each other well and how REFUGIUM workshop functions. Regarding this, Nele reported that:

"If we do this women health workshop, then we should first begin with the women who are in the program. Then we can know more or get the idea of how we can conduct the workshop in a better way" (Nele, 418-419).

Another participant Celine suggested conducting a workshop in a small group so that women won't feel uncomfortable or hesitate to share their personal things in a workshop with a few people. As the topic SRH is taken as a very sensitive topic by refugee women, most of the refugee women might feel discomfort to talk about their individual experiences. So, the workshop should start with topics like female hygiene, but not with sensitive topic like sexual violence.

One of the participants suggested that the workshop should be conducted only by a women health facilitator. And only female REFUGIUM team members should be allowed to enter in the workshop room, as most of the women won't feel comfortable to talk in the presence of an unknown man. Related to this, Abba said:

"*Most of the women feel shy to share their problems. They hide their problem as they feel it is a very private thing. We are very shy to share our intimate things and problems. We feel so uncomfortable, so if you want to conduct a workshop for women, it should be only for women*" (Abba, 422-425).

Some of the participants of this study think it will be very helpful for refugee women if REFUGIUM program could develop flyers in different languages and distribute to the women who are living in the refugee camp. Some participants predicted that women might not take part in the program due to various reasons, but they can at least learn something from the flyer. Zahra shared like this in this context: "*At least if you can distribute the flyer about women's health, they get a lot of things to know. The flyer should contain all important topics like help during pregnancy, maternal health, STI, help for women who experience violence etc."* (Zahra, 157-159).

Mostly the participants who already took part in other workshops conducted by REFUGIUM program suggested that the women's health workshops should have more content, unlike other REFUGIUM workshops which contained basic relevant information for refugee women. Ina expressed her views in this way: "*The workshop should contain more information because most of the workshops like nutrition, physical activity, they contain only a few things, I mean information. You can provide a little bit more information. They are very basic. Me, I really want to know more. So, I expected a little bit more from REFUGIUM workshops*" (Ina, 306-309).

These are some specific suggestions of study participants for REFUGIUM program to conduct a women's health workshop.

4.8.2 Suggested SRH topics

Participants were asked what topics they find relevant to women's health workshop. Participants suggested different topics such as female hygiene, pregnancy, menstruation, rights and law and help for women who experienced violence. Among these topics, almost all participants were not aware of the rights and laws regarding sexuality, about the help and support for women who experience violence. Therefore, they suggested including these topics in the workshop.

The other highly recommended topics are to mention some organizations which help women in Germany, as well as the medical care and services during pregnancy, including childcare and maternal care, such as organizations like "Adebar program", midwives help, pregnancy care, etc. "*The information about midwives help, Adebar program, medical service free of charge, such information help women like me during pregnancy*" (Bella, 414-415).

Further on, Bella suggested including the topic of breastfeeding and child parenting in the workshop. She also mentioned the points how women can take care of themselves during pregnancy like being free from any kind of stress "*It is also important to tell women that during pregnancy women should not take a lot of stress. If women suffer from stress, it directly affects*

the health of the child inside her belly" (Bella, 420-422).

Some participants were also curious to know about gynecologist services as they are not sure when they can visit a gynecologist. Some participants also mentioned the topics like U-Untersuchung, care during pregnancy, menstruation and STI. None of the participants suggested the topic family planning and information about women's physiology.

There were also participants who were interested to learn about various women's diseases like breast cancer and its screening program. Mona shared in this context like: "*it will also be helpful if you give hints or information about the organization which helps women in this topic. It would also be nice if you also give information about U-Untersuchung, or where we can do screening for breast cancer such things are also important"* (Mona, 207-209).

One of the participants suggested to include self-defense training for women in the workshop as a practical part where they can learn how they can protect themselves in a difficult condition like sexual harassment. *"You can also put self-defense training in the workshop. The self-defense training that we had in Köln was very helpful, especially for the single women like me. I am single and, usually, I have to go everywhere alone, and it is good for us to be strong and to take care of ourselves"* (Ina, 300-303).

Some participants also showed interest to know about the health insurance coverage as most of the refugees are very new in Germany. Many refugees are not well informed about the health insurance and the medical services that are covered by health insurance company. The SRH topics recommended by study participants for women's health workshops are listed below in the table:

Table 9 Suggested SRH topics by the participants

Recommended SRH topics by the participants
➢ Female hygiene ➢ Menstruation and care during Menstruation ➢ Gynecologist services ➢ Health care services for pregnant women ➢ Health care services during childbirth ➢ Health care service for child health ➢ Rights and law regarding sexuality ➢ Services concerned to STI ➢ Counseling center for contraceptives ➢ Help and support for women who are victims of sexual and gender-based violence ➢ Health care services covered by Insurance in Germany ➢ A screening program for cancer

(Source: own Illustration)

5 Discussion

5.1 Summary of the findings

Refugee women in Germany belong to a diverse group as they come from countries with different cultural backgrounds. The refugees participated in this study originated from Syria, Iran, Iraq, Pakistan and Nigeria. These women have varied perceptions towards the state of “being healthy”. Women from Syria, Pakistan, Iraq and Nigeria related good health with being free from diseases, whereas women from Iran associated good health also reflects in their beauty and outlook. Most of the refugee women do not give huge priority to their health. Due to horrible experiences from conflicts and dysfunction in their home country and their long, difficult journey and resettlement process in the new country, refugee women are not in a condition to “think” about their health. For some of them, to be alive and to see their family well is highly prioritized than their own health. Specially, the married women with children are more conscious about their family and children but unfortunately, not their own health. However, some educated refugee women showed more consciousness and practiced healthy behavior such as sports, healthy diet etc.

Refugee women in overall were not found to be conscious about their sexual and reproductive health (SRH). The topic SRH is taken as a very sensitive topic in most of the Islamic countries. Thus, most of the refugee women feel uncomfortable to talk about SRH except the women from Nigeria. Most of the women related SRH with pregnancy, care during childbirth, maternal health, menstruation, female hygiene, childcare, breastfeeding as well as diseases like breast cancer, ovarian cancer etc. The married women were found to have a wide view on SRH in comparison to single women as they already experienced pregnancy and know the importance of care during the pregnancy.

Comparing the women from five different countries, refugee women from Syria, Pakistan, Iraq have comparatively less knowledge on SRH than women from Iran and Nigeria. One of the reasons is lack of any forms of SRH education in their home country. Many women in remote areas are deprived of education. Even in the areas with access to schools SRH is not included in curriculum as teachers hesitated to talk about those topics. Thus, women generally get information from their sister, mothers and friends. Mostly in Muslim countries, women do not share their SRH problems with a male member of their family. In contrast to that, women in Nigeria could openly share their problems with male member of their family. These days, refugee women are also found to using internet to get information regarding SRH especially after their resettlement in Germany. Thus, there is both need and demand of SRH education among refugee women.

Although participants have very little idea about SRH, they shared their different problems during this study. Most of the unmarried participants have pain during menstruation. Despite having severe pain, they hesitate to visit a doctor. Instead they rely on bed rest, drinking hot tea etc. which sometimes helped to alleviate the situation, but in many cases it didn't. Some women also shared about pre-menstrual syndromes like irritation, mood swings, etc. Most of the women are, however aware of female hygiene especially during menstruation.

Another SRH issue among the refugee group is early and forced marriage where most of the girls from poor social background are affected (at the age of 15/16). Especially in Syrian girls, early and forced marriages have been associated with the conflicts. In many cases family were known to get their daughters married in the hope of protection from their husband. In some remote area of Syria and Pakistan, there is still the tradition of arranged marriage where the family member chose a life partner for a girl. In Iraq, there are still some people who follow the polygamy i.e. a man gets married to many women. Thus, some women are deprived of their rights to choose their own life partner. They are neither aware about the rights regarding sexuality.

Because of early marriage, women get pregnant at an early age. These pregnant women might face complication during their pregnancy and childbirth. These women also lack sufficient knowledge of childbearing, breastfeeding and thus could not properly take care of their children and their own health. There are many women in Nigeria, who suffer from urinary tract infection due to childbirth at an early age. Furthermore, women suffer many difficulties during pregnancy like having severe physical pain, mental stress etc. These further on, have bad impacts on the health of newborn and the mother. Refugee women at the initial stage are unfamiliar with the health care system in Germany and thus lack proper medical care and support. Due to this, a woman from Nigeria also lost her child. In comparison to single women, married women with children have better knowledge on the care during pregnancy from their own pregnancy experience.

Abortion is another SRH issue, which is not legal in most of the Islamic countries except when a woman's health is in danger due to pregnancy. But there are also cases, where women got pregnant before marriage. In such cases, abortion is mostly performed in secrecy. However, a woman cannot take the decision alone, for an abortion, both husband and wife should decide together. Nowadays women in Muslim countries are also following the family planning concept. Mostly educated and employed group is aware of family planning and contraceptive methods. However, women's decision about family planning and contraceptive use is based on her partner's decision. Therefore, men's knowledge on SRH also influences the women SRH behavior. There are also some married women who do not use contraceptives because of its negative side effects such as weight gain, skin damage etc.

Regarding Sexually transmitted infections, refugee women have very inadequate knowledge. Most of them are only familiar to HIV and Aids. Only few of them know about other STIs such as Gonorrhea, Syphilis etc. Other important issue regarding SRH is sexual and gender-based violence. Refugee women also expressed concerns that there are high risks of sexual violence inside the camp as well as outside the camp, even with the security. Few refugee women in this study had also experienced some kinds of sexual abuse outside the camp. However, it was mentioned they feel comparatively safer here in Germany. Refugee women also admit the existence of domestic violence in their culture due to unbalance power relation between men and women. They also mentioned women who are victim of violence are blamed for herself and there is no help and support for such victims in their home countries.

Refugee women who are living in Germany for a short time (1-2 years) do not get enough information about different health care services including the SRH services. Most of them knew about the availability of general physician in their camp and gynecologist service. Only few married refugees were aware about some medical care and service for pregnant women. Most of them were not aware about the pregnancy counseling center, counseling for STI, counseling for family planning and contraceptive, help and support for victim who experience sexual and gender-based violence. Similarly, women are also not aware of other health promotion programs like REFUGIUM. Only a few of them know about Caritas Hamburg, Adebar Hamburg and Aidshilfe Hamburg. None of them knew about BZgA and its website Zanzu which provide SRH information in different languages. That signifies that refugee women need to be informed about the available health care services in Germany. In addition to that, refugee women have only a few SRH services in their home country and hence behavioral aspect may have led to low utilization of such services here in Germany.

There are different barriers, which hinder refugee women in getting access to health care services in Germany. For most of the women communication is a huge barrier. As most of them could not speak German fluently, they are afraid to seek health care services. Moreover, SRH is taken as taboo topic, and they find it very hard to communicate about it with others. The gender of the health care workers also plays a significant role among the refugee women's group. Most of the refugee women preferred to get medical checkups from the same gender. As most of them have low language skill, they needed help from an Interpreter for translation. Even the Interpreter was expected to belong to the same gender, as women feel ashamed to tell their problem with other unknown men. Beside this, for many refugees the health care system in Germany is very new. They first have to know how the health care system works. Most of them still do not know about the health insurance coverage and some of them even have not got health insurance card which inhibits them to undergo medical checkups.

The next challenging factor for refugee women is the poor living condition in refugee camps. Many refugee camps have turned out to be unhygienic. Mainly the toilets and bathrooms are not clean as around 25 to 30 people normally use single toilet and bathroom thought the day. The overall environment and surrounding of refugee accommodations are unpleasant, noisy and crowded. Most of the initial camps for refugee do not offer kitchen, so the foods are offered in the canteen. Most of the refugees are not satisfied with the food that is offered in the canteen. That's why many were found to skip the lunch or dinner, and they admit that they are not getting a proper diet. Even the refugee women, who have a kitchen in the refugee camp must share their kitchen with others. But the women find very hard to share the kitchen with others as she could not build good relationship with her neighbour in camp. Due to this, most of the refugee women feel isolated in the new place, and they lack help and support from their relatives, friends and neighbors which they used to get in their home country. Some women are also mentally stressed with their private issues so that they could not focus on their health. Some women even mentioned that they are discriminated in many ways, especially inside the camp. Thus, all these factors are stressing them so much that they are not actively utilizing the available health care services or seeking health care services regarding SRH in the new place.

Apart from this, only few services are offered in refugee camps to promote refugee's health. There are availability of general physician, counseling for mothers, special doctors for children, activities such as Yoga class, German language course, support for finding a professional interpreter, etc. But there has been very little done in the field of SRH in refugee camps. Hence, there is need of services related to SRH in refugee accommodations.

Refugee women also showed their interest to gain some information regarding SRH. As most of them lack information about different SRH services, they are curious to know about the services during pregnancy, childbirth etc. Some women were interested to know about care during menstruation, female hygiene, women's rights, rights and law regarding sexuality, STI, help and support for women, especially regarding gender-based violence, diseases like cancer etc. Some of them desired to know more about insurance coverage in Germany. Only a few women showed their interest in family planning and contraceptives. Hence, it seems very crucial to discuss on different issues of SRH among refugee women.

5.2 Discussion of results

The main aim of this paper is to find out the needs of refugee women regarding SRH. The result of this study presents that refugee women living in the camp are not very conscious about SRH. It is clear from the findings that they lack SRH education and not an adequate background from their home country. Due to this, they are not giving priority to SRH even if they are experiencing many chronic and new issues. They are not seeking help and support to as well as a lot of women are also not aware of the health services that are available in the new country. Furthermore, they go through many barriers which are hindering their access to SRH care. However, the results of this study do not include the topic like parenting, family formation, breastfeeding, menopause etc.

Some of these findings obtained from the study resembles with many other previous researches. The study conducted by Common health welfare in Australia also presents similar results like the low utilization of health care services by refugee groups. They also present the challenges that refugees faced such as communication problem, cultural differences etc. (Commonwealth of Australia, 2010). Refugee women being a vulnerable group are a victim of sexual and gender-based violence is also presented in this study, which resembles with other scientific researches conducted with refugee women such as from Ivanova et al. (Ivanova, Rai & Kemigisha, 2018).

As the topic SRH is taken as very sensitive and a taboo especially in the Middle Eastern Islamic countries, it was very challenging to communicate about it with the women who arrived mostly from those countries. Therefore, the participants of this study also showed hesitation and discomfort in talking about SRH topics. Apart from this, if the researcher also belonged to the same cultural group, the participants might have expressed their views and opinion more openly. Thus, the researcher being from a different culture background might have also played some role for not being able to completely open them up during the interviews.

The result of this study could be more representative if the study could include a large sample size. Altogether we were able to gather 11 participants, which is a small size. The sample of this study consists of refugee women from different countries namely Syria, Iran, Iraq, Pakistan and Nigeria. But there are also many refugee women in Germany from other countries like Afghanistan, Eritrea, Turkey and Somalia etc. But this study does not include the participants from these countries. Thus, the result gained from this study could not be valid for another refugee group living in Germany. Further on, more than half of the participants in this study are well educated. There might be further emerging themes related to SRH when the study had included other participants with low education level. It is also important to consider that it might be more challenging to get contact with the refugee women who are not well educated due to the language barrier and their low participation in integration activities. All the participants of this study are living currently in Hamburg. So, there might be another need and demand of refugee women

living in other places as health care services, living condition of refugee women may vary in different city. Moreover, most of the women are from the age group 20 to 45. So, there might be other needs if the study will be conducted with wider age group as well (older generation).

Among eleven participants, there were only four refugee women who are married and have children. If there were more women with children, there might be another SRH issue and the results might explore more issues in the topic like family planning, contraceptive, domestic violence etc. More than half of the participants in this study are unmarried and haven't experienced any sexual relationship. Therefore, they haven't dealt with family planning, contraceptives, pregnancy. This might be one of the reasons that, most of them don't have knowledge about the availability of counselling center regarding contraceptives, family planning, services during the pregnancy. Hence, the results of this paper need to be studied in a larger sample for validity including different women from different age group, different countries, religious group, sharing different culture etc.

The participants were also asked about the health consciousness and health related behavior of other refugee women living in the camp. But, most of them could not provide information about the other refugee women as they have no good contacts or hesitation to talk about others. However, they were able to provide some information generalizing the women from their home country. Regarding consciousness about SRH, most of the participants were silent at the beginning and they needed time to think what is meant by sexual and reproductive health. Therefore, in some interviews the researcher made easier by explaining about SRH. Some of the participants were also not familiar with the term family planning, contraceptive, STI, sexual rights. These terms need to be explained or translated in their native language through Google translator before the participants could share their views on it. Before answering, some participants took time to come out with shyness and share their views and problems like problem during menstruation, experience of sexual violence etc. Regardless, participants were very enthusiastic while sharing their problems, which they are facing in the refugee camp such as unhygienic condition of toilets and bathrooms, unsuitable foods, feeling of unsecure environment in the camp, difficulties to know German health care system etc.

As most of the participants were not native German or English speaker, Google translator was used for translating the interview questions. It could be better, if there was a professional interpreter. But due to limited financial resources, it was not possible to get a translator. Also, the team member of REFUGIUM program who is native Farsi or Arabic speaker could not manage time at the time of interview. With Google translator there is a high chance that the sentences or some words might have not translated accurately. Therefore, there might be some misunderstanding in understanding the question. Some answers from the participants showed

that the questions were translated making another sense that the participants gave the answer in another subject area. Thus, the result interpreted from such statements might make bias in the findings. Another point to be noted is the present paper is written in English although some interviews were conducted in half German, half English. It is sometimes difficult to translate the content of the interview without losing the actual meaning.

Being a researcher, it was sometimes difficult to be in a neutral position as there were some moments when participants shared their problems regarding their unpleasant living condition. Some of them are still traumatized from what they experienced in their country or during migration and the participants were very sensitive while sharing their stories and experiences. Despite such limitations, this paper contributes to know gap in the knowledge regarding SRH among refugee women and to explore the SRH issues this under-researched vulnerable group.

5.3 Discussion of method

For this research, the chosen qualitative approach was appropriate to explore the needs of refugee women regarding SRH which helps to provide the real-life phenomenon of the target group (Flick, 2016, p.28). The interview with refugee women helps in gaining a detailed understanding of their living conditions, their health consciousness about SRH and available services.

Within a qualitative method, 2 focus groups and 7 face-to-face interviews were conducted in a different time. The first challenging factor is the development of an interview guideline. As the topic sexual and reproductive health is entrusted with the private matter of an individual and not openly communicated in the Arabic-Asian culture, the questions should be formulated in a way that participant can share their views, experiences without any hesitation. To reduce the hesitation and discomfort among the participants, the interviews and the focus groups were started in form of small talk. Secondly, as most of the refugees could not speak fluent German or English, the interview questions were formulated in simple ways so that the participants could understand easily. However, the interview questions consist of some terms, which are not familiar to participants. The terms like SRH, family planning, STI, contraceptive had to be explained or translated first in participants native language before they could share their views on it.

The REFUGIUM program follows the participatory action research in which the target group is involved in the research process. The same was the concept of this study. To get access to refugee women, all the female participants of REFUGIUM program were contacted either personally or through a phone call or sending messages. They were informed about the research and requested to take part in the study, but only a few showed their interest. Most of the female refugees feel uncomfortable to talk about this topic. This might be the reason that the participants

came up with excuses for some appointments. Another reason could be due to language barrier and trust issue. The researcher also contacted another organization “Patenschaftsproject of BergedorferfürVölkerverständigung” to get more participants for research. Moreover, the researcher also joined in the workshops, which were conducted in cooperation with Mut Café Afrika and Aids Hilfe Hamburg to get access to target groups. But the recruitment process turned out to be one of the difficult part of this study.

As it was hard to get participants for this research, it could not work as planned. At first, it was planned to conduct only focus group i.e. one focus group with an Arabic speaking participant and one focus group with Farsi speaking participant. But it was hard to fix the date and time suitable for all participants. In the first focus group, four participants had planned to join in the study but only two of them showed up. For the second focus group, three participants intended to come but at the end only two of them were present. Therefore, face-to-face interviews were conducted later so that the researcher could meet one participant at one certain time and it was easier easy to fix the appointments. Hence, face-to face interview turned out to be reliable, appropriate and efficient in this study. But the whole data collection phase was highly time consuming which resembles to one of the features of a qualitative study (Creswell 2013, 96).

Another problematic issue in this research was conducting focus group alone. For conducting focus group, a researcher had to manage suitable room and devices to record the interviews. The group room available at HAW Library in Berliner tor 5 or in Alexander Street 1 Hamburg were booked for around 1 and half hour for the focus group. But most of the participants did not come punctually so some interviews could not start as planned and the booked room for interviews could not be used for full hours. Therefore, in some interviews there were breaks in between. At the same time, there was difficulty in finding a replacement room or a suitable other place in a short time. In case of 2 interviews conducted at the participant home, there was presence of children who required more attention. Thus, the interview had to be stopped for 2-3 times in between. Therefore, there was no consistent flow of communication during the interview which might also have an indirect impact on transferring information.

Another tough part of this study is the topic itself. As the topic related to SRH is not communicated well in the countries like Syria, Iran, Iraq, Pakistan, participants could not freely share their views, opinions on this topic. Even as all the questions for the focus group and interviews were open-ended, which was meant to motivate the individuals to share their ideas and views freely, the participants felt uncomfortable in sharing their views. From the researcher’s point of view, it was easier to communicate with participants who had already taken part in REFUGIUM program as they were acquainted before. While comparing, the participants in the focus group were more

passive and silent than in face-to-face interviews. In addition, the later one was more open and provided a lot of information.

In terms of analyzing collected information, the systematic approach of the qualitative content analysis by Mayring (2014) was appropriate. The inductive approach of working through the transcripts, developing appropriate categories and assigning relevant paraphrasers to the categories was suitable to explore the research question. However, the data analysis took a long time as the collected notes and recording from interviews and focus groups had to be transcribed and saved in the computer.

Hence, there were some limitations in the data collection and analysis procedure of this study. However, the interview and focus group with refugee women helped in gaining a depth understanding on the different perceptions of refugee women towards SRH, their awareness level, SRH issues, awareness about available health services and their difficulties in accessing those services.

6 Recommendations

The less knowledge about SRH and less awareness about health care services among refugee women signifies that there is a need for SRH education. REFUGIUM program as a health promotion program can provide SRH education in form of heath workshops which it is offering in different subjects such as mental health, nutrition, etc. As Murphy (2004) stated that access to information and education is a powerful determinant of health" (Murphy, 2004, p. 187). REFUGIUM program can implement this idea to promote the sexual and reproductive health of refugee women. The important and relevant information for refugee women regarding SRH is provided in this chapter as a recommendation. At first the general recommendation for conducting women's health workshops focusing on SRH is given. The second part of this chapter provides the relevant SRH topics such as different services during pregnancy, service regarding STI etc.

6.1 General recommendations for REFUGIUM workshop

The women's health workshop, which focuses mainly on SRH is intended to develop, especially for refugee women living in Germany. The large proportion of refugee women is originated from Arabic culture with Muslim religion (BAMF, 2018) who feel very shy to share their problems and issues regarding SRH in front of strangers, especially with unknown men. Thus, the workshop should be conducted by a female health facilitator. To build a trustful atmosphere during the workshop, no male member should be present in the workshop.

The workshop participants can consist of single as well as married women. Therefore, the workshop should also offer childcare facility so that it motivates the women with children to take part in the workshop. The workshop participants could be from different countries, different religion, different ethnicity, culture, etc. Therefore, in the workshop the health facilitator should respect all the participants equally and there should not be discrimination in the name of religion, skin color, education level etc. All the participants should be given equal chance to share their experiences, problems and views. Along with this, the workshop should be conducted in a non-hierarchical manner where the health facilitator as a moderator should not treat herself as qualified person than the participants. This also helps in building trust from participants and due to this, participants might feel comfortable to contribute their knowledge and experiences. Beside this, the health facilitator of the workshop should be interculturally competent.

As the workshop is dealing with a very sensitive topic SRH, that's why the workshop activities should be dealt very carefully. The results of this study have illustrated that the women normally do not communicate openly about the problems and issues regarding SRH. Thus, the workshop should not start with sensitive topics like sexual violence right at the beginning. It should rather begin with the topic like female hygiene, care during pregnancy, contraceptive, maternal care

where women won't feel much discomfort. If there is a large number of participants in the workshop, women might not dare to share their views and opinion. So, it would be better if the workshop takes place in a small group (for e.g. maximum 8 people). In a small group it is also easy to create a peaceful environment and the health facilitator can also build trust among the participants. Building a trust between the facilitator and participants helps to increase the communications level among them.

The materials like flyers and manuals are the key elements of the REFUGIUM workshop. While developing flyer and manual, the aspects of culture sensibility should be considered. For e.g. the flyer should contain a woman with dark color hair instead of faired hair women. The symbols, pictures which will be published on the flyer and manual should represent the refugee women. While developing a flyer and manual, the use of scientific terms should also be neglected. The flyer and the manual should be developed in simple language and if there is any scientific terms or difficult terms, then it should be explained well. The explanation can be either done orally by a health facilitator or by giving explanation in the flyer or manual.

While conducting workshop, participants should be integrated into the discussion. The workshop should provide a platform for refugee women where they can share their problems and issues and discuss about it. Thus, the workshop should provide sufficient time for discussion so that participants can clarify questions if they have questions that have not been answered. At the end of the workshop the participants should also get time to give feedback about the workshop as well as health facilitator. From the feedback obtained from participants, the workshop could be improved further.

As public health interventions can be highly effective when it is implemented in the setting where the target group lives, thus it is highly recommendable to conduct refugee workshop in different refugee camps. Therefore, REFUGIUM program should cooperate with different refugee accommodations to get access to the target group.

6.2 Specific sexual and reproductive health topics for women's health workshop

Based on refugee woman needs, desires, and their interest and curiosity to gain the information regarding SRH topics, following topics are selected and recommended to include them as a workshop content in a women's health workshop on REFUGIUM program.

Women's rights in Germany

Most of the refugee women belong to the culture, where women have not equal rights as men. There is a power imbalance between the women and men thus refugee women should be informed about the women's rights to empower women. They should be informed that they have

the right to access affordable and culturally appropriate SRH care. They should know that they receive the same services regardless of their level of need in Germany i.e. equity where people's access to services is based on the need for those services. Regarding this, the workshop should provide following messages:

- Every woman has the same rights as a man
- Every woman has the right to be treated in a way that respects her dignity
- Every woman has the right to make her own life decisions, to speak freely, to act on her own behalf and in her own interest
- Every woman has the right to choose her partner freely and to have sexual self-determination
- The refugee women have equal rights as other women living in Germany also regarding SRH

(World Future Council, 2016, p. 24)

Gynecologist services in Germany

Even most of the refugee women know about the gynecologist service in their own country and in Germany, but they are not sure when to visit a gynecologist. It will be very helpful for women to know when they can visit a gynecologist and what kind of services they can get from the gynecologist. Through workshop the refugee women should be informed that if women have following symptoms, they can get service from a gynecologist:

- If women have pain in the abdomen
- If women have problems with urination or defecation
- If women have bleeding without menstruation
- If the menstrual period lasts more than ten days
- If the periods often occur in too short intervals (less than 25 days)
- If the menstrual period is very severe/painful
- If the menstrual period is absent for more than 30 days
- If the menstrual period is absent for more than 30 days
- If puberty has not started by the age of 15 (there was no menstrual period till the age of 15)
- If women experience itching and unusually strong or smelling discharge from the vagina
- If women feel pain during or after sexual intercourse
- If women have bleeding after intercourse
- If women suffer from a headache and blurred vision or other side effects when taking contraceptive method

  (BZgA, 2017, p. 18)

Women should also know that the gynecologist is the responsible person to look for cancer screening, reproductive health, urinary tract infections, STI, etc. (BZgA, 2017, p. 19).

Service and care during menstruation

According to the statements from study participants, refugee women feel shy to talk about the menstruation. Due to this, they do not share their problems like pain during menstruation to others and try to hide the problem. They do not seek help to get rid of the problems like by visiting a doctor or gynecologist. Thus, refugee women need to be informed about the following points:

- Menstruation is a natural process and every woman has it. Therefore, there is no need to hide and feel shy
- Women can get help from the gynecologist when they have strong pain during menstruation
- During menstruation, women should put their body clean, eat a healthy diet, do light exercise, avoid alcohol or caffeine, get enough sleep
- Women should change tampons or sanitary pads regularly
- Women should avoid wearing tight pants as it may cause a bacterial infection
- Women must not shave pubic hair for the good health
- Women can have sexual intercourse, but unprotected sexual intercourse has high risk for HIV
- If the menstrual period stops, but the pregnancy test is repeatedly negative, women should go for an examination in a medical practice or gynecologist

(BZgA / Sensoa, 2019)

If women have pain during menstruation, they can reduce the pain by the methods mentioned in the table below:

Table 10 Tips to reduce pain during menstruation

Tips to reduce pain during menstruation
- Women can take a hot bath or hot shower - Women can place a heat pad or a hot water bottle on her stomach or on her back - They can drink a relaxing tea (chamomile tea) which helps in reducing pain - Women can also do a light workout or some relaxation exercises - In acute pain, women can ask in a pharmacy for an appropriate medicine or visit the gynecologist.

(Source: BZgA & Sensoa, 2019)

Service and care during pregnancy in Germany

Being pregnant is one of the turning points in the life for every woman. But, most of the refugee women are not aware about the services offered for pregnant women in Germany. Therefore, it is important to inform them about the available services during pregnancy and childbirth. Following information might help refugee women to know about the different services provided during pregnancy and childbirth:

- Every pregnant woman in Germany has a legal right to adequate medical examination and counselling
- Women can do a pregnancy test by themselves in their home with a pregnancy test device which are available at drugstore
- To get accurate results, women can do a pregnancy test by the gynecologist or in clinic, or by midwives
- Pregnant women should regularly visit the gynecologist (at the beginning, every four weeks and from the 32nd week of pregnancy, every two weeks)
- Pregnant women should follow the gynecologist's tips like eating healthy food, avoiding food that harms pregnancy like raw meat, raw fish, raw egg, etc.
- Pregnant women can do prenatal diagnosis to determine whether the child has certain diseases or malformations which can be treated during pregnancy.
- Pregnant women can do ultrasound examinations at 10, 20 and 30 pregnancy weeks
- After the child birth, women can get midwives service for the newborn
- Pregnant women have the right to search pregnancy counseling center, which helps woman for all non-medical questions such as social and legal matters both before and during pregnancy
- Pregnant women should take medicines only after consultation with their doctor even though they are taking regular medicine, or they are taking any herbal remedies due to any chronic illness. Medicines can affect the birth process or development process of the child and milk production in the mother
- The costs of prenatal care will be paid by health insurance companies
- In Germany refugee women can also get financial support if they have insufficient funds to meet the expenses of pregnancy and birth and for growing up the child. In case of working women, they get maternity leave which begins six weeks before the birth and ends eight weeks thereafter

(BzgA, 2019; BZgA, 2014; BZgA, 2017c; Caritas Deutschland, 2019)

Pregnancy is a long journey in which maternal, perinatal and newborn health should be given a huge priority. Parents' overall health and their lifestyle before and during pregnancy can affect

fertility, infant's health as well as maternal health (WHO, 2019). Thus, the workshop can provide basic healthy living tips for pregnant women, which are mentioned in following table.

Table 11 Healthy living during pregnancy

Healthy living during pregnancy
▪ Avoid smoking and alcohol ▪ Stay physically active ▪ Have balance diet (take diet supplemented with iodine and folic acid) ▪ Take small meals frequently, if women feel hungry often ▪ Avoid harmful food during pregnancy, such as raw meat, fish, egg etc. ▪ Avoid heavy physical work ▪ Avoid stress

(Source: BzgA, 2017b)

Pregnancy at early age in Germany

Refugee women have often high risk to get married at an early age. Hence, they should be informed if a woman aged under 20 is pregnant then she has a higher risk of having a difficult delivery. The baby might risk premature birth, or low birth weight, which has further on risk for illness (BZgA, 2017). Moreover, if a girl or woman gets unintentionally pregnant or if she is against pregnancy, then she can get help from a pregnancy conflict counseling center. They help women in such condition showing different possibilities. They inform about the services that help women in pregnancy and to grow up a child and live with a new child (BZgA, 2018c).

Abortion in Germany

Following information regarding an abortion can be relevant for some refugee women:

If a woman has unintended pregnancy and does not want to have a baby, then she can do an abortion. In Germany, an abortion within the first twelve weeks after conception is legal if a woman can prove that she was in pregnancy counseling before (BZgA, 2017, p. 84). Except that, there must be at least three days between counseling and abortion date. An abortion in Germany must be performed by a doctor, who may not have been responsible for the consultation (BZgA, 2017, p. 85). In some cases, abortion is not illegal if the girl is not yet 14 years old at the beginning of her pregnancy or if a pregnancy is the consequence of a sexual offense like rape and sexual abuse. An abortion beyond the twelfth week of pregnancy is also allowed in Germany if there is medical indication like if the pregnancy is seriously damaging the physical or mental health of the pregnant woman and if the danger cannot be averted in another way except abortion (BZgA, 2017, p. 85).

Services regarding contraception in Germany

Contraceptives help women to prevent from getting pregnant, especially unintended pregnancy. Refugee women have generally negative perception towards contraceptive. They are afraid to use contraceptive. Thus, it is important to inform the refugee women that contraception is not bad for health. To each person suits a contraception based on a person's lifestyle, age and physical condition, etc. For that, a woman can ask a health professional for advice (BZgA, 2018d). Following information concerning contraceptives might help refugee women to enhance their knowledge:

- In Germany, people can trust health professional (gynecologist) and share their problem as they are obliged by law to respect the privacy of people and cannot misuse any information
- All usual methods of contraception are easily available in Germany
- Every individual has rights to choose certain methods which suits to them
- Contraceptives such as hormonal contraceptives (the birth control pill, implants, injections), IUDs (intrauterine devices such as the spiral), and diaphragms can be taken only when they are prescribed by a gynecologist
- Contraceptives like condom are easily accessible at every drugstore or pharmacy
- Condom is one method of contraception that also protects against HIV and reduces the risk of STI

(BZgA, 2018d)

In Germany, people usually have to pay themselves for contraceptives. But there are some exceptions: In the case of young women who are insured by a statutory health insurance, the health fund covers the costs of medically prescribed contraceptives (the pill, the mini-pill, the contraceptive patch, vaginal ring, three-month injection, hormonal implant, spiral and emergency contraception). There are also counselling centers for contraceptive in Germany. Many refugees are not informed about it. So, it is important to aware them about counselling centers and the services provided by counselling center (BZgA, 2018d).

Information regarding STI

As most of the refugee women know about HIV and Aids but do not have sufficient knowledge of other STIs. It is important to share knowledge about other STIs such as Herpes, fungal, Gonorrhea, syphilis, genital warts which are becoming common nowadays. Following information regarding STI can be shared in the women's health workshop:

- STIs are triggered by different pathogens such as bacteria, viruses, fungi or parasites
- STIs are spread primarily through person-to-person sexual contact

- A mother with STI can transfer the infection to her newborn during pregnancy, or delivery or through breastfeeding
- People can also get the STI by sharing injection
- The disease like hepatitis B can be transferred by sharing toothbrush, towels and bed linen with someone else
- Unsafe sexual intercourse increases the risk of STIs
- Most STIs can be treated and cured
- Condom is one of the cheapest and easiest means to protect against many STIs, especially against infection with HIV
- Depending on STI, vaccines can also protect against many infections
  (BZgA /Sensoa, 2019); WHO, 2018; BZgA, 2018e)

Furthermore, it is important to share them that, different STI can be treated differently. For the therapy and treatment people should seek the health professionals. People can also get information without any charge from the responsible counselling agencies or from local health office in Germany. Some of them are listed below.

Table 12 Service centers, which provide information on the STI

Service centers, which provide information on the STI
▪ General practitioners ▪ Health insurance funds ▪ Local health office ▪ Pro Familia ▪ AIDS counselling Center ▪ The Migration Advisory Service for Adult Immigrants and the Youth Advisory Service.

(Source: Federal Office for Migration and Refugees, 2015)

Services regarding sexual violence in Germany

Refugee women often experience sexual violence, including domestic violence. And they are also not aware of their rights and available support services in relation to domestic and sexual violence. In this study, none of the participants knew about the helpline “violence against women”. Therefore, it is very important to inform refugee women about the help and support services available in Germany. The REFUGIUM workshop can provide following message through the workshop.

If women get victim of sexual and domestic violence

- She should not hide it
- She should seek for help and support
- She can call in the helpline violence against women
- She can also get help from police
- The violence against women help all women with and without migration background
- This "Violence Against Women" provide free, anonymous, confidential, barrier-free, multilingual advice by phone, email or chat
  (BZgA /Sensoa, 2019)

Further on, women should know that all victims of sexual violence, particularly women and girls, have equal protection and access to justice and they have the right to make decisions about reproduction, free of discrimination, coercion or violence (Garcia-Moreno & Heikl, 2009, p.146). The workshop can also provide self-defense training as a practical part which was mentioned by one of the participants of the study.

Cancer Screenings in Germany

For every woman over the age of 20, both state-funded and private health insurance in Germany covers an annual exam at her gynecologist to check for early symptoms of cervical cancer, ovary cancer, breast cancer, and similar cancers of the reproductive organs.

- Breast exam (usually for women over 30)
- Rectal exam (for women over 45)

The German health insurance provider should pay for this yearly examination since it is part of basic medical care in Germany (BZgA /Sensoa, 2019).

Organizations supporting refugee women in Germany

Here are some organizations which are working to promote refugee's health in Germany. Refugee women can get different kinds of help and support from these organizations. Therefore, refugee women should be informed about these organizations.

Caritas Deutschland: They provide counselling for migrant women about pregnancy, medical service, financial support, etc. (Caritas Deutschland, 2019).

ADEBAR Beratung und Begleitung von Schwangeren und Familien (Hamburg): ADEBAR supports the family with a special burden in coping with their everyday life. They help mothers by providing parenting skills, good parent-child bond, in improving the health of the child such as with breastfeeding, etc. (ADEBAR Beratung und Begleitung von Schwangeren und Familien).

CASA blanca: They offer free and anonymous HIV/AIDS test (CASA blanca).

The Deutsche AIDS-Hilfe: They provide HIV therapy and counselling for people infected with HIV. The counselling can be directly with the person, or over the phone as well as online. Normally the counselling is provided anonymously (The Deutsche AIDS-Hilfe).

The Hamburg protection plan: It targets to protect refugee women from violence, especially gender-based violence in refugee accommodation centers. The protection plan lays out a minimum set of infrastructural measures that needs to be implemented in all facilities. These include separate rooms and sleeping areas with lockable doors, gender-segregated and lockable sanitation and health facilities and the possibility of gender-separated accommodation facilities for particularly vulnerable persons (World Future Council, 2016, p. 17).

Campaign: "No Camps for Women and Children / Abolish all Camps": They organize empowerment training and peer education workshops "from refugee women to refugee women" (World Future Council, 2016).

EmpowerVan – Mobile Information and Advice Service: The EmpowerVan is a mobile information and advice service in a multi-van that regularly visits initial reception centers and accommodation in Hamburg. Its goal is to counteract the isolation of girls and women in reception and accommodation centers. The van is used as a safe space to assist women with everything from medical appointments to finding new accommodation if a woman has experienced abuse. It also provides an area for women to meet, interact and share experiences (World Future Council, 2016, p. 36).

MiMi – Violence Prevention with Migrants for Migrants: Capacity Building for Violence Prevention, Self-Protection and Empowerment for Refugee Women and Girls in Germany: This project aims to inform refugee women and girl about the different forms of violence and possibilities for protection in a way that is culture, language and gender–sensitive through intercultural mediators (World Future Council, 2016, p. 25).

Zanzu – The multilingual online portal for sexual and reproductive health: Zanzu is a web portal that provides comprehensive information on SRH in 13 different languages which is free of cost (Zanzu, 2018).

7 Conclusion

In Germany, there is a high inflow of refugees since last few years. Due to overwhelming refugee population, Germany is facing challenges in providing adequate health services (Entre Nous, WHO & UNFPA, 2016, p. 27). The increasing number of refugee also demands the need for health promotion and awareness and especially regarding women's health. Generally, refugee women have been found to have poor health conditions affected due to many physical, social and mental factors. Concerning SRH, refugee women have inadequate knowledge and the topic is generally considered a taboo among refugees from majority Muslim nations. Thus, even after the resettlement, many refugee women face difficulties to negotiate and access services on SRH.

Many refugee women in their home country were victims of forced and early marriage due to which several of them got pregnant in an early age. Refugee women have also low level of awareness on family planning, modern contraceptives and sexually transmitted infections (STIs). This knowledge deficit may put refugee women at greater risk of unwanted pregnancies, complications during childbirth and STIs. Further on, they also have a high risk of sexual and gender-based violence including domestic violence.

The findings from this study also show that refugee women's previous experiences in accessing health services influenced how they access the services in the new country. As there are a comparatively low numbers of health care providers and less access to SRH services in their home country, they don't utilize these services regularly. Even in the refugee accommodations here, there are not enough health care services addressing SRH. Due to this, they have to seek health care services outside the camp. But, there are lots of challenges which hinder refugee women to seek SRH services in a new country such as communication difficulties, cultural difference, unfamiliarity with the health system, lack of support and gender role of health provider also shows to play a vital role. Due to these challenges, refugee women hesitate to seek health care services and hence cannot improve their health condition.

Thus, refugee women need educational programs which should inform them about the importance of SRH in people's life. Most of the women need to be aware of women rights and sexual and reproductive health rights, as well as support and convincing of their male partner or member of the family. The SRH education should include information about family planning, benefits of contraception, STI, the consequence of early childbirth etc. Refugee women need to be aware of the available health care services in Germany such as gynecologist services, midwives' services during childbirth, counseling regarding family planning and contraception and services regarding STI test. They need to be informed about availability of support and service for women who are the victim of sexual and gender-based violence including domestic violence.

They also should get information about programs and projects which are involved to promote SRH of refugees such as Zanzu portal from BZgA, MIMI project, Aids Hilfe Hamburg etc. Some of these topics were also suggested by refugee women who participated in this study to include in the REFUGIUM women's health workshop.

The findings from this study will help REFUGIUM program to develop a women's health workshop focusing on SRH for refugee women. The suggested SRH topics from refugee women should be highly respected, valued and should be included in REFUGIUM women's health workshop. Moreover, the recommended SRH topics of this paper can be utilized as a workshop content. The general recommendations provided in this study will also help REFUGIUM program to conduct a women's health workshop efficiently. Through health workshop, REFUGIUM program can fulfill the needs of refugee women to some extent and increase the utilization of health. The proper utilization of SRH care can improve SRH, overall health as well as positive social and economic outcomes for women. It can reduce the rates of STI and unplanned pregnancy. Thus, it is important to educate refugee women about SRH aspects to improve their health and well being.

Based on the finding of this study many other health education interventions can be implemented for refugee women. There should be cooperation, collaboration and strong policy coherence between the education, social and health sectors to provide comprehensive sexual and reproductive health education and services for refugee women. Further on, there should be multiple and multidimensional intersectoral approaches or interventions for providing effective SRH education for refugee women and increase the utilization of SRH services by refugees.

The SRH health of refugee women is also influenced by her partner. Partner's SRH knowledge also influences the SRH behavior of women such as men's interest in seeking health care service in the new country tends to increase the utilization of health services by the couple. Therefore, there is also need of in-depth understanding of refugee men's perception and consciousness towards SRH. Both refugee women and men are now part of German society. So, the SRH needs of both women and men should be understood and fulfilled. For an effective result, this SRH education should be part of early resettlement services for both refugee women and men. Therefore, there is a need of a good quality program about sexuality for refugee women as well as for men.

Findings from this study signify that SRH care provision for refugee women can be complex due to the sensitive and culture-bound nature of SRH. Therefore, the health care provider should be intercultural competent to deal with refugee women from different backgrounds and to understand also from their perspective. The health care provider should also offer more time to refugee

women because of the use of interpreters, and they should keep in mind that most of the refugee women might hesitate to negotiate on SRH topic.

This result of this study included the refugee women from Syria, Iraq, Iran, Pakistan and Nigeria. To get a detailed understanding of other large refugee groups such as from Eritrea, Somalia, and Russia, there is a need for further study those groups as well. This will help policymaker and education provider to get an overview of the sexual and reproductive health needs of other refugee group too.

8 References

ADEBAR Beratung und Begleitung von Schwangeren und Familien (Hamburg). (o.D.). Unterstützung. Hamburg. Retrieved 14.12.2018, from URL https://www.adebar-hh.de/unterstuetzung/

Alexander, G.R. and Carol C. Korenbrot, C.C. (1995). The Role of Prenatal Care in Preventing Low Birth Weight. *The Future of Children* Vol. 5, No. 1, Low Birth Weight Spring, pp. 103-120 Retrieved 14.09.2018, from DOI: 10.2307/1602510 https://www.jstor.org/stable/1602510?seq=1#page_scan_tab_contents

Asylum Information Database (AIDA) & European Council on Refugees and Exiles (ECRE). (2018). Health Care Germany. Retrieved 08.08.2018, from URL http://www.asylumineurope.org/reports/country/germany/reception-conditions/health-care

BAMF. (2019). Aktuelle Zahlen zu Asyl. Retrieved 12.01.2019, from URL file:///C:/Users/User/Desktop/asyl%20antrag%20statistik%20.pdf

BAMF. (2019). BAMF-Kurzanalyse. Ausgabe 01|2019 der Kurzanalysen des Forschungszentrums Migration, Integration und Asyl des Bundesamtes für Migration und Flüchtlinge. Retrieved 12.01.2019, from URL http://www.bamf.de/SharedDocs/Anlagen/EN/Publikationen/Kurzanalysen/kurzanalyse1-2019-fortschritte-sprache-beschaeftigung.pdf?__blob=publicationFile

BAMF. (2018). Aktuelle Zahlen zu Asyl (12/2018). Retrieved 22.11.2018, from URLhttp://www.bamf.de/SharedDocs/Anlagen/DE/Downloads/Infothek/Statistik/Asyl/aktuelle-zahlen-zu-asyl-dezember-2018.pdf?__blob=publicationFile

BAMF. (2017). Bundesamt für Migration und Flüchtlinge. Retrieved 07.07.2018, from URL http://www.asylumineurope.org/sites/default/files/resources/bundesamt-in- zahlen-2016-asyl.pdf

BAMF (Federal Office for Migration and Refugees). (2017). Refugee women in Germany: language, education and employment. Brief analysis. Retrieved 5.8.2018, from URL http://www.bamf.de/SharedDocs/Anlagen/EN/Publikationen/Kurzanalysen/kurzanalyse7_gefluchtete-frauen.html

BAMF. (2015). Bundesamt für Migration und Flüchtlinge. Retrieved 28.11.2017, from URL https://www.bamf.de/SharedDocs/Anlagen/DE/Downloads/Infothek/DasBAMF/2015-08- 20-prognoseschreiben-asylantraege.html

BAMF. (2015). HIV/AIDS counselling/Information on sexually-transmitted infections (STI). Retrieved 16.11.2017, from URL http://www.bamf.de/EN/Willkommen/GesundheitVorsorge/Aidsberatung/aidsberatung-node.html

Baum, F., MacDougall, C., & Smith, D. (2006). Participatory action research. *Journal of Epidemiology and Community Health*, *60*(10), 854–857. Retrieved 31.08.2017, from URL https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2566051/

Blanc, A.K. (2001). The effect of power in sexual relationships on sexual and reproductive health: An examination of Evidence. In*: Studies in family Planning*. Vol. 32. Retrieved 12.08.2018, from URL https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1728-4465.2001.00189.x

Bortz, J. & Döring, N. (2006). Forschungsmethoden und Evaluation für Human und Sozialwissenschaftler, 4. überarbeitete Auflage. Springer Medizin Verlag. Heidelberg

Bundesamt für Familie und zivilgesellschaftliche Aufgaben, (2018). **Das Hilfetelefon** – Beratung und Hilfe für Frauen. Retrieved 26.10.2017, from URL https://www.hilfetelefon.de/

Bundesamt für Familie und zivilgesellschaftliche Aufgaben. (2018). HIV/AIDS counselling/Information on sexually-transmitted infections (STI). Retrieved 23.10.2018 from URL www.bamf.de/EN/Willkommen/GesundheitVorsorge/Aidsberatung/aidsberatung-node.html

Bundeszentrale für gesundheitliche Aufklärung (BZgA). (2016). Wissen: Safer Sex. Retrieved 26.10.2018, from http://www.gibaidskeinechance.de/wissen/safer_sex.php?L=0%3Fbg%3DMethode_300%3Fbg%3DMethode_468%3Fbg%3DBeratung_468%3Fbg%3DMethode_160%3Fbg%3DMethode_300%3Fbg%3DBeratung_728%3Fbg%3DWissen_728%3Fbg%3DKampagne_160 Accessed on 10.07.2016

BZgA (2019). Recht und Amt nach der Geburt. Retrieved 15.10.2018, from URL https://www.familienplanung.de/schwangerschaft/nach-der-geburt/recht-und-amt/

BZgA /Sensoa. (2019). Zanzu, my body in words and images. Retrieved 28.10.2018, from URL https://www.zanzu.de/en/

BZgA. (2018**a**). Gewalt. Retrieved 28.10.2018, from URL https://www.frauengesundheitsportal.de/themen/gewalt/

BZgA. (2018**b**). Sexuell übertragbare Infektionen. In:Frauengesundheitsportal. Retrieved 26.10.2018, from URL https://www.frauengesundheitsportal.de/themen/sexuell-uebertragbare-infektionen-sti/mehr-zum-thema/

BZgA. (2018**c**). Schwangerschaft. Retrieved 25.10.2018, from URL https://www.familienplanung.de/

BZgA. (2018**d**). Sichergehen. Verhütung für sie und ihn. Retrieved 15.10.2018, from URL file:///C:/Users/User/AppData/Local/Packages/Microsoft.MicrosoftEdge_8wekyb3d8bbwe/TempState/Downloads/13060000%20(1).pdf

BZgA. (2018**e**). STI- Was ist das? Retrieved 15.10.2018, from URL https://www.liebesleben.de/fuer-alle/sexuell-uebertragbare-infektionen/sti-was-ist-das/

BzgA, (2017**a**). Die ersten Tage in der Klinik. Retrieved 26.10.2018, from URL https://www.familienplanung.de/schwangerschaft/nach-der-geburt/die-ersten-tage/die-ersten-tage-in-der-klinik/

BZgA. (2017**b**). Gesund leben in der Schwangerschaft. Retrieved 25.10.2018, from URL https://www.familienplanung.de/schwangerschaft/gesundheit-und-ernaehrung/gesund-leben/

BZgA. (2017**c**). Medikamente in der Schwangerschaft. Retrieved 25.10.2018, from URL https://www.familienplanung.de/schwangerschaft/das-baby-vor-gefahren-schuetzen/medikamente/

BZgA. (2017**d**). Welche Verhütungsmethode passt zu mir? Retrieved 14.10.2018, from URL https://www.familienplanung.de/verhuetung/passende-methode-finden/

BZgA. (2016). Die Zeit im Wochenbett. Retrieved 27.10.2018, from URLhttps://www.familienplanung.de/schwangerschaft/nach-der-geburt/das-wochenbett/die-zeit-im-wochenbett/

BZgA. (2014). Vorsorgeuntersuchungen: Sicherheit für Mutter und Kind. Retrieved 26.10.2018, from URLhttps://www.familienplanung.de/schwangerschaft/schwangerschaftsvorsorge/vorsorge-zur-sicherheit/#c24911

Caritas Deutschland. (2019). ONLINE-BERATUNG. Schwangerschaftsberatung. Retrieved Retrieved 25.10.2018, from URL https://www.caritas.de/hilfeundberatung/hilfeundberatung

Centrum für AIDS und sexuell übertragbare Krankheiten in Altona (CASA blanca).(2018). HIV/AIDS-Beratung und -Test. Retrieved Retrieved 25.10.2018, from URL https://www.hamburg.de/casablanca/

Charite. (2017): Charité für geflüchtete Frauen. Universitätsmedizin Berlin. Retrieved 02.07.2017, from URL https://femalerefugees.charite.de/

Creswell, J.W. (2013). Qualitative Inquiry and research design. Choosing among five approaches. 3rd Edition. SAGE publication.

Crossland, N. Hadden, W.C., Vargas, W.E., Valadez, J. Jeffery, C. (2015). Sexual and Reproductive Health Among Ugandan Youth: 2003-04 to 2012 In: *Journal of Adolescent Health. Elsevier 393-398* Retrieved 08.07.2017, from https://doi.org/10.1016/j.jadohealth.2015.06.015

Commonwealth of Australia, 2010. National Women's Health Policy 2010. Retrieved 25.9.2018, from URL https://www.health.gov.au/internet/main/publishing.nsf/Content/3BC776B3C331D5EECA257BF0001A8D46/$File/NWHP.pdf

DeJong, J., Jawad, R., Mortagy, I. & Shepard, B. (2005). The Sexual and Reproductive Health of Young People in the Arab Countries and Iran, Reproductive Health Matters. Retrieved 17.09.2018, from URL https://www.tandfonline.com/doi/full/10.1016/S0968-8080%2805%2925181 9?scroll=top&needAccess=true

Diakonie Deutschland. (2019). Flucht und Migration. Retrieved 22.11.2018, from URL https://www.diakonie.de/unbegleitete-minderjaehrige-fluechtlinge/

Diekmann, A. (2006). Empirische Sozialforschung. Grundlagen, Methoden, Anwendungen. 16. Auflage. Rowohlts Enzyklopädie im Rowohlt Taschenbuch Verlag. Reinbek bei Hamburg

Entre Nous, WHO & UNFPA (2016). Together for a better sexual and Reproductive health. No.84. Retrieved 15.10.2018, from URL http://www.euro.who.int/__data/assets/pdf_file/0017/319301/Entre-Nous-84-full-book.pdf?ua=1

Flick U. (2016). Qualitative Sozialforschung. Eine Einführung.7th ed. Reinbek: Rowohlt.

Flick U. (2006). An Introduction to Qualitative Research. 3rd Ed. Sage: London

Fuß, S. & Karbach, U. (2014). Grundlagen der Transkription, Eine praktische Einführung, Barbara Budrich Verlag. Opladen und Toronto

Garcia-Moreno, C. & Stöckl, H. (2009). Protection of sexual and reproductive health rights: Addressing violence against women. In: *International Journal of gynecology and Obstetrics*. Retrieved 12.10.2018, from https://doi.org/10.1016/j.ijgo.2009.03.053

Gagnon, A.J., Merry, L. & Robinson, C. (2002). A Systematic Review of Refugee Women's Reproductive Health. Retrieved 06.06.2018, from URL http://www.evidenceaid.org/wp-content/uploads/2016/08/Gagnon-et-al-Refugee-Womens-reproductive-health-Can-J-Refugees-2002.pdf

Hennink, M., Hutter,I., & Bailey,A. (2011). Qualitative Research Methods. London. SAGE publication Ldt. Retrieved 17.10.2018, from URL https://books.google.de/books?hl=de&lr=&id=zN70kC0E3XQC&oi=fnd&pg=PP2&dq=qualitative+research+methods&ots=HXW8ZxpIzu&sig=9oC78RE4rlZ5dFjmDXuGJw9Tin8#v=onepage&q=qualitative%20research%20methods&f=false

Ivanova, O., Rai, M., & Kemigisha, E. (2018). A Systematic Review of Sexual and Reproductive Health Knowledge, Experiences and Access to Services among Refugee, Migrant and Displaced Girls and Young Women in Africa. *International Journal of Environmental Research and Public Health*, *15*(8), 1583. Retrieved 14.09.2018, from http://doi.org/10.3390/ijerph15081583

Kaddour, A. Hafez, R., & Zurayk, H. (2005). Women's Perceptions of Reproductive Health in Three Communities around Beirut, Lebanon, *Reproductive Health Matters*, Retrieved 04.11.2018, from DOI: 10.1016/S0968-8080(05)25170-4

Keygnaert, I., Vettenburg, N., & Temmerman, M. (2012). Hidden violence is silent rape: sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands, Culture, Health & Sexuality. Retrieved 06.06.2018, from DOI: 10.1080/13691058.2012.671961

Keygnaert, I., Vettenburg, N., Roelens, K., & Temmerman, M. (2014). Sexual health is dead in my body: participatory assessment of sexual health determinants by refugees, asylum seekers and undocumented migrants in Belgium and The Netherlands. *BMC public health*, Retrieved 06.06.2018, from doi:10.1186/1471-2458- 14-416

Kohlbacher, F. (2006). The Use of Qualitative Content Analysis in Case Study Research. Volume 7.Retrieved 29.09.2018, from URL.https://pdfs.semanticscholar.org/33a6/2dcbb00f86d99b1e10e4fad4fc9983e1a247.pdf

Kuckartz, U. (2005). Einführung in die computergestützte Analyse qualitativer Daten. 1. Auflage. VS Verlag für Sozialwissenschaft/ GWV Fachverlage GmbH, Wiesbaden.

Kuckartz, U. (1999). Computergestützte Analyse Qualitativer Daten. Eine Einführung in Methoden und Arbeitstechniken. Westdeutscher Verlag GmbH, Opladen/ Wiesbaden.

Kurmeyer, C., Abels, I., & Merkle, I., (2017). Charité für geflüchtete Frauen. Women for Women. Jahresbericht 2016. *Frauen- und Gleichstellungsbeauftragte der Charité*. Berlin. Retrieved from URL:https://femalerefugees.charite.de/fileadmin/user_upload/microsites/sonstige/mentoring/pdfs/Jahresbericht_femalerefugees_2016_final-1.pdf

Lewis, J., and Nicholls, Mc. C. (2014). Design Issues. In*: Qualitative Research Practice*: A Guide for Social Science Students and Reserachers. SAGE Publication. Los Angeles. Retrieved from URL:https://books.google.de/books?hl=de&lr=&id=EQSIAwAAQBAJ&oi=fnd&pg=PP1&dq=ethical+aspects+in+scientific+reserach+&ots=l_POmwSs0O&sig=1G8YoprMtbmwhRSJurJHWQbJCXI#v=onepage&q&f=false

Mayring, P. (2008). Qualitative Inhaltsanalyse. Grundlage und Techniken. 10. Auflage. Beltz Verlag. Weinheim und Basel.

Mengesha, Z. B., Perz, J., Dune, T., & Ussher, J. (2017). Refugee and migrant women's engagement with sexual and reproductive health care in Australia: A socio-ecological analysis of health care professional perspectives. Retrieved 08.10.2018, from URL. http://doi.org/10.1371/journal.pone.0181421

Multicultural Centre for Women's Health (MCWC) (2012). Best Practice Guide. COMMON THREADS, COMMON PRACTICE. WORKING WITH IMMIGRANT & REFUGEE WOMEN IN SEXUAL & REPRODUCTIVE HEALTH. Retrieved 25.10.2018, from URL http://www.mcwh.com.au/downloads/publications/MCWH_CommonThreads_BestPracticeGuide_WEB.pdf

MCWH. (2010). Points of Departure. An Advocacy Toolkit for Immigrant and Refugee Women. Melbourne: *Multicultural Centre for Women's Health*. Retrieved 25.10.2018, from URL http://www.mcwh.com.au/downloads/publications/MCWH_POD_Advocacy_Toolkit.pdf

Multicultural Centre for Women's Health. (2010). Points of Departure Project. Discussion Paper National Issues for Immigrant and Refugee Women. Australia. Retrieved 25.10.2018, from URL http://www.mcwh.com.au/downloads/publications/MCWH_POD_Advocacy_Toolkit.pdf

Murphy, B. (2004). Health education and communication strategies. In H. Kele- her & B. Murphy (Eds.), *Understanding health. A determinants approach* (pp. 187–203). South Melbourne, Vic., New York: Oxford University Press.

Narasimhan, M., Pillay, Y., García, P.J., Allotey,P., Gorna, R., Welbourn, A., Remme, M., Askew, L., Nordström,A., Haufikuon, B. (2018). Investing in sexual and reproductive health and rights of women and girls to reach HIV and UHC goals In*: the Lancet Global Health*. Retrieved 30.10.2018, from https://www.thelancet.com/journals/langlo/article/PIIS2214-109X%2818%2930316-4/fulltext

pro familia Deutsche Gesellschaft für Familienplanung, Sexualpädagogik und Sexualberatung e.V. Bundesverband.(o.D). Schwangerschaft und Geburt. Retrieved 12.10.2018, from https://www.profamilia.de/themen/schwangerschaft.html

REFUGIUM: Rat mit Erfahrung: Flucht und Gesundheit – Information und Multiplikation. Retrieved from www.refugium.agency

RHTAC (Refugee Health Technical Assistance Center). (2011). Women's Health. Retrieved 25.10.2018, from http://refugeehealthta.org/physical-mental-health/health-conditions/womens-health/ (Access on: 07.07.2017

Slobodin O., de Jong J. T. (2015). Mental health interventions for traumatized asylum seekers and refugees. What do we know about their efficacy? In: *International Journal of Social Psychiatry.* Vol. 61(1) 17–26. SAGE publication. Retrieved 15.08.2018, from http://isp.sagepub.com/content/61/1/17.long

Sönmez, E.J., Jesuthasan, J., Abels, I., Nassar, R., Kurmeyer, C., & Schouler-Ocak, M. (2017). Study on female refugees – A representative research study on refugee women in Germany. *European Psychiatry.* Volume 41, Supplement. Retrieved 22.10.2018, from https://doi.org/10.1016/j.eurpsy.2017.02.038

Statistisches Bundesamt (Destatis). (2018). Bevölkerung und Erwerbstätigkeit. Schutzsuchende Ergebnisse des Ausländerzentralregisters. Retrieved 14.09.2018, from URL https://www.destatis.de/DE/Publikationen/Thematisch/Bevoelkerung/MigrationIntegration/Schutzsuchende2010240167004.pdf?__blob=publicationFile

The Deutsche AIDS-Hilfe. (o.D). HIV and Aids. Retrieved 14.09.2018, from URL https://www.aidshilfe.de/hiv-aids
The UN Refugee Agency. (2017). Figures at a Glance. Retrieved 17.08.2018, from: http://www.unhcr.org/figures-at-a-glance.html

Tracy, S.J. (2013). Qualitative Research Methods. Collecting Evidence, Crafting Analysis, Communicating Impact, First Edition. Blackwell Publishing Ltd. Retrieved from URLhttp://okt.kmf.uz.ua/atc/oktatatc/Basics_of_research_methodology/Tracy_2013_qualitative_research_methods_collecting_evidence_crafting_analysis_communication.pdf

United Nation Population Fund (UNFPA). (2018). Family planning. Retrieved 14.09.2018, from URL https://www.unfpa.org/family-planning

UNFPA. (2016). Reproductive health and development. Retrieved 14.09.2018, from URL

https://www.unfpa.org/sexual-reproductive-health

Webster, S., Lewis, J. and Brown, A. (2014). Ethical Considerations in Qualitative Research. In: *Qualitative Research Practice: A Guide for Social Science Students and Reserachers*. SAGE Publication. Los Angeles. Retrieved from URL https://books.google.de/books?hl=de&lr=&id=EQSIAwAAQBAJ&oi=fnd&pg=PP1&dq=ethical+a

spects+in+scientific+reserach+&ots=l_POmwSs0O&sig=1G8YoprMtbmwhRSJurJHWQbJCXI#v=onepage&q&f=false (Access on: 18.07.2017)

WHO (2019). Maternal and newborn health. Retrieved 14.09.2018, from URL http://www.euro.who.int/en/health-topics/Life-stages/maternal-and-newborn-health/maternal-and-newborn-health

WHO. (2018a). Sexual and reproductive health. Retrieved 14.09.2018, from URL https://www.who.int/reproductivehealth/en/

WHO. (2018b). Family planning/Contraception. Retrieved 15.09.2018, from URL http://www.who.int/en/news-room/fact-sheets/detail/family-planning-contraception

WHO. (2018c): Sexual and reproductive health. Strengthening the health system response to violence against women. Retrieved 15.09.2018, from URL http://www.who.int/reproductivehealth/topics/violence/en/

WHO. (2018d). Health topics. Reproductive Health. Retrieved 14.09.2018, from URL http://www.who.int/topics/reproductive_health/en/

WHO. (2018e). Refugee and migrant health. Retrieved 14.09.2018, from URL http://www.who.int/migrants/en/

WHO. (2017a). Promoting health through the life-course. Ten top issues for women's health. URL: http://www.who.int/life-course/news/commentaries/2015-intl-womens-day/en/

WHO. (2017b). Health topics. Women's health. Retrieved 14.09.2018, from URL http://www.who.int/topics/womens_health/en/

WHO. (2001). WHO REGIONAL STRATEGY ON SEXUAL AND REPRODUCTIVE HEALTH. Copenhagen, Denmark: World Health Organization, 2001.

Worbs, S., & Baraulina, T. (2017). Female Refugees in Germany: Language, Education and Employment. *BAMF Brief Analysis. Issue 1|2017 of the Brief Analyses by the Migration, Integration and Asylum Research Centre at the Federal Office for Migration and Refugees.* Retrieved 08.08.2018, from URL https://www.bamf.de/SharedDocs/Anlagen/EN/Publikationen/Kurzanalysen/kurzanalyse7_gefluchtetefrauen.pdf;jsessionid=8BC00E77BA0758B9DB1D806B94515782.1_cid286?__blob=publicationFile

World Future Council. (2016). PROTECTING REFUGEE WOMEN AND GIRLS FROM VIOLENCE. A Collection of Good Practices. Retrieved 20.09.2018, from URL https://www.worldfuturecouncil.org/file/2016/12/WF_2016_Protecting-refugee-women-and-girls.pdf (Accessed on: 17.07.2017)

Yasmine, R., & Moughalian, C. (2016). Systemic violence against Syrian refugee women and the myth of effective intrapersonal interventions, *Reproductive Health Matters*, 24:47, 27-35. Retrieved 20.09.2018, from URL DOI: 10.1016/j.rhm.2016.04.008

9 Appendix

Appendix A: Recruitment Script

Project Information

Hello.....,

My name is Sona Sainju, a student of Health Sciences in the University of Applied Sciences in Hamburg and a research peer facilitator in REFUGIUM program.

I would like to invite you to participate in a focus group/ interview for a research study on "Exploring the sexual and reproductive health needs of refugee women in Germany". The study aims to investigate the sexual and reproductive health problems and issues of refugee women to better understand their needs regarding sexual and reproductive health. The results gained from this study will help REFUGIUM program to develop a women's health workshop for refugee women.

If you agree to participate, you will be invited to a focus group or face-to-face interview. The focus group / interview will have 11 open-ended semi-structured questions and will take around 1 hour. The interview will be recorded with an electronic device if you agree to do so.

You may feel uncomfortable in answering some of the questions. You have the right to refuse to answer any question that makes you uncomfortable. You also have the right to stop your participation in the study at any time without any consequences.

There may be a potential breach of confidentiality because private stories could not be identified or recognized by third parties. In addition, the consent form will not be connected to the data. A pseudonym will be given to you to reduce the chance of identifying information in the interviews. Data will be recorded and stored in a secure and password protected computer.

Your participation is completely voluntary. You can choose to be in the study or not. Participation or non-participation will not affect any services, benefits or any other personal consideration or right you usually expect.

If you have any questions or if you like to participate then please contact me at [redacted] or email me at [redacted]

Thank you very much.

Appendix B: Interview Guideline

Interview Guideline (Questionnaire) about Women's Health focusing on reproductive and sexual health

Background information about women in own home country

1. Could you please tell me from which country are you from?
2. How is the condition of women /girls in your country regarding health, education, equality, freedom?
3. When can a girl called as women in your country/culture?
4. What is the average marriage age of women in your country/culture?
5. How are health care services for women in your country?
6. How much importance do women give to their health?
7. How openly can women share their health problems with others (life partner, parents, and siblings)?#

Current situation of refugee's women living in refugee accommodation

8. In Which type of refugee accommodation are you living now?
9. Are there lots of single women or women with children?
10. How many children does one married woman have in average?

Women's health in the perspective of refugee's women

11. What comes in your mind, when I said, today we will talk about women's health. /What is women's health in your perspective/in your view? / What do you think, what kind of topic are related to women's health?
12. How important is women's health to you? / How much conscious are you about women health
13. Could you please tell us what do you do to maintain your women's health' in good condition?
14. Could you please share us, how is women's health in general in refugee accommodation?
15. How much conscious are women in refugee accommodation about women's health

For e.g. Feminine hygiene, violence, pregnancy, childcare, no privacy to have intimate moments with your partner etc.

16. If you have some problem, regarding women problem, to whom you will share this problem at first?

17. Are there any health care facilities special for women in refugee accommodation? If yes, are you using those facilities?

18. Do you know any health care facilities that are provided specially for women in Hamburg? Are you utilising it?

19. How much conscious are you with diseases, which most of the women suffers from?

Reproductive and sexual health in the perspective of refugee's women

20. How much conscious are you with reproductive health or sexual health?
21. What do you think, how much conscious are women in accommodation camp about reproductive and sexual health?
22. What kind of health care facilities/services do you know in Germany regarding reproductive health?

For e.g. Family planning counselling, Frühe Hilfen(BZGA)

- During pregnancy
- Before pregnancy
- After birth of new born baby

23. Are you using any health care services for sexual and reproductive health in Germany?

(Adults can get information from counselling centres or doctors. Moreover, the German Federal Centre for Health Education (BZgA) offers brochures and online resources)

24. What opinion do you have concerning contraceptives?
25. Are contraceptives acceptable in your religion / culture? If no, why do you think it's not acceptable? Or how openly can you talk about contraceptives methods with your partner or other family member?
26. What do you think do married women use any contraceptives methods in your culture?
27. How much conscious are you with sexually transmitted diseases like HIV, human papillomavirus (HPV) infection (the world's most common STI)
28. Like human rights there are also certain rights regarding sexuality. Are you aware with rights concerned to sexuality?

(People can decide for themselves whether and how you want to live out your sexuality.

No one can force you into carrying out sexual acts.

You are free to choose your partner.

No one can discriminate against you or attack you because of your sexuality.

(source: zanzu.de))

29. Do you know anyone or Have you heard from anyone who had experienced sexual violence during the migration and after settling down in Germany?

30. What do you think, where women can get help in Germany if they are having problem due to sexual violence?

(If women are affected by violence in their relationship or marriage, they can go to a or directly to the police or Women's refuges (facilities that take in women who are mistreated by their partners/husbands and offer them protection and help. If the women have children, the children are also taken in with them. In most cases, women's refuges are managed by women or a women's group) "Gewalt gegen Frauen (Violence Against Women)", telephone number 08000 - 116 016, is available all over Germany 24 hours a day

31. Regarding sexual and reproductive health, there are lot of prevention and awareness program like zanzu

Do you know about it?

What are the things that you like from zanzu portal? And which things you didn't like it?

Ideas gaining for conducting reproductive and sexual health workshop

32. We want to conduct workshop about women health, could you please suggest us, which topic should we cover in Refugium? or which topics are important to discuss to promote women health.

33. Is there anything else you would like to share how women's health including sexual and reproductive health can be promoted for those women living in refugee accommodation?

Socio-demographic Questionnaire

- Age:
- Home country
- Status: Single / married
- Native language:
- Education level:

Appendix C: Consent form

Consent form:

I declare my willingness to participate in an interview /focus group as part of the mentioned REFUGIUM Program. I have been well informed about the purpose and the process of the research project. I can stop the interview at anytime, decline participation in further interviews and withdraw my consent to recording and transcription without causing any irregularities.

I agree that the interview can be recorded using a recording device so that it can be then put into a written form. For further scientific evaluation of the interview, all indication to my personal details will be removed from the transcript or anonymised. Furthermore, I am also assured that in scientific publications, the interview will only be cited in excerpts, to ensure that it will not be identified by a third party through the sequence of the events reported.

Date: Signature:

Einverständniserklärung

Ich erkläre mich dazu bereit, im Rahmen des genannten REFUGIUM Program an einem Interview/ Fokus group teilzunehmen. Ich wurde über das Ziel und den Verlauf des Forschungsprojekts informiert. Ich kann das Interview jederzeit abbrechen, weitere Interviews ablehnen und meine Einwilligung in eine Aufzeichnung und Niederschrift des/der Interviews zurückziehen, ohne dass mir dadurch irgendwelche Nachteile entstehen.

Ich bin damit einverstanden, dass das Interview mit einem Aufnahmegerät aufgezeichnet und sodann in Schriftform gebracht wird. Für die weitere wissenschaftliche Auswertung des Interviewtextes werden alle Angaben zu meiner Person aus dem Text entfernt und/oder anonymisiert. Mir wird außerdem versichert, dass das Interview in wissenschaftlichen Veröffentlichungen nur in Ausschnitten zitiert wird, um sicherzustellen, dass ich auch durch die in den Interviews erzählte Reihenfolge von Ereignissen nicht für Dritte erkennbar werde.

Datum: Unterschrift:

Appendix D: Observation protocol

Observation protocol

Date:
Time:
Observation Site: Name of refugee camp:
Description of camp:

Healthcare services available in refugee accommodations

- General health care service for refugee:
  For e.g. General physician

- Health care service special for refugee women:
  For e.g. Sports, Consultation for mothers

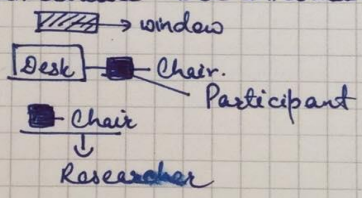
- Service regarding sexual and reproductive health:
  Like Midwives service, Information regarding STI, contraceptive, family planning, sexual and gender-based violence

- Other services, or programs or activities:
  Like REFUGIUM workshop, Information about different organizations

Appendix E: Interview Fieldnote

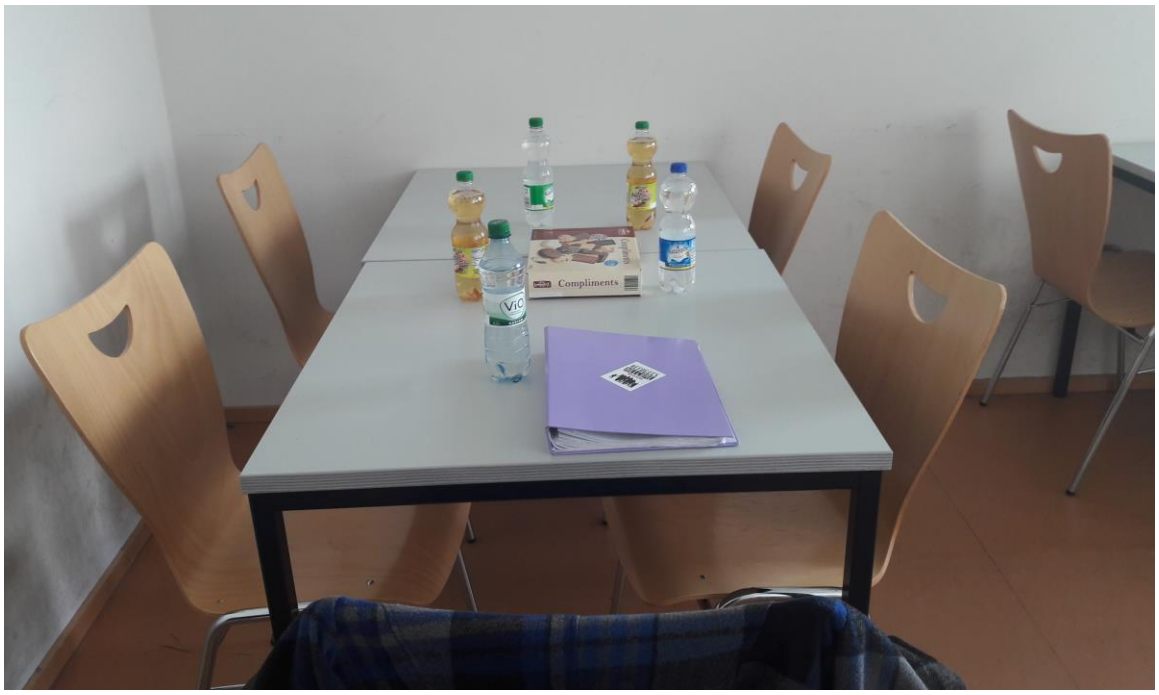
Field Notes
Interview with T.

Date : 06. May 2018
Place : Alexander Straße, Library
Group work Room.
Room : available of chairs and desk
→ booked for 1 hour
→ Participant came around 10. Min. late.
seems little bit nervous
→ Participant said → feeling not so well.
→ came after having language class.
→ at first - drink water
but reject to eat cookies.
During Interview : smiling, silence
in between looking at mobile, mostly for translation
regular eye contact.
Position of interviewee and interviewer



Interview took around 1hour 10 Minutes
took long time : due to translation through Google translate
At last, participant shared other problems like
problem in camp, difficulties in learning language
(after interview)
⊕ No noise and distraction during interview.

Appendix F: Focus group setting



Declaration of Authorship

I hereby declare that the thesis submitted is my own unaided work. All direct or indirect sources used are acknowledged as references.

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This paper was not previously presented to another examination board and has not been published.

Hamburg, 28.02.2019