CLOSER TO CARE:

LIVED EXPERIENCES AND ACCESS TO SRHR FOR FEMALE ASYLUM SEEKERS

A PARTICIPATORY STUDY ON ON-SITE CONSULTATIONS
IN DUTCH ASYLUM CENTERS

Sofieke Hofman

MASTER OF SCIENCE IN INTERNATIONAL HEALTH
KIT INSTITUTE
VRIJE UNIVERSITEIT AMSTERDAM (VU)

CLOSER TO CARE:
LIVED EXPERIENCES AND ACCESS TO SRHR FOR FEMALE ASYLUM SEEKERS
A PARTICAPTORY STUDY ON ON-SITE CONSULTATIONS IN DUTCH ASYLUM CENTERS

A thesis submitted in partial fulfilment of the requirement for the degree of
Master of Science in Public Health

by

Sofieke Hofman

Declaration:
Where other people's work has been used (from either a printed or virtual source, or any other source), this has been carefully acknowledged and referenced in accordance with academic requirements.

The thesis *'Closer to care: lived experiences and access to SRHR for female asylum seekers. A participatory study on on-site consultations in Dutch asylum centers'* is my own work.

Signature

Master of International Health
09 September 2024 – 29 August 2025
KIT Institute/Vrije Universiteit Amsterdam Amsterdam, The Netherlands

August 2025 Organised by:

KIT Institute
Amsterdam, The Netherlands

In cooperation with:

Vrije Universiteit Amsterdam (VU) Amsterdam, The Netherlands

ABSTRACT

BACKGROUND

Female asylum seekers in the Netherlands face persistent, multifaceted barriers to sexual and reproductive healthcare (SRHR), resulting in underutilization and unmet needs, despite legal entitlements and available services. Tailored care is better suited to address women's specific SRHR needs.

OBJECTIVE

This study explores how on-site SRHR consultation services can be adapted and implemented to reflect the SRHR-related needs, preferences, and lived experiences of female asylum seekers in the Netherlands, using a participatory research approach.

METHODOLOGY

This qualitative study used a participatory approach by involving peer researchers: migrant ambassadors with lived experience. Data were collected through key informant interviews and focus group discussions with female asylum seekers, using visual prompt cards to facilitate dialogue on sensitive SRHR topics. Thematic analysis, guided by the Levesque framework, explored access at both user and system levels.

RESULTS

Key SRHR needs include care related to gender-based violence, support for the consequences of female genital mutilation, and access to reliable and appropriate information to make informed choices. Critical facilitators of access are trusted communication, culturally sensitive care, integrated on-site services, and involvement migrant ambassadors. Main barriers include stigma, limited health literacy, cultural taboos, lack of continuity, and unsuitable living conditions. Trust and inter-organizational partnerships emerged as essential cross-cutting factors influencing access and engagement with care.

CONCLUSION

Women express a clear need for safe spaces to discuss SRHR-related concerns. Adapting services to their lived experiences requires trust-building, cultural responsiveness, and system-level coordination. On-site, community-informed interventions hold strong potential to improve access, equity, and quality of SRHR care.

Key words

Access to care, SRHR, asylum seekers, The Netherlands, participatory research

Word count

13.112 words

TABLE OF CONTENT

LIST OF TABLES AND FIGURES

ABBREVIATIONS

Abbreviation	Full term
SRHR	Sexual and Reproductive Health and Rights
STI	Sexual Transmitted Infection
COA	The Central Agency for the Reception of Asylum Seekers (Centraal Orgaan Opvang Asielzoekers)
IND	Immigration and Naturalisation Service (Immigratie- en Naturalisatiedienst)
GP	General Practitioner
GGD	Municipal Public Health Service (Gemeentelijke Gezondheidsdienst)
GZA	Healthcare for Asylum Seekers (Gezondheidszorg Asielzoekers)
CBPR	Community-Based Participatory Research
CSG	The Sexual Assault Centre (Centrum Seksueel Geweld)
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
GBV	Gender-Based Violence
JGZ	Youth Healthcare (Jeugdgezondheidszorg)
KII	Key Informant Interview
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and others
MSM	Men who have Sex with Men
PrEP	Pre-Exposure Prophylaxis
RMA	Regulation medical care asylum seekers (Regeling Medische Zorg Asielzoekers)
SDG	Sustainable Development Goals
WHO	World Health Organization

GLOSSARY OF KEY TERMS

Asylum seeker	An individual who is seeking international protection. In countries with individualized procedures, an asylum seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum seeker will ultimately be recognized as a refugee, but every recognized refugee is initially an asylum seeker (IOM) (1).
Sexual and Reproductive Health and Rights	A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (WHO) (2).

ACKNOWLEDGEMENTS

I am deeply grateful for the support of the research team and for Peter's unwavering belief in this project. I want to thank Rut Debesai, Lilas Fahham, Najah Yousuf, Zamsam Raage, and Tsega Effrem, without you, this research would have been far less rich and meaningful.

I also want to thank R & I, L and L for their practical help and continuous encouragement, your support made a real difference.

Most of all, my heartfelt thanks go to A, C & C. Without the space you gave me, emotionally, practically, and in time, this would not have been possible. Your contribution was indispensable, even when it required a lot from all of us.

Funding for this project was kindly provided by the Centre for Infectious Disease Control (Cib) of the National Institute for Public Health and the Environment (RIVM).

RESEARCH TEAM

Sofieke Hofman (SH)

Lilas Fahham (LF)

Rut Debesai

Najah Yousuf

Zamsam Raage

Tsega Effrem

Edwin Spijkers

Hilde Post

Irene Goverse

Jolien Groeneveld

INTRODUCTION

Equitable access to healthcare is a topic that speaks to me personally. In my professional experience, I have seen how asylum seekers are often insufficiently reached by the healthcare system. While there is no shortage of good ideas, warm intentions, and small-scale pilot projects, these efforts rarely make it into published literature. As a result, valuable knowledge and experience remain with individual practitioners and are not shared more broadly.

This study takes a different approach. We actively involve the women themselves, ask for their perspectives, and work closely with migrant ambassadors as peer researchers. The findings are systematically documented and shared with stakeholders who can influence policy. Ultimately, the aim of this study and thesis is to contribute to more equitable access to healthcare for women in the asylum system.

BACKGROUND

UNMET NEED IN SEXUAL AND REPRODUCTIVE HEALTHCARE

Access to sexual and reproductive health (SRHR) care is not guaranteed for female asylum seekers. This is reflected in both national and international research, which highlights persistent barriers to SRHR care among asylum-seeking women.

Research on SRHR services for migrants in the Netherlands, mostly from 15 years ago, demonstrated that women faced significant barriers to access. These included lack of information about reproductive health and contraception, financial constraints, and a loss of autonomy (3). Reported consequences were low contraceptive use, high rates of unintended pregnancies and abortions, teenage pregnancies, sexually transmitted infections (STIs), and gynaecological or sexual health problems (4). Asylum seekers may themselves have experienced sexual and gender-based violence (SGBV), or know others who have, reflecting their extreme vulnerability to violence (5, 6). More recently, research on maternal health showed that female asylum seekers in the Netherlands are also at increased risk of adverse maternal and perinatal outcomes during perinatal care (7, 8).

At the global level, recent reviews have explored barriers, facilitators, and interventions related to SRHR care access among migrant and refugee populations across different contexts. This is illustrated by the systematic review by Davidson et al., who identified three main domains affecting *access* to preventive SRHR care for women with a refugee-like background: interpersonal (e.g. limited knowledge, language barriers), health system (e.g. provider discrimination, financial barriers), and sociocultural (e.g. family influence, cultural norms). The review covered studies from low-, middle-, and high-income countries. Barriers were often more pronounced in low- and middle-income settings, while enablers, such as women's agency, equality in relationships, and positive provider interactions, were mainly reported in high-income contexts (9).

Another study by Sawadogo et al. used a different classification of ten access dimensions, including affordability, availability, quality, stigma, and administrative complexity. Enablers included translation tools, telehealth, health promotion workers, and culturally sensitive care (10).

When it comes to interventions to improve SRHR care for migrant populations, recent studies offer valuable insights into both content and implementation. A scoping review by Bouaddi et al. identified a wide range of interventions aimed at improving individual and organisational outcomes. Most interventions focused on education and information dissemination. The authors call for more theory-driven and participatory approaches to better understand what makes these interventions effective (11).

A recent Swiss study compared standard and specialized SRHR care for female asylum seekers. Specialized care, offering interpreters, contraceptive access, provider choice, and culturally sensitive approaches, was found to better meet women's needs. The study is especially relevant given its high income context and focus on care models within our research scope (12).

RECEPTION OF ASYLUM SEEKERS IN THE NETHERLANDS

Female asylum seekers in the Netherlands are entitled to reception, including shelter, food, and access to medical care, as outlined in the Central Agency for Reception of Asylum Seekers (COA; Dutch: Centraal Orgaan opvang asielzoekers) Act. COA is the Dutch governmental body responsible for delivering these services.

The asylum seekers centre in Ter Apel, a small village in the North-East of the Netherlands, is one of two national registration points for new asylum seekers, alongside a facility at Schiphol Airport. The centre hosts up to 2,000 people and provides initial information on the Dutch healthcare system, including basic health education on self-care.

After registration, asylum seekers wait for their procedure to begin and are usually relocated to other reception centres. The duration of their stay in Ter Apel varies, from a few days to several months, depending on the capacity of other centres, the processing speed of the Immigration and Naturalisation Service (IND), and the assigned procedural track. Multiple relocations between centres are common (13).

HEALTH CARE SERVICES FOR ASYLUM SEEKERS

Medical care for asylum seekers in the Netherlands is organised by COA, which contracts various healthcare providers, including general practitioners (GPs), midwives, and the Public Health Service (GGD; Dutch: Gemeentelijke Gezondheidsdienst). All registered asylum seekers are automatically insured under the government-funded healthcare scheme[1], covering a broad range of services without requiring out-of-pocket payments (14, 15).

Primary care is delivered by GPs affiliated with the organisation GezondheidsZorg Asielzoekers (GZA; Healthcare for Asylum Seekers), usually located in or near reception centres. These GPs offer general medical care, including SRHR services such as counselling, contraceptive prescriptions, STI diagnostics and treatment. Referral by a GP is required for access to specialist or hospital-based care, including fertility services (16).

Public health services are provided by local GGD branches under a national contract with COA. Their responsibilities include infectious disease control (e.g. tuberculosis), health education (covering topics such as self-care, mental health and SRHR), sexual health care, and child and youth health programmes (JGZ; Dutch: Jeugdgezondheidszorg). JGZ provides child immunisations and includes the programme *Nu Niet Zwanger* ("Not Pregnant Now"), supporting vulnerable individuals in making informed reproductive health choices (17–19).

[1] Regulation medical care asylum seekers. (RMA; Dutch: Regeling Medische Zorg Asielzoekers)

Maternal care is midwifery-led. COA contracts nearby midwifery practices to provide antenatal, birth, and postnatal care. Midwives also play a role in health education and routinely offer contraceptive counselling during postpartum visits. Abortion care is provided by GPs, and in specialised clinics or hospitals. First-trimester abortions are accessible without referral, even for asylum-seeking women. Second-trimester procedures may require referral by a GP (20).

The Sexual Assault Centre (CSG; Dutch: Centrum Seksueel Geweld) offers specialised care for victims of sexual violence, recent or past, including online abuse. Multidisciplinary teams, consisting of medical, legal, and psychosocial professionals, provide integrated support. CSG services are also available to asylum seekers (21).

POLICIES AND ACTS

Several policy documents and regulations define access to SRHR care for asylum seekers in the Netherlands. Below, the main frameworks are summarised.

GGD–COA CONTRACT

The contract between the GGD and COA explicitly identifies sexual health as a focus area. In addition to group education, female asylum seekers are entitled to individual counselling to promote healthy sexual behavior and prevent STIs. Financial resources for these individual consultations are available within this contract between GGD and COA (17).

NATIONAL ACTION PLAN ON SEXUAL HEALTH

The Dutch government introduced a National Action Plan on Sexual Health in 2012 (updated every four years) to supplement public health law. Its main pillars are sexuality education and surveillance. Other goals include prevention of STIs/HIV, unwanted pregnancies, and sexual violence. Targeted subsidy schemes support its implementation. The plan highlights vulnerable groups, including those at higher risk of adverse SRHR outcomes due to age, socioeconomic status, literacy, migration background, or risky sexual behaviour. Female asylum seekers are explicitly recognised as such a group (22).

SUSTAINABLE DEVELOPMENT GOALS

This research aligns with two relevant targets:
SDG 3.7 – Universal access to SRH care, family planning, and education
SDG 5.6 – Universal access to reproductive health and rights, promoting gender equality (23).

PROPOSED INTERVENTION: ON-SITE SRHR WALK-IN CONSULTATIONS

In the Netherlands, public health services offer sexual health clinics for individual counselling, including in the city of Groningen. Yet, despite being situated in a high-income country with established policies, action plans, and contractual agreements, SRHR services are still underutilized by (female) asylum seekers, as observed in practice. Public health nurses working at asylum reception centres observed a clear need for improved access to SRHR care. In response, they proposed offering SRHR care on-site, shifting services from the municipal clinic to the reception centre to reduce barriers.

PROBLEM STATEMENT AND JUSTIFICATION

Although barriers and unmet SRHR needs among female asylum seekers in Dutch reception centres have been described, there is little evidence on concrete interventions. Specifically, published research on the implementation and evaluation of on-site SRHR services within the Dutch asylum system is lacking.

This gap underscores the need for context-specific, evidence-based approaches. To address the persistent underutilisation and unmet needs of SRHR care, we propose an intervention that embeds accessible SRHR services within a reception centre. Yet, its relevance and acceptability from the perspective of the women themselves remain unclear.

Understanding the perspectives, needs, and preferences of female asylum seekers is essential for the successful and sustainable design of such services. This study serves as an exploratory step towards translating policy intentions into practice, by informing a tailored intervention grounded in the experiences of the women it is meant to serve.

RESEARCH QUESTION AND OBJECTIVES

RESEARCH QUESTION

How can the proposed on-site SRHR consultation services be adapted and implemented in a way that reflects the SRHR-related needs, preferences, and lived experiences of female asylum seekers in the Netherlands, as explored through a participatory research approach?

SUBQUESTIONS

1. What are the SRHR-related needs, priorities, and care-seeking experiences of female asylum seekers in the Netherlands?

2. What barriers and facilitators influence their access to SRHR services?

3. What are the perceptions of the proposed on-site consultation service?

4. What design and implementation conditions are needed to ensure the proposed SRHR consultation service aligns with the preferences, cultural context, and daily realities of female asylum seekers?

OBJECTIVES

1. To explore the SRHR-related needs, priorities, and care-seeking experiences of female asylum seekers in the Netherlands.

2. To identify perceived barriers and facilitators affecting access to SRHR services.

3. To gather views on the proposed on-site consultation service.

4. To generate recommendations for the adaptation and implementation of the SRHR consultation service, based on the preferences, cultural context, and lived experiences of female asylum seekers.

METHODS AND ANALYTICAL FRAMEWORK

STUDY DESIGN

QUALITATIVE STUDY

Given the research objectives a qualitative approach was deemed most appropriate, enabling for in-depth exploration of needs and lived experiences related to SRHR, as well as perceptions of a proposed walk-in SRHR consultation service at asylum seeker centres.

Key informant interviews (KIIs) with professionals and focus group discussions (FGDs) with asylum-seeking women were conducted to gain insight into lived experiences, care-seeking behaviours, and perceived structural barriers to access.

PARTICIPATORY APPROACH – MIGRANT AMBASSADORS

Research on SRHR among asylum seekers may face several challenges, including language barriers, lack of trust, cultural and religious sensitivities, and the sensitive nature of the topic. All of which can affect participation and data quality.

To address these challenges, a community-based participatory research (CBPR) approach was adopted, promoting equal collaboration between researchers and community members (24). (Vaughn et al.). This approach enhances rigor (in study design, data quality and analysis), relevance (by aligning questions with community priorities), and reach (through broader dissemination and practical impact) of the study (25).

In this study, migrant ambassadors played a central role through both consultative and collaborative participation, acting as peer researchers. Migrant ambassadors have a migration background themselves and can navigate between cultures. They are familiar with Dutch society, healthcare systems, and research settings, while also applying their own linguistic skills, cultural knowledge, and sensitivity in interactions with participants. By involving migrant ambassadors as peer researchers, the study gains trust, cultural insight, and stronger engagement.

Peer researchers were *selected* based on key criteria: female gender, migration background, affinity with SRHR, and strong facilitation skills. Three language groups were selected in accordance with the most common countries of origin among asylum seekers. For each language group (Arabic, Somali, and Tigrinya) a suitable peer researcher was selected. The Arabic group was led by a qualitative researcher employed by GGD Groningen. For the Somali group, a contracted migrant ambassador was appointed, and at her request, accompanied by second ambassador to ensure that both more traditional and more modern perspectives were represented. The Tigrinya group was facilitated by a dedicated nurse known for her strong interpersonal skills.

Peer researchers contributed to multiple stages of the research process. Table 1 outlines the involvement of peer researchers in each phase of the study.

TABLE 1 - CONTRIBUTIONS OF PEER RESEARCHERS

Research Phase	Contributions of Peer Researchers
Adaptation of selected tools and methods	Provided feedback on the topic list, adapted visual prompt cards, and translated the informed consent form
Data collection	Facilitated focus group discussions, enabling culturally attuned communication and sensitivity to non-verbal cues and group dynamics.
Data analysis	Transcribed, translated, and contributed to the coding of data
Interpretation & discussion	Participated in the interpretation of findings and discussion of results

All peer researchers were briefed and trained prior to data collection. This included a thorough explanation of the study's background, rationale, and research question, as well as the methodology. They were also introduced to the concept of FGDs, key facilitation principles, and the specific roles of the facilitator and other participants.

TOOLS

FRAMEWORK

This study focuses on access to SRHR among female asylum seekers in the Netherlands. It explores both their SRHR-related needs and the barriers and facilitators they encounter in seeking and receiving care. To analyse these complex and interrelated factors in a structured way, the Levesque framework on access to healthcare was used.

The framework, developed by Levesque et al., conceptualises access as the dynamic interface between the characteristics of health services (supply side) and the abilities of individuals to seek, reach, and engage with care (demand side). It distinguishes five dimensions of accessibility on the supply side: approachability, acceptability, availability and accommodation, affordability, and appropriateness. Five corresponding abilities on the demand side: the ability to perceive, seek, reach, pay, and engage (26). The framework is presented in figure 1, conceptual and operational definitions in annex 1.

In this study, the framework was applied to analyse accessibility at both system (supply) and individual (demand) levels. It served as a tool to structure the qualitative data analysis by helping to group codes and identify key themes that emerged from the interviews and focus group discussions. The framework made it possible to systematically explore how institutional factors and individual experiences shape asylum seekers' access to SRHR care, and where opportunities for adaptation and improvement lie.

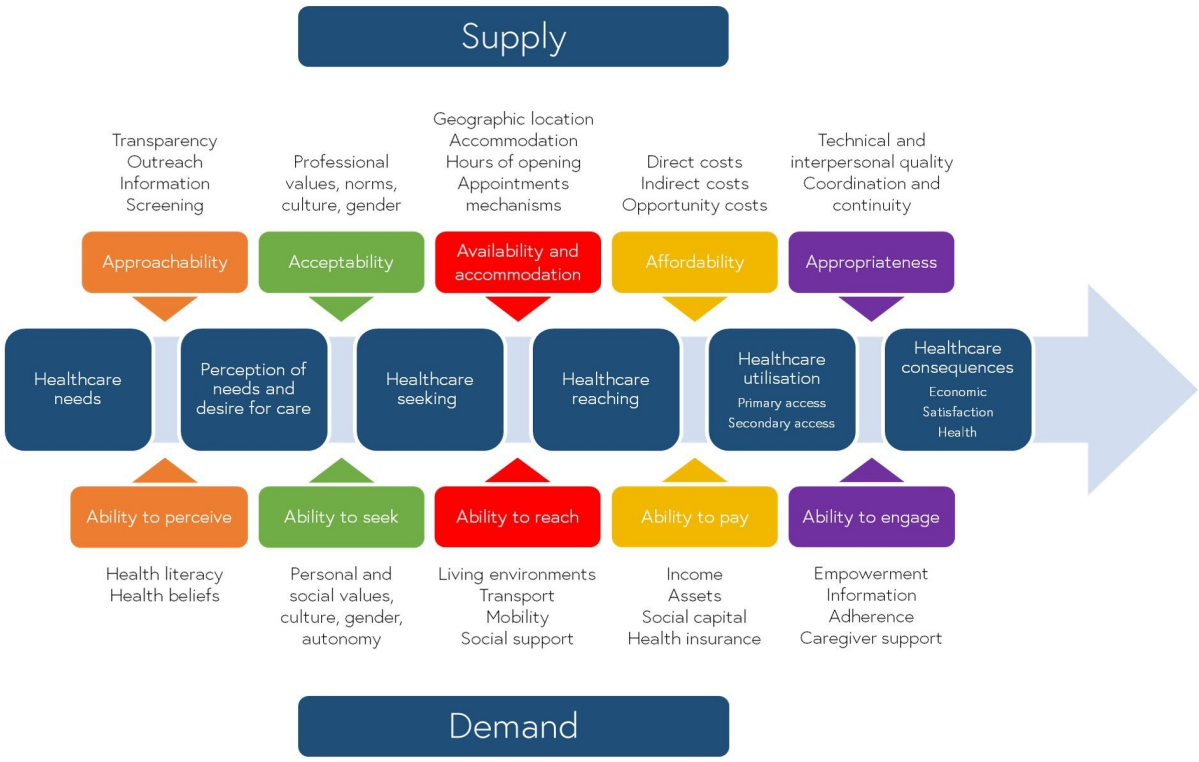
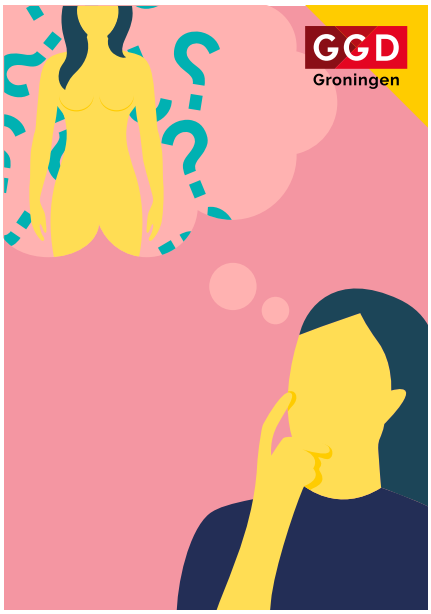


FIGURE 1 - A CONCEPTUAL FRAMEWORK TO ACCESS OF CARE, LEVESQUE. SOURCE: FUTURE LEARN (31).

VISUAL PROMPT CARDS

Visual prompt cards are tools that feature images or pictograms to support communication, reflection or interaction. They can be used as starting points of discussion (27). In this study, the visual prompt cards were used to explain the different areas of SRHR care, to open conversation, and to help participants express the perceived importance of each area. Additionally, they supported the reduction of language barriers, addressed issues of illiteracy, and facilitated non-verbal communication. Besides, it can shift the focus from a personal opinion to a card, making it easier to talk about a sensitive topic.
Table 2 presents the design and development process, including feedback cycles. Figure 2 presents some examples of the visual prompt cards, all cards can be found in annex 2.

Gender-based violence and harmful practices, support and care



Information about the (female) body

Contraception counselling and provision

FIGURE 2 - EXAMPLES OF VISUAL PROMPT CARDS

TOPIC GUIDES

KIIs were conducted to gather context-specific insights relevant to SRHR access among female asylum seekers. A semi-structured interview guide was used to allow for consistent exploration of key topics while remaining flexible to emerging themes. Topics included the professional's role in SRHR care, urgent needs, barriers and facilitators, suggestions for improvement, and perspectives on the proposed walk-in consultations (see Annex 3).

FGDs explored collective SRHR needs, shared experiences, and group responses to the proposed on-site SRHR consultations. The discussions allowed for interaction between participants, helping to surface common concerns as well as diverse perspectives.
Main topics included perceived needs, barriers and facilitators in access to care, views, strengths and challenges on the proposed SRHR consultations, and participant recommendations (see Annex 4).

TABLE 2 - DESIGN AND DEVELOPMENT PROCESS OF VISUAL PROMPT CARDS

<table>
<tr><th>Step</th><th>Description</th></tr>
<tr><td>Selecting topics</td><td>Selection of areas within SRHR was based on the WHO's Framework for Operationalizing Health and Its Linkages to Reproductive Health (28). This framework identifies eight key areas. SRHR care, provided by the GGD, primarily focuses on testing, information and education, sexual wellbeing and to a lesser extent, violence. Therefore, these areas were further subdivided, resulting in the following list of 12 topics:
<table>
<tr><th>WHO identified area</th><th>Topics</th></tr>
<tr><td>Comprehensive education and information</td><td>1. Health education sessions (group)
2. Information about the (female) body</td></tr>
<tr><td>Sexual function and psychosexual counselling</td><td>3. Information about intimacy/sexual well being</td></tr>
<tr><td>Prevention and control of HIV and other sexually transmissible infections</td><td>Prevention and control of HIV and STIs
4. Screening HIV
5. Pre exposure prophylaxes (PrEP)
6. Screening STI</td></tr>
<tr><td>Gender-based violence prevention, support and care</td><td>7. Gender-based violence and harmful practices, support and care</td></tr>
<tr><td>Contraception counselling and provision</td><td>8. Contraception counselling and provision</td></tr>
<tr><td>Safe abortion care</td><td>9. Unintended pregnancies and safe abortion care</td></tr>
<tr><td>Fertility care</td><td>10. Fertility care</td></tr>
<tr><td>Antenatal, intrapartum and postnatal care</td><td>11. Perinatal care</td></tr>
<tr><td>Others</td><td>12. Outstanding issues</td></tr>
</table></td></tr>
<tr><td>Selecting designer</td><td>The designer was selected because of his professional connections with the Public Health Service (GGD) and the successful completion of a previous assignment.</td></tr>
<tr><td>Criteria for designer</td><td>The cards were required to meet the following criteria:
- Clarity of the depicted element
- Cultural sensitivity; respectful, appropriate for the participants of FGDs, non-offensive, and not unnecessarily explicit.
- Inclusivity; adequate representation, irrespective of individuals' language, gender, or cultural backgrounds.</td></tr>
<tr><td>Feedback from principal investigator</td><td>The first and second version was adjusted based on feedback on the cards from the principal investigator.</td></tr>
<tr><td>Feedback from migrant ambassadors and the second investigator</td><td>The revised version was adjusted based on feedback on the cards from two migrant ambassadors, two key informants and the second investigator.</td></tr>
<tr><td>Feedback from participants of the first FGD</td><td>The second-to-last version was presented and used during the first FGD. Participants were also invited to give feedback on the cards.</td></tr>
<tr><td>Completing the final version of the cards</td><td></td></tr>
</table>

DATA COLLECTION

Recruitment and data collection took place between September and December 2024.

POPULATION

The study was conducted among women living in one of the fifteen asylum seeker centres across the province of Groningen, in the northern Netherlands.
In 2024, approximately 53,000 individuals registered at the national reception centre in Ter Apel, one-third of whom were women. Top 5 countries of origin are Syria, Turkey, Iraq, Eritrea, Somalia (29,30). Based on these figures, Arabic-speaking, Eritrean, and Somali groups were selected for the FGDs. Demographic data per location were not available.

STUDY LOCATION

The study took place at various asylum seeker centres in the province of Groningen. Although the asylum seeker centre in Ter Apel, the national registration centre, was initially selected for the FGDs, low attendance made this unfeasible. In consultation with COA, alternative locations were chosen where more women with the same language background were housed together. Recruitment of Somali- and Tigrinya-speaking participants in Ter Apel was not possible due to small numbers, but sufficient participants were found in centres in Winsum, Farmsum, Delfzijl, and the city of Groningen.

SELECTION AND RECRUITMENT OF PARTICIPANTS

Key informants were selected using purposive and snowball sampling, based on their professional involvement in SRHR, experience with asylum seekers, ability to provide in-depth insights into the Dutch healthcare system. Seven professionals were recruited, mostly through the principal investigator's network.

These included public health nurses, department of sexual health (from Groningen, Drenthe, and Zeeland), a physician assistant and general practitioner from GZA, a project manager at Sense[2] and coordinator of the migrant ambassadors, and a case manager for human trafficking at COA. One additional informant was contacted via the national umbrella organisation of the GGD, based on relevant experience with SRHR consultations. The numbers linked to quotes in the findings section do not correspond to the order in which informants are listed here.

Planned interviews with midwives connected to the asylum seeker centre in Ter Apel and JGZ staff involved in the 'Nu niet zwanger' programme could not be realised due to time constraints and difficulties in scheduling.

The participants for FGDs were selected based on the following inclusion criteria:
- Female;
- aged 18 years or older;
- residing in one of the asylum seeker centres in the province of Groningen.

[2] Sense is an initiative by Rutgers, Soa Aids Netherlands, and the Public Health Services (GGDs). It provides reliable information on sex, STIs, and contraception to people under 25 through sense.info and GGD clinics.

Participant recruitment for the FGDs followed the usual procedure used by COA to invite women to health education sessions. COA was asked to organize a session, which served as a standard way to reach potential participants.

COA is typically responsible for inviting a specific target group to health education sessions, and the same procedure was followed for this study. Women were invited to a session through COA, which selected participants from the resident list based on factors such as accommodation location within the centre, spoken language, country of origin, and age. Although the exact criteria are not formally documented, this method is commonly used in practice. Selected residents received an invitation letter specifying the date, time, and location of the session. The content of the session was not disclosed in the letter. In some cases, visual icons were added to improve accessibility for individuals who are illiterate or use non-Latin scripts.

For this study, COA was specifically asked to invite groups of adult women who spoke Arabic, Somali, or Tigrinya, on dates coordinated in advance with the FGD facilitators. The health education session was voluntary; participation in the FGD was explained at the start, and non-participants could leave after a scheduled break. Informed consent was obtained before each FGD.

SETUP OF THE FGDS

All FGDs were conducted in designated, private education rooms, to ensure confidentiality.

Women were invited to a health education session, which began with light-hearted and interactive introductions involving all present: the researcher, the nurse educator, and the peer researcher. Roles and purposes were briefly explained to help build trust.

The session then covered a typical SRHR topic, such as gender roles or contraception. Afterward, the study was introduced in detail. Women were then invited to consider participation in the study. During a coffee break, women could opt out. The informed consent form (annex 4), translated into participants' native languages, was read aloud and explained by the peer researcher for those with limited literacy. Upon signing, the FGD commenced and was audio-recorded with permission.

The migrant ambassador moderated the discussion in the participants' language, ensuring inclusivity and respectful dialogue. Her role was key in fostering trust and openness. To ensure comfort and confidentiality, no other individuals, particularly men, were present during sessions.

The discussion started with visual prompt cards. Each participant received an individual set of cards. The cards were reviewed one by one, with an explanation of what each image represented. Participants were then asked to take a moment to reflect on which themes (represented by the cards) they considered most important for women, which aspects should be prioritized, and why. Sharing individual reflections led to group dialogue exploring motivations and experiences. Although the main researcher did not participate due to a

language barrier, she observed and noted the individual rankings, which informed a collective ranking to further guide discussion.

A brief explanation of current SRHR services in the Netherlands preceded the introduction of the proposed on-site consultation. Women discussed barriers, facilitators, and practical preferences (e.g., provider characteristics, timing, and location), and provided recommendations for implementation.

Each FGD ended with a wrap-up, during which participants could ask individual questions. As discussing SRHR can be triggering for women with traumatic experiences, information was provided on where to seek support. Contact cards were distributed for the GGD, the Centre for Sexual Violence, and an SRHR information website. Help with making appointments was also offered.

ANALYSIS

RECORDINGS, TRANSCRIPTS AND TRANSLATION

KIIs were conducted by the principal investigator, either in person or via video call, in Dutch, transcribed verbatim, and translated into English using the AI tool Amberscript.

FGDs were recorded and transcribed by peer researchers, with variation in transcription language (Dutch or English), style (verbatim or summarised), and translation approach. These choices depended on the peer researchers' language skills and practical constraints. Table 3 provides an overview of the transcription process. All names used during FGDs, transcripts and quotes are pseudonyms, used to personalise the study while protecting identities. As the Somali FGD was paraphrased rather than transcribed verbatim, quotes are attributed to the group as a whole.

TABLE 3 - OVERVIEW OF THE TRANSCRIPTION PROCESS

FGD	Recording	Language transcription	Transcription method	Translation
Arab-speaking women	Arabic	English	Ad verbatim	none
Tigrinya-speaking women	Tigrinya	Dutch	Ad verbatim	To English, using chatGPT
Somali	Somali	English	Detailed, summarized	none

ANALYSES

Data from KIIs and FGDs were analysed using inductive thematic analysis (open, axial, and selective coding) in ATLAS.ti 25. Two researchers (SH and LF) jointly coded an initial portion of the data to align on coding approach and interpretation. Subsequently, each researcher continued coding independently, resolving uncertainties through discussion and consensus. Peer researchers contributed to interpretation and reviewed draft findings to ensure cultural relevance and accurate representation of participants' perspectives.

ETHICAL CONSIDERATIONS

This study was approved by the Research Ethics Committee of KIT Royal Tropical Institute (REC 2024) and did not fall under the Medical Research Involving Human Subjects Act in The Netherlands. Data were anonymised or pseudonymised in line with local protocols. Information security and data management was oversight by the data protection officer.

Migrant ambassadors involved in the study were bound by confidentiality agreements, either through their formal role as migrant ambassadors or through a temporary appointment specific to this project. Their involvement contributed to the ethical integrity of the study by helping to ensure cultural sensitivity, accessibility, and a safer environment for participants.

RESULTS

This section begins with a description of the participant demographics, followed by an overview of their health needs. Barriers and facilitators to accessing care are then presented using Levesque's framework. The results are based on both the FGDs and the KIIs, unless stated otherwise.

DEMOGRAPHICS

Seven key informants, professionals working with asylum seekers and/or in the field of sexual health, were interviewed.

A total of 45 women participated in the FGDs. Three focus group discussions were conducted with Arabic-speaking women, two with Somali women, and one with women from Eritrea. Table 4 presents details of their countries of origin. Marital status was not discussed in the Somali groups; therefore, this data is unavailable. Table 5 shows the marital status. The average age of the participants was 31 years (range 18–49, median = 30). Seven women had no children, while fourteen had between one and four children.

TABEL 4 - COUNTRY OF ORIGIN, LANGUAGE OF PARTICIPANTS

Country of origin	number of participants	Language of participants
Somalia	24	Somali or Arabic
Syria	12	Arabic
Eritrea	5	Tigrinya or Arabic
Morocco	2	Arabic
Palestine	1	Arabic
Yemen	1	Arabic

TABEL 5 - MARITAL STATUS

Marital status	Number of participants
Married	10
Unmarried	8
Divorced	1
Relationship, other	1
Widow	1
Unknown	24

HEALTH NEEDS

The following section describes the health needs as experienced and expressed by the women, supplemented at times by the migrant ambassador. This is followed by key informants' perspectives, based on women's complaints, questions during education sessions, or issues identified by the informants themselves.

NEEDS IDENTIFIED BY WOMEN

Using visual prompt cards, women identified their key health needs. In the collective ranking exercises, gender-based violence (GBV) emerged as the most pressing concern among most Arabic- and Tigrinya-speaking groups, while Somali women focused strongly on female genital mutilation (FGM). Access to information on the body, sexual wellbeing, and general health was the second major need, with clear interest in group-based education. Family planning followed, particularly among Somali women. The next section presents these identified needs in more detail.

GENDER-BASED VIOLENCE AND HARMFUL PRACTICES

GBV emerged as an urgent health concern, addressing it as a health need. Participants stressed the importance of knowing where to seek help, whether to cope with past experiences or to address a current situation, for themselves or for other women.

> *"This (violence) is my most important. Like everyone is encountering beating, experiencing verbal abuse, like violence.....like a lot a lot of women I have seen.... Like me and more.... like we used to say this is just in our countries but even here (in the Netherlands) I have seen experiencing abuse." Warda, Morocco*

However, in one Arabic-speaking group, violence was not identified as a major issue. Women emphasized that, in their Muslim communities, violence is considered *haram* (forbidden).

> *"Violence against woman, like it is little to happen, [...] we also don't have many such things other than in a (halal[3]) way, so that is the last important to us in our society." Naya, Syria*

The Eritrean women spoke openly about the violence they had experienced at home, during their journey, and in their current lives. Violence emerged as the most urgent concern in this group. These experiences are often kept within the community.

[3] Permitted, allowed

> *"About this, sexual violence against women is everywhere. I myself came through Libya, across the Mediterranean Sea, thank God nothing happened to me. [...] Also here, those who have come through Libya and the Mediterranean Sea should be asked about this, about their experience with it, or by their husbands here, especially Eritrean ones, because we as women have the habit, coming from the community, of saying: how are we going to betray our men? This happens among all of us; it's only that we talk about it in Tigrinya. This shows that this happens to women and it must be asked about. Especially with men." Akberet, Eritrea*

Azeb, from Eritrea, echoed this need for support:

> *"This is like our sister said: men rape women violently, against their will. I saw a lot in Libya, many of our sisters were taken by force, by the smugglers to be abused. When you come here, there should be psychological help or other medical support for these women."*

Somali women did not prioritize violence as a key concern. According to the Somali migrant ambassador, violence against women is perceived as less common in Somali culture, where women are seen as strong, independent, and resilient. Although FGM is increasingly recognized as a form of abuse, it was not explicitly framed as such by participants. The ambassador noted that awareness is growing, and many women now acknowledge its long-term impact. During FGDs, they discussed FGM and expressed a need for a safe space to talk about it.

Information and education

Understanding the (female) body

Many women expressed the need of understanding their own bodies and being able to ask questions:

> *"Getting introduced to our organs and bodies, what is marriage, what is anything...that is first of all." Naya, Syria.*

Furthermore, the lack of knowledge in conservative families was highlighted:

> *"There are families that are very conservative, very, very, the girl doesn't know what her body is. [...] Especially, talking about the reproductive system." Lily, Palestine*

Somali women emphasised that this need is particularly for those who have undergone FGM.

> *"It's very important for women to monitor their health, especially those from countries like Somalia, where female circumcision may be common. It's also crucial to seek information and support from healthcare professionals when needed. This card holds significant value for women in the refugee centre." Somali women*

The need for care after FGM was also mentioned in the Eritrean FGD:

> *"About the female body internally, we are circumcised. When you come here, you feel the need to talk to someone close about your shortcomings, we don't have this yet. This is important." Azeb, Eritrea*

Topics that were explicitly raised and resonate within the group include vaginal discharge, menstrual issues, and concerns about detecting a breast lump.

Health education sessions

Group-based health education was seen as both valuable and comfortable across the groups. Eritrean and Somali women welcomed opportunities to share experiences and learn from others:

> *"We desire for someone to explain more about the symptoms they experience and provide guidance. It feels more comfortable discussing these issues in a group setting, where we can share their experiences and learn from one another." Somali women*

Information about intimacy and sexual well being

Women, especially Arabic speaking, expressed a strong need for a safe space to discuss intimacy and sexual wellbeing.

> *"The intimate relation between married couples, especially many women are shy to ask someone else, so it is good to have a trusted place to ask, that is also important." Dana, Syria*

Cultural taboos in conservative settings help sustain this lack of information.

> *"It is important, because in the Arab conservative society, you find the mother not talking to her daughter about the things that happen, the daughter enters a marriage, and she has no idea originally what she is doing." Lily, Palestine*

Familiy planning

Contraception

Access to contraception was considered important for both married and unmarried women. Reasons included spacing or preventing pregnancies and having informed choices.

> *"Regulate children or don't want children or just temporarily don't want. [...] Especially for married women... pregnancy and contraceptives..." Lily, Palestine.*

Supported by Naya from Syria:

> *"... and for new young people, and newlywed couples...very important.".*

Women from Eritrea and Somalia emphasized the need for clear information and choice regarding available methods:

> *"There are different types available [...] Many women don't know about these options, so having someone explain them is invaluable." Woman from Somalia*

For Somali women, family planning was closely tied to their ability to properly care for their children:

> *"Women like us should be aware of contraception options so we can plan our families and ensure we give each child the attention and care they need. [...] especially in places like where we are now, where there is limited access to information and guidance." Ilhan, Somalia*

Unintended pregnancies and safe abortion care

Unintended pregnancy was not perceived as a pressing need. The Somali women commented on this as follows:

> *"We don't think we need this service. It's new to us." Somali women*

Responses from Arabic-speaking women were mixed. Some emphasized the importance of support for women facing an unwanted pregnancy, particularly those with different cultural or religious backgrounds. At the same time, they stressed that abortion is not considered relevant or acceptable within Islam. Others remained more neutral or did not express a clear stance on the topic.

> *"No it is important to be offered. But as our societies as Muslims, abortion is not.... so...other societies yes so it has to be offered to respect all societies." Amal, Yemen*

Among Eritrean women, abortion was not discussed during the FGD. The Eritrean migrant ambassador explained that abortion is generally considered a taboo within the community. The concept of unintended pregnancy is not widely acknowledged, as pregnancy is typically viewed as something inherently positive: '*a child is always wanted and a gift from God',* as people commonly say. However, pregnancy resulting from rape is considered a valid reason for abortion.

Fertility

Women broadly supported access to services related to fertility and the desire to have children.

> *"Also those who are looking for a way to get pregnant and they can't find someone to help them how to organise pregnancy." Dana, Syria*

Prevention and control of HIV and STIs

STI and HIV screening

Concerning STI and HIV screening, Arabic-speaking women were divided. Some acknowledged its general importance (for other women), while others considered it irrelevant within their cultural context, since sexual relations are only within marriage:

> *"Our society as an Arab Muslim society, we don't have several sexual relations that would bring these diseases, and I expect it to be the least important as an Arab Muslim society." Lily, Palestine.*

Eritrean women strongly emphasized screening due to experiences of sexual violence during migration. Somali women also saw its value and suggested workshops, but noted persistent stigma.

> *"Many people tend to avoid discussing this topic because they fear being judged by others. However, it's crucial to get tested and monitor your health because failing to do so could put others at risk. In our community, people are often reluctant to talk about or address this issue, so it's even more important to encourage regular testing and awareness." Woman from Somalia*

Pre-exposure prophylaxis (PrEP)

PrEP was rarely discussed. Among Arabic-speaking women, it was viewed as relevant mainly for others. Somali women focused on stigma, while Eritrean women again stressed the need for testing, though PrEP itself did not receive attention.

Perinatal care

Support during pregnancy was universally seen as important by participants. The topic was considered so self-evident that it sparked little discussion.

Outstanding issues

Women expressed the need for a place to ask questions on a broad range of topics, not limited to SRHR. As Dana explained:

> *"Things related to women, but not only about sexual stuff, it has to do with how the woman looks or her interests."*

Relevant topics mentioned include nutrition, weight loss, vitamin D, mental health, cancer, migraines, and even cosmetic procedures. Somali women also voiced many questions about parenting in the Dutch context. Moreover, Somali women highlight the need for mental health support.

> *"[...] the importance of addressing mental health and trauma and acknowledge that there are facilities and professionals in the Netherlands who can provide support. [...] a conversation about their feelings or past experiences would make a big difference."*
> *Somali women*

NEEDS IDENTIFIED BY KEY INFORMANTS

Key informant interviews explored the health needs they observe: what signs do they notice, and what complaints do women bring to consultations?

Gender-based violence and harmful practices

All seven key informants reported harmful practices as a frequent concern, including forced marriage, forced prostitution and sexual exploitation, human trafficking, rape, smuggling, GBV and FGM. These issues are rarely the initial reason for a consultation but often surface during follow-up.

> *"I once saw a woman who had come to a colleague three times with stomach complaints. [...] It turned out that there was a history of sexual violence behind it, with somatic symptoms like acid reflux. And the woman didn't bring this up herself, but the moment you ask about it, the whole story comes out." KII 3*

FGM is similarly underreported. Women often present with symptoms resulting from FGM.

> *"My experience is that almost all women are circumcised, if you really ask about it. If you don't, they won't mention it. And sometimes people walk around for a very long time with pelvic floor hypertonicity or with urge incontinence. And those people, for example, have been to the consultation five times, because you're thinking of a bladder infection." KII 3*

Information about the (female) body and intimacy

Women also seek care for various gynaecological concerns, such as irregular menstruation, menopausal symptoms, breast lumps, prolapse, and discharge. Sexual wellbeing is rarely raised by women themselves, but often addressed by providers as an entry point to discuss consent and bodily autonomy.

> *"I try to talk about sexual pleasure and that women actually have a working sexual system just like men. [...] And then a lot of women also say, yes well, I have actually always been told that my body should be made available to the man and that if he feels like it then I should just lie down. [...] Quite a lot of women say: yes, but I am really in a lot of pain, but I do it every time, so then the conversation is also about limits and wishes." KII1*

Family planning

Questions around fertility and contraception (especially the copper IUD) are common. Some women are well-informed; others rely on breastfeeding as contraception or the withdrawal method.

Suspected or ongoing pregnancies are frequently discussed, including regular cases of unintended pregnancy and abortion. This contrasts with the FGDs, where abortion was generally not seen as very relevant. However, a key informant noted:

> *"Sometimes you really go through periods where you're mostly arranging abortions and making appointments for terminations. And yes... young women, that can be quite distressing." KII 5*

HIV and STI screening

STI and HIV screening is occasionally requested, mainly by men who have sex with men (MSM) and LGBTQ+ individuals. Among women, requests often relate to past trauma or trafficking. PrEP is offered only to MSM; women generally do not inquire about it.

BARRIERS AND FACILITATORS IN ACCESS TO SRHR CARE

The barriers and facilitators to accessing care are presented using Levesque's framework, following the five dimensions of accessibility on the supply side, and five corresponding abilities on the demand side.

APPROACHABILITY

AWARENESS OF SRHR SERVICES

Approachability starts with awareness. Without knowing that SRHR services exist, individuals are unlikely to seek help, regardless of need or willingness:

> *"The women then discuss among themselves the different places they've tried to seek help, such as the local GP and mental health care. They exchange thoughts on whether these are the right places to go for advice and support. However, they remain unsure about where exactly they should go for these specific issues." Somali women*

Posters and flyers can raise awareness, especially when shared through existing contact points like health screenings, registration moments, or informal workshops. These settings also allow for direct engagement. Group activities, such as health sessions or women's gatherings, offer opportunities for both distribution and referral to individual SRHR counselling.

> *"It depends on how you spread it and market it. People will come. If I didn't know I wouldn't go, but if I know and there is a brochure I will come. If it is known to people they will come." Naya, Syria*

Word-of-mouth is widely seen, by both key informants and focus group participants, as the most effective way to raise awareness of SRHR services, as it builds on trust and lived experience.

> *"If one went and had an experience, and then told her experience, people will be encouraged. [...] Yeah like now I go tell my neighbour, do not be shy, this is what happened to me... " Fatima, Syria*

LANGUAGE AS A BARRIER

Language remains one of the most persistent barriers in SRHR access. Professional interpreters are essential, not only for clear communication but also for building trust and matching the patient's health literacy level.

> *"[...] a complex case of a woman who at times seems like she's not cooperative or doesn't show up. And with the right interpreter, we were able to explain things at a level she could understand, and through that he was also able to offer some trust." KII3*

Although professional interpreters are considered essential by key informants, practical barriers, such as delays during short consultations, can be frustrating for providers, leading some to rely on translation apps instead.

Proactive outreach

There are cases in which women do not actively seek assistance, despite care professionals perceiving a need for support. In such situations, staff members may take proactive measures to initiate help. This may involve individuals in various roles, such as housing supervisors or security personnel.

> *"I'd have an evening shift and then a woman would come in with nothing but a small plastic bag. You could see in her eyes that something was wrong. [...] It would very often turn out to be human trafficking." KII 3*

THE ABILITY TO PERCEIVE

HEALTH LITERACY

Key informants noted that health literacy varies across cultures and genders. Young women from Arab countries, Yemen, and Somalia were described as having particularly limited knowledge, often lacking even basic understanding of female anatomy. The importance of gaining knowledge is not always recognized by these young women, as one informant explained:

> *"Well, with the girls it is 'I don't need to know this and if I am married then it will be explained to me by my husband or something or I will be told what I need'." KII 1*

Low health literacy can prevent women from linking symptoms to their cause, and thus from seeking care. This was illustrated in the Somali FGD:

> *"The women begin discussing FGM and how it affects their menstrual cycles. Many of them share how difficult it is to deal with their periods, with some experiencing extreme symptoms without realizing that these issues are not normal. [...] They believed these symptoms were just part of life, until someone else mentioned otherwise." Somali women*

Additional barriers include language, cultural unfamiliarity, and lack of awareness about available services. As one Somali woman shared:

> *"Yes, this service is needed, but many women don't know what options are available. Especially in places like where we are now, where there is limited access to information and guidance. There's a lack of information, and not understanding the Dutch language makes it even harder." Somali women*

RECOGNIZING NEEDS

The asylum seeker center in Ter Apel is perceived as hectic and overwhelming. According to care providers, newly arrived individuals are often preoccupied with urgent concerns, legal procedures, medical screenings, and uncertainty about their future. People often appear to have little mental space to recognise or act on health needs.

> *"Health is not priority. So, you often see that the medical urgency is not there for people, but other things are more important. So those things need to be ticked off first and then comes health." KII 5*

At the same time, key informants and participants acknowledge that Ter Apel is the one place where all newcomers pass through, creating an opportunity for outreach.

> *"An idea just occurred to me. You should do this for the new incomers, you should tell them we have something like this." Lily, Palestine*

ACCEPTABILITY

PROFESSIONAL VALUES

Key informants showed strong motivation and a sense of responsibility in providing quality SRHR care to asylum seekers. They viewed themselves as both capable and accountable, taking proactive steps, such as offering to handle specific complaints personally, and often went beyond the expectations of their role.

> *"Yes, yes, you can't just throw it over the fence and think, well, now it's gone. No, no, no, I hold on. [...] I only let go when I know someone else has taken hold. [...] Well, I do think you have to think a bit more outside the box more often." KII 4*

This strong sense of engagement was reflected in their working methods. For example allowing time for concerns to unfold over one or more consultations, and intentionally creating a safe, supportive environment. Healthcare providers described routinely scheduling extended appointments, acknowledging that complex issues often emerge gradually and require multiple sessions to address. This approach fosters trust and enhances the quality of care.

> *"How can you share those stories? How can you make sure that you also get help for that? That you don't have to carry it alone? Because rape is something... You need to get tested, but you also need to be able to tell your story." KII 4*

This level of commitment was not universal. At some sites, care was provided remotely by locum GPs, with less cultural sensitivity due to their infrequent presence and limited cultural familiarity.

GENDER

Nearly all women expressed a clear preference for female providers. Feelings of embarrassment play a major role in this preference. Some noted that SRHR-related topics like menstruation are considered inappropriate to discuss even with their husbands, let alone a male doctor.

> *"There is something very very very important. The person to give these services should be a woman. Do not dream that anyone will enter to you." Lily, Palestine*

The interpreters gender also matters. While Eritrean women said the interpreter's gender didn't matter to them, most women preferred a female interpreter.

> *"We us, an Arab society for sure, we are modest (have shyness) if there is a man listening to us and sitting with us, we are shy to talk about it. Because it happened to me, I went to the GZA, I am explaining to him while I was shy...(...) I was embarrassed from him really." Arab woman, name unknown*

Health professionals are aware of this and try to accommodate it. One noted that two female GPs in their practice mainly handle SRHR care, while another reflected on the role of gender more broadly.

> *"Well, I do notice that people appreciate the fact that I'm a woman. [...] So maybe, if you have to choose between male/female, then preferably a female person. The other way around, I notice that men don't find it difficult when I, as a woman, do a rectal exam or something like that. So I think it's more of an issue for women, than for men." KII 3*

A male key informant also encountered his gender as a barrier in practice:

> *"The majority of those I see are men; there are very few women. (...) Of course, it's a disadvantage that I'm a man. So if it's a case of female genital mutilation, I would, in my case, send a female colleague." KII7*

THE ABILITY TO SEEK

Religion and culture – expressing health needs

Cultural and religious norms strongly shaped how women understood and expressed their health needs. Abortion is one example, with Arab and Muslim women emphasising sexual exclusivity within marriage and rejecting multiple partnerships. Such views influence
These views affect how they perceive STI and HIV screening, and who they believe contraception is intended for. Different groups are therefore associated with different needs and types of care, for example, based on whether women are married or unmarried.

> *"Marwa: 'but are the contraceptives good?' Fatooma: 'yes for the married not for us..'" both women unmarried, from Syria*

Among Somali women, stigma around HIV, the reluctance to discuss mental health, and the practice of FGM are all strongly rooted in cultural norms.

> *People are often too afraid to talk about it, but it's crucial to address these issues openly. For our health, we need safe spaces where we can speak with someone without fear or judgment, instead of keeping everything to ourselves. Somali women*

Eritrean women experience high levels of GBV. Gender roles are deeply rooted in the culture, but many women express a desire to break away from these patterns.

> *"Especially in our Habesha community [...] With us, there's this sense of manhood, our upbringing has oppressed us, not them. They think: a woman is not going to tell me how it should be." Akberet, Eritrea*

Supported by Hadas:

> *"Can you clearly teach them what respecting women means?"*

Openness to discuss

Culture and religion play an important role in how open discussions about SRHR can be.
The topic is difficult for young women to discuss with a health care professional.

> *"And you notice that the Arab girls, for instance, don't want to hear it all, because it's not allowed, [...] it's haram, we don't want that." KII 1*

Adult women are often reserved in discussing SRHR with healthcare professionals, though it's unclear whether this stems from cultural norms or personal shyness. As one woman noted, it's about your health, so seeking help matters, even if the conversation remains difficult.

> *"About me, when I used to get sick and go to the women's doctor (gynaecologist), I would find it difficult to express what's with me, and she is the women's doctor." Fatima, Syria*

In some cultures, SRHR knowledge is shared informally, often through grandmothers or neighbors, rather than with healthcare providers. These topics are seen more as social than medical.

> *"You will turn to your woman friend. These topics are talked about among women. Women trust each other." Arabic-speaking woman*

This was also observed by one of the key informants, who joined a picnic with a group of Arab women.

> *"Well and then I got a really nice conversation [...] I thought yeah actually, without me starting about that topic (SRHR), people already started talking about it openly themselves." KII 3*

The Eritrean community is perceived by healthcare providers as very closed, and the women themselves confirmed this. An underlying reason is the fear of being judged by others or that people might talk about you.

> *"What you have here is that you hide many things, the others must not know or find out about me. [...] It's very often that you don't want to be judged by others, so you suppress your feelings and problems, which makes you suffer a lot inside." Hadas, Eritrea. Support by Azeb: "Yes, we live with pain inside us."*

AVAILABILITY AND ACCOMMODATION

Several factors influence availability and accommodation, including consultation hours. Early morning appointments are often unsuitable due to disrupted sleep patterns. Additional accessibility factors are outlined below.

Accommodation

Several suggestions were made about consultation locations. One key informant noted that unfamiliar sites lead to low attendance. A commonly proposed option is a room in the GZA building, often shared with the GGD and equipped with a refrigerator for storing vaccines.

A key condition, stressed by both professionals and women, is that the reason for visiting or waiting should not be immediately visible, to protect privacy and reduce stigma.

> *"Yes same building, so no one would know where she is going, same medical building. Like they see her entering but no one would know for what is she going there." Naya, Syria*

Appointment mechanism

Appointment systems can vary. According to one healthcare professional, walk-in hours work well in some settings, a view shared by some women. In another group, however, the topic sparked considerable debate.

> *'Well, if it is without an appointment, it will be chaotic, with an appointment it is better.[...] If there is that machine that gives numbers then yes. But some people understand the system, some don't, so then problems happen [...] No there will be fights and problems." Warda, Morocco*

One proposed condition is the introduction of a clear and easy understandable check-in system, where individuals report upon arrival, a queue is established, and they are informed if that day's consultation slots are full.

Frequency

Participants discussed on whether daily opening hours were necessary, based on their own observations and experiences.

> *"Naya: It can also be distributed, like 4 hours over 4 days, an hour per day. Because sometimes a person would need something, but then wouldn't find someone for this need, so like daily but then for an hour.*
> *Amal: Two days two hours per day is enough. Because these are consults for information you receive. But for a medical emergency you go to the doctor.*
> *Lily: I don't think it's a daily necessity, because you go to ask about something and leave. In my opinion.*
> *Naya: but here there are new people arriving daily.*
> *Sumaya: true, you are talking about a large amount of people.*
> *Naya: like what I saw, minimum 30-50 new commers are arriving daily, so you cannot limit it to just specific days, all the week is better for just an hour, in my opinion."*

The Eritrean women indicated that once a month would be sufficient, for example if group education is combined with individual counselling.

> *"Education and then you can directly ask questions and you can understand it better. [...] Once a month should be sufficient." Akberet, Eritrea*

Integrated service delivery: linking education or event and individual care

Linking consultation hours to health education sessions was seen as valuable. Group discussions often triggered personal questions, with women seeking individual counselling afterward, such as for contraception. This approach also fostered peer support, as participants learned from both facilitators and each other. As one participant explained:

> *"If we get an invitation, we can come for the education session, and you learn from it and from each other. Just like now, together as a group, we learn a lot from each other's stories." Akberet, Eritrea*

Among the Somali women, the idea of education followed by individual counseling spontaneously emerged during the discussion on FGM.

> *"They suggest that such a session could be organized as part of a workshop or similar format. Additionally, they propose that if someone feels the need for a private conversation, they should have the option to speak with a professional discreetly, ensuring confidentiality. The group collectively agrees that this kind of support is something they would greatly value and need." Somali women*

Some healthcare professionals highlight the benefits of this approach and actively recommend it. One key informant noted that similar models already exist, such as LGBTI-focused events that combine group activities with on-site counselling, screening, and vaccination to address individual needs immediately. Some women also recognize the advantages of this model:

> *"If it is available, of course it makes it easier." Amal, Yemen*

The reverse also occurs: health education sessions may spark motivation, but without immediate access to care, women must schedule a separate appointment; an extra step that is often not taken within the current system. This makes it difficult to link women to care at the moment their need and motivation align. One key informant noted, however, that offering individual counselling after each session is too resource-intensive to implement routinely.

Male engagement

In discussions with Eritrean women, a significant part of the FGD focused on gender roles related to SRHR and GBV. To address these challenges more effectively, participants suggested actively involving and informing men and husbands.

> *"Because our husbands, when it comes to violence or arguments [...] We become very afraid of that. You think this is going to happen to me too. Especially because our husbands haven't received enough education... They need to have understanding, they need to learn. Just like you give us explanations, you should also explain to them so that they understand too.*
> *The men also need lessons or education. Just like you gave us a separate explanation or session, you should give them a separate session too, that is important." Akberet, Eritrea*

THE ABILITY TO REACH

LIVING ENVIRONMENT

Asylum seeker centres can feel hostile, with reports of theft, aggression, and intimidation. This creates barriers to going alone to places like food distribution, and possibly to medical care. One key informant noted:

> *"There are also a lot of young men here. So the women also indicate, like, well, we do feel quite intimidated. But it's a very anxious, frightening feeling of course, that you think like yeah, I'm here now, but am I actually safe here? [...] Or that late at night someone just bangs really hard on the windows or something." KII 6*

COA staff, such as residential supervisors, pick up on these signals and respond by, for example, accompanying residents to food distribution or encouraging mutual support within units.

DISTANCE AND TRANSPORT

The considerable distance between Ter Apel and key facilities like GGD Groningen was seen by key informants as a barrier, as illustrated by this focus group:

> *"No we can't. It is very far. It is difficult. You need a bus ticket. We can't go." Wafaa, Syria*

COA reimburses travel for external appointments with proof, and without this support, attendance at off-site sessions is low. Taxis are sometimes arranged for abortion care or when public transport isn't feasible. Still, not all asylum seekers are aware of this, and some cite lack of money as a barrier.

Transport is not the only barrier; travel itself, language issues, physical distance, and unfamiliarity with the area also play a role. As one key informant noted, even when the GGD is nearby, its regular consultation hours are rarely used. An Arabic-speaking woman described the following situation:

> *"I have met this Yemeni girl, she says: I am afraid to go outside. [...] as long as I am in the camp I am good, because there are people like her, [..] they speak her language [...] so she can communicate better. But outside of the camp, no you speak Dutch and I cannot understand you, and she also doesn't speak English, so she needs a translator, but in the camp things are easier." Lily, Palestine*

Moreover, a consultation hour located within walking distance is appreciated by nearly all women. Its accessibility not only reduces the need for travel and time investment, but also contributes to a greater sense of comfort, as the setting is familiar, and the asylum seeker centre is perceived as a safe environment.

> *'Like here is better. Close, and everything is here.' Warda, Syria*

AFFORDABILITY

Funding Structures and Systemic Limitations

Sustaining consultation hours requires additional funding, mainly to cover healthcare staff. Expanding access to multiple centres would demand more travel and preparation time, as these facilities are spread across the entire province. One healthcare professional noted that it would be too burdensome for the small existing team. Maintaining partnerships also takes time and effort, adding to their workload.

One GGD, funded through a specific COA arrangement, has hired an additional provider to deliver both health education and individual counselling on-site.

> *And you can simply send an invoice to COA for it, because it's quite a significant amount, so you can definitely hire someone for that if you're going to do it. KII 7*

Nevertheless, SRHR service funding for asylum seekers ultimately depends on political decisions, making it structurally vulnerable.

THE ABILITY TO PAY

Asylum seekers in the Netherlands are covered by a no-cost, no-deductible health insurance scheme, yet key SRHR services remain excluded. For instance, PrEP requires an unaffordable out-of-pocket payment, and fertility treatments are not covered without residence status. As one key informant explained:

> *"Yes, but for example infertility treatment, they don't get that here. […] They have to wait until they get their residence status, and then, yes, their own health insurance." KII 5*

These financial limitations underscore how structural barriers in the design of health coverage can undermine effective access to care, even in the absence of direct costs for basic services.

APPROPRIATENESS

Continuity of Care

Due to its function as both an entry and transit centre, Ter Apel presents specific challenges to ensuring continuity of care. Short stays often obstruct specialist referrals or disrupt ongoing treatment, FGM care being a commonly cited example. This discontinuity is a structural barrier. A warm handover between centres could reduce loss to follow-up.

One healthcare professional described bridging mental health care after sexual violence by providing structure, psychoeducation, and medication, to temporarily cover needs until specialist care becomes available. However, expert input remains the preferred standard:

> *"But often there is so much more trauma that this alone is not enough. And you would really prefer a psychologist or psychiatrist who, well, looks at the whole package together. Because it's not just that isolated trauma, it's everything together that needs to be treated actually." KII1*

In exceptional cases, transfers can be postponed on medical grounds to complete care. Other individual needs, such as pregnancy or postpartum recovery, may also influence placement.

Providing Adequate Care

Many healthcare professionals wished to offer more than current constraints allow. Limitations in primary care, such as mental trauma support and referral delays, are common. Strong networks and direct communication help mitigate these issues.

Key informants also noted the unavailability of essential resources like PrEP, and the inability to offer contraception or STI screening immediately after health education sessions. On-the-spot provision is seen as beneficial but not always feasible.

Technical and interpersonal qualities of health care professionals

Training

Professional skills and training greatly impact care quality. Without specific knowledge, such as on FGM, underlying causes may be missed.

> *"For example, FGM. If you don't know from which countries that occurs, and you keep seeing someone with urinary complaints every time? Yes, how would you know what's causing that?" KII3*

Not all professionals working with asylum seekers are well-trained, partly due to system structure (e.g., remote or temporary GPs). Training often occurs in their own time, and working with interpreters isn't always routine.

Qualities of health care professionals

Key qualities for SRHR providers during walk-in consultations include cultural sensitivity, communication skills, and managing language barriers. These were highlighted by interviewed professionals and are summarized in Table 6. One provider explained:

> *"Female circumcision falls under child abuse. How can you then clearly explain what it is? It's not like you just do Google Translate and then you're done. On that topic, you have to explain a lot and make things clear." KII2*

In the FGD with Eritrean women, the following was added:

> *"It has to be someone who has knowledge about female sexual health, it doesn't necessarily have to be a doctor as long as it is someone who has the right knowledge." Azeb, Eritrea*

TABLE 6 - QUALITIES OF HEALTH CARE PROFESSIONALS

Knowledge & Cultural Sensitivity - Familiar with diverse cultures, religions, and country-specific practices (e.g. FGM, human trafficking). - Trained to recognize and appropriately address culturally sensitive issues. - Experience or strong affinity with working with migrants and asylum seekers. - Comfortable using interpreters; speaking an additional language is a plus.
Communication & Flexibility - Able to tailor consultations to cultural context and patient needs. - Communicates clearly and sensitively, e.g. in framing diagnoses. - Listens actively so patients feel heard. - Picks up on group dynamics (e.g. taboo or peer pressure in group settings).
Attitude & Interpersonal Skills - Approachable, open, and non-judgmental. - Kind, respectful, and a good team player. - Thinks flexibly and creatively ('outside the box'). - Shows no stigma, hesitation, or taboo in discussing SRHR topics.
Resilience & Emotional Strength - Can handle intense or traumatic stories without being overwhelmed. - Stays calm when facing frustration, anger, or aggression off patients toward the system. - Manages emotional impact of systemic barriers and group tensions. - Coping well with workload and risk of burnout.
Commitment - Dedicated professional, ideally part of a specialized SRHR team.

THE ABILITY TO ENGAGE WITH CARE

Engagement with care is shaped by multiple factors, including empowerment. As specialist referrals don't always lead to effective care, provider support can be key. One professional shared:

> *"With migrants I usually just go with: hey, shall we call together now? Then we can make an appointment right away and get things started." KII 1*

Creating a safe, open atmosphere during health education can also support engagement. One provider recalled a session on sexual wellbeing for LGBTQ+ individuals:

> *"A lot of people told quite personal stories from their home countries. [...] So the atmosphere there was already such that nobody thought it was weird to come out to me afterwards. And in fact everyone also said: I think it's great that I can be vaccinated now, because I want to protect myself as much as possible." KII 1*

Still, professionals struggle with how to truly empower people to engage with care, to follow through on health decisions:

> *"People who say, I use contraception but then don't use it properly or end up not using it at all. Or say, I don't need contraception and then end up being pregnant and say they actually didn't want that. Or they don't show up after you give them an appointment, or people who choose a contraceptive method and then don't use it afterwards. [...] How do we reach that group?" KII3*

INTERSECTING FACTORS

The Role of Trust Across Levesque's Dimensions of Access

Trust plays a crucial role across all five Levesque's dimensions. It shapes the *ability to perceive* needs; some individuals only act when they feel safe. As one provider explained:

> *"Then people know who you are, and what you do. And then there's the trust that they will come." KII 3*

Trust also affects the *ability to seek care,* especially in group settings. Cultural dynamics can hinder openness. In contrast, a familiar provider can foster safety and openness. Terms like 'a familiar face' or 'building a relationship' were seen as trust-building elements. Word-of-mouth is powerful:

> *"If one woman has already spoken with me and had a positive experience, she tells her friend, and then that woman comes to the front desk and says: I want an appointment with that specific doctor." KII 3*

However, in high-turnover settings like Ter Apel *(ability to reach),* continuity is limited, but peer communication helps newcomers find trusted providers.

Trust is critical for the *ability to engage,* especially on sensitive topics like sexual wellbeing. Psychological safety must be built gradually. Providers often start with general education sessions to build comfort before introducing SRHR topics. Emotional safety was central in a focus group with Eritrean women. One said to the peer researcher:

> *"You keep things to yourself as a secret. I would personally, for example, really like it to have a one-on-one conversation with you, to talk about these things." Hadas, Eritrea*

Somali women also indicate a need for safe spaces:

> *"For our health, we need safe spaces where we can speak with someone without fear or judgment, instead of keeping everything to ourselves." Somali women*

To foster engagement and continuity, trust must be built over time through consistent, structured contact. One provider shared:

> *"I usually block half an hour per consultation. And if I think more time is needed, I schedule it. In my experience, one conversation is rarely enough. You want to build that connection first, so I often have people come back for another session or two, each for half an hour." KII3*

Collaboration and Partnerships

Key informants consistently emphasized the importance of collaboration for effective SRHR care. Strong partnerships between GZA, COA, and the GGD enable coordinated referrals. For example, GZA refers to the GGD for sexual wellbeing support, while the GGD refers back for contraception services. COA staff inform residents and support psychosocial referrals. A shared understanding of each partner's role is key to efficient, complementary care.

Regional and national networks, such as FGM working groups, further strengthen collaboration by facilitating relationship-building and the exchange of best practices.

Clear referral pathways beyond the centre (e.g. to CSG or medical specialists) are also vital. A structured consultation and evaluation mechanism is recommended to improve coordination across organizations, though current collaboration remains inconsistent. As one key informant put it:

> *"But ideally, it would be good to have some kind of chain agreements for, for example, after FGM or after sexual violence, like, how do we organize that care? Because, that prevents people from falling out of view. People are not always assertive enough to come forward themselves. But I also think it would allow us to fine-tune together, what kind of care we want to provide and which care provider fits with that part." KII 3*

The Potential Role of Migrant Ambassadors in SRHR Access and Implementation

Although not on the original topic list, the role of migrant ambassadors emerged spontaneously in several interviews. Key informants recognized their potential to support SRHR access by sharing information, promoting care uptake, and bridging the gap between providers and communities.
Ambassadors can help tailor services by advising on practical aspects like location and timing, and serve as approachable contact points. Despite this promise, there is no formal policy to support their involvement, and informants called for clearer guidance.

Women themselves also valued their role: Eritrean participants, for example, wanted one-on-one follow-up with the peer researcher and suggested involving male ambassadors to engage men and support health education.

DISCUSSION

SUMMARY OF THE MAIN RESULTS

This study identified several urgent *SRHR-related needs* by both health care professionals and the women themselves. Key SRHR needs include care related to gender-based violence, support for the consequences of female genital mutilation, and access to reliable and appropriate information to make informed choices. These identified needs align with those commonly described in the literature on SRHR in displaced and migrant contexts.

Barriers and facilitators to accessing SRHR services were analysed using the Levesque framework, which represents one of several approaches found in the literature for classifying access-related challenges. Limited awareness of available services, low health literacy, and language barriers reduce the approachability of care and the perceived need for it. Cultural norms, stigma, and gender dynamics influence the acceptability of services and constrain women's ability to seek care. Availability is often hindered by distance, lack of privacy, and the chaotic environment of reception centers, especially in Ter Apel. Although SRHR services are generally covered by health insurance, continuity and appropriateness of care are affected by frequent relocations and fragmented service delivery.

Across all dimensions, trust emerged as a crucial factor, both in healthcare providers and in the system. Building this trust requires culturally competent professionals, flexible and integrated services, and strong interpersonal relationships. In this context, the involvement of migrant ambassadors was seen as an important facilitator, helping to build trust, bridge cultural gaps, and promote access to care.

The proposed intervention, on-site SRHR walk-in consultations, was positively received and recognised as valuable, particularly when existing facilitators are draw upon and key barriers are addressed. For women, this approach may offer a promising way to better meet their SRHR needs. This aligns with findings from previous studies conducted in similar settings.

STRENGTHS AND LIMITATIONS

COMPLEMENTARITY OF DATA SOURCES

The combination of KIIs and FGDs allowed for triangulation and enhanced the credibility of findings. FGDs highlighted shared concerns and cultural norms, while KIIs offered insights into system-level barriers and surfaced sensitive topics less likely to emerge in group settings. The two methods complemented one another, revealing both overlapping and contrasting perspectives.

One shared concern across both groups was *violence*. However, the way violence was understood differed. Professionals included harmful practices such as FGM, whereas women did not always frame these experiences as violence. This divergence is crucial for service delivery: women may not respond to the term 'violence', yet still require care for physical and psychological effects of FGM. Women often did not associate their symptoms with FGM,

highlighting the importance of trained healthcare professionals who can recognize these patterns and initiate appropriate care.

Another contrast concerned *abortion*. While professionals reported frequent requests for abortion or support with unintended pregnancy, women did not identify this as a pressing health need. This discrepancy suggests a strong taboo, or that FGDs were not perceived as safe spaces to discuss the topic. It also reflects how religious ideologies are interpreted and integrated into daily life in diverse ways. These insights underscore the importance of privacy and safe spaces when addressing sensitive issues like unintended pregnancy.

A related issue is SRHR access for *unmarried women and adolescents*. In communities where religion and culture prescribe sexuality only within marriage, women who live differently may lack safe opportunities to seek care. This further underscores the need for confidential, non-judgmental spaces where SRHR can be discussed and accessed regardless of marital status.

Regarding the *location* of SRHR consultations, perspectives differed. Professionals described the reception center in Ter Apel as chaotic and unsuitable for sensitive care, though not dismissive of its potential. Women, however, saw it as an opportunity to reach everyone and introduce SRHR early in the asylum process. Participants who no longer lived in Ter Apel also preferred on-site services in their current centers. This supports the need for SRHR consultations at both reception and regular asylum centers, potentially with content tailored to each location.

Opinions on *frequency and appointment systems* varied widely, even among women themselves. These discussions reflect diverse expectations and preferences, suggesting a need for flexible, user-informed service models.

RELEVANCE OF THE ANALYTICAL FRAMEWORK

The Levesque framework was a helpful tool for organising the complex topic of SRHR. It enabled systematic grouping of themes and supported a comprehensive exploration of access by breaking it down into clear dimensions, which was particularly valuable when analysing qualitative data.

However, access in practice is more fluid than the framework suggests. Cross-cutting themes like trust and religion span multiple dimensions, making classification occasionally arbitrary. For example, provider gender is shaped by intersecting cultural and religious factor, making it difficult to assign to just one domain.

The framework also overlooks intersectoral collaboration. Key elements such as coordination across disciplines and the bridging role of migrant ambassadors fall outside its scope, despite their importance in asylum-related SRHR care.

SET UP

A key strength of this study was the integration of FGDs into familiar and trusted structures. Women were invited through COA procedures, sessions were held in known locations, and facilitated by professionals already involved in regular health education. This familiar setting, combined with personal introductions and the involvement of migrant ambassadors, helped foster trust: crucial for discussing sensitive SRHR topics. Embedding the research in an existing context likely contributed to the openness and depth of participants' responses. However, the group-based set-up may also have limited what could be shared. Group dynamics and social norms may have hindered open discussion of taboo topics, possibly leading to socially desirable answers. Individual interviews might have offered a safer space for more personal or stigmatized experiences.

LIMITATIONS IN SAMPLING, SCOPE AND TOPICS

The *sample* of key informants did not include youth healthcare professionals (JGZ) or midwives, which may have limited our insights into maternal and adolescent SRHR care. The absence of these perspectives may have narrowed the scope of professional input related to pregnancy prevention and reproductive decision-making.

This *scope* of this study focused exclusively on adult women, excluding adolescents, men and gender-diverse individuals from participation. As a result, the specific SRHR needs and perspectives of these groups remain underexplored, which constitutes a limitation. Notably, the importance of male engagement was explicitly raised by Eritrean women, who emphasised involving men in SRHR education and counselling.

Discussion *topics were largely predefined*, based on selected SRHR themes reflected in the visual prompt cards and topic guide. While this structure provided clarity and focus, it may have constrained the spontaneous emergence of issues. At the same time, participants were encouraged to bring in additional concerns. For instance, women asked why there were no cards on FGM or menstrual problems, and used the "other questions" card to raise issues they felt were missing but widely relevant.

PARTICIPATORY APPROACH

A key strength of this study was its participatory approach. Migrant ambassadors were involved early in the process, contributing to the design of the data collection and providing feedback on the structure and cultural relevance of the research approach. As peer researchers, they played an active role in facilitating focus group discussions, interpreting salient findings, validating key insights, and reviewing the final report. Their involvement enhanced both the depth and cultural sensitivity of the research process. Crucially, they were able to pick up on non-verbal communication and culturally specific nuances that might have been missed when working through a professional interpreter alone.

At the same time, working in a multilingual context posed challenges. Transcripts were not always in the language of analysis, requiring later translation and risking loss of nuance. Language barriers limited cross-checking across transcripts, and the lack of full verbatim transcription may have affected interpretation, especially regarding phrasing.

REFLEXIVITY STATEMENT

This study was led by a researcher with a background in public health and without personal migration experience. The initial plan was to conduct FGDs with interpreters; however, conversations with peers working with asylum seekers, and reflection on the inherent power dynamics in cross-cultural research, highlighted the importance of involving peer researchers. Migrant ambassadors were engaged for their ability not only to speak the participants' language, but also to understand their cultural context and lived experiences, helping to create a more trusting and equitable research environment.

Although this study incorporated participatory elements, it did not fully align with CBPR principles, as migrant ambassadors were not engaged from the start of the research process, such as identifying research questions or shaping the study design. The process highlighted the value of engaging migrant ambassadors from the outset. Future research would benefit from a more community-driven approach, starting with problem identification, and moving beyond predefined interventions developed from a provider or systems perspective.

Respectful and inclusive language was used throughout this report. *'Women'* refers to adult individuals who self-identify as women and who participated in the focus groups. While SRHR needs also affect adolescents, men, and gender-diverse individuals, these groups fell outside the scope of this study.

Terms like *violence* and *sexual wellbeing* reflect public health framing but did not always resonate with participants' perspectives. For example, FGM was not always seen as violence. This underlines the need for language that reflects lived realities and is sensitive to cultural and religious context.

CONCLUSION

This study identified several urgent *SRHR-related needs, priorities and care-seeking experiences of female asylum seekers in the Netherlands*. By involving both health care professionals and the women themselves, the study explored barriers and facilitators to accessing SRHR services were analysed, aiming to inform service design and delivery.

To ensure that the proposed SRHR consultation service aligns with the preferences, cultural context, and daily realities of female asylum seekers, several *key design and implementation conditions* must be met. The service should be responsive to women expressed needs and offered through well-connected, collaborative actors; recognising that SRHR care is currently provided by multiple, fragmented providers. Health professionals must be dedicated, culturally sensitive, and specifically trained in SRHR. Clear communication and promotion of the service are essential to enhance visibility and accessibility. Using appropriate language is fundamental. Combining consultations with health education may increase engagement, trust and understanding. Personal contact and the involvement of trusted migrant ambassadors at every stage, from outreach to care delivery, are crucial to building the trust needed for women to access and continue using the service.

A qualitative study using a participatory approach offers deep insights by actively listening to the perceptions of the target group. This method of engagement fosters trust and creates the conditions for women to share their experiences, needs, and ideas openly. As the findings of this study are translated into practice through the establishment of an SRHR consultation service, the meaningful involvement of both the women concerned, and migrant ambassadors is essential to ensure relevance and effectiveness.

RECOMMENDATIONS

Based on the findings of this study, the following recommendations are made for the implementation of the proposed intervention:

1. Establish a *multidisciplinary working group* that includes all healthcare professionals involved in SRHR service delivery. Clearly define each actor's role and contribution to ensure coordinated care, mutual support, and efficient referral pathways.

2. *Involve migrant ambassadors* from the outset to contribute to the design, implementation approach, and evaluation of the service. Their insights are essential to ensure cultural relevance, build trust, and tailor the intervention to the lived realities of the women it aims to serve.

3. *Involve an implementation specialist* to guide the process, including the development of a pilot timeline, process indicators, and a structured evaluation cycle. Publish results.

4. *Identify a suitable consultation space*, such as a private room within the GZA building. This location offers privacy, appropriate facilities, familiarity for asylum seekers, and proximity to other services, facilitating collaboration and referrals.

5. *Plan consultation hours at regular intervals*, balancing the workload of the healthcare provider with accessibility for patients and ensuring sufficient visibility of the service. A consistent schedule helps build trust and familiarity, while also allowing women to plan their visit and encouraging word-of-mouth promotion.

6. Ensure that the healthcare provider is *adequately trained* to address the specific needs of female asylum seekers and deliver high-quality, culturally sensitive care.

7. *Schedule the consultation sessions immediately after health education sessions* whenever possible. This allows for timely follow-up on questions raised and encourages help-seeking behaviours.

8. *Prioritise personal contact* through health education sessions and informal gatherings, so women can get to know the healthcare provider and build trust. While this may be more challenging in Ter Apel due to its transient nature, word-of-mouth remains a powerful tool to increase engagement and familiarity.

9. Investigate in detail how financing mechanisms operate under the existing COA-GHOR arrangement, to *ensure that financial resources* and reimbursement structures are in place to support sustainable implementation.

DISSEMINATION

The findings of this study will be shared through the following channels:

- Internal sharing: The full report will be circulated within relevant departments, including PGA (Public Health and Infectious Disease Control) and the Sexual Health (SG) unit.
- FGD participants: Women who provided contact details will receive a plain-language summary and an accompanying infographic.
- KII participants: Will receive the full report directly.
- GGD staff: An infographic and one-pager
- Stakeholder event: A presentation event will be organized for participants, departments, and key stakeholders; serving as both a dissemination moment and opportunity for networking.
- External platforms: Results will be presented at relevant forums such as CAPI and the GGD public health conference.
- Partner follow-up: Key external organisation (e.g. Doctors of the World, SOA AIDS Netherlands, and GGD GHOR) will be contacted directly to share findings.
- Academic output: The results will be submitted for publication in peer-reviewed journals.
- Thesis submission: The report will be finalised and defended as part of the study's academic requirements.

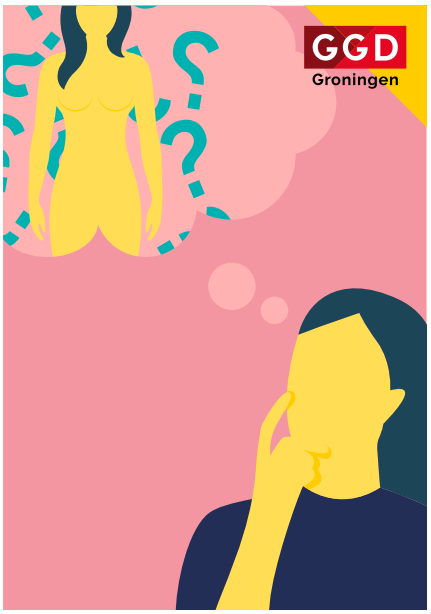
ANNEX 1 – DEFINITIONS LEVESQUE'S FRAMEWORK

Conceptual and operational definitions adapted from Levesque's framework (26).

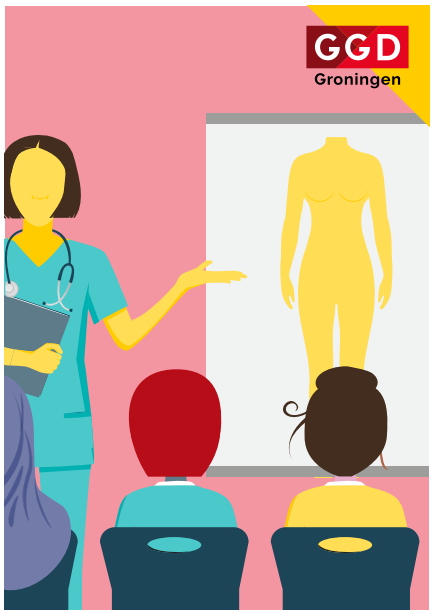
Dimensions	Conceptual definitions	Operational definitions
Approachability	Existence of reachable services	Adequate supply of services, goods, and facilities, including types of services, sufficient skilled human resources
Acceptability	Cultural and social acceptance of services	ethical standards, and the appropriateness of services, goods, and facilities in addressing cultural and gender differences and life-cycle requirements, (this includes confidentiality, effective communication and facilitating attitudes)
Availability and accommodation	Getting services in time	Proximity, means of transportation and travel time
Affordability	Financial capacity necessary to use services	Direct and indirect costs of accessing healthcare
Appropriateness	Fit between services needed and obtained	Organization of service, including the standard of the facilities and meeting user expectations
Ability to perceive	Need-perception for care among populations	Health literacy, health beliefs, trust, and expectations
Ability to seek	Personal autonomy and capacity to choose to seek care	Personal and social values, culture, gender, autonomy
Ability to reach	Personal mobility and availability of transportation, occupational flexibility, and knowledge about health services	Living environments, transport, mobility, social support
Ability to pay	Capacity to generate economic resources (income, savings, borrowing or loans - to pay for health care services without catastrophic expenditures	Income, assets, social capital, health insurance
Ability to engage	Participation and involvement of the client in decision-making and treatment decisions	Empowerment, information, adherence, caregiver support

ANNEX 2 - VISUAL PROMPT CARDS

Information about intimacy/sexual well being



Information about the (female) body



Health education sessions (group)

Screening HIV

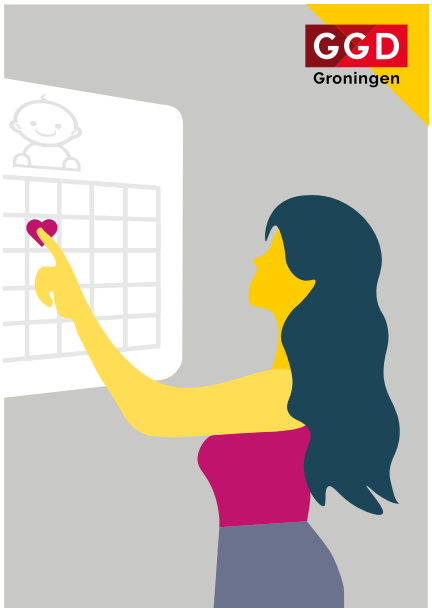
Pre exposure prophylaxes (PrEP)

Screening STI

Gender-based violence and harmful practices, support and care

Contraception counselling and provision

Unintended pregnancies and safe abortion care



Fertility care

Perinatal care

Outstanding issues

ANNEX 3 – TOPIC GUIDE KEY INFORMANT INTERVIEWS

Background information of the key informant concerning our topic of interest, e.g. working experience in SRH care, working experiences with (female) asylum seekers.

Only if health care professional

- Can you tell me about your role in providing SRHR care?

Needs

- What do you see as most pressing needs in SRHR care?

Barriers

- What are common barriers you encounter about SRHR care?
- How do these barriers affect the access to SRHR care?

Enablers

- What are common enablers among you encounter about SRHR care?
- How do these enablers affect the access to SRHR care?

Recommendations

- What recommendations do you have for improving access to SRHR care?

Intervention

- First explanation of the proposed intervention
- What is your view on the proposed SRHR walk-in consultation?
- What would be strengths and challenges?
- What recommendations do you have for the offered SRH care services (both content as practical implementation)?

Review

Topic list FGDs and visual prompt cards for FGDs.

- How would you review these tools?

ANNEX 4 – TOPIC GUIDE FOCUS GROUP DISCUSSIONS

Opening

Sociodemographic data of the participants, like age and country of origin

Introductory

- Introduction to the topic SRHR care in general, using visual prompt cards
- What do you see as most pressing needs in SRH care?

Intervention (general)

- Explanation of walk-in consultations situated at the reception centre (detailed)
- What is your view on this proposed SRH walk-in consultation?
- What would be strengths and challenges?

Intervention (content)

Probing questions to support the discussion:

- Why is this selection of services important?
- What is a most important and why?
- What recommendations do you have for the offered SRH care services concerning the services provided?
- How do women perceive SRHR services?

Intervention (practical execution)

- When, how frequent, where should the walk-in consultation ideally run? Why?
- What recommendations do you have for the offered SRH care services concerning the practical execution?

Final questions

- Any other recommendations, ideas of comments?

ANNEX 5 – INFORMED CONSENT FORMS

KEY INFORMANTS

Titel van het onderzoek
Een kwalitatieve studie naar de percepties van vrouwelijke asielzoekers over inloopspreekuren voor seksuele en reproductieve gezondheid in een asielzoekerscentrum.

Hoofdonderzoeker/Onderzoeker
Sofieke Hofman

Inleiding
U wordt uitgenodigd om deel te nemen aan een onderzoek uitgevoerd door Sofieke Hofman, arts werkzaam bij GGD Groningen en student aan KIT/VU. Het is belangrijk om te begrijpen waarom het onderzoek wordt gedaan en wat uw deelname zal inhouden.
Lees de volgende informatie zorgvuldig door. Daarna kunt u beslissen of u wilt deelnemen aan het onderzoek. U mag altijd vragen stellen voor u een beslissing neemt.

Doel van het onderzoek
Het team voor publieke gezondheid asielzoekers (van de GGD) heeft een opzet gemaakt voor een inloopspreekuur voor seksuele gezondheid. Dit spreekuur is bedoeld voor vrouwelijke asielzoekers in de vruchtbare leeftijd, die verblijven in Ter Apel. Het doel van het onderzoek is om de opzet van deze inloopspreekuren te verbeteren.
Op dit moment worden dergelijke inloopspreekuren niet aangeboden. Met de input van de vrouwen die in Ter Apel verblijven, en sleutelinformanten, willen we het ontwerp van deze spreekuren verbeteren.

Onderzoeksprocedures
Als u besluit mee te doen aan dit onderzoek, zult u deelnemen aan een interview als sleutelinformant. Dit betekent dat u wordt gevraagd naar uw mening en ervaringen met betrekking tot ons onderzoeksvraag. Het hoofdonderwerp is seksuele gezondheid. U wordt niet gevraagd naar uw eigen seksualiteit en seksuele gezondheid. De interviews zullen naar schatting één uur duren.

Vertrouwelijkheid
Uw privacy is belangrijk voor ons. Alle informatie die tijdens dit onderzoek wordt verzameld, zal strikt vertrouwelijk worden behandeld en is alleen toegankelijk voor bevoegde personen die bij het onderzoek betrokken zijn.
Uw gegevens worden gepseudonimiseerd. Wij spannen ons in om uw informatie zo te verwerken, dat deze zowel direct als indirect vrijwel niet herleidbaar is naar u als persoon.

Vrijwillige deelname
Uw deelname aan dit onderzoek is vrijwillig. U bent vrij om uw medewerking te stoppen op elk moment tijdens het interview. Dit heeft geen gevolgen. Uw beslissing om wel of niet deel te nemen, zal geen invloed hebben op uw persoonlijke of professionele positie.

Risico's en voordelen
Uw input zal nuttig zijn voor het faciliteren van toekomstige inloopspreekuren. Er zijn geen vergoedingen of compensaties voor deelname aan dit onderzoek.

Delen van resultaten
Na afloop van het onderzoek zal de onderzoeker de resultaten delen in een rapport voor lokaal en landelijk gebruik. De resultaten worden ook gedeeld in een masterthesis. Als u een kopie van het rapport wilt ontvangen, kunt u contact opnemen met de onderzoeker.

Contactinformatie
Als u vragen heeft over het onderzoek of uw rechten als deelnemer, kunt u contact opnemen met:

Sofieke Hofman
E-mail: s.hofman@ggd.groningen.nl
Telefoon/WhatsApp/SMS: +31 6 1507 8623

Toestemming
Als u de informatie heeft gelezen, begrijpt wat uw deelname inhoudt en geen verdere vragen heeft, zet dan hieronder uw handtekening. Door uw handtekening te zetten geeft u aan vrijwillig te willen deelnemen met dit onderzoek.

Handtekening deelnemer: _____

Datum: _____

Handtekening onderzoeker: _____

Datum: _____

FOCUS GROUP DISCUSSIONS

Example in English.

Study title
A qualitative study to the perceptions of female asylum seekers on walk-in consultations for sexual and reproductive health provided at a reception centre.

Principal Investigator/Researcher
Sofieke Hofman

Introduction
You are being invited to take part in a research study conducted by Sofieke Hofman, GGD Groningen. Before you decide if you want to join, it is important that you understand why the research is being done and what your participation will involve. Please read the following information carefully and ask any questions you might have before making your decision.

Purpose of the Study
The purpose of the study is to improve the walk-in consultations for sexual and reproductive health for female asylum seekers of reproductive age, residing in a reception centre in the Netherlands. At this moment walk-in consultations are not available. With the help of women residing in a reception centre, we will work on improving the design of these consultations.

Study Procedures
If you agree to take part, you will be asked to join in a focus group. This means that you will share for your opinion with other participants. The main topic will be sexual health. You are not asked about your personal sexuality and sexual health. The group discussion will last around one hour.

Confidentiality
Your privacy is important to us. All information collected during this study will be kept private and only accessible to the researchers. Your data will be pseudonymized. We make every effort to process your information in such a way that it is virtually impossible to trace it back to you as an individual, both directly and indirectly. If you agree to participate, you also agree that the information shared in the group should not be discussed outside the room.

Voluntary Participation
Your participation in this study is completely voluntary. You can choose to leave the study at any time without any consequences. Your decision to take part or not will not affect any services or benefits you receive. It will not affect your asylum procedure in any way.

Risks and benefits
Your input will help improve the walk-in consultations in future. This means that you don't directly benefit yourself of these walk-in consultations.
If you need any health care or support, the public health nurse (Rut Debasai) can help you with advice, referrals and access to the right services.

Contact Information
If you have any questions about the study or your rights as a participant, please contact Sofieke Hofman.

Email: s.hofman@ggd.groningen.nl
Telephone/whatsapp/SMS: +31 6 1507 8623

Consent
By signing below, you confirm that you have read and understood the information in this form, that all your questions about the study have been answered, and that you agree to take part in this study voluntarily.

Participant's Signature: _____
Date: _____

Researcher's Signature: _____
Date: _____

ANNEX 6 – AI USE

KIT Institute (Masters or Short course) Participants
Declaration for Use of Generative AI (GenAI)

Check the box that applies to your completion of this assignment:

☐ I confirm that **I have not used** any generative AI tools to complete this assignment.

☒ I confirm that **I have used** generative AI tool(s) in accordance with the ***"Guidelines for the use of Generative AI for KIT Institute Master's and Short course participants".*** Below, I have listed the GenAI tools used and for what specific purpose:

Generative AI tool used	Purpose of use
ChatGPT	- Suggestions for editing texts, refinement, writing more concisely - Translation Dutch - English - Suggestions for summarizing and restructuring - Brainstorming titles and subtitles - Recommendations to formulate the research question
Amberscript	- Transcription of recordings - Translation of KIIs from Dutch - English

REFERENCES

1. IOM Key Migration Terms [Internet]. [cited 2024 Jul 19]. Available from: https://www.iom.int/key-migration-terms#:~:text=Asylum%20seeker%20%E2%80%93%20An%20individual%20who%20is%20seeking%20international%20protection.
2. WHO Defining sexual and reproductive health [Internet]. [cited 2024 Jul 19]. Available from: https://www.who.int/teams/sexual-and-reproductive-health-and-research/key-areas-of-work/sexual-health/defining-sexual-health
3. Schoevers MA, van den Muijsenbergh METC, Lagro-Janssen ALM. Illegal female immigrants in The Netherlands have unmet needs in sexual and reproductive health. Journal of Psychosomatic Obstetrics & Gynecology. 2010 Nov 4;31(4):256–64.
4. Goosen S, Uitenbroek D, Wijsen C, Stronks K. Induced abortions and teenage births among asylum seekers in The Netherlands: analysis of national surveillance data. J Epidemiol Community Health (1978). 2009 Jul 1;63(7):528–33.
5. Keygnaert I, Vettenburg N, Temmerman M. Hidden violence is silent rape: sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. Cult Health Sex. 2012 May;14(5):505–20.
6. Keygnaert I, Vettenburg N, Roelens K, Temmerman M. Sexual health is dead in my body: participatory assessment of sexual health determinants by refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. BMC Public Health. 2014 Dec 1;14(1):416.
7. Tankink JB, Verschuuren AEH, Postma IR, van der Lans PJA, de Graaf JP, Stekelenburg J, et al. Childbirths and the Prevalence of Potential Risk Factors for Adverse Perinatal Outcomes among Asylum Seekers in The Netherlands: A Five-Year Cross-Sectional Study. Int J Environ Res Public Health. 2021 Dec 8;18(24):12933.
8. Maternity care for refugees and asylum seekers in the Netherlands. University of Groningen; 2024.
9. Davidson N, Hammarberg K, Romero L, Fisher J. Access to preventive sexual and reproductive health care for women from refugee-like backgrounds: a systematic review. BMC Public Health. 2022 Feb 27;22(1):403.
10. Sawadogo PM, Sia D, Onadja Y, Beogo I, Sangli G, Sawadogo N, et al. Barriers and facilitators of access to sexual and reproductive health services among migrant, internally displaced, asylum seeking and refugee women: A scoping review. PLoS One. 2023 Sep 14;18(9):e0291486.
11. Bouaddi O, Zbiri S, Belrhiti Z. Interventions to improve migrants' access to sexual and reproductive health services: a scoping review. BMJ Glob Health. 2023 Jun 13;8(6):e011981.
12. Cignacco E, zu Sayn-Wittgenstein F, Sénac C, Hurni A, Wyssmüller D, Grand-Guillaume-Perrenoud JA, et al. Sexual and reproductive healthcare for women asylum seekers in Switzerland: a multi-method evaluation. BMC Health Serv Res. 2018 Dec 14;18(1):712.
13. The COA [Internet]. [cited 2025 Jun 10]. Available from: https://www.coa.nl/en/coa
14. COA Medical Care [Internet]. [cited 2023 Jun 21]. Available from: https://www.coa.nl/en/medical-care-asylum-seekers
15. RMA healthcare [Internet]. [cited 2024 Apr 20]. Available from: https://www.rmasielzoekers.nl
16. GZA healthcare [Internet]. [cited 2024 Apr 19]. Available from: https://www.gzasielzoekers.nl
17. GGD GHOR. 2025. [cited 2025 Jul 8]. Factsheet gezondheidszorg voor asielzoekers in Nederland. Available from: https://ggdghor.nl/wp-content/uploads/2025/06/Factsheet-Gezondsheidszorg-asielzoekers-in-NL-2025.pdf

18. Sense. Sense.info [Internet]. [cited 2023 Jun 23]. Available from: https://sense.info/nl/hulp-advies
19. Nu Niet Zwanger. [cited 2025 Jul 1]; Available from: https://www.nunietzwanger.nl/
20. Government of The Netherlands. I'm considering abortion. What should I do? [Internet]. [cited 2024 Apr 20]. Available from: https://www.government.nl/topics/abortion/question-and-answer/i-am-thinking-about-getting-an-abortion-what-should-i-do
21. Centrum voor Sexueel Geweld [Internet]. [cited 2024 Apr 20]. Available from: https://centrumseksueelgeweld.nl/en/
22. National institute of public health and the environment. National Action Plan on STIs, HIV and sexual health - goals. [cited 2023 Jun 21]; Available from: https://www.rivm.nl/sites/default/files/2018-11/010700_113824%20Nationaal%20Actieplan%20Soa%20ENG%20V2_TG.pdf
23. Starrs A. A Lancet Commission on sexual and reproductive health and rights: going beyond the Sustainable Development Goals. The Lancet. 2015 Sep;386(9999):1111–2.
24. Vaughn LM, Jacquez F, Lindquist-Grantz R, Parsons A, Melink K. Immigrants as Research Partners: A Review of Immigrants in Community-Based Participatory Research (CBPR). Vol. 19, Journal of Immigrant and Minority Health. Springer New York LLC; 2017. p. 1457–68.
25. Balazs CL, Morello-Frosch R. The three Rs: How community-based participatory research strengthens the rigor, relevance, and reach of science. Environmental Justice. 2013 Feb 1;6(1):9–16.
26. Levesque JF, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. Int J Equity Health. 2013;12(1):18.
27. Page J, Broady T, Kumar S, de Leeuw E. Exploratory Visuals and Text in Qualitative Research Interviews: How Do We Respond? Int J Qual Methods. 2022 Jun 1;21.
28. Geneva: World Health Organization. Sexual health and its linkages to reproductive health: an operational approach. [Internet]. 2017 [cited 2024 Apr 19]. Available from: https://www.who.int/publications/i/item/978924151288
29. COA Personen in de opvang van het COA [Internet]. [cited 2025 Jul 1]. Available from: https://www.coa.nl/nl/lijst/personen-de-opvang-van-het-coa
30. COA instroom en uitstroom [Internet]. [cited 2025 Jul 1]. Available from: https://www.coa.nl/nl/lijst/instroom-en-uitstroom?destination_nid=1146
31. Future Learn, The London School of Hygiene & Tropical Medicine. Improving access to healthcare services for children with developmental disabilities [Internet]. [cited 2025 Jul 31]. Available from: https://www.futurelearn.com/info/courses/children-with-developmental-disabilities/0/steps/60072