UNIVERSITY OF WEST ATTICA
ΠΑΝΕΠΙΣΤΗΜΙΟ ΔΥΤΙΚΗΣ ΑΤΤΙΚΗΣ

The perinatal experiences of refugee, migrant and asylum seeker women as part of the implementation of the ORAMMA Project at the Refugee Reception Center of Alexandria, Northern Greece.

A thesis submitted in partial fulfillment of the requirements for the degree of "Master of Science in Advanced and Evidence Based Midwifery Care" of the University of West Attica.

By Ziogou Revekka

r.n: 19010

EXAMINATION COMMITTEE

Principal Supervisor: Dr. Vivilaki Victoria

VIKTORIA VIVILAKI
Digitally signed by VIKTORIA VIVILAKI
Date: 2021.05.12 12:50:33 +03'00'

Committee member: Dr. Iliadou Maria

Maria Iliadou
Digitally signed by Maria Iliadou
Date: 2021.05.12 22:13:25 +03'00'

Committee member: Dr. Sarantaki Antigoni

Antigoni Sarantaki
Digitally signed by Antigoni Sarantaki
Date: 2021.05.18 19:49:01 +03'00'

STATEMENT OF AUTHOR'S WORK

"Being the author of this master's thesis I declare that all the support I had for its preparation is fully recognized. In addition, any sources from which the data, the ideas, or words were collected, whether exact or paraphrased, are listed in their entirety with full reference to the authors, publisher, or papers, including any sources that may have been utilized from the Internet. I also certify that this research has been performed exclusively by me and is a product of intellectual property of both myself and the Foundation. Violation of the above academic responsibility is an essential reason for the revocation of my degree."

The Declarant

Ziogou Revekka

PERMISSION TO USE

In presenting this thesis in partial fulfilment of the requirements for a Postgraduate degree from the University of West Attica, I consent that the Libraries of this University may allow free access to this thesis. It is understood that any copying or publication or use of this thesis or parts thereof for financial gain shall not be allowed without my written permission. It is also understood that due recognition shall be given to me and to the University of West Attica in any scholarly use which may be made of any material in my thesis.

Acknowledgements

This thesis was prepared between March 2020 and March 2021 in the framework of the postgraduate program “Master of Science in Advanced and Evidence Based Midwifery Care” of the University of West Attica.

As a minimum mention, with this paragraph I must thank all those who contributed to its elaboration and especially my supervising professor, Dr. Vivilaki Victoria for her valuable support and guidance, her outstanding mentorship, constructive criticism, and supervision, which have guided me throughout the stages of this research. In addition, my friend and colleague Triantafyllou Elena for the very good atmosphere shaped by contributing the most to the edit and fine-tune my thesis and furthermore the other two members of the three-member committee, Dr. Iliadou M. and Dr. Sarantaki A., for their great contribution in the acquisition of my knowledge on Obstetrics- Midwifery and the writing of scientific papers.

I would like to thank all the women that took part in this study. Without their participation, this project would not have been feasible.

Finally, I would like to express my appreciation to my biggest supporters—my parents, sisters and my partner—for their abundant love, encouragement and for providing me with tremendous support during my

time at this thesis. Without them, I would not have achieved what I have until now.

Dedication

I dedicate this research to all refugees who have been forced to flee to a foreign country to build a new life. I dedicate this research to all migrant women, hoping that it will help in a deeper understanding of their needs and their better integration in Greece.

Revekka

Table of contents

Abstract

Background: Proper perinatal care contributes to the birth of healthy babies and the reduction of maternal and neonatal mortality. As women from Middle Eastern countries get married noticeably young, give birth at such young age and have many children, proper information from a midwife is essential.

Purpose: The aim of this study is to investigate the experiences of refugee women in the provision of perinatal care by a midwife in the Refugee Accommodation Center of Alexandria, Imathia, within the context of the ORAMMA project's guidelines.

Sample and Method: This is a qualitative research which was conducted by face to face, in depth interviews. A questionnaire with open-ended questions was used as a guide for data collection. The sample used was pregnant women during the second and third trimester, as well as postnatal women.

Results: Refugee women claimed they were satisfied with the care they received at the Refugee Reception Center in Alexandria by their midwife. The main difficulties these women faced were the lack of interpreters during hospital visits, bureaucracy issues, transportation to the hospitals, and cultural-religious problems.

Conclusions: Women were satisfied by the services their midwife provided at the Refugee Reception Center in Alexandria. This fact confirms that the perinatal care in Refugee Camps in Greece is at a high level. There is a vital necessity of having more interpreters in hospitals. Health care professionals working with refugees, migrants and asylum seekers must be properly trained in managing any incident that might occur in such a vulnerable group of people, and be aware of their cultural differences, in order to avoid racist behaviors.

Key words: *refugee; migration; asylum seeker; perinatal care; labour; vulnerable women; reception centers; prenatal care; postnatal care; perinatal mortality; maternity care; Antenatal care; Migrant/ refugee/asylum seeker experiences; Qualitative interviews.*

Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AMKA	Social Security Number
HIV	Human Immunodeficiency Virus
IOM	International Organization for Migration
MAR	Migrant, asylum seeker or refugee
PAYPA	Temporary Social Security Number
ORAMMA	Operational Refugee and Migrant Maternal Approach
WHO	World Health Organization
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund
UNHCR	United Nations High Commissioner for Refugees

Introduction

According to the United Nations High Commissioner for Refugees, during the last five years, through the eastern Mediterranean route, approximately 1.951.365 thousand refugees and migrants made it reached Europe (Greece, Italy, Malta, Spain and Cyprus), most of which were hosted by Greece and Italy (IOM, 2018). (Figure 1)

Figure 1. Eastern Mediterranean route

In 2015, Greece, compared to other European countries, received most of the arrivals, which reached 856.723 thousand (UNHCR, 2015). The access was either by sea or by land.

Second in line was Italy, which received 153.842 refugees by sea and finally Spain, with only 5.312 thousand arrivals from both sea and land borders (UNHCR, 2015).

In order to stop the uncontrolled movement of mixed refugee flows between the European Union and Turkey, an agreement was authorised in March 2016, which provided the safe transfer of refugees to European territory. Those who arrived in Greece without seeking asylum or those whose asylum request was not approved by the Greek government agency, would return to Turkey (European Commission, 2016).

As stated by the United Nations High Commissioner for Refugees, in Greece, in 2016 the arrivals were estimated at 177.200. In 2017 there was a vertical drop with only 36.300 arrivals in total. A small increase was observed in 2018 with a total of 50.500 refugees arriving in Greece, the same in 2019 where the number reaches 74.600 refugees. Finally, in 2020 there were only 13.896 arrivals of refugees and migrants in Greece (Figure 2).

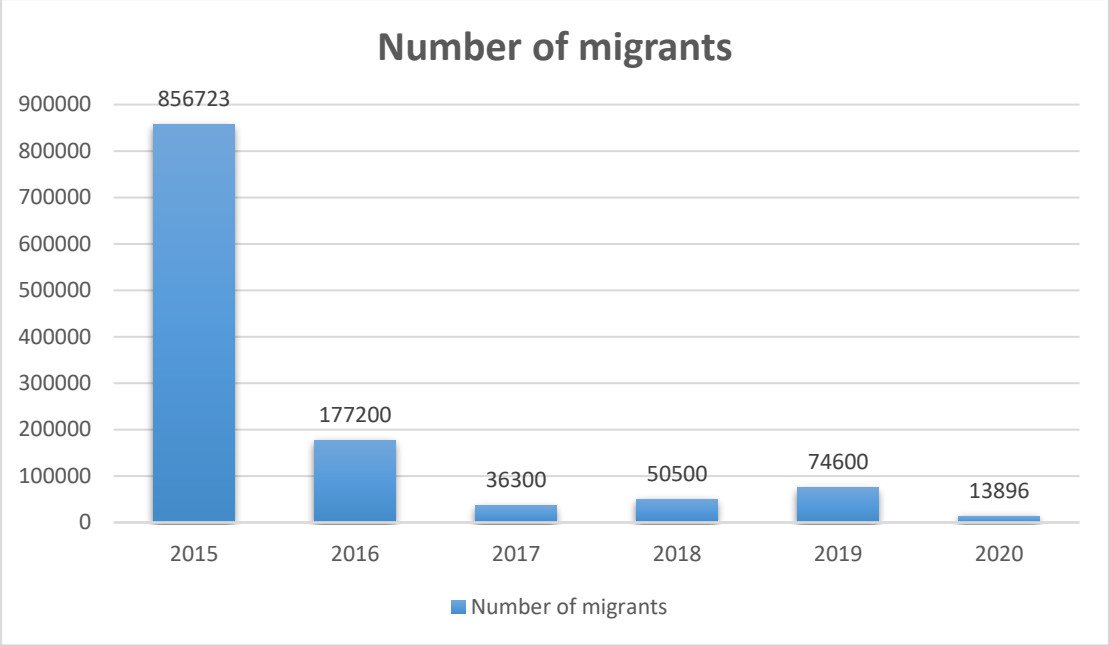

Figure 2 Number of migrants by year

The nationalities of migrant and refugees were mainly from Syria, Afghanistan and Iraq, however there were also migrants from other countries such as Congo, Somalia, Algeria, Nigeria etc. (UNHCR, 2016, 2017, 2018, 2019). The following diagram shows the nationalities and their percentages depending on the year they entered Greece (Figure 3).

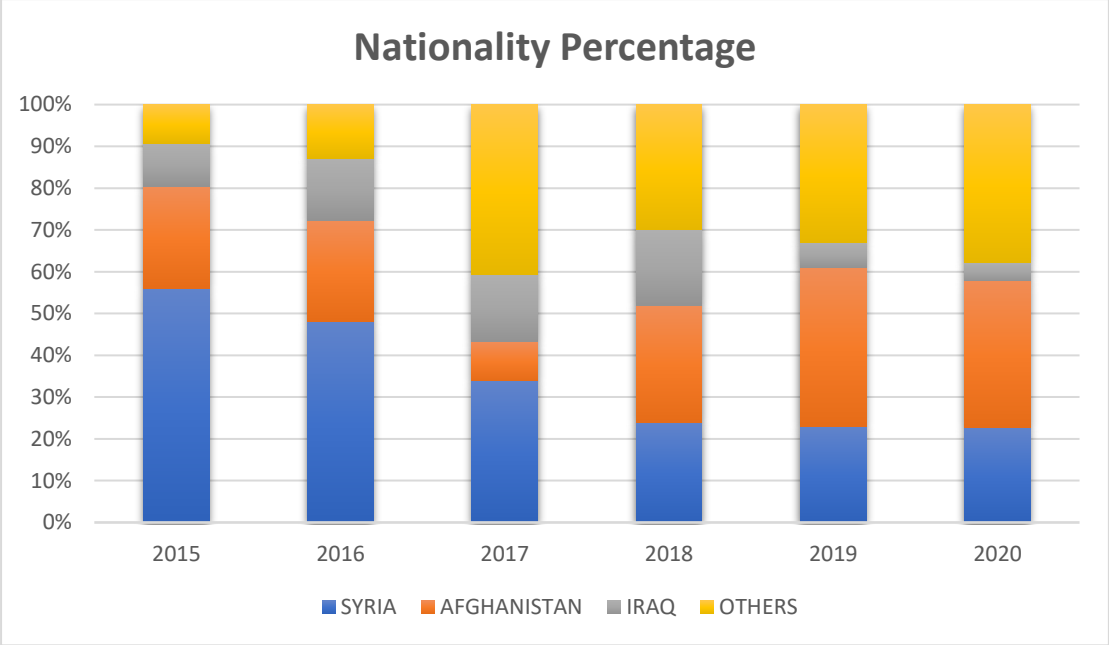

Figure 3 Nationality Percentage

Migrants were beginning to access the host system on the isles, many of which have been appointed as hotspots by the EU-Turkey agreement. Upon arrival of the refugees on the shores of the Eastern Aegean they reached the Hosting and Identification Centers of Moria, Chios, Kos, Samos and Leros, where registration and healthcare of refugees started (European Commission, 2016).

Categories of accommodation for refugees

The first form of accommodation is in spaces used for the purpose of housing asylum seekers where they can stay until their asylum application is examined, at the border or in transit zones (Legislation Information Bank, Law 4540/2018).

The second form are the Refugee Centers. They can be public or private buildings and can be supervised by public or individual non-profit organizations or global organizations (Legislation Information Bank, Law 4540/2018).

Refugee centers are scattered throughout the country (Médecins du Monde / Doctors of the World, 2016). (Figure 4).

Eventually, the third form is the private houses, apartments, or hotels rented by housing programs for refugees and asylum seekers. All the above types of housing are supervised by the competent Host Authority, in cooperation with the state bodies and under their responsibility (Legislation Information Bank, Law 4540/2018).

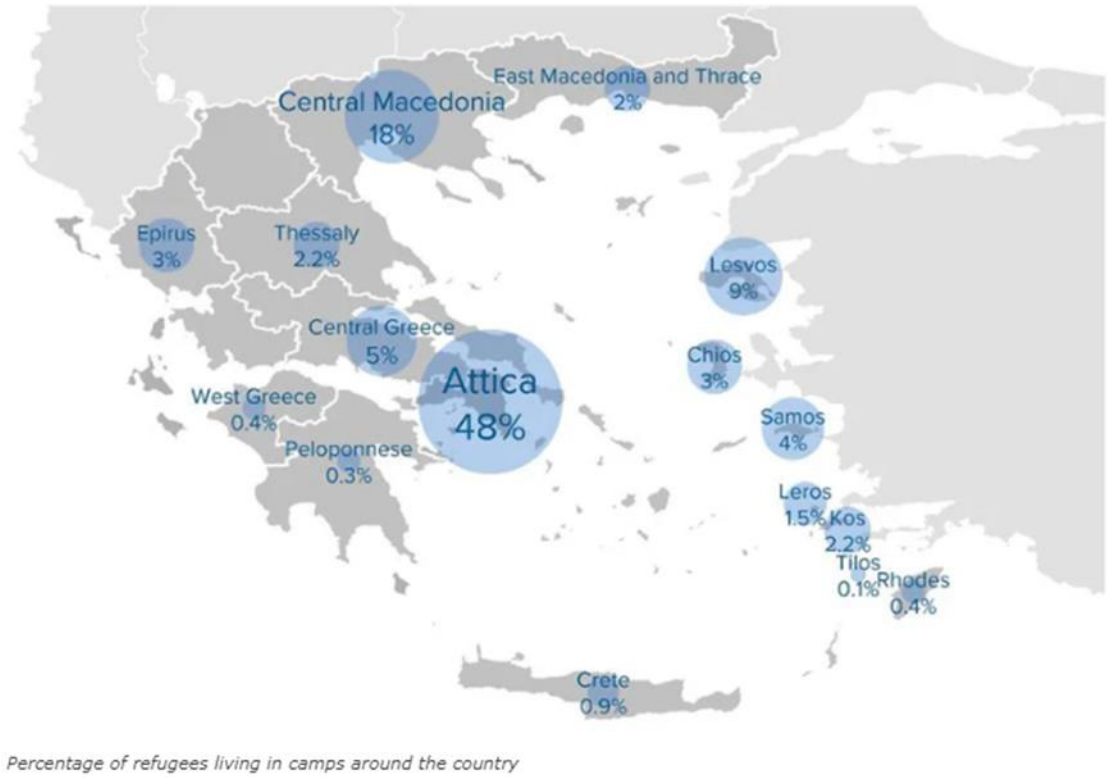

Figure 4 www.greekreporter.com (Sep.2018)

European policies for refugees: access to healthcare services

In 1948, the World Health Organization first stated that the right to health is a primary human right.

In Greece, the law stipulates unimpeded access to free public health services for recognized refugees, including asylum seekers, from the first day of their asylum application. Regarding undocumented persons who are already in the country, their access to the health system is limited and only emergency medical care is provided (Law 4251/2014).

Although the national law provides refugees the right to free medical care, the reality is often different.

The National Health System "has not incorporated practices of intercultural approach" (Kotsioni I., Hatziprokopiou P., 2009). The lack of information of the state services about the refugee status (Sklavou, 2008: 165), the limited knowledge of the rights of use of the refugee health services (First Reception Service / Annual Report, 2014), the different culture (e.g. refusal of a Muslim woman to be examined by a male doctor) together with the absence of interpreters raises objective difficulties (Ascoly N. et al, 2001).

Briefly, Non-Governmental Organizations carry out important work. Specifically, Doctors of the World and PRAKSIS operate polyclinics in Athens and Thessaloniki offering free primary care, medicines and counseling on welfare and integration issues, to refugees and persons "without administrative documents" who do not have permission to use the National Health System (Doctors of the World, nd; PRAKSIS, 2016).

Refugees' access to health services is a key parameter for their integration into the Greek society, ensuring public health and eliminating social exclusion. Refugees who stay in shelters for a long time must be able to fulfil both their health and mental needs.

Hygiene conditions in Refugee Centers

On their arrival in Greece, refugees are likely to be vulnerable to infectious diseases as a result of malnutrition, non-potable water consumption during their journey, lack of sensitization and excessively crowded and atrocious hygiene amenities in transit or at reception (Rojek, A.M et al., 2018).

The European Centers for Disease Control (ECDC), in 2015, underlined the importance of accommodation in refugee reception areas in order to prevent the risks of spreading diseases such as scabies or other diseases transmitted by air, hydrogen or through food.

According to research, overcrowded accommodation in Refugee Centers and poor sanitation can induce the dissemination of viral infections, together with sexually transmitted diseases and HIV / AIDS (World Health Organization, 2013; Xiushi & Guomei, 2006). International graphics present that 80% of the refugees and internally displaced people are women and children (Qayum, M., Mohmand, S., & Arooj, H., 2012).

Studies have indicated that often migrant, asylum seeker and refugee women have late HIV screening in pregnancy (Fakoya et al. 2015). A study in Canada shows that the likelihood for refugee mothers to be HIV-positive is increased in comparison to migrant mothers (Wanigaratne et al. 2018).

However, healthcare providers and policy makers do not often emphasize at the sexual and reproductive health in the framework of forced migration (Knipper, 2016; Warren et al., 2015).

Background

Perinatal morbidity and mortality in refugees/migrants/asylum seekers

According to the World Health Organization "*About 287.000 women died in 2010 of complications during pregnancy or childbirth. Most of these deaths can be avoided as the necessary medical interventions exist and are well known. The key obstacle is pregnant women's lack of access to quality skilled care before, during and after childbirth.*"

The number of intrauterine deaths and deaths during the first week of life are termed as Perinatal mortality (WHO, n.d).

Research data shows that pregnant women are among the most vulnerable groups of both refugees and migrants and have higher rates of stillbirth, perinatal mortality and morbidity compared to pregnant women of the general population (Médecins du Monde/Doctors of the World, 2016; Jamal et al., 2012).

Women related health hazards are notably elevated, as shown by refugee women's increased mortality rate (van den Akker & van Roosmalen, 2016). A study in Netherlands, showed that parity, birth weight and

gestational age at birth are not related to the high risk of perinatal mortality in asylum-seeking women. (Verschuuren, A.E et al., 2020).

A large proportion of female refugees are in reproductive age and have little knowledge about contraception, unsafe abortions and prenatal - postnatal care (United Nations Population Fund, 2016; Austin et al., 2008). They are also more likely to have unmet needs of family planning, undesired pregnancies, and experience higher incidence of induced terminations of pregnancy (UNPF, 2016; Women's Refugee Commission, 2016).

Proper perinatal care contributes to the birth of healthy babies and decrease in the mortality rate of women and their neonates. Infant mortality rates are increased among refugee and migrant women (Phillimore, 2016).

Gender-based violence and female genital mutilation

The risk of exposure to gender-based violence during migration is significant (United Nations High Commissioner for Refugees, 2016; Women's Refugee Commission, 2016). Refugee and migrant women are more prone to experience gender based violence (IOM 2018; Janssens, K. et al., 2005; Jensen, M.A., 2019), which prevents them from receiving the necessary care, as their husband may not allow them to attend healthcare appointments or due to their feeling worried that the healthcare staff could

notice their injuries (Phillimore, 2016). This could be dangerous for the life of both the mother and the fetus.

In addition, in this population, female genital mutilation is common, specifically among women originating from Sub Saharan Africa (United Nations Children's Fund, 2020). This can increase the risk of difficulties during labour (Jina & Thomas, 2013) and can also result in one to two extra perinatal losses for every 100 childbirths to women from Africa (World Health Organization, 2017).

Pregnancy outcomes

As women from Middle Eastern countries get married at a young age (ICME, 2013; United Nations Population Fund, 2012), give birth too young and have many children, proper information from a midwife is essential.

Expectant refugee women showed increased frequency of unfavourable pregnancy results, inclusive of caesarean section, pregnancy loss, and other maternal and perinatal morbidities (Wanigaratne et al. 2018; 19.Dopfer et al. 2018; Bozorgmehr, K., Biddle, L., Preussler, S., Mueller, A., & Szecsenyi, J. 2018).

According to a survey conducted in Turkey comparing pregnant Turkish women with pregnant refugees from Syria, Syrian women had a higher rate of normal births, an increased incidence of premature births and increased rates of low-birth-weight neonates (Turkay, Ü., 2020).

A US study on prenatal care for refugees has shown that there is a delay in starting care during pregnancy, which leads inevitably to fewer hospital visits (Kentoffio et al., 2016; Hoogenboom et al. 2015). Additionally, as stated above, some other studies have indicated that migrant and refugee women have late HIV screening during pregnancy (Fakoya et al. 2015).

Moreover, a study which compared pregnancy end results of Syrian refugee and women from Jordan, shows that refugee mothers had a higher rate of anaemia and birth via caesarean section. Also, as mentioned in the above researches, it was found that Syrian refugee women have a higher chance incidence of having low birth weight neonates (Alnuaimi K. et al., 2017).

Furthermore, a recent report in Europe of pregnant women who have applied as asylum seekers or having been declined international protection, showed that 65% did not manage to access prenatal care, 42% accessed healthcare post the third month of pregnancy and some were categorized as risky calling for emergency care (Chauvin P., et al. 2015).

Perinatal Health Care in Greece

Healthcare professionals who are working in refugee centers face a number of difficulties when providing care to pregnant refugees as there are language barriers, frustration in understanding how to navigate to the health system as well as cultural obstacles (Winn, Hetherington & Tough, 2018). Some medical procedures may be unacceptable from the women because of their culture or religion (amniocentesis, fetal malformation screening), or because they don't understand the necessity of each screening test (Pottie et al., 2011).

Lack of healthcare professionals' understanding of the women's various traditions about pregnancy and parturition could increase communication difficulties as well (Lyons et al., 2008). Many women have expressed that they prefer being monitored by a female health care professional during their prenatal visits, labour and during delivery (Khanlou et al., 2017).

A research in Greece shows that refugee women are starting prenatal care at the first trimester of pregnancy, but miss one or more visits to the doctor due to the inability to communicate in hospitals, financial obstacles and because they consider pregnancy to be woman's nature (Iliadi, 2008).

In addition, over 14.000 women were interviewed by the Doctors of the World and were treated for three years at their clinic in Greece. It was

found that only 47% acquired access to prenatal care prior to their intervention. Furthermore, they did not request medical attention, due to the fact that they were not aware of their rights, and also, they found the health system very complicated and were worried they would be arrested or discriminated (Tagaris, 2017).

At refugee centers in Greece, the midwife is the reference person for all pregnant women (ORAMMA, 2017). The midwife is monitoring all pregnancies and collaborating with local hospitals, referring for the necessary prenatal checkups and any other issue that might arise. Midwives also look after postnatal women, promote breastfeeding and family planning through info-sessions in the community. The antenatal care includes a physical inspection, glucose and blood pressure check, urine and blood sample tests, measurement of fetal growth and listening at the heart rate of the fetus (Malebranche et al., 2020; Gibson-Helm et al., 2014).

Every mother deserves quality care antenatal, during labour and after the birth of the baby.

The aim of this thesis is to explore the experiences of refugee women during their pregnancy or recently after having had their baby in Greece and were being monitored at the Alexandria's Refugee Center from the camp's Midwife according to the ORAMMA project's guidelines.

Research Questions

1. How satisfied were the pregnant refugees with the perinatal care they received in Greece?

2. How did they feel when they were examined by a woman (Midwife) during their visits to the clinic of the structure and how satisfied were they?

3. What were the problems they faced?

4. What could improve the care they received?

5. How did they feel during pregnancy?

Methods

The proposed research is a descriptive / exploratory qualitative type study. Qualitative research methodology is esteemed to be the most suitable approach for investigating and analyzing experiences, attitudes and views. Through it, people's experiences and the study of phenomena can be understood more deeply (Berg, 2001; Nancy & Grove, 2001).

The research period was from February 2020 to July 2020. It took place in the Accommodation Structure of Refugee/Migrants, in Alexandria, Imathia, where the researcher was allocated.

Face-to-face semi-structured interviews were performed to collect data. Through them, not only a lot of information was gathered from the target population, but also complex emotions and perceptions were extracted. This method includes a questionnaire-interview guide of the ORAMMA project, including open-ended questions thus enabling the interviewees to answer openly, covering at the same time the whole range of information to be collected (Merkouris, 2008). The interviews were performed with the presence of an interpreter, depending on the mother language of each participant.

After the data collection, an analysis followed. There are various qualitative analytic methods, such as qualitative content analysis, narrative analysis, discourse analysis, analysis based on the principles of phenomenology or grounded theory (Denzin & Lincoln, 2008; Smith, Larkin, & Flowers, 2009; Lykeridou et al. 2014; Bowling A. 2009).

In the present study, thematic analysis was used. In thematic analysis, the data were re-read and re-grouped into codes, summarized into categories and themes, labeled and analyzed (Polit, Beck & Hungler, 2006; Braun & Clarke, 2006). The result of the analysis is a thematic section which describes people's experiences, ideas, views or representation of the given topic (Braun & Clarke, 2006).

Thematic content analysis was used in the present study. Thematic content analysis includes specific steps, after reading the text that emerged from the interview (Polit, Beck & Hungler, 2006; Braun & Clarke, 2006). Specifically, it is a method which identifies, describes, reports and "thematises" repetitive semantic pattern, that is "themes" that arise from research data (Braun & Clarke, 2006).

Setting

This research was conducted in the Refugee Center of Alexandria in Northern Greece. Approximately 650 migrants, are accommodated in this Center mostly from Syria and Afghanistan, and some from Iraq and Iran. They are all of Muslim origin. In this camp, the refugees are living either in building or containers (i.e. isobox). State services and non-governmental organizations are responsible for providing sheltering, access to health, and education services. Pregnant refugees are a vulnerable group within the community and need special care. The present thesis was based on the ORAMMA project's guidelines. The purpose of the ORAMMA project is the provision of risk-free and equal maternal management for all refugees and migrants within the European Union. Furthermore, it is important to gain knowledge about this group of people, so as to enhance the quality of health services, as well as to create a better and more suitable environment

for both refugees and healthcare professionals. (Operational Refugee And Migrant Maternal Approach, 2017).

Participants and sampling

The participants were expectant women after the 12th week and up to the end of pregnancy, as well as postnatal women living in the Refugee Accommodation Center in Alexandria. The method used was non-random intentional sampling, as the goal was to involve people who belong to specific population groups and have experiences related to the subject under study. The only criterion for inclusion in the study was for pregnant women to be in the 2nd-3rd trimester of pregnancy, in order to assess if they have received adequate prenatal care. Women in the first trimester of pregnancy were excluded.

Eligible women were individually contacted during their regular antenatal and postnatal visits at the Refugee Center's clinic. In order to achieve maximum sampling variation, Arabic-speaking Syrian women were first approached, since it was easier to use an Arabic-speaking interpreter than other languages.

Information was provided on the subject of the study. Women were

reassured that taking part in the interviews was optional and also that if they did not want to participate, they would not bear any consequences.

Those who participated signed a consent form and then the interviews were then scheduled.

Socio-demographic features of the women that participated are summarized in Table 1 (Appendix A). The major part of the women that participated were from Syria (n=7) and the rest from Afghanistan (n=2) and Iraq (n=1).

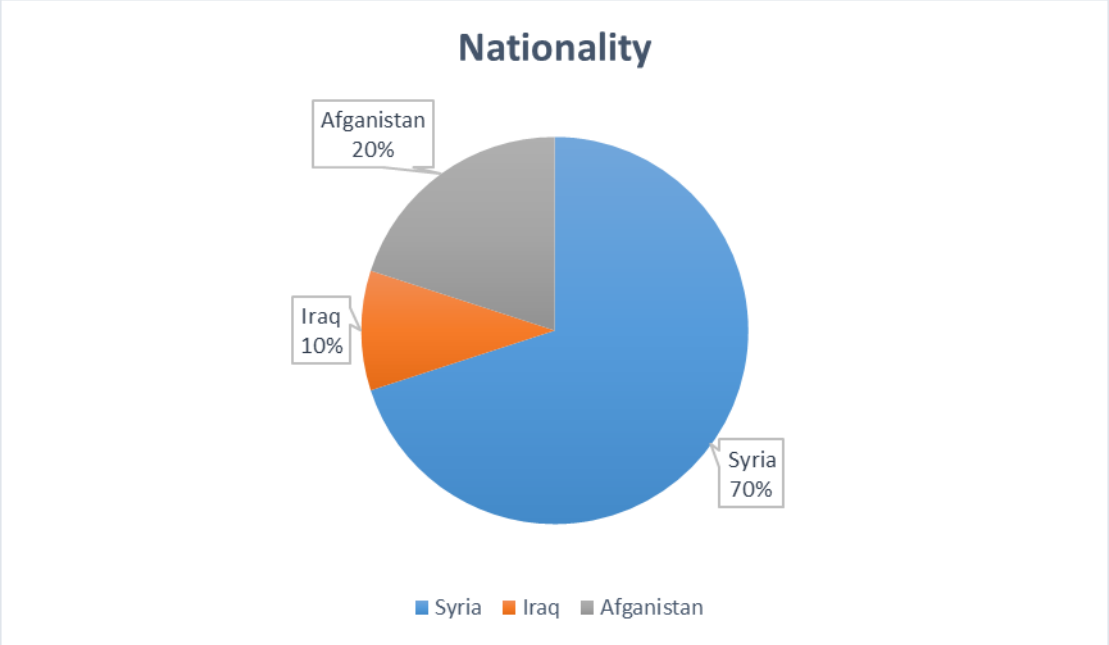

Figure 5 Nationality

What is observed from the above, is that in terms of their nationality 70% of respondents are Syrians, 20% are from Afghanistan and 10% are from Iraq (Figure 5).

According to the diagram below (Figure 6), the majority of women aged 21-25 participated in the study.

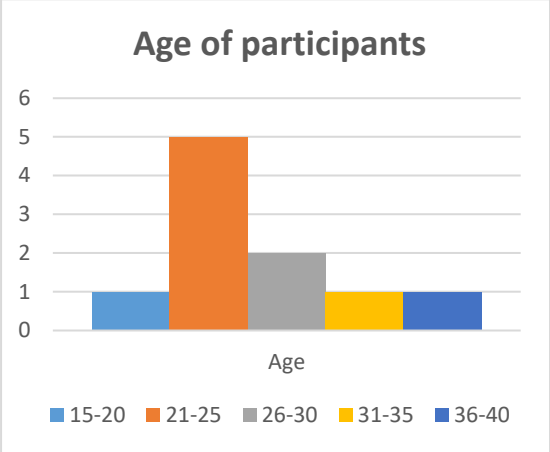

Figure 6

Regarding women's parity, information is given in the chart below (Figure 7). Most of the participants in the research had two to four children, however there were also women during their first pregnancy.

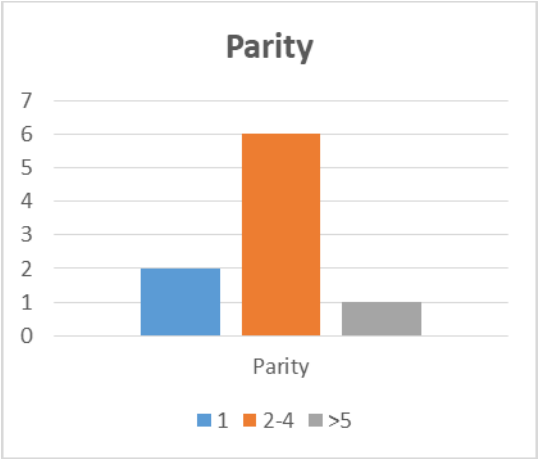

Figure 7

Ethics

From the beginning of the study, the consent of the participants was ensured, and each woman was informed individually that the participation was anonymous, voluntary and the withdrawal could take place at their convenience free from any adverse consequences for the participants. The rights of the study participants were protected throughout the investigation. The right of physical-mental integrity and avoidance of harm of the participants, the right of autonomy, and the right of privacy for each respondent were guaranteed from the beginning. This study did not include therapeutic interventions. The ethical approval for the ORAMMA project in Greece was obtained from Elena Venizelou - Alexandra General Hospital (Reference Number: 5154/12-03-2018, G.H. "Elena Venizelou - Alexandra").

Interview

An interview guide- questionnaire of the Oramma project was used to conduct in-depth interviews. The questionnaire contained open-ended questions regarding the experience of the care the women received during and after their pregnancy.

The participants were encouraged to share any other issues they might have faced. Interviews were conducted from the Midwife who worked in the

camp with the presence of an Arabic and Farsi interpreter. The interviews took place in private rooms inside the clinic. Participants spoke Arabic or Farsi. The questions were translated from Greek into Arabic or Farsi by the interpreter. Each woman responded in her own language.

Interviews were not audio or video-recorded. All responses were stored in a computer and all the necessary steps have been taken to maintain the anonymity of the participants, in such a way that personal data were not violated (European Commission. (n.d.). What is personal data?).

Analysis

Thematic analysis was used in the present study. The data were managed by one author using the consecutive phases described by Braun and Clarke (2006).

Initially, the data set that was collected was read several times until an familiarization was achieved, so that it could be categorized into thematic sections. At the same time, the initial ideas were noted.

The next step was data encoding. The codes were categorized according to their content into thematic sections. The categorization was based on the existence of common meaning in the data, which allow their grouping and classification in the same category. Afterwards, the thematic sections were

evaluated based on the research questions, and then they were labeled. Finally, their interpretation and analysis followed.

Braun and Clarke (2006) described the significance of transparency in qualitative research, which includes the acknowledgement of the active role of the researchers in the thematic identification and the selection of those considered to be of interest.

It is important to understand the difficulty for researchers to be objective and unbiased on data collection and analysis, along with how meanings are attributed to findings (Braun and Clarke, 2006).

In this research the interviewer had previous experience with working with refugees, and the interpreter had the same ethnicity with the some of the participants. This enabled conferring an advanced level of cultural sensitivity to the interviews.

The identified categories were highlighted with quotations from women's interview transcripts.

Results

Nine pregnant women and one postnatal woman took part in in-depth question and answer sessions. This final sample constituted a convenient sample of women that we had the ability to contact and which accepted and were available to participate in the research. Out of a total of 15 suitable women, 9 could be contacted (5 third trimester, 4 second trimester and 1 postnatal woman), (Figure 8).

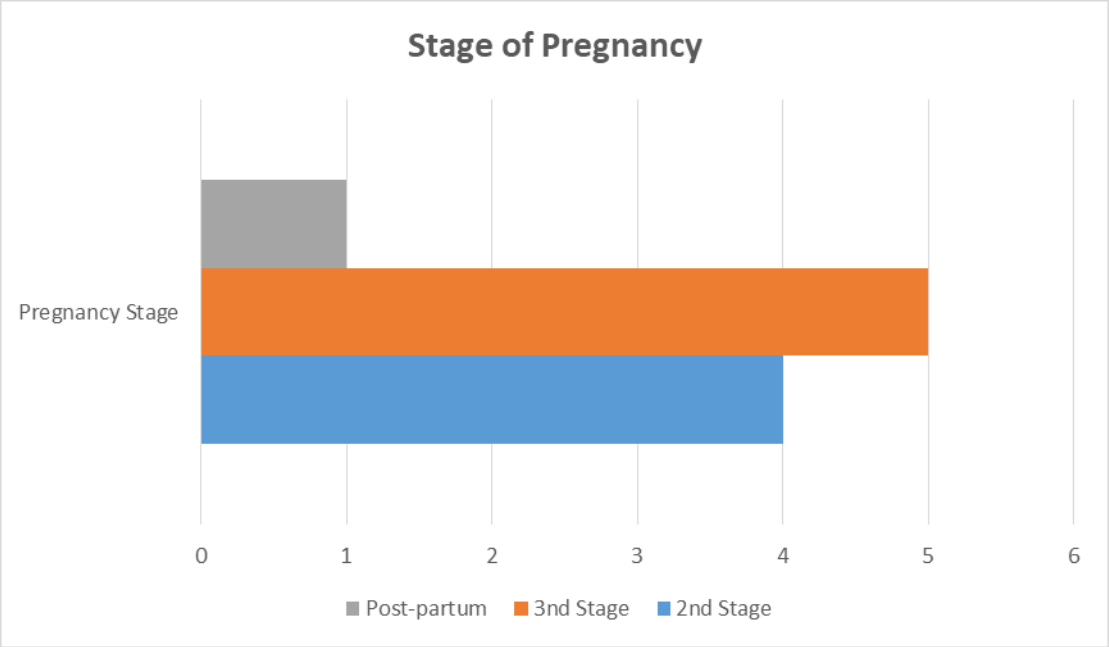

Figure 8 Semester of Pregnancy

This was due to the fact that some women left the camp during the period of the study and while there was a quarantine period due to the Covid-19

pandemic that prohibited gatherings. The approach of the women was immediate at Alexandria's Refugee Center, since the participants already lived inside the structure and had easier access to the clinic. Subsequently, the final sample had refugee women over-represented.

The interview sessions were performed among February 2020 and July 2020 and lasted approximately 30-45 minutes each.

Five themes were generated from the analysis. 1) Provision of care at the Hospitality Center by the midwife of the structure, 2) Provision of care by some hospitals in Northern Greece, 3) Monitoring during pregnancy, 4) Situations that made it difficult for women to receive care, 5) Refugee women's cultural background contributing to their need to be treated exclusively by female staff.

A. Provision of care at the Hospitality Center by the midwife of the structure

One finding that emerged from the interviews was the relationship of pregnant women with the midwife of the structure. They all reported they were satisfied with the care they received at the Alexandria structure by the

midwife. They managed to build a strong connection with their midwife and stated that they received respectful and appropriate perinatal care.

The trust created by their midwife provided security during their pregnancy and reduced the women's worries.

They specifically reported:

"Because my pregnancy was unexpected, I liked that the midwife helped me undertake all the necessary exams and sent me to the hospital. Overall, I liked her interest."

"The midwife was always close to me and advised me, comforted me. I could listen my baby's heart rate, and all my questions were being answered."

"I like that pregnant women are being cared for and the midwife ensures that every woman has her screening tests. "

"I loved that she showed understanding to me and that she did the best to help me. Also, she's always smiling, eager and cheerful and that builds up my psychology every time I visit the camp clinic."

However, they reported they were less satisfied with the care provided at the host islands. The islands are the first place to host refugee and migrants. Unfortunately, many times the quantity of guests surpasses the capacity of

the centers and as a result the health system is pressured and there are delays in the provision of health care.

Specifically they stated:

"I did not receive good care at Lesvos camp because of the large population."

"At the island I didn't feel that the care provided to me was good. It is better here."

"I liked the care provided here (at the camp) because it was immediate, without waiting like it was in Lesvos."

B. Provision of care by some hospitals in Northern Greece

For the most part, women were happy with the care provided to them. However, some women did not have a good experience, as they reported that the doctors did not treat them in a kind and respectful way. They were impersonal and seemed uninterested in them and ignored them.

Several women described how they felt when no one of the doctors gave them the opportunity to share matters, or ask questions about their pregnancy.

Especially they reported:

"The hospital doctor, without reading the medical document I had, gave me a bunch of medication and injections, and if I hadn't mentioned that I was pregnant I would have had an injection and lost my baby. Also, I didn't like the other day I went to the hospital and I was told that I was there on the wrong day, although I visited the right date. I was exhausted. I begged them to help me and started crying."

"Generally I'm very satisfied with the care I receive at the camp, but I have a complaint about a particular doctor at the hospital. His behavior to us was very bad, he didn't call us by our names, but he addressed to us making a noise like "psit" and during the u/s examination he asked us to look at the wall. Also, he throwed the used tissues he cleaned the gel with to us."

"Something that I didn't like was that at the beginning of the pregnancy, the doctor didn't give me anything about the stomach pain I had. When I visited the midwife at the camp, she helped me, took care of me and the pain disappeared. Back home, I had to take care on my own, same here in Greece. If I don't look after myself no one will help me."

C. Monitoring during pregnancy

At present, the Greek government provides free of charge National Health System services for refugees if they have a Social Security Number (AMKA) (Getting a Social Security Number, n.d).

Women who did not have AMKA number had problems performing laboratory tests. In particular, the lack of AMKA does not allow the doctor / midwife to prescribe the necessary prenatal examination and this is why some of these women failed to perform all the tests until they managed to obtain their AMKA number. Refugees come across administrative obstacles when it comes to access in the health care system that are connected to the inability of the authorities to supply a Social Security Number. Those women who did not have AMKA, expressed regret because they could not complete the prenatal check-up and felt exhausted with this situation. In addition, they did not manage to attend the suggested amount of antenatal hospital visits.

The interviewees reported:

"I wasn't given an AMKA number and that was the reason why I had difficulty having my blood tests done."

"I have been in Alexandria for 3 months, have my own container, not like in Lesvos where I was staying out in the woods. My exams were delayed there. And here I have no AMKA number to perform them."

However, those who had AMKA claimed that they are happy and satisfied with the monitoring during pregnancy, as well as with the reassurance their camp midwife provided them. Women with AMKA could perform all the examinations that are necessary during pregnancy, such as laboratory tests and specific ultrasounds.

They stated:

"She makes sure I always have the proper pregnancy follow up."

"She made sure all the necessary tests and screening were taking place."

"I like that pregnant women are being cared for and the midwife ensures that every woman has her screening tests"

D. Situations that made it difficult for women to receive care

Although the majority of women stated that they were generally fulfilled with the care provided during pregnancy, they encountered some obstacles during their prenatal hospital appointments. The main ones were the

frequent lack of interpreters, the access to the hospital from the accommodation structure and the delay in the appointments.

The refugee women do not speak or understand the language of the host country, in this case Greek or English. As a result, this creates severe difficulties in communication.

There were no interpreters available in the hospitals of each city, which created anxiety and fear among women. The availability of interpreters was very limited and as a result this frequently headed to misapprehension and complications between interaction with the hospital doctors and the women. In contrast to the hospitals, there was almost always an interpreter available in the Refugee Centers.

Women described that although there where both female and male interpreters and occasionally of the same nationality, this was not a major issue for them. Some women preferred having female interpreters.

About the lack of interpretation the women reported:

"I would like to give me more attention, since they know that I do not know the language (Greek.) They should have an interpreter at the hospital. I would also like to avoid going to the hospital alone."

"I would like to have an interpreter in every hospital visit and the ability to have all the tests at the camp to avoid visiting the hospital."

"It would be very helpful to have an interpreter everytime I visited the hospital. Two times, when I went to the hospital without escort, they didn't accept me."

When healthcare provision takes place beyond the limits of the Refugee Centers, the absence of free of charge shuttle bus transport makes it challenging for pregnant migrants to attempt hospital visits. Expectant women have to find their way to the healthcare facility on their own or to be accompanied by center staff members. However, some women claimed that they felt confident transporting to hospitals on their own.

Regarding hospital access, women reported:

"I would like to be closer to the hospital so I can walk there."

"I didn't like that I had to go to the hospital alone and at my own expense, I always needed an escort to help me.

"I didn't like being asked to go to the hospital regularly because of the distance."

It was also mentioned in the interviews that there was a long delay in the hospital lounge, but also a delay in scheduling appointments in general,

which made women feel unpleasant and insecure. The available hospital appointments were very late due to the heavy workload.

About the appointment delay they reported:

"There is a long delay to book a hospital appointment and I had to visit a second time to receive the results and the hospital was too far."

"It was difficult to book an appointment on time for the gestational age. I had to wait a long time and this made me nervous."

"Sometimes there were delays at the hospital and I had to wait a long time"

E. Refugee women's cultural background contributes to their desire to be treated solely by a female healthcare professional.

Through the interviews, the largest percentage of women expressed the desire to be examined by same-sex health care professionals in hospitals. Due to their culture and religion, women do not feel comfortable being examined by male doctors.

They specifically reported:

"I want to give birth with a female doctor.."

"I would like to have AMKA number, better access to the hospital and doctors to be female."

"I would like to only be examined by female staff when I visit the hospital"

"I want to be examined by women."

During their visits to the midwives' clinic of the hospitality center, they stated that they felt happy and comfortable, as they knew that they would be examined by a female healthcare professional. They did not feel ashamed to express themselves, they felt close to the midwife and there was sympathy.

Women stated:

"I was feeling very good, I don't like being examined by men. I wish I was examined by female health care professionals every time."

"I loved that you are a woman. I don't like men. I feel comfortable talking to you about anything. You are always smiling and happy. You are listening to my problems carefully and show interest. I feel like you are listening everything I'm saying.""

"The midwives and the fact that they were women made me feel very comfortable."

"Having female midwives was a very positive thing. I wouldn't like to be examined by a man."

"Having female midwives made me feel relieved. I wasn't shy."

"I liked that every time I visited the midwife for my examination we heard the baby's heart and also I liked that sometimes if I was were late or I didn't came, the midwife was looking for me."

Discussion

The participants at the Reception Center where the research was conducted, reported they were satisfied with the perinatal care provided by the midwife allocated at the center. All the necessary tests for the well-being of the fetus and the mother were performed and the women were informed about the stages of pregnancy and the necessary examinations by the midwife of the structure.

The main problems they faced were related to the lack of interpretation in hospitals, the lack of AMKA number and access to hospitals. The appointment delay in hospitals is also an issue that was reported by many women, however this was due to the workload of each hospital.

There was also a strong desire for women to be examined by health care professionals of the same sex. Due to their religion and culture they did not feel comfortable being examined by men. The fact that the midwife of the Reception Center was a woman made them feel comfortable and not ashamed.

The refugee women that participated in this research emoted gratitude for the care that was provided to them.

This study highlights the significance of confidence among pregnant women and midwives and the need to strengthen health services along with interpretation services.

The health of a pregnant woman and the proper monitoring during pregnancy and childbirth contribute significantly to the reduction of maternal and neonatal mortality as they are part of the whole. This is a matter of major importance for Public Health.

Limitations and strengths

The observations of this qualitative study are restricted by a some limitations.

Initially, the findings are based on a restricted number of interviews with a appointed group of pregnant women. This is due to the fact that during the research period many pregnant women were relocated to different structures and could not participate in the study. Secondly, the AMKA issue was discontinued and this led to the point that some pregnant women were not able to perform laboratory tests. This in itself has been a negative experience both for women and healthcare professionals.

In addition, the fact that the researcher was also the midwife of the center, could be mentioned as negative, considering that the women may have been reluctant to express themselves freely, even though they had been informed that what they said would have no effect on the care they received.

The strengths of this research are that up to this day there is no other similar research in a Reception Center in Greece.

With this research, an initiative is made to assess the quality of the services provided in the Refugee Reception Centers and it gives the opportunity to be continued by other researchers. It is essential to be aware of the needs of this group of people in order to provide the best possible care.

Conclusions

The purpose of this thesis was to present the experiences of refugee women regarding the perinatal care they received inside and outside the hospitality center in the hospitality structure of Alexandria.

It is well known that young migrants, asylum seekers and migrants face various difficulties when accessing health care. Recognizing the needs of this vulnerable group is vital, to enhance the quality of services provided.

It is crucial for these women to feel understood and welcome. It is essential to have an interpreter present at all their visits to hospitals and hospitality facilities, so that they receive the care that woman from the host country would receive. Women should be offered continuity of care from the same

midwife (Royal College of Obstetricians and Gynaecologists [RCOG], 2008).

It has been noted by other studies that some migrant women can feel uncomfortable when interacting with the opposite gender and they may find the presence of a female healthcare professional more satisfactory. Sharing similarities between women and health professionals, such as gender or religion, motivate women to trust the health care provided. (Balaam et al., 2013; Carroll et al., 2007)

The present study will contribute to a thorough comprehension of how pregnant refugees experienced the perinatal care they have received in Greece and to identify their needs, in order to produce the best possible care.

The results will add to the further expansion of knowledge about the support needed by pregnant refugees monitored in Greece and can be used as findings in the development of care protocols on which health professionals working in hosting structures or coming into contact with these population groups can be trained.

With a rising number of migrant users of the health care system, public health services must adjust to meet the diverse needs of different migrant groups (WHO, 2018).

Healthcare professionals working with refugees, migrants and asylum migrant must be properly trained in managing such incidents, and be aware of the cultural differences of this vulnerable group of people, in order to avoid racism behaviors.

References

Ahmed, J. A., Katz, M. A., Auko, E., Njenga, M. K., Weinberg, M., Kapella, B. K., ... & Eidex, R. B. (2012). Epidemiology of respiratory viral infections in two long-term refugee camps in Kenya, 2007-2010. *BMC infectious diseases*, 12(1), 1-8. https://doi.org/10.1186/1471-2334-12-7

Alnuaimi, K., Kassab, M., Ali, R., Mohammad, K., & Shattnawi, K. (2017). Pregnancy outcomes among Syrian refugee and Jordanian women: a comparative study. *International nursing review*, *64*(4), 584-592.

Ascoly, N., Van Halsema, I., & Keysers, L. (2001). Refugee women, pregnancy, and reproductive health care in the Netherlands. *Journal of Refugee Studies*, *14*(4), 371-393. https://doi.org/10.1093/jrs/14.4.371

Austin, J., Guy, S., Lee-Jones, L., McGinn, T., & Schlecht, J. (2008). Reproductive health: a right for refugees and internally displaced persons. *Reproductive health matters, 16(31), 10-21.* https://doi.org/10.1016/S0968-8080(08)31351-2

Balaam, M. C., Akerjordet, K., Lyberg, A., Kaiser, B., Schoening, E., Fredriksen, A. M., ... & Severinsson, E. (2013). A qualitative review of migrant women's perceptions of their needs and experiences related to pregnancy and childbirth. *Journal of advanced nursing, 69(9), 1919-1930.* https://doi.org/10.1111/jan.12139

BERG L., BRUCE. (2001). Qualitative research methods for the social sciences.

Bozorgmehr, K., Biddle, L., Preussler, S., Mueller, A., & Szecsenyi, J. (2018). Differences in pregnancy outcomes and obstetric care between asylum seeking and resident women: a cross-sectional study in a German federal state, 2010–2016. *BMC pregnancy and childbirth, 18(1), 1-8.* https://doi.org/10.1186/s12884-018-2053-1

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative research in psychology, 3(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Carroll, J., Epstein, R., Fiscella, K., Gipson, T., Volpe, E., & Jean-Pierre, P. (2007). Caring for Somali women: implications for clinician–patient communication. *Patient education and counseling*, *66*(3), 337-345. https://doi.org/10.1016/j.pec.2007.01.008

Chauvin, P., Simonnot, N., Douay, C., & Vanbiervliet, F. (2015). Access to healthcare for the most vulnerable in a Europe in social crisis.

Denzin, N. K., & Lincoln, Y. S. (2008). *Collecting and interpreting qualitative materials* (Vol. 3). Sage.

Doctors of the World. (n.d). Open Polyclinics. Retrieved from: https://mdmgreece.gr/en/missions/in-greece/programs/open-polyclinics/

Dopfer, C., Vakilzadeh, A., Happle, C., Kleinert, E., Müller, F., Ernst, D., ... & Jablonka, A. (2018). Pregnancy related health care needs in refugees—A current three center experience in Europe. *International journal of environmental research and public health*, *15*(9), 1934. https://doi.org/10.3390/ijerph15091934

European Commission. (2015). *Tackling the refugee crisis in Europe: The role of EU external action.* Retrieved 22/03/2021 from: https://eur-lex.europa.eu/legal-content/EL/TXT/PDF/?uri=CELEX:52015JC0040&from=EL

European Commission. (2016). *EU-Turkey refugee crisis agreement: second progress report.* Retrieved 22/03/2021 from: https://ec.europa.eu/greece/news/2016/20160615_prosfygiko_2ekthesi_proodou_el

European Commission. (n.d.). *What is personal data.* Retrieved 25/03/2021 from: https://ec.europa.eu/info/law/law-topic/data-protection/reform/what-personal-data_el

Government Gazette. (2020). Joint Ministerial Decision 717/2020 - Government Gazette 199 / B / 31-1-2020 Arrangements for ensuring the access of the applicants for international protection to the health services, the medical care, the social security and the labor market - Published by ΡΑΑ Υ.Π.Α. *Athens: Government Gazette*. Retrieved 15 Dec 2020 from:

https://www.e-nomothesia.gr/kat-allodapoi/prosphuges-politiko-asulo/koine-upourgike-apophase-717-2020.html

Fakoya, I., Álvarez-del Arco, D., Woode-Owusu, M., Monge, S., Rivero-Montesdeoca, Y., Delpech, V., ... & Burns, F. M. (2015). A systematic review of post-migration acquisition of HIV among migrants from countries with generalised HIV epidemics living in Europe: mplications for effectively managing HIV prevention programmes and policy. BMC public health, 15(1), 1-14. https://doi.org/10.1186/s12889-015-1852-9

Getting health care without PAAYPA or a social security number (AMKA). (n.d) Accessed on 15/12/20, Retrieved from: https://www.refugee.info/greece/working-in-greece--greece/getting-a-social-security-number-amka?language=en

Gibson-Helm, M., Teede, H., Block, A., Knight, M., East, C., Wallace, E. M., & Boyle, J. (2014). Maternal health and pregnancy outcomes among women of refugee background from African countries: a retrospective, observational study in Australia. BMC pregnancy and childbirth, 14(1), 1-11. https://doi.org/10.1186/s12884-014-0392-0

Greek Reporter. (2018, Sep). Greece Vows to Relocate 2,000 Refugees from Lesvos to the Mainland. Retrieved 10/12/2020 from: https://greekreporter.com/2018/09/18/greece-vows-to-relocate-2000-refugees-from-lesvos-to-the-mainland/

Hoogenboom, G., Thwin, M. M., Velink, K., Baaijens, M., Charrunwatthana, P., Nosten, F., & McGready, R. (2015). Quality of intrapartum care by skilled birth attendants in a refugee clinic on the Thai-Myanmar border: a survey using WHO Safe Motherhood Needs Assessment. BMC pregnancy and childbirth, 15(1), 1-9. https://doi.org/10.1186/s12884-015-0444-0

Iliadi, P. (2008). Refugee women in Greece: a qualitative study of their attitudes and experience in antenatal care. Health science journal, 2(3). Retrieved from: https://www.hsj.gr/medicine/refugee-women-in-greece--a-qualitative-study-of-their-attitudes-and-experience-in-antenatal-care.php?aid=3663

International Center for Missing & Exploited Children. (2013). Child Marriage in the Middle East and North Africa A White Paper. Retrieved from: https://www.icmec.org/wp-content/uploads/2015/10/Child_Marriage_in_the_MENA_Region.pdf

International Organization for Migration. (2018). Flow monitoring surveys: the human trafficking and other exploitative practices indication survey male and female respondents interviewed along the central and the eastern Mediterranean routes in 2017, 2018. Retrieved from:

https://migration.iom.int/docs/FMS_CT_Analysis_male%20female_Central_Eastern_2017.pdf

International Organization for Migration. (2018). Mixed Migration Flows in the Mediterranean. Compilation of Available Data and Information March 2018. Retrieved from: https://migration.iom.int/docs/Flows_Compilation_Report_March_2018.pdf

Janssens, K., Bosmans, M., & Temmerman, M. (2005). Sexual and Reproductive Health and Rights of Refugee Women in Europe: rights, policies, status and needs. Literature review.

Jensen, M. A. (2019). Gender-Based Violence in Refugee Camps: Understanding and addressing the role of gender in the experiences of refugees. *Inquiries Journal*, *11*(02).

Jina, R., & Thomas, L. S. (2013). Health consequences of sexual violence against women. Best Practice & Research Clinical Obstetrics & Gynaecology, 27(1), 15-26. https://doi.org/10.1016/j.bpobgyn.2012.08.012

Kentoffio, K., Berkowitz, S. A., Atlas, S. J., Oo, S. A., & Percac-Lima, S. (2016). Use of maternal health services: comparing refugee, immigrant and

US-born populations. Maternal and child health journal, 20(12), 2494-2501. https://doi.org/10.1007/s10995-016-2072-3

Khanlou, N., Haque, N., Skinner, A., Mantini, A., & Kurtz Landy, C. (2017). Scoping review on maternal health among immigrant and refugee women in Canada: Prenatal, intrapartum, and postnatal care. Journal of pregnancy, 2017. https://doi.org/10.1155/2017/8783294

Knipper, M. (2016). Migration, public health and human rights. *Int J Public Health* **61,** 993–994 https://doi.org/10.1007/s00038-016-0893-x

Kotsioni I., Hatziprokopiou P. (2009). MIGHEALTHNET: Information network on good practice in health care for migrants and minorities. Retrieved 23/03/2021 from: file:///C:/Users/user/Downloads/docl_18081_81179552.pdf

Legislation Information Bank. Law 4251/2014: Code of Immigration and Social Integration and other provisions. Retrieved 23/03/21 from: https://www.e-nomothesia.gr/kat-allodapoi/n-4251-2014.html

Legislation Information Bank, Law 4540/2018 art. 18 of Directive 2013/33 / EU, "Arrangements for material reception conditions". Retrieved 23/03/21 from: https://www.enomothesia.gr/kat-allodapoi/prosphuges-politiko-asulo/nomos-4540-2018-phek-91a22-5-2018.html?q=4540

Legislation Information Bank, Presidential Decree 220/2007 Government Gazette A-251 / 13-11-2007 Adaptation of Greek Legislation to the provisions of Council Directive 2003/9 / EC of 27 January 2003, on the minimum requirements for the reception of applicants asylum in the Member States (OJ 31 / 6.2.2003). Retrieved 19/03/2021 from: https://www.e-nomothesia.gr/kat-allodapoi/prosphuges-politiko-asulo/pd-220-2007.html

Lykeridou – Avramioti, A., Vivilaki, V., Gourounti, K., & Sarafis, P. (2013). Bowling A. (2009). *Research Methods In Health: Investigating Health And Health Services.* Broken Hills.

Lyons, S. M., O'Keeffe, F. M., Clarke, A. T., & Staines, A. (2008). Cultural diversity in the Dublin maternity services: the experiences of maternity service providers when caring for ethnic minority women. Ethnicity and Health, 13(3), 261-276. https://doi.org/10.1080/13557850801903020

Médecins du Monde/Doctors of the World. (2016, Nov). International Network Observatory Report: Access to Healthcare for People Facing Multiple Vulnerabilities in Health in 31 Cities in 12 Countries. Médecins du Monde/Doctors of the World. Retrieved 15/12/20 from: https://mdmeuroblog.files.wordpress.com/2016/11/observatory-report2016_en-mdm-international.pdf

Merkouris A.B. (2008). Nursing Research Methodology. *Ellin, Athens.*

Nancy, B., & Grove, S. K. (2001). The Practice of Nursing Research: Conduct, Critique, and Utilization.

Operational Refugee And Migrant Maternal Approach. (2017). *Approach To Integrated Perinatal Healthcare for Migrant and Refugee Women. Operational Refugee and Migrant Maternal Approach.* Retrieved 15/12/2021 from: http://oramma.eu/the-project/

Phillimore, J. (2016). Migrant maternity in an era of super diversity: new migrants' access to, and experience of, antenatal care in the West Midlands, UK. Social Science & Medicine, 148, 152-159. https://doi.org/10.1016/j.socscimed.2015.11.030

Polit, D. F., Beck, C. T., & Hungler, B. P. (2006). Examining sampling plans. Essentials of Nursing Research. Methods, appraisal and utilization. sixth ed. Philadelphia: Lippincott Williams & Wilkins, 258-284. https://pubmed.ncbi.nlm.nih.gov/advanced/

Pottie, K., Greenaway, C., Feightner, J., Welch, V., Swinkels, H., Rashid, M., ... & Tugwell, P. (2011). Evidence-based clinical guidelines for immigrants and refugees. *Cmaj*, *183*(12), E824-E925. https://doi.org/10.1503/cmaj.090313

Praxis. (n.d). Refugees. Retrieved 24/03/2021 from: https://praksis.gr/refugee-crisis/

Rojek, A. M., Gkolfinopoulou, K., Veizis, A., Lambrou, A., Castle, L., Georgakopoulou, T., ... & Horby, P. W. (2018). Clinical assessment is a neglected component of outbreak preparedness: evidence from refugee camps in Greece. *BMC medicine*, *16*(1), 1-8. https://doi.org/10.1186/s12916-018-1015-9

Qayum, M., Mohmand, S., & Arooj, H. (2012). Frequency and physical factors associated with gender-based violence in the internally displaced people of Pakistan. Journal of the College of Physicians and Surgeons Pakistan, 22(1), 63-65.

Royal College of Obstetricians and Gynaecologists. (2008). Standards for Maternity Care: Report of a Working Party. *RCOG Press at the Royal College of Obstetricians and Gynaecologists.*

Smith, J. A. Flowers P. Larkin M. (2009) Interpretative phenomenological analysis: theory, method and research. https://doi.org/10.1080/14780880903340091

Sklavou, K. (Ed.) - Hellenic Council for Refugees (2008). Intercultural counseling guide. *Athens: Papazisi.*

Tagaris K. (2017, March 17) Fewer Than Half Of Pregnant Refugees In Greece Have Prenatal Care. *HuffPost.* Retrieved 15/12/2020 from:

https://www.huffpost.com/entry/fewer-than-half-of-pregnant-refugees-in-greece-have-prenatal-care_n_59d3b483e4b06226e3f3cf84

Turkay, Ü., Aydın, Ü., Salıcı, M., Çalışkan, E., Terzi, H., Astepe, B. S., & Varlıklı, O. (2020). Comparison of pregnant Turkish women and Syrian refugees: Does living as a refugee have an unfavorable effect on pregnancy outcomes?. *International Journal of Gynecology & Obstetrics*, *149*(2), 160-165. https://doi.org/10.1002/ijgo.13117

United Nations High Commissioner for Refugees (UNHCR). Refugees and Migrants Sea Arrivals in Europe. [Update 2016 Jun] Retrieved 15/03/2020 from: https://data2.unhcr.org/ar/documents/download/49921

United Nations High Commissioner for Refugees (UNHCR). Mediterranean Situation in Greece. Retrieved 20/04/2020 from: https://data2.unhcr.org/en/situations/mediterranean/location/5179

United Nations High Commissioner for Refugees (UNHCR). (2015). Europe Refugees & Migrants Emergency Response Nationality of Arrivals to Greece, Italy and Spain. Retrieved 20/03/2021 from: https://reliefweb.int/sites/reliefweb.int/files/resources/MonthlyTrendsofNationalities-ArrivalstoGreeceItalyandSpain-31December2015.pdf

United Nations High Commissioner for Refugees (UNHCR). (2016). Refugees & Migrants Sea Arrivals in Europe. Retrieved 20/03/2021 from: file:///C:/Users/user/Downloads/1486039616.pdf

United Nations High Commissioner for Refugees (UNHCR). (2017). Refugees & Migrants Arrivals to Europe in 2017. Retrieved 15/03/2021 from: file:///C:/Users/user/Downloads/20180213%20UNHCR-EU_Sea_Arivals-JAN-Dec%202017%20V2.pdf

United Nations High Commissioner for Refugees (UNHCR). (2018). Refugees & Migrants Arrivals to Europe in 2018 (Mediterranean). Retrieved 13/03/2021 from: file:///C:/Users/user/Downloads/Mediterranean%20Arrivals%20-Jan%20to%20Dec-v7.pdf

United Nations High Commissioner for Refugees (UNHCR). (2019). Refugees & Migrants Arrivals to Europe in 2019 (Mediterranean). Retrieved 10/03/2021 file:///C:/Users/user/Downloads/UNHCR-EU_Arivals-Jan%20to%20Dec%202019-FINAL.pdf

United Nations International Children's Emergency Fund. (2020). Female genital mutilation (FGM). At least 200 million girls and women alive today living in 31 countries have undergone FGM. [Internet]. United Nations International Children's Emergency Fund. Retrieved 13/12/2020 from: https://data.unicef.org/topic/child-protection/female-genital-mutilation/

United Nations Population Fund. (2013). Marrying Too Young End Child Marriage. UNFPA, New York. Retrieved 13/12/2020 from: https://www.unfpa.org/sites/default/files/pub-pdf/MarryingTooYoung.pdf

United Nations Population Fund. (2016). Women and Girls in the Syria Crisis: UNFPA Response. Facts and Figures. United Nations Population Fund. Retrieved 19/03/2021 from: https://www.unfpa.org/sites/default/files/resource-pdf/UNFPA_FACTS_AND_FIGURES_2016.pdf

Van den Akker, T., & van Roosmalen, J. (2016). Maternal mortality and severe morbidity in a migration perspective. Best Practice & Research Clinical Obstetrics & Gynaecology, 32, 26-38. https://doi.org/10.1016/j.bpobgyn.2015.08.016

Verschuuren, A. E. H., Postma, I. R., Riksen, Z. M., Nott, R. L., Feijen-de Jong, E. I., & Stekelenburg, J. (2020). Pregnancy outcomes in asylum seekers in the North of the Netherlands: a retrospective documentary analysis. *BMC pregnancy and childbirth*, *20*, 1-10. https://doi.org/10.1186/s12884-020-02985-x

Wallin, A. M., & Ahlström, G. (2006). Cross-cultural interview studies using interpreters: systematic literature review. *Journal of advanced nursing*, *55*(6), 723-735. https://doi.org/10.1111/j.1365-2648.2006.03963.x

Wanigaratne, S., Shakya, Y., Gagnon, A. J., Cole, D. C., Rashid, M., Blake, J., ... & Urquia, M. L. (2018). Refugee maternal and perinatal health in Ontario, Canada: a retrospective population-based study. *BMJ open*, *8*(4). https://doi.org/10.1136/bmjopen-2017-018979

Warren, E., Post, N., Hossain, M., Blanchet, K., & Roberts, B. (2015). Systematic review of the evidence on the effectiveness of sexual and reproductive health interventions in humanitarian crises. *BMJ open*, *5*(12). https://doi.org/10.1136/bmjopen-2015-008226

Winn, A., Hetherington, E., & Tough, S. (2018). Caring for pregnant refugee women in a turbulent policy landscape: perspectives of health care professionals in Calgary, Alberta. *International journal for equity in health*, *17*(1), 1-14. https://doi.org/10.1186/s12939-018-0801-5

Women's Refugee Commission. (2016) *Falling Through the Cracks: Refugee Women and Girls in Germany and Sweden*. [Internet] New York: Women's Refugee Commission. Retrieved 14/03/2021 from: https://www.refworld.org/docid/56ef98954.html

World Health Organization. (2003). *Gender and HIV/AIDS. In. Geneva.* World Health Organization. Retrieved 14/03/2021 from: https://www.who.int/gender/hiv_aids/hivaids1103.pdf

World Health Organization. (2017). *Female Genital Mutilation. Fact Sheet*. Switzerland: World Health Organization. Accessed on 14 Dec 2020, Retrieved 14/03/2021 from: https://apps.who.int/iris/bitstream/handle/10665/112328/WHO_RHR_14.12_eng.pdf

World Health Organization. (2018). Report on the health of refugees and migrants in the WHO European Region: No public health without refugees and migrant health. Retrieved 19/03/2021 from: https://apps.who.int/iris/bitstream/handle/10665/311347/9789289053846-eng.pdf

Yang, X., & Xia, G. (2006). Gender, migration, risky sex, and HIV infection in China. Studies in family planning, 37(4), 241-250. https://doi.org/10.1111/j.1728-4465.2006.00103.x

First Reception Service / Annual Report (2014, April). Part B - First reception of illegally entering Third-country nationals. Retrieved 19/03/2021 from: https://migration.gov.gr/wp-content/uploads/2020/07/%CE%95%CF%84%CE%AE%CF%83%CE%B9%CE%B1-%CE%AD%CE%BA%CE%B8%CE%B5%CF%83%CE%B7-%CE%A5%CF%80%CE%B7%CF%81%CE%B5%CF%83%CE%AF%CE%B1%CF%82-

%CE%A0%CF%81%CF%8E%CF%84%CE%B7%CF%82-

%CE%A5%CF%80%CE%BF%CE%B4%CE%BF%CF%87%CE%AE%

CF%82-2013.pdf

Appendix I

Table 1 Characteristics of participants of qualitative study component (*n* = 10)

Age	
15-20	1
21-25	5
26-30	2
31-35	1
36-40	1
Ethnicity	
Syria	7
Iraq	1
Afganistan	2
Religion	
Muslim	10
Else	
Parity	
1	2
2-4	6
>5	1
Stage of Pregnancy	
2nd	4

3rd	5
Post-partum	1

Appendix II – Interviews

Interviews Refugee Women Northern Greece

- Participants: 10 women, 8 Arab speaking, two farsi speaker living in Alexandria camp
- 10 individual interviews conducted by a female midwifery researcher.
- All the interviews were carried out with the help of a female mediator, so that women's answers can be objective.
- Questions were made in Greek. The answers were given in Arabic or Farsi and translated in Greek by the mediator.
- All interviews lasted between 30-45 minutes.
- Informed consent was obtained for all women.

1. How satisfied were you with your care overall?

RW1-"*70%"*

RW2–"*From the moment we left Lesvos, a lot."*

RW3 –"*Very Much. Even though I am tired of such frequent monitoring."*

RW4 – *"A lot."*

RW5 –*"80%."*

RW6 –*"At the island I didn't feel that the care provided to me was good. It is better here."*

RW7 –*"Quite satisfied."*

RW8 – *"I am happy with the care I received, nothing to complain for."*

RW9 – *"I am generally satisfied. Something that didn't make me happy is that there is no interpreter at the hospital."*

RW10 – *"I am very satisfied, 80%."*

2. Could you tell me about any parts you particularly liked during perinatal care? Why did you like those parts/how were they beneficial?

RW1-"*Because my pregnancy was unexpected, I liked that the midwife helped me undertake all the necessary exams and sent me to the hospital. Overall, I liked her interest."*

RW2 -*"I liked the care provided here (at the camp) because it was immediate, without waiting like it was in Lesvos."*

RW3 -*"I liked that I felt respected and I was given the right advice."*

RW4 –*"That the midwife was available anytime I needed something and she made sure all the necessary tests and screening were taking place."*

RW5 –*"The midwife was always there for me and this made me feel secure."*

RW6 –*"I like that whenever I visit the clinic, I am not afraid to talk to the midwife. I can ask any question I might have and she is always willing to help me."*

RW7–*"The midwife was always close to me and advised me, comforted me. I could listen my baby's heart rate, and all my questions were being answered."*

RW8 – *"I am very satisfied because if the midwife didn't help me I wouldn't have done this specific examination to see if my baby is healthy or not. I am happy with the care provided at the hospital as well."*

RW9 – *"I like that pregnant women are being cared for and the midwife ensures that every woman has her screening tests. Also, I like that there is not much waiting time for our ultrasound appointments."*

RW10 – *"In Lesvos, where I was before, the doctors' behavior was nice. I heard that at the hospital they don't provide proper care to refugees, but when I visited this was not the case. They took care of me. I was studying as a Midwife in my country but since we came here, I stopped. I had only 7 months left to graduate."*

3. Could you tell me about any parts you did not liked during perinatal care? Why didn't you like those parts?

RW1-"*I wasn't given an AMKA number and that was the reason why I had difficulty having my blood tests done. I didn't like that I had to go to the hospital alone and at my own expense, I always needed an escort me to help me. The hospital doctor, without reading the medical document I had, gave me a bunch of medication and injections, and if I hadn't mentioned that I was pregnant I would have had an injection and lost my baby. Also, I didn't like the other day I went to the hospital and I was told that I was there on the wrong day, although I visited the right date. I was exhausted. I begged them to help me and started crying."*

RW2 –*"I did not receive good care at Lesvos camp because of the large population. I have been in Alexandria for 3 months, have my own container, not like in Lesvos where I was staying out in the woods. My exams were delayed there. And here I have no AMKA number to perform them."*

RW3 -*"I didn't like being asked to go to the hospital regularly because of the distance. Sometimes there were delays at the hospital and I had to wait a long time."*

RW4 –*"Nothing."*

RW5 –"There is nothing I didn't like."

RW6 – *"There is a long delay to book a hospital appointment and I had to visit a second time to receive the results and the hospital was too far."*

RW7 –*"It was difficult to book an appointment on time for the gestational age. I had to wait a long time and this made me nervous."*

RW8 – *"What I didn't like is that I knew that my baby didn't have this infection, but I was scared that it did. I was 9 months pregnant when I was given the pill. When I started it, the baby was not moving as much as before. However, I want to thank the midwife so much for making sure that I took this test and find out that the baby is healthy. Also, thanks a lot for transferring me to the hospital until the time I gave birth. Also, the doctors at the hospital were very kind."*

RW9 – *"Generally I'm very satisfied with the care I receive at the camp, but I have a complaint about a particular doctor at the hospital. His behavior to us was very bad, he didn't call us by our names, but he addressed to us making a noise like "psit" and during the u/s examination he asked us to look at the wall. Also, he throwed the used tissues he cleaned the gel with to us."*

RW10 – *"Something that I didn't like was that at the beginning of the pregnancy, the doctor didn't give me anything about stomach pain I had. When I visited the midwife at the camp, she helped me, took care of me and the pain disappeared. Back home, I had to take care on my own, same here in Greece. If I don't look after myself no one will help me."*

4. What was your experience of the care you received by midwives?

RW1 -*"I was feeling very good, I don't like being examined by men. I wish I was examined by female health care professional's every time."*

RW2 -*"That was very good, you know we Muslims don't want to be examined by men."*

RW3 -*"I loved that you are a woman. I don't like men. I feel comfortable talking to you about anything."*

RW4 –*"The midwives and the fact that they were women made me feel very comfortable."*

RW5 –*"Having female midwives was a very positive thing. I wouldn't like to be examined by a man."*

RW6 –*"I was very happy with the midwives. I find it hard to express myself in front of men. I feel very comfortable with the midwife."*

RW7–*"Having female midwives made me feel relieved. I wasn't shy."*

RW8 – *"I liked that every time I visited the midwife for my examination we heard the baby's heart and also I liked that sometimes if I was were late or I didn't came, the midwife was looking for me."*

RW9 – *"I like it very much because here they are women, not like in Veroia where they were men."*

RW10 – *"I am satisfied because they are women."*

5. Can you tell us two things you liked about the care by your midwife?

RW1-*"I loved that she showed understanding to me and that she did the best to help me. Also, she's always smiling, eager and cheerful and that builds up my psychology every time I visit the camp clinic."*

RW2 -"*Her behavior and good care."*

RW3 -*"She is always smiling and happy. She is listening to my problems carefully and shows interest. I feel like she is listening everything I'm saying."*

RW4 –*"The attention she pays to me every time I visit the clinic."*

RW5 –*"She was providing information about everything related to my pregnancy and she would book all my appointments."*

RW6 –*"She wouldn't refer me to the hospital for no reason. She would advise me on everything."*

RW7 –*"I liked that she taught me a few things about my baby's development."*

RW8 - *"I am very satisfied, I liked everything."*

RW9– *"I am very satisfied; I feel properly being cared for. They make sure I always have the proper pregnancy follow up."*

RW10 – *"In Lesvos, the midwife took good care of me. Also, here in Alexandria the midwife takes good care of me. She is very kind, lovely and helps me."*

6. Can you tell us two things that could have been improved in the care you received by your midwife?

RW1 -"*There is nothing that I didn't like here at the camp."*

RW2 -*"I have no complaints for the midwife, I liked everything."*

RW3 -*"I can't recall something I didn't like."*

RW4 –*"I don't have any complains."*

RW5 -*"I liked everything."*

RW6 –*"I was treated the best possible way."*

RW7 –*"I have no complain, apart from one time that I was slightly delayed to be seen for my appointment."*

RW8 – *"There is nothing that I didn't like. Something that scared me was that I was told that the baby may be delivered with big/deformed head, but this was before the test."*

RW9 – *"There was nothing that I didn't like."*

RW10 – *"I didn't like that I had to wait long for an ultrasound appointment to be booked at the hospital. I also heard that some women*

who were planned to have a c/s were examined vaginally by the doctor at the hospital. I am a Muslim and I don't want to be examined by a man. I am satisfied with the camp midwife, but at the hospital I want a female doctor."

7. Did it help that there was an interpreter in your appointments within the structure but also in the hospital?

RW1 -"*There wasn't always a female interpreter available. Whenever there was one it was helpful. But in the hospital it didn't exist most of the time. Only once and it was a man."*

RW2 -*"Yes, and a friend of mine found it very helpful as well."*

RW3 -*"I felt more comfortable expressing myself around women. At the hospital there were both men and women. An interpreter existed only in the hospitals of Thessaloniki."*

RW4 –*"Whenever there was one, yes."*

RW5 –*"Here in the camp yes. At the hospital it didn't exist most of the time"*

RW6 –*"I believe it was very helpful."*

RW7–"Whenever there was one, I found it helpful."

RW8 – *"Yes, I felt supported by a person that has some knowledge of my cultural background and how things work back home."*

RW9 – *"Yes, I was very happy with that."*

RW10– *"It was nice to have one. Here in the camp the most time, but at the hospital it was a huge problem because there was no interpreter"*

8. Did the interpreter increase your knowledge and confidence around pregnancy, childbirth and looking after your child?

RW1 –*"I believe she did, even though my midwife was very informative and I did not have many questions. At the hospital, no. He went to the doctor's office, said what I had to the doctor and left without waiting for me to explain what the doctor said."*

RW2 – *At the camp there was an interpreter, yes she helped a lot.*

RW3 -*"Yes, Yes, so much, he was exactly translating the words of the doctor and I could have a dialogue."*

RW4 –*"She was always too busy and I didn't have much time to ask all my questions."*

RW5 –*"Yes, she was very helpful."*

RW6 –*"Yes, it was always helpful and happy to fill any gaps I had."*

RW7– *"When there was one available, yes."*

RW8 *"Of course. It was very helpful and make me feel confident"*

RW9- *"Yes, he translated all my questions to the doctor and made a good conversation"*

RW10- *"I did not have many questions. "*

9. Was the interpreter the same ethnicity as you? What are your thoughts about this?

RW1 -*"No, she wasn't and I didn't like that. I didn't help me."*

RW2= *"Yes, she was the same. But nationality doesn't matter, sometimes other nationalities are better than ours."*

RW3 -"*Sometimes yes, others not. I didn't feel any difference because everyone was speaking Arabic and I could communicate."*

RW4–*"I am not aware, I didn't ask."*

RW5 –*"Yes, we had the same ethnicity and we were from nearby villages. This made me feel very familiarly."*

RW6–*"Yes, this made me feel comfortable."*

RW7 –*"Yes, it was nice."*

RW8 – *"No, but that was not a problem, she was very nice."*

RW9 – *"Yes, we had the same nationality and also back home we lived in close villages. I felt very good because I saw that she wanted to help me."*

RW10 – *"At the camp Yes, it made me feel more confident."*

10. What if anything do you think could be improved in the services you were offered during pregnancy,birth or after having our baby?

RW1 -*"I would like to give me more attention, since they know that I do not know the language (Greek.) They should have an interpreter at the hospital. I would also like to avoid going to the hospital alone."*

RW2- *"I would like to have AMKA number, better access to the hospital and doctors to be female."*

RW3 –*"No, everything was okay. I am satisfied."*

RW4-*"I would like to have an AMKA number in order to have all the tests at the closest hospital and avoid travelling so far."*

RW5 – *"I would like to only be examined by female staff when I visit the hospital and I would like to be closer to the hospital so I can walk there."*

RW6 –*"I am satisfied."*

RW7 – *"I would like to have an interpreter in every hospital visit and the ability to have all the tests at the camp to avoid visiting the hospital."*

RW8 – *"No, because the midwife at the camp offered me everything."*

RW9 – *"It would be very helpful to have an interpreter every time I visited the hospital. Two times, when I went to the hospital without escort, they didn't accept me."*

RW10 – *"No, everything was good."*

11. Prior to this current baby had you previously accessed maternity services in Greece?

RW1 –*"No."*

RW2 –*"No."*

RW3 -*"Yes, I gave birth in Greece last year. In my previous pregnancy I didn't have to visit the hospital so often."*

RW4–*"I don't have other children."*

RW5 –*"No, I haven't given birth in Greece before."*

RW6–*"Yes, and I am very happy with the care I received."*

RW7 -*"No."*

RW8 –*"Yes, I delivered my eldest daughter in Greece. The care was better then, because we were transferred to our appointments in the hospital with a Van and they helped us navigate at the hospital and they escorted us in order to speak with the doctors."*

RW9 – *"No."*

RW10 – "No."

12. What were your experiences of accessing maternity services? If you got pregnant again would you know how to access maternity services?

RW1 –*"Yes, I have understood the steps I need to take for my care."*

RW2– "I haven't visited the hospital yet."

RW3-*"I can visit a hospital on my own, as long as there is an interpreter. If I knew that there will always be one present, I would go with more confidence."*

RW4 –*"With the presence of an interpreter, yes."*

RW5 –*"I have understood what kind of tests I need to have and the reason why I need to have them as well as where I have to address to."*

RW6 – *"I get confused sometimes, but I think I will make it."*

RW7 –*"I know how to visit the hospital by myself. What stresses me every time is whether there will be an interpreter or not."*

RW8 – *"Yes, I believe that the care I received, helped me understand the Greek system. However, I don't want to get pregnant again."*

RW9 – *"Yes, I understand a little. I know why I have to do the examinations and where I have to go."*

RW10 – *"Only if there will be an interpreter present."*

13. Did you share any of the information you learned about perinatal care and how to handle the maternity services in Greece with other pregnant women (eg friends, relatives, etc.)

RW1 -"*Yes, I have discussed it with women in the camp and with my relatives back home."*

RW2 -*"No, I haven't shared anything. In general, we do not spread either bad or good words. But I have heard from a lady who gave birth here that the doctor at the hospital did not have a good behaviour and I was scared."*

RW3 - *"Not with friends, just with my husband. I don't have friends here."*

RW4 – *"I don't know many people here, so until now I haven't talked to anyone."*

RW5 –*"Yes, I discuss about it with my sister who lives in another country."*

RW6 –*"Only with my mother."*

RW7 – *"No."*

RW8 – *"Yes, with the women here at the camp. We talked about my Health and the examinations I had."*

RW9 – *"Of course I shared my experience with some women at the camp. Also, the new ones are coming to me asking how the care here in Greece is. I told them, that everything that the midwives advise you to do, are the right things for a healthy pregnancy."*

RW10 – *"Yes with the women here at the camp."*

14. Do you have any further comments you would like to make about your maternity care or the ORAMMA project?

RW1 -*"My mood changed during pregnancy. I became more sensitive, more nervous. I feel tired and exhausted. I am thinking when I have my c/s,*

who will help me, what will happen and that I will not be active. I have no help from anyone."

RW2 -*"I want to give birth with a female doctor and have an interpreter at the hospital. I'm worried about leaving my toddler when I give birth or if he needs something in the night when he sleeps .. I will be in the hospital and will not be able to take care of him."*

RW3- *"I love my midwife here at the camp very much and I want to thank her for the attention she gave me. I am pleased with her, but not from the Greek system, I want to leave this country. At the camp and the hospital, the care was very good, but I want to live in Germany with my family."*

RW4 – *"I can't wait to give birth and cuddle with my baby."*

RW5 – *"I feel very tired during this pregnancy. My previous wasn't like that. But I am getting closer to having my baby and after that I will be very careful and try to avoid a further pregnancy, at least not very close to this one."*

RW6 *–"I am happy that I have given birth in Greece before and I am not stressed about what I will face at the hospital. I just wish there will be an interpreter for better communication."*

RW7*–"No."*

RW8 – *"When I saw my baby, I felt very good. In Syria, the prenatal care was the same, but there I could communicate better because they spoke Arabic. Also, I want to say that my midwife helped me so much with breastfeeding and solved all my problems and I'm very thankful about that."*

RW9 – *"No."*

RW10 – *"I want to be examined by women."*