Hochschule für Angewandte Wissenschaften Hamburg
Hamburg University of Applied Sciences

Master thesis

Occupational Stressors and Coping Strategies among Midwives working in Refugee Camps in Hamburg

A Qualitative Study

Hamburg University of Applied Sciences

Faculty of Life Sciences

Master Program Health Sciences

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List of Abbreviations

AG	Arbeitsgruppe
AsylbLG	Asylum Seekers Act
BAMF	Bundesamt für Migration und Flüchtlinge
CTG	Cardiotocography
HAW	Hamburg University of Applied Sciences
HIV	Human Immunodeficiency Virus
ZEA	Zentrale Erstaufnahmeeinrichtung

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Abstract

Background

Pregnant refugee and asylum-seeking women are a vulnerable group and therefore midwives are of high importance. The woman-midwife partnership is a constant balancing act between professionalism and intimacy. Therefore, the aim is to identify stressors, coping strategies and resources among midwives in refugee camps in Hamburg within the transactional model of stress.

Methodology

Participants were recruited via purposeful sampling and eleven qualitative interviews were conducted and transcribed based on Mayring (2014). Afterwards, paraphrases were developed with an inductive approach and allocated to categories with MAXQDA. The ethics committee at the HAW Hamburg approved the thesis.

Results

Major stressors were diversity, living conditions and uncertain future of the women. Insufficient temporal capacities lead to superficial treatment. Midwives needed to demarcate and adhere to professionalism. Further stressors included the impossibility to implement medical recommendations. Additionally, lack of interpreters and inaccurate translation were reported. The interviewees utilized non-verbal communication, smartphones and illustrations. Other stressors were the appointment allocation and perception that induced the use of guidance pilots. Moreover, the women had a different shame and provided other care for infants compared to natives. The midwives applied cultural openness. Due to the project status of one year, the finances were scarce. Primary resources were experience, empathy, contact with foreigners, own motherhood, the team, gratitude of the women and donations.

Conclusion

Overall, extended temporal resources, interpreters and a data collection of employees engaged in refugee work are needed. Further, an accelerated procedure for the women to obtain their own living space and translated documents are wanted.

1. Introduction

Considering the worldwide situation, the global population of humans who were forcibly displaced has increased from 33.9 million in 1997 to 65.6 million in 2016. Caused by the Syrian conflict, the main growth occurred between 2012 and 2015. Moreover, the high record is induced by conflicts in other regions including Iraq, Yemen and the Sub-Saharan regions of Africa such as Burundi, the Central African Republic, Democratic Republic of the Congo, South Sudan and Sudan (United Nations Refugee Agency 2016, p. 5).

In Germany, 117.313 first asylum-applications have been made between January and July 2017 from which one third have been women (German Federal Agency for Migration and Refugees 2017, p. 8). According to the study on female refugees from Schouler-Ocak et al., refugee and asylum-seeking women are a highly vulnerable target group. The experiences and necessities are different from men. This includes gender-specific traumatizations, responsibility for accompanying children or traditional stereotypes, which restrict the mobility and participation in educational and medical offerings (Schouler-Ocak et al. 2017, p. 8).

Considering these facts, midwives are of high significance regarding the medical supply and psychological support of pregnant refugee and asylum-seeking women. Accordingly, four expert interviews were conducted with the author's fellow students in June 2016. Structural and financial challenges, which involved low payment and lack of professional interpreters, were identified. Consequently, the mutual understanding between the midwives and the women was impaired which led to cultural and religious challenges as well as mistrust towards the midwives. In addition, most of the women were traumatized and the midwives had to cope without any supervision or trauma-sensitive training.

Following the assignment with fellow students, the researcher wanted to gain a deeper understanding about the occupational stressors of the midwives working in refugee camps and their coping strategies. Consequently, the category system could be extended and saturated in this sub-section. Another personal reason for choosing this topic was the author's career aspiration. The objective was to work in the field of occupational health by enjoying an intercultural variety. Therefore, the researcher favors the international aspect of this subject and is curious to explore the living environment of this special target group. As a result, the aim of the present thesis is to identify occupational stressors with particular emphasis on coping strategies and resources of the midwives working in refugee camps within the conduction of a qualitative inquiry.

The first chapter provides an insight into the topic followed by the methodology part. Afterwards, the results, which are based on the category system are presented and finally critically discussed with a subsequent conclusion and future directions.

2. Insight into the topic

The first section outlines the nature of midwifery and focuses particularly on the woman-midwife partnership and academization of the profession. Furthermore, circumstances of refugee and asylum-seeking women in Germany are described in conjunction with the medical care of asylum seekers that is based on the Asylum Seekers Act (AsylbLG). Lastly, the transactional model of stress by Lazarus and Folkman (1984) is introduced.

2.1 Nature of midwifery work

The genuine origin of birth assistance traces back to mutual solidarity support of women. Present midwives are professionals regarding all aspects of pregnancy and the time before and after birth. Furthermore, they serve as advocates for the pregnant, birthing and breastfeeding mothers. Thus, the midwives make an important contribution to women and family health in our society since they ensure and strengthen the well-being of the mother and her child (German Midwifery Association 2016a, p. 1). Thereby, different forms of employment are distinguished. A midwife can be employed full time by the hospital and work on a part time basis at the same time as work in a solely self-employed capacity. Consequently, the midwife profession is characterized by heterogeneity regarding the types of employment (German Midwifery Association 2012, p. 8).

Based on the German Midwifery Law (1985), the objective of the professional training is to give advice to women during pregnancy, birth and postpartum period and to provide all the requisite help. In addition, the midwives should be able to manage a normal childbirth, recognize early complications during the birth process and to supply care for the newborns. Additionally, they are concerned with the monitoring of the puerperal process as well as the documentation of the birth procedure. The professional training consists of theoretical and practical tuition as well as a practical training at the hospital. It lasts three years and ends with a state-approved examination (German Federal Ministry of Justice and Consumer Protection 1985, p. 5).

At present, the occupational training is confronted with large transitions regarding the academization of the profession. The German Midwifery Law and the Training Examination Regulations are 30 years old. Primarily, they are aimed at midwives who work in clinics. This no longer corresponds to reality. Now, 75 to 80 % of the midwives also work on a self-employed basis. In addition, the demands for the occupation have changed. That involves the scientific justification of assessments and actions (German Midwifery Association 2016b, p. 1). Since 2009, the achievement of a university degree for the qualification as a midwife is possible in Germany (Pflanz et al. 2013, p. 6).

The academization is associated with various chances and risks. On the one hand, there is the opportunity for enhanced social recognition and improved evidence-based decision-making. This could be especially useful for sensitive topics such as prenatal diagnostics. Also interdisciplinary and network thinking and the European compatibility could be promoted. On the other hand, there could be a fragmentation of the professional group into academic and professional staff. In addition, the loss of practical workability and proximity to the subject of midwifery is a risk. Further, it is not clear if the academization is connected with better income opportunities (Pflanz et al. 2013, p. 20).

One of the core challenges within the work of the midwives is the constant balancing act between professionalism and intimacy. This means that the midwife and the women form a trusting relationship, but the midwife wants to maintain her own professionalism at the same time. According to the Nursing and Midwifery Board of Australia (2010), this boundary is defined as:

"…the limits of a relationship between a midwife and the woman and her infant(s) and any of the woman's significant other persons. These limits facilitate safe and appropriate practice and result in safe and effective midwifery care. Limits of a relationship may include under or over involvement in the provision of midwifery care" (Nursing and Midwifery Board of Australia 2010, p. 2).

In this context of partnership, it is essential that the midwife provide professional knowledge and skills adapted to the needs and aspirations of the woman. However, the woman should be considered an expert for herself, her body and her infant(s). Therefore, she retains control over choices and the midwife and the woman are equal partners. In some situations where the woman-midwife partnership may not be apparent within midwifery, an acknowledged power imbalance can occur. This can place the woman, her infant(s) and family in a position of potential vulnerability and can lead to abuse. Thus, the trust placed in the midwife is crucial in order to provide comprehensive care to the woman, her newborn(s) and significant other persons (Nursing and Midwifery Board of Australia 2010, p. 2; see figure 1).

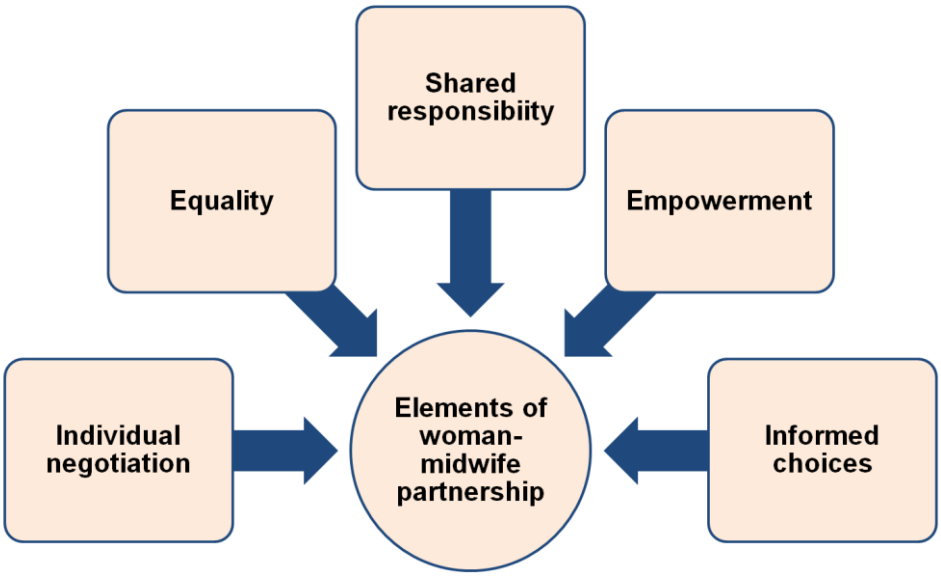

Figure 1: Elements regarding the woman-midwife partnership

Source: Own illustration, based on Nursing and Midwifery Board of Australia 2010, p. 2

The woman-midwife partnership could be described as a continuum of professional behavior. The majority of interactions between a midwife, a woman, her newborn(s) and family should occur in the 'zone of helpfulness'. Boundary crossings can appear at each end of this zone. The two extremes are called 'over'- and 'under'- involvement. 'Over involvement' includes boundary violations and inappropriate behavior towards the woman or her family. It is placed on the right side of the continuum. In contrast, the 'under involvement' is located on the left side. It implies distancing, disinterest, coldness and neglect. Overall, there are no definite lines, which separate the 'zone of helpfulness' from the ends of the continuum (Nursing and Midwifery Board of Australia 2010, p. 2; see figure 2).

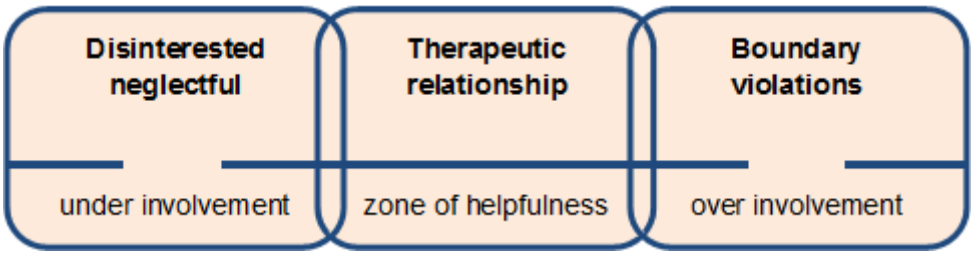

Figure 2: Continuum of professional behavior in terms of the woman-midwife partnership

Source: Own illustration, based on Nursing and Midwifery Board of Australia 2010, p. 2

2.2 Circumstances of refugee or asylum-seeking women in Germany

As with the woman-midwife partnership, boundaries are also an important element in terms of refugee and asylum-seeking women in Germany. In the most literal sense, they crossed the international frontiers, one of the largest boundaries a woman can cross; similarly the midwives sometimes needed to cross professional boundaries in order to provide the best possible care for the women. Overall, 117.313 initial requests for asylum in Germany were made in the period from January until July 2017 from which one third have been women. Figure 3 shows the countries of first asylum applications from January until July 2017 in Germany. The Syrian Arab Republic represents the largest proportion of first asylum applications with 23.9 %, followed by Iraq with 10.1 %. Afghanistan accounts for the third biggest part with 9.3 %, whereas Eritrea has a share of 6.0 %. The percentage for the Islamic Republic of Iran, Nigeria, Somalia, Turkey, the Russian Federation and Guinea come to under 5 % (German Federal Agency for Migration and Refugees 2017, p. 8).

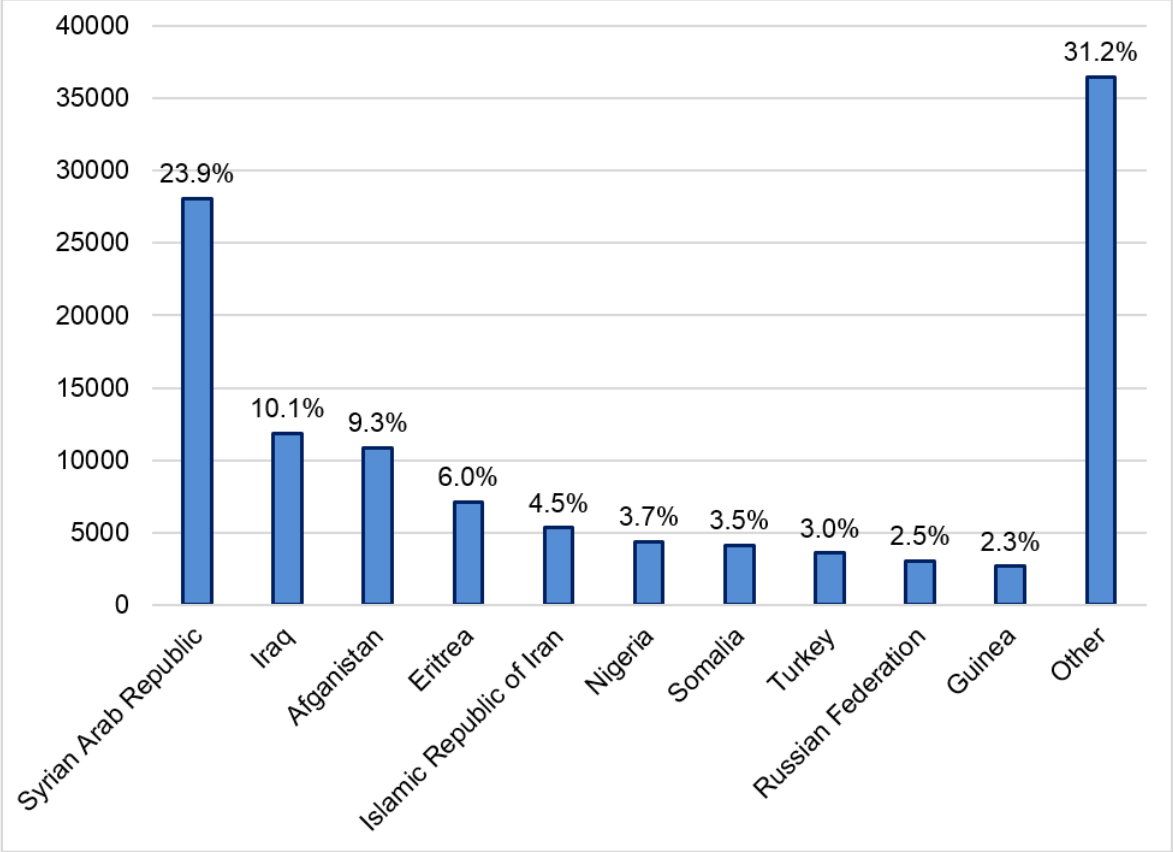

Figure 3: Countries of first asylum applications from January until July 2017 in Germany

Source: Own illustration, based on German Federal Agency for Migration and Refugees 2017, p.8

Hamburg received 489 refugees in January 2017. Currently, 8.035 people live in 32 central refugee camps (*Zentrale Erstaufnahmeeinrichtungen, ZEA*) that are official contact points in Germany and accommodation for the initial stay. 2.792 of these are women. 24.390 people live in accommodation for prolonged stay (*Folgeunterkünfte*) including 9.050 women. Around 1.200 people still stay in halls and former construction markets (Central Coordination Staff for Refugees Hamburg 2017; German Federal Agency for Migration and Refugees 2016).

The medical care of asylum seekers is governed by the Asylum Seekers Act (AsylbLG). According to § 4 (1 and 2), asylum seekers are entitled to a health care for acutely treatable diseases and pain. Thus, expectant mothers have a legal right to medical and nursing care as well as midwifery, medication, dressing and remedies. In 2012, Hamburg introduced the electronic health card for asylum-seekers. However, asylum-seekers do not have a real membership in the health insurance companies since the responsible social welfare authority reimburses the treatment costs plus a five percent administrative lump sum § 264 SGB V. Services, which are not covered, include artificial insemination, disease management programs, birth and maternity allowances and benefits abroad. In addition, there is generally no claim to psychotherapy. Due to the limited access to medical services during the first 15 months of their stay, a disproportionately large number of asylum seekers and refugees are not covered on a comprehensive basis (Frank et al. 2017, p. 36). On World Refugee Day, the German Working Committee for Women's Health urges ministers of the respective federal states to improve the camp and supervision conditions for refugee and asylum-seeking women (German Working Committee for Women's Health 2015, p. 1).

2.3 Theoretical framework

This section describes the term occupational stress and illustrates the transactional model of stress by Lazarus and Folkman (1984). Additionally, the midwife-specific stress is characterized.

2.3.1 Work-related stress

According to the World Health Organization (2017), occupational stress is the response that occurs when the knowledge and ability of a person are unequal to the demands and pressures of the situation. It can be aggravated by little support from supervisors and colleagues and lack of control over the work process. Furthermore, work-related stress can be triggered by poor work organization, poor management and unsatisfactory working conditions. In contrast, if the pressure is perceived as acceptable, it can motivate individuals, keep them alert and enable them to learn. This depends on the resources and characteristics of the person (World Health Organization 2017, p. 1).

These different types of stress involve the differentiation between eustress and distress. Eustress causes a positive reaction for mind and body, whereas distress is harmful to health. The evaluation depends on the individual who is subject to stress. Considering positive stress, endorphins such as dopamine and serotonin are released. In contrast, distress causes a defensive reaction of the body and enhances the production of stress hormones like adrenaline (Psychology Encyclopedia 2017, p. 1).

The German Federal Institute for Occupational Safety and Health (2012) pursues a similar approach in terms of the work-related stress definition. It is considered as the result of an imbalance between external demands and available resources in order to cope with them. Factors that lead to an actual stress response are called stressors. Attributes that support the dealing with stress are named resources. Thereby, stress is the consequential reaction and not the cause (German Federal Institute for Occupational Safety and Health 2012, p. 13).

2.3.2 Transactional model of stress based on Lazarus and Folkman (1984)

The possible causes of stress development and coping are explained by various key concepts. This includes the stress-strain model by Rohmert and Rutenfranz (1975), job-demand-control-model by Karasek (1979) and the model of occupational gratification crisis by Siegrist (1996). In addition, the transactional model of stress by Lazarus and Folkman (1984) is applied which provides the basis for the present master thesis.

According to this theoretical framework, a subjective perception is essential for perceiving a stressful situation rather than the objective nature of stimuli. It means that situations can be evaluated as positive, irrelevant or threatening. If the circumstances are regarded as stressful, it can be assessed as challenge, threat or harm/loss (Lazarus and Folkman 1984, German Federal Institute for Occupational Safety and Health 2012).

As response to a stressful situation, three kinds of coping are differentiated: problem-oriented strategies, emotion-oriented coping and valuation driven approach. Problem-oriented coping involves the overcoming of critical situations with the help of information search or direct actions. Whereas, emotion-oriented coping includes the effort to relieve emotional arousal which involves neglecting activities. The last coping strategy is about the reappraisal of a stress situation that depends on the relationship between the individual and the environment. Therefore, it allows the individual to reappraise cognitively the whole process. The primary aim regarding the reappraisal is to view strain as a challenge since it encourages the liberation of resources (Lazarus and Folkman 1984, German Federal Institute for Occupational Safety and Health 2012; see figure 5).

In contrast to the other concepts, the transactional model of stress focuses on the mutual influence between the individual and the environment that is constantly changing. In addition, this model stresses cognitive approaches and it is organized as a dynamic process. Therefore, it is possible for the individual to change its appraisal and thus its response. Lastly, it illustrates alternative methods for managing psychological responses to stressors (LinkedIn Cooperation 2017, p. 1).

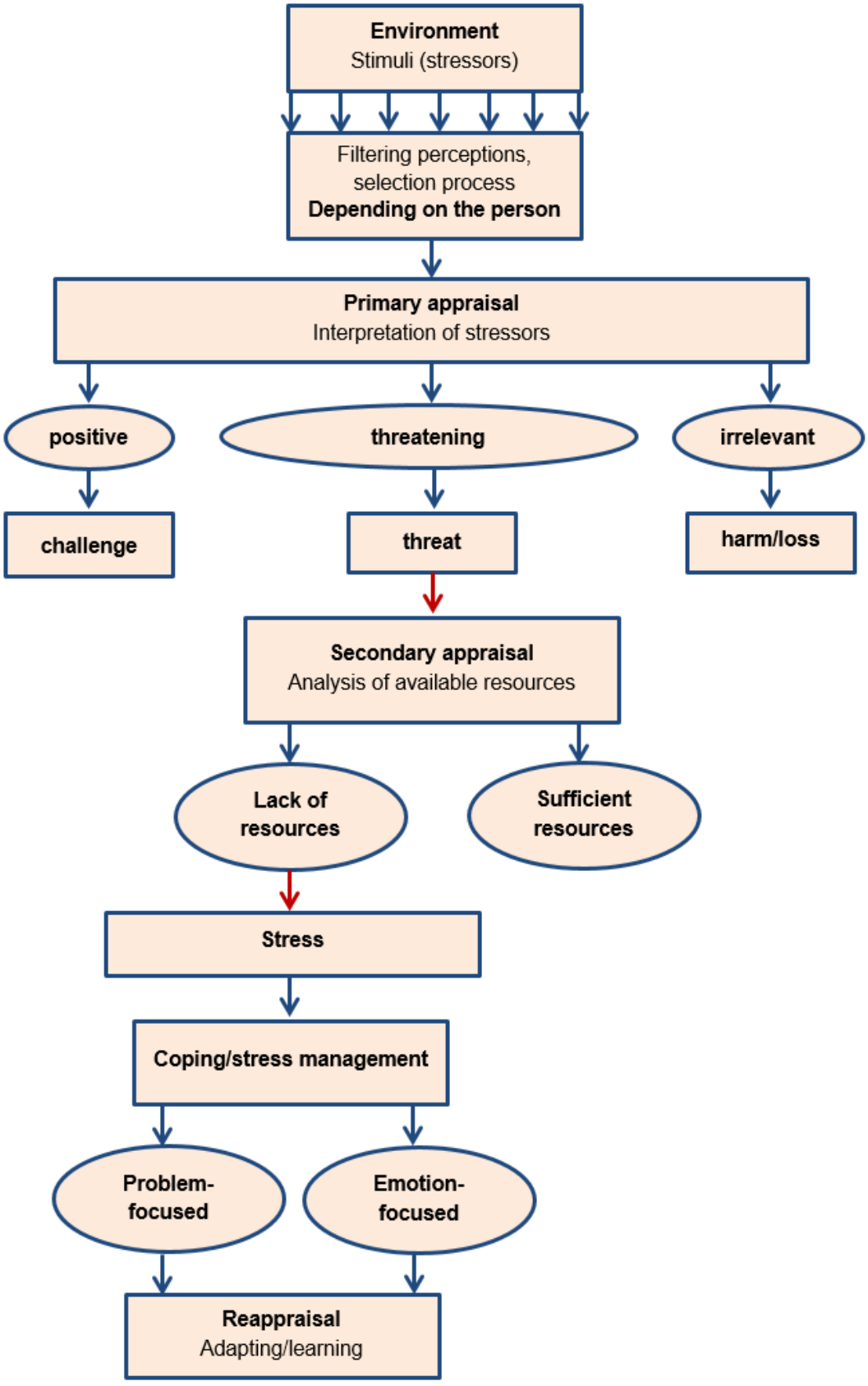

Figure 4: Psychological stress, appraisal and coping processes

Source: Own illustration, based on Lazarus and Folkman 1984, German Federal Institute for Occupational Safety and Health 2012

2.3.3 Midwife-specific psychological stress

For one thing, midwives perceive their partnership with the mother- to- be as a primary source of job motivation and satisfaction. It is the very essence or heart of midwifery care and therefore defines its distinctive nature to other healthcare professions. This includes a high degree of mutuality and reciprocity between the midwife and the woman that can go beyond empathy. Empathic identification is employed by the midwives to facilitate their availability for the expectant mother and to enhance the provision of sensitive care (Leinweber et al. 2010, p. 76). Apart from that, this high level of involvement and blurred professional boundaries can imply a risk for developing stress for the midwife as well as for the birthing woman. Consequently, it is difficult for the midwives to carry out their professional mission to be with the woman without affecting their own emotional well-being. It is also important to note that not all women wish to enter an intimate partnership with the midwife and not all midwives are able and willing to provide care on a high level of empathic identification. Research on the impacts of job-related stress in midwives has focused on burnout and emotional dimensions. According to Borritz et al. 2006, this can be captured with the Copenhagen Burnout Inventory, which is a rating scale that differentiates between workplace-related, client-related and personal burnout. In addition, it considers exhaustion as a key characteristic (Leinweber et al. 2010, p. 82).

This is also the key issue of the article by Neben (2016) who describes her daily challenges of working as a family midwife in Hamburg as well as attending labours in a refugee accommodation for a period of three years. She emphasizes that the number of professional midwives is not sufficient to provide for the desired supply. Since the need for care of expectant mothers cannot be met, the German Midwifery Association in Hamburg urges the midwives to reduce their length of care. This supply is of course at the expense of quality, because every midwife has limited time resources. In the case of Neben, she has 25 hours per week available for parent breakfast, postnatal exercises, baby massage, home visits, team exchange, discussions with social services and other professionals. This in turn leads to a service which Neben calls ‘puerperium light‘. It means that the short-term supply is not compliant with the standards and guidelines. Thus, Neben has to support ten women instead of five with the same number of working hours. Consequently, she tries to fill the home visit with all necessary content. Due to the legal security in this version of the midwife work, she needs to document accurately the care, which is again consuming many temporal resources. For many women, the number of visits seems sufficient or is better than nothing, but the women also do not have any comparison and are unaware of their legal rights (Neben 2016, p. 1).

3. Research questions and aim

Derived from the background and theoretical framework of the present thesis, the following main research question was developed which reads as follows:

- *Which stressors are midwives working in refugee camps in Hamburg exposed to and how do they cope with them?*

Especially the sub-questions are based on the transactional model of stress by Lazarus and Folkman (1984) which are presented below:

- *Which kind of stressors influence the work of a midwife in a refugee camp?*
- *How do midwives address the daily challenges in the refugee camps and what are their coping strategies (emotion-focused, problem-focused or valuation driven)?*
- *Do they evaluate the occupation-related stressors as a challenge, threat or harm/loss?*
- *To what extent does the high level of empathic identification with the women lead to a risk for the midwives for developing stress?*
- *How is the psychological well-being of the midwives affected by work-related stress?*
- *Which kind of resources support the midwives when dealing with occupational stressors?*

4. Methodology

In the methodological part, the rationale of a qualitative inquiry and the underlying philosophical views are described. Afterwards, the recruiting and conduction process is characterized, followed by the transcribing and analyzing procedure. Lastly, the process of the ethical aspects of data protection is depicted.

4.1 Choosing a qualitative inquiry based on the philosophical worldview

Philosophical worldviews influence the practice of research and explain why a specific approach is chosen. They emerge out of discipline orientations, students and mentor inclinations and past research experiences. The present master thesis was based on a constructivist worldview. This philosophical orientation assumes that individuals pursue an understanding of the world in which they exist based on historical and social perspectives. In this process, the participants developed subjective meanings about objects based on their experiences. Consequently, these meanings vary and the aim of the researcher was to investigate the complexity of views and rely on the participants beliefs as best as possible. Thereby, open-ended questions helped to gain a deep understanding of how the participants live in their setting. The process was primarily inductive which involves the generation of meaning from data collection in the field. Constructivism included the recognition of the role of this researcher and how it was shaped by experiences and background (Creswell 2014, p. 35).

Based on this approach, a qualitative inquiry has been chosen. The focus was on the subjective impressions of midwives working in refugee camps regarding their stressors and coping strategies. A qualitative study is characterized by its emergence. Therefore, some parts of the entire process change or shift after entering the field (Creswell 2014, p. 235).

4.2 Recruiting, sampling and conducting expert interviews

The participants were recruited via purposeful sampling (Creswell 2014, p. 23). One of the primary advantages of this strategy was the gathering of information-rich cases. Therefore, the approach of snowball sampling was used. At first, individuals who were relevant to the study were identified and asked to locate further useful informants (World Health Organization 2016, p. 1). In practice, it means that the first chairwoman of the Association for Midwifes in Hamburg was asked for interviewees. Further, participants were recommended by the first supervisor of the thesis. Additionally, personal visits to public institutions and midwife practices in order to ask for potential interview partners and distribution of flyers were conducted (see appendix C). For the purpose of encouraging further participation, the interviewees were given some incentives.

Overall, eleven face-to-face expert interviews with midwives working in refugee camps in Hamburg were conducted. The characteristics of the sample are visualized in table 1.

Table 1: Sample characteristics

ID	sex	age	nationality	profession
E01	female	45	German	family midwife
E02	female	33	German	self-employed
E03	female	46	German	family midwife
E04	female	24	German	self-employed
E05	female	55	German	attending midwife at the hospital
E06	female	45	German	family midwife
E07	female	40	German	family midwife
E08	female	38	German	family midwife
E09	female	50	German	family midwife and self-employed
E10	female	38	German	family midwife
E11	female	33	German	family midwife and self-employed

Source: Own illustration

The interviews were carried out with the help of a semi-structured guideline. Expert interviews consist of questions that are few in number. The aim was to elicit meanings from the interviewees (Creswell 2014, p. 239). The interviews were available within two types of documentation, including audio recordings and transcripts (Flick 2013, p. 12). Before the interview, the midwives signed an informed consent. The data was collected in a natural setting to avoid the influence of a contrived situation. Therefore, the setting was chosen by the midwives, depending on which place was more convenient for them (Creswell 2014, p. 234). Apart from the expert interviews, memos and a research diary were written.

4.3 Transcribing, paraphrasing and analyzing

After conducting the interviews, they were transcribed based on Mayring (2014). Then, the transcripts were paraphrased within an inductive approach. Therefore, categories were built by summarizing the data into increasingly abstract units until a comprehensive set was achieved (Creswell 2014, p. 234). The paraphrases were allocated to the categories and analyzed with the software MAXQDA based on a coding guideline (see appendix E). Before beginning with the analysis, the field access was established, sampling decisions were taken and the data was recorded and transcribed. The data analysis could only begin after the data collection and preparation was completed (Flick 2013, p. 9). It is defined as the classification and interpretation of linguistic material in order to make implicit and explicit statements (Flick 2013, p. 5). Figure 5 visualizes the whole process of data analysis.

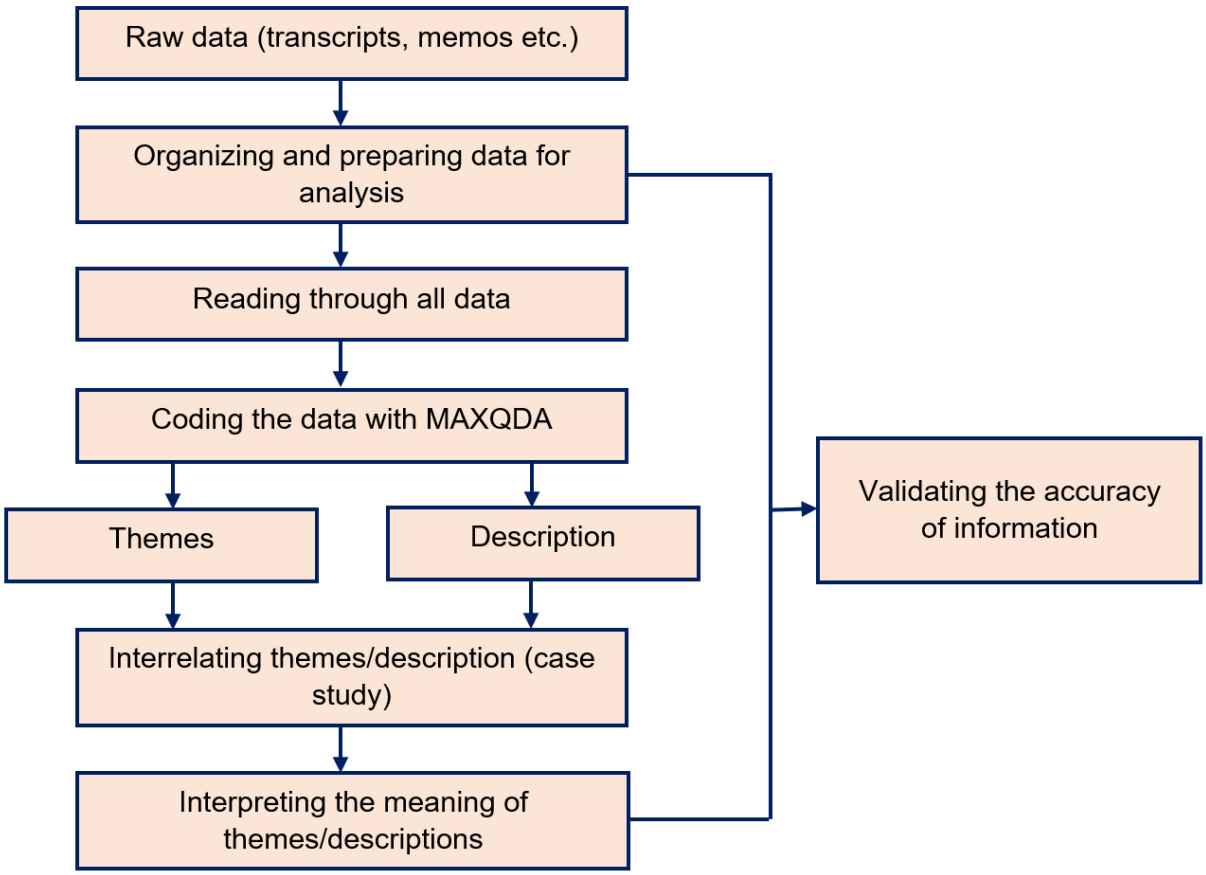

Figure 5: Process of data analysis in a qualitative inquiry

Source: Own illustration, based on Creswell 2014, p. 247

The intercoder agreement was conducted in the following manner: two researchers matched the paraphrases of the interviews independently of each other with the agreed upon codes and code definitions. It should be noted that the two researchers could not see how the other person had coded. This process was conducted with three relevant interviews (interview 01, 02 and 06). Values from 0.61 to 0.80 are classified as 'substantial' and values from 0.81 are rated as 'almost perfect' (MAXQDA 2017, Scheibler 2017).

4.4 Ethical considerations

The conduction of qualitative research raised issues of data protection and how the analysis could provide justice for the participant's perspective. This included the voluntary approval within an informed consent as well as keeping the privacy of the interviewees. In practice, the midwives working in refugee camps signed an informed consent and were informed about the possibility to withdraw from the participation at any time during the interview without penalty. Furthermore, the participants were informed about the aim and process of the master thesis. Personal data were documented in an anonymized form (Flick 2013, p. 15). In order to ensure all ethical considerations, the conduction of interviews was approved by the ethics committee at the Competence Center of the Hamburg University of Applied Sciences (see appendix D).

5. Results

First, the category system is introduced, followed by the identified stressors, coping behavior and resources of midwives working in refugee camps in Hamburg. Furthermore, personal motives and structural causes for working with refugee and asylum-seeking women are introduced.

5.1 Category system

Table 2 visualizes the category system with five main categories. The first one describes the general facts of the midwives working in refugee camps. After that, the specific stressors of the interviewees are depicted. It should be noted that the categories are arranged by meaning. The occupational stressors are divided into subcategories. These include the circumstances and characteristics of the refugee and asylum-seeking women, mental stressors, linguistic barriers and negative statements that are concerned with the organization. In addition, there are categories for financial and cultural stressors as well as challenges, which deal with person-related facts in the refugee camp. Further categories are the professional and physical stressors. Additionally, the coping strategies are also classified as subcategories and arranged according to the order of the occupational stressors. Categories for resources infer professional skills, personal strengths and abilities as well as human capabilities. This involved people who are supporting the midwifery work at the refugee camp in a direct and indirect way. Moreover, categories are created for the appreciation of work, cultural and financial resources as well as structural capabilities. Lastly, the midwives' reasons for working with refugee women are divided into personal motives and structural causes.

Table 2: Category system

1 General facts about midwives in refugee camps	
2 Occupational stressors of midwifery in refugee camps	Circumstances and characteristics of refugee and asylum-seeking women Mental stressors Linguistic stressors Organizational stressors Financial stressors Cultural stressors Person-related stressors Professional stressors Physical stressors
3 Coping strategies of midwives in refugee camps	Strategies mental challenges Strategies language barriers Strategies organizational challenges Strategies financial difficulties Strategies cultural challenges Strategies person-related difficulties Strategies professional difficulties Strategies physical challenges
4 Resources of midwives in refugee camps	Professional skills Personal strengths and abilities Human capabilities Appreciation of work Cultural resources Financial resources Structural capabilities
5 Reasons for working with refugee women	Personal motives Structural causes

Source: Own illustration

5.2 General facts about midwives in refugee camps

Expert 01, 03, 06, 07, 08 and 10 were employed as family midwives for an institution or an association. Expert 09 and 11 worked part-time as family midwives and were self-employed at the same time. Expert 02 and 04 were solely self-employed and Expert 05 was hired as an attending midwife at the hospital. Eight of the interviewees conducted a two-hour midwife consultation every one or two weeks in a room at the refugee camp. This consultation was conducted in *ZEAs* and *Folgeunterkünfte* and the number of women varied. On average, eight women visited the consultation hour. It took place once a week. Expert 08 and 11 combined the consultation with a parent's café. Sometimes, the consultation hours resulted in home visits or mentoring, which was organized together with the Youth Welfare Office. Thereby, child protection was of major importance.

Expert 02 and 04 carried out their work with the refugee women voluntarily and were part of a team consisting of midwives and gynaecologists. One of their consultations was conducted in an automobile at the main station. Expert 09 performed outreach work and walked from container to container at the camp. The work with refugee woman was a small part of the overall duties of the midwives. It was characterized as diverse. Expert 01 worked with refugee women for several years. The other interviewees had less experience regarding work in a camp, which varied between one and four years.

5.3 Challenges of midwifery in refugee camps

When working in refugee camps, the midwives faced several challenges that are described in the subsequent sections.

5.3.1 Characteristics and circumstances of refugee women

Expert 01 pointed out the diversity of the refugee women. On the one hand, a refugee could be a person who has been in Germany for a long time and mainly speaks German. On the other hand, it could be someone who hardly speaks the local language and has been in Germany only a short time. Also each woman has experienced a very different situation and therefore it was difficult to know what type of support she would require. Expert 08 worked with many educational inequalities. Some refugee women were highly educated and had studied. The children were taught at home or were not given any schooling in rural areas of Afghanistan, because of the long-lasting war. According to expert 08, the women who studied had a different relationship to their husbands and were equal to them compared to women from rural areas without any education. Furthermore, expert 07 reported that some of the women experienced partial genital mutilation and rape. It took a long time to build up a mutual trusting basis and encourage the women to speak about their experiences.

In addition, the interviewees mentioned that Arab women had a different boundary of shame regarding physical examinations compared to native women. Expert 07 worked primarily with women from Afghanistan, Syria, Somalia, Eritrea, Ghana and Albania.

The traumatization depended on the refugee background and country of origin. There were dramatic individual fates that had to do with the flight, the situation in the country of origin, war experience and torture. Women who were severely traumatized or physically affected by war injuries had problems building a solid relationship with their child:

„Die Frauen, die richtig aus Kriegsgebieten geflohen sind, also die auch teilweise schwerst traumatisiert sind, sind eher unbeholfen und ängstlich im Umgang mit ihren Kindern, finde ich, überfordert auch schnell. Manchmal sind sie auch körperlich selber eingeschränkt, die Mütter, nicht, es gibt auch Frauen mit Kriegsverletzungen, die selber kaum von der Matte hochkommen und runter und dann auch nicht so den Blick auf ihr Kind haben, weil sie mit sich am Kämpfen sind“ (E7).

Many of the challenges that affected the women had to do with the accommodation or eating. The families lived in cramped conditions. The air conditioning in the containers was difficult and it was very noisy. At night, the women quickly gave their infants the bottle. Otherwise, the neighbours would be disturbed. In the winter, the women and children often caught cold:

„Einen Container muss man sich vorstellen, der ist aus Metall. Ist es draußen kalt, ist der Container kalt, ist es draußen warm, ist der Container warm. Wenn ich viel lüfte, hab ich alle Geräusche von allen Nachbarn. Es ist sehr, sehr hellhörig. Das heißt, wenn die abends Party machen und ich hab kleine Kinder, dann lüfte ich nicht. Bin ich aber in einem Raum, der unter zehn Quadratmetern ist mit fünf Leuten, läuft mir das Wasser von den Wänden. Ich krieg auf jeden Fall Schimmel und Feuchtigkeit, weil das allein die Kondensierung durch die Atemluft ist“ (E9).

There were shared kitchens and bathrooms in the refugee camps. This lead to problems as different cultures meet. For traumatized people it was difficult to be in close contact with people from different nations since they often suffered from social phobia and anxiety. Cooking their own meals was not allowed at the *ZEAs* and in the *Folgeunterkünfte* there were community kitchens. The canteen dining usually consisted of a finished product where the single components could not be selected. The refugee women had a great food culture in their countries of origin and did not like the food in the cafeteria, because it was not adapted to their culture. Thus, pregnant women suffered from constipation or ate little and were therefore very lean. Even with a newborn, the women had to use the communal lavatories that were outside the accommodation. Additionally, there were cases of tuberculosis, hepatitis and HIV. Additionally, the women and children had a bad tooth status.

The refugee women wished to get an apartment with their own kitchen and bathroom, especially if they were in a *ZEA* for more than one year. However, the large mass accommodations were increasingly closed. Expert 09 had experienced the clearance of a ZEA with 900 residents. Often, they had to relocate into another *ZEA*, although they wished to move into a *Folgeunterkunft*. None of the employees were allowed to say anything until two weeks before the clearance. The residents had to reorientate themselves completely in terms of paediatricians, gynaecologists and day-care facilities for their children. There was no longer any integration into social life. For the refugees this meant a re-traumatization:

„Eine Mutter, die ihren Säugling aus dem Fenster hielt im zweiten Stock und meinte: ‚Das Kind fällt zuerst, dann springt sie hinterher.' Für die wir dann die Polizei rufen mussten und eigentlich diese Menschen mit so einer Umgangsform komplett Kopf stehen, weder vorbereitet sind, noch einen Ansprechpartner haben und es, was immer sie traumatisch erlebt haben, so was von triggert und es ist Standard" (E9).

The resident status and fear of deportation to their country of origin represented another challenge for the refugee women. Expert 07 emphasized, if everything went straight, the first opportunity to obtain their own living space was given after two years. This included an available residence permit as well as the transfer from the social welfare office to the job centre. According to expert 08, the refugees tried hard to learn German as soon as their status was clarified and they had obtained a residence permit. If the families knew their stay was temporary, they were in a poor state:

„…und das ist dann auch häufig der Fall, dass wir in Familien reinkommen, wo wir wissen, die haben überhaupt kein Bleiberecht, die kriegen kein Bleiberecht, die würden am liebsten jetzt sofort irgendwie zurückgehen, weil es gar nicht Sinn macht, hier zu bleiben, aber zehn Tage vor Geburt keine Chance. Die dürfen bleiben, bis die Kinder sechs, sieben Monate alt sind und dann werden sie abgeschoben und gehen zurück in die Heimat" (E9).

5.3.2 Mental stressors

One of the mental challenges were the temporal stressors. The capacities for the consultation hours were not sufficient and this lead to stress, especially if the midwives had subsequent appointments. Expert 09 said that the three hours for the work in the refugee camp included arrival, departure, documentation and time for preparation and follow-up. Expert 02 had only little time for the voluntary work at the camp since the working hours as a self-employed midwife were difficult to estimate. A strong concentration was required by the midwives because of the short-term temporal capacities. The interviewees wished the work could be somewhat more holistic.

Expert 01 and 07 were worried about not being able to meet all the women's individual needs due to the scarce resources:

„…allen gerecht zu werden und so, dass ich eben manchmal wirklich acht oder dreizehn Frauen hintereinander weg in ungefähr eineinhalb Stunden. Das an sich ist schon, wie soll da dokumentieren? Wie gehe ich auf jeden ein? Was sind die Themen? Was kann ich überhaupt noch an Struktur halten? Kann ich mir noch Dinge merken vom letzten Mal und die noch hinterfragen? Also sprich, Stichwort Qualitätssicherung" (E1).

Another mental challenge was the superficial treatment of the women's health issues during the consultation hours. The midwives wanted to give the women more support and they had to accept that this was not possible. During the consultation, the women's topics could only be dealt with superficially. It was not so much about physiological processes rather than a kind of emergency counselling. Expert 11 thought that an in-depth consultation would be only possible if sufficient time was available.

Moreover, the perception of further tasks was a challenge. In addition to the consultation hours in the camp, the midwives had various other duties such as home visits, organizing parent's breakfast or recovery gymnastics, documentation or induction of a new colleague.

The voluntary work of expert 02 and 04 included supplemental work in terms of searching for a location for the automobile, presswork, answering emails and forwarding inquiries. Expert 01 thought that the outreach work was essential. It was hard for her to refuse home visits, but her boss exhorted her because of the many overtime hours.

Furthermore, psychological strain based on personal stories and circumstances of the women lead to stress. Expert 02, 03 and 08 found it difficult to deal with the individual destinies. Expert 06 mentioned that is was hard for her to know about the women's escape situation and to see difficulties in bonding with their children. In addition, the uncertainty of the deportation into the women's countries of origin burdened the midwives. It was psychologically stressful for expert 05 and 07 that some of the women were exhausted and had to deal with tight living conditions.

Especially during the winters, they felt sorry for the women when they had to go back to the containers:

„…es ist jetzt auch so, dass die Frauen die ich jetzt habe, oft schon Monate bis über ein Jahr in diesen Containern wohnen. Die haben manchmal eine Frau und vier Kinder ein Zimmer von vielleicht 15 Quadratmetern. Das ist natürlich eine Situation, wenn ich das mitkriege belastet es mich, weil ich denke, ich wohne hier mit meinem eigenen Zimmer in einem riesen Haus, habe Platz für meine Kinder immer gehabt und so“ (E5).

Expert 08 was sometimes frustrated if she organized a lot for the women and they did not want to accept her help. She cared about a woman who suffered from severe nausea and provided medicine to ease it, but the women did not want to take it. In addition, expert 01 mentioned that the women sometimes get aggressive when she distributes charitable donations during the consultation hour.

5.3.3 Linguistic stressors

The barriers of language represented a challenge for the midwives. First, there was a lack of translators. Especially for rare languages such as Tigrinya and Somali, it was difficult to find translators. Expert 07 mentioned that there are no fixed interpreters available for the consultation hours. Everything needed to be mimed or translated with iPhones. Therefore, no detailed medical history of the women could be given. If there were serious medical conditions, it was not possible to have a profound conversation. Due to the language barrier, expert 06 received very little feedback from the women whether they could implement her medical recommendations into practise. In addition, it was difficult to organize an interpreter for appointments.

Secondly, a challenge was that sometimes the interpreters did not translate the original context of the midwives. Expert 01, 03, 05 and 09 found it hard to work with interpreters as they spoke a long monologue even if they only said one sentence. The precise question to the refugee women remained unanswered. That took a lot of time. Expert 05 objected that in the Arabic language, matters were described in an elaborate, often poetical way compared to the German language. Additionally, expert 03 mentioned that the interpreters saw themselves not only as translators, but also rather as persons in a position of trust, since they were often descending from the same country of origin.

Another challenge was the lack of female interpreters. In addition, relatives were usually male since they spoke better German or English. Sometimes there were only male translators available with whom the women did not want to talk about gynaecological problems. For instance if the midwives asked a pregnant woman about her last menorrhea, it was conflictual:

„Dann kommt da jemand, aber es ist dann ein Mann, weil gerade keine Arabisch sprechende Frau da ist. Und dann guckt die Frau mich total entsetzt an […] und schüttelt so mit dem Kopf und dann muss der Dolmetscher wieder gehen, weil sie über diesen Dolmetscher, der männlich ist, eben nicht über ihre Probleme sprechen möchte“ (E6).

Further, the translation of the terms and professions in the German healthcare system was difficult. It was confusing to explain the differences between the various forms of midwives or to explain for which purpose the consultation hours in the camp were conducted. In addition, documents such as corresponding papers for the birth certificate were often only available in German:

„…in den Krankenhäusern kriegen die Frauen häufig nach der Geburt zum Beantragen der Geburtsurkunde Unterlagen mit. Und die finde ich manchmal irgendwo in den Unterlagen, weil die nicht übersetzt sind, die sind auf Deutsch. Es ist überhaupt nicht klar, was man damit macht“ (E1).

When dealing with documents and signatures, expert 07 found that illiteracy was more common than she would have expected. Lastly, the communication within group gatherings was restricted. When one nationality prevailed, the other women no longer came because they could not communicate.

5.3.4 Organizational stressors

In terms of organizational stressors, the medical appointment allocation was a provocation because of the high work density of paediatricians and gynaecologists. In addition, the mediation of physiotherapists and occupational therapists proved to be challenging:

„Also es sind sowieso in Hamburg, die Kinderärzte sind überfüllt, die Frauenärzte sind überfüllt, aber wenn ich dann noch sage: ‚Hallo, ich bin Familienhebamme, ich sitze gerade im Camp Nummer [zensiert] und suche für eine Frau einen Arzt‘, dann habe ich zumindest das Gefühl, dass noch eher nein gesagt wird, weil auch die Ärzte die Problematik sehen, sie können sich mit den Frauen nicht verständigen“ (E7).

Moreover, the perception of services and appointments was a challenge. The refugee women often did not keep appointments. They did not understand that they had to pay for all costs incurred in case of non-compliance. Also in terms of the consultation hours, it took a long time before the refugee women made use of it. Expert 06 emphasized that it was essential to be reliable at the same day at the same time. If the women did not come to the consultation, expert 07 walked from container to container which was time consuming. Also accepting offerings outside of the camp was a barrier. Expert 01 mentioned that she was very happy to welcome two refugee women at the parent‘s breakfast. For this event, they had to change trains several times and drive by bus. The perception of offers outside the camp was only possible with guidance pilots:

„Es braucht eine relativ lange Anlaufzeit, bis die Frauen den Termin verinnerlicht haben und es braucht teilweise Begleitung, dass man wirklich gerade bei Terminen außerhalb sagt: ‚Ich komm, ich hol euch ab, ich bring euch dahin‘ und dann machen wir das gemeinsam“ (E10).

Besides the midwifery work, the interviewees had to perform various other tasks during the consultation hours. Within a short time, medical care, distribution of donations and organisation of medical appointments needed to be managed. Expert 07 made many phone calls regarding unpaid invoice papers, liabilities and payment reminders. Additionally, she took care of two women from Ghana who were single mothers and had a lot to organize. Expert 06 was often asked for apartment and job search, a place for a day-care facility for children, a letter of recommendation to move into a *Folgeunterkunft* or an attestation for the canteen.

Furthermore, it was challenging to organize the working schedule for the consultations. Requests from colleagues regarding working times needed to be considered. For example for expert 09, the best time for visiting the camp was early in the morning. However, if she had walked to the containers before ten o clock, no one would have opened the door since the families were often still asleep due to lack of daily structure.

In addition, the work at the camps included bureaucratic obstacles. Especially if the women did not have any health insurance coverage, the financial situation was difficult. Some women needed to wait a long time for their healthcare card and had to pay the money for the physician appointment in cash, but they could not afford it.

Another bureaucratic obstacle was the application for the birth certificate:

„…die muss jetzt losgehen, direkt nach der Geburt und ihre Geburtsurkunde für das Kind beantragen und da […] zu allen möglichen Ämtern. Das ist natürlich total schwierig, diese Herausforderung dann in der Wochenbettzeit. Man muss es aber recht früh machen, weil davon abhängig ist, das eine Versicherung läuft, das man zum Kinderarzt gehen kann, das Gelder kommen. Die Bürokratie hängt wirklich an dieser Geburtsurkunde“ (E1).

In order to exchange information about cases with the social management and physicians, it was compulsory to have a release from medical confidentiality. However, this was difficult to obtain since the residents did not understand what that meant.

Another challenge was the transfer of women to other camps. If the women moved to other places, the midwives could no longer care for them. Often, the women did not know themselves about their transfer until shortly before the move. Thus, no medical hand-out for further treatment could be prepared. If the women no longer attended the consultation hours, expert 05 was unsure whether they had been transferred or poorly medically cared for.

5.3.5 Financial stressors

The financial resources for the midwifery work were scarce due to the project status. It was a question of capacity whether the midwives could perform outreach work, single case management or consultation hours in the refugee camp. The budget of the project was always planned at the beginning of the year. If expert 10 noticed that she needed additional equipment, she depended on charitable donations. Sometimes it took several weeks before financial funds were available. Contraceptive devices such as the pill, spiral and condoms were financed by neither the health insurance funds nor the social welfare office. Expert 08 reported that consultations and available resources and services took place in a room where no rent needed to be paid. Expert 01 wished she could deduct the medical services via the health insurance company, but there was no capacity for this. The remuneration of the midwives was downgraded and they earned less salary for the same work. For expert 09 it was difficult to account for enough working hours and have sufficient money since she worked part-time as a family midwife and part-time self-employed.

The contract for the work at the camp was always limited to one year:

„…also die Stellen, die geschaffen sind, für die Arbeit, die ich mache, sind immer befristet. Und weil man nicht weiß, wie lange die Hilfe nötig ist. Das heißt, ich arbeite immer befristet ein Jahr, ein Jahr, ein Jahr“ (E6).

5.3.6 Cultural stressors

The interviewees reported that one of the cultural challenges lay in a different sense of shame of the refugee women regarding physiological examinations compared to native women. The refugees did not always want to be physically inspected. Expert 06 mentioned that she offered cautiously to have a look at the affected part of the body and that this process could only be conducted step by step. She also stated that Afghans and Syrians had different expectations regarding the medical treatment. She had cared for a Syrian family and was invited several times to dinner and offered to stay at the family's place over night. The family explained to her that in some rural areas it was common for the midwife to stay with a family for several weeks until the mother and child were strong enough and then they moved on to the next family.

However, expert 01 experienced a situation where people did not want to shake hands, because the midwives were viewed as impure:

„Sehr unterschiedlich, wie der Beruf der Hebamme gesehen wird. Also es gibt Kulturen, die geben auch der Hebamme nicht die Hand, weil die Hebamme ist sozusagen schmutzig“ (E1).

Expert 02 said that an Afghan always receives some medication or natural medicine after a physician’s appointment:

„…wenn man in Afghanistan zum Arzt geht, man immer irgendwie was in die Hand gedrückt bekommt, ein Medikament mitbekommt mit dem man dann geht. Und dann haben sie auch den Anspruch und denken halt irgendwie deine Arbeit ist nicht richtig erfüllt, wenn du denen nichts mitgegeben hast“ (E2).

In addition, the approach to infant nutrition was different in Germany compared to the women's country of origin. The transition from milk-only diet to solid food such as dates occurred early. Furthermore, the handling of the infants was partly different. According to the interviewees, women from African countries tend to take their children by one arm only out of the baby carriage. Sometimes the midwives found it hard to distinguish if there was a severe endangerment of the child's welfare or if the action occurred due to cultural circumstances.

Referring to expert 08, the bonding and appreciation of a child was different to native women. It occurred several times that women left their infants for medical examination in the room for the consultation hours and went out. Further, she reported that for Afghans and Syrians it was not customary to go to a different place with the children to keep them entertained such as a playground since they grew up in multi-generational homes where the offspring usually played with the neighbour's kids. Furthermore, the interviewees noticed that brushing the teeth was not as important as in Germany and thus many children had poor tooth status.

Another cultural stressor was the unequal division of rights between women and men. For instance, the allocation of responsibilities was traditional. Taking care of the children was considered a female duty and the attendance of a German language course was viewed as a male task. According to the interviewees, the women also did not demand to participate in different offers.

Expert 11 referred to a woman who had been married as second wife and had to leave her own children behind in order to flee to Germany. Instead, she was allowed to take the child of the first wife with her. Her husband used her own children as strong leverage. Thus, he was in a powerful position. Financial social support for this woman and child was received by her partner and she needed his signature to make a withdrawal. If and how a family reunification could happen was questionable according to expert 11.

Some of the refugee women also suffered from partial genital mutilation. Expert 09 emphasized that some couples talked openly about this issue during the consultation hours, but should they be deported back into their country of origin, the family would decide whether they were allowed to undergo surgery:

„Es gab eine Frau, die in Afrika tatsächlich zugenäht wurde und das musste operiert werden vor der Geburt, damit es sich eröffnet. Und da gab es zumindest ein Gespräch: ‚Wie ist es denn hinterher, soll es denn wieder verschlossen werden?‘ Und der Mann war zum Glück da und ich konnte ihn fragen und die waren sehr offen. Also es ist glaube ich eher diese Überraschung, dass die da sehr offen drüber reden und sagen: ‚Nein, nein auf gar keinen Fall, so.‘ Wo aber nicht sicher ist, weil es kein Flüchtlingsland ist, ob sie nicht zurückgeschickt werden und dann ist es eine neue Frage, weil dann ist es nicht mehr allein deren Entscheidung“ (E9).

5.3.7 Person-related stressors

Person-related stressors were primarily due to holiday and illness cover. If expert 06, 07, 08 and 10 were unable to attend the consultation hour, it needed to be cancelled. Some interviewees were concerned about the management of the refugee camp. The managing staff had different objectives. For instance, a severely traumatized woman was supposed to take contra-indicated medication against abscesses even when she was still solely breastfeeding her child. Expert 06 was then urged to advise the woman to stop breastfeeding, which did not comply with her own attitude and led to discussion with the management staff.

At the beginning of her work at the camp, expert 07 tried to talk with the management on behalf of families without a permanent residential status, to transfer them to a larger apartment since it was unclear how long they had to stay in the *ZEA*. However, her requests were strongly rejected. Sometimes expert 09 found it difficult to communicate with the social management and she had not been informed about things that directly affected her work. If the staff had no time for her concerns, she needed to leave a note and found that unsatisfactory. Due to inadequate communication, some employees of the social management were not informed well:

„…manche Sozialmanagementsleute sind sehr gut organisiert und wissen genau, um wen geht es hier, um wen geht es nicht. Manche sind überhaupt nicht informiert und wissen gar nicht, welche Schwangere und welches Baby sich auf dem Gelände überhaupt befindet“ (E7).

The midwives also indicated a lack of trauma therapists in the camp. In addition, the number of volunteers declined:

„Das ist irgendwie bisschen mau, es ist müde. […] es gab ja damals eine riesen Welle von Ehrenamtlichen. Es gab unglaublich viele Leute, die gesagt haben: ‚Oh wir müssen helfen, wir müssen was tun.‘ Es gab zu viele, dass man schon zurückgebremst wurde. Jetzt fragt man sich, wo sind die denn alle?“ (E7).

The team of expert 02 and 04 had many volunteers available, but most of the work was performed by a few.

5.3.8 Professional stressors

A main professional challenge was the great responsibility of the midwives during the consultation hours. In the short amount of time, they needed to pay attention not to overlook serious conditions. Two years ago, midwives were the first medical personnel to examine the women after their escape to Germany. The contents during the consultation hours referred to basic medical care. The midwifery work was a low-threshold offering. This included determining the pregnancy, clarifying the insurance status and organizing appointments with paediatricians and gynaecologists. The work could be described rather psychosocial than medical. It was hard for the refugee women to understand the German healthcare system and that there were different tasks allocated to various professions. Some women were very insecure and concerned because of the many information sources and recommendations.

Moreover, medical recommendations of the midwives could not always be implemented into practice due to structural and financial barriers:

„Und ist auch bei vielen Sachen, das sind so Hausmittelchen, die kann sie gar nicht machen. […] zum Beispiel eine Frau, die Wassereinlagerungen hat und ich würde der sagen: ‚Hier, geh mal zu Budni und kaufe dir basisches Badesalz und dann mach da mal ein Bad.' Das kann die halt nicht, weil die hat keine Badewanne. […] die kann auch kein Fußbad machen, weil sie nicht die Schüssel mit Wasser 500 Meter einmal quer durchs Camp tragen kann, um sich dann da hinzusetzen und ein Fußbad zu machen, so" (E2).

Expert 05 expressed regret regarding the lack of equipment. Especially that there were only some care products present during the consultation hours without any laboratory available. There was a lack of trauma-sensitive training, too. Additionally, there was no offering for further education after the increased arrival of refugees in 2015. Expert 04 had to stop her voluntary work with refugee women since she was still in the training phase as a midwife and had to wait until she completed her education.

5.3.9 Physical stressors

Sometimes, expert 01 was physically compromised due of lack of equipment. Additionally, she often carried large bags and cartons with material resources. In order to conduct the consultation hours, the group room needed to be completely rearranged. This included carrying tables and moving chairs. Expert 07 said she regularly had to climb many stairs and to sit on the floor instead of a chair. However, expert 03, 05 and 08 stated that they were very used to dealing with these physical challenges within their working experience and therefore found it no different.

5.4 Coping strategies of midwives in refugee camps

In the following, various strategies are depicted to cope with the notified stressors.

5.4.1 Strategies mental challenges

A major strategy with regard to mental challenges was the conversation with members of the team or the husband. It provided the midwives with useful advice and assistance.

On the one hand, demarcation and adoption of a professional attitude was a primary strategy to cope with mental challenges. Expert 05 thought that she could only be a good support if she managed to distance herself in a healthy way. Expert 08 saw herself as an anchor and a piece of normality in the unstable life of the refugee women, but she could not solve all the women's problems. For this reason, expert 02 tried to distinguish clearly between private and professional environment:

„…also ich glaube, ich hab einfach tatsächlich gelernt hab, dass Beruf Beruf ist und privat privat, dass ich es einigermaßen trennen kann. Ich sitze jetzt nicht zu Hause und denke mir noch tagelang: ‚Oh Gott die arme Frau.' So, weil das keinem was bringen würde" (E2).

In order to protect her own mental well-being, expert 01 rejected a lot of work such as home visits. She emphasized the importance of a balanced inner setting to manage a demarcation. To achieve this, she conducted a ritual after every consultation hour to calm down.

„Da muss ich erst mal gucken, dass ich nicht zu schnell weitermache. Weil ansonsten hab ich so ein ganz anderes Tempo dann und merke auch so eine innere Unruhe. Und da im besten Fall schon so ein Ritual zu finden, so das ist jetzt geschafft, jetzt geht's in einem anderen Modus weiter" (E1).

On the other hand, it was essential to empathize fully with the individual situation during the consultation hours. Expert 09 tried to stay focused on the woman during consultation and that she could achieve something for her here and now. In particular, she looked for specific resources in the woman's close surroundings.

Further, the midwives used various strategies to deal with the individual stories of the traumatized women. One primary strategy was to be patient and to put no pressure on the women. It took time to build up a trusting mutual relationship:

„…es ist viel zeitaufwändiger mit denen überhaupt ins Gespräch zu kommen, überhaupt ein Vertrauen aufzubauen mit denen, weil sie glaube ich grundsätzlich da leiden, dass sie nicht sehr viele Bindungspersonen haben oder auch viele verloren haben und eben auch keine hier sind" (E6).

Especially with regard to partial genital mutilation and sexual violence, the midwives did not know how to address these kind of issues:

„Ich weiß von Genitalverstümmelung, ich weiß von Vergewaltigungen, aber es ist so, dass ich noch nicht eine Frau hatte, die von sich aus mit mir darüber gesprochen hätte. Also das sind Tabuthemen und du weißt dann davon und weißt aber nicht, wie du sie ansprechen sollst“ (E7).

In one case, which was particularly difficult to handle, one interviewee obtained support from a counselling centre for sexual violence. Also in the case of deportation into the countries of origin, it was hard for the midwives to cope with this situation. Expert 01 considered it important not to work exclusively in the refugee camp as a midwife. If she had the opportunity to see a healthy woman with an agile baby, she could recharge her energy to care about a traumatized woman with a dystrophy baby. Also providing a balance during leisure time was of major importance. The interviewees said that they recharged their energy by spending time with their family, friends and pets:

„Ich habe einen Hund. Also ich geh ganz viel Spazieren, in der Natur bin ich unterwegs. Das, denke ich ist eine gewisse Erdung, die mir einen Ausgleich bringt. Auch wirklich nicht am Schreibtisch zu sitzen oder jetzt was mit dem Kopf zu machen“ (E1).

In addition, membership in a sports club and choir could create an appropriate balance:

„Also für mich ist es tatsächlich ein Großteil Sport und Singen, also ich merke, ich bin halt im Chor und das ist ein großer Stressabbau sozusagen. Also sich selber was Gutes zu tun und sich selber vor allen Dingen zu spüren. Das heißt, in dem Moment, wo ich empathisch irgendwo mitschwing, brauche ich irgendwas, um wieder gut bei mir ankommen zu können“ (E9).

At the beginning of her job at the refugee camp, expert 01 had a phase where she was unsure whether she was able to deal with all the mental pressure, but now she has the feeling she can cope with it. For instance, if the women became aggressive during the distribution of charitable donations, she tried to remain calm:

„Und ich hab in dem Moment einfach eine gewisse Ruhe, dass ich mich da nicht persönlich gekränkt fühle oder auch so übergangen fühle, dass mir Dinge aus der Hand gerissen werden. Ich seh da einfach den Menschen, der wenig hat und kann damit ganz gut umgehen“ (E1).

5.4.2 Strategies language barriers

If no interpreters were available, an effective way was to use non-verbal communication. In the consultation hours of expert 05, 06, 07 and 08 there were hardly any interpreters available, so they were using many gestures and hand signs to communicate. They mentioned that it was crucial to smile at the women and to look into their eyes. For single words, the translation with electronic devices such as the smartphone worked. According to expert 07 if that did not work well, the midwives and women would laugh about it together.

Expert 06 and 10 used illustrating pictures and materials to visualize facts:

„Das heißt, wirklich anschaulich mit den Frauen zu arbeiten und beim Kochprojekt eben Trockenpflaumen, Pflaumensaft, Sauerkrautsaft, Leinensamen […] den Frauen hinzustellen und zu sagen: ‚Das, das, das, das, das könnt ihr alles tun, wenn ihr Probleme habt mit der Verdauung, probiert es, was euch schmeckt. Nicht jedem hilft jedes. Probiert durch.‘ Preise drauf geschrieben, drauf geschrieben, wo hab ich es besorgt…“ (E10).

However, sometimes, expert 06 also cancelled the consultations with individual women if there were no interpreters available, since she was worried that the women might misunderstand important information. Another strategy in case of no available interpreters was to learn the German language in group situations.

In addition, if there were translators available, the interviewees needed strategies to address many discrepancies since interpreters tended to convey their own contents. Expert 01 used short sentences so the translator would not confuse the meaning and add unnecessary information. The midwives tried to challenge the interpreters who appeared to be implementing their own personal ideas:

„…hab der Übersetzerin gesagt, die Frau soll sich doch bitte mal so eine App runterladen, eine ZyklusApp […] dann sieht sie auch, wann ihre fruchtbaren Tage sind und kann dementsprechend dann auch Sex haben und so und dann hat die Übersetzerin gesagt: ‚Hahahaha das macht sie sowieso nicht.‘ Und dann habe ich gesagt: ‚Sie muss es halt auch übersetzen. So nicht.‘ Ich hab das jetzt gesagt und dann muss sie das jetzt auch übersetzen“ (E2).

5.4.3 Strategies organizational challenges

In terms of strategies for coping with organizational challenges, it helped the midwives to keep an appointment calendar. In case of increased workload, expert 01 tried to rearrange dates. This meant she moved the weekly home visits and the parent’s breakfast up to every two weeks to provide a certain degree of relief. Another strategy regarding high workload was to distribute tasks within the team.

For instance, in the voluntary team of expert 02 and 04, one colleague conducted the statistics for a presentation and another one printed brochures. Expert 11 said she could deal well with the fact that there was no proper consultation room now since a new building with suitable facilities would be constructed soon. Sometimes, expert 08 organized a lot for the women, but they did not want that. In this case, she tried to pursue the personal objectives of the women instead of her own.

5.4.4 Strategies financial difficulties

Expert 05 reported that it was complicated to reorder equipment for the midwifery work since in the various institutions, different people were in charge and often no one felt responsible to fund additional material. Partially, she paid this money out of her own pocket.

5.4.5 Strategies cultural challenges

In order to deal with cultural characteristics, expert 10 emphasized the importance of being creative, flexible and curious about the foreign culture. The midwives thought that it was fundamental to respect the diversity:

„Aber das auch zu respektieren, dass sie da auch ihre eigene Art hat und das ist mit vielen Sachen so gewesen und da finde ich das anmaßend zu sagen, sie müssen das jetzt genauso machen wie hier, oder so. Weil da haben die in den Ländern auch schon immer ihre Kinder so großgezogen und die sind jetzt auch nicht unbedingt alle dadurch geschädigt worden oder so“ (E3).

If the women did not understand what expert 07 had in mind, she often asked the women how their mothers and grandmothers managed certain matters. Expert 08 tried to come together in conversation with the help of interpreters and did not try to force them to accept the European culture. Expert 09 highlighted the fact that she could only give recommendations and then allow the women to decide on their own. This cultural openness also applied for the different nutritional habits and transition from milk-only diet to solid food:

„Die kriegen sehr schnell süß und sehr schnell scharf und auch da breche ich keine Lanze für uns Europäer und sage: ‚So muss das gemacht werden, nicht?‘ Du musst halt irgendwie so ein bisschen kulturoffener werden, so und viele Hebammen neigen ja dazu, immer so deren Meinung, meine Meinung überzustülpen, auch bei den deutschen Frauen und das lernst du nochmal mehr, dass das eben nicht geht“ (E8).

Also in terms of the unequal division of rights between women and men, the interviewees stressed the significance of being culturally sensitive. However, sometimes it was important for the midwives to be consistent and self-confident towards the women's partners:

„…sie muss halt heimlich verhüten und sie braucht aber was, was sie jetzt mitnehmen kann, weil sie war jetzt ja beim Arzt. […] Sonst denken die, sie hätte hier irgendwas Geheimes gewollt. Also haben wir ihr Hustensaft mitgegeben, sie hatte tatsächlich auch ein bisschen Husten, aber zehn Minuten später standen halt trotzdem drei Männer vor uns und haben uns gefragt: ‚Was sie von uns wollte und was sie hier, so nicht?' Und ich glaube, da ist dann mein Standing einfach, da kann ich viel besser mich durchsetzen" (E2).

If the handling of the infant was performed very quickly, expert 11 checked whether it was part of a routine. When it occurred, she would not say anything, but if she observed that the woman was insecure, she showed her how she could carry the handling out in a secure manner. According to expert 11, this was often accepted by the women. In the event of leaving the baby alone with the midwife in the room of the consultation hours, expert 08 ran after the departing woman and stressed that it was only possible to examine the infant together or not at all.

Expert 10 sometimes wondered if she should change her clothing style, for instance if a dress showed too much décolleté. After a while, she gave up on that thought since she received no negative feedback about her choice of dress.

5.4.6 Strategies person-related difficulties

To prevent person-related difficulties, expert 10 introduced herself as a person and her function to every employee at the camp and walked from container to container to see the families. Expert 03 considered it important to have a regular exchange between social management, midwives and physicians.

5.4.7 Strategies professional difficulties

If the medical recommendations could not be implemented into practice due to financial barriers, expert 02 tried to search for an affordable alternative and had a look on-site for any available resources that the women could use in the camp.

5.4.8 Strategies physical challenges

The interviewees did not mention any particular strategies to handle physical challenges.

5.5 Resources of midwives in refugee camps

Various resources supported the midwifery work during the consultation hours.

5.5.1 Professional skills

One of the primary professional resources was previous working experience. Expert 01, 02, 05, 06, 09 and 11 could resort to many years of professional activity. Due to this fact, the midwives were flexible and could easily attune to the refugee women. They could provide helpful medical advice regarding pregnancy problems based on their broad experience. Expert 02 mentioned that she was more self-confident and able to assert herself especially in terms of the women's partners. Also because of long-term experience, expert 05 adhered to her personal limits since she noticed what happened if she did not keep them. Additionally, expert 01 had experience working as a nurse in a hospital and engaged in topics such as life and death at an early stage of her life. Expert 09 completed training as a German alternative practitioner.

Another professional resource is further educational training. Within their framework of the family midwifery training, expert 01, 03, 06, 07, 08 and 10 obtained a few modules with regard to circumstances of refugee women and trauma sensitive training. In addition, expert 06 completed a holistic education program about trauma sensitivity before she began work at the refugee camp. Expert 01 felt that the performance of her work was more structured since her recent training:

„…und dann hab ich vor vier Jahren die Familienhebammenausbildung gemacht und seitdem hab ich schon das Gefühl, da noch besser strukturiert arbeiten zu können in diesen besonderen Schwerpunkten. Da ist Flucht, traumasensibles Arbeiten ein Schwerpunkt, wir haben auch viele Gewaltsituationen“ (E1).

Methods such as the further training for acupuncture helped expert 01 to care adequately for the women. She called this ‘tools for hope‘.

5.5.2 Personal strengths and abilities

The personal strengths and abilities lay in social competencies such as empathy. Expert 11 respected the fact that the refugee women needed greater personal space than native ones. She provided immediate feedback when she saw that a particular arrangement worked well. In addition, expert 07 mentioned that she could adjust to the women's need within a short period. The women then viewed her as a friend instead of just medical personnel.

Expert 01, 02, 08 and 09 spent a prolonged time abroad. Thus, they had an experience of how it feels to be somewhere new and how to communicate using gestures and signs. Due to their international experience, the individual language abilities in English and partly Spanish were well developed which helped during the consultation hours. In addition, the private contact with non-German people helped expert 03 and 06 to gain insight into foreign cultures.

In addition, some midwives, being mothers themselves gave them an understanding of the women's requirements as expectant mothers:

„Ich bin selber Mutter, habe vier Kinder, war also auch viermal schwanger, ist eigentlich so, dass einem die Bedürfnisse in dieser Zeitspanne doch sehr präsent sind, in dem Moment, wo es so eine Spiegelung gibt, dass einfach so diese Erwartungen und Wünsche und Empfindungen schnell transportiert werden, ohne dass alles ausgesprochen wird. Hat den Vorteil, man kann sich viel nonverbal unterhalten“ (E9).

5.5.3 Human capabilities

With regard to human capabilities, the interviewees viewed their working team as part of a strong network as a major resource:

„Wir besprechen die Fälle tatsächlich im Team. Also es gibt zur Supervision so was, das nennt sich kollegiale Beratung und da gibt’s die kleine, wo es nur von Kollegin zu Kollegin geht. Dann gibt’s so eine Dienstbesprechung, wo sich auch wirklich nur das Team, also jetzt mit der Babygruppe austauscht und ich glaube, so dieses verankert sein im Team ist eine wichtige Quelle“ (E9).

For one thing, the meetings, collegial consultation and supervision could be used for discussing difficult situations. In the team of expert 11 for instance, the midwives used a variety of different approaches and therefore could positively influence each other. Moreover, the colleagues had individual work, language and cultural experience from which the midwives could benefit.

In the voluntary team of expert 02 and 04, the work during the consultation hours was performed in tandem with gynaecologists so the midwives could profit from that. In addition, the midwives often worked in tandem with social education specialists who took care of matters regarding the German social system.

In some family teams, a psychologist was present who could take care of trauma processing. In case of an increased workload, tasks could be distributed within the members. For example some colleagues helped with holiday and illness cover. Expert 06 mentioned her dedicated employer who always tried to acquire financial funds if she needed it.

Furthermore, social managers, nurses, psychologists and child welfare officers were available as contact partners. Expert 07 reported that if she could not achieve something during the consultation hour for a woman who needed acute help, she could hand the case to the social management.

Interpreters could explain many cultural peculiarities since they were from the same country of origin as the refugee women. Often, the interpreters were earlier refugees themselves and had escaped to Germany, where they had resided for several years and could relate to the women's situations. Sometimes, the consultation hour had few appointments and the interpreter of expert 05 took the time to give some insight into her home country. The interpreters could be available in person, accessible via telephone or video chat. With the help of the interpreters, conversations between the midwife and the women were more profound and informative compared to non-verbal conversations.

Further, the security guards at the refugee camp often had a migration background and thus could be used for translation. In one of the camps, the consultation hours of the midwives and physicians took place at the same time and the security staff helped to organize the order and allocation of the patients. In addition, family members and friends were used for translation. Pre-schoolchildren and schoolchildren spoke very good German and could support their parents with their language abilities.

Another important human resource were the voluntary workers at the camps. Unpaid helpers that often descended from the same country of origin accompanied the women to appointments. Expert 01 appreciated the cooperation of the volunteers since they had various professional qualifications from which the refugee women could benefit. The voluntary team of expert 02 and 04 included receptionists, a licensed driver and an IT specialist besides the midwives and gynaecologists. The project was well positioned from a human resource perspective. Consequently, expert 02 only had to conduct a midwife consultation hour once in a month.

Lastly, the family and partners of the midwives represented an essential resource. Expert 02 and 03 talked a lot with their husbands about the work, especially if a woman told a mentally stressing story.

5.5.4 Appreciation of work

Overall, the feedback of the refugee women to the midwives was positive. Even under the present circumstances, the women were grateful that someone was there for them:

„Ich habe eher das Gefühl, dass die Frauen, wenn sie mich länger kennen, auch in ihrer großen Not und ihren eingeschränkten Möglichkeiten unglaublich dankbar dafür sind, dass da jemand ist, der ihnen zuhört und das alles so akzeptiert, wie es so ist“ (E7).

Expert 05 and 07 reported that families were transferred to other camps and nevertheless still sought contact with the midwives. They visited them again just to have a conversation:

„Ein Pärchen mit ihrem Baby, die sind sogar noch von dieser anderen Unterkunft extra nochmal angereist und zu mir gekommen. Das fand ich auch total nett, weil sie immer noch so ein paar Fragen hatten und eben den Kontakt zu mir gut fanden“ (E5).

5.5.5 Cultural resources

According to expert 05 and 11, the refugee women were very self-confident in terms of the handling of their children and took good care of them:

„Das macht auch total Spaß, wie kompetent die Frauen überhaupt mit Kindern sind, weil sie einfach viel Kontakt zu kleinen Kindern hatten, wahrscheinlich in ihrer Jugend oder in den Ländern das ein anderer Kontakt ist. Viele sind wirklich sehr viel kompetenter als die meisten Frauen, die man hier in Deutschland sonst betreut“ (E5).

In addition, the refugee women had a greater naturalness to breastfeed compared to native women. Referring to the interviewees, this was often recommended by their mothers and grandmothers.

Another cultural feature was the characteristic food culture of the countries of origin, which was used as a resource in the form of joint cooking events:

„…diese Montagskochgruppe, die ist also unglaublich vital und redselig und lustig und laut. Das haben wir eben festgestellt, übers Kochen kriegst du sie alle irgendwie an einen Tisch […] und da kommen sie auch untereinander in Kontakt und fragen einander: ‚Und wie alt ist dein Kind? Und wie heißt es denn? Und was heißt denn der Name?‘ Und die eine hat ein Kopftuch und die andere hat ein Kreuz und das würde in der Unterkunft nie funktionieren, wenn man sie da nicht rausholt und in einem anderen Kontext zusammenbringt und das finde ich total schön, dass zu sehen, dass das klappen kann“ (E7).

5.5.6 Financial resources

A major source of financial funds for the midwifery work were the organizations who managed the refugee camps and associations who employed the midwives. Expert 06 could draw on a monthly budget from which materials such as diaper bags, nursing pads, prescription medicine and disinfectants could be financed. Expert 09 emphasized the importance of building a strong network in order to know the sources for funding. Additionally, further education for the midwives was paid for by the organizations who employed them.

Furthermore, donations were a financial source. Due to an anonymous contribution, the automobile for the voluntary team of expert 02 and 04 was purchased. It was well equipped with an ultrasound scanner, CTG-device to monitor the heart rate of the foetus and a notebook. In addition, the team were given smartphones to contact the interpreters during the consultation hours via telephone.

5.5.7 Structural capabilities

In terms of structural capabilities, a roster in the teams helped to organize the shifts and the times for the consultation hours and further services for the women. The interviewees reported that a room at the camp was provided to have an appropriate work place. Within the team of expert 02 and 04, the nearby church could be used as a waiting area.

5.6 Reasons for working with refugee women

The motivation for working with refugee women was divided between personal motives and structural causes.

5.6.1 Personal motives

It was crucial for expert 01 not to allow any distinctions between nationalities regarding medical support. She lived in Northern Africa for a few years and participated in demonstrations to set a sign for diversity in Germany. She found it quite normal to look after all women in her district:

„Also unsere Projekte werden immer gerne beworben mit ‚guter Start für Hamburgs Kinder'. Und ich finde, das sind alles Hamburgs Kinder, die hier leben. Und dementsprechend bin ich immer schon dafür gewesen, keine Unterschiede zu machen" (E1).

Moreover, the destiny of the refugee women deeply affected their thoughts and activities. Expert 02 wanted to provide professional support and attended a volunteer recruitment day in order to find an appropriate volunteer working group:

„Da war so eine Versammlung, wo halt die einzelnen AGs vorgestellt worden sind und dann saß ich da und war schon irgendwie so ganz berührt von dieser ganzen Stimmung, weil irgendwie viel mehr Leute gekommen waren, als sie gedacht hatten und alles war irgendwie so voll und es war Sommer und heiß und irgendwie saßen da alle rum und waren auch alle so ein bisschen hippelig“ (E2).

Expert 05 and 06 were mentally strained by the refugee crisis and followed the news on the television. They wanted to actively help the affected women:

„Und dann gingen diese Bilder aber über Wochen und Monate und das wurde irgendwie auch nicht besser und dann habe ich irgendwann mir gedacht, also entweder mache ich den Fernseher einfach nicht mehr an oder ich lese auch keine Zeitung mehr oder ich mache irgendwas. Also es gab irgendwie nur diese beiden Varianten. Und dann habe ich tatsächlich diese Stelle auch gefunden, wo ich jetzt angestellt bin, ich war da noch nicht angestellt, die, meine Stelle ist speziell geschaffen worden für die Arbeit mit Geflüchteten“ (E6).

Further, the awareness of the refugee situation by foreign friends and relatives also played a role for personal motives. Expert 05 had a friend from Nigeria she had known for 30 years and reported that this encouraged her decision to work with refugee women.

Sometimes, the acceptance of a job offer in a refugee camp was connected to doubt. Expert 07 had concerns regarding the many young men travelling to Germany on their own. Nevertheless, her concerns had not been confirmed:

„…ich hatte so ein bisschen Sorge vor, muss ich ganz ehrlich sagen, den ganz vielen alleinreisenden jungen Männern und ich dann alleine da in so einem nicht abschließbaren Raum frei zugänglich und da hatte ich Respekt vor und ich habe dann, seit ich mit der Arbeit angefangen habe, nicht einmal ein ungutes Gefühl in irgendeiner Art und Weise gehabt und freue mich immer total auf den Donnerstag“ (E7).

Nevertheless, expert 08 viewed the midwifery activity at the camp as a job rather than a passion and would not perform it if it did not fit in with her duties as a family midwife. She acknowledged that she could not endure to work solely with refugees and could not imagine helping them voluntarily. Expert 10 started her work because it suited her private life situation and out of curiosity. Expert 11 found it important that all refugee women were medically well cared for and that they had the possibility to ask qualified personnel for advice.

5.6.2 Structural causes

Every family team was assigned to a district in Hamburg, which was defined per postal code. If the refugee camp was located within this area, the midwives were responsible for it. Expert 01, 03, 07, 08, 09 and 11 reported that they were directly requested by various organizations to conduct midwifery consultation in the refugee camps.

6. Discussion

In order to ensure a high quality level, this master thesis is based on the three central scientific criteria for qualitative research. The first includes transparency of the methodology and results. For this purpose, the whole process was described in detail that covers the research question, justification of chosen procedures and actual implementation. Secondly, the inter-subjectivity needs to be guaranteed. This involves a plausible demonstration of the analysis of the data. Lastly, the scientific scope in a qualitative inquiry is substantial. Due to a small number of cases, it must be explained that it is not possible nor was it intended to have the generalization of results (Flick 2010, Steinke 2010).

Therefore, the discussion part critically reflects the methodological approach, sampling and analyzing process of the present thesis. Moreover, the results are evaluated with regard to the research questions. Additionally, the strengths and limitations of the theoretical framework are presented.

6.1 Methodological discussion

The choice of the qualitative approach refers to a constructivist worldview. This includes the development of subjective meanings based on experiences. Therefore, it is an adequate choice in order to examine the complexity of views among the interviewees regarding challenges, coping strategies with the related resources and reasons for working with refugee and asylum-seeking women. Further, the present concept allows for relying on the midwives personal statements as best as possible. In addition, the semi-structured interview guideline facilitates the aim to elicit subjective meanings and views from the midwives. Moreover, the coding guideline enhances the transparency with which statements are allocated to the single categories. Accordingly, it is possible to gain a deep understanding about midwifery in refugee camps in Hamburg (Creswell 2014, p. 239).

Another strength of this thesis is the sampling method. The participants were recruited via purposeful sampling which supports the gathering of information-rich cases (Creswell 2014, p. 23). Thereby, different forms of access strategies to the target group were used. Partly, the interviewees were acquired by the first chairwoman of the Association for Midwifes in Hamburg and the first supervisor of the present thesis. In addition, a personal visit to public institutions and midwife practices to ask for potential interview partners and the distribution of flyers helped to gain further participants. In addition, the obtained interviewees were requested to locate further informants, which proved to be an effective way of getting more participants for the interviews.

Subsequently, the sample differs in various characteristics. This gave a varied and more enhanced representation. The interviewed midwives work in different urban districts in Hamburg and the age includes a wide range that varies from 24 to 55 years. In addition, the midwifery work, either short-term or long-term, is represented in both kinds of refugee camps. The frequency and duration of the consultation hours is equal. They usually take place once a week and last for two hours. Therefore, the statements of the interviewees are comparable. Furthermore, the data is collected in a natural setting to prevent the influence of a contrived situation. For this purpose, the setting is chosen by the midwives (Creswell 2014, p. 234). Moreover, the triangulation of data is an essential qualitative criterion regarding internal validity. This includes the collection of data from multiple sources. Therefore, memos and a research diary were written apart from conducting the expert interviews (Creswell 2014, p. 259).

In terms of the analyzing process, the interviews are transcribed according to Mayring (2014). The inductive approach regarding the paraphrasing facilitated the generation of meaning from data collection in the field. This includes the summarizing of the statements into increasingly abstract units and is therefore an appropriate approach to explore subjective meanings in a novel field of study (Creswell 2014, p. 234). Before the analysis process, the category system and a coding guideline were developed which enhances the transparency of the research.

Using the software MAXQDA for the analysis allows the realization of the intercoder agreement. This includes the repetition of the allocation process from paraphrases to the category system with three relevant interviews (interview 01, 02 and 06) by another researcher without seeing how the other person has coded. The conduction of the intercoder agreement enhances the objectivity and reliability of the results. In the present thesis, 83.3 % are achieved for interview 01, 75.4 % for interview 02 and 81.3 % for interview 06 (MAXQDA 2017, p. 1).

The issue of data protection of the participants is addressed within an informed consent, which is voluntarily signed by the interviewees. That implies the possibility for them to withdraw from the participation at any time during the interview without any consequences. In addition, the midwives are informed about the purpose of the research before the interview started. Individual data are anonymized and safely stored. Moreover, the conduction of the data collection is approved by the Competence Center of the Hamburg University of Applied Sciences. Hence, another essential quality criterion of the research is met (Flick 2013, p. 15).

According to Creswell (2014), the inquirer of a qualitative study needs to reflect how their own background, culture and experiences influence the direction of the study (Creswell 2014, p. 235). The data collection and analysis are shaped by different influencing factors. Due to training as a physiotherapist, the author has empathy with the midwives. This gives an advantage in conducting the interviews with the midwives; as medical personnel there is a shared experience. The training includes modules in gynaecology and therefore the researcher knows specialist terms that occur during the conversations. In addition, the author is of German origin and therefore familiar with the German culture of the interviewees. This fact might enhance the objectivity with regard to the refugee women compared to an author who comes from the same country of origin. Since the researcher is a woman, she might be more affected when the midwives report gender-specific traumas of the refugee and asylum-seeking women compared to a male researcher. Furthermore, the interviewees are mostly older or about the same age as the inquirer.

Nevertheless, the methodology of this research is subject to some limitations. To begin with, some characteristics of the sample are homogeneous, which challenges the representation of the target group. This applies to the fact that primarily family midwives, but also two self-employed and one attending midwife are represented. Another uniform feature is the German nationality of the interviewees that might have influenced the statements during the data collection process. A midwife with an immigration background might have a more in-depth understanding of some aspects of the refugee's situation such as the restrictions in daily life through language barriers. In addition, the number of women attending the consultation hours varies within the camps.

Another limitation is the fact that the text is written in English whereas the interviews are conducted in the native language of the German midwives. This includes the possibility of some contents getting lost in translation since the composition of the full text derives from the transcripts and paraphrases. In order to minimize this effect, the direct quotations are delivered in the original language.

6.2 Discussion of the results

According to the main research question, the primary aim of the thesis is to investigate which occupational stressors and coping strategies occur among midwives in refugee camps in Hamburg. The interviewees viewed the circumstances of the refugee and asylum-seeking women as one of the primary challenges of the midwifery work. On the one hand, the women have to deal with their experiences before they arrive in Germany. That depends on the situation in the country of origin and the escape circumstances. This includes physical and psychological violence in terms of rape, torture and partial genital mutilation. On the other hand, they have to adjust to the current circumstances in the German camp including cramped and noisy living conditions and uniform canteen food. Particularly dramatic under the given circumstances is the uncertainty regarding the future. This could include the forced relocation into other camps and deportations into the home countries. Expert 09 argued that these circumstances exacerbate the traumatization. The period from the arrival in Germany until the first opportunity to obtain their own living space including an available residence permit and registration at the job center takes two years. Hence, there is a great urgency to accelerate the administrative processes.

Some of the occupational stressors had to do with the diversity of the refugee women. Especially with regard to educational inequalities, expert 08 questioned what she could assume and she claimed that women with a university education have an equal relationship to their husbands compared to less educated ones. For instance, the women do not request to participate in the German language course. Consequently, the husbands speak the native language better and their wives hide behind them.

With regard to the mental stressors, the insufficient period for the midwifery consultation was of major importance. Expert 11 argued that in-depth counseling is only possible with enough temporal resources. Therefore, only an emergency consultation is performed, which leads to superficial analysis of the medical history. This is a severely questionable fact due to the high responsibility of the midwives. In order to address the mental stressors, the midwives applied different coping strategies. One primary strategy was demarcation and adherence to a professional attitude, but it was important to empathize fully with the women during the consultation hours at the same time. This was also essential in terms of trust building with the traumatized women. Moreover, this is precisely where the difficulty lies: finding a balance between intimacy and demarcation to protect the personal mental well-being.

The reduced medical care lead also to professional stressors since a holistic treatment is not possible. Thus, there is a high risk to overlook some serious medical conditions. Further, linguistic stressors due to the lack of interpreters cause the shallow treatment. Especially, the fact that female interpreters were missing prevents an in-depth counseling since the women do not want to talk about gynaecological problems with a man. In case of missing interpreters, some interviewees applied a problem-focused coping strategy in using nonverbal communication and illustrating pictures. However, expert 06 reported that she would prefer to cancel the counseling, because of the risk of misunderstandings. This corresponds to emotion-focused coping strategies including avoidance behavior (German Federal Institute for Occupational Safety and Health 2012, p. 16). Additionally, the interpreters spoke in long monologues even if the midwives said only one sentence, because they were incorporating their own ideas. This causes further use of temporal resources. Nevertheless, the midwives found it hard to discuss this matter with them since the interpreters have no bad intentions. The interpreters rather see themselves as a reference person with the same descending background.

An important organizational challenge was the medical appointment allocation. The interviewees found it difficult to organize a date with the gynaecologist and paediatrician practices. For one thing, this might be due to the high workload of the physicians, but expert 07 argued that the medical personnel hesitated with the appointment allocation because of the language barrier and the related higher effort. Secondly, expert 07 reported that the refugee women often do not keep appointments. According to the interviewee, one reason could be a different cultural understanding, but a large number of appointments at different authorities and offices is also a possible explanation.

A major cause of financial stress was the project status of the midwifery work. The carriers and employees justified this decision by stating that they do not know to what extent the midwives work will be required in subsequent years. This means that the whole yearly budget is planned in advance for that year. This is precarious if the midwives need additional equipment and material during the present year. Also, a short-term contract leads to financial uncertainty of the interviewees. The scarce financial resources lead to emotion-focused coping strategies of the midwives. Expert 05 paid money out of her own pocket if the funds were insufficient.

For the most part, the coping behavior of the interviewees can be assigned to problem-focused strategies since it aims at finding a suitable solution for the problems rather than concentrating on the reduction of the burden through resistance, ignorance or search for emotional support (German Federal Institute for Occupational Safety and Health 2012, p. 16).

Moreover, the coping strategies are strongly linked with the resources. The midwives have access to a large range of capabilities. Their professional skills and personal strengths are considered crucial in order to deal with the stressors at work. With the help of long-term working experience and further training, the interviewees can adequately care for the women. Also related to this is the fact that empathy is viewed as an important social competency. Regarding human resources, other persons such as the social management staff, the head of the refugee camp and the interpreters can be a resource if they contribute and support a successful counseling of the refugee women. In this context, the team of midwives was regarded as indispensable in terms of useful advice and assistance. However, other staff can sometimes represent a barrier. This mainly depends on the work context, each camp is slightly different and the experiences vary widely. In addition, the interviewees outlined their reasons for working with refugee women. The personal motives strongly diverged. Firstly, the reasons are influenced by compassion for the women's destiny. Further, having international experiences in terms of spending time abroad or having foreign relatives and friends seems to be an important motive. Secondly, some midwives viewed the work with refugee women more as a job than a passion.

The results of the present thesis are partly consistent with the findings from previous research. According to the study on female refugees by Schouler-Ocak et al. 2017, employees who were directly engaged in work with female refugees suffered from psychological stress caused by the traumatic experiences despite professional training and supervision. The authors of the study report that employees from the same country of origin were more affected than German staff. Schouler-Ocak et al. also investigated cramped living conditions of the refugee families and the unhygienic conditions. In addition, language barriers including the lack of female interpreters and the urgent need for translators especially for rare languages such as Somali and Tigrinya were identified (Schouler-Ocak et al. 2017, p. 48).

Nevertheless, the results of the master thesis have some limitations. The work in the refugee camps represents only a small part of the midwives scope. Thus, the statements might have been influenced by impressions from various other responsibilities. Furthermore, the statements of the interviewees regarding challenges, coping strategies, resources and personal motives partly diverge. In order to enhance transparency regarding which statement is applicable for the individual interviewee, they are always referred to with their anonymity designation.

Lastly, the scientific scope in a qualitative inquiry needs to be narrowed. Due to a small sample of interviewees from Hamburg, the generalization of results is limited. Consequently, no universal statements can be derived for other districts of Germany (Flick 2010, Steinke 2010).

6.3 Discussion of the theoretical framework

The transactional model of stress by Lazarus and Folkman (1984) provides the theoretical framework for the present thesis. The use of this model has several benefits. Depending on success or failure, a selection of coping strategies are acquired or reinforced. Beyond that, the success rate facilitates a dynamic adaptation to new situations. Strengthened by gained experience, it is possible that the midwives do not perceive a new situation as a challenge in the future. However, a situation that was successfully managed before can also turn into a threat in the case of insufficient resources or if no appropriate coping strategy is available. Thus, this process can be described as dynamic. Another advantage is the consideration of individual differences since the coping behavior with stressors can vary. It is therefore well suited to investigate stressors and individual coping strategies of midwives working in refugee camps (German Federal Institute for Occupational Safety and Health 2012, p. 16)

Apart from that, this theoretical framework has some weaknesses. This model does not take all of the stress-inducing conditions into account and presupposes a conscious assessment of the situation and resources, which is not always the case in order to trigger a stress situation (German Federal Institute for Occupational Safety and Health 2012, p. 16) In addition, the research sub-questions were strictly based on the theoretical framework. However, while developing the interview guideline and implementing it into practice, it was not possible always to adhere to the transactional model of stress.

7. Conclusion and future directions

In the following, the main findings are summarized and public health recommendations are presented. One of the major challenges is the diversity of the refugee women in consideration of traumatizing experiences in the country of origin and the educational background. Cramped living conditions and universal canteen food or rather shared kitchen and bathroom are standard. Forced relocation into other refugee camps entails the risk of retraumatization. Also an uncertain future regarding deportation into the country of origin, family reunification, the move into their own flat and transfer from social welfare office to job center characterize the circumstances of the refugee and asylum-seeking women.

Psychological strain of the midwives is caused by insufficient temporal capacities, which leads to superficial counseling of the traumatized women. Sometimes, the interviewees are frustrated if the women do not accept the offered support. Primary coping strategies include talking with members of the team, containing their emotions until after work hours as well as adherence to professional attitudes. At the same time, they try not to put the women under any pressure. In addition, the interviewees try to reject a lot of work and spend time with family and friends to protect their own mental well-being. Doing sports and music is another strategy.

Further, there is a lack of interpreters, especially for rare languages such as Somali and Tigrinya. Thus, no detailed medical history and feedback from the women to the midwives regarding implementation of recommendations into practice is possible. Particularly the lack of female interpreters leads to challenges since women do not want to talk with men about gynaecological problems. Another provocation is that interpreters include their own ideas and do not translate the original text of the midwives. In this case, the midwives selectively talk with them or speak in short sentences to make sure the original context is being transferred. In addition, documents such as the birth certificate are often only available in German. Illiteracy is more common than expected, too. A major strategy for the lack of interpreters is using non-verbal communication, translation with the smartphone and illustrating pictures. Some interviewees even cancel the consultation.

Another challenge is the medical appointment allocation especially for paediatricians, gynaecologists, physiotherapists and occupational therapists. The perception of appointments especially outside the refugee camp requires guidance pilots. During the consultation hours, the interviewees have to perform other tasks such as distribution of donations. Additionally, there are bureaucratic obstacles if women do not have any health insurance coverage. Further, the release from medical confidentiality is difficult to obtain. In order to organize the working schedule, interviewees use an appointment calendar, rearrange dates in case of high workload, and distribute tasks within the team.

Due to the project status for one year, the financial funds are scarce. Contraceptive devices are not financed by health insurance funds nor social welfare office and depend on charitable donations. One coping strategy is to pay money out of their own pocket.

Regarding cultural features, women have a different sense of shame towards physiological medical examinations and other requirements in terms of the medical treatment. Additionally, the nutrition and handling of the infants is diverse. Another cultural challenge are the unequal rights of women and men. Some women suffer from partial genital mutilation. To address these issues, the midwives try to respect differences and do not force the women to accept the European culture. Nevertheless, they are also acting self-confidently with regard to the women's partners. Other person-related stressors include a lack of holiday and illness cover and the diverse objectives of management staff and midwives, which can be caused by insufficient communication. Additionally, more trauma therapists and volunteers are required. Midwives prevent challenges from occurring by introducing themselves at the camp and engaging in regular exchange.

Conducting the counseling in a short amount of time leads to great responsibility. This is a major professional challenge with regard to not overlooking any serious conditions. The counseling hours are low-threshold offerings and the interviewees have no laboratory facilities available. Medical recommendations cannot always be implemented into practice due to structural and financial barriers of the women. To cope with this fact, the midwives search for affordable alternatives and see what the women can realize in the camp. Due to lack of equipment, the interviewees have to adopt forced postures and carry large bags with materials. In addition, the rearrangement of the room for the consultation hour leads to physical strains.

The work of the midwives is supported by various resources. Long-term working experience and additional professional training as well as social competencies and being a mother themselves facilitate coping with occupational stressors. Also having spent prolonged time abroad is regarded as important. Moreover, the team as part of a strong network is viewed as a major human capability. Interpreters and security guards can provide insights into cultural peculiarities due to their migration background. In addition, the schoolchildren of the refugee women speak good German. Family members of the midwives give emotional support. Furthermore, the gratefulness by the women and their competencies regarding the handling of the infant as well as their food culture is an essential resource. In terms of financial issues, funds are provided through carriers, associations and charitable donations. In addition, a room for the consultation hours is supplied.

Overall, there are different personal motives to engage in work with refugee women. Midwives stated that they were very aware not to discriminate between nationalities regarding medical care. They are affected by the future destiny of refugee and asylum-seeking women. Some increased their awareness of the refugee situation by engaging in conversations with foreign friends and relatives. In turn, other midwives view the work at the camp as part of their job as family midwives or started the job out of curiosity. Structural causes include the assignment as family midwives to defined districts in Hamburg and the direct request by a carrier to conduct consultation hours.

With regard to future directions, a major necessity is the extension of temporal capacities for midwifery care in the refugee camps in Hamburg. The insufficient time, lack of interpreters and limited opportunities for the women in the camp to implement medical recommendations into practice lead to an emergency counseling rather than medical treatment. This is associated with the urge to provide an accelerated procedure for the women to obtain their own living space including the transfer from the social welfare office to the job center. In addition, documents such as the birth certificate need to be translated into the women's native languages and the release from medical confidentiality needs to be provided in a different manner to enhance the exchange between midwives, social management and physicians. Moreover, a data collection of people and institutions that are engaged with work in refugee camps is necessary. A strong network is regarded as important to know for instance which interpreters can be called and where to get financial funds.

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Appendix A: Interview guideline

Hochschule für Angewandte Wissenschaften Hamburg
Hamburg University of Applied Sciences

Leitfaden zur Erhebung der berufsbedingten Stressoren und Bewältigungsstrategien von Hebammen in Hamburger Fluchtunterkünften

Vor Beginn unseres Gespräches, möchte ich mich Ihnen kurz vorstellen. Ich heiße Luise Richter und bin Studentin im Fach Gesundheitswissenschaften an der Hochschule in Hamburg (HAW).

In meiner Abschlussarbeit möchte ich herausfinden, welche berufsbedingten Herausforderungen bei der Hebammenarbeit in Fluchtunterkünften auftreten und welche Ressourcen Ihnen dabei zur Verfügung stehen. Auch was Ihnen hilft, mit den Herausforderungen umzugehen, steht im Mittelpunkt.

Am Anfang werde ich Ihnen ein paar allgemeine Fragen zu Ihrer Person stellen und danach ausführlicher auf Ihre persönliche Situation als Hebamme in einer Fluchtunterkunft eingehen. Ich freue mich sehr, wenn Sie möglichst offen von Ihren individuellen Erfahrungen und persönlichen Sichtweisen berichten.

Ich möchte Sie auch darauf hinweisen, dass das Interview mit Ihrem Einverständnis mit einem Aufnahmegerät aufgezeichnet wird, um den Gesprächsverlauf anschließend nachvollziehen zu können. Ihre Daten werden selbstverständlich vertraulich behandelt, die Aussagen werden anonymisiert und nach der Auswertung werden die Aufnahmen gelöscht. Sie haben das Recht, das Interview zu jeder Zeit abzubrechen.

Haben Sie vor dem Interview noch Fragen an mich?

Allgemeine Angaben

Vor-und Nachname:

Geburtsdatum:

Staatsangehörigkeit:

Hauptberuf (Familien-oder Beleghebamme):

Ich möchte gerne mehr darüber erfahren, wie die Arbeit als Hebamme mit den geflüchteten Frauen aussieht. Bitte erzählen Sie mir von Ihrer Tätigkeit.

…In welchem Stadtteil arbeiten Sie?

…Zentrale Erstaufnahmeeinrichtung oder Folgeunterkunft?

…Wie lange üben Sie die Tätigkeit in der Fluchtunterkunft schon aus?

…Wie oft gehen Sie in die Unterkunft?

…Wie viele Flüchtlingsfrauen betreuen Sie zurzeit?

…Haben Sie eine Fortbildung für die Tätigkeit in der Fluchtunterkunft absolviert (traumasensible Ausbildung etc.)?

Berichten Sie mir bitte von eventuellen Herausforderungen, welche während Ihrer Arbeit als Hebamme in der Fluchtunterkunft auftreten.

…fachliche Herausforderungen

...persönliche Herausforderungen (körperlich, psychisch)

…personelle Herausforderungen (z.B. Personalmangel)

…finanzielle Herausforderungen

…organisatorische Herausforderungen

Weiterhin interessiert mich besonders, wie Sie mit diesen Herausforderungen umgehen.

…welche persönlichen Vorgehensweisen nutzen Sie, um mit schwierigen Situationen als Hebamme in der Fluchtunterkunft zurecht zu kommen?

…haben Sie das Gefühl, die Herausforderungen bewältigen zu können?

Welche Ressourcen stehen Ihnen zur Verfügung?

…auf welche fachlichen und persönlichen Fähigkeiten und Stärken können Sie zurückgreifen?

…Sind personelle Ressourcen verfügbar?

…Sind finanzielle Ressourcen vorhanden?

…strukturelle Ressourcen (z.B. flexible Arbeitszeiten)?

Warum haben Sie sich entschieden, die Tätigkeit in der Fluchtunterkunft aufzunehmen?

…Was waren Ihre Beweggründe oder Ihre Motivation?

Was wäre Ihnen in diesem Zusammenhang noch wichtig, zu sagen? Gibt es etwas zu ergänzen?

Vielen Dank für Ihre Teilnahme!

Appendix B: Declaration of Confidentiality

Hochschule für Angewandte Wissenschaften Hamburg

Department Life Sciences

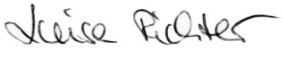
Projekt: “Occupational Stressors and Coping Strategies among Midwives working in Refugee Camps in Hamburg. A Qualitative Study“

Erklärung zur Schweigepflicht und zum Datenschutz

Ich bin darüber aufgeklärt worden, dass ich über alle Daten und Informationen, die mir im Rahmen meiner Mitarbeit beim Projekt „Occupational Stressors and Coping Strategies among Midwives working in Refugee Camps in Hamburg. A Qualitative Study“ über einzelne Studienteilnehmer/innen bzw. deren Familie und Lebenssituation zugänglich werden, zur Verschwiegenheit verpflichtet bin. Diese Daten und Informationen dürfen nur direkten Projekt-Mitarbeitern der HAW zugänglich gemacht werden. Insbesondere unterliegen alle personenbezogenen Daten dem Datenschutz und dürfen nicht an dritte Personen oder Institutionen weitergegeben werden [auch nicht an die beteiligten Schulen oder Lehrkräfte]. Ich darf auch keine eigenen Aufzeichnungen personenbezogener Daten über die Dauer meiner Projektmitarbeit hinaus aufbewahren. Sofern ich während meiner Projektmitarbeit vorübergehend personenbezogene Daten verarbeite und/oder aufbewahre, verpflichte ich mich, Missbrauch oder die unbefugte Weitergabe dieser Daten zu verhindern.

Name: Luise Richter

Hamburg, den 22.03.2017

Unterschrift: 

Appendix C: Flyer for recruiting interview partners

Interviews über berufsbedingte Stressoren der Hebammenarbeit in Hamburger Fluchtunterkünften

Liebe Hebammen,

ich bin Studentin an der Hochschule für Angewandte Wissenschaften in Hamburg und schreibe meine Masterarbeit über berufsbedingte Stressoren der Hebammenarbeit in Hamburger Fluchtunterkünften. Dabei liegt der Schwerpunkt darauf, wie Sie mit diesen Herausforderungen umgehen.

Dazu möchte ich gerne 30 bis 60-minütige Interviews mit Ihnen führen. In dem Gespräch geht es um Ihre Arbeit als Hebamme mit den Flüchtlingsfrauen. Die gewonnenen Informationen aus dem Interview werden selbstverständlich vertraulich behandelt und anonymisiert.

Diese Befragung wird im Auftrag des Hebammenverbandes Hamburg unter der Leitung von [redacted] und [redacted] von der Hochschule für Angewandte Wissenschaften in Hamburg durchgeführt.

Als kleines Dankeschön erhalten Sie Schokolade und Tee.

Ich freue mich sehr, wenn Sie bereit wären, an dem Interview teilzunehmen und somit das Forschungsprojekt voranbringen.

Herzliche Grüße

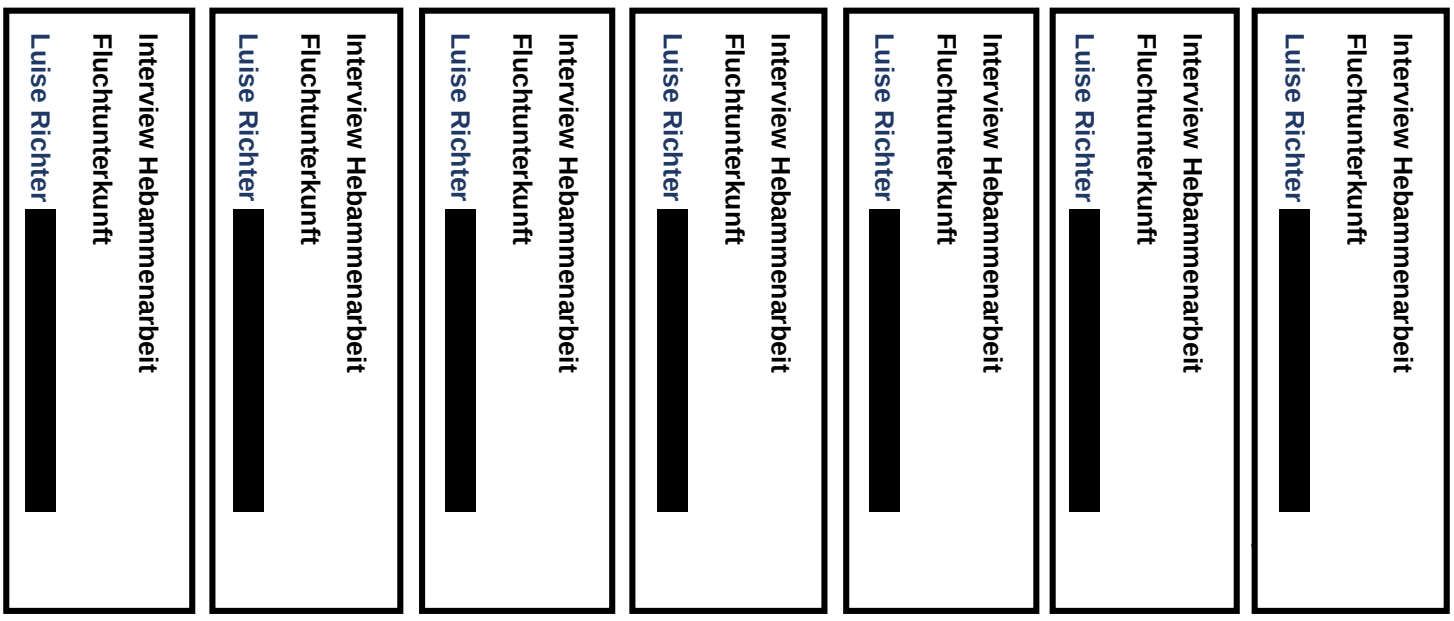
Luise Richter

Bitte kontaktieren Sie mich unter:

Luise Richter

E-Mail: [redacted]

Mobil: [redacted]



Appendix D: Ethical Approval

Hochschule für Angewandte Wissenschaften Hamburg
Hamburg University of Applied Sciences

CCG Ethikkommission

HAW Hamburg • CCG • Alexanderstraße 1 • D-20099 Hamburg

Frau Luise Richter

Cc Prof. Ensel, Prof. Färber

Datum

Ihr Antrag auf Stellungnahme zum Projekt

Occupational stressors and coping strategies among midwifes in refugee camps in Hamburg

Vom 24.03.2017

Sehr geehrte AntragstellerInnen,

Das o.g. Projekt wurde von der Ethikkommission des Competence Center Gesundheit CCG begutachtet.

Das Vorhaben wird als „ethisch unbedenklich" bewertet. Das Projekt kann, wie derzeit geplant, durchgeführt werden.

In der Anlage sind noch einige Hinweise beigefügt, um deren Beachtung gebeten wird. Das Projekt kann dann ohne erneute ethische Begutachtung beginnen.

Im Fall unvorhergesehener unerwünschter Ereignisse bittet die Kommission um unverzügliche Benachrichtigung.

Im Falle einer Veröffentlichung bittet die Ethikkommission, eine elektronische Kopie der Publikation unaufgefordert einzureichen (Gilt nicht für Abschluss- und Qualifikationsarbeiten).

Wir wünschen für das geplante Projekt viel Erfolg.

Mit freundlichen Grüßen

Joachim Westenhöfer

Prof. Dr. Joachim Westenhöfer
Vorsitzender der CCG-Ethikkommission

Ethikkommission

Hinweise und Anmerkungen:

- Ist die Bezeichnung Probanden für die teilnehmenden Hebammen angemessen? Es ist ja keine experimentelle Studie.
- Die Studie ist keine Sekundärforschung.
- In der Einwilligungserklärung wird von der Beschreibung der Studie in die Ich-Form gewechselt. Das ist zumindest stilistisch etwas verunsichernd.

Appendix E: Coding guideline

Category	Coding rule	Sample quotation
1 General facts about midwives in refugee camps	Implicit and explicit statements of the general characteristics of the interviewed midwives who work in refugee camps are coded	„Meine Aufgabe, mit der ich hier angestellt bin, ist Frauen in Flüchtlingsunterkünften im Stadtteil [zensiert] in der Schwangerschaft zu unterstützen und auch im ersten Lebensjahr in der Betreuung ihrer Kinder zu unterstützen in allen Bereichen, die da anfallen, sei es Erziehung, sei es Pflege, sei es Ernährung, Arztbesuche koordinieren, Bedarfe feststellen“ (E10).
2 Occupational stressors of midwifery in refugee camps	Implicit and explicit statements of stressors that the interviewees are confronted with are coded	„Wir sind einfach irgendwann drüber gestolpert und mussten uns dann selbst die Sachen nachfragen. Zum Beispiel die Mittagsessenszeit wurde verschoben direkt in unsere Babygruppenzeit. Das sieht man dann zufällig, wenn man durchläuft und denkt: Oh!“ (E09).
2.1 Circumstances and characteristics of refugee women	Implicit and explicit statements about the situation and the characteristics of refugee women are coded	„Die Frauen, die richtig aus Kriegsgebieten geflohen sind, also die auch teilweise schwerst traumatisiert sind, sind eher unbeholfen und ängstlich im Umgang mit ihren Kindern, finde ich, überfordert auch schnell. Manchmal sind sie auch körperlich selber eingeschränkt, die Mütter, nicht, es gibt auch Frauen mit Kriegsverletzungen, die selber kaum von der Matte hochkommen und runter und dann auch nicht so den Blick auf ihr Kind haben, weil sie mit sich am Kämpfen sind“ (E07).
2.2 Mental stressors	Negative statements about psychological stressors are coded	„Und packen dann zum Beispiel in diesen fünf Minuten, die wir für sie haben die krassesten Stories von ihrem Herkunftsland und von ihrer Flucht aus und du hast aber irgendwie keine Zeit, da jetzt darauf einzugehen, weil du irgendwie die anderen noch alle machen willst“ (E04).
2.3 Linguistic stressors	Implicit and explicit statements regarding language barriers and negative statements about interpreters are coded	„Dann kommt da jemand, aber es ist dann ein Mann, weil gerade keine Arabisch sprechende Frau da ist. Und dann guckt die Frau mich total entsetzt an und sagt, und schüttelt so mit dem Kopf und dann muss der Dolmetscher wieder gehen, weil sie über diesen

		Dolmetscher, der männlich ist, eben nicht über ihre Probleme sprechen möchte“ (E06).
2.4 Organizational stressors	Negative statements about organizational stressors are coded	„…die muss jetzt losgehen, direkt nach der Geburt und ihre Geburtsurkunde für das Kind beantragen und da zu den Standesämtern und zu allen möglichen Ämtern. Das ist natürlich total schwierig, diese Herausforderung dann in der Wochenbettzeit. Man muss es aber recht früh machen, weil davon abhängig ist, das eine Versicherung läuft, dass man zum Kinderarzt gehen kann, dass Gelder kommen. Die Bürokratie hängt wirklich an dieser Geburtsurkunde“ (E01).
2.5 Financial stressors	Negative statements in terms of financial funds are coded	„…und das ist dann auch 'ne Kapazitätenfrage, ob man aufsuchende Hilfe, Einzelfallbetreuung macht oder in einer Wohnunterkunft dann 'ne Sprechstunde anzubieten“ (E11).
2.6 Cultural stressors	Negative statements about cultural challenges are coded	„…wenn man in Afghanistan zum Arzt geht, man immer irgendwie was in die Hand gedrückt bekommt, ein Medikament mitbekommt mit dem man dann geht. Und dann haben sie auch den Anspruch und denken halt irgendwie deine Arbeit ist nicht richtig erfüllt, wenn du denen nichts mitgegeben hast“ (E02).
2.7 Person-related stressors	Negative statements regarding person-related stressors are coded	„Das ist irgendwie bisschen mau, es ist müde. Mir fehlen, es gab ja damals eine riesen Welle von Ehrenamtlichen. Es gab unglaublich viele Leute, die gesagt haben: Oh wir müssen helfen, wir müssen was tun. Es gab zu viele, dass man schon zurückgebremst wurde. Jetzt fragt man sich, wo sind die denn alle?“ (E07).
2.8 Professional stressors	Negative statements about professional stressors are coded	„Und ist auch bei vielen Sachen, das sind so Hausmittelchen, die kann sie gar nicht machen. Also weiß ich nicht, zum Beispiel eine Frau, die Wassereinlagerungen hat und ich würde der sagen: ‚Hier, geh mal zu Budni und kaufe dir basisches Badesalz und dann mach da mal ein Bad.‘ Das kann die halt

		nicht, weil die hat keine Badewanne. Die kann das auch, die kann auch kein Fußbad machen, weil sie nicht die Schüssel mit Wasser 500 Meter einmal quer durchs Camp tragen kann, um sich dann da hinzusetzen und ein Fußbad zu machen, so“ (E02).
2.9 Physical stressors	Negative statements about physical stressors are coded	„Also wir müssen da schon Tische hin- und herschleppen, um uns die Räumlichkeit einfach so dann zu gestalten, wie, wie wir sie brauchen“ (E11).
3 Coping strategies of midwives in refugee camps	Implicit and explicit statements about the applied coping strategies of the interviewees in refugee camps are coded	„…also eine eigene Strategie ist ein richtiges inneres Setting zu haben, sich abzugrenzen auf der einen Seite.“ (E01)
3.1 Strategies mental challenges	Implicit and explicit statements about strategies in order to deal with psychological challenges are coded	„Also für mich ist es tatsächlich ein Großteil Sport und Singen, also ich merke, ich bin halt im Chor und das ist ein großer Stressabbau sozusagen. Also sich selber was Gutes zu tun und sich selber vor allen Dingen zu spüren. Das heißt, in dem Moment, wo ich empathisch irgendwo mitschwing, brauche ich irgendwas, um wieder gut bei mir ankommen zu können.“ (E09)
3.2 Strategies language barriers	Implicit and explicit statements about strategies to cope with language barriers are coded	„…Also wenn ich das Gefühl habe, ich kann mit der Frau nicht wirklich kommunizieren oder weil kein Dolmetscher da ist, dann muss ich eigentlich teilweise abbrechen oder verkürzen, weil wir einfach nicht weiterkommen. Und bevor ich das Gefühl habe, dass die was falsch versteht oder missversteht, ist ja auch die Gefahr könnte auch groß sein, dann muss ich halt abwägen, ob ich es lieber ganz lasse.“ (E06)
3.3 Strategies organizational challenges	Implicit and explicit statements referring to organizational challenges are coded	“Dann sind das bestimmte Hausbesuche, bei denen ich weiß, ist eigentlich alles in Ordnung. Die lege ich dann auf vierzehntägig, statt auf

		wöchentlich, um da eine Entlastung zu bringen.” (E01)
3.4 Strategies financial difficulties	Implicit and explicit statements in order to deal with financial difficulties are coded	“…also ich mache das schon sehr bewusst und mache das so, dass ich mir sage: Ist das okay für mich, wenn ich diese Summe jetzt spende?” (E05).
3.5 Strategies cultural challenges	Implicit and explicit statements in terms of strategies to cope with different cultural features are coded	“Aber das auch zu respektieren, dass sie da auch ihre eigene Art hat und das ist mit vielen Sachen so gewesen und da finde ich das anmaßend zu sagen, sie müssen das jetzt genauso machen wie hier, oder so. Weil da haben die in den Ländern auch schon immer ihre Kinder so großgezogen und die sind jetzt auch nicht unbedingt alle dadurch geschädigt worden oder so” (E03).
3.6 Strategies person-related difficulties	Implicit and explicit statements about strategies to deal with person-related difficulties are coded	“…ich bin nicht gekommen, um deren Ziele und deren Wünsche zu ermöglichen, sondern ich bin nur dazu da, um die Frauen zu unterstützen und das kann auch sein, dass meine Ziele oder was ich für sinnvoll halte nicht mit denen übereinstimmen und dann müssen wir oft uns auseinandersetzen und Gespräche führen” (E06).
3.7 Strategies professional difficulties	Implicit and explicit statements referring to strategies to deal with professional difficulties are coded	“…da muss man halt so ein bisschen gucken: ‘Was gibt es denn noch für Alternativen, nicht? Oder auf was für Hausmittelchen kann man irgendwie sonst zurückgreifen oder was ist vielleicht günstig?’ Ja, so. Kann ich irgendwie eine günstigere Alternative finden?” (E02).
3.8 Strategies physical challenges	Implicit and explicit statements about strategies to cope with physical challenges are coded	The interviewees did not mention any particular strategies to handle physical challenges.
4 Resources of midwives in refugee camps	Implicit and explicit statements about various resources of midwives in refugee camps are coded	“Ich habe auch privat viel Kontakt zu nicht europäischen Menschen, also das finde ich jetzt nicht schwierig“ (E03).
4.1 Professional skills	Positive statements about professional experience and skills of the interviewees are coded	„…und dann hab ich vor vier Jahren die Familienhebammenausbildung gemacht und seitdem hab ich schon das Gefühl, da noch besser strukturiert arbeiten zu können in diesen besonderen Schwerpunkten. Da ist Flucht, traumasensibles Arbeiten ein

		Schwerpunkt, wir haben auch viele Gewaltsituationen“ (E01).
4.2 Personal strengths and abilities	Positive statements regarding personal strengths and abilities are coded	„Ich bin selber Mutter, habe vier Kinder, war also auch viermal schwanger, ist eigentlich so, dass einem die Bedürfnisse in dieser Zeitspanne doch sehr präsent sind, in dem Moment, wo es so eine Spiegelung gibt, dass einfach so diese Erwartungen und Wünsche und Empfindungen schnell transportiert werden, ohne das alles ausgesprochen wird. Hat den Vorteil, man kann sich viel nonverbal unterhalten“ (E09).
4.3 Human capabilities	Positive statements about human resources are coded	„Wir besprechen die Fälle tatsächlich im Team. Also es gibt zur Supervision so was, das nennt sich kollegiale Beratung und da gibt’s die kleine, wo es nur von Kollegin zu Kollegin geht. Dann gibt’s so eine Dienstbesprechung, wo sich auch wirklich nur das Team, also jetzt mit der Babygruppe austauscht und ich glaube, so dieses verankert sein im Team ist eine wichtige Quelle“ (E09).
4.4 Appreciation of work	Positive statements referring to the midwives work in the refugee camp are coded	„Ich habe eher das Gefühl, dass die Frauen, wenn sie mich länger kennen, auch in ihrer großen Not und ihren eingeschränkten Möglichkeiten unglaublich dankbar dafür sind, dass da jemand ist, der ihnen zuhört und das alles so akzeptiert, wie es so ist“ (E07).
4.5 Cultural resources	Positive statements about cultural characteristics are coded	„Das macht auch total Spaß, wie kompetent die Frauen überhaupt mit Kindern sind, weil sie einfach viel Kontakt zu kleinen Kindern hatten, wahrscheinlich in ihrer Jugend oder in den Ländern das ein anderer Kontakt ist. Viele sind wirklich sehr viel kompetenter als die meisten Frauen, die man hier in Deutschland sonst betreut“ (E05).
4.6 Financial resources	Positive statements regarding financial resources are coded	„Der Verein macht immer jedes Jahr 'n neuen Antrag für irgendwelche Gelder und die werden meistens halt bewilligt für die Flüchtlingsarbeit auch und im Kontext mit den Frühen Hilfen, so genau,

		daher kommt das Geld letztendlich“ (E11).
4.7 Structural capabilities	Positive statements about structural resources are coded	„Es ist so, das Mobil steht ja an der Kirche, also wir können die Kirche als Warteraum benutzen. Also wenn jetzt zum Beispiel auch mehrere Frauen kommen, dann können sie sich in die Kirche setzen und können warten, bis sie an der Reihe sind und Kinder, Angehörige können da auch warten“ (E02).
5 Reasons for working with refugee women	Implicit and explicit statements referring to the individual reasons of working in a refugee camp and structural causes are coded	„Also unsere Projekte werden immer gerne beworben mit "guter Start für Hamburgs Kinder". Und ich finde, das sind alles Hamburgs Kinder, die hier leben. Und demensprechend bin ich immer schon dafür gewesen, keine Unterschiede zu machen“ (E01).
5.1 Personal motives	Implicit and explicit statements about personal motivations to work with refugee women are coded	„Und dann gingen diese Bilder aber über Wochen und Monate und das wurde irgendwie auch nicht besser und dann habe ich irgendwann mir gedacht, also entweder mache ich den Fernseher einfach nicht mehr an oder ich lese auch keine Zeitung mehr oder ich mache irgendwas. Also es gab irgendwie nur diese beiden Varianten. Und dann habe ich tatsächlich diese Stelle auch gefunden, wo ich jetzt angestellt bin, ich war da noch nicht angestellt, die, meine Stelle ist speziell geschaffen worden für die Arbeit mit Geflüchteten“ (E06).
5.2 Structural causes	Implicit and explicit statements in terms of structural casus are coded	„Dafür haben wir uns nicht, also ich habe mich dafür nicht entschieden, ich muss, das ist mein Job“ (E08).

Appendix F: Transcripts and memos of the expert interviews

Please refer to the CD for transcripts and memos in the electronic version.

Statutory Declaration

I declare that I have developed and written the enclosed master thesis completely by myself and have not used sources or means without declaration in the text. Any thoughts from others or literal quotations are clearly marked. The master thesis was not used in the same or in a similar version to achieve an academic grading or is being published elsewhere.

Hamburg, September 19th 2017