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How Afghan Refugee Women in Germany navigate Reproductive Health

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Summary

Global displacement over the last two decades means that an increasing number of refugee women will be in need of reproductive health in receiving countries. Refugee women face unique challenges which undermine their strength and values, such as language difficulty, medical/comorbidity issues (e.g. missing vaccinations), isolation, loneliness due to loss of family and of support networks, violence and discrimination. Because of this exposure, refugee women are groups considered particularly vulnerable with regards to maternity care and pregnancy.

Germany is one of the largest host country of refugees and more than half a million girls and women applied for asylum in Germany between 2012 and 2016. Afghans and Syrians constituted on average 40% of the total asylum applicants in Germany between 2011 and 2019. In Germany, policy and legal frameworks are in place to increase the accessibility of reproductive health services for refugees. However, in practice refugees face numerous challenges to accessing and benefiting from the reproductive healthcare system.

In this study, while using the qualitative method focused on the challenges of refugee women related to accessing reproductive healthcare services, solutions to their barriers were sought together by involving community partners through the participatory health research process, with further purpose of empowering them and improving their reproductive health.

Aim:

The aim of this research was to investigate the challenges and experiences of Afghan refugee women living in Munich in accessing reproductive healthcare after their arrival in Germany, as well as to create a space to promote their self-help competencies in

negotiating the healthcare system for reproductive health individually and within their communities.

Methods:

This study was guided through a combination of participatory health research and qualitative research, conducted in three phases; first, a qualitative exploratory assessment phase, second participatory health research and third, participatory and photovoice follow-up. The research used multiple methods through data triangulation for increasing accuracy.

After obtaining the ethical approval, the qualitative exploratory assessment involving 18 in-depth interviews (13 Afghan refugee women ageing from 20 to 40 years arrived in Germany since 2015 and five German volunteers from Helferkreis) were conducted in suburbs of Munich, Germany, the field notes and observations were also collected while accompanying refugee families in healthcare services in 2019-2020. The second phase included eight participatory meetings, cooperating with nine refugee women using the cycle of Stringer “look, think, act”. In addition photovoice was conducted via social networks due to the Covid-19 pandemic’s lockdown. Finally in the follow-up phase two focus groups involving six refugee women were conducted.

All interviews and conversation were transcribed and translated into English, each diary, field note, memo and the transcripts of the interviews were verbatim and analyzed. Data was analyzed and categorized in the MAXQDA program according to constant comparison in grounded theory. Finally, the researcher shared categories and themes with refugee women as co-researchers in small participatory meetings. They reflected on the themes as outcomes, selected those that were important and relevant to them for promoting their health. The final findings were reviewed several times with academic supervisors and peers.

Result:

Participants have mentioned their experiences with the German healthcare system and the difficulties they had to overcome. The main theme was the communication and information-gathering barriers. The other theme emphasized by the participants was volunteers' role as bridges to the German healthcare system, who supported refugee women to overcome the barriers they face. Moreover, structural barriers and strengths were identified: such as location of the refugee residents, large amount of paperwork, long waiting times and lack of e-health translation tools. Insurance coverage for the cost of maternal health and midwife's home visiting was pointed out as a structural strength.

Nine out of thirteen refugee women through cooperation and collaboration in the participatory health research could reflect and create coping strategies in which they managed the barriers accessing reproductive health. Two themes emerged in this phase: seeking solutions to overcome language barriers and seeking strategies to overcome being intimidated.

Refugee women actively shared their experiences and reflection on their wellbeing and strength through photovoice. Five more themes were emerged: devotion to motherhood, the value of safety, sisterhood: bonding beyond blood, perceived wellbeing and promoting activity and value in sharing experiences and learning from one another.

Conclusion:

This study highlighted the refugee women's challenges of accessing reproductive healthcare services in Munich, Germany. The participatory research and learning cycle process were practical and fostering refugee women to overcome those barriers. Meanwhile, sharing experiences via participatory meetings and photovoice was uplifting and solidarity was generated between these refugee women, which was a key factor in maintaining their health and giving a voice to their stories.

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List of Abbreviations

BAMF	(Bundesamt für Migration und Flüchtlinge) Federal Office for Migration and Refugees in Germany
CBPR	Community-based participatory research
EMN	European Migration Network
HIC	High Income Countries
IVF	In vitro fertilization
LMU	Ludwig Maximilians University of Munich
NGO	Non-governmental organization
ORAMMA	Operational Refugee and Migrant Maternal Approach
PAR	Participatory action research
PHR	Participatory health research
PTSD	Posttraumatic stress disorder
SDG	Sustainable Development Goals
UK	United Kingdom
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization
WRC	Women's Refugee Commission

Chapter One: Introduction

The Story of Maryam

"Maryam [pseudonym] is a 26 years old Afghan woman, who became pregnant while setteling in a temporary camp, a tennis hall "Traglufthalle", in a Munich suburb. As a newcomer, she and her family struggled with the authorities to ensure their legal status, as well as with settling in a new environment. Along with sharing the restrooms with 300 other refugees, she was also not allowed to cook her own meals, limiting her ability to eat the food she craved while pregnant. This was the time period we met, while I was visiting the temporary camp as a volunteer in 2015, when I accompanied her to and translated at a visit to her obstetrician. Later in 2020, she agreed to participate in my study. She seemed to be a generally healthy person but despite that, her pregnancy was confronted with many complications. During a sonographic examination she was told by the obstetrician that her fetus had a brain cyst, which caused her great anxiety. As a result, she was referred for further examination to a sonography specialist. The medical center was far from her residence and difficult to find. Despite her concern for the baby's health, she was not allowed any guide to interpret and clarify the results of the sonography or her baby's health status. Later I was able to contact the physician, and I relayed to her the information that the baby was healthy.

A few days later she had severe pain in her mouth due to an infection, resulting in her hospitalization. The first visiting doctor was an anesthesiologist. She became terrified, believing that the doctors wanted to perform surgery and remove the premature baby at sixth months. She panicked and called me crying, stating the hospital was to perform a cesarean section; I rushed to the hospital, talked to the doctor, and was able to calm her. As it turned out, the visit of the anesthesiologist was merely a routine checkup they had with every pregnant woman who was hospitalized. The fact that this checkup was just routine had not been communicated to Maryam, which caused her fear and distrust of the healthcare system in Germany. At the end of the

> *pregnancy, her husband called me stating that her contractions had started, but she did not want to go to a hospital because she was afraid. I spoke to her with empathy and was able to convince her to go with her husband to the hospital for delivery. He was also from Afghanistan and could neither speak German nor English. Some hours later her husband called me again: "Please, please help us Ms. Tayebi. The midwife is telling my wife lots of things we don't understand." I asked him to pass the telephone to the midwife, who was desperate and said: "This mother doesn't cooperate with us; she refuses to breathe well and holds herself so tight, which is very dangerous for the baby." I requested her husband to hold the telephone beside the ear of the young mother, as I encouraged her to breathe slowly, and I tried to increase her calm until she relaxed her muscles. I could hear the distant voices of the midwife and the doctor telling her to breathe and push, so I repeated their words in Farsi. Suddenly her husband screamed, "Ms. Tayebi, the baby is born, the baby is here! It's a boy …."*

Maryam is just one of the many refugee women who needed to find maternity care and support for her child birth while residing out of their country. Due to extraordinary global displacement over the past 20 years, an increasing number of refugee women are having similar experiences in host countries (Heslehurst *et al.*, 2018; Pangas *et al.*, 2018). The status, experiences, and circumstances that have forced refugee women to leave their country of origin render them more likely to have poor health (Pangas *et al.*, 2018; Fair *et al.*, 2020). Refugee Women also face unique challenges which undermine their strength and values, such as language barriers, isolation, loss of family and support networks, violence, discrimination, and pre-existing health and mental problems (Higginbottom *et al.*, 2013, 2017; Yelland *et al.*, 2015, 2016; Heslehurst *et al.*, 2018; Pangas *et al.*, 2018; Al Shamsi *et al.*, 2020; Davidson *et al.*, 2022).

Improving the quality of maternal healthcare is one of the key objectives formulated by World Health Organization (WHO), which is the advocacy of mother and child health in order to decrease the rate of maternal death and child death under 5 years (Riggs *et al.*, 2015a; WHO, UNICEF, UNFPA, World Bank Group, 2015; Sulekova *et al.*, 2021).

Furthermore, one of the top priorities of the United Nations Sustainable Development Goals (SDG) 2030 is to reduce health inequalities amongst countries, particularly for marginalized populations. Unfortunately, during this crisis, most women with their newborn and children are victims of a process of displacement they did not choose, causing significant suffering (Feldman, 2013; Sansonetti, 2016; World Health Organization, 2018; UNFPA, 2020). According to Women's Refugee Commission (WRC) in January 2016 more than 55% of the migrants were women and children compared to 27% in June 2015 (Hersh and Obser, 2016). UNFPA reported in 2018 that significant numbers of female migrants are likely to be pregnant or to become pregnant. It is estimated that one in ten refugee women traveling through Europe was pregnant or in early motherhood (Ramrayka, 2016). In the chaos of displacement and traveling they may lose access to sexual and reproductive health care, such as family planning, antenatal services and safe childbirth care. Lack of these can result in serious health issues and maternal mortality (UNFPA, 2020).

UNHCR 2020 reported that Germany is the fifth largest host country of refugees. Also, The Federal Office for Migration and Refugees in Germany (BAMF) 2017 stated that, compared with other EU members, the highest number of first time asylum seekers coming to Europe was registered in Germany (Eurostat, 2017; BAMF, 2018a; Inci *et al.*, 2020). Furthermore, the European Commission in Asylum Quarterly stated that the number of first time asylum applicants increased by more than 130% in the fourth quarter of 2015 in Germany compared with the same quarter of 2014 (Eurostat, 2018). Afghans and Syrians constituted an average 40% of the total asylum applicants in Germany between 2011 and 2019, and 55% of total arrivals in 2016 (Eurostat, 2018; UNHCR, 2021; Matsangos *et al.*, 2022).

Furthermore, studies mentioned that forced migrant women are in a risk of invisibility within maternity services, consequently missing valuable maternity care as well as increasing mental health issues during early motherhood (Yelland *et al.*, 2016; Firth and Haith-Cooper, 2018; Fair *et al.*, 2020; Katherine, 2020).

In Germany, policy and legal frameworks are in place to increase the accessibility of reproductive health care services for refugees (Bozorgmehr, 2016; Bozorgmehr *et al.*, 2018). Despite these regulations, refugee women face numerous challenges to accessing and benefiting from the reproductive health care system in practice (Bozorgmehr *et al.*, 2018), which has a significant impact on their health and pregnancy outcome (Heslehurst *et al.*, 2018; Fair *et al.*, 2020; Sulekova *et al.*, 2021). To reduce maternal health and reproductive health disparities, these challenges and their causes should be acknowledged and discovered since they play a crucial role in fetal and infant development, as an indicator of adult health, and reproductive justice (Egli-Gany *et al.*, 2021). Furthermore, the mothers' health is crucial because of the vital role they play in their families (Gagnon *et al.*, 2006; Sami *et al.*, 2019; Kikhia *et al.*, 2021).

This study used qualitative research and participatory research to shed light on challenges and experiences of birth and early motherhood of Afghan refugee women who are living in Munich, Germany, specifically on their ensuing reproductive health care support. Furthermore, it is providing an opportunity for Afghan refugee women to develop their own self-help competencies individually and within their communities.

Chapter Two: Background and Literature Review

There are factors which have impact on refugees' health experiences and their ability for accessing health care in host countries such as legal status, social class, education, nationality and race (WHO, 2017, 2022; MacFarlane *et al.*, 2021; Harcourt *et al.*, 2022). In this study, the terms of "migrant", "refugee" and "asylum seeker" will be used often. It is critical however to understand these terms and how they differ because these people have overlapping but distinct legal rights. "Refugees" are defined and protected by international refugee law, and states' obligations to them are regulated both under international law and national legislation. The term "asylum seeker" refers to someone who "is claiming or applying for protection as a refugee and who has not yet received a final decision on his or her claim. It may also refer to someone who has not yet submitted an application for refugee status recognition" (Eurostat, 2018, page 22; MacFarlane *et al.*, 2021). The term migrant refers to a broader group that includes refugees and asylum seekers: "migrants are people, who have moved away from their usual residence, whether within a country or across an international border, for a variety of reasons, either temporarily or permanently" (WHO, 2022, page 5).

II.1 Concepts in Reproductive Health

II.1.1 Sexual and Reproductive Health

"Reproductive health involves the capacity to enjoy a satisfactory sexual life without risks, to procreate, and the freedom to decide whether to procreate or not, when and how often." There should be "safe, effective, affordable and acceptable contraceptive methods; and appropriate health care services that allow for pregnancies and deliveries with the lowest level of risk and the highest possibility for couples to have healthy children." Sexual health refers to "the integration of the emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love" (UNFPA, 2020; UNFPA, 2021, p11).

II.1.2 Maternal Health

Maternal health includes the health of women during pregnancy (prenatal), birth and postnatal which refers to the time after childbirth. Each stage of this should be a pleasant process and practices with positive results of health and well-being of mother and baby (UNFPA, 2021; WHO, 2022).

It is recommended that pregnant women have regular monthly prenatal visits with obstetricians or midwife in order to be evaluated regarding the situation of pregnancy and the well growing of the infant. Studies reported that late access and inadequate prenatal care are associated with poor maternal and infant outcomes (Heaman *et al.*, 2008; Evans *et al.*, 2023). Therefore the mother should feel comfortable with her doctor or midwife and can ask questions about her pregnancy and infant's condition (WHO, 2016). In Germany it is recommended that pregnant women should have prenatal care visits every 4 weeks in early pregnancy, after 32 weeks every 2 weeks and in case of a prolonged pregnancy they should go for a checkup every second day (Bundesausschusses, 2022). Definitely, in this situation the communication between mother and the healthcare staff is very crucial for receiving correct information. This information from the mother might be about her past diseases, which is necessary for the healthcare staff for being prepared for any risks or complications during or after pregnancy. Moreover, the way in which women view themselves as mothers during pregnancy can have a significant impact on their emotional well-being following birth (Riggs *et al.*, 2015; UNFPA, 2020). So, the woman's sense of confidence needs to be enhanced by providing accurate and realistic information that enables her to be well informed about choices regarding child birth and making wiser decisions as well as allowing her to feel being in control of labor and birth (Dahlen, Barclay and Homer, 2008; UNFPA, 2020). The category "Preparing for Birth" consists of two subcategories, "Finding a Childbirth Setting" and "Setting up Birth Expectations". The mediating factors that were influential in the subcategories were beliefs, convenience, finances, expectation, knowledge, and what was termed as "previous life experiences" (Dahlen, Barclay and Homer, 2008).

II.1.3 Motherhood

The transition to motherhood is an important development in a woman's life which starts with pregnancy and extends into the postpartum (Redshaw and Martin, 2011; Hwang, Choi and An, 2022). Motherhood has been described as a process which involves strong emotions as well as physical, sexual and spiritual changes rather than just the end of pregnancy (Barker, 2011).

For many women, becoming a mother is very emotional along with experiencing great changes, through pregnancy, child birth and motherhood: the mother is confronted with psychological and social changes and feeling of loneliness which many women are not adequately prepared for (Stapleton *et al.*, 2013; Guardino and Schetter, 2014; Corrigan, Kwasky and Groh, 2015). Hence, preparing for motherhood is essential for women, they need to learn about safe birth and healthy motherhood (Lothian, 2009). Women should have access to support when necessary as well as get information that considers the various phenomena that can happen during pregnancy, birth and motherhood (UNFPA, 2020). Transition to motherhood for women seeking asylum is very challenging since they are far from their family and are exposed to stress, isolation and marginalization (Feldman, 2013; Tobin and Murphy-Lawless, 2014).

II.1.4 Reproductive Justice

Reproductive rights as defined by WHO refers to the fundamental rights of women and girls which enables them to choose the number of their children and the right to access information and highest standards of sexual and reproductive health. Moreover, it encompasses women's right to decide without any discrimination and force according to the human rights documents (WHO, UNICEF, UNFPA, World Bank Group, 2015). Thus, every woman has the right to access and afford reproductive health care and safe pregnancy (UNFPA, 2018). Focus of reproductive justice is on making arrangements for women and girls and their communities to stand against structural power inequalities

through transformational procedure of empowerment (Ross, 2020). Reproductive justice has a crucial role for women's physical and mental health (Sigal *et al.*, 2012). Unfortunately, in the time of refugee crisis, women and children are victims of a process of displacement they did not willingly choose, and this inflicts considerable suffering (Feldman, 2013; Eapen *et al.*, 2016; Sansonetti, 2016; UNFPA, 2020). Therefore, providing adequate social, medical and psychological support for refugee women who did not have the opportunity for accessing reproductive health and their body is crucial (Bekyol and Bendel, 2016; Eapen *et al.*, 2016; Freedman, 2016; Sansonetti, 2016).

II.2 Refugee Women's Sexual and Reproductive Health Vulnerability

According to the United Nations High Commissioner for Refugees (UNHCR), approximately half of all refugees worldwide are women and girls, who are far more vulnerable than men, particularly those who are unaccompanied and have experienced gender-based violence (Mangrio, Zdravkovic and Carlson, 2019; Davidson *et al.*, 2022). The stressful period of asylum seeking and the traveling overland until resettlement is when vulnerability is greatest (Barndt, 2014; Parater, 2015; Eapen *et al.*, 2016; Freedman, 2016; Sansonetti, 2016; Mangrio, Zdravkovic and Carlson, 2019; Walther *et al.*, 2021; Davidson *et al.*, 2022).

Luna (2019) emphasized that the vulnerability should not be utilized as a label, it has many layers which may overlap. For example, accessing to reproductive rights is more challenging for migrant women, if she is poor, illiterate, and undocumented. Another example: she may be capable to an unwanted pregnancy since she cannot reach the emergency contraceptive (Luna, 2019b). These additional vulnerabilities have been observed also in other studies which claimed that newly arrived migrant childbearing women have lack of social support, feeling of loneliness and isolation, and difficulties to communicate with healthcare staff, eventually related to negative health outcomes during pregnancy and motherhood (Feldman, 2013; Tobin, Murphy-Lawless and Beck, 2014; Balaam *et al.*, 2016; Heslehurst *et al.*, 2018; UNFPA, 2018; Winn, Hetherington and

Tough, 2018; Kaufmann *et al.*, 2022). In addition migrant women are more vulnerable than men and at greater risk of experiencing emotional disorders and have higher risk of mental health issues; these rates are even higher during pregnancy, childbirth and postpartum. (Rintoul, 2010; Feldman, 2013; Johnson-Agbakwu *et al.*, 2014; Russo *et al.*, 2015; Eapen *et al.*, 2016; Sansonetti, 2016).

II.3 Refugee Women's Experiences with Maternal and Reproductive Healthcare in Host Countries

Studies reported that refugee and migrant mothers are experiencing more complications during pregnancy, child birth and the postpartum period compared to the residents of the high income countries (Sami *et al.*, 2019; Fair *et al.*, 2020; Kaufmann *et al.*, 2022; Evans *et al.*, 2023). Fair *et al.* (2020) assessed migrant women's experiences of pregnancy, childbirth, and maternity care in their systematic review, which included 51 studies with qualitative or mixed methodology designs from 14 European countries. Several themes emerged as barriers to care for women refugees as a result of this review: insufficient language abilities, lack of information about maternity care and pregnancy, and difficulty navigating a new healthcare system that differs significantly from the system in their home countries. Another theme was the cost of accessing care, which resulted in financial strains and difficulties covering basic living expenses. Poor living conditions and living in a temporary camp were also frequently mentioned problems. In the UK, maternity care is free for everybody, but the health system cannot provide optimal care for refugees (Balaam *et al.*, 2016). Furthermore, they face poor outcomes such as high rates of infant mortality and maternal mortality; these rates are six times higher for newly arrived women than for residents (Feldman, 2013; Balaam *et al.*, 2016).

An Australian study found that having limited English proficiency increased refugee mothers' risk for marginalization, isolation, and family dysfunction, while a stronger proficiency made them more comfortable accessing mainstream services (Riggs *et al.*, 2012, 2015). Engaging interprets can be helpful for confronting the language barriers.

However, lack of professional interpreters caused misinterpretation and unsatisfactorily receiving care (Meuter *et al.*, 2015; Fair *et al.*, 2020). Meanwhile, for overcoming language barriers sometimes partners interpret for women, which may result in some women feeling vulnerable and embarrassed (Dopfer, *et al.*, 2018; Al Shamsi *et al.*, 2020; Fair *et al.*, 2020; Pandey *et al.*, 2022).

Refugee women's fear and distrust of the healthcare system in a new country were reported in several studies (Sami *et al.*, 2019; Fair *et al.*, 2020; Kikhia *et al.*, 2021). The main reasons given were that healthcare staff did not interact well with them and that the staff's attitude was very important for women, as some were unfriendly, disrespectful, and ignoring them, and many women stated that they were treated differently than others (Al Shamsi *et al.*, 2020; Fair *et al.*, 2020; Pandey *et al.*, 2022). Other barriers reported by women due to being in a new health system and being unable to communicate with health professionals included long waiting times for their appointments, the impression that healthcare providers were overburdened, which prevented women from sharing their needs, lack of knowledge of legislation by administrative staff, not being involved in decision-making, and limited access to specialist care (Sami *et al.*, 2019; Fair *et al.*, 2020; Kikhia *et al.*, 2021). On the other hand migrant women stressed the importance of good quality care, reported some positive experiences, and appreciated the healthcare staff who were encouraging, supportive, good listeners, and providing good information (Fair *et al.*, 2021). The women also stated that they wished be cared for by healthcare providers who would take their concerns seriously and with empathy, and that these interactions would make them feel safe (Fair *et al.*, 2020, 2021; Kikhia *et al.*, 2021). Moreover migrant women were thankful when the healthcare staff respects their customs and traditions. This kind of good care and positive attitudes between women and healthcare providers empowered women to feel confident and prepared for childbirth, and even overcome a lack of family and social network support (Barkensjö *et al.*, 2018; Fair *et al.*, 2021; Shorey, Ng and Downe, 2021).

The impact of dispersal[1] whereby women were moved by migration authorities to new, unknown areas within the host country caused increased women's feelings of stress and powerlessness. Many childbearing migrant women experienced trauma or persecution prior to or during migration and the resulting stress often became evident as pain and illness in their body (Balaam *et al.*, 2016; Fair *et al.*, 2020; Ng, 2022). Feldman (2013) had a qualitative study to explore the experiences of pregnant women in the asylum system, which is the decision-making process to get asylum in the United Kingdom, where Border Agency's dispersal policies is common. This study incorporated telephone interviews with 20 women who were dispersed during pregnancy and 17 midwives, offering maternity care to the women. Dispersal is putting the health of pregnant women and their babies in danger, as a result they cannot reach their healthcare and their support networks, and they are put into a lonely and vulnerable situation.

Fair *et al.* (2021) also explored the importance of midwifes' culture sensitivity in three countries (Greece, Netherlands, and United Kingdom (UK)) with access to ORAMMA (Operational Refugee and Migrant Maternal Approach) model with training on practice and clinical perinatal. Fair *et al.* (2021) explained that midwives gained a better understanding of migrant women's behavior such as reasons for nonattendance at antenatal care and so were better prepared for putting migrant women at ease within an appointment. Also, they noted that midwives wished to learn more such as living condition, legal statues and financial of migrant women and improve their culture competence. Tobin and Murphy-Lawless (2014) used a narrative research approach to explore Irish midwives' perceptions concerning women refugees' experiences during childbirth. Findings reveal a lack of communication including language difficulties, poorly organized maternity services, missing cultural training and infrequent interpreter services, leading to ineffective care provision. Urgent need for action on policy, legislation and practice was found, as well as providing good relationships and trust between midwives and women in the asylum process. Individualized and friendly care can bring trust;

[1] 'Dispersal' means relocating asylum seekers during the admission process for being accepted as a refugee.(Balaam *et al.*, 2016)

unhurried healthcare providers encouraged women to attend maternity care and influenced their sense of well-being (Tobin and Murphy-Lawless, 2014; Tobin, Murphy-Lawless and Beck, 2014; Kaufmann *et al.*, 2022).

Sami *et al*. (2019) in the qualitative study with six focus groups explored migrant women's experiences during pregnancy and childbirth in Geneva and Zurich. This study reported positive and negative experiences. The positive experiences included availability of maternity services, especially during emergency situations and the postpartum period, and also the availability of specific maternity services for undocumented migrants in Geneva. Negative experiences include personal barriers such as the main themes being language barriers and a lack of information as well as lack of social support from family members. Furthermore Sami *et al*. (2019) explained that the structural barrier is lack of health literacy, since some of the migrants come from countries with less developed health systems and lower education, so sometimes they might misinterpret medical procedures due to a lack of information. Also the ability to understand the information might cause being worried about the consequences of medical examinations.

In a qualitative research by Russo *et al*. (2015) with 38 Afghan women in Australia involving two focus group discussions and 10 in-depth interviews, findings indicate that participants consistently discussed experiencing emotional challenges following birth. Identifying symptoms commonly associated with postnatal depression, these women attributed this emotional state to separation from family and culture, leading to loneliness, isolation, and disconnection. A positive aspect was the support of their husband throughout pregnancy and childbirth, which is more seen in Australia compared to their home country. Religion, strong relationship with the child, forming friendships and education were identified as positive influences on emotional wellbeing.

These challenges are not just in high income countries as Masterson *et al*. (2014) reported in the needs assessment of reproductive health and violence against women among 452 displaced Syrian women in Lebanon. These refugees experienced various indicators of poor reproductive health and gynecologic conditions, including high rates of menstrual

irregularity, severe pelvic pain, and vaginal infection as well as pregnancy and birth complications (Reese Masterson *et al.*, 2014).

10-25% of women experience significant mental distress during and/or after pregnancy and during postnatal (Yelland *et al.*, 2014; Agic *et al.*, 2016). However, depression, anxiety and with a rate of 42.7% of posttraumatic stress disorder (PTSD) is a frequent comorbidity among women refugees and migrants (Fellmeth, Fazel and Plugge, 2017; Firth and Haith-Cooper, 2018; Wood and Kallestrup, 2021; Abi Zeid Daou, 2022; Kaufmann *et al.*, 2022).

The publications by Tobin and Murphy-Lawless (2014) from Ireland, Rintoul (2010), Feldman (2013) and Russo *et al.* (2015) from Australia, Balaam *et al*. (2016) from UK and Walther *et al.* (2021) and Kaufmann *et al.* (2022) from Germany considered that refugee women who newly arrived in a host country are at higher risk of mental health issues and physical problems since they are confronted with lack of communication and language barriers, separation from families and isolation. Poor reproductive health, complicated birth situations and postnatal depression were identified as being the main issues causing mental health problems among refugee women (Kaufmann *et al.*, 2022).

II.4 Refugee Women's Access to Maternal and Reproductive Healthcare in Germany

In Germany accessing reproductive health for legal status refugees is without restriction and it is covered by insurance (Bhugra and Becker, 2005; Bozorgmehr and Razum, 2015; Bozorgmehr, 2016; Bozorgmehr *et al.*, 2016, 2018; BAMF, 2018b; Inci *et al.*, 2020). Despite this accessibility, refugees have numerous challenges to reach and get benefits from the healthcare system (Bozorgmehr *et al.*, 2018; Inci *et al.*, 2020; Kaufmann *et al.*, 2022). Often, refugees after arriving in Germany had disproportionately settled in German municipalities and cities, which have primarily been responsible for solving enormous problems related to accommodation, integration and healthcare of refugees (Nam and J. Steinhoff, 2018).

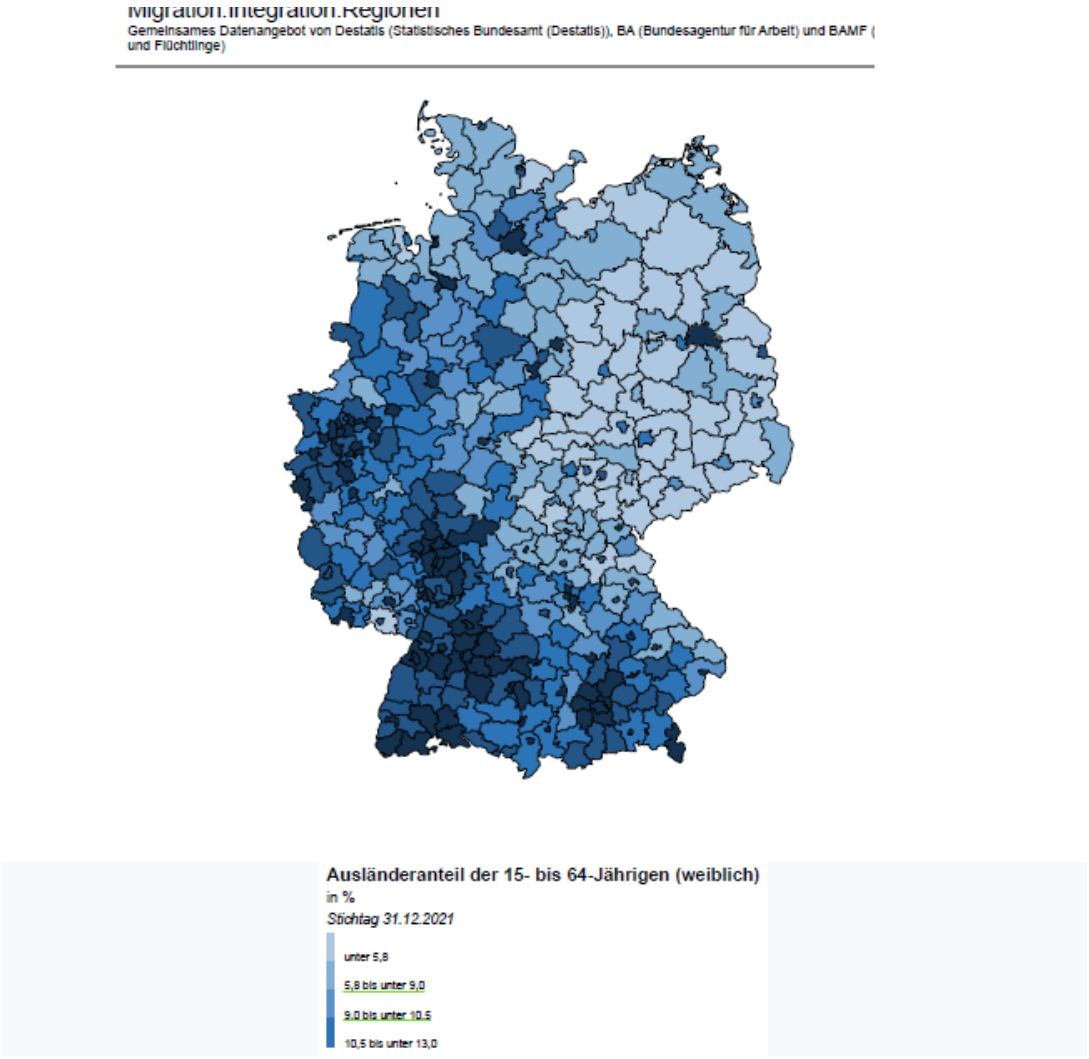

Figure 1: Percentage of female migrants aged from 15 – 64 in the regions of Germany on Dec 31st 2021 (Statistisches Bundesamt, 2023)

Figure 1 above is a map showing the regional distribution in Germany of the female migrants population aged from 15 to 64 years (Statistisches Bundesamt, 2023). The dark blue colour indicates a population of more than 17.3% and the lightest blue colour indicates a population of fewer than 5.8%. In Munich about 21% of the population are female migrants (Statistisches Bundesamt, 2023).

Razum *et al.* (2008) stated that the mortality rate of mothers and infants is a very sensitive parameter for social injustice. In 1980 – 1988 the mortality rate in Germany was double in the migrant population compared to the non-migrant population and was falling to about same levels in 2001 – 2004, while adjusted data show a remaining 60%

higher risk of death in the migrant population (Razum *et al.*, 2008), indicating that the migrant population is socially marginalized. The mortality risk for infants born from migrant mothers was higher than that of the non-migrant population. The report concluded that there is a deficit in epidemiological health-related research in Germany (Razum *et al.*, 2008). Eight years later, these researchers emphasized again that there is a lack of data regarding the health care activities for asylum seekers in Germany (Bozorgmehr and Razum, 2015). Also, Hofen-Hohloch (2015) mentioned a deficit of studies on maternal health of migrants in Germany since 1990. A group of researchers from Germany, Canada and UK had a preliminary scoping study focused on the maternity experiences and outcomes of migrant women in these three countries. They emphasised that insufficient consideration has been taken to maternity care service needs of migrant women in Germany (Higginbottom *et al.*, 2013; Bozorgmehr *et al.*, 2018). The researchers believed that at least three factors were responsible for this little knowledge about the experiences of migrant women in maternity services: first the hesitation of Germany's political actors and society to recognize the county's multicultural status, second the power and domination of a medical model of maternity care and finally patients are not involved in determining healthcare policies. On comparing the three countries, the researchers concluded that racism may affect the maternity care outcome of minority women and causes different possibilities for accessing the resources and influences the perception and behavior of health professionals towards migrant women. They emphasized that there is need to prepare a framework to facilitate migrant women to participate more in the health system in Germany (Higginbottom et al., 2013; Higginbottom *et al.*, 2017b)

Kikhia *et al.* (2021) conducted a qualitative study with nine Syrian refugees to investigate how they managed their health during the migration process in Germany. According to the authors, post-migration stressors such as discrimination harmed the participants' health. Furthermore, Syrian women reported feeling disempowered when navigating the German healthcare system, as well as a lack of knowledge about their rights and options under the health insurance plan. Kikhia *et al.* (2021) also mentioned the language barrier,

which made the Syrian women in their study feel vulnerable. Women were also experiencing declining doctor treatment and were dissatisfied with the emotional/cultural aspects of care. According to the perception of the women interviewed many doctors and nurses were impatient and not empathetic.

Concerning refugees support, Andrees *et al.* (2018) conducted a qualitative study which included interviews with 10 German volunteers and 11 interviews with experts that reported the positive role of volunteers in assisting refugees in accessing healthcare services. However, this study also reported that support and honorary activities can have negative effects on volunteers such as suffering a burnout syndrome, which is more among volunteers than among professionals, especially among those who carry a high emotional burden (Andrees *et al.*, 2018).

II.5 Afghan Refugees and Maternal Health

Afghanistan is one of the most dangerous places in the world to be pregnant, which has the highest maternal mortality rates in the world. According to United Nations data out of 100,000 live births 638 women died (Eapen *et al.*, 2016; UNFPA, 2020). The reason of this high mortality rate could be poverty and lack of access to health services; less than 60 per cent of births have received care by skilled health professionals (UNFPA, 2021). The Afghan population had a long time war in the past with an unstable political situation over decades. There is a lack of primary healthcare concerning vaccine for eradicating communicable diseases as well as maternal and child healthcare (Matsangos *et al.*, 2022). Diseases such as Tuberculosis and Hepatitis B are prevalent among Afghans so there have been more challenges and health issues for them as well as for their host countries (Matsangos *et al.*, 2022; Lee, Emeto and Walsh, 2023).

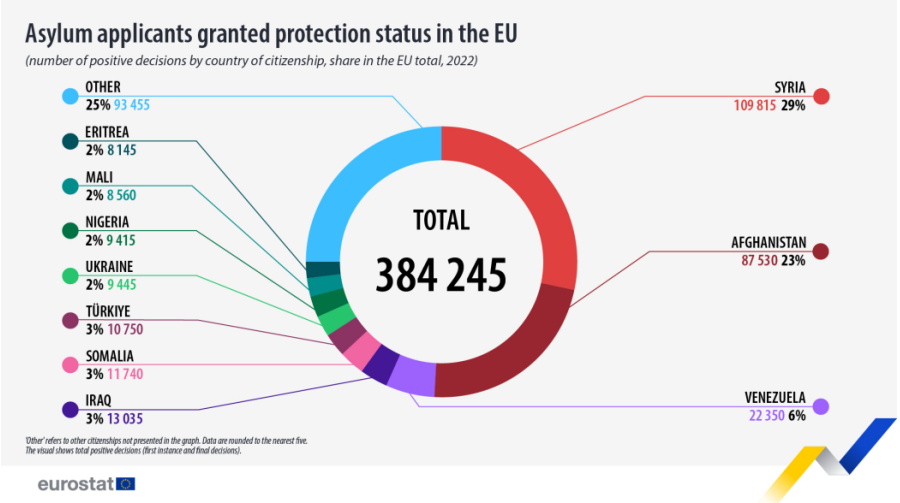

Figure 2: Asylum applicants granted protection status in Europe (Eurostat, 2022)

Figure 2, from Eurostat in 2022, shows that Afghan nationals rank second in number of positive decision and granted protection by the European Union countries, following Syrian. In Germany the number of Afghan refugees has doubled since 2015. (Eurostat and European Migration Network (EMN), 2022) At the same time, the German government recognized Afghanistan as a safe country, and increased the deportation of Afghans to their home country (Sökefeld, 2019). Thus, fear of deportation is a great source of stress among Afghan refugees who fled to Germany.

Research suggests that Afghan refugees and asylum seekers often have mental health problems resulting from prolonged exposure to war and the uncertainty of seeking international protection, as well as the challenges they face while seeking asylum, which often begins in childhood and spans in multiple countries (Kreczko, 2003; Rintoul, 2010; Yelland *et al.*, 2014; Riggs *et al.*, 2016). As a result, there is a need for healthcare providers to focus more on this group during maternal health. Promoting maternal mental health benefits not only the mothers, but also her baby and the rest of her family (Kassam and Nanji, 2006; Rintoul, Szwarc and Smith, 2010; Yelland *et al.*, 2016; Kaufmann *et al.*, 2022).

Chapter Three: Rationale, Questions and Aims of the Study

III.1 Rationale of the Study

Refugee women might face difficulties and challenges in the first year after arrival in Germany during “the European refugees’ crisis". This study through qualitative research and participatory health research sheds light on these experiences and creates opportunities for women to reflect on their challenges and develop a strategy to overcome them.

Refugee women’s reproductive health is an important issue in public health because of the crucial role of fetal and infant development as an indicator of adult health and reproductive justice (UNFPA, 2014; Davidson *et al.*, 2022). The reason of chosen participatory health research is that most of the times, women's voices are ignored during policy-making and planning process (Wallerstein *et al.*, 2017; Solà-sales *et al.*, 2021). Therefore, many researchers asked for qualitative as well as participatory studies in order to explore refugee women's experiences along with the aim of providing health equity and empowerment (Wallerstein, 2002; Somekh and Lewin, 2005; Sardenberg, 2008; Higginbottom *et al.*, 2013; Bozorgmehr, Schneider and Joos, 2015; Kleba *et al.*, 2021).

III.2 Study Questions

The research questions of this study are:

- How do Afghan refugee women entering Germany as refugees, navigate pregnancy, birth and reproductive health since 2015 during the “refugee crisis” in Europe?

- What are the benefits and challenges for refugee women and are their needs adequately addressed in the short and long term?

III.3 Aims of the Study

The primary aim of this study is to gain deep understanding and to investigate Afghan refugee women's experiences, facilitators and challenges during accessing reproductive healthcare after arriving in Munich, Germany.

The second aim of the study is to develop their self-help competencies negotiating the healthcare system for reproductive health individually and within their communities.

III.4 Objectives of the Study

1. To create a forum for women to express their experience of accessing reproductive health services during the time of asylum seeking within the first year of being in Germany.
2. To explore access barriers and other challenges for refugee women during birth and early motherhood.
3. To investigate refugee women's experiences and expectations of maternity and reproductive healthcare as an asylum seeker in Germany.
4. To facilitate the participants to develop their own peer support group.
5. To encourage discussion within the participant group to overcome potential barriers and challenges when accessing reproductive healthcare.
6. To reflect on their experiences during pregnancy and motherhood for finding potential new ways to achieve a happy and healthy motherhood.
7. To consider the role of voluntary networks for helping the refugee women during this time.

Chapter Four: Ethical Considerations

IV.1 Ethical Reflexivity

Ethical reflexivity and ethical consideration is one of the main aspects of qualitative and participatory research in practice (Roth, 2005; Maria *et al.*, 2018; Roth and von Unger, 2018; Banks and Brydon-Miller, 2019; von Unger, 2021).

This chapter[2] will discuss some of the ethical considerations that proved essential in the preparation for the field work of qualitative / participatory study with refugee women in Munich, Germany. These ethical challenges increased in the Covid-19 pandemic, as the researcher was confronted with further responsibility for the participants of this study and their additional challenges due to lockdowns and measures under Covid-19. Since, she was obliged to implement certain guidelines during the meetings, such as social distancing and reducing the number of participants in the meetings. Eventually, there was a lockdown in Munich, and the researcher resorted to holding the photovoice via social networks (WhatsApp).

Ethical considerations are critical in studies of refugee women, since they are a vulnerable group that might suffer from trauma and an unstable legal status (Clark-Kazak, 2017, 2021). One of the initial challenges to start the empirical project was obtaining ethical approval[3] from the Ethical Committee at the Faculty of Medicine, Ludwig Maximilians University of Munich (LMU). This necessary step had a profound effect on the researcher and encouraged her to reflect more on the project, minimize any harm to the participants, and remain cautious when entering the research field and data collection. The researcher's self-reflection of ethical concerns gave rise to numerous ethical questions in each phase of the research process: Could the questions in the interview guide remind the participants of any bad memories? Is this project beneficial to refugee

[2] This chapter will be published in detail in the "Invisibility of Refugee" autumn 2023 in the Forced Migration Studies Series, Volume 3 published by Transcript Publishing House.

[3] The Faculty of Medicine at the Ludwig Maximilians University requires any research proposal to be reviewed by an Ethical Committee.

women? What kind of risks might the study pose for them? Could the researcher treat all participants equally? The researcher kept reviewing the study's proposal again and again from research questions to study design.

There are plentiful issues to consider when conducting research on vulnerable groups and applying a consciously ethical approach in order to minimize any harm to participants (Clark-Kazak, 2017, 2021; Barkensjö *et al.*, 2018; Daley, 2021; Banks *et al.*, 2022). The researcher was fully aware that the participants are at risk of being hurt, and she did not want to remind them of any bad memories and cause mental health issues during data collection. Still, the researcher did not look at the participants as just vulnerable people. These women, in fact, are strong and show considerable resilience in tolerating hard times – from passing the dangerous route and traveling to Europe to settling down in a new country, where they are confronted with various challenges. For this reason, the participants in this study were recognized for their own power and agency, instead of being regarded as members of a vulnerable group only. After all, when we describe someone as 'vulnerable', we might face the risk of missing to see their power and agency (Banks and Brydon-Miller, 2019; Roth and von Unger, 2018; von Unger, 2018).

Among the key principles of research on refugees and forced migration are autonomy and partnership (Clark-Kazak, 2021). Autonomy means that refugees have an opportunity to get involved in data collection and have a say in the results of the study. Meanwhile, it is important that the findings of any research are beneficial to participants and their community in advocacy or project level (Jacobsen and Landau, 2003; Clark-Kazak, 2021).

Aside from qualitative research through in-depth interviews, this study is based on participatory research, as this method promotes partnership and collaboration with the potential of empowering and developing ideas and possible solutions (Morgan *et al.*, 2010; Minkler *et al.*, 2012; Wright, 2013; Wallerstein *et al.*, 2017; Erel, Reynolds and Kaptani, 2018; Cook *et al.*, 2020; Roura *et al.*, 2021; Banks *et al.*, 2022). The Afghan refugee women were able to share their experiences in participatory meetings, while photovoice enabled them to visualize their challenges and success in receiving

reproductive healthcare services. The research process would eventually help to promote the women's self-confidence and empower others in their community.

Nevertheless, the researcher kept reflecting on each and every interview or participatory meeting to avoid any harm to the participants and prevent the interviews or discussions from going the wrong way and awaking any negative memories. Furthermore, the researcher assembled a list of organizations that support refugees and are specialized in mental health; also she offered the women to contact her whenever they might need extra support.

IV.2 Presenting the Informed Consent

The first ethical challenge of an interview-based project is to ensure the informed consent of the interviewees. In research with refugees, the issue of signing a consent form should be done with consideration; the refugees should sign it voluntarily and should be offered to have an oral agreement alternatively (Clark-Kazak, 2017; Roth and von Unger, 2018). Before the interviews and meetings started, the participants of the study had received consent forms together with information letters in simple Farsi. Obtaining consent from the participants was much more complex than just handing them a form to sign; it required some time with each participant (Clark-Kazak, 2021).

As refugees in Germany have to sign a lot of forms during asylum procedures, a consent form might bring back negative memories. Some participants were afraid of signing anything due their legal status and were worried that their signature might get them in trouble in future asylum procedures. Therefore, the researcher offered them also an oral agreement for the interview alternatively. Only five out of thirteen refugee women wanted to sign the informed consent, while the others preferred an oral agreement. In addition, all participants got an information form that explained the project and the aim of the study in Farsi; an English version was handed to the German helpers. Nevertheless, the researcher explained the information once again in plain words before each interview

just in case they did not understand the details of the study could not read properly or did not have time to read the information.

IV.3 Anonymity, Privacy and Confidentiality

Anonymity was yet another important factor that should be taken into consideration. Roth and von Unger (2018) emphasize that true anonymity is achieved when researchers do not know the identities of the participants. However, von Unger (2021) states that in qualitative studies, the researcher deals with so much detailed information and descriptions of participants that are impractical to erase that it is virtually impossible to accomplish true anonymity (von Unger, 2021). Anonymisation, on the other hand, is rather a process that reflects the importance of anonymity in the research process (von Unger, 2021). In this study, pseudonyms were used that the participants had chosen themselves. All private information and address was deleted from the transcripts, field notes, and all other written documents pertaining to the participants to ensure that they could not be traced. Still, the researcher tried to keep the participant's narratives authentic in order to avoid missing the wealth of their data.

Although the participants trusted the researcher and talked freely, however, privacy and confidentiality were just as important in participatory meetings. Before each group meeting, the researcher emphasized to the women as co-researchers that not only the researcher but also the group members had to keep anything said in the meeting confidential, as the debates often included their stories and private experiences (Banks and Brydon-Miller, 2019; Banks *et al.*, 2022).

IV.4 Ethical Considerations through Participatory and Photovoice Research

Participatory research seeks to promote the agency of refugees and empower them individually and within their communities (Pittaway and Van Genderen Stort, 2011;

Minkler *et al.*, 2012; Wallerstein *et al.*, 2017; Banks and Brydon-Miller, 2019). There are several particular ethical issues to consider in participatory research, such as collaboration and power, boundaries between researcher and community partners, conflict and democratic representation, ownership and dissemination of data, as well as anonymity, privacy and confidentiality (Israel *et al.*, 2006; Wallerstein *et al.*, 2017; Banks and Brydon-Miller, 2019a).

When the researcher processed the participatory research meetings, she kept asking herself: What is her task as a facilitator in the meeting? How can she stay true to the ethical principals in participatory research? What is the best way to collaborate with the participants on the theme of the project? As reproductive health is a sensitive topic in itself, the researcher was not sure how easy it would be for the women to talk about it in a group setting.

Another fundamental issue is the balance of power in participatory meetings (Banks and Brydon-Miller, 2019; Israel *et al.*, 2006; Koch and Kralik, 2006; Wallerstein *et al.*, 2017). The researcher reflected on her role and position in each focus group and participatory meeting, when attempting to encourage the women refugees to participate: was she an advocate, a researcher or a friend?

The following section is from the field notes after a participatory meeting:

> *The involvement of the women was challenging at the beginning. When somebody had a question, often other mothers just looked at me, waiting for my answer, but after a while they started to talk more. They needed time to have the courage to share their own views and answers* (field note of first participatory meeting, Dec 2019).

The position as a facilitator during meetings can be quite challenging. After all, visualizing the voice of mothers should not harm them in their own community. In one of the meetings, for example, one of the mothers talked about her experiences during pregnancy and how to get family planning; she explained that she became pregnant right

after arriving in Germany. In response, another mother who had not become pregnant in Germany started to mock her as if she could not keep herself being pregnant; when others started laughing as well, the researcher immediately interfered and changed the topic, to avoid that the mother feels ashamed or loses her position in the community because of her testimony. Whatever was said or shared during meetings had to remain confidential. Otherwise the women would not have felt safe to talk about their experiences and stories.

IV.5 Keeping in Touch with Participants for Support in Health Issues

Since the researcher set up the WhatsApp group, six of the thirteen women have been infected with Covid-19; two of them were pregnant and eventually hospitalized and quarantined.

One of the ethical concerns and care during the lockdown was to keep in touch with the participants, especially those who had health issues. According to Israel *et al.* (2006), the researcher should remain humble and get to know the participant by being present in different occasions rather than just collecting data. Although the researcher received many distressed phone calls from these mothers, the support of a midwife speaking their language was fundamental. When refugees try to access health and maternity care, they are primarily confronted with the challenge of communication barriers. The situation became even worse during the lockdown, as they were not allowed to bring anyone to the hospital, including an interpreter. For this reason, the researcher actively supported them by answering their questions and interpreted their visits to health care centers via telephone several times. In conclusion, the pandemic raised new ethical issues, and through being flexible, successful small participatory meetings were held. Solidarity generated between the women was a key factor in maintaining their health and giving a voice to their stories.

Chapter Five: Methods

V.1 Design of the Study

This study combines participatory health research and qualitative research, conducted in three phases; first, a qualitative exploratory assessment phase, second participatory health research, and third, a participatory follow-up. The research used multiple methods through data triangulation for increasing accuracy. Using multiple sources of data collection increases the validity of the study's conclusions (Kolb, 2012; Newton Suter, 2012; Wilson, 2014). Therefore, the sampling criteria were triangulated through qualitative research with interviews and observation due to the diversity of living arrangements among women refugees, and participatory research together with photovoice (figure 3). Each of these three distinct phases is described in the following sections.

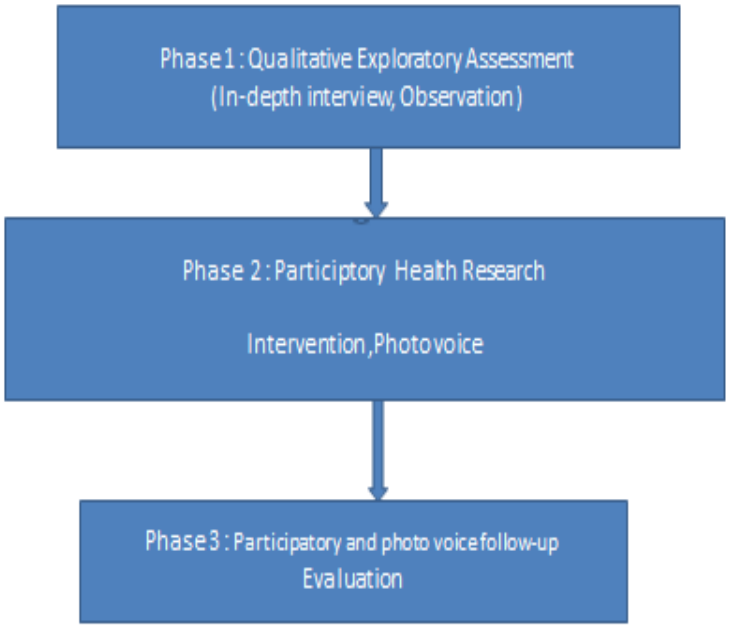

Figure 3: Overview of multi-component study design and planning process

V.2 Qualitative Exploratory Assessment Phase

The qualitative exploratory phase was specifically developed to gather qualitative data through observations and interviews (Charmaz, 2006, 2011; Chapman, Hadfield and Chapman, 2015). The aim of this phase was to explore Afghan women's challenges and experiences with emphasis on pregnancy, childbirth, and reproductive health. In-depth interviews aided the research in gaining a better understanding of the participants and their lived experiences; their voices and narratives were also prioritized (Seidman, 2006; Marshall and Rossman, 2016). Participants in the study narrated their experiences about accessing reproductive healthcare while seeking asylum in Germany, as well as their emotional needs.

This phase of the study employed a qualitative methodology according to grounded theory, which allows researchers to understand the perceptions and ideas within human experiences (Charmaz, 2006, 2011; Chapman, Hadfield and Chapman, 2015). A grounded theory approach shapes data gathering and provides explicit strategies for its analysis, allowing important concepts to emerge out of the data. The purpose of this approach is to construct a theory that offers an abstract understanding of one or more core concerns in the studied world (Somekh and Lewin, 2005; Kolb, 2012; Charmaz and Thornberg, 2021). Grounded theory is the most frequently chosen method in human and social sciences, it has also become one of the main methods in qualitative studies used in healthcare research (Charmaz, 2006, 2011; Kolb, 2012).

In this qualitative exploratory phase, eighteen in-depth interviews were conducted from December 2019 to October 2020 with thirteen Afghan refugee women whose ages ranged from 18 to 40 years at the time of the interviews, and who arrived in Munich, Germany in 2015 or later. The study also involved German volunteers who accompany refugees in various everyday activities and jobs, including visiting to health services, to better understand the obstacles Afghan refugee women experience when seeking healthcare. Ultimately, the data is derived from interviews, field notes and observation reports collected while accompanying the women in this sample as interpreter (from Farsi

to German and vice versa) on doctor and hospital visits; furthermore, the diaries of mothers who wished these to be added to the data of their interviews.

V.2.1 Study Participants and Recruitment

In December 2019, after ethical approval by the ethics committee of the LMU medical school (as described in the ethical considerations chapter), the researcher contacted members of a NGO *Helferkreis*[4] ("helping circle"), where she had previously volunteered, and asked their support to access the women who met the inclusion criteria. The researcher applied the snowball technique with the help of her experiences and network as a volunteer since 2015. Finally, thirteen refugee women and five German volunteers accepted to be interviewed.

V.2.1.1 Afghan Refugee Women

The inclusion criteria for Afghan women were determined as being over 18 years of age and having received reproductive healthcare services and / or giving birth in Munich, Germany between 2018 and 2019. For ethical reasons women with a mental health disorder, which may be exacerbated through participating in this study, were not included. Nine out of the 13 refugee mothers experienced pregnancy and childbirth in Munich soon after their arrival. All participants were hospitalized in Germany at least once for various health issues and all had experience accessing the German reproductive healthcare system. They were living in temporary refugee residences (Flüchtlingsunterkunft) or in social housing (Sozialwohnung).

[4] "Helferkreise" were founded in Germany in the 1990s with the goal of helping asylum seekers settle into their new neighbourhoods. There are "Helferkreis"-groups throughout Germany, found in most cities/towns.

V.2.1.2 Volunteers

Five German volunteers were interviewed, aged from 25 to 79 years, who were involved in refugee support since 2014. Four of them had joined several refugee mothers during their babies' delivery and had accompanied them to obstetrician doctors or other specialists.

V.2.2 Data Collection

Data was collected using individual face-to-face interviews with open-ended questions. The interview guide covered the topics and themes of the study which developed to in-depth interviewing proposed by Seidman (2006). The interview guide was created to cover the study topics and themes as well as to guide the flow of discussion in accordance with Seidman's recommendations for in-depth interviews (Seidman, 2006). The interview guide included individual experiences and challenges of the refugee women while accessing reproductive health and maternal care in Germany. The participants were encouraged to talk about their experiences during motherhood as a newcomer in Germany. Furthermore there were questions for exploring their perceptions and coping strategies to reach better services in the German healthcare system. The participants' demographic characteristics were also captured including age and number of children and the year in which they arrived in Germany (interview guide see appendix 5). Participants frequently described their general difficulties in Germany rather than their experiences obtaining reproductive healthcare. As a result, when the interview seemed to veer off course, they were encouraged to return to the topic and discuss their experiences with general and reproductive healthcare services.

The interview guide for the German volunteers included their demographic characteristics including age and years of their experiences working as a volunteer for supporting refugee families and their experiences while accompanying refugees in healthcare centres. The German volunteers narrated through semi-structure interviews their support

for refugee families which could promote their primary and reproductive health (interview guide see in appendix 6).

V.2.2.1 Development of the Interview Guide

In order to assess the feasibility of data collection, the interview guide was initially tested through two pilot interviews with two refugee women who arrived in Munich, Germany in 2015 with different living arrangements in refugee residences (Flüchtlingsunterkunft). Both women had been known to the interviewer for several years. Following the assessment of the transcription of these two pilot interviews, the data was critically and analytically analysed to ensure that the research objectives were met. According to Charmaz (2006), criticizing data does not imply criticizing research participants; rather, researchers should question their data. These inquiries help researchers identify actions and critical processes (Charmaz, 2006, 2011; Seidman, 2006). These facts enabled the researcher to consider the pilot study data and there was no need to change the questions of the interview guide. The pilot interviews data were included in the analysis of the study, as well as the researcher's notes from the interviews and observation in the fieldwork.

V.2.2.2 Conducting the Interviews "Having a Chat (*Gapp* ; گپ)"

The word "interview" was replaced by the Dari word "Gapp" meaning "friendly chat", when making appointments with refugees women for interviews, since the word "interview" has a legal connotation for refugees in Germany (with reference to observations during field work), usually emotionally connected to obtaining or losing an opportunity to remain in Germany. Refugee women recounted that those interviews to determine legal status in authority offices often triggered anxiety and worries about the outcome. With this in mind, replacing the word "interview" by "Gapp" was helpful for this empirical research.

At the start of the empirical data collection process, interviews were coded concurrently using theoretical sampling which is the key aspect for researchers to manage their data collection and analysis (Charmaz, 2011; Charmaz and Thornberg, 2021). According to Charmaz (2006, 2011) this method allows researchers to maintain focus early on to avoid mistakes and shapes data collection to better inform future research and analysis.

Clark-Kazak (2017, 2021) discussed special considerations for research with refugees and migrants to minimize harm and maximize benefits. Hence, we aimed to provide situations in which participants would feel most comfortable, while keeping in mind the previously mentioned ethical considerations before conducting each interview. For example, if they were unable to read or if reading was too difficult for them, the consent letter was read aloud; also, they were given the option to consent verbally for the interview instead of signing the consent letter. In many cases signing a letter brought back negative memories of the many obligatory papers they signed since arriving in Germany. Even recording interviews was not easy for some. Hence it was repeatedly emphasized that the audio would remain confidential and was simply a tool to allow the researcher to remember their words, and that nobody but her would listen to them. They often became more talkative once recording stopped. Those parts of the conversations were later written from memory. Two mothers did not agree to be recorded at all, and the questions were asked without recording and notes were written afterwards.

Each interview took 45-60 minutes and was conducted in the participant's home or in a café, depending upon their request. After every data-gathering event, interview or fieldwork (i.e. in camps, healthcare offices or meetings), the researcher immediately recorded observation reports on a cell phone as a precaution to avoid missing or forgotten information. These voice records included any insights, important notes as well as the researcher's self-reflections, which were later transcribed. This timely recording of impressions proved very helpful in preserving useful thoughts and data after observations and fieldwork.

Some women who agreed to participate asked the researcher to accompany and translate for them or their children during doctor visits. This allowed the researcher to make direct observations, build trust with the participants, and have in-depth conversations with them. In the interviews conducted in the doctor's office waiting room, problems from daily life as well as experiences with healthcare services were discussed. Permission was sought to use this additional information, as well as the quotations that emerged following the interview, for research purposes in the thesis study.

During interviews the researcher occasionally recounted her own personal experiences or those of other migrant mothers and the challenges during their pregnancy without mentioning names or private information. These affirmations followed participants' questions regarding personal or anecdotal experiences to confirm their own impressions, and often encouraged them to talk more openly about their similar experiences and struggles.

Five additional semi-structured interviews were conducted with five German women volunteers aged 25 to 79 years, who were involved in refugee support. Interviews were recorded and took 45 – 60 minutes and were conducted in their home.

V.2.3 Memo-Writing

Throughout the research and analysing process, memos were helpful in recording personal thoughts and reflections, and became an aid in further developing ideas and thoughts. According to Charmaz (2006) memo-writing is an important method in grounded theory because it prompts the researcher to analyse data and codes early in the research process. Charmaz (2006) also emphasized that memos give the researcher a space for making comparisons between data and data, data and codes, codes of data and other codes, codes and category and category and concept. In this way researchers can develop fresh ideas, create new concepts, and discover connections between categories and gaps in data collection. With memo-writing, researchers can even build whole

sections of their papers, which also improve researcher's confidence (Charmaz, 2006; Charmaz and Thornberg, 2021).

Like personal diaries or letters to a friend, memos are free from constraints. The researcher consequently took memos ongoing through data gathering and shared them with peers and supervisors, which proved useful in developing the results of this study.

V.2.4 Data Transcription and Translation

The thirteen interviews with Afghan women were transcribed and translated from Farsi into English (the researcher is native Farsi speaking). The other five interviews with German volunteers were transcribed and translated from German into English with the assistants of a native German speaking. The researcher listened again to the interview's records and repeatedly read and reviewed all transcriptions since the interval between the first and last interviews was more than eight months, because of Covid-19 lockdown and its regulations. Each diary, field note, memo and transcript of the interviews was verbatim and analysed.

V.2.5 Data Analysis

In this study the process of data analysis continued with constant comparison according to the grounded theory methodology (Charmaz, 2006, 2011). The researchers can use constant comparative methods to develop concepts from the data by coding and analysing at the same time (Kolb, 2012). The constant comparative methodology introduced by Glaser and Strauss (Bergaus, 2013) consists of four stages: first – comparing incidents applicable to each category, second – integrating categories and their properties, third – delimiting the theory, and fourth – writing the theory (Glaser, 1965, p. 439). Throughout these four stages, the researcher continually sorts through the data collection, analyses and codes the information, and reinforces theory generation through

the process of theoretical sampling (Charmaz, 2006). For this study, the purpose of conducting grounded theory and constant comparatively analysing was not to develop a theory, but to explore a concept and gain knowledge about the experiences of Afghan women refugees, through accessing reproductive healthcare in Munich, Germany. The concepts of reflexivity and self-questioning regarding the data were integral to the research process and to maintain the credibility of the research writing memos after developing the analysis was utilized (Charmaz and Thornberg, 2021). Von Unger (2021) also emphasized reflexivity through conducting qualitative study from starting until analysing increases the validity of the results.

V.2.5.1 Coding Process

Coding the data was secured using constant comparison within the "MAXQDA" program. The first step was initial coding, or line-by-line coding, then analysis with focused coding continued.

V.2.5.1.1 Initial and Focused Coding

To remain open to all possible theoretical directions indicated by the data, the process began with line-by-line coding. As pointed out by Charmaz, this provided the researcher with detailed data about the fundamental empirical processes of interviews, observations, and filed notes and allowed to capture implicit concerns as well as explicit statements (Charmaz, 2006, 2011). According to Charmaz, line-by-line coding enables researchers to discover shading in data and gain a close look at what participants explain or struggle with. Also, Charmaz and Thornberg emphasized that this way of coding allows researchers to understand their research participants' experiences and perspectives (Charmaz, 2006, 2011; Charmaz and Thornberg, 2021).

After determining the merging codes, focused coding started, the most important codes were focused on and these codes were developed. Following that, comparing the data to these codes assisted the researcher in refining them (Charmaz and Thornberg, 2021; McCall and Edwards, 2021). It was focused on the categories most pertinent and valuable to the research question, which is how Afghan women arriving in Germany as refugees navigate pregnancy, birth, and reproductive healthcare services.

V.2.5.1.2 Defining Categories

At the end of the coding procedures, Charmaz and Thornberg's (2021) recommendation was followed by self-questioning about the created categories and their properties in order to reflect on how they were connected and related to each other. Meanwhile, after the analysis was completed, they were compared to relevant material from a review of other studies, with a focus on the ideas and themes that the researcher had developed. According to Charmaz and Thornberg, this review allows researchers to see how the analysis fits and extends ideas in their field (Charmaz and Thornberg, 2021).

In this study, feminist[5] and participatory health research approaches were used to make refugee women's experiences visible and to apply gender equality as well as health equity, with the goal of empowering and emancipating participants by developing their autonomy skills (Harding, 1987; Barbeck, 2004; Somekh and Lewin, 2005).

Meanwhile, Charmaz (2011) emphasized that the analytic power of grounded theory offers to researchers distinct advantages in pursuing social justice inquiry. Hence, core consideration of this study was experiences of refugee women and to let them to further narrate those issues which constituted their main consideration. So, through analysing the interviews simultaneously with beginning the data collection process, the researcher intended to uncover a new phenomenon in a study concerning women refugees'

[5] Feminist research is based on social and individual women's experience and applies their experiences as scientific resources (Harding, 1987)

experiences through accessing reproductive healthcare services. However, it led to a clear theme: that the women considered language barriers and lack of proper communication as their main obstacle to navigating the healthcare system. Furthermore, the theme of refugee language barriers was articulated by volunteers who took part in this study, each of whom supported two or more refugee families; they were first hand witnesses to the difficulties refugees faced when seeking healthcare in Munich. Eventually, after line-by-line and focused coding of all transcriptions, the researcher found that the phenomenon of communication barriers and language barriers were explicitly mentioned as a core concept which emerged within different subcategories. The other implicit theme in their stories was a lack of confidence of Afghan women refugees when attempting to access healthcare in Germany. The selected quotes and themes were shared with experts and peers several times.

V.3 Participatory Health Research Phase

The participatory health research method was used in the second phase of the study to give refugee women the opportunity to recover their power and develop their own self-help competencies both individually and within their communities for promoting their reproductive health.

V.3.1 Overview of Participatory Health Research

Participatory research is defined as the "systematic inquiry", with emphasis on collaboration and the potential to empower, emancipate, and facilitate learning of those affected by the issue being studied (Barbeck, 2004; Koch and Kralik, 2006; Barndt, 2014; Coghlan and Brydon-Miller, 2014; Pant, 2014; Reid and Gillberg, 2014; Brabeck *et al.*, 2015; Njeru *et al.*, 2015; Gubrium *et al.*, 2016; Gilfoyle, MacFarlane and Salsberg, 2022). This methodology is also chosen for vulnerable and marginalized groups to document their daily lives and experiences (Wang and Redwood-Jones, 2001; Brydon-Miller,

Greenwood and Maguire, 2003; Kaufman and Morgan, 2005; Morgan *et al.*, 2010). Participatory research has an advantage of being used in a wide variety of research fields such as social sciences and healthcare (Burgess, 2006; Coghlan and Brydon-Miller, 2014; Loewenson *et al.*, 2014; Holliday, Phillips and Akintobi, 2020). Meanwhile, Koch and Kralik (2006) articulated that talking about the individual experiences was liberating and strengthening the participants' confidence and resulted in health promotion in their community.

Participatory health research is a research paradigm with recognition of each participant as a co-researcher to construct knowledge through the research aligned with the needs and interests of those involved in health / public health and who are affected to addressing health inequalities (Cook *et al.*, 2020; Kleba *et al.*, 2021; Banks *et al.*, 2022). The participants who engaged as active research partners can be patients or users of healthcare services, members of health-related interest groups or other communities of identity or place, healthcare or related practitioners, managers and policy-makers (WHO, 2022). A common goal of participatory health research is to foster a collective process of active co-learning (Cook *et al.*, 2020; Banks *et al.*, 2022).

V.3.2 Preliminary Groundwork and Recruitment of Community Partners

Through the recruitment process of Afghan refugee women as co-researchers for the participatory meetings, the researcher negotiated with two different centers in the suburbs of Munich because she was familiar with the Helferkreis members and the Afghan refugee community. It was discovered that a monthly gathering ("Frauentreffen") for Afghan refugee families was held in a public café in the suburb (Landkreis) of Munich. The researcher knew several Afghan mothers in this café, who were regularly participating in educational meetings in the frame of Elterntalk[6]. After attending some of

[6] Elterntalk is a series of educational meetings in Bavaria / Germany for parents with children younger than 14 years, also for families with migratory background. Elterntalk is funded by the Bavarian Ministry of Family, Work and Social as well as the Bavarian Ministry of Health and Care. In this forum the moderator

these meetings, the researcher realized that they have some common features with participatory meetings, such as sharing ideas and experiences concerning a specific issue. She decided to attend in a two-day workshop about facilitating a participatory meeting in the same organization which was in charge of holding the meetings in different locations around Munich, so that she could work with them a moderator. This was a great opportunity for improving her knowledge about facilitating participatory meetings and to enter the field. It was taught that the moderator of the Elterntalk meetings should not interfere in the discussion of the participants and not correct them since there is no right or wrong experience and the participants have to (learn to) respect each other's different ideas.

The participants were asked to explain their own thoughts and ideas about the given picture in different themes of child education. This method of prepared pictures was similar to photo elicitation: the introduction of participant-driven photographs or other visual stimuli is aiding the researcher's attempts to understand the experiences during qualitative interviews (Bates *et al.*, 2017; Copes *et al.*, 2018).

Following the workshop, the researcher observed an Elterntalk meeting to gain more experience before being granted permission to be a moderator herself. Hence, in November 2019, she attended a meeting with five refugee mothers in the same café. The theme of the meeting was about the challenges they were confronted with by their children's education. After the meeting, which lasted for about an hour, the coordinator left the place but the researcher stayed a bit more to talk with mothers and get to know their ideas about the meeting as well as its theme. This allowed simultaneous observation and listening and brought comprehensive information about their ideas, feelings, and thoughts of the meetings. The researcher asked them to stay a little longer and gave information about her study. The observation and conversation with mothers have showed that they were eager to learn and willing to cooperate in sharing their voices concerning health issues. The women agreed to participate as co-researchers in the

demonstrates several prepared pictures with different themes (childhood education, consume, prevention of addiction and media

participatory meetings in the same place every month. This location was the most convenient for all of them as it was close to their homes. Their motivation for participating in the study was to share their experiences and coping strategies in order to learn from one another and help their community. Meanwhile, they hoped to show newly arrived migrant women how to deal with the challenges of settling in Germany. At the end, they were given an information letter and a signed consent letter. The letters were read load for two participants whose reading skills were not sufficient and the study was explained again. The issues related to the consent letter are mentioned in the "Ethical consideration" chapter.

V.3.3 The Cycle of "Look, Think, Act" in the Participatory Meetings

In this study the framework of "Look, Think, Act"-cycle (Stringer model) was performed during the participatory meetings, this process is mainly discussed in action research, which is presented in many ways and discussed in several studies for increasing confidence and enabling empowerment of the participants as co-researchers (Koch and Kralik, 2006; Patterson *et al.*, 2010; Loewenson *et al.*, 2014; Stringer, 2014).

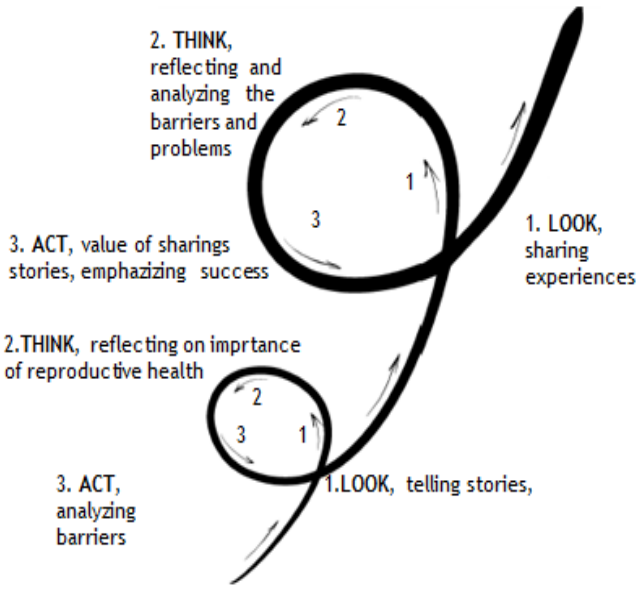

Figure 4: The cycle of "Look, Think, Act" adapted from participatory action research in Health system (Loewenson *et al.*, 2014)

During the study's participatory meetings, the look, think and act cycle model was used continuously and repeatedly to develop Afghan women refugees' self-help competencies in negotiating the German healthcare system for reproductive health individually and within their communities. They were able to share their experiences through participatory meetings, making visible their challenges and successes in receiving reproductive health care services. By continuing the cycle, the co-researchers could implement the ideas from the meetings, reflect on them in the next meeting and by this enhance the scheme further. Following details of conducting the process as shown in figure 4 are explained.

Looking:

The Afghan women were encouraged to talk about their experiences during pregnancy and delivery in the first year after arriving in Munich, Germany. Those who were not pregnant were encouraged to tell their experiences about accessing the reproductive healthcare system and visiting gynaecologists. As co-researchers and community partners, the women discussed not only the challenges and various difficulties they faced while navigating reproductive health, but they also shared success stories and actions they took to better manage their healthcare resources. Because the experiences were shared in a participatory setting, the accounts of some of the community partners supplemented the story of other women by reminding them of different aspects of their own experience.

Thinking:

Following information gathering in the form of listening to their community partners' experiences and stories, it was time for the women to reflect together on the importance of reproductive health in the context of their own wellbeing, which would later affect and improve the overall wellbeing of their children and families. The second purpose of the thinking stage was analysing challenges faced by each member of the group individually

and as members of the community to which they belonged. In a sense the accounts facilitated the identification of barriers to healthcare access because by reflecting and evaluating different aspects of their experiences, they came to appreciate the multi-faceted nature of access to healthcare and by extension realize their strengths and analyse their coping strategies. We presume that the co-researchers laid the foundation for further exploration of their experiences and discovered how to make sense of them in order to create a strategy for the future.

Acting:

In this last stage the participants suggested possible courses of action to facilitate healthcare access and together they analysed the appropriateness, effectiveness, and scope of the propositions. For example, one of the identified challenges was fear of visiting doctors. In this context the community partners suggested turning to each other for support and encouraging one another to have courage.

In the beginning of each meeting the co-researchers were asked to review the reflections and potential actions of the previous meeting and explain again the main takeaways. At the end of each meeting, the researcher suggested that they investigate the connections between the day's outcomes and reflection topics and the previous meeting's outcomes in order to highlight common themes and extend the existing dialogue.

V.3.4 Process of the Participatory Meetings

The second phase of the study consisted of eight participatory meetings which were held with nine women refugees between December 2019 and June 2020. In the participatory meetings tools such as photovoice were utilized. Four of the participatory meetings included 4 to 5 women as community partners and further four meetings consisted of 2 mothers due to the Covid-19 pandemic and the regulation to keep social distancing in the refugee residents and other indoors meeting places. The characteristics of the nine women as co-researchers are mentioned in Table 1.

All meetings were conducted according to the community based participatory research (CBPR) principles (Minkler *et al.*, 2012; Wallerstein *et al.*, 2017; Holliday, Phillips and Akintobi, 2020) as follows:

- They were participatory and cooperative, engaging refugee women and researcher in a joint process in which both contribute equally
- They were a co-learning process
- They involve systems development and local community capacity building
- They were an empowering process through which women could increase control over their lives

Code	Age range	Number of Children	Living in refugee residents	Year of arriving in Germany	Ethnicity	Main support person	Age of youngest child
W1	30-39	3	No	2015	Hazari	Husband	4 years
W2	20-29	3	Yes	2015	Hazari	Husband	4 years
W3	30-39	6	No	2015	Harati	Husband	6 years
W4	30-39	3	No	2015	Harati	Husband	8 years
W5	30-39	5	No	2015	Harati	oldest daughter	7 years
W6	20-29	0	No	2019	Hazari	Father	No child
W7	20-29	3	Yes	2015	Hazari	Husband	1 years
W8	20-29	3	Yes	2015	Hazari	Husband	6 months
W9	30-39	0	Yes	2015	Hazari	Husband	No child

Table 1: Characteristics of the women co-researchers in the participatory meetings and photovoice

In the beginning of each meeting the researcher explained to the women that they can decide and choose the theme but preferably in reproductive health. During these team meetings, it was emphasized about equal responsibility for decision-making and explained about the principles of participatory research. They could choose themselves who wants to speak (first) and others continued the discussion on that theme. They could choose the place of the meeting as well as date and time. Two of the women in the groups were more active than others and they voluntarily informed others about the schedule of the meetings and sent reminders. They also invited their friends or other mothers who had time and interest about joining in the group; they could participate as well after signing the consent letter.

Each meeting lasted about one and a half hour and the language spoken during meetings was Farsi/Persian. Two of the mothers were talking in Dari (the name used for several Persian language dialects spoken in Afghanistan) with a very strong accent which sometimes was difficult for the researcher to understand; nevertheless the mothers had no difficulty to understand the Persian language the researcher spoke since all of them have been living in Iran before moving to Germany.

In spite of being allowed to choose their own theme of the meeting, they often kept to the main research theme reproductive health, since they were all interested a lot in discussing their challenges with gynaecologists and obstetricians. Some of them also emphasized that since the researcher is midwife, they were very happy and eager to talk and ask their questions, which they never could get answered.

Nevertheless, the theme of discussion was often influenced by the general circumstance and the persons who were attending the meeting or sitting in another part of the room such as their children or helpers from Helferkreis. Also the theme depended on the place where the meetings were held. For example, if the meeting was held in a refugee residence the women preferred to talk about the difficult circumstances of living and the fear of getting diseases because of the shared sanitations.

Two of the meetings were conducted in the participants' homes. Together with cooking traditional food, the atmosphere was more relaxing and they felt more open and comfortable. At the same time it was obvious that they were having fun and enjoyed being together. In this situation, their role became more powerful because of their knowledge about preparing their food and the researcher was learning from them. Therefore, it turned out to be very successful and helpful for a better achievement of the principle of empowering and cooperation.

Also at the beginning and ending of each meeting again the important issue of confidentiality was emphasized. This was important for the women to feel safe to talk about their experience and stories. The researcher encouraged them to contact her if they had any issues or inquires related to the research and meetings. After each meeting filed notes and observations were written, which were used as data for the study.

Ground Rules: (Koch and Kralik, 2006)
- Try to be good listeners without judging others and commenting on other women's stories.
- Involve every woman in the group dialogue.
- Do not interrupt others. One person speaks at a time.
- Be mindful of other women who want the opportunity to speak.
- Ensure privacy and confidentially of group members (what is said in the group stays in the group).

Plan: Look, Think, Act Model (Stringer, 2014)
LOOK
Recounting experiences related to themes chosen by the women themselves and possibly expand their account of the previous meeting.
THINK
Formulate challenges and positive aspects of the experiences in a collaborative manner.
ACT
What can we do about the formulated challenges and how can we capitalize on the strengths of the group members in order to move forward and achieve better results in managing available healthcare resources?

Figure 5: Plan for involving and collaboration with refugee women; Dec 2019 to Jan 2020

As explained above in V.3.3 these meetings were conducted together with refugee women as co-researchers according to the cycle of the Stringer model (Stringer, 2014), the plan is presented in figure 5.

V.3.5 Small Group but Powerful Participatory Meetings

Before the Covid-19 pandemic and subsequent lockdowns, the researcher had fortunate to conduct three focus group meetings, each with four to five mothers. The restrictions enforced in March 2020 made it difficult to host other meetings. However, the mothers in the project wished to have personal instead of virtual meetings. Due to the trust that was developed in the group, the researcher organized meetings with hygienic requirements and health regulations. In consequence, the meetings were held in smaller groups, consisting of the researcher and two or three women refugees as co-researchers, while maintaining safe distance in open air or inside the camp's rooms with open windows.

Participatory meetings should have a minimum of five to eight participants according to literature (Minkler *et al.*, 2012; Cook *et al.*, 2020); however, the tiny groups – created in extraordinary circumstances – for the first time enabled the women to discuss issues that they had not been able to talk about privately, in previous larger groups, or during in-depth interviews. In spite of partially conducting the meetings in small groups, the women actually fulfilled their role as co-researchers in these participatory meetings, while the researcher was still able to act as a facilitator in keeping with the principals of participatory research: it was participatory and cooperative, and engaged the participants in a joint co-learning process, in which they were empowered and controlled the topics of discussion (Minkler *et al.*, 2012; Yelland *et al.*, 2016). These participatory meetings with only two or three co-researchers were very deep and intense, and had a great atmosphere for the mothers to share their stories. The women themselves described their relationship as a sisterhood, since they got to know each other on the long journey to Germany, or when arriving and living in temporary camps together. Moreover, they

could also discuss the challenges posed by the pandemic as well as their experiences of getting access to reproductive healthcare.

V.3.6 Data Analysis of Participatory Meetings

Many researchers mentioned that involvement of community partners in the analysis has benefits, and the data encourages them, increases participation, and strengthens external validity of the research findings (Patterson *et al.*, 2010; Minkler *et al.*, 2012; Pant, 2014; Reid and Gillberg, 2014; Wallerstein *et al.*, 2017). Nevertheless, the strongest contribution to the participatory research happens, if the community partners are involved from the beginning in recruiting participants, designing the study, and implementing the research, while engaging them in the data analysis. The contribution by the participants is less if they involve in the interpretation of the data only (Wallerstein, 2002; Jackson, 2008; Rhodes *et al.*, 2013; Reid and Gillberg, 2014; Kleba *et al.*, 2021). In this phase of the study of analysis the researcher involved the participants in the last step of analysing, since the transcribing or analysis with verbal data was not easy for them and needed long time for learning. On the other hand, due to Covid-19 regulation, it was time consuming to coordinate meetings and teaching within the group. Nonetheless, during few focus group discussions for analysis, the researcher shared with them a summary of her field notes and memos, as well as the analysis and interpretation. Finally, the researcher shared categories and themes with refugee women for confirmation of accuracy. They reflected on the themes as outcomes, selected those that were important to them and expressed their concerns about the quality of healthcare. For example the theme of “communication barriers” and “timidity and lack of self-confidence” were their most important concerns and the women were ready to create change and action strategy about them. They believed these themes were necessary for their health outcomes. So, they were also reflecting on them in more than one meeting.

V.4 Photovoice Project: "What Gives Us Strength"

Photovoice was introduced as a medium for Afghan women refugees in this phase of study to explore their perceptions and experiences of accessing reproductive health in Munich with a focus on voice to encourage a dialogue to see, to hear and to make sense of their pregnancy and time of motherhood. With the improvement of communication, also by sharing their experiences, their health perception and practices can be improved (Moffitt and Vollman, 2004; Pant, 2014; McMorrow and Saksena, 2021).

V.4.1 Overview of Photovoice

Photovoice is accounted as one of the techniques in participatory research, which has been utilized worldwide in several projects with vulnerable groups as well as in projects related to marginalized populations and their public health issues (Wang, 1999; Wang and Redwood-Jones, 2001; Moffitt and Vollman, 2004; Brandt *et al.*, 2017; Woodgate, Zurba and Tennent, 2017).

Photovoice gives the participants a further possibility, next to oral and written expression, to present themselves and explain experiences with pictures and images. It can be an empowering process for the participants and results in images influencing individual and community action (Barndt, 2014; Brandt *et al.*, 2017). The photovoice study of Morgan *et al.* (2010) with women from Costa Rica stated that the process through photographs and stories empowered the women and could give them voice for the policy makers and community leaders (Morgan *et al.*, 2010).

V.4.2 Conducting Photovoice

Photovoice via social media was introduced to the participants since there were no participatory meetings for two and half months due to the lockdown and restriction on gathering because of the Covid-19 pandemic. Meanwhile, after previous meetings a

trustful atmosphere was built in the group, so, with the participants' agreement the researcher created virtual photovoice meetings via social media. The women had their own smartphones already and knew how to take pictures and share them with others, so there was no need to teach them how to take pictures, also, they were familiar with the WhatsApp application, therefore a group was created in WhatsApp with the name "let's chat with pictures". The participants wished to take pictures with their cell phone about wellbeing, the theme which they were concerned about most due to their struggles during lockdown, with the title: ***"what makes them feel happy, keeps them healthy and promotes their wellbeing in their everyday life".*** This theme for photovoice was opened, so participants could focus on any subject that keeps them and their families healthy and happy. This method had the advantage of giving the participants the space to choose and create their own theme which was important for them.

While introducing the photovoice project to the participants, the ethical concerns were also emphasized such as not to take a photograph of the face of children, not to take a picture which threatens their own or others' wellbeing, not to violate someone else's privacy and not to photograph the face of people who do not want to be in the picture.

Women participated in the photovoice project learned how to communicate through images, and interestingly found out that with photographs they could communicate in a better way. With sharing each picture in the group they addressed a new theme and anticipated that it would be important to keep wellbeing and they wrote a narrative about it. They were offered to explain what they see in the picture or what their idea about the problem or issue is and what they could suggest to solve the problem concerning that issue. For those who could not write properly, it was suggested to record their audio voice in the group and talk about their ideas and feelings about their own and about others' pictures as well.

The participants who were living in refugee camps kept from taking pictures of their residents' surroundings, for that might cause them trouble with the gatekeepers or

communities; however, they were recommended to take pictures inside their rooms. They collaborated very actively and chatted about the photos each time.

Still, some of their photographs were of their personal life and with their children's faces, so it was just kept in the group discussion but not used public. Sometimes they shared their messages with symbolic or metaphorical pictures, so their narrative was made clearer, and it was vital for the context.

V.4.3 Data Analysis of Photovoice

Narratives of each photograph and their audio records were transcript verbatim and then translated to English together with field notes and memos. Data was categorized in the "MAXQDA" program and analysed according to constant comparison grounded theory (Bergaus, 2013), as explained in detail in V.2.5.

Furthermore, the reflection on the discussions and comments of the women as co-researchers helped to shape the results. They were reflecting more in detail on their pictures and evaluated the theme which was discussed. Particularly they selected those themes which could promote their strength through extra challenges during lockdown and pandemic. All themes and sub-themes were discussed several times with peer researchers.

V.5 Participatory and Photovoice Follow-up Phase

This phase was the evaluation of the participatory and photovoice part of the study.

V.5.1 Conducting Follow-up

For follow up two focus group discussions were conducted with six participants, which were audio recorded. The six women participants in these focus groups were active during the participatory meetings and photovoice. These focus group discussions aimed to involve community partners in the analysis and for further confirmation of the theme as an outcome and finding. Moreover the participants were asked about the effect of the participatory and photovoice research on their health promotion individually and within their community.

V.5.2 Data Analysis

The process of analysis was on the data of focus groups discussions in the follow-up phase. The records were transcribed and translated from Farsi into English; (the researcher is native Farsi speaking). The researcher listened again to the records and repeatedly read and reviewed the transcriptions. Field notes of the focus groups, memo and transcripts were verbatim and analysed. The process of the line by line coding and categorising them were according the constant comparison (explained before in V.2.5) for generating the concept and ideas (Charmaz, 2011). This procedure was done with the data management system computer program "MAXQDA". The final findings were reviewed several times with academic supervisors and peers.

V.6. Reflecting on the Position of the Researcher

"If you see your experiences in your data, you will be an insider."

The above quotation is from a conference[7] talk on qualitative research. It is closely related to the researcher's position and data in her thesis study. The researcher has experienced

[7] The Eighth Annual Qualitative Research Symposium (QRS), "Researcher Vulnerability",1-2 Feb, 2022, Bath university, UK.

ongoing reflexivity on her position and standpoint throughout the study[8]. These personal views could affect the data gathered during fieldwork, as well as the coding and analysing processes (Naples, 2003; Charmaz, 2011). Although the researcher repeatedly submitted the coding and memos for review to her peers and other researchers, the influence of her position on the research, data collection, and analysis was unavoidable. Furthermore, her dual roles as researcher and advocate, as well as friend and ally, inevitably influenced this research and how it was carried out.

According to Naples (2003) in data collection and analysis it is important that researchers reflect on the standpoint and subsequent positionality. For instance, a researcher as insider can gain more and deeper understanding of data; on the other hand, a non-native person or outsider can be more objective in analysing data according to the social context and cultural practices (Naples, 2003; Berger, 2015). Naples believes that reflecting on the feminist standpoint, on the position as an insider or outsider, and on the researcher's power is essential during data gathering (Naples, 2003). In this study the researcher was aware that her position had both sides, being insider and outsider[9]. Her insider position involved her role as a mother and a migrant, who volunteered as a refugee translator since 2015. As a witness to the refugees' challenges in these places and having been affected personally, she was viewed as an insider. Meanwhile, by joining refugee families in several healthcare centres and offices, some of the women participants of this study knew her already. Her position as a friend took precedence over her position as a researcher. For the most part, the participants of the study felt comfortable during the interview and participatory meetings and talked freely about their experiences and challenges when accessing reproductive health during their pregnancy and in motherhood. Some participants recounted that they were often asked for interviews but refused. They agreed to interview with her since they considered her a friend or a peer.

[8] According to Ralph, Birks and Chapman (2015) the ontological (what is reality?) and epistemological (what can be known about reality?) assumptions of the researcher will influence the study and should be identified by the researcher.

[9] (Islam, 2000), a Bangladeshi American researcher on racism, reflected that she had two contradictory positions in her research within the Bangladeshi immigrant community in Los Angeles, which influenced her study and data collection during interviews.

Yet the researcher was an outsider, being privileged in many ways. Her husband is a German physician, she has an academic education and she does not have any constraints for living in Germany due to German citizenship, or in accessing health insurance.

Meanwhile, she was often part of the women's stories in the interviews, being a companion or translator. For example when she asked how they communicated with the doctor or nurses during birth or early postnatal care? She responded: *"You were translating my words to the doctor!"* So, during her field notes after their interviews she reflected on her memories of joining them to their doctors. The following is a quote from a refugee mother who mentioned that the researcher had clarified her symptoms to the doctor, so she received the correct treatment:

> *Nasim: How were you able to tell them that you have allergies after your delivery?*
> *Maryam: You told them, don't you remember?*
> *Nasim: Really, I did? I don't remember!*
> *Maryam: (laugh) I told you my skin was itching, and my body was feeling very hot. You told the nurse and doctor that I have allergies, and later they gave me a pill."*
> (Maryam, Feb 12th 2020, Pos. 74-79)

This clarified that the researcher's position as a healthcare professional and supporter had influenced the data and consequently, the results. The following is another quote from Maryam during her pregnancy; she was very worried about her baby after she got an infection:

> *Maryam: "Yes, then you talked to the doctor, and came back to tell me that everything was ok, and the baby was healthy. I was very happy! Ah (sigh of relief)."*
> (Maryam, Feb 12th 2020, Pos. 162)

Two other participants also shared their diaries during pregnancy, in which they mentioned the researcher as a friend who helped them by translating and explaining her symptoms to the doctors and nurses.

Meanwhile, her position as a facilitator during participatory meetings was also considered. During each meeting the researcher strived to coordinate the process of participatory meetings so her role as a facilitator superseded her role as an advocate or health professional, a position which was sometimes challenging during meetings. She was conscientious in enabling the voice of mothers without causing them harm in their community. If one of the women was mobbed or blamed by the others while telling her stories, the researcher intervened immediately and diverted the topic. She was cautious that no one to feels ashamed or loses their position in the community as a result of their testimony.

So, during the researcher's observations and interviews in this research, she was aware of being influenced by her feminist standpoint, and had reflexivity, methodologically as well ethically, about her position and power which could increase validity of the study (von Unger, 2021).

Chapter Six: Results

This chapter describes the selected findings of the analysis from the three phases of the study, which were based on all data collected through 18 interviews, field notes, and eight participatory meetings together with photovoice and two focus groups as follow-up. There are several volumes of data but because of academic writing and word limit, only key encounters are presented here which were chosen as most relevant for improving reproductive health by women participants as co-researchers.

The analysis from qualitative exploratory assessment study yielded four themes that incorporate findings: 1) Communication and information-gathering barriers; 2) Volunteers' role as bridges to the German healthcare system; 3) Being intimidated and lacking self-confidence; and 4) Structural barriers and strength to access to reproductive healthcare.

Furthermore, results from participatory health research meetings were achieved through collaboration with women co-researchers. These are the two primary themes that emerged from the meetings' reflections: 1) Solutions to overcome language barriers; 2) Possible strategy to overcome being intimidated in communicating with healthcare staff.

The findings from photovoice were primarily about well-being and reflecting on the strength and strategies of the women who participated in confronting challenges, particularly during the Covid-19 pandemic. 1) Devotion to motherhood; 2) The value of safety; 3) sisterhood: bonding beyond blood; 4) Perceived well-being and promoting activity; and finally the value in sharing experiences and learning from each other emerged as a theme in the follow-up phase.

No	Interviewer pseudonym name	Age range	Number of children	Year of arrival in Germany	Living in refugees camp in the time of interview	Having pregnancy and birth in the first year of arrival
1	Masumeh	30-39	3 children	2015	No	Yes
2	Sahar	20-29	2 children	2015	Yes	Yes
3	Neda	20-29	1 child	2015	No	Yes
4	Maryam	20-29	3 children	2015	Yes	Yes
5	Zahra	30-39	0	2015	Yes	Treatment for infertility
6	Soraya	30-39	6 children	2015	No	No
7	Sara	20-29	3 children	2015	Yes	Yes
8	Aubi	30-39	3 children	2015	No	No
9	Mahnas	30-39	2 children	2015	No	Yes
10	Saeedeh	30-39	6 children	2015	No	Yes
11	Lili	20-29	3 children	2015	Yes	Yes
12	Samira	30-39	5 children	2015	Yes	Yes
13	Roz	20-29	0	2019	No	No

Table 2: Participants' characteristics (Afghan Refugee Women)

VI.1 Qualitative Exploratory Assessment

The interviewed Afghan women were living in temporary refugee residences (Flüchtlingsunterkunft) or social housing (Sozialwohnung), table 2 above shows their characteristics. Nine women experienced pregnancy and childbirth in Munich soon after their arrival. All participants were hospitalized in Germany at least once for various health issues and all had experience accessing the German reproductive healthcare system. Some participants claimed that their pregnancy was complicated because they had acute and / or chronic infections such as tuberculosis, acute allergic reactions, depression, placenta previa (when the placenta is not in the correct position in the uterus), diabetic

pregnancy, and so on, and they had to visit the doctors several times. Three of them were hospitalized during pregnancy because their symptoms became severe.

Five additional semi-structured interviews were conducted with five German women volunteers aged 25 to 79 years, who were involved in refugee support, three of them were supporting and helping more than two Afghan refugee families. Table 3 below shows their characteristics.

No	Interviewer pseudonym name	Age range	Number of refugee families taken care for	Year starting work in Helferkreis	Joining refugee to birth and health centers
1	Anita	60-69	One Afghan family	2015	Yes
2	Meg	60-69	Two Afghan families	2015	Yes
3	Luisa	50-59	Two Afghan families	2015	Yes
4	Joanna	20-29	Two young Afghan women	2016	No
5	Dina	60-69	Three Afghan families	2015	Yes

Table 3: Participants' characteristics (German members of Helferkreis)

VI.1.1 Communication and Information-gathering Barriers of Refugee Women

During interviews almost all refugee women expressed difficulties communicating with healthcare staff due to language barriers, which made it impossible for them to clearly express their symptoms and needs. They added that they found it confusing to receive so much written information about each treatment. They felt helpless and distressed emotionally because of this. Additionally, some of the participants stressed that they did not trust the process of treatment because they believed the doctors did not understand what they were saying and as a result, did not accurately diagnose the cause of their illnesses.

"It is tough to be tongue-tied." (in Farsi: بی زبونی خیلی بده) (Maryam, Feb 12th 2020, Pos. 119)

The quote above is from an interview of Maryam, an Afghan refugee mother (pseudonym name), who's pregnancy began within the first year of her arrival in Munich. She explained that her distress stemmed largely from her inability to communicate with the doctors and healthcare staff due to language barriers as she mainly speaks Farsi. She was unable to communicate with the medical team and, feeling helpless, was concerned that her pregnancy had been terminated by misunderstanding. All other participants shared similarities in their narratives concerning the challenge of being unable to adequately express their problems to doctors and to the rest of the healthcare staff, as well as not understanding the doctors' diagnoses themselves. They also claimed that they would advise newly arrived women to wait until they understand the language before they become pregnant.

> *"Sara: the newly arrived women should not get pregnant immediately, first she should learn the language and should be able to talk, then she should get pregnant so she can communicate with doctors. When I came here and I got pregnant, I could not talk and communicate, it was so hard!"* (Sara, Mar 5th 2020, Pos. 115)

All eight refugee women who had pregnancy and delivery experiences in their first year after arrival in Munich emphasized that because they were unable to communicate properly with midwives and nurses after birth, they became mellow and isolated. The following quote comes from a woman who had her baby via cesarean section, which was followed by excruciating pain, without medication, because she did not take the drugs given to her since she did not know what was put next to her bed and could not explain herself to the staff.

> *"It was so difficult to be pregnant in the first year after arrival in Germany; it is un-forgettable, the time of pregnancy and delivery. I didn't understand any word they said, and they never had time for me. For example, I didn't know that there is a button that I can press when I need help, and they gave me a pill and a glass of*

> *water on the table that was so far away that I could not reach the glass and they didn't take care. Then a nurse asked me to walk, which caused intense pain and she was so angry when she saw I did not take my pill for pain and I was just crying."* (Lili, Sept 24th 2020)

Anxiety and feeling isolated due to lack of proper communication were also reported by other participants. Most of the refugee women described their feeling emotionally unstable especially during pregnancy and motherhood and feeling very lonely. The following quote stems from an Afghan refugee woman who was living in a temporary camp for about five years in a suburb of Munich. She had no prior pregnancy experience in Germany, but she had to visit a gynecologist several times due to repeated vaginitis, which she assumed was caused by the refugee camp's living conditions and shared sanitary facilities.

> *"Sahar: Every time I had to go to the doctor, I cried a lot since I couldn't talk.*
> *Nasim: Why were you crying?*
> *Sahar: Because I went alone to the doctor with my child since my husband had to work. I struggled a lot with the communication between me and the doctors who couldn't understand me. Again and again I had my symptoms and didn't get the right treatment."* (Sahar, Feb 6th 2020, Pos. 4)

The refugee women reported that their first year of motherhood in Germany was very different from their experiences in their home countries as if their bodies responded differently to hormonal changes and that a lack of support from their families played a significant role in this.

Some participants reported hostility and discrimination from medical professionals because they were unable to communicate effectively due to language issues. For example, Zahra who was undergoing in vitro fertilization (IVF) after suffering from infertility for more than eight years had to return to her family doctor's office and a hospital for treatment several times over several months because she did not understand

which examinations and documents the gynecologist in the infertility center required from the family doctor to begin the procedure, while the gynecologist refused to contact the family doctor herself. She claimed that the personnel at the doctor's office told her not to come back unless she was accompanied by an interpreter. She also experienced a sense of exclusion since she was required to wait until all other patients, including those who arrived at the clinic after her, had seen the doctor. As a result, she stated that instead of receiving assistance, she encountered an uncooperative staff, leaving her feeling discriminated again.

> *"Although the doctor could call herself the family doctor and ask for these documents, she didn't do it and just wanted to annoy us (deep breath), just because we were migrants, annoyed us. Then she wrote the medicine and explained to us wrongly the way that I should use it. She accused me again that I used wrong the medicine and I should have used it another way, she didn't accept that she made a mistake, and she said it is our fault, she just harassed us*." (Zahra, Feb 12th 2020, Pos. 10)

A solution for overcoming language barriers was to use an interpreter. However, according to the data, it was extremely rare and not always satisfactory. Since women emphasized that when they could hire someone to translate, this person was frequently insufficiently professional and could not understand the medical terms used by the doctor, or they could not understand the refugees well due to the dialect they used. Another option they mentioned was to bring their children or other family members with them. Women, on the other hand, did not want their family members, particularly their children, to be aware of their reproductive health issues. As a result, having a proper professional interpreter to help communication with the medical staff was described as a rare blessing. The following is the researcher's observation field note from accompanying refugee women for interpreting while they were receiving health services, which pointed in the same direction.

> *"Every time I company a refugee mother to the offices or hospital, the doctors are very happy to have my assistance as a translator. Even more, when I tell them I'm a midwife. Doctor H. said that having me there was much better than having their husbands there. He said that they give long explanations to the women. But men only translate a few words to their wives. Most likely because their German is not good enough."* (field note, Nov 2019)

The language barrier not only hampered verbal communication but also written communication: many mothers received written information in German when they visited a hospital or a physician's office, which they were unable to fully comprehend. Most women also mentioned that filling out forms before a doctor's visit was a big challenge for them. This did not stem from being illiterate, many were educated in both German and English, and only two participants in this study could not write. However, the amount of paperwork and information they receive is often overwhelming. As a consequence, it was not possible to understand the core of the treatment or further procedure. Participants stated that they were hesitant to sign a large number of documents because they were afraid that doing so would result in something they did not want, which was not foreseeable at the time. According to their testimonies, the written documentation was frequently overly complicated, they could understand little about the treatment procedure, and they did not fully trust the services to assist them.

VI.1.2 Volunteers' Role as Bridges to the German Healthcare System

Ten out of the 13 refugee women who participated in this study had support from a woman volunteer since arriving in Germany and believed that this support was essential for accessing the right points of healthcare services. Four out of the five volunteers who were interviewed in this study had joined several refugee mothers during their babies' delivery and had accompanied them to obstetrician doctors or other specialists. These volunteers were neither employed social workers nor were they assigned by the authorities. As language barriers and poor communication were major issues for refugee

families when they first arrived, volunteers spend a lot of time with them, assisting them with settlement and other paperwork required by authorities such as for school registration, doctor's appointments, and other appointments. Meanwhile, to overcome the language barrier, German volunteers frequently assisted women by providing translators; because they had networked with other organizations in Munich that provide support to refugees and could aid the refugees in accessing interpreters, which was their great support for reducing communication barriers with healthcare staff.

> *"The doctor told me: You don't understand anything, you should come with a translator! She was talking very unfriendly, and my husband also felt very bad. We came back again home very hopeless and sad and then German helpers introduced us to an Iranian translator. We finally went with a translator to the doctor; she (the translator) is very kind like my mother, my sister. Then we fetched her to the doctor and the doctor told her we need a certificate from my family doctor, which I didn't understand before. Then finally we went to the family doctor, and we fetched the certificate for starting the treatment."* (Zahra, Feb 12th 2020, Pos. 10)

In the quote above, Zahra stated that she was in a pressure for accessing the right care. Finally after a long period she was able to start her treatment with the assistance of a translator (who was introduced by a Helferkreis member). This was an example of how volunteers played an important role in facilitating better access to healthcare for refugee women. Most of the refugee women in this study had very positive experiences with volunteer assistance and were very grateful for their support. Some of the German volunteers even accompanied them to the delivery room and throughout child birth, which they described as a very supportive experience. The following quote is from Masumeh whom the women volunteers joined during the prenatal visits and delivery; she believed without the support of the helper she could never get the right treatment from the hospital.

> *"My doctor during pregnancy was a very nice German doctor, Dina [her helper] found her for me. Dina was making appointments and fetched me there and*

> *stayed with me and talked to the doctor and came back with me."* (Masumeh, Jan 12st 2020, Pos. 15)

Five German women who have been members of "Helferkreis" since 2015 were interviewed for this study. Through social action, these networks of untrained volunteers assist refugees in finding their way and settling into their new environment. Also women volunteers stated that they tried to find Iranian doctors for those refugees who spoke Farsi, as well as a doctor who would accept patients without insurance. Although these volunteer women also communicated with them in German, they were able to understand each other much better than other members of the society, such as medical personnel, because they were more patient and spent more time with the refugee women. The volunteers reported that each one supported at least one family and have continued to do so. Some of them also expressed that they became close to these refugee families as a result of their years of service, which motivates them to continue volunteering. Dina is one of these volunteers, more than 60 years old and participating in this study; she assisted Masumeh and her family after arriving in Munich in 2015. During her interview, she explained the time that she accompanied Masumeh during her childbirth. She stated:

> *"Wir haben ja die Schwangerschaft schon gemeinsam erlebt (translation*: We did experience the pregnancy together). *It is obvious to us in Germany that during birth the husband stays close to his wife, but in this case the husband had to take care of the children, so I should stay and be close to her, there was no discussion about that. Her husband was not there, so I should stay with her, you know the situation, she was in the small room before delivery and nobody was there to whom she could talk in her language, there was no translator, we both could communicate with hand talking since we trust each other due to spending time together."* (Dina, Sept 15th 2020, Pos. 24)

Dina explained during the interview that she supported more than three refugee families settling in Munich since 2015. She also recalled a time when she accompanied a woman

in labor and tried her best to provide comfort, explain what was happening, and keep the woman from feeling alone. She accompanied mothers in hospitals as she knew that the midwives and other healthcare staff tend to be extremely busy, which does not leave them with enough time to properly communicate with an immigrant mother. Often, healthcare staff talks very quickly after examining the mothers and leaves the room shortly thereafter. Dina helped by staying at the mothers' sides and explaining the information given by the staff in a way that the mothers could understand. Those refugee mothers who had the chance to have a German-speaking person accompanying their delivery, reported that they were supported through communicative help during delivery and visits after birth. This support and empathy were crucial for them, as their ability to understand the information given by healthcare staff also had an impact on their emotional well-being and helped them feel less alone.

> *"Es war wirklich für uns beide a Erlebnis, des war für uns beide a Erlebnis, dann, muss ich schon sagn (translation: It really was an experience for both of us, it really was an adventure for both of us, I should mention.)"* (Dina, Sept 15th 2020, Pos. 32)

Most refugee women expressed that although their German language was not good, they could understand the volunteers somehow, also the German volunteers explained that they tried to take time and find a way to communicate with the women and refugee families. Following is a quote from a young volunteer who often supported younger female refugees, especially for integrating faster into German society:

> *"Because in university I learned 'Deutsch als Zweitsprache' (German as a second language), I know how to reduce language to the most important things. Also I experienced that mobile phone helps a lot and her mobile helped a lot, she was talking to the Google translator and then gave me the translation then I wrote back to her."* (Joana, Jun 3rd 2020, Pos. 44)

The participants called their volunteers who supported them "SARPARAST", a Farsi word which means "guardian" in English. So they respected them so much and let them decide behalf on them, such as choosing hospitals or choosing a doctor for treatment. Even they

accepted their suggestion for family planning. It is worth mentioning that the "Helferkreis" volunteers referred to themselves as "Betreuer*innen", which also means guardian. The researcher also observed an emotional bond between them.

Despite the positive role of the volunteers, some of the women also expressed that there is a lack of mutual cultural and religious understanding between them and the volunteers. For example, the importance of the physician's gender for the refugee women resulted in negative outcomes. This issue led to the refugee mothers not following up with their checkups until they found a female doctor themselves after one or two years.

> *"Now, my doctor is a woman, she is very nice and you know that with male doctors the examination is very difficult. My husband didn't like it either; that time [2016] when we just arrived here, we didn't know anything and there was a German woman helper who was fetching all of us, who were pregnant, to Dr. H. It was very hard to have a male doctor"* (Lilli, Sept 23rd 2020, Pos. 12)

> *"I go to another doctor now, who is a woman, with a female doctor, you know, we feel a lot more comfortable. During the time of my pregnancy, I had to go to a male doctor, the helpers fetched me there, I did not have any other choice."* (Sahar, Feb 6th 2020, Pos. 15)

The quotations above are examples of experiences of two refugee women who were pregnant and living in a temporary camp in the first year of arriving in Munich. They were accompanied by German volunteers to the male obstetrician for their monthly routine visits for prenatal care, and both of them felt very uncomfortable with these visits and examinations by a male doctor. This issue led to the mothers not following up with their checkups until they found a female gynecologist themselves after one or two years.

Some of the refugee women also shared stories of attempts to gain more independence from volunteers. For example, they tried to make doctor's appointments by themselves or asked their older children to translate for them during doctor's visits. They were thankful for the volunteers' assistance but happy and proud for managing to access

healthcare services on their own. The stories they shared about managing their tasks developed their autonomy skills. They believed these strategies uplifted their strength and confidence.

VI.1.3 Structural Barriers and Strengths

The results from in-depth interviews as well as observations during fieldwork have led the researcher to identify some structural barriers to Munich's healthcare system, which can be amplified by language barriers and refugee insecurities. Meanwhile, some of the women who participated in this study have had experiences of birth already in Afghanistan and Iran or Turkey; during interviews, they sometimes discussed their experiences within those countries and Germany, comparing the healthcare system and its challenges.

Following is part of the researcher's filed note for having prenatal care and checking the status of fetal health, which explained the structural barriers that caused difficulties in receiving care for a pregnant refugee woman. This woman had active tuberculosis during pregnancy with the obligation to take several medications.

> *"I was joining the pregnant Afghan mother who was living in the temporary camp to an obstetrician. The refugee camp was very far from Munich and it took a long time until we arrived at the doctor's office. The women in the administration said that we arrived too late and the doctor will not visit her. I insisted so much, she asked me if I could show the insurance card. We have had just a paper from the social worker of the refugee camp, but she said this is not enough for visiting the doctor. Then I called the social worker in the camp's office and she talked to the receptionist again, but they didn't accept to visit the pregnant mother. We were more than 2 hours on the way to go to the office, the pregnant mother was feeling very weak and very upset that doctor didn't accept to check her baby since she was*

very worried about her baby, I also felt very desperate since I could not help either." (field note, Dec 2020)

VI.1.3.1 Health Insurance

Another topic commonly mentioned as being a barrier to the healthcare system is the insurance for asylum seekers, which is especially an issue for refugees who are at the beginning of the procedure of being accepted as a refugee. All refugee women in this study already got the insurance a few months after arriving, even those who were not accepted as a refugee but had the legal status of being tolerated (Duldung). They addressed that at the beginning of the asylum procedure (about the first year) for visiting doctors they need a yellow paper (Schein), which was issued by the social department in the municipal office (Landratsamt). First, they had to get this permission paper for seeing a family doctor, for further examinations and treatment by a specialist, this family doctor then had to write letter to the specialist (Überweisungsschein) and a letter to the authority offices of their local place (Landratsamt) which then again had to give permission for the refugee to see the specialist. This procedure always took a long time and was challenging due to the complicated procedure in an unknown setting and language. The participants also expressed the issue as a difficult and time-consuming procedure, especially when they urgently needed treatment.

Furthermore the participant who suffered from infertility stated that the majority of the high costs of infertility treatment and medication had to be paid out of pocket, affording this posed a challenge for her. Also the others claimed that family planning services were not covered by insurance and that the social department only covered a portion of the costs.

VI.1.3.2 Long Waiting Times

During the interviews participants mentioned that finding the right doctor and long waiting times for getting appointments was challenging. Especially when they had complications of their pregnancy and they were concerned about the health status of their baby this time-consuming procedure affected them emotionally.

VI.1.3.3 Locations of Refugee Residences

Another issue worth mentioning was the location of the temporary camps and refugee residences. At the beginning of the refugee crisis in Munich, refugees were also distributed into the suburbs, where they were accommodated in temporary refugee camps, often far away from the specialist needed. So, accessing the healthcare system was challenging, especially for those who were newly coming to Germany and not familiar with the transportation system and regulations. Nevertheless, the women participating mentioned that some volunteers also supported them by transporting them with their private cars or by joining them in public transportation.

VI.1.3.4 Lack of Proper Information Considering Health Literacy

This theme was appeared during interviews and the researcher's fieldwork when she had short talks with two obstetricians who were treating several pregnant refugee women. Following is a part of a quotation from one of the doctors, which is noted in her field notes.

> *"During pregnancy some women have anemia, but these refugees often have severe anemia or Thalassemia, and I always emphasize that they should eat their iron tablets. I suppose they don't do so, because the blood examination shows that deficiency getting worse."* (field note, Nov 2019)

Following is a quote from a young mother who explained her problem during pregnancy in the in-depth interview:

> Sahar: *"In the eighth month of pregnancy I had a strong headache and vertigo. Then we went to my doctor, he was angry and asked why I didn't eat those pills for anemia. I didn't know this kind of pill; I was thinking they are for pain relief. I knew the pink one that I had in Iran."*
>
> Nasim*: "The doctor was giving you the pills, but you didn't know how to use them and so you didn't take them?"*
>
> Sahar: *"Yes, yes … he was giving me so many pills, but I supposed they were just for my daughter. I didn't realize that I should take them, so then my anemia was getting worse and worse."* (Sahar, *Feb 6th 2020,* Pos. 57-60)

Both quotations above show that the doctor and the mother were aware of the anemia but lack of proper communication and clear information caused the mother's anemia to get worse, which had an impact on her health during pregnancy.

As a finding of this study, Afghan refugee women affected by unclear information experienced difficulties with access to healthcare. Since they could hardly understand the information provided by healthcare providers including a large amount of written information, they were not aware of their rights and the services available in the German healthcare system.

All the information given to the women in this study was in German; the procedure of filling forms and signing them is obvious and routine for German residents, but unclear for refugees, especially for newcomers. The Afghan women in this study expressed that they were often confused about the reason behind so much paperwork which was required to be admitted into hospitals and other healthcare institutions.

VI.1.3.5 Positive Aspects of the German Healthcare System

Most of the Afghan women in this study had experiences with childbirth in Afghanistan, Turkey and / or Iran. The mothers mentioned they received much better care in Germany in comparison with other countries, so the structural strength of Munich's healthcare can be seen as being solid. For example, some women mentioned that the healthcare staff was friendly, and all hospitals and healthcare centers were well equipped. Also, the most positive aspect of the German healthcare system was that all treatment costs and professional care are covered by insurance.

Regular visiting a midwife after childbirth is another positive aspect that some of the refugee women mentioned, since these also went to the refugee camps. Those regular home visits, which were also covered by insurance, were very helpful and supportive, especially since all of the participants in this study were away from their families who would have provided support after birth in their home country. Although mothers addressed that they often could not communicate properly with the midwife, still they were grateful that a professional is around to check the health status of their baby in early motherhood.

VI.2 Participatory Health Research

The result of this phase is on the reflection of the refugee women as co-researchers through sharing their personal stories in participatory meetings on the issues and themes which were most important and relevant for them individually and their community for accessing healthcare and improving reproductive health.

VI.2.1 Seeking Solutions to Overcome Language Barriers

All the women who were participating in the meetings agreed to reflect critically on the issues around the language barrier and lack of communication since they are very

essential for accessing reproductive health. The following is an observation made by the researcher during conducting the participatory group meetings with five mothers.

> *"All women confessed that knowing the German language plays a crucial role for them, not only in social interaction but also in terms of the interaction between them and the healthcare staff and also with their helpers. They believed that proper language skills or translation were essential to them to communicate and express themselves. A mother with six children said learning language is most important for us but it is so difficult to learn. She said: 'Whatever I learn I forget soon, since, I have so many things in my head.' They all agreed that it is very difficult to learn German since they have a lot of responsibilities as well; some women said that they couldn't get an education in Afghanistan and therefore were not familiar with the Latin alphabet either, which made progressing in the German course very slow. Also the fact that they all have small children, who often get sick, prevented them to attending regular German courses."* (field note from participatory meeting, Jan 2020)

According to the field note above, all women in this meeting agreed on the importance of studying German and making an effort to learn the language. Also, the importance of being able to communicate with physicians and authorities in the local language was clear to all participants. However, the co-researchers often mentioned that they struggle with language learning since they did not have the opportunity to receive more than a few years of education in Afghanistan. This means that they had to start by learning the Latin alphabet to study German, making their language-learning process very time-consuming. Additionally, their responsibilities as mothers – the necessary work of caring for and looking after their children – and their daily responsibilities already take most of their time and energy. Studying the German language becomes an even more difficult task in a very busy home (the few rooms in the camps are rather small). Their concentration was also impaired since they were additionally confronted with many challenges regarding settling in a new country and due to having anxiety and stress.

The women as co-researchers in the participatory meetings reflected on their experiences and challenges, emphasizing the positive role of the helpers in confronting language barriers. The volunteers made appointments for each doctor's visit, accompanied the mothers to hospitals and handled the paperwork. Since German receptionists tend to speak very quickly and sometimes with a local German dialect (Bavarian) that is hard to understand for non-native speakers, Afghan refugee women could not make appointments for doctor's visits on their own even if they had prior German language lessons. Filling out forms to be admitted into the hospitals for treatment was another major hurdle the women had to overcome; having volunteers to handle this was a major advantage as well. Finally, they reported that sharing their ways of navigating difficult experiences gave them confidence. Sharing their stories about language learning in the participatory meetings also helped them realizing that they were not alone in their challenges, which was a relief for them.

VI.2.2 Seeking Strategies to Overcome Being Intimidated

Feelings of timidity and insecurity were mentioned by most refugee women. Many of them were afraid of going to the doctor for many reasons, including their inability to talk about their symptoms in German.

Figure 6: Lack of self-confidence in communicating with healthcare staff (picture taken by the researcher)

The timidity and lack of self-confidence (Figure6) described by the Afghan refugee women took on several different forms, as each person mentioned different additional causes for their timidity apart from their lack of knowledge of the German health care system and the German language. They were intimidated when the staff in the healthcare system was busy, did not have empathy and were in a hurry and therefore their need for more time to express themselves in a foreign language resulted in negative, disapproving looks from the staff. As a result, some of the women reported that they preferred to stop their efforts to communicate although their needs were not yet satisfied. In conclusion, they avoided visiting a doctor or even stopped their treatment for these reasons. Some of the women explained that they went to an Iranian gynecologist for treatment who spoke Farsi to avoid communication problems, but this also proved to be unsatisfactory because the doctor was often unfriendly and in a hurry during examination since she had so many patients sitting in the waiting room, consequently, they did not feel comfortable enough to ask questions and talk openly about their needs.

Lilli is an Afghan mother with three children that needed regular checkups for her intra uterine device (IUD) for family planning by a doctor. Because of her German language deficiency, she prefers to have treatment by an Iranian doctor who can understand her better, but she did not feel comfortable either.

> *Lili*: *"I am afraid to ask my gynecologist to further explain my diagnosis.*
> *Nasim*: *But she [the gynecologist] is from Iran, she understands you.*
> *Lili*: *Exactly, she understands me, but she is always in a hurry and has many patients waiting for her. I am afraid to talk more."* (Lili, Sept 23rd 2020, Pos. 25)

This fear happened also by a lack of empathy from healthcare staff concerning communicating with receptionists or nurses who work in doctors' offices and hospitals.

> "*I prefer not to go to the office of my child's dentist. I am afraid of the reception women. She is very unfriendly and when I asked her to write down the date of my next appointment, she got very angry and showed me that she didn't have time."* (Maryam, Feb 12th 2020)

During the participatory meetings, almost all of the women expressed that they need more discussion to solve the problem of their timidity and insecurity while accessing the healthcare system. One participant, for example, explained in one of the participatory meetings that she received many referral letters (Überweisungsschein) from her family doctor but did not use them, effectively delaying her treatment. She explained that she did this because she was afraid of not being able to express her diseases properly. These emotions were echoed by most of the co-researchers, but taking the importance of their health into account, they agreed upon the need to find a solution to this issue and follow up on their medical treatments despite their insecurities.

Some women as co-researchers also shared their stories of moments when they felt guilty about their communication with the German healthcare staff. Because they were unable to speak German fluently and quickly and also were not as informed on standard procedures and processes as German residents, they were taking up too much of the staff's time and avoided asking questions. However, some of them believed that the language barrier is not their fault and tried to bring an interpreter along or ask the healthcare staff to talk and explain slowly or repeat their sentences. This group emphasized that it is their right to have their needs met when they have an appointment with a doctor. This reflection encouraged everyone in the participatory group to try to overcome negative patterns and confront their timidity.

Through data from the field notes of participatory meetings, women tried to reflect and elaborated more on what they could do about their fear and timidity. The researcher also encouraged others to share their success stories about times when they managed to communicate successfully. The request of the researcher prompted two women to talk about their courage and continued attempts to communicate despite the staff's non-verbal communication of being in a hurry. In the end, these attempts were successful in getting their needs met. Eventually, the accounts of these two women gave other women the courage to continue expressing their needs despite their timidity and insecurity about other people's perceptions of them. They all believed that through sharing their

challenges and fears they were able to discover their strength and abilities. In this context, the community partners suggested turning to each other for support and encouraging one another to have courage.

VI.2.3. Photovoice: Reflection on "What Gives Us Strength"

Through the photovoice technique refugee women discussed the theme of "*Reflection on well-being and strength*" focusing on the difficult period during the Covid-19 pandemic. This theme chosen by the women as co-researchers is mainly about their mental health, by reflecting on their experiences and discussions during photovoice. They selected this issue which could promote personal strength as well as support their community despite extra challenges during lockdowns and pandemics. Hereby the refugee women could create space for a reflective process and they explained that this reflection had a positive impact on them, since they had to consider on why they chose and took each picture. So they realized that there were issues which they never took care about and these were effective to their health. This self-reflection also happened during the photovoice group discussions.

VI.2.3.1 Devotion to Motherhood

Most of the women, who participated in the photovoice activity, had experienced pregnancy and early motherhood in the first year after arrival in Germany. Through meetings they shared the experiences and challenges of visiting their doctors, as well as language barriers to accessing reproductive healthcare services. They expressed that their sense of love and duty for their children was the motivation for coping with the many challenges.

Observation of the data and photographs of the participants indicates that those who were mothers dedicated their life to the health and well-being of their children. They

emphasised that the work required to care for their children and daily responsibilities is already exhausting, made more severe by many challenges of living in a new country, leading to anxiety and stress. However, all participants saw their role in the family and their children's care as vital and recognized the importance of maintaining their strength and health and hence, proper access to healthcare centres.

VI.2.3.2 Value of Safety

The participants cited their incentive to move to Germany as the reality that their home country had become increasingly dangerous, resulting in an unsafe atmosphere for families. Therefore, the safety of living in Germany was of utmost significance for these mothers. They described travelling on dangerous roads through several countries to reach a safe country, with the hope to raise their children in a proper environment with an opportunity for a good future. While discussing this topic, they shared pictures of their children when they were happy and playing, but as these pictures were private, they are not presented in this thesis.

Figure 7: Value of Safety

The following is a narrative a mother with six children wrote about figure 7.

> *"Whenever I see my children playing like this, I am filled with joy and nice feelings. They are in a peaceful area, away from any danger. For me as a mother, this is the best thing, to watch the happiness of my children, their smiles and pure joy. Most important is that they are healthy. This is the wish of every mother".* (Soraya, Jun 24th 2020, Pos. 7)

The theme "Value of Safety" was chosen by the participants who had experienced persecution in their home country. Other women who were refugees from childhood could relate to this theme as well.

VI.2.3.3 Sisterhood: Bonding Beyond Blood

The Afghan refugee women participating in this study expressed that they felt isolation and loneliness when they began living in Germany, which was very emotional for them. To manage this isolation, they established friendships and created a network. These relationships were based on their common experiences through their journey as asylum seekers. Many were together on the challenging path to Germany, others while settling in the temporary refugee camps in or around Munich. These mothers said these friends had become like family, and that having connections kept them strong. Although the pandemic and restrictions had affected their interactions with friends, they mastered new means of communication, including social media and outdoor meetings.

Figure 8: Sisterhood: bonding beyond blood

Figure 8 was chosen from the 19-year-old participant, who felt lonely and isolated at the beginning of living in Germany, and then she found a friend from Iran.

> *"Being lucky is when you have somebody to talk to and share your feelings, especially in this unknown country, where finding one whom you can talk to is difficult."* (Roz, Oct 2020)

Figure 9: Sisterhood: bonding beyond blood (2)

The following are narratives of two women writing about figure 9.

> *"In my opinion, in addition to a lot of things that help a person [to find happiness], socializing and communication can bring about inner peace and calmness."* (Masumeh, Jul 1st 2020)

> *"I love being with other people, but since the coronavirus came about, we no longer can feel the joy of being with loved ones. I hope that a vaccine for corona gets created so I can invite some company."* (Soraya, Jun 28th 2020)

The Afghan refugee women in this study regarded the theme of "Sisterhood: bonding beyond blood" as very important for them since that bond enabled them to feel less alone and isolated.

VI.2.3.4 Perceived Wellbeing and Promoting Activity

"Is walking not great? It is really good for the overall health of our body. I enjoy strolling especially in this type of weather." (Soraya, Jun 2020, Pos. 1)

The above quote is from one of the active participants through photovoice. She chose this theme as a reminder of the need to stay healthy, especially during the Covid-19 pandemic. In this stage of the study, she played the role of a group advocate and encouraged other women to take walks outside and take energy from nature. Subsequently, every week each of the women took pictures of various landscapes and shared them with the group while expressing their positive feelings with the pictures and narratives. The theme of perceived well-being from nature was a positive one for the refugee women who actively took part in photovoice. Most of them expressed that having a walk in nature and taking pictures was an effective inspiration, so, eventually improved their well-being and happiness, since during lockdown they did not have any motivation to go out and do any activities.

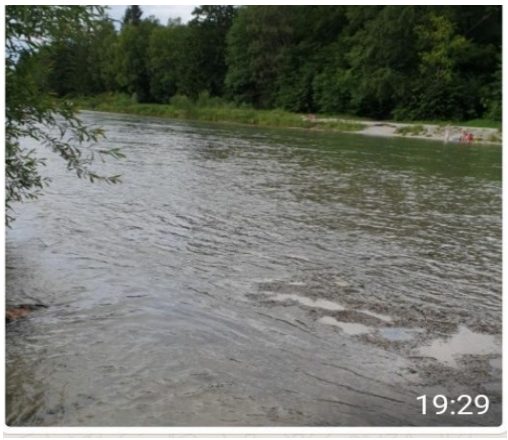

Figure 10: Perceived well-being and promoting outdoor activity

Figure 10 is a picture from a mother of three, shared in the group with the narrative:

> *"Today was warm and we had a walk along the river, it was very good. I think rivers and seas can give us calmness, too."(Sara*, Jun 2020, Pos. 1)

This theme was also elaborated on by those in quarantine who were unable to go outside. For their positive ideation and well-being, these women found a little part of nature, taking it into their home, or photographing nature from their windows. Figure 11 is an example of these pictures with its narrative below.

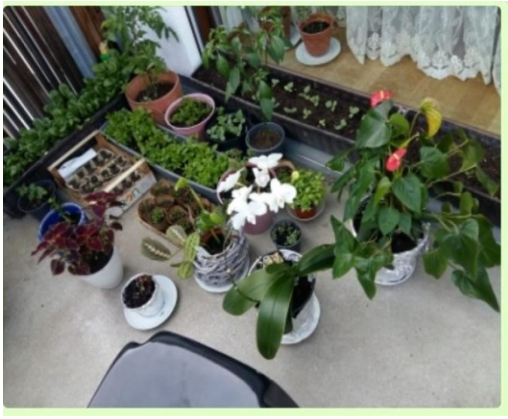

Figure 11: Perceived well-being and promoting activity

> *"I would like to share with you my feelings about this picture. First of all, the health and well-being of me and my family is very important. By touching these flowers which I planted myself, I feel relieve, especially during lockdown; whenever I feel sad, watching the plants brings calmness to me."* (Ayubi, Jul 2020, Pos. 1)

Some of the women reported although this theme was simple in practice it was powerful in motivating them for keeping their mental health to share and support each other since during the lockdown due to the Covid-19 pandemic they were confronted with additional challenges and anxiety. Moreover, they expressed that sharing their experiences in this activity promoted their self-confidence.

All refugee women in this study reported that they enjoyed and had fun taking pictures and sharing them with each other. Meanwhile the women emphasized that this way was very inspirational for them and those who never could talk in a group were motivated to cooperate actively and they shared photographs as well.

VI.3 Value in Sharing Experiences and Learning from Each Other

> *"It is a relief that I am not alone in these challenges"* (Masumeh, Jul 19th 2020)

The quote above was often repeated in the group, as they recognized the value of the participatory meetings, photovoice, and sharing experiences. Most of them emphasized the impact of sharing experiences for improving accessing reproductive healthcare as well as their confidence. This co-learning was echoed during the focus groups in the follow-up phase as being very effective. Meanwhile, they reported that these meetings proved to be most helpful to women whose pregnancies were complicated and required more interaction with healthcare staff. Examples of complications they experienced included gestational diabetes, placenta previa, anemia and allergic reactions during pregnancy.

> *"We always ask each other how to get a hospital appointment or about the procedures after birth. For example, once another mother reminded me to have a*

translator with me while giving birth. Since I had a cesarean section, there was a special need of talking with the anesthesiologist before the surgery; I was not aware of that." (Soraya, Nov 2020)

Figure 12: Value in sharing experiences and learning from each other

The women who took part in the participatory meetings and photovoice affirmed that it gave them the realization that they were not alone in their struggles and that the gatherings strengthened their community and eventfully, was helping them for better access to healthcare services.

Chapter Seven: Discussion

This study used a triangulation of qualitative approaches to gain a comprehensive and deep understanding of refugee women's experiences and challenges during pregnancy, childbirth and access to reproductive healthcare in Germany. The study only included Afghan refugee women living in Munich's suburbs. However, this group has provided significant insights into the experiences, challenges, and perspectives of migrant women from similar demographic and sociocultural backgrounds. The most notable findings were language barriers with caused failure to effectively communicate with healthcare providers and an inability to navigate the healthcare system due to a lack of information on available services. At the same time, the research pointed to positive experiences and demonstrated that the support of German volunteers was crucial in making these experiences a success. The structural barriers and strengths to reproductive healthcare was another theme, as the participants' emphasis on insurance coverage, which entitles them to prenatal and midwife care, highlights the critical role of the healthcare system in access to reproductive health services. Meanwhile, conducting a participatory approach and the photovoice technique along with in-depth interviews, prevented the study from being limited to a framework that focused solely on barriers but also gave the refugee women space to discover and reflect on their challenges as well as exploring strategies to cope with barriers and promote their reproductive health, such as overcoming being intimidated in communicating with health care staff. Additionally there are findings in this study through photovoice technique which were mainly about reflection on well-being and strength focusing on their difficulties during the Covid-19 pandemic.

VII.1 Barriers to Reproductive Healthcare Access for Refugee Women

This study showed that language barriers caused serious difficulties for Afghan refugee women, especially in care settings where their pregnancy involved complications and co-existed with other health issues. This theme specifically addressed their difficulties with

proper communication in interacting with healthcare staff and those charged with assisting them. In fact, many studies emphasize that the language barrier is the fundamental and key obstacle for refugee women in accessing healthcare (Higginbottom *et al.*, 2013; Yelland *et al.*, 2016; Pangas *et al.*, 2018; Winn, Hetherington and Tough, 2018; Al Shamsi *et al.*, 2020; Nassar *et al.*, 2021; Nowak, Namer and Hornberg, 2022). This impediment is not a new finding and is regularly mentioned in many studies, maintaining there with neither solution nor strategy, or implementation is very slow (Meuter *et al.*, 2015; Yelland *et al.*, 2016; Pangas *et al.*, 2018). This study showed that language barriers and lack of communication has several impacts on accessing reproductive healthcare for refugee women such as misdiagnosis and prolonging the treatment or the refugee women mistrust the treatment process. Eventually, confronting these barriers often caused mental health problems and feeling loneliness and isolation. Other studies showed similar barriers for women immigrants accessing maternity care in a host country (Sami *et al.*, 2019; Al Shamsi *et al.*, 2020; Fair *et al.*, 2020; Pandey *et al.*, 2022). According to the results of these studies performed in Canada (Pandey *et al*., 2022), in Switzerland (Sami *et al*., 2019) and a systematic review in European countries (Fair *et al.,* 2020), immigrant women face significant language barriers and lack of proper communication, impacting the procedures for accessing reproductive health. Pandey *et al.* (2022) also reported that language barriers among migrant women in Canada result in wrong medications or delay in diagnosis.

Fair *et al.* (2020) with reviewing 51 qualitative papers about migrant women's experiences of maternity care in European countries also reported that even when women could manage everyday living, there was a barrier while interacting with doctors or nurses due to lack of vocabulary and medical terminology.

This study demonstrated that the refugee women participating in this study were not aware about the available services for their maternity care. Despite their top priority during and after pregnancy being the health of their babies, they had only a vague understanding of the procedures for maternal and prenatal care. Fair *et al.* (2020) and

Sami *et al*. (2019) noted similar issues; refugees were often unfamiliar with the health system and unaware of their rights and entitlement to care. Also, several studies on migrant and refugee women's experiences of maternity-care services in European countries, Canada, the US and Australia claim that immigrant women do not utilize the formal healthcare and other community services that they are entitled to, primarily due to the difficulty in understanding healthcare information, which can develop mistrust (Sami *et al.*, 2019; Fair *et al.*, 2020; Kikhia *et al.*, 2021; Pandey *et al.*, 2022).

Kikhia *et al.* (2021) also demonstrated that Syrian women have developed mistrust and passivity to the German healthcare system. This result ties well with this study, since the Afghan refugee women in suburbs of Munich also reported their desperation from the inability to properly interact with their German healthcare providers; although their physicians had provided them with written information, the documents were very complicated and difficult to understand, so they feared receiving the wrong treatment, resulting in a distrust of their treatment procedures and doubt if it is the correct one.

The experience of discrimination and stigma was also reported in several studies (Sami *et al.*, 2019; Fair *et al.*, 2020; Kikhia *et al.*, 2021; Davidson *et al.*, 2022; Pandey *et al.*, 2022). Participants of this study also mentioned similar challenges and experienced negative attitudes from healthcare providers; especially when they needed more time for communication they felt disempowerment when they could not express themselves and explain their symptoms. Similarly Kikhia *et al.* (2021) explored in their qualitative study how Syrian refugees manage their health during migration process; for example Syrian women experienced being disempowered and discrimination when they were not able to reach proper information and the feeling being vulnerable due to language barriers. Additionally, Kikhia *et al.* (2021) reported that the interviewed women implied that doctors and nurses were perceived to be impatient and not empathetic. In this study Afghan refugee women reported that the German healthcare staff often was impatient, which caused them feeling intimidated; this sometimes resulted in stopping further treatment, a result which was not found in other studies.

This study also revealed how language barriers relate to feelings of isolation and anxiety. Additionally, the women refugees described a sense of isolation from being far from their families, but not being able to network within German society due to their limited German proficiency. Studies with similar findings identify the main issues causing mental health problems among refugee women as lack of communication and language barriers, separation from families and isolation, as well as poor reproductive health, complicated birth situations and postnatal depression (Pangas *et al.*, 2018; Fair *et al.*, 2020, 2021; Kikhia *et al.*, 2021; Walther *et al.*, 2021). Similarly, an Australian study found that having limited English proficiency increases refugee mothers' risk for marginalization, isolation, and family dysfunction (Riggs *et al.*, 2012). However during photovoice, refugee women noted that by networking in their community and building relationships they were able to manage these issues.

To overcome these barriers, Fair *et al*. (2020) recommended healthcare providers provide suitable information in multiple languages and cooperate with professional interpreters to allow women the opportunity to express themselves completely, to access an accurate diagnosis and treatment. However, healthcare services have limitation to access interpreters (Al Shamsi *et al.*, 2020; Davidson *et al.*, 2022). In this study, Afghan women participants recounted their attempts to engage a translator to overcome their language barriers. Having a professional translator was rare; often the interpretation was inadequate if the translator was not well versed in their language or in the medical terminology and family members as translators caused embarrassment. Studies also emphasize the lack of translators in receiving care and the lack of professional interpreters may even cause misinterpretation, or when having family members as interpreters the support consequently often is unsatisfactory (Dopfer *et al.*, 2018; Sami *et al.*, 2019; Fair *et al.*, 2020; Pandey *et al.*, 2022). Al Shamsi *et al.* (2020) with reviewing 14 studies in different countries (mainly in the US) found out that implementing online translation tools could improve the quality of communication in accessing healthcare. The MediBabble program or Goggle translator as a successful example of these tools had

positive effect on the satisfaction of the healthcare providers and patients (Al Shamsi *et al.*, 2020).

Sami *et al.* (2019) in their qualitative study in Geneva about the barriers to reproductive healthcare for migrant women reported that lack of information could be linked to health literacy[10]. Health literacy has impact on the women's reproductive health and provides the foundation on which citizens are enabled to play an active role in improving their own health, engage successfully with community action and push governments to meet their responsibilities in addressing health and health equity (Kilfoyle *et al.*, 2016). WHO stated in the health promotion glossary that "health literacy is critical to empowerment; therefore people's access to health information needs to be enhanced as well as their capacity to use it effectively" (WHO, 1986; Nutbeam, 1998 ,p 351). In this study almost all refugee women who participated were aware of the importance of reproductive health but they neither know about the process of the maternal healthcare system in Germany nor about the available services. These structural barriers of the German healthcare system with a lack of adequate presentation of the information might result in having a lack of health literacy for the Afghan refugees.

This study also looked at how the financial structure of the German healthcare system affects access to reproductive healthcare. High treatment costs and other financial barriers reported in other studies (Dopfer, *et al.*, 2018; Fair *et al.*, 2020; Davidson *et al.*, 2022) were not mentioned by our participants as a significant barrier to access. Only one participant stated that the majority of the costs of infertility treatment had to be paid out of pocket, also others stated that family planning services were not covered by insurance and that the social department only covered a portion of the costs. In contrast, almost all participating women cited maternity care insurance and regular midwife visits as important benefits of Germany's healthcare system. This suggests that the financial structure of the host country's healthcare system is one of the important determinants of

[10] Health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve individual and community health by changing lifestyles and living conditions (WHO, 2009)

the barriers and challenges migrants face when seeking healthcare services (Schmidt *et al.*, 2018).

VII.2 Improving Maternal and Reproductive Health for Refugee Women

Overcoming obstacles and ensuring access to healthcare is critical in reducing health inequality. This study focused on improving maternity care for Afghan refugee women in Munich, Germany; cultural competence and migrant-sensitivity are elements which studies report as having a positive effect on establishing trust between healthcare workers and refugees (Winn, Hetherington and Tough, 2018; Sami *et al.*, 2019; Villa and Raviglione, 2019; Fair *et al.*, 2020). Sami *et al.* (2019) noted that cultural awareness can prevent the experiences of discrimination in refugee women. Likewise Kikhia *et al*. (2021) reported that Syrian refugees believe some healthcare providers to be insensitive and sense stereotyping and prejudice in Germany. Similar findings have been reported by Al-Kebsi (2014) regarding Pakistani women whose birth experiences in Germany were affected by healthcare professionals' attitudes, which they recognized to be culturally insensitive; the participants hoped that their healthcare provider would be culturally competent. The women in the present study described occasionally being dissatisfied with the attitude of healthcare providers and their German volunteers as well.

There is a need for healthcare providers to receive training in culturally competent care; as shown in several studies, this awareness of and respect for the patient's culture can considerably improve accessing healthcare for immigrant women (Schmidt *et al.*, 2018; Winn, Hetherington and Tough, 2018; Sami *et al.*, 2019; Fair *et al.*, 2020; Kikhia *et al.*, 2021; Rogers *et al.*, 2021; Shorey, Ng and Downe, 2021). Kikhia *et al*. (2021) also suggests that medical students could be included in intercultural competence training for healthcare providers. Fair *et al*. (2021) also explores the importance of culture sensitivity among midwives in three countries, Greece, the Netherlands and the United Kingdom (UK). In assessing ORAMMA (Operational Refugee and Migrant Maternal Approach), they

noted that midwives are eager to learn more about refugees such as living conditions, legal statutes, the financial situation and culture of migrant women. Also the Swiss researchers Villa and Raviglione (2019) emphasized that healthcare services should have migrant-sensitive systems, decreasing challenges and stressful experiences for both migrants and healthcare providers (Villa and Raviglione, 2019).

This study verified that German volunteers could support networks on fostering access to reproductive healthcare for refugee women and their role is recognized as a positive aspect of integration, especially during the first year of arrival. The volunteers can also be seen as an extra step between the refugees and the healthcare system. However, this study showed that the role of volunteers promotes an environment of empathy and reduces the barriers of communication for refugee women. A similar conclusion was reached by the qualitative study of Balam (2015), who reported that in the UK volunteer agencies can act as bridges in improving access support for asylum seeking and refugee women, notably in the maternity healthcare system. Fair *et al.* (2020) also mentioned that there are NGOs providing information on the available services and rights to maternal health for refugee women. Correspondingly, in their study, Andrees *et al.* (2018) validated the positive effect of supporting German volunteers for refugees.

This study also highlighted the impact of the gender issue on receiving reproductive healthcare for Afghan women after migration to Germany. All participants preferred to receive reproductive healthcare from female practitioners, otherwise they would postpone their treatment. Several studies mentioned similar issues and emphasized gender preference for doctors as an important issue for maternity healthcare (Winn, Hetherington and Tough, 2018; Fair *et al.*, 2020; Kikhia *et al.*, 2021; Rogers *et al.*, 2021; Shorey, Ng and Downe, 2021; Pandey *et al.*, 2022). Furthermore, this study proved that German women volunteers provided valuable support for the Afghan refugee women; their gender showed having a positive impact on their role. Nevertheless, some participants of the study reported that their treatment was postponed because the volunteers were making appointments with male obstetricians. So, there is a need to

improve this crucial service by implementing training in cultural sensitivity, increasing awareness of the customs and beliefs of migrant women, and an understanding of the impacts of trauma on mental health. This study suggests that volunteers trained in cultural competence promote improved access for Afghan refugee women's needs, help reduce hesitancy and reduce the instance of postponed treatment. The study of Andrees e*t al*. (2018) details the motivation among volunteer German participants who themselves wished to improve their cultural competence to support refugees. Additionally, it is important that the migrant women have culture competence of the host country as well, which would have an impact on their interaction with the healthcare staff.

VII.3 Empowerment and Health Promotion through Participatory Health Research and Photovoice

This study demonstrated that the implementation of participatory health research and photovoice intervention with refugee women is feasible and practical, but also had challenges. Refugee women found this intervention to be acceptable, interesting and a useful tool, particularly during the period of the Covid-19 pandemic and lockdown. Studies confirmed that refugee women are interested in opportunities to solve their problems (Pittaway and Van Genderen Stort, 2011; Russo *et al.*, 2015; USAID, 2023). In this study, refugee women were eager to collaborate in the participatory meetings and they had opportunities to achieve strength by sharing experiences.

The Afghan refugee women in this research could reflect on their experiences more deeply cooperating as co-researchers. The theme of the meetings concerned the challenges and barriers they faced when accessing reproductive healthcare, as well as during pregnancy and the postnatal period. They reflected on their challenges and successes in accessing healthcare services through the cyclical processes of look, think and act (Stringer, 2014), as well as on the learning process and attempts in finding strategies to overcome the barriers. They exhibited great interest in helping other women

in their community by sharing their stores. All the participants of the participatory health research in this study expressed their recognition of the value of forums, as well as sharing their experiences with one another in agreement with several studies (Koch and Kralik, 2006; Lenette and Boddy, 2013; Jager *et al.*, 2017). Koch and Kralik (2006) also explained that talking about individual experiences promotes learning and strengthens the participant's confidence, resulting in advanced health in their communities (Koch and Kralik, 2006). Afghan refugee women in this study discovered that they are not alone in facing their challenges and the meetings brought solidarity to their community.

The refugee women in this study found the advice and suggestions given to them by peers who had similar experiences accessing healthcare in Munich to be supportive and a useful source of information. They noted that sharing experiences were even more helpful when pregnancies were complicated by issues, when intense communication with healthcare staff was necessary. This is in agreement with the results of the qualitative study performed by McLeish and Redshaw (2017) who emphasized that peer support during pregnancy and after birth has a positive impact on the wellbeing and maternal health of mothers, especially for migrant women. They also reported that peer support projects overcome the feeling of isolation and disempowerment. This current study confirmed similar findings, showing that refugee women cope more successfully with the isolation and loneliness through participatory meetings and photovoice by networking in their community. However, the Covid-19 pandemic increased isolation as refugee women had no personal contact aside from utilizing cell phones and social media; however, these tools through photovoice had a positive impact on their emotional health. Meanwhile participants expressed that during photovoice they realized the value of their power and agency, and expressed those participatory meetings promoted self-confidence and empowerment[11] for themselves and within their community.

[11] The term empowerment has been widely used in a variety of contexts and is generally considered to be multifaceted. It has been defined as an intentional ongoing process centered in the local community, involving mutual respect, critical reflection, caring, and group participation, through which people lacking an equal share of valued resources gain greater access to and control over those resources; or a process by

In term of empowerment[12] this study pursued to strengthen refugee women's awareness by reflecting their experiences of reproductive healthcare, since the aim of participatory research is achieving emancipation and empowerment for marginalized groups through the cycling processes of research and learning and action (Wallerstein, 2002; Israel *et al.*, 2006; Wallerstein *et al.*, 2017). According to Wallerstein (2002) empowerment is a process by which individuals and communities increase control over their lives and assert influence on their social and political environment to improve health equity and quality of life (Minkler *et al.*, 2012; Kleba *et al.*, 2021). Several studies explained that community empowerment includes the process and outcomes which have multi-level construct within individual and organization level. Individual level can be demonstrated with the psychological empowerment with improving self-esteem to include people's conscious control their lives, their awareness of their social context and their involvement for change (Winn, Hetherington and Tough, 2018; Fair *et al.*, 2020; Kikhia *et al.*, 2021; Rogers *et al.*, 2021; Shorey, Ng and Downe, 2021). Kleba *et al*. (2021) also explained that empowerment allows a dynamic cooperation between peoples' own personal transformation and the sense of belonging they experience as they participate with others (Kleba *et al.*, 2021) which could also be illustrated through the participatory health research in this study.

All refugee women in this study believed that their health plays an essential role on their family and children's health and were aware of their right to receive appropriate care. The importance of this awareness was affirmed when listening to those women who claimed to not follow their treatment or stopped trying to access healthcare services. As a result, through the procedure of photovoice and participatory meetings everyone was encouraged to find ways to overcome negative patterns, confront shyness and lack of

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which people gain control over their lives, democratic participation in the life of their community, and a critical understanding of their environment (Perkins & Zimmerman, 1995).

[12] According Kabeer, empowerment revolves around the triad factors of resources, agency, and achievement. Resources are the medium through which agency is exercised; and achievements refer to the outcomes of agency (Kabeer, 1999, 2005). Also it is a process for enhancing the health and social equity outcomes (Wallerstein, 2002; Kleba *et al.*, 2021). However, empowerment cannot clearly be defined or measured (Kabeer, 1999), it is an ongoing process rather than a product.

confidence. WHO in the guidance about participatory health research highlighted that participatory approach has positive effects in health research with migrant communities and emphasized that in participatory health research "change does not happen at 'the end' – it happens throughout" (WHO, 2022, p 29).

Eventually, for developing the result of this study, reflections with participating women as co-researchers were very important for the outcome of the study. Jackson (2008) emphasized that through the involvement of community partners in the process of interpreting the findings, they were able to provide deeper understanding of the issues which were of relevance in the community. For example for the Afghan refugee women in this study the theme of "communication barriers" and "timidity and lack of self-confidence" were most important concerns and they were ready to create change and action strategy about them.

VII.4 Limitations and Strengths

There are some limitations to this study that should be considered when interpreting its findings. First, this study was focused on a specific group of Afghan refugee women who have been living in suburbs of Munich. A larger study population that included participants from multiple cities could have investigated the broader range of healthcare services available across Germany's regions, especially given that each federal state (Bundesland) may have its own set of regulations. Additionally, the participants are limited to Afghan women only. On the other side, women from Afghanistan constitute a significant proportion of recent immigrants to Germany and are a strong representative group for qualitative research on the challenges faced by other Muslim women and non-European women.

Another source of the study's limitations could be that participants were afraid of losing their legal status because they were refugees or in the process of seeking asylum, and thus there could have been unspoken issues. However, because the researcher is Iranian

and female, and has a similar culture and language to Afghan refugee women, a more trusting environment for conducting interviews and participatory meetings could be created. Meanwhile, the researcher was member of organizations for supporting refugee families and had companied the Afghan women in the healthcare centers as an interpreter, so there were several opportunities for collecting observation data in the study. On the other hand this issue could affect the answers of the participants during interviews or participatory meetings, or the participants might provide a desirable answer to the questions. Nonetheless, the use of multiple data collection resources (individual interviews and observation) in the qualitative assessment phase, as well as photovoice during participatory meetings in the participatory health research phase, under the supervision of academic supervisors, contributed to the rigor of this study.

The study was influenced in several ways by the fact that it was conducted during the Covid-19 pandemic. This particular time required the researcher to be adaptable and to organize relatively small groups of participatory meetings with the participants' agreement and consent. However, these small group meetings provided very rich content because the women felt comfortable and shared openly their stories and challenges, which ultimately had an empowering impact on them. Although the methodology of the participatory research approach requires participants to participate and cooperate as co-researchers during the analysis (Jackson, 2008; Minkler *et al.*, 2012; Banks and Brydon-Miller, 2019a), due to Covid-19 pandemic regulation, only a few women refugees were able to participate in the analysis.

Despite efforts to make the data analysis and interpretation as rigorous as possible, the researcher's background as a midwife and volunteer translator could not be overlooked. To minimize research methodology limitations, self-reflexivity and a constant comparative method were used throughout the entire research process, including discussions with academic supervisors and presentations to peers.

Chapter Eight: Conclusion

Through the experiences of Afghan refugee women attempting to access reproductive healthcare services in Munich and the story of their struggle, this study sheds light on the barriers faced by migrant women with similar social structures while receiving healthcare services. The most important barrier identified by the study was difficulty communicating and interacting with healthcare personnel. This barrier frequently had a detrimental effect on antenatal care, treatment procedures, access to family planning, and consequently on maternal health and mental health. Additionally, their treatment and care were affected by their timidity and lack of self-assurance in communicating. On the other hand, the study found that the assistance of volunteers is supportive for communication, for ensuring access to healthcare services, and for ensuring efficient treatment procedures.

Through the cycling process of look, think, act in the participatory health research (Koch *et al.*, 2005; Greenwood and Levin, 2007) refugee women pursued to sketch a path to find their strategies for coping and managing the barriers they faced on their own. The reflection and sharing stories of women appears uplifting and strengthened women's awareness and desire to reflect on their experiences of reproductive healthcare to facilitate better accessing to care. Moreover, refugee women in this study identified that they got more confidence and coped better to face challenges especially during Covid-19 pandemic. This impact brought them to create support and networks for other women in their community.

In addition to keeping ethical considerations, the researcher took care to adapt the participatory meetings and photovoice activity in accordance with the pandemic's needs in order to prevent harm to the participants during the lockdown of the Covid-19 pandemic. She also continued to involve the refugee women, which had a positive impact on their solidarity during this specific challenging time.

Finally, some suggestions can be made based on the study process and analysis findings. First, it can be advised that, to strengthen health equity and make structural improvements, disadvantaged communities should have access to information in comprehensible and multilingual forms. Second, technology could also be useful for interpreting between patients and medical professionals. Cultural training for health service providers, monitoring and continuous evaluation to detect systematic discrimination are other recommendations in this regard.

The importance of empowerment in reducing health disparities should be considered in further research. Participatory research and other research methods that mediate emancipation and empower migrants and refugee women is recommended (WHO, 2022). This study demonstrated the interest in reproductive health issues among Afghan refugee women. Furthermore, this study found through participatory health research that there is a need for creating partnerships between academic institutions and refugee communities. In doing so, stakeholders and policy makers will have more chances to learn about the actual needs of migrants and develop interventions and other future initiatives for improving health equity (Kleba *et al.*, 2021; MacFarlane *et al.*, 2021; WHO, 2022). This study did not explore the views of German healthcare staff for better assessing the barriers of refugee women through accessing reproductive health. This issue and exploring their views can be suggested for future research.

The capacity of the German volunteers should be recognized, and more research into the potential of NGOs for supporting refugees and promoting health equity in Germany is recommended.

Finally, this study recognized the potential of the refugee youth community in supporting mothers in healthcare centers. This significant group can be trained to be professional interpreters for refugee families in healthcare centers or to distribute information to newcomers to help them find and use available healthcare services (Schmidt *et al.*, 2018). Such a collaborative effort could reduce the difficulties that the refugees faced.

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Chapter Ten: Appendix

Appendix 1: Study Information and Consent Form

Study information and Consent Form for Collecting and Processing Data by Conducting in-depth Interviews and Participatory Research with Female Afghan Refugees "How Afghan Refugee Women in Germany navigate Reproductive Health"

This Form has two parts:
I. Information Sheet (to share information about the study with you)
II. Consent form (for signatures if you agree to participate)

Dear participants,
You are invited to participate in this study, which is a PhD project at the Institute for Medical Information Processing, Biometry, and Epidemiology at the Ludwig-Maximilians-Universität, Munich.

Introduction

Improving health and wellbeing of mothers and children by supporting reproductive health is one of the main aims of any organization who advocate for women's health issues. For many women, becoming a mother is a very emotional experience; through pregnancy, childbirth and motherhood women may be confronted with emotional changes and every woman needs to learn how to deal with these changes to have a physically and emotionally safe child birth. So the aim of this study is in-depth understanding of your challenges and experiences in accessing reproductive health care after arriving in Germany. Additionally, together with other mothers you can create strategies to support your own self-help competencies negotiating the health system.

The procedure

The procedure of this research will be gathering information in form of two interviews, each of which will last about 60 – 90 minutes. The interview will take place at your home or, if it is better for you, we will arrange for another place. During the interviews, I will ask you easy questions about your experiences during pregnancy and motherhood and receiving reproductive health in

Munich, Germany. You do not have to share any experiences that you are not comfortable with telling. Interviews will be only audio-recorded for future reference and to aid in the analysis of findings. For the safety and comfort of the participants, the interview and audio recordings will be kept confidential. Pseudonyms will be used in transcripts, to keep identities secret. The records and transcript will be stored safely. For the convenience, the interview will be conducted in your native language Dari or Farsi. Also, if you like to participate in group meetings with other mothers, information can be collected by photo voice and digital story telling. With these tools you are able to tell your story in form of pictures or taping your voice. This will be done in small groups of 4 – 5 women. After 4 – 6 month the second interview will be only with those, who were participating in these group meetings.

Voluntary Participation

Participation in this study is entirely **voluntary**; refusal to participate will involve no penalty. Each participant is free to withdraw consent and discontinue participation in this project at any time. This research has nothing to do with the asylum procedure. Please keep in mind that regardless of your answers to the interview questions or your choice to participate in this study, your residency status will not be affected.

Risks

The study does not expose you to any risk, please keep in mind that if you feel uncomfortable answering any of the questions posed in the interview, you can either choose to not answer that particular question, or refuse to participate further in the study and withdraw your consent, in which case all records of the interview will be erased. During the interview any sensitive topics will be avoided, questions are easy to answer, also keeping your emotional wellbeing in mind.

Benefits

During this study, you will have the opportunity to open up about your experiences when trying to benefit from reproductive healthcare services in Germany. This feedback will help health practitioners, social workers, and other professionals better cater to the needs of refugee and migrant families. Participants may also choose to discuss these matters in their communities to raise awareness of such issues. We would like to arrange a group of your friends in which you can discuss together and learn from each other. From this participation group you will get more information and tips to better find reproductive health from your gynecologist or midwife; also you can help your friends and community with your suggestions and tips to be more successful for receiving reproductive health.

Data protection

This study complies with the requirements of medical confidentiality and EU data protection regulations. Personal data and findings about you are collected, saved and pseudonymized (all name will be changed). You will create your own pseudonym. Neither your name nor your initials nor the exact date of birth appear. In the case of the revocation of your consent, the pseudonymized stored data will be destroyed.

The access to the original data is restricted to the researcher. The documents will be kept confidentially on a secured and encrypted storage. In case of publication of the study results the confidentiality of the personal data remains guaranteed.

The personal data is collected from you on the basis of your consent in accordance with §4 Abs.1 Federal Data Protection Act (BDSG) and with validity of the data protection basic regulation (DSGVO), according to Art. 6 Abs .1 lit. a DSGVO. If special categories of personal data are concerned, the personal data collected from you are processed on the basis of your consent in accordance with §4 Abs. 1BDSG and with application of the Basic Data Protection Ordinance (DSGVO) in accordance with Art. 9Abs. 2 lit. a DSGVO.

Who to contact

If you are interested to learn more about the study please feel free to contact me. Also for participating, withdrawing the consent and all other information please contact:

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Consent (Einverständniserklärung) to participate in this study **"How Afghan Refugee Women in Germany navigate Reproductive Health", a PhD project in the Institute for Medical Information Processing, Biometry, and Epidemiology at the Ludwig-Maximilians-Universität, Munich.**

Pseudonym: _____

Informed by: _____

1. I have been informed about the method and aim of this study and I had enough time to ask questions, which are all clarified.

2. I agree to participate in this study.

3. I am informed that my participation is voluntarily and whenever I want I can withdraw the participation in the study.

4. I am informed that my answers will be confidential and my real name will be not mentioned in this study, pseudonyms will be used. I agree that these data will be used in reports and publications.

5. I agree that a transcript of my interview could be discussed for further analysis in a group of researchers.

6. I will receive a copy of this informed consent.

7. I am informed that this study has no affect to my residency status in Germany.

Participant: "The topics mentioned above are correct and I agree with the collection of data and with using them as mentioned above"

_____ _____ Interviewee's pseudonym Signature of Interviewee, Place and Date

Researcher: "I explained the study, how to collect data and how they will be used to the interviewee" ___Naseem Sadat Tayebi___ _____ Name of the Researcher Signature of Researcher, Place and Date

Appendix 2: The Translation of Consent Letter in Farsi

فرم رضایت جهت انجام مصاحبه پیرامون پروژه دکترا دانشگاه مونیخ پیرامون چگونه یک خانم مهاجر افغان از بهداشت باروری در آلمان برخوردار می شود

نام مستعار .....

نام توضیح دهنده .....

1. من در مورد روش و هدف این مطالعه شفاف سازی شده ام و وقت کافی برای شنیدن در مورد مطالعه و فرصت برای پرسیدن سوال داشتم.

2. من رضایت دارم که در این مطالعه شرکت کنم

۳- به من اطلاع داده شده که مشارکت من کاملا داوطلبانه است و هر وقت بخواهم می توانم از شرکت در این مطالعه خارج شوم.

4- من مطلع هستم که پاسخ من محرمانه خواهد بود و نام واقعی من در این مطالعه ذکر نخواهد شد و به صورت اسم مستعار خواهد بود

5- من موافقم که متن مصاحبه من می تواند برای تجزیه و تحلیل بیشتر در گروه محققان بحث شود.

6. یک نسخه از این رضایت را دریافت می کنم.

7. من مطلع هستم که این مطالعه تاثیری در وضعیت اقامت من در آلمان ندارد.

من موارد بالا را پذیرفته و رضایت دارم برای انجام این مصاحبه

نام مستعار..... امضاۀ و تاریخ

من موارد بالا را کامل توضیح دادم و پرسش ها را پاسخ دادم

نام ..... امضاۀ و تاریخ

Appendix 3: Information for the Participants

Title of the Research Project:

"How Afghan Refugee Women in Germany navigate Reproductive Health"

Researcher: Naseem Sadat Tayebi

Resources

These are organizations for supporting refugees for your information

Name of organization	Type of services	addresses
Refugio	Psychotherapie und psychologische Beratung	www.refugio-muenchen.de
Caritas	Die Online-Beratung der Caritas, Anonym, kompetent, sicher	www.caritas-germany.org
Beratungsstelle für Natürliche Geburt und Elternsein	Counseling for mothers and further training about reproductive health and birth	www.haeberlstrasse-17.de
Helferkreise	General ,care and support	integration.landkreis-muenchen.de/helfen/helferkreise
Mehria	Mental Health in Refugees and Asylum Seekers	
Homepages of organizations	Which have workshops for reproductive health, if mothers need further training about reproductive health for themselves or their young children	www.miramue.de/home.html www.fabi-muenchen.de www.amanda-muenchen.de/home www.imma.de/einrichtungen/wuestenrose/angebot/4-fortbildungen-workshops-fuer-schueler-innen-und-elternseminare.html www.aufklaerungsprojekt-muenchen.de www.profamilia.de/bundeslaender/bayern/beratungsstelle-sexualpaedagogik-muenchen.html
MiMi-Bayern	Mit Migranten für Migranten – Interkulturelle Gesundheit in Bayern	www.pro-migration.info/42.0.html

Appendix 4: The Translation of Information Form in Farsi

فرم اطلاعات جهت انجام مصاحبه پیرامون جمع آوری اطلاعات با خانم های افغان مهاجر

چگونه یک خانم مهاجر افغان از بهداشت باروری در آلمان برخوردار می شود

مقدمه

شرکت کننده محترم شما را جهت انجام شرکت در یک مطالعه دکترا دعوت شدید .

بهبود سلامت و رفاه مادران و فرزندان و بهداشت باروری یکی از اهداف اصلی هر سازمانی است که طرفدار سلامتی مادر و کودک می باشد.
برای بسیاری از خانمها ، مادر شدن یک تجربه بسیار عاطفی است ،و در هنگام بارداری ، زایمان ممکن است با تغییرات عاطفی روبرو شوند و هر زن نیاز به آموزش در این دوران دارد برای داشتن بارداری سالم و شاد.دراین راستا این مطالعه با

هدف بررسی چالشها و تجربیات شما در سالهای اخیر زندگی در آلمان انجام می شودهنگام
دسترسی به مراقبت های بهداشتی و باروری پس از ورود شما به آلمان. علاوه بر این مطالعه با از زنان و مادران پناهنده افغان است که در مونیخ زندگی می کنند ، برای توسعه وتقویت در تبادل نظر در مورد سیستم بهداشت باروری و زنان به صورت فردی و عمینطور در جوامعشان.
این تحقیق در قالب دو مصاحبه برای جمع آوری اطلاعات کیفی خواهد بود که هر یک از آنها در حدود 60 - 90 دقیقه طول خواهد کشید. در طی مصاحبه ، سؤالات آسانی از شما خواهد شد در مورد تجربیات شما در دوران بارداری و مادری و دریافت سلامت باروری در مونیخ ، آلمان سؤال خواهم کرد. مصاحبه ها به صورت صوتی برای کمک به تجزیه و تحلیل ضبط می شوند. برای ایمنی و راحتی شرکت کنندگان ، مصاحبه و ضبط صدا محرمانه نگه داشته می شوند. برای مخفی نگه داشتن هویت ، از نام مستعار در متن استفاده می شود. برای راحتی شرکت کنندگان ، مصاحبه می تواند به زبان مادری آنها دری یا فارسی انجام شود.
همچنین اگر دوست دارید در جلسات گروهی شرکت کنید ، می توانید اطلاعات را با گفتن عکس و گفتن داستان دیجیتالی جمع آوری کنید. با استفاده از این ابزارها می توانید داستان خود را به صورت تصاویر به
با صدای خود بگویید. این کار در گروه های کوچک 4 تا 5 نفره انجام می شود. بعد از 4 - 6 ماه ، مجددا مصاحبه دوم فقط برای کسانی خواهد بود که در این جلسات گروهی شرکت می کردند.

مشارکت در این مطالعه کاملاً داوطلبانه است. امتناع از شرکت هیچ مشکلی نخواهد بود و شما حق دارید به سؤالات پاسخ ندهید. در عین حال هر یک از شرکت کنندگان در هر زمان آزاد است که رضایت خود را پس بگیرد و شرکت در این پروژه را قطع کند. این تحقیق هیچ ارتباطی با مراحل پناهندگی ندارد. لطفا در نظر داشته باشید که پاسخ های شما به سوالات مصاحبه یا انتخاب شما برای شرکت در این مطالعه ، به وضعیت اقامت شما را تحت تأثیر قرار نمی دهد.

لطفا در نظر داشته باشید که اگر هر یک از شرکت کنندگان در پاسخ به هرکدام از سؤالات مطرح شده در مصاحبه احساس ناراحتی کرد ، می تواند از پاسخ دادن به آن سؤال صرف نظر کند ، یا از مشارکت بیشتر در مطالعه خودداری کند و رضایت خود را پس بگیرد ، در این صورت همه سوابق مصاحبه پاک خواهد شد .در طی مصاحبه از هرگونه مباحث ناراحت کننده اجتناب می شود ، سؤالات آسان می توان به آنها پاسخ داد. کلیه مصاحبه ها و اطلاعات محرمانه نگه داشته می شوند.

سؤالات مصاحبه مورد نیازها و چالش های شما در مورد بهداشت باروری است و در عین حال ، سلامت روانی شرکت کنندگان را نیز مورد توجخ دارد.

در طی این مطالعه ، شما می توانید در مورد تجربه های مثبت خود هنگام تلاش برای کسب خدمات مراقبت های بهداشتی باروری در آلمان بازگو کنید.نتایج این مطالعه به متخصصان بهداشت ، مددکاران اجتماعی و سایر متخصصان کمک می کند تا نیازهای پناهندگان و خانواده های مهاجر را بهتر برطرف کنند. شرکت کنندگان همچنین ممکن است برای افزایش آگاهی از چنین مسائلی ، بحث و گفتگو در مورد این موضوعات را در در گروه خود انتخاب کنند. ما می خواهیم گفتگوی گروهی با دوستانتان را ترتیب دهیم که در آن

می توانید با هم بحث کنید و از یکدیگر یاد بگیرید. از این گروه مشارکت شما می توانید اطلاعات و راهنمایی های بیشتری را برای یافتن سلامت باروری از متخصص زنان و زایمان یا ماما خود کسب کنید. همچنین می توانید با پیشنهادات و نکات خود به دوستان و جامعه خود کمک کنید تا در دریافت سلامت باروری موفق تر باشند.

مبنای قانونی اطلاعات شخصی

ما اطلاعات شخصی جمع آوری شده از شما را براساس رضایت شما مطابق با §4 Abs.1 قانون محافظت از داده های فدرال (BDSG) و با اعتبار مقررات اساسی حفاظت از داده ها (DSGVO) ، از 25 مه (ماه مه 2018) پردازش می کنیم. هنر 6 1. ABS لیتر DSGVO ، اگر به دسته بندی ویژه داده های شخصی مربوط می شود ، ما داده های شخصی جمع آوری شده از شما را براساس رضایت شما مطابق با Abs 4 Abs پردازش می کنیم. BDSG1 و با استفاده از دستورالعمل اصلی حفاظت از داده ها (DSGVO) مطابق با هنر. 9 2. Abs .lit. DSGVO

تماس با ما

اگر علاقه مند به کسب اطلاعات بیشتر در مورد این مطالعه هستید ، لطفا با من تماس بگیرید.

نسیم السادات طیبی دهگان

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Appendix 5: Interview Guide for Refugee Women

Title: "How Afghan Refugee Women in Germany navigate Reproductive Health"
After introducing me and explaining about the research project, presenting the consent form and obtaining their agreement to record the interview

Warm-up

1. Can you tell me about yourself (how old are you? How long are you living in Germany?)

2. Would you like to tell me a story or special moment of one of your pregnancies?

3. Do you like to tell me about your daily life in Germany? How does your usual day look like?

Family life, motherhood and time of pregnancy in Germany

4. Could you please tell me about your family? How many children do you have and where have
you had delivery? How old were you in your first pregnancy
5. What are your responsibilities in the family; what are the responsibilities of your partner / husband?
6. Do you have any relatives or any friends who can help you taking care of the children?
7. Is there a German friend who helps you here?

Experience about obtaining the reproductive health services

8. Would you like to describe your experiences in the hospital during your child birth in Germany, from admission and until discharge?
9. How often do you go to the obstetrician, gynecologist? Do you go alone or do you prefer others to join you? How do you get your appointments? Do you go so often women Doctor?
10. What do you feel when you go to the obstetrician or women Doctor?

11. Do you have nice and happy moment when you are receiving any reproductive health services?

12. If you've been pregnant during your journey to Germany, can you tell me about your experiences?

13. How do you use family planning, do you have to pay for any of the reproductive health services yourself?

Challenges

14. How did the health care staff treat you in the office or hospital?

15. What difficulties in communication do you face, how have you managed these difficulties?

16. What is hard / difficult about receiving reproductive health in Germany?

17. What should change to make it better and improve reproductive health care for refugees in

Germany?

18. What makes you happy when thinking about your pregnancy and motherhood? Please describe the situation.

19. What makes you angry or sad, when you think about your pregnancy and motherhood?

Closing

20. Do you have any suggestions and advice for a newly arriving refugee woman, so that she can

get successfully reproductive health services and have an easy child birth and a happy motherhood?

21. If you would be the German midwife or obstetrician, how would you treat refugee women?

22. Did I miss something - would you like to add anything else or comments to my questions? Thank you very much

Appendix 6: Interview Guide for Volunteers

1. Would you like to tell me a bit about yourself? (warm up)

2. When did you started to work as a volunteer?

3. What are your responsibilities as a volunteer? Can you describe me what you are doing with the refugee family?

4. What did you learn from being as a volunteer?

5. How many families are you tacking care? How often you visit the families? How do you communicate with them?

6. Can you tell me a bit about the refugee families: how is their life in Germany?

7. Did you get any training to be a volunteer?

8. Have you ever joined women refugee for going to the Doctor or in hospital? Do you have any special memory and experience form maternal visiting or Birth of them?

9. What is easy for the women when visiting gynecologist or finding reproductive health? (Such as family planning …)

10. What is hard for women refugee families while accessing the reproductive health?

11. Did you have any difficult situation as a volunteer with the refugee family? Can you describe it?

12. How can we improve accessing of reproductive health women refugee?

13. If a new volunteer wants to start what would be your advice for this women, so she can be a good and successful?

14. What do you like about being a volunteer?

15. Thank you very much, did I miss something? Would you like to add any comment?

Appendix 7: List of Interviews

Interviewer's pseudonym Name	Date	Type of interview	Participants	Place	recording Duration
1-Masumeh	23 Jan 2020	Recording 31 min	Afghan Mother of 3 children	In a private home	One and half hour
2-Sahar	6 Feb	Recording 17 min	Afghan mother of 2 children	In her home	2 hour
3-Neda	6 Feb	Was not ready for recording	Afghan mother of 1 child	In her sister's home	half hour
4-Anita	6 Feb	Recording 18 min	Member of Helferkreis	In the Rathaus	half hour
5-Meg	6 Feb	About 10-15 minutes' talk	Member of Helferkreis	In the Rathaus	half hour
6-Maryam	12 Feb	Recording 21min	Afghan mother of 2 children	In the refugee residents	One hour
7-Zahra	12 Feb	Recording 40 min	Afghan woman	In the refugee residents	One hour
8-Soraya	2 March	Recording 30 min	Afghan mother of 6 children	In a café	One hour
9-Sara	5 March	Recording 31 min	Afghan mother of 3 children	In the café of Hospital	One and half hour
10-Luisa	13 March	Recording 33 min	member of Helferkreis	In her home	One hour
11-Roz	10 May	Recording 45 min	Afghan 20 years old	In the park	One and half hour

Interviewer's pseudonym name	Date	Type of interview	Participants	Place	recording duration
12-Joanna	3 June	Recording 45 min	German women, member of Helferkreis	In balcony of home	One hour
13-Aubi	3 June	Recording 30 min	Afghan mother of 3 children	In the Cafe	One hour
14-Mahnas	29 June	Recording 40 min	Afghan mother of 2 children	In her room in the refugee residence	One hour
15-Dina	15 Sept	Recording 60 min	German women, member of Helferkreis	In her house	One and half hour
15-Saeedeh	18 Sept	Recording 30 min	Afghan mother of 6 children	In their home	One and half hour
16-Dina	15 Sept	Recording 60 min	German women, member of Helferkreis	In her house	One and half hour
17-Lili	23 Sept	Without recording	Afghan mother of 3 children	In her room , In the refugee residents	Half hour
18-Samira	6 Oct	without recording	Afghan mother of 5 children	In her friends' room, In the refugee residents	One and half hour

Table 4: list of interviews with 13 refugee woman (six women in the refugee residents, seven in their home) and five German volunteers

Appendix 8: List of Observations

Observation	Date	Task	Place	Duration of being in the filed
1-Kinderwunsch centre	12 Jun 2019	I was translating for Zahra	Hospital	3 hours
2-in the refugee residence meeting with Helferkreis	17 July 2019	I was invited there as member of Helferkreis	refugee residence	3 hours
3-Joing during the IVF	4 Aug 2019	I was translating for Zahra and her surgeon	Hospital	2 hours
4-Joining to the Gynaecologist	11 Nov 2019	I was joining her for showing the way to the doctor	Private office of Iranian Gynaecologist	2 hours
5-Iranian mosque lecture for Couple relationship	2 Feb 2020	I was invited as a participant	Iranian Islamic centre	3 hours
6-Program of Helferkreis	8 Feb 2020	I was invited there as member of Helferkreis	Rathaus	3 hours
7-Ceremony Mother day in JA school	8 Feb 2020	I was invited as a participant	the JA school (school for Farsi and Arabic)	3 hours
8-In the hospital with Masumeh and Sara	19 Feb 2020	I was visiting Sara and translating for her	hospital	2 hours
9-Visiting Fate in the hospital	2 Mar 2020	I was visiting Sara translating for her	Hospital	2 hours
10-joining with M, in dentist office for her son	11 Mar 2020	I was translating for the anaesthesiologist	Children dentist office	5 hours
11-visitng Maryam because her mother passed away in Iran	6 Oct 2020		In the refugee residents	2 hours
12-joining Sara, in Hausarzt office for her sonography	6 Oct 2020	I was visiting Sara and translating for her	Hausarzt office	1 hour

Table 5: List of observations

Appendix 9: List of Group Meetings

Participatory meetings	Date	Type of meeting	Place	Duration of meeting
1-Cooking together	19 Oct 2019	Cooking and eating together with 3 women a traditional food and eating with a member of Helferkreis	In the home of Sara which is for refugees (Heim)	4 hours
2-Cooking together	12 Nov 2019	Cooking and eating together a traditional Afghan food with 5 Afghan women and a members of Helferkreis	In the home of Sara which is for refugees	3 hours
3-ElternTalk meeting	12 Dec 2019	Participatory Meeting with 5 Afghan mothers	In the international café	One and half hour
4-ElternTalk meeting	19 Dec 2019	Participatory Meeting with 5 Afghan mothers	In the international café	One and half hour
5-Cooking together	5 Jan 2020	Cooking a traditional Afghan food together	In the Masumeh home	3 hours
6-ElternTalk meeting	23 Jan 2020	Participatory Meeting with 4 Afghan mothers	In the international café	One and half hour
7-ElternTalk meeting	20 Feb2020	Participatory Meeting with 3 Afghan mothers	In my home in the working room	One and half hour
8-meeting about photo voice (focus group)	3 Jun 2020	Participatory Meeting with 3 Afghan women	In a Café, About their view about the participatory group	One and half hour
9-meeting about photo voice and corona	14 Sept 2020	Participatory meeting with 2 Afghan women	In the Balcony our home, About their view about the participatory group	2 hour

Participatory meetings	Date	Type of meeting	Place	Duration of meeting
10-meeting about the birth experiences	23 Sept 2020	Meeting with 2 Afghan women	In the refugee residents,room of one of the	One hour
11-photo elicitation with Zahra about the challenges with the doctor	18 Sept 2020 29 Sept 2020	photo elicitation	In our home In the way to visit the other family	One hour
12-photo elicitation with Maryam about the challenges with the doctor	23 Sept 2020	photo elicitation	In her room at refugee residents	One hour
13- photo elicitation with Maryam about the challenges with the doctor	26 Oct 2020	photo elicitation	In our home	One hour

Table 6: List of group meetings

Appendix 10: A Section of MAXQDA 2020

Theme: Barriers and Lack of Proper Communication

Document	Coded Segments	Codes
Roz, Pos. 10	I got so many injections, I don't know why and for which reason, but I don't think that I had vaccination already. I didn't understand any things that doctor said and my father was translating for me always	as a Guardian awareness on the treatment/procedure language barrier accompanying relative
Roz, Pos. 12	my father didn't understand everything neither Yes sure D with very plane words explaining to father and he translated for me	Try to communicate without words? language barrier accompanying relative
Dina, Pos. 38	because we could not communicate and that the mother of the young women could talk very little German and the young man could talk a little then we should have fetched some body because it was cesarean section as well and the man went inside of operation room	proper communication language barrier
Lili 24 Sep , Pos. 7	was very hard and difficult I didn't understand anything that doctor or others said	Difficult pregnancy? language barrier
Lili 24 Sep , Pos. 19	I didn't understand any word of them and they never took care ,for example I didn't know that there is a button and I can press when I need ,	Difficult pregnancy ? language barrier (un)clear information / explanation perception of being ignored
Lili 24 Sep , Pos. 23	when you just arrived and cannot talk to the doctor or nurses	Advice for others? don't be pregnant when recently arrived language barrier recent arrival mind the timing of pregnancy
Zahra,6, Pos. 10	,first day my husband was with doctor and he showed all the paper to them but she didn't say any things and write more examinations and said go and do this examinations and didn't say anything about the translator or any things else	role of husband accompanying relative (un)clear information / explanation
Zahra,6, Pos. 10	finally in one day we went there and we collected all the documents to her and she said no you don't understand any things you should come with a translator she as talking very unfriendly	not understanding word of doctor, feeling bad, unfriendly staff, angry, role of husband accompanying spouse to the doctor (un)clear information / explanation Communication style of the providers (or disrespectful communication??)

Sara 4.03, Pos. 30-31	How did you communicate with them then? Sara : How, I didn't ,just haha…(laugh)	cannot talk about your problem, try to communicate without words ? language barrier communication style of the providers uncomfortable in asking questions
Sara 4.03, Pos. 115	I could not talk and communicate	don't be pregnant when recently arrived recently arrived / first time after arrival timing of pregnancy
Sara 4.03, Pos. 131	I can talk a little but still is difficult I don't understand when they talk fast or medical vocabulary	not understanding word of doctor language barrier lack of empathy in communication unclear explanations
Sahar 6.02, Pos. 26	I was very lonely, nobody else was visiting me	loneliness
Sahar 6.02, Pos. 39-40	How did you communicate with them? Sahar: It was difficult for me ...uhhmm . I was trying to tell them"(می حالیشون جوری یک کردم) ..(haha, laugh)	try to communicate without words ? language barrier
Sahar 6.02, Pos. 53	He was very nice and kind, in my last month of pregnancy he supposed that I eat medication for my Anemia but I didn't have any medicine or any Iron. He told me that you have very sever lack of Iron in your blood ,you know on those days I was feeling very bad even I was eating raw and wet rice	kind staff and treatment communication style of the providers (un)clear information / explanation
Masume first interiveiw.23.01, Pos. 158	like me I didn't understand anything when I was pregnant ,I	don't be pregnant when recently arrived recently arrived / first time after arrival
Masume first interiveiw.23.01, Pos. 158	when I had allergy I told them that I have itching but they didn't understand me then I was showing with my hand and scratching myself and we went to hospital ,there also they didn't understand what was the reason of my allergy I knew because of my pregnancy ,but they didn't understand	try to communicate without words language barrier
Masume first interiveiw.23.01, Pos. 159	But I could not never talk when we went to hospital my husband searched and found a person who could talk Turkish and it was helpful .but with DO I could not understand her and she didn't either and we talk with hands ,it was difficult ,first they should learn language.	try to communicate without words language barrier

maryam 12 Feb, Pos. 34	Maryam; Yes I was so worried if I lose my child or something bad happens for the child	difficult pregnancy, fear of delivery concerns about the child health
maryam 12 Feb, Pos. 52-53	When you have been in hospitalized how could you communicate with staff ,was hard P SEP Maryam; It was very hard, I could not understand any things, laugh with shy...	not understanding word of doctor language barrier
Maryam 12 Feb, Pos. 72-73	And how could you communicate with the staff during your delivery, your German was not good that time Maryam; I could understand them a little bit, for example when they took my blood pressure, or she asked do you have pain or not, for example she said when you need help ring the bell (5:42) and they change themselves the baby's pampers	try to communicate without words, kind staff and treatment language barrier communication style of the providers (lack of) support from the providers
maryam 12 Feb, Pos. 79-83	then they gave me a tablet and said I should eat it but didn't get better ,then I came home and it is got worst And what did you have done ,you were eating tablet ,but you gave mil as well I stayed 2 days at home and it was getting worst and Ambulance came and fetched me to hospital special for skin and I was hospitalized there and they put a crème on my body every day ,I think , because of the medicine I think it was the reason that they gave me before delivery NT; because of the anesthesia? Maryam; Yes, for anesthesia, I think .. before that they asked me if I have allergy and I said no I don't have	misunderstanding, challenges after delivery (+) awareness on the treatment/procedure language barrier (un)clear information / explanation uncomfortable in asking questions
maryam 12 Feb, Pos. 88-89	NT: how could you communicate there Maryam; No ,there accidently one of the doctors was Iranian laugh	kind staff and treatment language barrier providers speak the same language
maryam 12 Feb, Pos. 117-119	Laugh .I don't know P SEPNT; For example a mother told me that I would say don't get so fast pregnant until you can talk and understand P SEP Maryam; That's right it is very difficult not understand anything ," it is very bad to not talk when you are suddenly pregnant "(خیلی زیونی بی بده),	feeling powerless, try to communicate language barrier during of pregnancy
maryam 12 Feb, Pos. 158-162	I was hospitalized there ,I was feeling very alone there ,for example ,and the day that you came in hospital visiting me I was getting very happy ,I never forget NT; Very nice and I talked to Anesthesia doctor P SEPMaryam; Yes I didn't understand what did he say and what he wanted to with me and child and I didn't understanding	needs to have helper (+), feeling powerless, cannot talk about your problem, lack of family around, feeling alone, difficult pregnancy loneliness language barrier

	anything[P SEP] NT; Yes, you afraid that if they put your baby out [P SEP]Maryam; Yes, then you went and talk to the doctor and came to me and told me ever things is ok I was very happy ….AHHH…(like relieve breath)	lack of support
Leila 2, Pos. 4-5	How do you talk to the staff [P SEP].I don't talk to them and just wait behind the door for one hour.it is very difficult staying in hospital	language barrier long waiting times lack of information how to access care
Soraya and Ayubi 6 Oct, Pos. 4	This added to her problems and she mentioned that she cried alone a lot	feeling powerless, not understanding word of doctor, feeling bad loneliness language barrier lack of support sadness

Table 7: A section of MAXQDA 2020

Appendix 11: The Transcription Legend and Symbols

(the exact word of Farsi)	"the English translation"
[researcher explanation]	about the interviewer and her behavior or reaction, or something happened in the room during the interview
Laugh:	haha when she is laughing
Laugh:	when she is laughing loudly
(Name):	when the name of a person mentioned
…..umm:	pause, when the interviewer thinks and does not answer immediately
Ahhh…:	when she breathes deeply (sadness, or relieve)
BOLD writing	when she talked laud

Acknowledgments

Dedication

To all refugee women and children who teach us with their footprints and their stories
To my parents
To my husband
To my daughter, Bita

I am thankful for the support of my supervisors, Prof. Dr. Hella von Unger, Prof. Dr. med. Georg Marckmann and Prof. Dr. Eva Annette Rehfuess, who shared their knowledge and experiences and navigated this journey patiently with me.

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I am thankful to Daniel who was supporting me all the time and was patiently encouraging me to keep go on and for his perspective.

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Affidavit

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I hereby declare, that the submitted thesis entitled

How Afghan Refugee Women in Germany navigate Reproductive Health

is my own work. I have only used the sources indicated and have not made unauthorised use of services of a third party. Where the work of others has been quoted or reproduced, the source is always given.

I further declare that the dissertation presented here has not been submitted in the same or similar form to any other institution for the purpose of obtaining an academic degree.

Pullach, 01.08.2023

Place, Date

Naseem Sadat Tayebi Dehgan

Signature doctoral candidate

Affidavit Human Biology

Date: 01.08.2023

Confirmation of Congruency

LMU LUDWIG-MAXIMILIANS-UNIVERSITÄT MÜNCHEN

Dean's Office Medical Faculty
Doctoral Office

Confirmation of congruency between printed and electronic version of the doctoral thesis

Doctoral candidate: Naseem Sadat Tayebi Dehgan

Address:

I hereby declare that the electronic version of the submitted thesis, entitled

How Afghan Refugee Women in Germany navigate Reproductive Health

is congruent with the printed version both in content and format.

Pullach, 01.08.2023
Place, Date

Naseem Sadat Tayebi Dehgan
Signature doctoral candidate

Congruency of submitted versions Human Biology Date: 01.08.2023

List of Publications

1 .**Researching with Care – Participatory Health Research with Afghan Women Refugees in Germany During the Covid-19 Pandemic: A Case with Commentaries (2023)**
Naseem S. Tayebi, Marilena von Köppen, Petra Plunger, Susanne Börner and Sarah Banks Ethics and Social Welfare, DOI: 10.1080/17496535.2023.2209364
https://doi.org/10.1080/17496535.2023.2209364

2. **Participatory Health Research A Guide to Ethical Principles and Practice**: **(2022).**
Sarah Banks, Michelle Brear, Barbara Groot, Pradeep Narayanan, Petra Plunge, Pinky Shabangu, Naseem Sadat Tayebi, Marilena von Köppen, 2nd edition, July 2022. ICPHR (International Collaboration for Participatory Health Research). Position Paper 2: <www.icphr.org/uploads/2/0/3/9/20399575/ethics_icphr_positionpaper-7.6.22.pdf

3. **Linking Refugee Families with the Host Societies. A Mixed-Methods Evaluation Study of Family Education Programs in Germany (2021)** (*Creando vínculos entre las familias refugiadas y las sociedades de acogida. Una evaluación de métodos mixtos sobre los programas de educación familiar en Alemania*) Annette Korntheuer, Nassem Sadat Tayebi and Nisren Habib, Culture and Education, DOI: 10.1080/11356405.2021.1975457, https://doi.org/10.1080/11356405.2021.1975457