# “Do Not Leave Me Behind and Do Not Put Me in Your Box”: Exploring Unmet Family Planning Needs Among Women with Migration Histories in Germany—A Mixed-Methods Study

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# Abstract

**Introduction:**
Family planning is a fundamental human right and central to achieving several Sustainable Development Goals (SDGs). Women with migration histories often experience greater reproductive health needs and face multiple barriers to care. This study explored family planning needs, including barriers and facilitators to rights-based reproductive healthcare among women with migration histories in Germany.

**Methods:**
We conducted an emergent sequential exploratory study in Berlin among 29 women with migration histories who had accessed reproductive healthcare within the past two years. Interviews were conducted in participants' preferred languages using multilingual recruitment strategies. Data were analysed thematically and descriptively, and barriers and facilitators were interpreted using the Education, Training, and Research (ETR) Health Equity Framework.

**Findings:**
Participants (mean age 33.76 years) originated from diverse low- and middle-income countries, and most (89.7%) had at least one child. Contraceptive use varied: barrier methods (27.6%) and mixed approaches (24.1%) were most common, while 20.7% reported no contraceptive use and 17.2% relied on traditional methods. Hormonal methods were used less frequently, largely due to concerns about side effects and financial constraints. Women emphasized the need for affordable and continuous access to contraception, linguistically accessible information, and respectful, shared decision-making. Unmet needs were shaped by four interrelated themes: psychological factors, individual factors, systems of power, and relationships and networks.

**Conclusion:**
These findings highlight intersecting psychological, social, and structural barriers and underscore the need for culturally sensitive, trauma-informed services and strengthened communication to support equitable reproductive healthcare. Improved financial and administrative accessibility across the life course, aligned with universal health coverage, may serve as important facilitators.


# Introduction

Universal access to family planning is widely recognized as a human right and is central to gender equality and women's empowerment, grounded in states' obligations under international human rights law [1,2]. This human rights perspective is formally embedded in the United Nations Population Fund (UNFPA) approach to family planning, which emphasizes bodily autonomy and agency, informed decision-making, and principles of non-discrimination and equality across four programmatic levels: community; laws and policy; service delivery; and the individual [3]. This perspective aligns with ecosystem-based approaches in high-income countries that position family planning as a shared responsibility of health systems and public policy rather than solely an individual one [3,4]. This rights-based framing is particularly crucial for refugee and migrant populations, who must be recognized as

equal partners and rights-holders in healthcare systems [5]. Strengthening equitable access to family planning benefits not only migrant populations but also host communities, as effective family planning programs are a cornerstone of public health and contribute to multiple Sustainable Development Goals, most notably gender equality, while supporting sustainable national development, productivity, and economic growth [5,6].

In Germany, a high-income country with a well-resourced health system and low overall levels of unmet family planning need, levels remain substantially higher among women with migration histories [7]. Women with migration histories (WMH)—an adapted term from the German *Menschen mit Migrationsgeschichte* ("people with a history of migration")—are increasingly described by German scholars as a more inclusive and less stigmatizing term than earlier labels such as *Ausländer* or *Migrantin/Migrant* [8–10]. In population statistics, this category includes both first- and second-generation women and comprises 38.4 percent of the female population, with nearly half in their peak reproductive years [11,12]. Despite their demographic significance, women with migration histories face striking disparities in access to family planning services. In Berlin, unmet need has been reported as high as 47 percent, approximately five to seven times the national level of 7 to 9 percent [7,13].

The association between unintended pregnancy and unmet need for family planning, defined as the proportion of women of reproductive age who are married or in a union, wish to limit or postpone childbearing, but are not using any method of contraception is well established [14]. Unmet need is also strongly associated with increased maternal morbidity and mortality, making it a key indicator of reproductive health outcomes and health system performance [15]. In Germany, 94,596 abortions were performed in 2021, corresponding to a rate of 43 per 10,000 women [16]. Although comparative data between the general population and women with migration histories remain limited, some studies indicate that women with migration histories experience disproportionately higher rates of unintended pregnancy [17], suggesting persistent unmet family planning needs.

Despite these findings, a fundamental gap remains in the field. Existing research on women with migration histories in Germany is limited in reproductive scope and has focused primarily on mental health or on women with refugee or asylum-seeker status [18,19]. Few studies have adopted a health equity perspective capable of capturing the complex and systemic dynamics influencing access to family planning, including legal and financial constraints and broader social determinants of health across the life course [17,20,21]. In particular, there is limited differentiation between migration trajectories, insufficient focus on lived experiences, and inadequate understanding of how these barriers translate into everyday life across different life stages, including what women themselves identify as effective facilitators for improving access [13,20].

This research focuses on family planning needs and access among women with migration histories in Berlin, Germany's most diverse urban center and a major destination for migrants. Recognizing this diversity is essential, as migration trajectories and social contexts shape how women experience family planning services and whether their needs are met [8,9]. Using a mixed-methods approach with an

emergent sequential exploratory design, the research centers the voices of women with migration histories to understand unmet family planning needs from their own perspectives and to examine why existing services may fall short. It investigates the barriers and facilitators influencing access to family planning, with particular attention to the social, legal, and structural factors shaping women's reproductive choices. Guided by a health equity lens and the UNFPA rights-based framework, the research aims to deepen understanding of unmet family planning needs among women with migration histories in Germany.

## Methods

# Study Design and Setting

This mixed-methods study employing an emergent sequential exploratory design centers the voices of women with migration histories to understand their unmet family planning needs from their own perspectives and to examine why existing services may not fully meet those needs. The study used an exploratory–descriptive qualitative (EDQ) research design with a contextual approach, using individual in-depth, semi-structured interviews to examine family planning needs and access to reproductive healthcare among women with migration histories (WMH) in Germany. This qualitative phase formed the core component of the emergent sequential design and generated the empirical basis for subsequent conceptual synthesis and interpretation.

The EDQ design was appropriate given the limited empirical evidence on WMH's reproductive healthcare experiences and the lack of comprehensive data addressing the specific needs of this population. The design enabled the examination of individual perspectives alongside systemic and structural factors influencing access to care [7,22].

The study followed the EDQ framework described by Hunter et al., which emphasizes methodological flexibility alongside analytical rigor in the study of under-researched and complex health topics [22]. The integration of exploratory and descriptive qualitative methods supported the documentation of women's experiences and the identification of barriers and facilitators within the healthcare system [22].

Figure 1 presents the study framework and methodological approach used in the Family Planning and Reproductive Healthcare Access Study conducted in Berlin, Germany (2024).

## Terminology

In this study, the term *women with* a history of *migration* refers to first-generation women who have personally migrated to Germany, regardless of migration reason, nationality, or legal status. The term is used to capture the diversity of migration trajectories, including migration for asylum, family reunification, education, or employment, while avoiding categorizations based solely on nationality or legal status, which may obscure relevant differences in healthcare access and entitlement. This

terminology aligns with recent recommendations in migration and public health research to adopt inclusive and non-stigmatizing language when describing populations with migration backgrounds [8–10].

In this study, *unmet need* is interpreted more broadly as constraints on contraceptive autonomy rather than solely the absence of contraceptive use. Although unmet need for family planning is defined by the United Nations as a situation in which a woman is fertile and sexually active, does not wish to become pregnant in the near future or at all, and is not using any method of contraception [14], this demographic definition primarily captures discrepancies between fertility intentions and contraceptive use. While widely applied as an indicator of reproductive health system performance, this study adopts a qualitative perspective that also considers how barriers related to information, affordability, communication, and culturally responsive care may limit women's ability to obtain or use contraception that aligns with their reproductive preferences. In this study, *access barriers and facilitators* in family planning refer to structural, institutional, and service-related conditions that shape women's ability to obtain and use reproductive healthcare services. These include factors such as affordability, availability of services, language and interpretation support, administrative procedures, transportation, and health system navigation [23].

## Theoretical Framework

This study was guided by two complementary frameworks. The UNFPA rights-based framework provided the normative foundation, situating family planning as a human right and emphasizing non-discrimination, autonomy, participation, and accountability. The ETR Health Equity Framework extended this lens to examine how systems of power, relationships, and social structures interact to shape inequities in reproductive health [24]. Taken collectively, these frameworks positioned women's reproductive health as both an entitlement and a matter of structural equity, guiding analysis from rights recognition to systemic reform.

## Study Population and Eligibility Criteria

The study population consisted of first-generation women with migration histories (WMH) who had personally migrated to Germany for a range of reasons, including asylum or refuge, family reunification, education, or employment. This definition was intended to capture the heterogeneity of migration pathways relevant to experiences of family planning and access to reproductive healthcare. Purposive sampling was used to recruit WMH who could provide rich and detailed accounts of their reproductive healthcare experiences. Eligible participants were women aged 18 years or older, residing in Berlin, who had accessed reproductive healthcare services within the past two years. Inclusion further required that participants had experienced at least one pregnancy or childbirth within the past five years, ensuring diversity in reproductive health encounters and patterns of service use.

During recruitment, priority was given to women originating from low- and middle-income countries by focusing outreach efforts on community organizations, non-governmental organizations, and healthcare settings predominantly serving these populations. When more eligible participants expressed interest than could be included, purposive selection favored women from low- and middle-income countries to ensure adequate representation of groups more likely to experience structural, social, and cultural barriers to accessing reproductive healthcare. Women who were unable or unwilling to provide informed consent were excluded.

## Recruitment, Data Collection, and Interview Guide Development

# Recruitment and Sampling Strategy

Recruitment was conducted in Berlin using a multilingual and culturally sensitive approach developed in collaboration with healthcare providers, migrant support organizations, and non-governmental organizations [7]. Participants were recruited through community networks and healthcare settings serving women with migration histories. Data collection took place in locations chosen by participants, including private homes, secure online platforms, and neutral settings such as NGO support centers.

## Data Collection and Interview Guide Development

Data were collected through semi-structured, in-depth interviews using a topic guide developed for a broader qualitative study examining maternal health service experiences, reproductive healthcare, family planning, and maternal mental health among women with migration histories in Germany. For the present analysis, only the family planning and reproductive healthcare components were included.

The interview guide was informed by the UNFPA rights-based family planning framework and the ETR Health Equity Framework. The UNFPA framework guided the inclusion of questions on informed choice, autonomy, non-discrimination, and quality of care, while the ETR framework ensured attention to four interrelated domains: systems of power, relationships and networks, individual pathways, and psychological pathways. These domains were applied flexibly through context-specific questions and probes capturing multiple dimensions of women's experiences (e.g., access barriers, partner dynamics, knowledge, and emotional responses).

This approach enabled the guide to capture the structural, relational, and psychosocial conditions shaping reproductive autonomy. The family planning–relevant sections included: (1) sociodemographic and reproductive background; (2) family planning knowledge, practices, and decision-making; (3) access to services and system navigation; (4) communication, counseling, and quality of care; and (5) social, cultural, and psychological influences on contraceptive use.

The guide also captured descriptive variables reported in this study, including migration history, reproductive profile, and current and lifetime contraceptive practices. The full interview guide is provided

as Supplementary File 1.

## Pilot Testing and Validation

The interview guide was pilot-tested with two women with migration histories who met the same eligibility criteria as study participants. The pilot interviews assessed clarity, cultural appropriateness, sensitivity of questions, and overall flow. Two different researchers conducted the pilot interviews, which were audio-recorded and subsequently reviewed by the research team through listening, note-taking, and structured feedback to improve the interview process. Both pilot interviews were conducted using the same procedures as the main study, including the use of language support where required. Following pilot testing, the research team held debriefing discussions to evaluate comprehension across different language levels, the sequencing of questions, and the adequacy of probes. Minor revisions were made to simplify wording, improve flow, and strengthen probes related to family planning decision-making, access barriers, and communication. No major structural changes were required. The pilot interviews were not included in the final analysis but contributed to strengthening the content validity and feasibility of the interview guide.

# Interview Procedures

Interviews lasted between 40 and 90 minutes and were conducted by trained researchers with experience in qualitative methods and culturally sensitive interviewing. Interviewers received training in bias minimization and the management of sensitive topics. Professional interpreters were engaged when needed and were briefed on study objectives, confidentiality, and qualitative interviewing principles to preserve meaning and nuance. Data saturation was assessed iteratively after 25 interviews, with four additional interviews conducted to confirm thematic completeness. The final sample reflected diverse migration trajectories and reproductive experiences, although the predominance of married women with young children is acknowledged as a limitation.

# Reflexivity and Quality Assurance

The study was conducted by an interdisciplinary research team with expertise in qualitative research, sexual and reproductive health, migration and health, public health, and clinical care, enabling a multidimensional analytic perspective. Two researchers conducted all interviews with support from five multilingual research assistants who facilitated communication in participants' preferred languages. Prior to data collection, all interviewers and language facilitators completed structured training covering study objectives, ethical procedures, qualitative interviewing techniques, cultural sensitivity, and confidentiality. Training was followed by a quality assurance assessment with individualized feedback. Each interviewer conducted a pilot interview, which was reviewed by the research team to refine interviewing techniques and ensure consistency across data collection.

Reflexivity and quality assurance were maintained through ongoing team engagement, including three preparatory workshops, six scheduled online meetings during data collection, and four analytic

workshops. These sessions supported reflexive examination of researchers' positionality, discussion of field experiences, and critical reflection on emerging interpretations [25]. To enhance analytic rigor, investigator triangulation was applied during data analysis. Two researchers independently analyzed the dataset in separate NVivo projects, while a third researcher reviewed and compared analytic outputs to assess consistency. Discrepancies were discussed in joint analytic meetings until consensus was reached. Analytic decisions were documented in shared memos to maintain a transparent audit trail. Credibility was further strengthened through member checking, with preliminary findings shared with two participants via follow-up calls or secure messaging and incorporated into the final analysis [26].

# Data Analysis

Data analysis combined inductive thematic analysis with theory-informed framework mapping and proceeded in four analytical stages.

## Stage 1: Thematic Coding Guided by a Rights-Based Framework

In the first stage, interviews were transcribed verbatim and analyzed using a combination of inductive and deductive coding in NVivo 12. Analysis was guided by the UNFPA rights-based family planning framework [3]. Initial codes were generated inductively from the data while also drawing on key dimensions of rights-based family planning access. Coding followed principles of reflexive thematic analysis [25]. Codes were iteratively refined through team discussion, constant comparison, and analytic memo writing to strengthen interpretive rigor. Subgroup analyses explored variations across participant characteristics, including age, language proficiency, migration pathway, and patterns of healthcare access, with particular attention to differences between refugee and non-refugee migrant women.

## Stage 2: Framework Mapping Using the Health Equity Framework

In the second stage, findings were interpreted using the ETR Health Equity Framework [24]. Framework mapping was conducted across four domains: systems of power, relationships and networks, individual pathways, and psychological pathways, consistent with the framework method commonly applied in qualitative health research [27]. This stage examined how structural conditions, relational contexts, and individual capacities interacted to shape reproductive healthcare experiences across the life course. Integrating the rights-based family planning framework with the health equity framework enabled the analysis to move beyond individual narratives toward identifying broader systemic mechanisms influencing access to family planning.

## Stage 3: Examination of Social Determinants Through Matrix Coding

In the third stage, demographic characteristics, including legal status, language proficiency, education, migration reason, duration of stay, employment, and marital dynamics, were examined using matrix

coding in NVivo (Table 3). This approach enabled systematic comparison across participant groups and clarified the intersecting structural and intermediary conditions under which unmet family planning needs were most pronounced [28].

## Stage 4: Conceptual Model Synthesis

In the fourth stage, iterative team-based mapping was undertaken to synthesize findings into a conceptual model. The analysis identified four interacting pathway domains, systems of power, relationships and networks, individual pathways, and psychological pathways, which were linked to four manifestations of unmet family planning need: communication and information gaps; continuity and affordability barriers; respect and shared responsibility; and cultural and life-course responsiveness. The resulting conceptual model (Fig. 2) represents a theory-informed and data-derived synthesis of these dynamics. Matrix-coded demographic determinants were subsequently integrated to illustrate how migration-related structural and intermediary factors intersect with these pathways. Through this integration, the model conceptualizes unmet family planning need not as an isolated outcome but as the product of interacting structural, relational, psychological, and individual mechanisms operating across the life course.

The model illustrates how migration-related social determinants shape reproductive autonomy and family planning access through structural, relational, psychological, and individual pathways, ultimately contributing to unmet family planning needs.

## Ethical Considerations

**Ethical approval**

was obtained from Charité–Universitätsmedizin Berlin (EA4/076/23). Additional permissions were obtained from organizations involved in participant recruitment. Participation was voluntary, and written and verbal informed consent was obtained from all participants prior to data collection. Participants received information about the study purpose, procedures, potential risks, and their right to withdraw at any time without consequences. Measures to protect privacy and confidentiality included the use of pseudonyms, secure data storage on password-protected devices, and restricted access to study data for authorized research personnel. Consent procedures included permission for audio recording and the use of data for research purposes. Interviews were conducted with attention to participants' comfort, and information on psychosocial support services was made available to participants if needed. The study followed established ethical principles, including respect for persons, beneficence, and justice, and employed inclusive and non-stigmatizing language during data collection and reporting.

## Reporting

The Comprehensive Criteria for Reporting Qualitative Research (CCQR): Reporting Guideline for Global Health Qualitative Research Methods was used to prepare the manuscript [29].

## Results

# Participant Characteristics

The study included 29 participants (mean age = 33.8 years, SD = 4.8, range 25–45), representing 17 countries across five continents (Table 1). Participants had lived in Germany for an average of 5.5 years (SD = 3.6, range 0.5–18), with most (75.8%) residing in the country for 3–10 years. The primary reasons for migration were family reunification (44.8%), education (24.1%), employment (17.2%), and protection/asylum (13.8%).

# Education, Employment, and Marital Status

The sample was highly educated: 86.1% held tertiary qualifications (37.9% bachelor's, 44.8% master's, 3.4% doctoral). Employment patterns varied, with 34.5% employed, 24.1% on parental/maternity leave, and 41.4% not currently employed. The vast majority were married (86.2%). Table 1 presents detailed sociodemographic characteristics.

Table 1
Sociodemographic and Reproductive Characteristics of Participants (n = 29).

| Variable | Category | Frequency (n) | Percentage (%) |
|---|---|---|---|
| Age (years) | 25–29 | 3 | 10.3 |
| | 30–34 | 15 | 51.7 |
| | 35–39 | 8 | 27.6 |
| | 40–45 | 3 | 10.3 |
| | Range (Mean ± SD): 25–45 (33.8 ± 4.8) | | |
| Time in Germany (years) | 0–2 | 5 | 17.2 |
| | 3–5 | 11 | 37.9 |
| | 6–10 | 11 | 37.9 |
| | 11–18 | 2 | 6.9 |
| | Range (Mean ± SD): 0.5–18.0 (5.5 ± 3.6) | | |
| Time in Berlin (years) | 0–2 | 5 | 17.2 |
| | 3–5 | 11 | 37.9 |
| | 6–10 | 13 | 44.8 |
| | Range (Mean ± SD): 0.0–9.0 (4.9 ± 2.6) | | |
| Reason for Moving | Family reunification | 13 | 44.8 |
| | Protection/Asylum seeker | 4 | 13.8 |
| | Education | 7 | 24.1 |
| | Employment | 5 | 17.2 |
| Marital Status | Married | 25 | 86.2 |
| | Single | 4 | 13.8 |
| Education Level | Secondary/High school | 4 | 13.8 |
| | Bachelor's | 11 | 37.9 |
| | Master's | 13 | 44.8 |

**Note: *Other countries (single respondents): Argentina, Bangladesh, Guinea, Guinea-Bissau, India, Indonesia, Lebanon, Philippines, Somalia, Vietnam, Yemen, Zimbabwe**

| Variable | Category | Frequency (n) | Percentage (%) |
|---|---|---|---|
| | Doctorate/PhD | 1 | 3.4 |
| Country of Origin | Pakistan | 5 | 17.2 |
| | Mexico | 4 | 13.8 |
| | Afghanistan | 3 | 10.3 |
| | Ghana | 3 | 10.3 |
| | Turkey | 2 | 6.9 |
| | Other countries* | 12 | 41.4 |
| Employment Status | Employed | 10 | 34.5 |
| | On parental/maternity leave | 7 | 24.1 |
| | Not currently employed | 12 | 41.4 |

**Note: *Other countries (single respondents): Argentina, Bangladesh, Guinea, Guinea-Bissau, India, Indonesia, Lebanon, Philippines, Somalia, Vietnam, Yemen, Zimbabwe**

# Reproductive Profile

Most participants (89.7%) had at least one child (mean = 1.3, SD = 0.8). On average, they reported two pregnancies (SD = 1.1), and 34.5% had experienced a miscarriage. At the time of data collection, 69.0% were parenting a child under two years, 27.6% were pregnant, and one participant (3.4%) had recently experienced an abortion (Table 2).

Family Planning Practices

At the time of the study, 28 of the 29 participants (96.6%) reported being sexually active, indicating ongoing chance of repeated pregnancy. Current contraceptive use was diverse. The most common methods were barrier methods (27.6%) and mixed or combined approaches (24.1%). One-fifth of participants (20.7%) reported not using any contraceptive method, while traditional methods such as withdrawal were used by 17.2%. Hormonal contraceptive use was less common (6.9% oral contraceptives, 3.4% copper intrauterine devices).

Lifetime contraceptive experiences reflected broader exposure, with 55.2% having used barrier methods, 44.8% traditional methods, and 37.9% hormonal contraceptives. Contraceptive choices were shaped by cultural norms, health priorities, and levels of autonomy.

Table 2
Reproductive History, Status, and Family Planning of Participants (n = 29)

| Variable | Category | Frequency (n) | Percentage (%) |
|---|---|---|---|
| Reproductive History | | | |
| Number of Children | 0 | 3 | 10.3 |
| | 1 | 16 | 55.2 |
| | 2 | 7 | 24.1 |
| | 3 | 3 | 10.3 |
| | Range (Mean ± SD): 0–3 (1.3 ± 0.8) | | |
| Total Pregnancies | 1 | 12 | 41.4 |
| | 2 | 7 | 24.1 |
| | 3 | 7 | 24.1 |
| | 4 | 3 | 10.3 |
| | Range (Mean ± SD): 1–4 (2.0 ± 1.1) | | |
| Miscarriages | 0 | 19 | 65.5 |
| | 1 | 8 | 27.6 |
| | 2 | 2 | 6.9 |
| | Range (Mean ± SD): 0–2 (0.4 ± 0.6) | | |
| Current Reproductive Status | | | |
| | Parenting a child under two | 20 | 69.0 |
| | Currently pregnant | 8 | 27.6 |
| | Recent abortion | 1 | 3.4 |
| Current Family Planning Methods | | | |
| | Not using any methods | 6 | 20.7 |
| | Condoms/barrier methods | 8 | 27.6 |
| | Withdrawal/traditional methods | 5 | 17.2 |
| | Pills/hormonal contraceptives | 2 | 6.9 |

| Variable | Category | Frequency (n) | Percentage (%) |
|---|---|---|---|
| | Copper IUD | 1 | 3.4 |
| | Mixed/combined methods | 7 | 24.1 |
| Lifetime Family Planning Experience | | | |
| | Barrier methods | 16 | 55.2 |
| | Traditional methods | 13 | 44.8 |
| | Hormonal methods | 11 | 37.9 |
| | IUDs | 2 | 6.9 |
| | Mixed methods | 4 | 13.8 |

Unmet Family Planning Needs

Unmet family planning needs among women with migration histories clustered around four interlinked themes: continuity and affordability, communication and information, respect and shared responsibility, and cultural and life-course responsiveness (Fig. 2). As illustrated in Fig. 2, these themes reflect manifestations of constrained reproductive autonomy operating across structural, relational, psychological, and individual pathways. Across themes, women described barriers that limited their ability to access contraception that aligned with their preferences, health needs, and life circumstances.

# Communication and Information Barriers

Many women described difficulty accessing clear, consistent, and culturally and linguistically appropriate information about family planning. Several participants noted that healthcare encounters often felt rushed and reactive rather than supportive of open discussion. Bushra explained that providers often expected patients to initiate conversations about contraception themselves, stating:

In Germany, doctors aren't very… well, they don't usually give you a lot of information. You kind of have to push them and ask questions yourself. I feel like that's just how the system works here. So that was always my expectation. I didn't really expect the doctor to tell me everything automatically. I always had my questions ready, so I kept asking them and doing my own research.
(Bushra, 33 years, Pakistan)

This dynamic sometimes discouraged women from asking questions, particularly when language barriers or uncertainty about the healthcare system reduced their confidence in interacting with providers. Others described broader challenges in navigating reproductive health information as migrant women. Kylie reflected on how limited consultation time and lack of guidance left many women unsure where to find reliable information, noting that:

*“Most of us migrant women don’t really know where to find the information. When you go to the doctor, the visit always feels rushed, like there is no time to ask questions. I had to do a lot of research myself. Sometimes it’s tough because most of the information is in German. Since my German is only at a B1 level, it was quite a struggle for me to read and understand everything. Even the support from the government is usually only in German. So, for someone who doesn’t speak German very well, it can be challenging to deal with bureaucracy and paperwork. No one really tells you that as a pregnant woman you have this right or that right. Most of the time, I had to figure it out by myself.”*

(Kylie, 39 years, Zimbabwe)

Language barriers further complicated these interactions, sometimes forcing women to rely on partners or informal translators to communicate with healthcare providers.

Participants also described the absence of centralized, multilingual information resources. When formal information channels were difficult to access, several women reported relying on digital tools and online resources to navigate reproductive health information. As Kylie explained:

ChatGPT has changed everything… That is how I am surviving now.
(Kylie, 39 years, Zimbabwe)

Another participant described using digital applications to support fertility awareness and guide contraceptive decision-making:

I use apps to track my period and understand ovulation so I can avoid having sex on those days. So far, it has always worked.
(Isabella, 33 years, Mexico)

As illustrated in the communication pathway shown in Fig. 2, gaps in accessible information and supportive counseling functioned as structural barriers to informed and confident contraceptive decision-making.

# Continuity and Affordability

Women also described financial and logistical barriers that disrupted the continuity of contraceptive use. Out-of-pocket costs, short prescription durations, and the limited availability of preferred methods made it difficult to maintain consistent access to contraception. Rosa explained that while she wanted to continue using her preferred contraceptive method, the cost created ongoing stress:

I had to pay for them… and because I’m not working it can be expensive. Sometimes I ask people to bring them from Portugal. The last time I paid about 15 euros.
(Rosa, 38 years, Guinea-Bissau)

Access was further complicated when specific contraceptive methods were not readily available in local pharmacies. For women balancing childcare responsibilities and limited appointment availability, frequent prescription renewals created an additional burden. Isabella expressed frustration with the need for repeated consultations simply to maintain access to contraception, explaining:

My doctor only gave me a prescription for six months, so I have to go back to the doctor again to get a new prescription for more pills. It feels like a lot of wasted time. I don't know why they can't just give a prescription for one year or something like that. It's kind of stressful, you know, because as a woman you only have a prescription for a few months, and then you have to go back to the doctor again to renew it.
(Isabella, 33 years, Mexico)

As illustrated in Fig. 2, disruptions in financial protection and continuity of care limited sustained contraceptive use and contributed to unmet family planning needs.

# Respect and Shared Responsibility

Participants also described family planning as largely framed as women's responsibility, reinforcing gendered expectations around reproductive health management. Hina reflected on the imbalance she perceived in available contraceptive options, explaining that:

My honest opinion is that most contraception methods are more focused on women than on men. The side effects are also mostly on women — hormonal side effects or birth-control side effects, everything. If you take medicine or use a coil or anything like that, the side effects are on the woman's side. For men, there are very few methods.
(Hina, 30 years, Pakistan)

This perception contributed to feelings that reproductive responsibility was unevenly distributed within both healthcare systems and intimate relationships. Some women also felt that their preferences were not always fully respected during clinical discussions about contraception. Sana described feeling uncomfortable when her doctor strongly recommended a particular method that she did not want to use, noting that:

My doctor has been trying to tell me to get a coil, you know, like a copper coil or something like that. She gave me the option the last time I visited her, and I told her that I would get back to her. But to be honest, I didn't think about it much because I do not plan to do it. I am fine with condoms for now, and I do not want to put anything else in my body.
(Sana, 37 years, Pakistan)

Participants emphasized the importance of respectful, autonomy-supporting care in which women's preferences were acknowledged and incorporated into decision-making. Ifrah captured this sentiment clearly when discussing her expectations for reproductive care, explaining that:

You should not put me in your box. You also need to listen to what works for me so that we can meet somewhere in the middle. For me, it has more to do with me as a woman and my freedom, because I grew up knowing that as a woman you are born into this world for procreation. The way it is forced on us is what makes me so angry.
(Ifrah, 30 years, Somalia)

As illustrated in Fig. 2, these experiences illustrate relational and systemic dynamics influencing women's ability to exercise reproductive autonomy.

# Cultural and Life-Course Responsiveness

Finally, participants expressed a desire for family planning services that better reflected their cultural backgrounds and evolving reproductive needs across different stages of life. Some women compared their experiences in Germany with practices in their countries of origin, particularly regarding the timing and availability of contraceptive counseling. Linh described how postpartum counseling was provided more proactively in her home country, explaining that:

In my country they give birth control information right after the baby is born, but here nobody talked to me about it unless I asked.
(Linh, 30 years, Vietnam)

Others felt that standardized approaches to reproductive counseling sometimes overlooked differences in cultural perspectives or perceived bodily responses to medical treatments. Hina reflected on this issue, noting that:

I think because we now have a bigger migrant population, doctors should actually study based on ethnicity as well… at least be more confident that there are other ethnic people here. Their bodies are different. They don't respond to medicine the same way, so they cannot have a one-fit solution. Everybody is different, and when ethnicity and other factors contribute, there can be differences in bacteria or resistance between a German body and a brown person's body, and I think this should be considered while treating patients.
(Hina, 30 years, Pakistan)

Women also described how their contraceptive needs changed over time, particularly during breastfeeding or postpartum recovery. One participant explained:

Right now, I am breastfeeding and using condoms, but I feel like I should probably talk to a doctor about other options that might work better for me later. I've never discussed family planning with my doctor. I'm using condoms now because I don't want more children, but I think I should ask my doctor about other options. It's necessary because sometimes condoms and natural methods don't work.
(Roya, 25 years, Afghanistan)

As illustrated in Fig. 2, misalignment between standardized care practices and women's cultural contexts or life-course transitions constrained access to contraceptive services tailored to their evolving reproductive needs.

Barriers and Facilitators to Reproductive Health

Access to reproductive healthcare was shaped by intersecting structural, individual, and social factors, as conceptualized in Fig. 2. Racism, financial hardship, legal restrictions, and language barriers limited women's ability to engage with services, while self-advocacy, active information seeking, and community networks supported access. Overall, women's reproductive healthcare trajectories reflected both systemic inequities and personal resilience, reinforcing the access-mediated structural equity model presented in Fig. 2.

# Psychological Pathways

Women described how pre- and post-migration trauma, including experiences of war, displacement, female genital cutting, and reproductive loss, shaped their emotional responses to family planning choices and influenced their reproductive decision-making and healthcare encounters. These experiences often created lasting fears, uncertainty, and psychological distress that affected how women approached pregnancy and contraception.

For example, Ifrah linked her childhood experience of female genital cutting to ongoing anxiety about childbirth. Reflecting on the long-term impact of this experience, she explained:

I was cut when I was six years old. I have lost a lot of parts of my body, and I am still discussing it with my gynecologist. Sometimes I wonder if I will even be able to give birth because of the cutting. That is one of my biggest fears, because I don't want to go through another cutting. That's also one of the reasons why I wasn't sure if I wanted to have a child. I was never sure if I would be able to give birth.

(Ifrah, 32 years, Somalia)

This experience contributed to persistent fear surrounding pregnancy and delivery. For other women, the stress of forced migration and exposure to violence created emotional strain that was often not addressed in healthcare settings. Khatoon described the traumatic memories associated with conflict and displacement:

The night the Taliban attacked, I saw my brother being killed in front of my eyes. He was just 25 years old. I have these memories in my head so many times. Of course, life in Germany is good, but how can I forget everything and pretend that everything is fine?
(Khatoon, 35 years, Afghanistan)

When asked whether these experiences affected her health or reproductive decisions, she added:

I cannot say if it is relevant to it. I don't know. No one ever asked me, and honestly, I prefer not to share because it brings me pain.
(Khatoon, 35 years, Afghanistan)

These narratives illustrate how psychological trauma may shape reproductive experiences, even when it is not directly discussed during healthcare encounters.

In contrast, some participants emphasized that empathetic communication from healthcare professionals could reduce fear and anxiety related to family planning and reproductive decisions. Bushra reflected on the importance of compassionate care, explaining that supportive interactions could improve women's experiences during vulnerable moments:

It's one thing to be just a doctor, but another thing to have an empathetic doctor in the medical field. They are two different things… You can have the best medical support, but if someone doesn't really listen or understand the emotional side, then something important is missing.
(Bushra, 33 years, Pakistan)

Overall, participants described provider communication as part of their experiences when accessing family planning and reproductive healthcare, including references to listening, understanding, and attention to the emotional aspects of care.

# Individual Pathways

Experiences with contraceptive methods, exposure to information from peers, health literacy, language skills, and personal confidence varied across participants. These individual factors influenced how women perceived and navigated family planning options.

Sana, for example, explained that concerns about side effects discouraged her from using hormonal contraception. She noted:

I was recommended birth control a lot of times, but then I've heard so many horror stories how it just messes up your hormones and then it's so hard to find one that actually suits you. So, I was like if I can treat all the problems without using a birth control, might as well. I just never ended up taking it.
(Sana, 37 years, Pakistan)

For Sana, negative stories circulating within social networks shaped her perceptions and discouraged her from adopting hormonal methods. Maheen described a different approach, emphasizing self-directed information seeking and confidence in her decision-making. She explained:

No, I pretty much research on my own and I'm very confident about the choices that I make. So, I don't think that I need someone to show me how to plan it. I know what I want and I kind of research on that.
(Maheen, 31 years, Pakistan)

For her, independent research provided reassurance and enabled her to make informed decisions without relying heavily on clinical guidance.

## Systems of Power

Women reported experiences of discrimination, uncertainty about entitlements, and financial barriers that undermined trust in the healthcare system and delayed access to care.

For example, Elina described an experience during pregnancy in which she felt she was treated unfairly at a gynecology clinic. She explained that although she arrived early for her appointment, she was made to wait while others who came later were seen first:

One day, during my pregnancy, I went to see my gynecologist… I had an appointment there, and I arrived early, even before my scheduled time. What I noticed was that I was made to wait for so long that it was painful. Every time someone came in after me, they were attended to immediately. I sat there for almost two hours waiting. I finally got up and asked the woman at the desk, 'I've been here before these people, so why aren't you attending to me?' … I told her directly, 'No, this is not right, it's not fair… This is not right. It's racism.'
(Elina, Guinea)

Experiences like this contributed to feelings of exclusion and mistrust toward healthcare providers. Other participants described subtle forms of othering during clinical encounters. Bushra recalled being hospitalized after being prescribed medication that caused complications. When she confronted her doctor afterward, the doctor apologized, explaining:

Sorry, because you're my first brown patient, I didn't consider this could be a problem.
(Bushra, 33 years, Pakistan)

Although framed as an apology, the comment reinforced Bushra's perception that healthcare providers were not always prepared to recognize or address the specific health needs of diverse patient populations. Ifrah described racism and discrimination as structural forces shaping migrant women's experiences. She explained:

The negative here is racism and discrimination. This is structural. When you are Black, people assume things about you. They describe Black women as aggressive. I would like to ask why people do this? I think it is because they don't want to share the good life they have here; they want to keep it within their own community. Women still have a long journey ahead. Women have to make the world better!
(Ifrah, 32 years, Somalia)

Legal and administrative uncertainty further complicated access to care. Several participants expressed confusion about their eligibility for healthcare services within the German system. Roya described this uncertainty, stating:

I did not know which services I am actually entitled to.
(Roya, 33 years, Afghanistan)

Financial barriers also constrained access to reproductive health services. Sana explained that contraception was expensive and not covered by insurance in her case:

*"Birth control is not free… she told me* [doctor] *I would have to pay, and I remember she said it costs more than 300."*

(Sana, 37 years, Pakistan)

Structural factors beyond the healthcare system also shaped women's reproductive health experiences. Housing insecurity and overcrowded living conditions added further strain during pregnancy and postpartum recovery. Khatoon described her living situation in refugee accommodation:

We spent eight months in Pakistan for interviews, but my children didn't have visas, so that caused delays. Once we arrived in Germany, we spent four days in one camp and a month and a half in another, with barely enough money to survive. We were in a very challenging situation… It was difficult to get nutritious food in the camps, and being pregnant I really needed it. We have our own room now, but it was still hard because there were many people living in the refugee house.
(Khatoon, 35 years, Afghanistan)

Overall, participants described discrimination, administrative uncertainty, financial constraints, and housing conditions as part of their experiences when accessing healthcare services.

# Relationships and Networks

Migration-related isolation, childcare responsibilities, and social stigma often limited women's access to support networks and made navigating the healthcare system more difficult.

Several participants described feeling socially isolated after migration, particularly when they lacked family members or trusted friends nearby. Roya reflected on the challenges of managing pregnancy and childcare without a support system, explaining:

I have no one here to help me with anything. The only help we get sometimes is from translators who work in the refugee housing. I don't have friends or relatives here to support me, and it is very hard.
(Roya, 33 years, Afghanistan)

Such isolation increased emotional strain and made it more difficult to access or understand available healthcare services.

In contrast, some women highlighted the important role played by community organizations, non-governmental organizations, and informal support networks in helping migrant mothers navigate

healthcare systems. Khatoon emphasized the value of these organizations in providing information and guidance during pregnancy and early motherhood, noting that:

Without the help of these organizations, many women would not know where to go or how to get care. (Khatoon, 35 years, Afghanistan)

Peer networks and digital communities also emerged as important sources of information and emotional support. Anicka described how collective knowledge-sharing among women could empower others to navigate healthcare challenges more effectively:

I started an online support group where women could share their experiences and information with each other, because knowledge is power.
(Anicka, 45 years, Argentina)

Overall, participants described both limited access to personal support networks and the use of community-based and peer-led resources when navigating healthcare services.

Intersecting Demographics and Systemic Factors

Access depended on how personal characteristics (migration reason, language proficiency, education, legal status, duration of stay, employment, marital dynamics) intersected with bureaucracy and immigration policy. Conflict-related migration often intensified trauma and mistrust, while family reunification could reduce autonomy; work/study migrants sometimes had stronger language and networks but still faced stress and administrative barriers. Language proficiency and longer time in Germany generally eased navigation, though interpreter shortages and complexity persisted. Overall, inequities reflected intersectional conditions rather than any single demographic factor (Table 3).

Table 3
Demographic factors shaping healthcare access, their effects, spheres, and barrier/facilitator roles.

| Factor | Core Effect | Spheres Affected | Barrier/Facilitator |
|---|---|---|---|
| Migration Reason | Shapes mental health and stress levels based on context (e.g., trauma, workload). | Psychological, Individual | Both (context-dependent) |
| Language Proficiency | Influences psychological stress and ability to navigate healthcare systems. | Psychological, Systems of Power, Individual | High = Facilitator; Low = Barrier |
| Education | Affects access to formal/informal support and system navigation. | Systems of Power, Individual | Higher = Facilitator; Lower = Barrier |
| Legal Status | Determines access to healthcare and insurance coverage. | Systems of Power | Secure = Facilitator; Precarious = Barrier |
| Duration of Stay | Impacts familiarity with systems and strength of support. | Systems of Power, Relationships and Networks | Longer = Facilitator; Recent = Barrier |
| Employment | Correlates with healthcare access via insurance. | Systems of Power, Individual | Stable = Facilitator; Unstable = Barrier |
| Marital Status | Shapes autonomy and level of dependence. | Relationships and Networks, Individual | Supportive = Facilitator; Dependent = Barrier |

**Note. Data derived from NVivo matrix analysis mapping demographic factors to spheres of influence and their role as barriers or facilitators of reproductive healthcare access.**

# Discussion

Despite Germany's well-resourced health system and the formal availability of family planning services, participants described multiple barriers that limited their ability to access contraception aligned with their preferences and life circumstances. Within this sample, contraceptive practices were largely dominated by short-term or user-dependent methods, while uptake of long-acting reversible contraception remained limited and a notable minority of women reported no current contraceptive use. These patterns suggest that unmet family planning need is shaped less by the absence of contraceptive technologies than by the conditions under which contraceptive decisions are made and sustained. Interpreted through a rights-based family planning perspective, reproductive autonomy may therefore be constrained when individuals cannot translate contraceptive preferences into feasible choices within existing healthcare systems (30, 1, 3). This interpretation is consistent with health equity research demonstrating that complex healthcare systems may shift the burden of access onto individuals with fewer linguistic, legal, or social resources (31, 32).

The conceptual model developed in this study situates these findings within a health equity perspective, illustrating how unmet family planning needs among women with migration histories emerge through

interacting structural, relational, psychological, and individual pathways. Consistent with the Health Equity Framework, upstream social determinants, including legal status, education, employment, and structural racism, shape women's position within healthcare systems and influence their access to reproductive health services (24). These determinants operate through mediating access pathways that either facilitate or constrain contraceptive use. Structural conditions such as legal entitlements, insurance coverage, and financial protection influence the feasibility of obtaining services, while relational factors including partner support, community networks, and social stigma affect women's ability to navigate systems and access information (33, 34). Psychological experiences, including trauma and trust in healthcare providers, further shape engagement with reproductive healthcare, while individual factors such as language proficiency, health literacy, and self-advocacy influence women's capacity to act upon their reproductive intentions (35, 36, 37, 31). When barriers accumulate across these pathways, reproductive autonomy becomes constrained, resulting in the forms of unmet family planning need identified in this study. In this way, the model conceptualizes unmet need as a structurally mediated outcome rather than solely an individual-level problem, highlighting the importance of addressing systemic barriers to achieve equitable access to family planning services (32, 38).

Participants frequently described unmet family planning needs not as the absence of contraceptive methods but as difficulty obtaining the "right method at the right time." Navigating the healthcare system itself emerged as a major barrier to consistent contraceptive use. Tasks such as identifying appropriate services, arranging appointments, managing childcare responsibilities, renewing prescriptions, and obtaining medications often required considerable effort and time. These challenges were compounded by language barriers and uncertainty regarding available services. Such findings support existing evidence indicating that health system navigation constitutes a central dimension of health literacy inequality affecting migrant populations and influencing contraceptive uptake, continuation, and switching behaviour (31, 37, 33, 5).

Importantly, these barriers emerged despite the formal availability of family planning services. Previous research suggests that family planning access for migrant populations in Germany is frequently described as "free" in principle (7). However, participants' experiences indicate that legal frameworks and administrative procedures may complicate access in practice. Under the Asylum Seekers Benefits Act (Asylbewerberleistungsgesetz, AsylbLG), healthcare coverage for asylum seekers is largely restricted to treatment of acute illness, pregnancy-related services, and selected preventive care, while broader reproductive healthcare may require additional approval (39, 40).

At the same time, statutory health insurance covers contraception only for women under the age of 22, leaving older women responsible for out-of-pocket payments (41). These arrangements may generate uncertainty regarding eligibility and reimbursement pathways and may discourage contraceptive initiation or continuation, revealing important gaps in financial protection (42, 43). National surveys similarly indicate that financial constraints, limited culturally responsive outreach, and gaps in reproductive health education disproportionately affect migrant women, particularly those who are newly arrived or socioeconomically disadvantaged (17, 4).

As of today, in Germany, abortion is prohibited under § 218 of the Criminal Code (Strafgesetzbuch, StGB) (44). Approximately 95% of abortions occur under the “counselling regulation” (German: “Beratungsregelung”), which means that the procedure is exempt from punishment after mandatory counselling and within a limit (45). This shows that, in the lack of institutional support for family planning, the situation becomes even more complex under the law, and disadvantages may increase. This study also shows that later, medically indicated abortion care is uneven, delayed, and sometimes effectively unavailable. This means that people cannot assume that prenatal testing, diagnosis, and follow-up options will connect smoothly. In practice, a wanted pregnancy can become a crisis without a dependable pathway to either continue or end it.

Communication between healthcare providers and patients also emerged as a critical factor influencing access to family planning services. Participants frequently described consultations as rushed or reactive, limiting opportunities to discuss contraceptive side effects, method suitability, or changing fertility intentions. Language barriers further constrained these interactions and sometimes required women to rely on partners or informal translators during medical encounters. From a rights-based perspective, such conditions undermine informed choice because meaningful consent requires timely, comprehensible, and non-coercive information alongside genuine participation in decision-making processes (3). These findings reinforce previous research demonstrating that linguistic barriers and limited interpretation services can restrict access to preventive healthcare services among migrant populations (33, 5).

The contraceptive patterns observed in this study should also be interpreted in light of women’s reproductive life-course needs. Participants described the importance of longer prescription durations, reliable access to preferred methods, and counseling that addresses postpartum and breastfeeding contexts as well as changing fertility intentions. Previous research indicates that contraceptive needs evolve across the life course and are shaped by partnership dynamics, migration experiences, and reproductive history (35, 36). Studies conducted in Berlin have similarly reported high unmet family planning need among migrant and refugee women even where access is described as “free” in principle, suggesting that formal entitlement and practical access frequently diverge (7). The present findings help explain this divergence: when interpretation services are unreliable, counseling is inconsistent, and follow-up is disrupted by administrative or financial barriers, women often rely on methods that are immediately available or culturally familiar rather than those that best match their preferences or clinical needs. Such dynamics may widen the effectiveness gap between contraceptive methods and increase the risk of unintended pregnancy, particularly among postpartum women facing intensive caregiving demands and limited flexibility to attend appointments (15, 14, 7).

Psychological and emotional factors also shaped contraceptive engagement. Participants described experiences of trauma related to war, displacement, female genital cutting, reproductive loss, and distressing medical encounters, which sometimes heightened anxiety regarding reproductive health procedures and discouraged return visits for counseling or follow-up care. Previous research indicates that pre-migration trauma and post-migration stressors influence health-seeking behaviour among

refugee and conflict-affected populations (35, 36). Participants therefore emphasized the importance of empathetic communication and trust-building within clinical encounters. Trauma-informed and culturally responsive care appears essential for facilitating engagement with reproductive healthcare services (46). Psychological vulnerability was also shaped by broader structural conditions including legal uncertainty, housing insecurity, and experiences of discrimination, illustrating how emotional distress and constrained agency may be jointly produced by social determinants of health (47, 19, 40).

Although individual factors such as language proficiency, health literacy, and self-advocacy influenced women's capacity to act upon their reproductive preferences, these operated within systems that either enabled or constrained agency. Some participants compensated for structural barriers through self-directed research, careful preparation for medical appointments, and reliance on peer support networks. However, dependence on such strategies reflects underlying inequities, as women with fewer resources, limited time, or smaller social networks may be less able to obtain information, manage prescription renewals, or challenge provider recommendations. Evidence from Germany similarly indicates patterned differences in health literacy among migrant populations, with system navigation representing a key barrier (37).

It is important to acknowledge that women with migration histories represent a heterogeneous population whose migration trajectories vary considerably in terms of legal status, language proficiency, social support, and exposure to discrimination or trauma. All of these factors shape experiences of accessing family planning services. Individual strengths and navigation capacities therefore operate within and are often constrained by broader social and structural determinants that shape access trajectories in advance. In this context, intersectional approaches offer a more comprehensive framework than those focusing solely on individual resilience and problem-solving, although these individual skills remain important for navigating the system. Informal networks and community organisations therefore play an important role in facilitating access to services for different sociodemographic groups as mediating mechanisms, but their centrality also signals that formal systems do not consistently provide equitable or low-threshold access pathways. This indicates that broader analysis and responsiveness to structural and social determinants should be put in place (34, 32).

Power dynamics within clinical encounters were also linked to constrained contraceptive choice and discontinuity of care. Participants described experiences of racism, stereotyping, and dismissive communication that undermined trust and discouraged discussion of side effects, fertility intentions, or requests for alternative methods. Evidence from across Europe indicates that racism against racialised migrants contributes to poorer healthcare experiences and reduced uptake of preventive services, including family planning (48). In the present study, such experiences often intersected with institutional constraints such as rushed consultations, insufficient interpretation services, and limited continuity of care. These conditions may reinforce asymmetries in knowledge and authority between providers and patients and undermine women's ability to participate meaningfully in contraceptive decision-making.

Addressing these challenges requires sustained institutional commitment to cross-cultural competence and improved structural support for clinicians working with diverse patient populations (49, 50).

Taken together, the findings suggest that unmet family planning needs among women with migration histories arise through interacting structural, relational, psychological, and individual pathways. Language barriers and system navigation challenges restrict informed decision-making, discriminatory encounters erode trust and discourage follow-up care, and legal or financial exclusions narrow the range of feasible contraceptive options. Interpreted through the Health Equity Framework, these factors represent structural mechanisms producing patterned inequities in reproductive healthcare access rather than isolated individual barriers (24, 32). Notably, these constraints were evident even among highly educated participants, indicating that disparities cannot be attributed solely to knowledge deficits but instead reflect systemic features of entitlement, affordability, continuity, and respectful communication (37, 51). Collectively, these findings highlight the importance of moving beyond the mere availability of services toward healthcare systems that ensure accessibility, acceptability, quality, and trust as fundamental conditions for achieving equitable and rights-based family planning for women regardless of migration status (38, 32, 5).

# Limitations

Several limitations should be considered. Recruitment challenges may have led to the underrepresentation of women with precarious legal status, limited social networks, or those residing in less accessible asylum-seeker accommodations, potentially biasing the sample toward participants with greater stability. This was partially mitigated through multilingual, community-based recruitment strategies. Although professional interpreters were used, some loss of nuance in translation cannot be excluded; this risk was minimized through interpreter briefing and culturally sensitive interviewing practices. The sample was highly educated and may not reflect the experiences of women with lower levels of education or health literacy. This may also indicate a structural recruitment dynamic, whereby women with fewer resources or lower literacy were more difficult to reach and engage, even when language-accessible approaches were used. The relative homogeneity of the sample, predominantly married mothers with young children, may limit the transferability of findings and obscure more diverse reproductive trajectories. This was addressed analytically by situating findings within a life-course perspective rather than treating them as representative. Researcher and participant subjectivities may have influenced interpretation; however, this was mitigated through reflexive practice, interdisciplinary collaboration, and member checking. Although the study employed an emergent sequential exploratory design and included some descriptive quantification, it was not intended to produce generalizable or statistically inferential findings. Rather, it provides in-depth, context-specific insights that can inform future quantitative research. Finally, the analysis did not fully capture intersecting dimensions such as sexual orientation, disability, religion, and social class, which may further shape reproductive healthcare access.

Practice Implications

Healthcare systems are recommended to integrate cultural competency and trauma-informed training that fosters active, empathetic practice and trust-based care. Providers can use active listening, tailored communication, and inclusive service standards to address systemic bias. Community-driven interventions involving local leaders, peer educators, and informal networks can bridge service gaps and promote culturally relevant health education. Addressing language barriers, improving health literacy, and engaging male partners in family planning can reduce stigma, support informed decision-making, and strengthen access to reproductive healthcare.

Research Implications

Further intersectional, systemic research is needed to examine how migration, gender, and structural inequities shape reproductive health disparities. Comparative and policy-focused studies, including assessments of asylum legislation, can guide reforms. Research should investigate the role of social networks, male partner involvement, and cultural or religious norms in family planning, as well as individual-level factors like health literacy, language proficiency, and empowerment. Longitudinal and generational studies can capture evolving needs, informing community-driven, culturally sensitive interventions across the life course.

Policy Implications

The policy implications of these findings are substantial. Equitable reproductive healthcare for women with migration histories, especially those who are forcibly displaced, asylum-seeking, or undocumented, cannot be achieved without addressing legal, financial, cultural, and psychological barriers simultaneously. If contraception is formally available but financially inaccessible, administratively opaque, or socially unsafe to seek, then access remains incomplete in practice. Policy responses should therefore go beyond nominal coverage and address the actual pathways through which women obtain care. This includes reforming age- and status-based exclusions in contraceptive coverage, strengthening funding mechanisms for uninsured women, improving interpretation and navigation services, and streamlining health coverage registration procedures. It also requires sustained institutional investment in trauma-informed and culturally responsive care, not as an optional addition, but as a basic condition of equitable service delivery. Community-led education and peer navigation, developed in partnership with migrant women's organizations, should be embedded within reform efforts so that accountability is shaped not only by systems but also by the women most affected by them.

# Conclusion

It is crucial that reproductive healthcare systems adapt to the realities of increasingly diverse populations if they are to provide equitable and meaningful care. This study, grounded in the Health Equity Framework, shows that unmet family planning needs among women with migration histories in Germany are shaped not only by individual preferences or knowledge, but by the interaction of structural barriers, relational dynamics, psychological vulnerability, and unequal access to information and care. Women described the importance of affordable and culturally appropriate contraception, accessible

information, respectful communication, and genuine autonomy in decision-making. At the same time, barriers such as legal uncertainty, financial insecurity, language difficulties, discrimination, and bureaucratic complexity often constrained their ability to realize these needs in practice.

The findings also show that supportive relationships, culturally competent providers, interpretation services, and community-based advocacy can serve as important facilitators of access. However, these supports cannot substitute for structural reform. If rights-based family planning is to be achieved in practice, health systems must move beyond the formal availability of services and ensure the conditions under which those services are genuinely accessible, acceptable, and responsive. This includes reducing legal and financial barriers to contraception, institutionalizing trauma-informed and culturally safe care, strengthening multilingual communication and interpretation, and embedding migration-sensitive indicators into health monitoring and accountability systems. Future research should continue to examine these issues using longitudinal, comparative, and participatory approaches that center migrant women not only as research participants but as co-producers of knowledge, policy, and programmatic change. In this way, family planning policy and practice can move closer to the goals of health equity and reproductive justice.

## Abbreviations

AsylbLG
Asylum Seekers Benefits Act (Asylbewerberleistungsgesetz)
EDQ
Exploratory–Descriptive Qualitative
ETR
Education, Training, and Research
NGO
Non–Governmental Organization
SDGs
Sustainable Development Goals
UNFPA
United Nations Population Fund
UNHCR
United Nations High Commissioner for Refugees
WMH
Women with Migration Histories

## Declarations

## Ethics approval and consent to participate

Ethical approval for this study was obtained from the **Ethics Committee of Charité – Universitätsmedizin Berlin (**EA4/076/23). Additional permissions were obtained from organizations involved in participant recruitment. Participation was voluntary, and written and verbal informed consent was obtained from all participants prior to data collection. Participants were informed about the study purpose, procedures, potential risks, and their right to withdraw at any time without consequences. Measures to protect privacy and confidentiality included the use of pseudonyms, secure data storage on password-protected devices, and restricted access to study data for authorized research personnel only. Consent procedures included permission for audio recording and the use of data for research purposes. Interviews were conducted with careful attention to participants' comfort, and information on psychosocial support services was made available where needed. All procedures were conducted in accordance with established ethical principles, including respect for persons, beneficence, and justice.

## Consent for publication

Written informed consent for participation and for the publication of anonymized data and quotations was obtained from all participants prior to data collection.

## Availability of data and materials

The datasets generated and/or analyzed during the current study are not publicly available due to ethical restrictions and the sensitive nature of the qualitative interview data but are available from the corresponding author on reasonable request, subject to ethical approval and data protection regulations.

## Competing interests

The authors declare that they have no competing interests.

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## Authors' contributions

AP served as Principal Investigator and coordinated the study, overseeing its conception, design, analysis, and implementation. BH led the manuscript writing and the family planning work package, contributing to the study's conception and design, overseeing data collection and analysis, and drafting the manuscript. GPK contributed to the study's conception, design, analysis, and implementation. MF

supported study design and contributed to analytical interpretation. NR contributed to data collection, participated in pilot testing of the interview guide, and was involved in qualitative data analysis, including coding and interpretation of findings, and assisted with participant recruitment. NIW assisted with participant recruitment and data collection. JL and JS provided methodological and clinical expertise and contributed to the interpretation of findings. All authors critically reviewed the manuscript, approved the final version, and agree to be accountable for all aspects of the work.

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# Figures

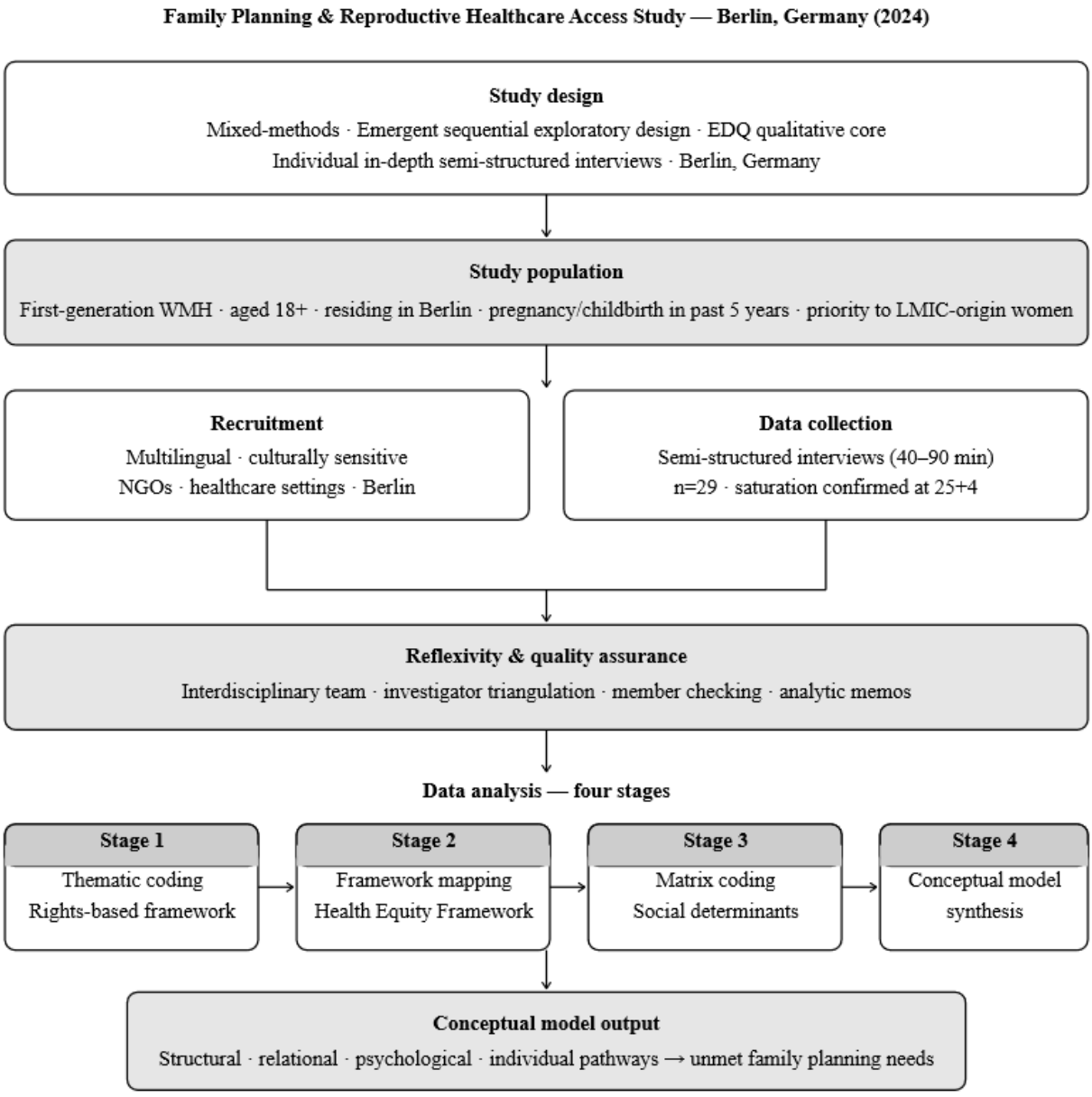


*Figure 1. Study framework and methodology — Family Planning & Reproductive Healthcare Access Study, Berlin (2024)*

**Figure 1**

Study framework and methodology for the Family Planning & Reproductive Healthcare Access Study conducted in Berlin, Germany (2024).

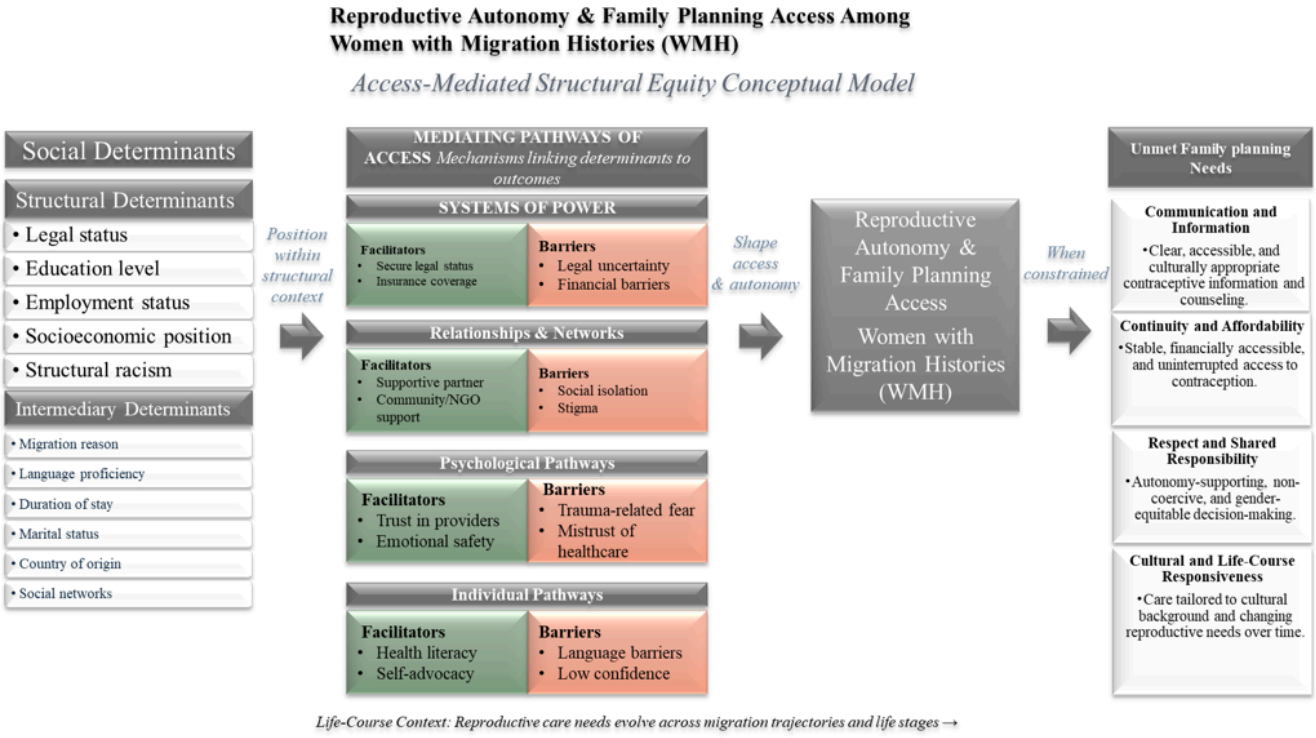


**Figure 2**

Conceptual model grounded in the Health Equity Framework among women with migration histories.

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