Impediments to accessing contraception in asylum centres: The perspectives of refugee women in Switzerland

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In Switzerland, women refugee's access to contraception is strongly influenced by their legal status. Unsecure funding and inadequate access to specialist counselling are major obstacles, which infringe on women refugee's reproductive rights. Beyond the question of access to contraception, affected women highlight the difficulties in living motherhood in collective refugee accommodation centres. The 'reproductive justice' approach at the heart of the "REFPER" research project takes this broader perspective articulated by refugee women into account.

As a result of various structural barriers, women refugees in Switzerland face significant gaps in the availability and access to family planning and contraceptives (Amacker et al., 2019; Cignacco et al., 2017; SEM, 2019). Switzerland's social welfare system classifies contraceptives as "noninsured medication", which must be financed by refugee persons themselves from the so-called basic needs provisions they receive from the government. At the same time, social welfare officials have some leeway in making additional funds available in individual cases. This results in unequal treatment, since the cantons, municipalities and related welfare offices do not follow standardised practises. Therefore, access to funding is not guaranteed for everyone; particularly persons affected by poverty face significant barriers (SGCH, 2017, 2019).

The various obstacles to accessing contraceptives

The uneven regulatory practice directly impacts the population of refugee women (Sieber, 2017). Their background as refugees places them in precarious conditions, producing a dependency on welfare assistance and third-party funding of contraceptives. Although condoms are generally provided free of charge in all asylum centres, their use requires the cooperation of both sexual partners. Access to oth-

er types of contraceptives is limited and depends on the person's legal status. Furthermore, women's right to information, which would enable them to make informed and self-determined decisions, is often unfulfilled in practice. Relevant decisions include, for example, resorting to contraceptives or not, which type to use, what kind of support services are available, and whether to use them (Amacker et al., 2019). An additional complication is that refugee women are generally unfamiliar with Switzerland's highly decentralised healthcare system and their knowledge about reproductive health varies considerably. This situation represents a significant obstacle to the reproductive freedom of refugee women.

Broader perspective: the "REFPER" project

For the study "REFPER. Reproduktive Gesundheit – Die Perspektive geflüchteter Frauen in der Schweiz" (REFPER. Reproductive Health – The Perspective of Refugee Women in Switzerland), the Berner Fachhochschule (BFH, Bern University of Applied Sciences) conducted 14 semistructured interviews with predominantly Arabic-speaking study participants (the project team members speak Arabic). Group discussions with the co-researchers, who also have a refugee background, supplemented the interview-based data analysis.

The research focuses on the individual needs of refugee women, which have been shaped by their biographies and the corresponding knowledge available to them. Reflecting an iterative research process and based on the results of interviews and group discussions, we broadened the research question by including the initial focus on effective access to self-determined contraception as well as the question of self-determined motherhood. Conceptually, the research was framed by the reproductive justice approach, thus combining reproductive health with social justice. The concept of reproductive justice emerged in the USA in the 1990s in the milieu of women of colour activists who felt unrepresented by the predominantly white and middle-class women's rights movement. Women of colour criticised the framing of the debates in terms of liberal rights and showed that reproductive rights could not be discussed in isolation from their respective social context. The reproductive justice approach thus consists of four areas as part of maintaining the right to personal bodily autonomy: (1) the right not to have children, (2) the right to have children, (3) the right to raise one's own children in a safe and healthy environment, and (4) the right to live one's sexuality in a self-determined way (Ross & Kitchen Politics, 2021; Ross & Solinger, 2017).

Beyond the access to rights and health services, the concept of reproductive justice also raises the question of who is socially legitimised to be a mother ("right to motherhood"), both historically and in modern discourses. Furthermore, it shows how structural inequalities drive marginalised mothers into life situations that make motherhood very difficult. Our research thus examines how refugee women in Switzerland plan and experience motherhood. The focus lies not only on the right to contraceptives understood as freedom of choice but also on the aforementioned reproductive rights as influenced by socioeconomic factors and social inequalities. Below, we outline the initial findings from the research process.

Biographies of refugee women and their influence on reproductive choices

The dangerous and risky routes to Switzerland taken by refugee women influence their reproductive health. The high prevalence of sexualised violence during the perilous journeys is particularly relevant in this context. Concerning contraception, the study participants describe different approaches taken, which depend on their personal situation and the specific routes taken. One example is the use of the IUD: One woman interviewed inserted it before fleeing, whereas a second removed it before fleeing because she did not know whether proper healthcare would be guaranteed during her journey. A third woman explained that she had completely forgotten about the IUD she had used in her home country during the long journey. Therefore, reproductive health counselling is advisable for women refugees arriving in Switzerland. Even more so, since many of the women interviewed associated their future host

country with stability and security, they considered it suitable for starting or expanding a family: "My husband said, 'Okay, we're going to a safe country. We can have another child, and then we won't have any problems there.'" However, once in Switzerland, the same women often and unexpectedly find themselves in very precarious living situations produced by the asylum procedure. The problematic conditions in the collective accommodation centres forced another study participant to realign her reproductive strategies: "My husband and I decided to have children later. Because, even in the camp, it was not good for women to be pregnant. It is very difficult for a woman to be pregnant in the camp." The inherent uncertainty and the undetermined temporal horizon of the asylum proceedings drive women refugees into a situation of instability. Against this background, it is essential that women refugees can deal with questions about self-determined contraception as soon as they arrive in the host country.

Social hierarchies shape access to specialised information

Upon arrival in Switzerland, the study participants needed information about available contraceptives, and particularly on how they work. However, not all study participants had access to qualified specialist information: "There are certainly many contraceptives available here, but I didn't know, for example, about the IUD or the injection in the arm or back, things like that. I didn't know exactly, but I assumed that it existed." Women often obtain relevant information through their social networks and digital channels. This is problematic because such informal channels can foster insecurity and fear: "You often hear terrible stories from others. I would never use an IUD either. Because I only ever hear bad things. When something good happens, you don't talk about it, do you? People often talk only about bad experiences (...) And contraception is one of them."

In addition to shame and sociocultural norms, refugee women also cite social hierarchies and the frequent lack of translations as barriers to communication: "Because this asylum system, everything, eh ... makes us small. And, somehow, we have to make sure that they don't ... that they always ... make us stupid or ... These are just feelings. Many things don't come so easily to us. Being self-confident or asking something, like that." In communication with professionals and caretakers, these factors shape refugee women's access to specialist information, which is ultimately crucial for women if they are to make informed decisions about contraception and family planning. Women refugees in precarious situations dispose of few resources and must proactively seek information about contraception. This is one possible explanation for their frequent recourse to natural methods of contraception (Inci et al., 2020). This can lead to unwanted pregnancies, which creates additional difficulties particularly for those refugee women accommodated in collective refugee housing.

Discussing motherhood and sexuality in the asylum context

The difficult living conditions, characterised by dependency on the authorities, high prevalence of violence, lack of privacy, precarious infrastructure, social marginalisation and limited access to healthcare, pose enormous challenges for pregnant women in collective accommodations (Gewalt et al., 2019). Some study participants discuss how life in collective refugee housing is not a safe and healthy environment for children, which makes motherhood more difficult. Some cited this as a key reason for not wanting to become pregnant in a collective accommodation: "And the woman was a poor woman, basically. And she was in the camp with a small baby. And she wanted to cook for her two other children, she had to give her daughter to someone else. And I imagined myself in her situation. And it would have been very difficult for me. I couldn't think about getting pregnant when I saw these things. Not until the environment is more suitable for children."

Thus, structural conditions severely restrict self-determined reproduction. During the research process, we realised that the right to reproductive and sexual health must be thought of not only in terms of access to healthcare, but situated more broadly within structural conditions. This broader view can

be conceptually framed using the reproductive justice approach, which focuses on the reproductive right and choice to have children or not, as well as the right to raise children in safe and healthy living conditions. According to Loretta Ross Solinger, one of the founders of this approach, the question of who can be a legitimate mother is closely linked to the question of whose sexuality is considered legitimate (Ross & Solinger, 2017). Refugee women also face these tensions. On the one hand, there are spatial barriers to sexuality: "When you see how the structure and everything is: that means no private life. I was with my husband at the time, I had to sleep with 15 people in the same room. That means our needs, sex and things like that, our private life ... it's all impossible, forbidden somehow! Nobody understands you, do they? Because you can't just close your door and just be with your husband for ten minutes. So, if you think sex isn't allowed here, that means getting pregnant isn't allowed, either!" On the other hand, refugee women also experience a discursive delegitimisation of their sexuality and potential pregnancy, as one story from a group discussion shows: "It wasn't quite clear to her yet whether she could stay here in Switzerland or whether she would be deported to Italy because she had fingerprints there and so on. And then at the first medical interview – they ask whether you are pregnant or not – she said: 'I'm newly married, I'm not pregnant, but I don't want to get pregnant now. And I want to have the birth control pill.' And then she [medical nurse] laughed at her. She [medical nurse] spoke to her in English and said: 'You're thinking about children and pregnancy while you are staying in the asylum centre!' The woman said she felt like she [medical nurse] was saying you can't sleep with your husband during this time. She said: 'But I need this!' And then the nurse told her: 'There are condoms outside, you can take a few.'" The institutional denial of sexuality and motherhood suggests that the issue of contraceptives is not always given the appropriate space.

Effects on reproductive rights and women's health

The following account of a research participant shows how the policy of denying sexuality and motherhood impacts access to contraceptives. Her asylum application was rejected and she was subsequently excluded from welfare assistance. She and her family had been housed in a collective accommodation for years. She says: "And I've been asking for a long time whether I could stop [getting pregnant, i.e., be sterilised] so that I definitely don't have any more children. And they said, 'No, we can't pay for it. If you want, you can pay for it yourself.' I would even have to pay for the IUD myself. (...) But now that I'm pregnant, they are prepared to pay for the abortion. So why, even though I've been asking for contraception for two or three years, why do they always say no?" In contrast to the cost of contraceptives, the cost of pregnancy termination is covered by Switzerland's mandatory health insurance. This impacts people in the asylum system. One expert describes the logic succinctly: "The current funding system promotes abortion instead of contraception" (Amacker et al., 2019, p. 100). The research participant also cites an economic rationale to explain her situation: "They pay for abortion because they don't want to spend much. Because they spend so much on us. They spend money on the children. They don't want there to be too many children so they don't have to spend too much money. They don't say it directly, but they make it clear to us. And if you have a lot of children, they tell you, 'Why so many?' Because it's expensive, the children."

The restricted access to contraception certainly has many causes. The limited financial resources, which fundamentally shape the Swiss asylum system's healthcare provisions, as well as the spatial and discursive logic described above that make sexuality and motherhood more difficult, are decisive factors. The reproductive justice approach at the core of our research highlights these various facets.

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