Sexual and Reproductive Rights of Migrants and Refugees: Exploring the Needs and Challenges in the Cypriot Reality

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migrants and refugees
on sexual reproductive
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This research has been conducted within the framework of the **"M – Power Migrants and Refugees on Sexual Reproductive Health and Rights"** project, which aims to empower migrants and refugees aged 18-35, through the provision of information on sexual health and rights issues, and to strengthen and enhance the capacity of civil society organizations and health professionals in the public and private sector on the same issues. The project is coordinated by Cyprus Family Planning Association in partnership with Sex Og Politikk.

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1. Introduction

The aim of this project is to assess the needs of migrants and refugees[1] aged 18-39 and to empower them on Sexual Reproductive Health and Rights (SRHR) issues. It is being implemented within the framework of the "M – Power Migrants and Refugees on Sexual Reproductive Health and Rights" project, which aims to empower migrants and refugees aged 18-35, through the provision of information on sexual health and rights issues, and to strengthen and enhance the capacity of civil society organizations and health professionals in the public and private sector on the same issues.

The project is coordinated by Cyprus Family Planning Association in partnership with Sex Og Politikk, two lead organizations on SRHR issues in their countries, as well as non-governmental organizations (NGOs) specialising in migrant and refugee issues in Cyprus.

The project benefits from a grant under the Active Citizens Fund Cyprus programme, funded by Iceland, Liechtenstein and Norway, through the EEA and Norway Grants 2014-2021.

Civil society and health professionals play a crucial role in informing, serving and effectively and practically supporting the needs of persons with a migrant background, ensuring their sexual and reproductive rights. Based on the qualitative research model, an attempt is made to map the knowledge and needs of migrant and refugee women, health professionals and professionals in civil society organizations regarding SRHR. An understanding of the needs of all three groups will be obtained through the research process, in order to develop appropriate training materials and, subsequently, conduct training workshops addressed to the aforementioned population groups, and develop the first strategy on sexual and reproductive rights of migrants and refugees in Cyprus.

[1] For the purposes of the project, the term migrant refers to persons with a migrant background, who are vulnerable. It refers to non-European citizens, asylum seekers, persons under temporary protection status, undocumented migrants, who mainly come from African and Asian countries.

2. Theoretical background

Migrants' and refugees' social integration is a major challenge in the Cypriot reality, which raises a broad discussion about the adequacy and quality of public services. As far as patients' rights are concerned, equal health care without discrimination, the right to information, confidentiality and dignified treatment are envisaged by the Ministry of Health of the Republic of Cyprus, in accordance with the *Safeguarding and Protection of Patients' Rights Law of 2004 (1(I)/2005)*[2]. The right to health, and consequently sexual and reproductive health is a human right, which is guaranteed regardless of race, gender, social class, religion or political opinion, and protected by European and international Conventions. There are increasing needs relating to migrants' sexual and reproductive health throughout the EU (Janssens et al., 2005), which raises questions about the preparedness and adequacy of public structures.

Research data on the difficulties faced by migrants, and in particular women migrants[3], remain scarcely available; as such, it is not easy to grasp the needs and challenges they face (GLIMER Cyprus Policy, 2018). There is no data available on the sexual and reproductive health and needs of migrant and refugee women living in Cyprus concerning SRHR, as there is no equivalent data for any other population group living in Cyprus. Living conditions, previous experiences and limited medical screening puts this group at very serious risk of Sexually Transmitted Infections (STIs), hepatitis A and C, and HIV. According to the World Health Organization (WHO, 2011), the migrant population group faces an increased risk of STIs and especially HIV.

Migrant women tend to have limited access to contraception and family planning (Mladovsky, 2005). In Cyprus, most vulnerable groups - especially those with a migrant

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[2] Ministry of Health, Cyprus, Patients' rights
https://www.moh.gov.cy/moh/moh.nsf/All/0C87EC2F2C7E9132C2257D00002BDC3E?OpenDocument (in Greek)

[3] The needs of LGBTQI+ persons with a migrant background and minors are of particular importance and perhaps differentiated, but are not the main focus of this project.

background - have very limited access to sexual and reproductive health services and information. Asylum seekers appear to lack knowledge about the health system and SRHR services in the country they are relocating to (Norredam et al., 2006). Asylum seekers in Cyprus are confronted with even more limited access to health services, as they are not beneficiaries of the General Healthcare System (GHS).

As far as sexual and gender-based violence is concerned, migrant women appear to be particularly vulnerable, and survivors do not feel safe to report the abuse they have suffered, as policies to prevent violence and protect women are insufficient (Freedman, 2016). Similarly, in Cyprus, the specific needs of women survivors are not taken into account during reception procedures, future risks are not prevented and no support is provided to deal with such traumatic experiences (UNHCR, 2021). In this context, cultural and religious considerations should also be taken into account, especially in relation to underage marriages and female genital mutilation. According to EIGE (n.d.)[4], about 12-17% of girls in Cyprus are at risk of female genital mutilation (FGM); this applies to girls from countries where FGM is somehow enforced.

Moreover, there is no data available on the needs of health professionals and NGOs concerning the provision of sexual health services to migrants and refugees, a group of persons with increased needs due to migration conditions and highly traumatic experiences (gender-based violence, female genital mutilation, rape, trafficking and other forms of violence). The aim of the project is to demonstrate and interpret these needs, and to create appropriate tools to provide effective training to health professionals and NGOs on the needs of migrants and refugees.

There are few opportunities for training and education of health professionals on a rights-based approach in service provision and on issues that may be relevant to migrants and refugees, such as cultural differences and sexual violence. In addition, there are no protocols on issues such as family planning, abortion in public hospitals, rape, and no

[4] https://eige.europa.eu/gender-based-violence/female-genital-mutilation/risk-estimations?language_content_entity=en

guidelines or minimum quality standards for individual counselling have been adopted by the Ministry of Health. Education and training for professionals can serve as a basic platform for the dissemination of knowledge about human rights in health care.

The group of NGO professionals works very closely with migrants and refugees and is aware of their difficulties and needs. At the same time, they are aware of the fact that there is a lack of services and that they themselves lack the necessary knowledge about SRHR that would enable them to provide quality guidance. Lack of data on migrants' and refugees' SRHR needs has a restrictive effect for NGO professionals, and primarily for public agencies, as far as the design and support of reforms and policy changes are concerned.

The lack of data will be established through the assessment of the needs of migrants, refugees and NGOs on SRHR. At the same time, material will be developed to empower all three groups with knowledge corresponding to each group's needs and thus improve migrants' and refugees' access to quality services. This project will also strengthen the capacity of NGOs to support their needs.

3. Research methodology

3.1 Methodological considerations

For the needs of this project, data was collected through qualitative research methods, using semi-structured interviews as a tool. The aim was to examine the needs, knowledge and awareness with regard to the safeguarding and protection of migrants' and refugees' sexual and reproductive rights, the adequacy of information, and the socio-economic and cultural factors that may affect the safeguarding of their rights.

Based on a flexible research design, an attempt was made to understand and document the needs of migrants and refugees in relation to SRHR and the way health and NGO professionals perceive this fluid and multifaceted issue. This assessment does not only concern the needs of vulnerable population groups with a migrant background, but also

the personal perspectives of professionals working with these groups on issues of sexual, reproductive and, ultimately, human rights, as applied in Cyprus. Cultural and social characteristics will be emphasized and the competence and needs of professionals themselves will be identified through the perspective and perceptions of qualified personnel working with this population group. The research technique of semi-structured interviews with three different population groups was chosen; the three groups included health professionals, NGO professionals, and migrants and refugees. As far as sampling is concerned, different methods of data collection were chosen. Criterion sampling was used in the case of health professionals and NGO representatives, based on their professional expertise and under the condition that they work with the group under study, while snowball sampling was chosen in the case of migrants and refugees.

3.2 Sampling

For the needs of this project, interviews were conducted with three different groups of the population: seven health professionals, medical and nursing staff working in medical units in Cyprus, seven NGO professionals and six persons with a migrant background that have different status. Their demographic characteristics are presented in more detail in the tables below (Tables 1 and 2).

As far as the professionals of the first research group are concerned, participants interact with the population group under study and specialise in management of sexual and reproductive issues in terms of physical and mental health. On the other hand, their needs are also mapped, thus ensuring better access to informed psychosocial and health services. More specifically, two urologists, two gynaecologists, a psychologist, a nurse and a general practitioner participated in the research. As a result, it is possible to identify different aspects affecting migrants' and refugees' access to informed and effective health services, the competence and awareness of professionals themselves, as well as the needs and gaps that need to be addressed in their opinion. Social, cultural and economic factors

play a key role in access to health services and the perspective of professionals in this multifaceted context is crucial.

The second research group includes employees of organizations that represent civil society in Cyprus and work in different, influential positions. The activities of the NGOs that are included in the research aim to inform, support and protect the rights of migrants and refugees living in Cyprus. The interviewees' job and specialisation vary; their studies and origin as well. The following organizations participated in the research: UN High Commissioner for Refugees (UNHCR Cyprus), Cyprus Refugees Council (CyRC), Generation for Change CY, Caritas and OASIS. All organizations were particularly willing and helpful during the research process and professionals were selected based on their specialisation, in order to gain the best possible understanding of the issue under study.

Table 1: NGO and health services professionals

	Pseudonym	**Research group**	**Profession**	**Language**
1.	Nina	NGO	Psychosocial worker	Greek
2.	Niki	NGO	Psychosocial worker	English
3.	Gina	NGO	Board member	English
4.	Nikoleta	NGO	Psychologist	Greek
5.	Harris	NGO	Director	English
6.	Ira	NGO	Community worker	Greek
7.	Alexis	NGO	Temporary director	English
8.	Damianos	Health professional	Urologist	Greek
9.	Lambros	Health professional	Urologist	Greek
10.	Fanos	Health professional	General practitioner	Greek

11.	Dimitris	Health professional	Gynaecologist	Greek
12.	Takis	Health professional	Gynaecologist	Greek
13.	Kyriaki	Health professional	Clinical psychologist	Greek
14.	Tonia	Health professional	Nurse	Greek

Finally, persons with different migration status, aged 18-39, from different countries of origin, living in Cyprus participated in the research. Some of them are asylum seekers, others are migrants, and others have refugee status.

It is worth mentioning that access to this population group, especially in terms of sexuality, is particularly difficult, while the language of communication is another barrier that needs to be overcome. None of the participants speak Greek and all interviews were conducted in English. By giving voice to them, it is possible to better interpret their needs and any shortcomings they may face.

In addition, the method of data triangulation with respect to the three different population groups was chosen. The strategy of triangulation may enhance the credibility of the research but also produce conflicting results (Miles et al., 2015).

Table 2: Migrants and refugees

	Pseudonym	**Sex**	**Country of origin**	**Age**	**Status**	**Employment status**	**Level of education**	**City of residence**

1	Fanya	Female	Cameroon	31	Beneficiary of supplementary protection	Unemployed	College graduate	Nicosia
2	Xamsa	Male	Afghanistan	23	Refugee	Full-time employment	University	Nicosia
3	Tiffany	Female	Cameroon	39	Refugee	Part-time employment	Secondary education	Larnaca
4	Badia	Female	Lebanon	37	Migrant with work permit	Full-time employment	University	Paralimni
5	Asma	Female	Afghanistan	26	Asylum seeker	Full-time employment	University	Nicosia
6	Samuel	Male	Cameroon	33	Asylum seeker	Unemployed	University	Nicosia

3.3 Research ethics and integrity

The Cyprus National Bioethics Committee has reviewed and approved the research (CNBC File number 2022.01.284), in compliance with the ethics and integrity protocol. To ensure participants' protection, pseudonyms are used in all reports, and no information that could reveal their identity is disclosed. During the interview process, the researchers were particularly cautious with regard to issues that could distress the interviewees, as sexuality and health issues may involve sensitive personal information and bring up life experiences, sometimes unpleasant, especially in the case of migrant and refugee women. Interviewees were free to stop at any time and withdraw from the research, and interviews were conducted in a safe environment of their choice, so as to achieve the highest degree of protection and comfort of the participants, with respect and empathy. The researchers themselves have a professional background in psychology, are highly trained in

management of violence, abuse and exploitation issues, and a protocol for referral to competent services was followed, where necessary.

3.4 Research limitations

The process of studying migrant and refugee populations is complex, as access to them is barely impossible. With regard to the qualitative data collection phase, the majority of the participants are from Cameroon and Afghanistan, all of them speak English and most of them have attained tertiary education. The testimonies of migrant and refugee participants in the qualitative research outline their experiences and needs regarding SRHR to a significant degree, but certainly cannot cover the full range of the issue. Testimonies of persons with diverse characteristics, especially those in extremely vulnerable position, who do not speak English, would be valuable to give voice to diverse experiences of migration, access to health services and information regarding SRHR. However, it was not possible to access individuals with such characteristics for a number of reasons. Firstly, there was the huge barrier of language and participant recruitment, as researchers do not speak Arabic or other non-European languages. In addition, persons who have only been in Cyprus for a few months, following a difficult, traumatic migration route may find it very difficult to trust someone outside their community to discuss issues of sexuality, which are considered a taboo subject for many communities, especially when they are in transition. There is a strong sense of fear and insecurity, which cannot be overcome.

On the other hand, the testimonies of NGO professionals and medical staff provide a comprehensive view of the needs, especially those of our most vulnerable fellow human beings with a migrant background, through their own interaction with this group. It should be noted that significant difficulties were also encountered with regard to medical staff recruitment, as information on the internet may have been out of date or professionals may have been reluctant. The concept of migration is undoubtedly much more complex,

including different forms of migration (for example, migrants from European countries, marriage migrants, etc.). However, the aim of this project is to highlight the needs of persons who are on the verge of social exclusion or socially excluded.

Quantitative data collection through online questionnaires was also carried out within the framework of this project. The barriers mentioned above regarding data collection through interviews also apply to quantitative research questionnaires, which aimed to assess the access of migrants and refugees to sexual and reproductive healthcare in Cyprus.

The number of participants (55) is very limiting and does not allow for generalisation of the results. This is the reason why they have not been included in the main analysis of the research. However, the main conclusions will be reported in the chapter of selected results, following the qualitative data analysis.

4. Data analysis

The first and most important issue to assess with regard to refugees' and migrants' SRHR is access, not only to health services, but mostly to information. Health issues such as sexually transmitted infections (STIs), HIV, pregnancy, abortion and issues of sexual and gender-based violence represent a broader umbrella of issues, which require information, treatment and support. In this context, the psychological aspect of such phenomena and the provision of appropriate psychological support, where needed, should not be neglected. Migrant and refugee women appear to be in a more vulnerable position.

There may be conflicting answers to the question how easy and/or feasible it is for a particular population group to access up-to-date information on SRHR. The point is to analyse the access, or lack thereof, to information and services, the quality and adequacy of information and services, and the barriers faced by the group of migrants.

4.1 Information on sexual health and rights issues

As far as information is concerned, testimonies vary considerably. According to testimonies of NGO professionals, there seems to have been some improvement in recent years. However, access to up-to-date information does not seem to be easy and systematic, while in some cases, it is even non-existent.

Civil society plays a vital role in this regard, as it often seems to be the main source of information, although there is sometimes a lack of expertise in SRHR issues. NGOs can inform about available services and provide some form of information through specific actions (sessions). For example, they may organise a workshop on Female Genital Mutilation (FGM) or HIV, addressed to a group of stakeholders, depending on their availability and competence. The services offered by NGOs and volunteers in terms of information and available services are undoubtedly invaluable, but they cannot be systematic, and there are spatial limitations involved.

> "I would say that there is certainly some kind of information, but it's not at all accessible to persons who have just come to Cyprus, who are just learning what's going on here. These persons, who are directly interested in this information, that is persons with HIV, any STIs, who are identified at Pournara, because they get tested, pregnant women, persons who come following some type of sexual violence in general, the way I see it, don't have easy access to information, in their language and in one place, where it's all together. I would say that information is definitely there, but it's hard to access even for us, who know how to look for it, where to look for it in the government and speak the language." (Nikoleta, NGO)

A key issue is access to quality information that can be understood. It seems that even if there are formal information structures, access is not easy. Another major issue is specialised information, which can only be provided by health professionals, especially on issues of STIs, pregnancy and other high-risk health conditions.

> "So, the first thing that is lacking is, probably information, is not given in writing, is not given to the beneficiaries by the doctor, as far as I know nobody sits with them and explains." (Gina, NGO)

The question is not only whether specific information is provided, but also whether it is understood and possible barriers - such as language, cultural differences, taboo subjects concerning sexuality (especially for those from the Arab world) and gender inequality - are taken into consideration. Migrants and refugees constitute a heterogeneous group of persons, diverse on many levels, such as origin, education, religious beliefs, etc. Their needs in general, but also in terms of information, are differentiated, especially in cases of medical conditions that require immediate treatment and high-risk situations, such as sexual abuse.

The perspectives of medical staff on information vary. In theory, technology could allow anyone to have access to up-to-date and reliable information and could certainly be utilised, to some extent. However, in practice medical issues are a little more complex and require professional, face-to-face information. Moreover, access to technology cannot be taken for granted, in the case of vulnerable persons.

> "This knowledge is certainly missing, because it does not exist in practice. I mean, in retrospect I understand that this knowledge is missing, they [migrants] are not interested in it." (Dimitris, gynaecologist)

Medical staff sometimes perceive ignorance as indifference, and other times as a result of difficult living conditions. However, even if access to health services is ensured, this does not necessarily entail access to information, in view of the considerable pressure health professionals face due to the volume of cases and language barriers. Doctors' sensitivity and personal willingness to inform and recommend preventive measures is often the only way to effectively transfer information and ensure access.

4.2 Access to and adequacy of health services - barriers

There are two main areas of concern regarding access to health services. The first is migration status. Refugees have access to the GHS, like any other Cypriot citizen. This is

not the case for asylum seekers. Questions about access, as well as adequacy and quality of services are raised.

The second major area of concern is socio-economic barriers, which affect the majority of this population, but also cultural and religious issues, which require a different, more sensitive approach to sexual health. In addition, the gender dimension of the phenomena and differentiated needs, which may arise as a result of the interplay of gender and cultural characteristics, should also be taken into consideration. Questions about the barriers and constraints faced by migrants and refugees in accessing information and services related to sexual health are raised.

> "Actually, even if there are rights and possibilities, sometimes the information about them is not clear. There are many obstacles, there is a strong cultural or religious influence, which this also creates extra obstacles, even and in the cases where the information is accessible. Another topic that is very problematic, if we consider that the most of the asylum seeker and refugees here in Cyprus are dealing with important socio-economic difficulties and this also has a big impact when we are talking about possibilities. Then there are the language barriers, community pressures and cultural pressures." (Niki, NGO)

Cultural pressures and religious beliefs pose a variety of barriers for refugee and migrant women in particular, rendering their access to information and services particularly difficult and complex. For example, they may find it difficult to be examined by a male doctor, or even feel shame around issues of sexuality; this is particularly the case for women of Arab origin. A typical example is the testimony of a refugee from Afghanistan, who has suffered from dysmenorrhoea and severe menstrual cycle disorders for years, but when she found herself in a male gynaecologist's office, she did not communicate her problem, as she felt ashamed to discuss it with a male doctor, and hoped that it would eventually be resolved on its own.

Gender is of fundamental importance, it should not be overlooked, and requires special attention, especially in cases of sexual violence. In these cases, access to quality and safe

services, cooperation between agencies and provision of psychological support are essential to begin the process of healing and managing trauma. However, such services are not provided on a systematic basis and not all survivors have access to them.

It should be noted that differences with regard to migration status also affect access to services. Refugees have their own personal doctor and can obtain referrals for any medical specialty covered by the national health system.

> "Before it was quite difficult to see a doctor, especially when you are not recognized, you have to pay a lot of money for the tests and for the doctors, the medications. Also, you don't know, what doctor you need? Where you should go? Who will give you the advice for that? Now, it's quite satisfactory. The system it's very easy, you just call your doctor and you just pay a very tiny amount of money for your medication. It's very easy." (Xamsa, refugee)

The testimony above demonstrates the differences between refugees and migrants and the inability to access information and services. Access to the national health system, however, entails another important service. There is an electronic health record, including all examinations, referrals and prescriptions. Another problem faced by migrants and consequently their doctors is access to a specific database that contains all their medical data. According to testimonies, important documents and examinations appear to be lost, as they are not available in electronic form and the living conditions of migrants (for example, large number of roommates in one space, young children, moving, etc.) are often not conducive to maintaining them. This puts a strain on the persons concerned, leading to missing appointments and deterioration of their health, but also burdening the health system and doctors with repetitive examinations and ambiguous information about patients' health records.

4.2.1 Language

All three research groups agree that language is the greatest barrier. Not speaking English and/or Greek and lack of interpretation services make it extremely difficult to communicate at any level.

> "Language, not being able to communicate. It all starts with language and you can't communicate and they get frustrated, both the refugee and the health professional. Which is something that shouldn't happen." (Ira, NGO)

Some NGOs offer interpretation services on a voluntary basis, but they are not available 24/7 and they do not cover the whole range of languages and needs. There do not seem to be certified interpreters in public hospitals and communication becomes very difficult, if not impossible. Even written information is often only available in English and Greek.

As far as sexual health issues are concerned, the language barrier is even more difficult to overcome, due to medical terminology and risks associated with STIs, hepatitis, HIV, (unwanted) pregnancy, sexual violence and other sexual health related conditions. For doctors, language may be the only major barrier, which is often addressed by NGOs on a voluntary basis. Alternatively, patients may be accompanied by someone who speaks English or call someone to act as an interpreter via phone during the appointment.

> "The biggest barrier is language. The majority don't speak English and for most of the people in Cyprus, our knowledge stops in English. So, if they don't come with an interpreter who is present and can help the situation, it's not only difficult to use the google translate, for example, but it's also dangerous sometimes, because you are trying to say something, google somehow translates something that you can't assess, the other person understands something. You know, the information from sender to receiver will undergo some distortion that you don't know what it's like. I mean, even if someone is willing to explain something more, I think communication stops at some point." (Dimitris, gynaecologist)

The issue of personal data should also be taken into consideration. Ensuring anonymity is crucial, especially in medical matters. In addition, poor communication/translation may put the patient at risk, if medication is not taken correctly or doctor's instructions are not

understood. This shortcoming is also related to the fact that patients are not able to express their questions, ask for clarifications and, mostly, explain their history in detail. Thus, it is not easy for them to consent (or not) to medical instructions, nor can they understand the seriousness of the problem they are facing.

4.2.2 Socio-economic barriers

The factor that was mostly emphasized by NGO participants and persons with a migrant background is socio-economic barriers. Precariousness, unstable housing, inability to find a job and meagre income are risk factors affecting access (or lack thereof) to services and information.

> "...because these populations are facing survival issues when they come to Cyprus, especially when they leave the reception centre. They have to find accommodation, they have to look for a job, they have to live with very little money, with very little benefits from the government, which, most the time, they don't even receive…. They often put these issues, sexuality, health, in second place." (Ira, NGO)

As a result of inability to meet basic necessities of life, the issues of information on sexual health and health itself are considered of secondary concern. Some needs, such as free transport to hospital, are covered during the stay in the centres, although living conditions are far from ideal. After leaving the centres, even the cost of a public transport ticket may sometimes be considered unbearable.

Spatial barriers are also relevant in this regard. They refer to persons living outside Nicosia (where most NGOs are based), mainly in rural, remote areas. They may pose obstacles both in terms of information that is offered by NGOs (for example, seminars, free testing, etc.), but also in terms of access to services, such as transport to hospitals or places where NGOs provide free HIV testing, and attendance of medical appointments, especially in case of diagnoses that require months of treatment and pregnancy testing.

4.2.3 Training and cultural diversity

The issue of training has two aspects, relating both to service recipients and service providers. On the one hand, the educational level of persons with a migrant background and their personal beliefs may have a restricting effect, especially with regard to sexuality (in particular, female sexuality) and the prejudices around it in some communities. In addition, the level of education, in combination with the language barrier, makes communication difficult.

On the other hand, medical and professional staff working with this population group should behave professionally, free of personal bias and racial stereotypes. It is important to understand the particularities and diversity encountered among the group of persons with a migrant background. Raising awareness among medical staff and, more broadly, public officials (such as police officers, civil servants, etc.) on issues of social inequality, gender, sexuality and cultural differences could facilitate access to quality services and prevent racist attitudes.

> "The barriers certainly include that altogether, there is need for information, continuous training and education of the staff of every agency, whether public or private." (Nina, NGO)

As a result, professionals themselves will have the tools to manage each case, and the persons concerned will receive appropriate information and support, tailored to their needs. It is no coincidence that migrants and refugees trust NGOs more and turn to them to solve their problems. Several NGOs appear to provide a safe, friendly environment that accepts diversity, as opposed to the coldness and detachment of public agencies.

Cultural dimensions affect almost all aspects of sexual health and relevant information. Refugee and migrant populations are not homogeneous, and this requires cultural integration in terms of information and service adequacy.

> "If you want to go deeper, within the conceptualization you'll also find that the information is not adjusted or refrain in a culturally appropriate way that you could use to attract the interest of them. So, it's very important to have appropriate people within the communities, with similar characteristics that can be able to act as messengers passing this information appropriately." (Harris, NGO)

Cultural dimensions emerge through the information framework itself. The way which information, whether written or spoken, is structured, conveys culture and should therefore be made inclusive to all. With regard to cultural diversity, gender roles are also important. Sometimes, communication can be more direct, if passed from woman to woman, and from persons of the same ethnicity and/or religion. This makes cultural integration more feasible and diminishes potential feelings of shame around issues that are considered a taboo. For example, in some regions of Africa, pregnancy is considered a great blessing and the termination of pregnancy or not having children by a woman of childbearing age is considered as failure, at the very least. This is why culturally appropriate information and informed medical staff that can be sensitive to her needs are essential.

4.3 Contraception

Contraception plays a key role in ensuring sexual health - especially in the case of women - and is largely related to access (or lack thereof) to appropriate information. Knowledge of methods of contraception is a key element in ensuring health, which minimises the risk of transmission of STIs and ensures protection against unwanted pregnancy. Ensuring the right to family planning is also important. This information may concern methods of contraception, their cost, prescriptions for contraceptive pills, and protection against STIs, HIV and hepatitis. All methods of contraception come with a cost, which is not covered by the national health system for any person in Cyprus. As such, vulnerable groups of the population often cannot afford it.

> "Takis: Well, they don't have money. Are you going to say to her "get contraceptive pills that cost 12-14 euros a month"? However, if the state came in and provided them, first of all, it would be more affordable. That's what needs to be done. All the years I've been in Cyprus, I've never had a girl come to me and say she wants contraception. [...] I would tell them about contraception, they would say "No! No! No!". They didn't want to, because they don't have money. They don't dare to..." (Takis, gynaecologist)

The health system would also benefit from ensuring methods of contraception, as STIs and unwanted pregnancies would be significantly reduced. According to testimonies, no reference to methods of contraception available in Cyprus is made upon entry to reception and accommodation centres. Some NGOs provide this type of information, as well as free male condoms, but this is not sufficient to cover all needs, while necessary training is lacking. In addition, the male condom method does not allow women to have total control over their bodies, especially in cases where they are not in equal relationships, are abused or are forced into sex work for survival reasons.

According to several gynaecologists' testimonies, contraception may also be crucial for some women's lives, as an upcoming pregnancy and subsequent childbirth may be very dangerous sometimes. Financial hardship may also have a deterrent effect. This is also the case for lack of information about the risks and methods of prevention (for example, coitus interruptus or identifying fertile days, which are mistakenly considered as adequate methods of contraception, according to some testimonies). Information and access to safe methods of contraception may play a preventive and protective role for migrants.

4.4 Abortion

Inability to access effective methods of contraception and lack of awareness concerning the possibility of emergency contraception (which is not a method of contraception), result to abortion being considered as a way of dealing with a possible unwanted pregnancy, according to some doctors, and as a method of contraception, as mentioned in the testimony below.

> "The most accessible method they have is abortion, because the others come with a cost." (Dimitris, gynaecologist)

Abortion is a medical procedure performed in hospitals (especially after the 8th week when medical abortion cannot be used) and is certainly not a method of contraception. Testimonies concerning the adequacy of abortion-related services in public hospitals vary. The majority of medical staff consider access to be fairly easy, while NGO representatives present a somehow different picture, as they mention in their testimonies that several anaesthetists and gynaecologists refuse to proceed with the procedure on grounds of belief (conscientious objectors). In these cases, hospitals and private clinics often do not provide an alternative to women and do not refer them to other doctors. This results to them seeking available doctors in public hospitals of other provinces, which entails difficulties with regard to communication and transport. In addition, there is a timeframe within which the procedure must take place (12 weeks, as defined by law) and thus time pressure to arrange the procedure within this timeframe. It appears that access in Nicosia is somewhat better than in rural areas and other cities, but it is still not certain that this specific need will be covered.

The GHS does not cover termination of pregnancy upon request on any ground; it is only permitted until the 12th week, and in the following cases:

(a) if pregnancy is a result of rape, incest or sexual assault, and until the 19th week of pregnancy; (b) if there is evidence of fetal abnormality based on prenatal diagnostics, regardless of the weeks of pregnancy; and (c) if there is risk to a woman's health, or risk of physical or mental harm, as a result of pregnancy.

In the private sector, the cost of abortion is very high and therefore prohibitive for any woman who does not have access to or whose request is not covered by the GHS. Because of the difficulty of accessing safe, free-of-charge services, it appears that women opt for illegal, unsafe abortion methods that endanger their lives, such as medication that supposedly causes miscarriage (as reported by three participants), which they obtain illegally, without medical supervision and with dubious results. Interviewees from different groups mentioned that this option may also be related to the stigma attached to abortion

and the intention to hide the incident from the migrant's/refugee's social environment. This is a particularly high-risk situation that may seriously endanger a woman's health and even life. For these reasons, firstly, information and awareness raising, and subsequently, access to safe services are critical to safeguarding migrant/refugee women's health.

> "Without all this knowledge, they are forced [by the community] to have the baby. Most of them don't afford to do the abortion, they don't have the money and it is not accepted within immigrants." (Fanya, beneficiary of supplementary protection)

Even today, abortion remains a taboo subject in Cypriot society. However, in several cases, the option of abortion is related to pregnancies resulting from sexual violence[5]. However, in this case, it is still a complex process, involving the police and other services, since a complaint must be filed. Data suggests that police officers need special training on handling rape cases in a sensitive manner and avoiding survivors' re-victimisation.

> "In terms of abortions, I think that because it's still a taboo topic, I think that's the reason why it's not discussed so much and secondly there's not enough access... the girl, an example of whom I mentioned before, who was a victim of rape in Cyprus, and wanted to have an abortion, she made an appointment with the doctor in another city, but because it's legal up to 12 weeks and the doctor postponed their appointment. She was crying in front of the doctor in Makario, so that they could arrange it [the abortion]. So, this was something unfair and I think it is also human right. Since abortion is legal here in Cyprus up to 12 weeks, but there is a group of persons who don't have access to it. That's a kind of discrimination. It certainly becomes too difficult." (Nikoleta, NGO)

Research data demonstrated that abortion is often approached as a controversial procedure. The legalisation of abortion should be combined with safe access to abortion, which does not always seem to be possible.

[5] In this case, if a complaint has been filed, the timeframe for abortion is increased to 19 weeks.

4.5 Pregnancy

Pregnant women and women with young children face complex issues that need to be resolved. Transport is difficult for migrant and refugee women with young children, because there is no one to take care of the children, especially in cases of second pregnancy. For pregnant women, visits to gynaecologists need to be more frequent and adherence to appointments is not always easy. In addition, they cannot buy vitamins and iron that are necessary during pregnancy, as reported by an NGO representative. NGOs can provide the necessary supplements to a limited extent, but are not in a position to cover the needs of all pregnant women who cannot afford to buy them. This may in turn cause problems, such as anaemia, to the infant. Access to medication is a problem that migrant women, who do not have access to the GHS, face in general.

> "But persons who are not on the GHS and who rely on medical booklets and medical cards unfortunately have no access to them at all and are forced to go and buy them, and are even more burdened than persons who are on the GHS. Even though they should have free access to medical care." (Nikoleta, NGO)

However, experiences of childbirth in public hospitals are quite positive, and efforts are being made to provide women with first essentials for the baby's care (baby's dowry). There is some criticism about increased numbers of caesarean sections, which is an issue of particular concern for the wider population.

> "It was very good, the gynaecologist was good. Any information I needed, he gave me any information, he was good. […] When I said that they gave me every support, like the nurses took care of me from when I gave birth until the time, I left the hospital." (Tiffany, refugee)

It should of course be noted that the participant who provided this testimony spoke English fluently and could easily communicate with the staff. In general, it appears that in public hospitals, the quality of services related to pregnancy and childbirth are better, compared to other types of health services. In addition, migrant/refugee women themselves are

more open to information and services related to pregnancy and childbirth, as this is not a taboo subject.

4.6 Sexually Transmitted Infections

The discussion about STIs, HIV and hepatitis B and C is multidimensional. First of all, it concerns the initial testing, conducted upon entry into the Republic of Cyprus and the reception and accommodation centres. Several initial tests are carried out there, based on the existing protocol. The issue is whether there is appropriate information and guidance, while maintaining the necessary discretion and confidentiality, especially in the case of persons who need treatment. It appears that in reception and accommodation centres, there is no appropriate space, where patients can be informed in detail about the results of their tests and how they may impact their quality of life, before they are transferred to specialised doctors of public hospitals.

Secondly, issues of ignorance around specific diseases and taboo subjects arise. In this context, access to information is essential. NGOs based in Cyprus are particularly engaged in this issue, while information campaigns, free HIV testing (Checkpoints HIV) and condom distribution are organised from time to time. Even though these are very important initiatives, perhaps not all stakeholders are aware of them, there is insufficient funding to cover the whole population, and spatial barriers arise in this case as well.

Consistency is another issue relating to STIs, especially those requiring chronic treatment (such as hepatitis). According to doctors, patients seem to find it difficult to comply with appointments.

> "There is no particular difficulty with regard to what we said before, I mean, the problem has to do with being punctual about certain things, which I don't know why you wouldn't be punctual, you may not care, you may not understand, or you may not consider it important. Let's say, especially in the case of infectious diseases, I think they don't care, the least they care is whether these women have hepatitis, at least that's how I see it.

> In the case of contraception, abortion, they understand and they comply with them, because follow up is easy. Whereas in the case of something that requires repetitive treatments, where they need to go back in a month, to go get tested, that's where they lose it." (Dimitris, gynaecologist)

Many patients' living conditions are extremely poor and their financial situation often does not allow them to prioritise their health. Even though this may be perceived as indifference, social and cultural characteristics, as well as the language barrier, must be taken into account. The person concerned may not understand the necessity of treatment if there is no interpreter to translate the diagnosis, the possible consequences of the disease, and treatment requirements, in a language that he/she understands. Another factor that should not be overlooked is the fact that a person suffering from STIs, especially HIV, may feel shame, especially if they have a migrant background; this may also have a discriminatory effect. Stigma is another central issue relating to STIs. Although public awareness around STIs and HIV has changed a lot since the 1980s, patients are still treated with discrimination. In the case of migrants and refugees, stigma may be multifaceted because of the multiple discrimination they may be experiencing.

> "The issue was that the behaviour towards the child, towards her, was not so much related to her ethnicity, but to HIV. You know, when types of stigma are combined, the situation is even more difficult. It's painful to experience things like this." (Kiriaki, psychologist)

As such, initial case management in migrant reception and accommodation centres is the most crucial phase. Due to living conditions and overcrowding, there is a considerably increased risk of overspreading of STIs, hepatitis, tuberculosis and other communicable diseases. Reception and accommodation centres could serve as spaces of information and awareness raising on STIs. Proper planning and improvement of living conditions at every level could enable the launching of structured, properly informed campaigns on issues of STIs, contraception, pregnancy and (sexual) abuse. This could control and limit overspreading of diseases, but it could also serve as a preventive measure for the wider control of STIs, and consequently ease the burden on the health system.

> "So, in the case of migrants, if there is a disease, it is very easily transmitted. So, with information, better information, to have better infrastructure, to empathize, to set up campaigns, the school, the little one that we mentioned before. All these things I think will limit, not to 0%, but they will limit this overspreading very much." (Fanos, general practitioner)

STIs are therefore a multifaceted issue with medical, social and psychological dimensions. Medical staff perhaps plays the most crucial role. Prejudice, stereotypes and racism by professionals against persons with a migrant background is a key issue that requires awareness raising and information, especially to improve the quality of services. If patients' needs and lifestyles are better understood and their specific cultural characteristics are respected, better healthcare can be achieved.

4.7 Sexual violence

Sexual violence covers a wide range of abuse, especially in the case of women with a migrant background. With regard to migrant and refugee women, it may include sexual violence, trafficking, underage marriages, FGM and sexual exploitation (forced prostitution). The more vulnerable a person is, the more difficult it is to escape the cycle of violence. In addition, sexual violence may have serious consequences in women's lives, such as mental health disorders, gynaecological complications, unwanted pregnancy; they are also at risk of social exclusion.

Sexual and gender-based violence may refer to: a) violence they - mainly women - suffered before entering Cyprus (in their country of origin, as well as during their journey) and b) violence they suffer while living in Cyprus. Many migrant women seem to have suffered particularly traumatic experiences before arriving in Cyprus, such as female genital mutilation (FGM), sexual violence leading to pregnancy, etc. According to the law, survivors may be protected with refugee status in some cases, but the process of

disclosure and trauma management is quite painful for survivors, while the abuse they have suffered is sometimes questioned. FGM management requires a two-fold approach. Firstly, appropriate medical care should be provided, while access to mental health services including psychological support and treatment should be ensured. Secondly, emphasis should be placed on information and empowerment with regard to beliefs around FGM. In the following testimony, Ira refers to the way migrant and refugee women perceive FGM.

> "Women had mixed reactions, some that had experienced trauma said that it was something wrong, they had possibly read the Koran better, that it was not actually foreseen there, and they said that it was wrong, that it had stigmatized them and that they didn't want to do this to their daughter. Others said that they had to, otherwise their child would be considered dirty." (Ira, NGO)

Prevention and awareness raising about the practice of FGM, as well as about marriages of underage girls, which there are indications that may be taking place illegally in Cyprus, are required in order to protect the rights of underage girls. As already mentioned, cultural and religious implications are of particular importance and therefore women's empowerment and education should play a preventative role. Moreover, many of these women have no control over these processes, as they are in patriarchal, perhaps even violent relationships, where their voice carries little weight, especially if it is differentiated from religious beliefs.

With regard to the management of incidents of violence that take place in Cyprus, migrant women do not seem to know where to turn to for protection. This type of incidents may involve violent partner relationships, but also sexual abuse/exploitation of women by locals in exchange for food or shelter. The following testimony demonstrates that women not only do not know where to turn to but they also do not trust that public authorities will take proper action.

> “Here, if the relationship is violent, we don’t know where we have to go and even if we knew, we don’t know if… they probably will help us, but we don’t know it yet.” (Asma, asylum seeker)

This fear is not unfounded. NGOs are usually the first ones to receive the complaint; however, a formal complaint should be filed before the police. The experience of filing a complaint and accessing the legal services involved is often more traumatic than the abuse itself, not only in the case of migrant women, but also in the case of women living in Cyprus in general. This whole process works as a deterrent. As a result, many rapes are never reported.

> “…there is SPAVO who is dealing also with violence, but the thing is that I had experience with some cases where the access to legal services were more traumatizing and this is a big problem. It is a big problem because there are people that are abused by other people… there is not a strong system to report these, to have protection.” (Niki, NGO)

Data demonstrated that this is an issue of concern in other cases as well. Re-victimization can be so brutal that it may push the survivor to her limits. NGO representatives maintain that police officers need to be trained on gender-based and sexual violence, so that women are encouraged to report it.

The quality of services provided in relation to gender-based and sexual violence should be considered an immediate priority for the actors concerned, both with regard to raising awareness of public officials around gender issues and with regard to survivors’ protection and support. NGOs carry out valuable work on issues of gender-based violence, but this does not rule out the responsibility of the state apparatus to ensure human rights, the first step being the prevention of re-victimisation by public authorities. Many of these offences are in any case criminal offences and should be treated as such.

4.8 Psychological support – mental health services

As a result of all the other barriers, mental health is one of the factors which is not given due attention, even though it falls within the broader scope of health safeguarding. Many of the above-mentioned situations, such as cases of sexual violence, STI diagnosis, abortion, etc., require psychological support. For example, being diagnosed with HIV may be a traumatic experience itself, but is often not treated as such.

> "It may also be related to psychological factors, someone who does not feel well psychologically, who is feeling sadness, who is in a state of apathy, desperation about other circumstances, is not going to try to deal with the stimulus he is feeling somewhere [referring to symptoms of infection in his body] when he is hungry." (Kiriaki, psychologist)

As already mentioned, low standard of living may put health itself, and consequently mental health, at risk. Language is another barrier, as it is not easy for a person to receive psychotherapeutic services in a language they do not speak well, while time and consistency are required. In addition, even nowadays, when dealing with traumatic experiences, such as abortion, rape, etc., mental health is considered to be of secondary importance.

> "Let's take things from the least, from sexual violence, prevention and treatment of sexual violence. Counselling and therapy are very-very scarce, CRC [Cyprus Refugee Council] is providing [counselling] from what I know." (Harris, NGO)

Referral to public mental health services is possible, but in any case, cultural, adequacy-related and socio-economic barriers need to be overcome. Taking into consideration the difficulties already mentioned and the stigma associated with mental health, access becomes even more difficult.

4.9 Selected results

A quantitative survey of persons with a migrant background was conducted, in order to better understand the needs, as they are expressed through the voices of migrants and refugees. The quantitative survey was carried out based on a shortened version of the questionnaire developed by Baroudi et al. (2022), which was adapted to the Cypriot context.

A number of key perceptions and attitudes of migrants on sexual and reproductive health and rights issues were identified by the quantitative research. The small number of participants (55 persons) does not allow for generalisation, but it provides useful information about the needs of migrant and refugee women. The aim was to assess migrants' and refugees' access to sexual and reproductive health care in Cyprus.

The number of participants is 55 and they are aged 19 to 46. The online questionnaire was administered in English, French and Arabic, 51% of the participants were women, and about 60% originated from African countries. Only 14 participants had received SRHR services in the last year; the majority of these were pregnancy related. Correspondingly, more women than men visited health care/social services related to sexual or reproductive health issues in the past year.

For most participants, Internet and social media appear to be the main sources of information about relationships, sexuality, contraception and STIs, while 2/3 of participants (67%) reported that they do not know where to look for additional information about STI issues, if needed. Qualitative data confirm this need.

Regarding the topics on which participants think they need more information, the majority mentioned family planning (how to plan a pregnancy, how to prevent an unwanted pregnancy, how to use methods of contraception, such as condoms and contraceptives). With regard to the way information is received, the majority reported that they prefer electronic mail (email, text message, etc.) and verbal information from care providers.

5. Discussion

Identifying the needs of migrants and refugees with regard to SRHR, their experiences and the barriers they face have complex social, economic, legal and cultural dimensions. According to the research data, information and access are two interrelated pillars, which are crucial in safeguarding SRHR. Diverse testimonies between the three population groups largely related to cultural characteristics. Language is perhaps the most important barrier to accessing quality information and services.

Migrants and refugees seem to trust NGO-provided services, perhaps more than public services, in almost all cases. Better coordination of individual actors (NGOs, health services, asylum services, legal services, etc.) could make available information more visible and would greatly facilitate the role of NGOs. Cooperation of NGOs with communities and enhancement of their support on behalf of public institutions would bring significant benefits in safeguarding sexual and reproductive rights, prevention and improvement of migrants' and refugees' quality of life.

In this regard, information has two dimensions: on the one hand, population with a migrant background, who need adequate information on wider sexual health issues, which they do not have access to, and are not aware of available information sources, and on the other hand, medical staff, who need guidance on the social dimension of sexuality, migration and the specificities of the population group in question. In order to ensure optimal impact, both of these groups need training and education. As far as the migrant population is concerned, the issue of SRHR includes several sub-topics, such as a) STIs and HIV, b) contraception, pregnancy and abortion, c) gender-based and sexual violence and d) mental health, which need to be covered both in terms of properly tailored information and, optimally, in terms of in-depth training with experiential workshops and trainings. On the other hand, medical professionals are adequately trained in their field of expertise, which is medical issues, but they cannot easily perceive the needs' cultural and social dimension. Proper training will enable them to develop social characteristics that will allow them to approach issues of race, gender, social inequalities and cultural differences with more empathy. This should be achieved through educational activities, including

experiential workshops and other training activities that will provide an in-depth understanding of complex cultural and racial issues. Such activities need to be systematic and accessible, in order to overcome spatial barriers.

It is equally necessary to ensure support of the valuable work offered by NGOs and volunteers. Financial support is also required to ensure the possibility to expand their work throughout Cyprus and enhance it. Moreover, NGO professionals are very often confronted with issues that do not fall under their core activities. In this context, it would be important to provide them with individual training on sexual health and rights issues relating to persons with a migrant background, but also to inform them about the options available in Cyprus and the legal framework.

It is clear that prevention is the cornerstone, on which we need to invest in order to improve migrants' and refugees' sexual and reproductive health, while it will also contribute to easing the burden on the public health system and ensuring the quality of services. Sexual health issues should not be considered as of secondary importance, as they provide the pathway to a broader improvement of the quality of life.

6. Recommendations

- Interpreters in key settings, such as hospitals, health centres, reception and accommodation centres.
- Creation of a database that contains the medical records of those not covered by the GHS to ensure the best possible care of patients and maintenance of their health records.
- Reimbursement of methods of contraception and all legal requests for termination of pregnancy under the GHS.
- Provision of family planning and pregnancy termination counselling services.
- Access to free medication, methods of contraception and sexual health services for extremely vulnerable persons (victims of violence, persons below the poverty line, etc.).

- Access to personalised mental health services for victims of gender-based and sexual violence.
- Adequate information in participants' native language, through experiential workshops and information provision upon entry to Cyprus in the reception and accommodation centres, by trainers with a strong background in sexual health and rights issues. Creation of an online website as a means of information and communication (email, social media etc.) in all necessary languages with up-to-date, culturally appropriate material on SRHR and available services.
- Training of volunteers and/or professionals working in the community on SRHR, in order to provide up-to-date information in the native language of the persons concerned.
- Awareness raising and provision of information on the specific socio-cultural characteristics of migrants, refugees and victims of violence to medical and police staff, in order to overcome prejudices and to provide the best possible protection of their rights.
- Strengthening civil society to create organized psychological support structures for persons with a migrant background who are in need of it, such as victims of sexual/gender-based violence, persons with STIs and HIV, sexual health issues, etc.

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