ΠΑΝΕΠΙΣΤΗΜΙΟ ΔΥΤΙΚΗΣ ΑΤΤΙΚΗΣ
UNIVERSITY OF WEST ATTICA

POST GRADUATE THESIS

Perinatal experiences of refugee, migrant, and asylum seeker women inthe context of the implementation of the ORAMMA project at Leros' Hospital.

ΜΕΤΑΠΤΥΧΙΑΚΗ ΔΙΠΛΩΜΑΤΙΚΗ ΕΡΓΑΣΙΑ

Οι περιγεννητικές εμπειρίες των προσφύγων,μεταναστών,αιτούντων άσυλο γυναικών στο πλαίσιο της εφαρμογής του προγράμματος Oramma στο νοσοκομείο της Λέρου.

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Ο/**η** κάτωθι υπογεγραμμένος/**η** Φρανζέσκου Ειρήνη Χρυσοβαλάντου του Γεωργίου, με αριθμό μητρώου 18042 φοιτητής/**τρια** του Προγράμματος Μεταπτυχιακών Σπουδών Κοινοτική Μαιευτική Φροντίδα του Τμήματος Προηγμένη και τεκμηριωμένη μαιευτική φροντίδα της Σχολής Μαιευτικής του Πανεπιστημίου Δυτικής Αττικής, δηλώνω ότι:

«Είμαι συγγραφέας αυτής της μεταπτυχιακής εργασίας και ότι κάθε βοήθεια την οποία είχα για την προετοιμασία της, είναι πλήρως αναγνωρισμένη και αναφέρεται στην εργασία. Επίσης, οι όποιες πηγές από τις οποίες έκανα χρήση δεδομένων, ιδεών ή λέξεων, είτε ακριβώς είτε παραφρασμένες, αναφέρονται στο σύνολό τους, με πλήρη αναφορά στους συγγραφείς, τον εκδοτικό οίκο ή το περιοδικό, συμπεριλαμβανομένων και των πηγών που ενδεχομένως χρησιμοποιήθηκαν από το διαδίκτυο. Επίσης, βεβαιώνω ότι αυτή η εργασία έχει συγγραφεί από μένα αποκλειστικά και αποτελεί προϊόν πνευματικής ιδιοκτησίας τόσο δικής μου, όσο και του Ιδρύματος.

Παράβαση της ανωτέρω ακαδημαϊκής μου ευθύνης αποτελεί ουσιώδη λόγο για την ανάκληση του πτυχίου μου».

Επιθυμώ την απαγόρευση πρόσβασης στο πλήρες κείμενο της εργασίας μου μέχρι 7/12/2021 και έπειτα από αίτηση μου στη Βιβλιοθήκη και έγκριση του επιβλέποντα καθηγητή.

Ο/Η Δηλών/ούσα

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Abstract

The risk of sexual and gender-based violence for women who are refugeesis high as, they represent a vulnerable target group when taking into consideration the prior course of migration, throughout migration as well asposthaving arrived in the country of destination. Due to this fact there is a high possibility for refugee women to have an adverse outcome in their reproductive and mental health.In this thesis the main goal is to investigate and propagate immigrants', refugees'and asylum seekers' contentment that have been provided care at Leros' Hospital under the Operational Refugee and Migrant Maternal Approach (ORAMMA) project and its structure of procedures.

Περίληψη

Ο κίνδυνος σεξουαλικής βίας με βάση το φύλο για γυναίκες που είναι πρόσφυγες είναι αρκετά υψηλός, καθώς αποτελούν μια ευάλωτη ομάδα-στόχο, καθ 'όλη τη μετανάστευση και όταν φτάνουν στη χώρα προορισμού. Λόγω αυτού του γεγονότος, υπάρχει μεγάλη πιθανότητα οι γυναίκες πρόσφυγες να έχουν αρνητικό αποτέλεσμα στην αναπαραγωγική αλλά και τη ψυχική τους υγεία. Σε αυτή τη διατριβή, ο κύριος στόχος είναι η διερεύνηση και διάδοση της ικανοποίησης των μεταναστών, των προσφύγων και των αιτούντων άσυλο γυναικών που τους παρέχεται φροντίδα στο Νοσοκομείο Λέρου ,στο πλαίσιο του Προγράμματος (ORAMMA) και τη δομή των διαδικασιών του.

1 Introduction

Background

Involuntary immigration is a growing issue which has been mainly caused by war, globalization and deprived living conditions.The quantity of individuals dislodged by strife and oppression on a global scale was evaluated to be over sixty-five million in 2016 (Sekeris & Vasilakis, 2016). As advised by the United Nations High Commissioner for Refugees (UNHCR) theuppermost number that has been recorded was, from the aforementioned total, approximately two million eight hundred thousand were asylum seekers, including twenty-two and a half million refugees (UNHCR, 2017). Furthermore, forty nine percent of the persons in exile were female which is in an analogous ratio as recounted each year since the year 2003 (UNHCR, 2017). The effect of immigration on wellbeing is expansive, causing transient populaces especially powerless which add to imbalances in wellbeing and brings about severe ramifications on general wellbeingworldwide.

There is a great challenge when conducting research on migrant populations due to the use of varied definitions and terminology. In thisthesis UNHCR definitionswill be utilized (UNHCR, 2017):

Asylum seekers are people who have looked for universal assurance and whose claims for exile status have not yet been resolved, this is regardless of the time that

they werefiled. An asylum seeker has submitted an application for refugeestatus as a consequence of mistreatment in their nation of origin identifying with their enrollment of a specific social gathering, race, religious beliefs, political conviction or nationality. Asylum seekers remain as such for whatever length of time that the application is pending.

Migrants incorporate the individuals who move, either briefly or for all time from one spot, zone or nation of living arrangement to another. The reasons for a migrant to move are usually due to job prospects, looking for a superior life, family reasons or educational dedications. The definition joins with the term asylum seeker and refugee as individuals likewise relocate to escape war or persecution.

Women make up more than half of the migrant populace within the WHO European Region; they are over-represented in higher-risk clusters for example their experience of violence or trafficking which has been shown to be eighty percent (De Leon Siantz, 2013). As recorded by the United Nations Population Fund (UNFPA), 500.000women of reproductive age from Syria,in the year 2015 were refugees in Turkey (Bergesen, Parmann & Thommessen, 2018). Alarmingly, almost three hundred thousand women in that category were pregnant (Keygnaert et al., 2016). The above has demographic inferences. Due to migration, population growth within 7 members of the European Union has subsequently increasedafter 1990 (Keygnaert et al., 2016). Furthermore, ten percent of live births in 2006 within the WHO European Region were by migrant

mothers. In addition, twenty percent of the contribution had been reached in Wales and England (United Kingdom), Sweden and the Netherlands and above fifteen percent had been presented in Belgium (Keygnaert et al., 2016). Although this was the case, at the same period the final result on countries general fertility number was at 0.05–0.1 (Keygnaert et al., 2016).

Due to the great number of migrants,a lot of pressure is placed on the existing health care systems which have a limited amount of funding (WHO Regional Office for Europe, 2016). Unevenly dispersed childbirths by migrant mothers geologically is predominant (Hayes, Enohumah & McCaul, 2011), due to this fact there are great amounts of challenges posed which therefore create alterationsin the health care needs and health care delivery in regions whereby there is a high concentration of migrant families and mothers needing care.

The most important factor to take into consideration is that of continuity of care when referring to maternity care.The most predominant elements that are to be taken into consideration before pregnancy are for exampleinfection, heart disease, malnutrition, violence, which could cause negativerepercussions in pregnancy (Lewicka et al., 2017). When planning care, the aforementioned possibilities have to be considered during the process of planning for care. Maternity care on its own incorporates care that is providedfor the duration ofthe pregnancy (antenatal consideration), throughout labor process and in the wake of conceiving an offspring (postnatal consideration)

(Knight et al., 2017). It is important to include both care and social help throughout pregnancy as they are critical to guaranteeing safe deliveryof care during birth, andnewborn babies and mothers that are healthy (Tunçalp et al., 2017). The after-birth process is just as important therefore WHO has endorsed a minimum amount ofantenatal care visits to 8 times as it has been provisioned for postnatal care as maternal mortality can occur withinforty-two days after the baby has been born (Tunçalp et al., 2017). In addition, there should be a comprehensivemaintenanceplatform provided to migrant and refugee women, something that all women should have at their disposal. Although this is essential,numerousmigrant and refugee women have supplementary needs, for instance, economic and social needs, which in usual casesobstruct or challenge care during pregnancy (Bawadi et al., 2020). Their wellbeing profiles mirror their clinical accounts just as the infection weight and nature of care in their nation of birthplace or travel nation (Sobotka, 2008). The characteristics mentioned above are intensified by pregnancy, thus it is important to make a specific consideration to maternity care.

Universal Declaration of Human Rights Care had been called for in copious procedural documentation from both wellbeing executive bodies and the broader setting for migrants and refugees, explicitly for that of childbearing women (Danieli, 2018). In 2015, the United Nations adopted the 2030 Agenda for Sustainable Development (Anderson et al., 2017). The 2030 Agenda for Sustainable Development

includes a particular wellbeing related Sustainable Development Goal (SDG 3), great wellbeing and prosperity) in addition to others that sway on migrant maternal and infant wellbeing, for example, SDG 5 (sex balance) and SDG 10 (diminished disparities) (Taran, 2016).SDG 5.6 explicitly positions that it is a nation'sobligationto "ensure universal access to sexual and reproductive health and reproductive rights" (Taran, 2016).

Human rights of irregular migrants, resolution 1509, that the Council of Europe assumedin 2006 by detailed (point 13.2) that "emergency health care should be available to irregular migrants and states should seek to provide more holistic health care, taking into account, in particular, the specific needs of vulnerable groups such as children, disabled persons, pregnant women and the elderly" (Resolution 1509, 2006). SDGs had sprung the significance of migrant health which had been advancedand underlined within the Horizon 2020, from the European Union (EU), which had been included in the segment for demographic change and well-being (WHA 61.17) and the WHO resolution WHA61.17 on the health of migrants (Martin et al., 2017).

The WHO Regional Office for Europe received the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region in September 2016, which demonstrated key needs that are vital for these regions (WHO Regional Office for Europe, 2016). This resultedin a need for global wellbeing inclusion as well as individual focused wellbeing frameworks and intersectional cognizance in

arrangements influencing displaced people and their admission to healthcare. In addition, the Strategy and Action Plan underscored the significance of refining the strength of the most helpless which is comprised of the young population and childbearing women, and organized matters identified with regenerative and sexual wellbeing(WHO Regional Office for Europe, 2016). The support at the World Health Assembly had followed in 2017for goals on the wellbeing of migrants and refugees (WHA 70.15, 2017). In May 2019, the 72nd World Health Assembly had been presented with a proposal of the complete declaration and its supplementary agendas (Higgins et al., 2020).

The initial 4 core values had been included. First is the privilege to the satisfaction in the most noteworthy feasible standard of physical and psychological well-being. The second core value is uniformity and non-segregation. The third core value is a fair access to wellbeing administrations. The fourth core value is individually focused, migrant, refugee and gender delicate wellbeing frameworks are to be in place (Higgins et al., 2020).

In parallel these approach records diagram what particular wellbeing frameworks are to remember in order to be migrant and refugee delicate, it is however even less distinguishable as to how this may be accomplished for mother and infant wellbeing explicitly. Since numerous variables meet there is a need for an intersectional approach enveloping in cooperation with the medication and sociologies in order to

review what is expected on how ethnicity, sex, class, religion and different issues that sway on the impartial conceptive wellbeing organization (Higginbottom et al., 2016). In addition, the ORAMMA venture wasin place whereby its aim was to build up an incorporated, mother and woman focused orientation which is also socially arranged and proof based in its methodology in order for all periods of the refugee and migrant women's perinatal services. The services in different periods of pregnancy included that of antenatal period, intrapartum period, delivery and postnatal care (Higginbottom et al., 2016). This methodology wasexecuted by an array of multidisciplinary groups of specialists, in particular birthing assistants (e.g. doctors, midwives, maternitypeersupporters), social workers and general experts. The practitioners had a dynamic cooperation with women from refugee and migrant networks which guaranteed a sheltered progression into parenthood relieving basic stress and implementing education on wellbeing and monitoring of the mothers and children.

It is important for mothers to have early exposure to perinatal services and this is a successful strategy to streamline pregnancy results and the long-lasting strength of women and their posterity as it has been found that when late access to maternity care takes place there is a possibility of complexities and perinatal outcomes that are unfavorable.

Pregnant women who arerefugees orasylum seekersare vulnerable in the system when looking for healthcare (Cheng, Drillich & Schattner, 2015), including maternity care and after care (Khanlou et al., 2017). An ongoing articleregarding helpless women in social emergency in Europe had also involvedexpectantwomen waiting for asylum andthose who were declined refugee status, sixty five percent of whom had no entrance to antenatal care(Chauvin et al., 2015). Furthermore, it has been documented that forty two percent were able to attain care following twelve weeks of pregnancy and women who were high risk(needing acute or semi critical care) were at 66.67% (Chauvin et al., 2015). If there is distinctiveness in access to and the utilization of perinatal healthcare services, there is a possibility that there will be a critical imbalance in wellbeing (Leseur et al., 2018). Therefore, the inability to adequately reach and contribute ideal perinatal consideration to women that are under asylum-seeking status and refugee status will cause a greater difficulty and inability to lessen wellbeing imbalances for these women and their future children (Leseur et al., 2018).

Purpose of the Research

In order to conduct the research under the subsequent WHO classifications, maternal health is defined as the wellbeing of women throughout pregnancy, delivery and the postnatalperiod, which is up to 6weeks after delivery, lastly newborn health applies to the initial four weeks of life after a baby has been born (Black et al., 2016).

The focus of this thesisis specifically on pregnancy and childbirth although other fundamentals such as sexual and reproductive health of migrants, namely that of greater numbers of unplanned pregnancies including abortions, a lessened amount of contraception utilized due to lack of access, lastly greater proportions of sexually transmitted diseases; although these components are important, they are beyond the remit of the study and therefore will not be included. A blend of the writing on migrant women's and their babies' wellbeing in the WHO European Region had been directed, paying attention in orderly surveys.

In this thesis the main goal is to investigate and propagate immigrants', refugees' and asylum seekers' contentment that have been provided care at the Hospital of Leros under the ORAMMA project and their structure of procedures. Individual interviews and questionnaires were conducted for the purpose of contributing to the research of the presentthesis.

Importance of Research

War and conflicts, poverty and persecution have forced millions of refugees to seek asylum outside of their country. It is noteworthy to state that asylum is found by the preponderance of the refugees worldwide, in countries that are of low and medium economy, for instance, Asia and Africa (UNHCR, 2018), however over the last few years this has changed increasingly, whereby refugees have migrated to Europe which has become a cause for alarm in EU countries (European Commission, 2016).

The risk of sexual and gender-based violence for women with refugee status is high, as they represent a vulnerable target group when taking into consideration the prior course of migration, throughout migration and yet,following their arrival in the country of destination(IOM, 2018; Jassens, Bosmans & Temmerman, 2005).Due to this fact there is a high possibility for refugee women to have adverse outcomesrelated with their reproductive and mental health (Shafiei & Flood, 2019). Internationalconventionsand the EU directive are to provide a portal to caring and protecting refugee women'ssexual and reproductive rights; there are loopholes along with barriers that prevent them from obtaining their entitlement to the care that is entitled to them (Keygnaert et al., 2014).

Worldwide relocation is at an unsurpassed high with repercussions on perinatal wellbeing (Shafiei & Flood, 2019). A denotation of an especially defenseless cluster is that of migrant women, in particular refugees, migrants and asylum seekers. Furthermore, an imperative requirement in order to improve care and results is comprehending the perinatal wellbeing of women and children and its impacts (Leuseur et al., 2018).

2 Literature Review

Perinatal health outcomes amongst women who are migrants (including asylum seekers and refugees)

Prevalence of perinatal mental health disorders

It is evident that in every systematized audit there has been a revealed predominance in data accumulated reasoning that perinatal emotional well-being illnesses were more incessant in transient women in comparison to women that were from the host nation(Anderson et al, 2017; Fellmeth et al, 2017; Alhasanat &Fry-McComish, 2015; Falah-Hassani et al, 2015; Collins et al, 2011; De Maio, 2010; Nilaweera et al, 2014). Postnatal despondency was the most detailed perinatal emotional well-being result in the systematized surveys. Predominance of postnatal depression among transient women was accounted for 2–60% (Alhasanat & Fry-McComish, 2015), < 1–59% (Anderson et al, 2017), 24–42% (18), 2.9–52% (Nilaweera et al, 2014) and 20% (95% certainty interim (CI) 17–23%) (Falah-Hassani et al, 2015). Furthermore, pervasiveness of prenatal depression among transient women was accounted for as high as 12–45% (Anderson et al, 2017), and predominance of any depressive disorder was shown to bethirty-one percent (95% CI 23.2–40%) (Fellmeth et al, 2017). Moreover, there was likewise an essentially expanded relationship between psychological illness among migrant women compared with nativewomen. Nervousness was expanded in migrant women that were of non-English-talking

foundations as Anderson et al. stated (Anderson et al, 2017), and PTSD(Post Traumatic Stress Disorder) was fifteen percent among non-transient women (Shafiei & Flood, 2019). Probabilities for postnatal depression that had been found in examinations were in a range between 1.8–2.5 for transient populaces as stated by Nilaweera et al. (2014). Likewise, in other meta-analysisconducted by Anderson et al. (2017) and Falah Hassani et al. (2015) there has been a demonstration that migrant women, in contrast to women that were from the host nation,had higher chances of experiencing postnatal depression for (OR 1.56 (95% CI 1.31–1.86) and a balanced OR (aOR) of 2.17 (95% CI 1.54–3.06 separately). When Falah Hassani et al. (2015) balanced for production inclination, the affiliation diminished yet stayed critical (OR 1.67, 95% CI 1.12–2.30). Anderson et al. (2017) likewise revealed that affiliations varied for prenatal as well as post-delivery discouragement while dividing the meta-investigations by nation of study: prenatal depression USA (OR 0.71, 95% CI 0.51–0. 99) and postnatal despondency Canada (OR 1.86, 95% CI 1.32–2.62); Australia (OR 1.115, 95% CI 0.96–1.38) USA (OR 0.87, 95% CI 0.59–1.28), and Canada (OR 1.98, 95% CI 1.57–2.49).

Risk factors for the development of perinatal mental health disorders

It has been revealed in seven continuous reviews quantitative and subjective proof of elements related with expanded danger, or protectively affecting perinatal

psychological well-being issue (Anderson et al, 2017; Fellmeth et al, 2017; Alhasanat &Fry-McComish, 2015; Falah-Hassani et al, 2015; Collins et al, 2011; De Maio, 2010; Nilaweera et al, 2014). Similitudes among the organised studies were present, and the findings are accounted for under the subjects of support and pressure, acclimations to host nation, care during pregnancy and feeding, wellbeing status and history and sociodemographics (Alhasanat &Fry-McComish, 2015).

Support and Stress. Support and stress were the most reported and reliably announced risk factors for the advancement of psychological wellness issues among transient women. Models that were presented included emotional pressure, a background marked by viciousness, having seen or suffered upsetting life occasions and their experience prior to migration, i.e., having moved for reasons of politics or issues with the police or armed force in their nation of origin (Anderson et al, 2017; Fellmeth et al, 2017; Alhasanat &Fry-McComish, 2015; Falah-Hassani et al, 2015; Collins et al, 2011).Furthermore, absence of social help and absence support from their family were additionally answered to be significant risk factors (Alhasanat&Fry-McComish, 2015). There was a predictable example of low social help which had in effect expanded the risk and great social help being defensive against perinatal emotional well-being issues(Anderson et al, 2017; Fellmeth et al, 2017; Alhasanat &Fry-McComish, 2015; Falah-Hassani et al, 2015; Collins et al, 2011; De Maio,

2010; Nilaweera et al, 2014). It has been made evident that the lack of having no family members or companions, an absence of passionate help from their mate, potentially being single or unmarried, having moved for marriage purposes, conjugal alteration issues and an absence of power to make household decisionsrelated to their infant were all factors leading to perinatal emotional distress among transient women, though the presence of a healthyrelation with their partner was accounted for to be defensive (Anderson et al, 2017; Fellmeth et al, 2017; Alhasanat &Fry-McComish, 2015; Falah-Hassani et al, 2015; Nilaweera et al, 2014).

Change in accordance with host nation. It has been revealed in most studies that the most regularly revealed risk elements for perinatal emotional wellness issues were troubles with the host nation language (Anderson et al, 2017; Fellmeth et al, 2017; Falah-Hassani et al, 2015; De Maio, 2010;, Nilaweera et al, 2014) and being new to their surroundings(De Maio, 2010). It has been detailed by Anderson et al. (2017) that conflicting proof in their included examinations identifying with the time allotment inhabitant in the host nation, though different surveys announced that shorter span of living arrangement was a riskelement for perinatal psychological well-being issues (Fellmeth et al, 2017; Falah-Hassain et al, 2015). Fellmeth et al. (2017) have stated that adherence to conventional post-delivery rehearses was defensive against depression during the postnatal period in transient populaces.

Pregnancy care and feeding care of a newborn child. Experience of perinatal social insurance including cesarean and instrumental delivery and poor fulfillment with assistance(Fellmeth et al, 2017;Collins et al, 2011) and furthermore newborn child feeding experience together withformula feeding issues and feeding issues (Fellmeth et al, 2017; Falah-Hassani et al, 2015; Nilaweera et al, 2014) were risk elements for the advancement of perinatal psychological wellness issue revealed by four orderly studies(Merry et al, 2016; Falah-Hassani et al, 2015; Collins et al, 2011; Nilaweera et al, 2014).

Wellbeing status and history of mental health. The danger of perinatal emotional well-being issues was expanded when transient women saw their general wellbeing to be depleted(Falah-Hassani et al, 2015; De Maio, 2010) or had a background marked by psychological wellness issues(Fellmeth et al, 2017; Nilaweera et al, 2014). ORs for postnatal melancholy is to be in the range of 24.9 and 29.7 when there was an individual or family ancestry of mental health issues as stated by Fellmeth et al. (2017).

Socio-demographics. Risk elementscomprised of depleted pay or financial ranking, primiparity (Fellmeth et al, 2017), joblessness (Anderson et al, 2017; Alhasanat & Fry-McCormish, 2015; Falah-Hassani et al, 2015), inadequate education(Falah-Hassani et al, 2015) and observable a minority status (De Maio et al, 2010). Moreover, maternal age under the age of thirty years and above the age of twenty-five years were risk elements for expanded postnatal discouragement as announced by Fellmeth et al. (2017).

Mortality

There had been 2 methodical studies announced on the subject of maternal mortality (loss of a woman at any stage of pregnancy, labor or in the initial forty-two days after delivery) (Pedersen et al, 2014; Gagnon et al, 2009). Furthermore, the relative risk hazard (RR) was noted being double among transient women in Western European nations in comparison to native women (RR 2. 00, 95% CI 1.72–2.33) and the total risk distinction being nine extra lossesof mothers for every one hundred thousand deliveries annually, for women who are migrant (95% CI 5.9–15.2) as revealed byPedersen et al. (2014). The most grounded affiliation has been viewed for direct reasons for death among this populace including hypertensive issues, which are fundamentally pre-eclampsia and eclampsia, deep vein thrombosis and pulmonary embolism (RR 2.65, 95% CI 1.88–3.74) as opposed to causes that were unforeseen

and were undefined (RR 1.83, 95% CI 1.37–2.45) (Perdersen et al, 2014). The inclusion of maternal mortality for a composite result for maternal wellbeing, in spite of the fact that this article did not report the outcomes for this result solely by Gagnon et al. (2009).

All three distributed studies in 2009 were systematized, and further included child mortality outcomes (Gagnon et al, 2009; Bollini et al, 2009; Gissler et al, 2009). Gissler et al. (2009) revealed expanded dangers of perinatal mortality (RR 1.35, 95% CI 1.26–1.45), stillbirth (RR 1.40, 95% CI 1.22–1.58), neonatal mortality (RR 1.34, 95% CI 1.30–1.38) and baby mortality (RR 1.33, 95% CI 1.30–1.36) among womenwho are migrant in European nations in comparison to nativewomen(Gissler et al, 2009). In addition, meta-examinations were limited to migrants from countriesoutside the European region, the risk expanded for intrauterine deaths (RR 1.88, 95% CI 1.58–2.23) and marginally expanded for perinatal, infant and newborn mortality (RR 1. 54, 95% CI 1.39–1.69; RR 1.40, 95% CI 1.36–1.44; RR 1.37, 95% CI 1.34–1.40 individually). Then again, transient women in the United States reflected improved results in comparison toinfants born in the USA by ethnic minorities (RR 0.77, 95% CI 0.63–0.65), showing a healthymigrant impact. Furthermore, modifications for risk factors in the meta-examinations represented a small amount of the chanceof mortality(Gissler et al, 2009). Moreover, meta-

investigations for fetal-infant mortality, neonatal, baby mortality and unconstrained premature birth, had been undergone by Gagnon et al. (Gagnon et al, 2009). In addition, it has been presented that North African and Asian women had a fundamentally expanded relationship with fetal-infant mortality in contrast with the one women in the host nation had encountered (aOR 1.29, 95% CI 1.02–1.63; aOR 1.25, 95% CI 1.10–1.41 individually). Moreover, no noteworthy contrast was found between majority conceiving-nation women and that of European-conceived migrants (aOR 1.14, 95% CI 0.75–1.72) or Latin American-conceived transients (aOR 1.02, 95% CI 0.76–1.39) (Gagnon et al, 2009). The meta-analysis for women from Africa indicated the greatest impact size, however this was not noteworthy in its number (OR 2.43, 95% CI 0.99–5.96) (Gagnon et al, 2009). It is however of importance to mention that these meta-investigations included a few examinations for every nation of birthplace and had significant degrees of heterogeneity. Furthermore, Bollini et al. (2009)had come to find that there has been an expanded relationship between infant mortality rates which accounts for intrauterine death, perinatal, newborn, postnatal and offspring mortality rates, and migrant women contrasted with mothers from the European host nations (OR 1.50, 95% CI 1.47–1.53). In addition, it has been estimated by the investigators that pregnancy results among migrant women were impacted by the level of usage of incorporation approaches in the host nations, where a solid joining strategy would be exhibited by nations which had in fairness and social

attachment included in their social orders (Bollini et al, 2009). Investigators completed further meta-investigations altering them for age of maternity, equality and national degree of usage of assimilation approaches and saw the relationship as weakened when there were solid and stringent execution arrangements (aOR 1.25, 95% CI 1.17–1.34) contrasted and frail usage strategies (aOR 1.45, 95% CI 1.13–1.86); despite the fact that the usage of solid reconciliation approaches lessened the relationship with posterity mortality, the distinction as a result did not arrive at centrality (p = 0.241) (Bollini et al, 2009).

Mode of delivery

There have been 3 quantitative systematized studies that researched the method of delivery among transient women which had contrasted with women from the host nations that were included in the study (Merry et al, 2015; Gagnon et al, 2009; Merry et al, 2013). Forty percent of the twenty-five examinations added in their survey, had discovered employable methods of delivery, such as cesarean and vaginal operation, to be higher among transient women as reflected by Gagnon et al. (2009). In addition, the rest of the investigations announced decreased usable methods of delivery results for migrant women reflecting twenty percent, blended outcomes which presented twelve percent, or the outcome of no contrast between transient women and host nation women which had shown twenty eight percent (Merry et al, 2013). Blended outcomes detailed for cesarean delivery in the 2013 study have been additionally

found as per Merry et al. (2013) which had reflected a relationship between transient women and cesarean fluctuated by nation of source and by host nation. Investigators detailed a fundamentally expanded chance of cesarean among women relocating from previous colonized Caribbean states (OR 1.91, 95% CI 1.37–2.66), South Asia (OR 1.28, 95% CI 1.22–1.35), the Philippines (OR 1.19, 95% CI 1.1–1.29) and Somalia (OR 1.13, 95% CI 1.02–1.26). Furthermore, it had been found that those relocating from Africa had expanded chances of cesarean which had been contrasted by host nation outcomes; France (OR 2.22, 95% CI 1.92–2.58), Australia (OR 1.17, 95% CI 1.11–1.24), Canada (OR 1.34, 95% CI 1.08–1.67) and North/West Europe (OR 1.43, 95% CI 1.16, 1.77) (Merry et al, 2013). Nonetheless, these expanded chances were not seen among women that had been relocated from North Africa to Canada (OR 0.81, 95% CI 0.74–0.90) or France (OR 1.09, 95% CI 0.95–1.26). Also, it is noteworthy to state that women relocating from Latin America had altogether expanded chances for cesarean in Norway (OR 2.41, 95% CI 1.79–3.23) after the review and Canada (OR 1.43, 95% CI 1.29–1. 59), however the cases that had not been so prevalent in Southern Europe (OR 1.03, 95% CI 0.94–1.12) (Merry et al, 2013). Moreover, the chances for cesarean were altogether diminished. It has been observed that the same as those of women from accepting nations where womenthat haverelocated from the following countries: Vietnam (OR 0.68, 95% CI 0.66–0.71), Kosovo (OR 0.49, 95% CI 0.36–0.67), Russia/Baltic States (OR 0.75, 95% CI 0.66–

0.85) and East Asia (host nations: Southern Europe (OR 0.59, 95% CI 0.47–0.73), USA (OR 0.73, 95% CI 0.71–0.75), and Australia, UK, Canada or Finland (OR 0.99, 95% CI 0. 95–1.03)) (Merry et al, 2013). Furthermore Merry et al. (2016) have updated a study that has been conducted in 2013 and was presented in 2016. The updated study had distinguished that transient sub-Saharan Africanwomen had increased cesarean segment rates, while migrant women from Eastern Europe had lower rates in comparison to women in the receiving nations. Moreover, higher crisis cesarean births were likewise announced for women relocating from North Africa and Latin America the Middle East as opposed to receiving nation women(Merry et al, 2016).

Birth weight

There have been opposing outcomes for Low birth weight (LBW) or small for gestational age (SGA) results were accounted for by 4 studies that were conducted(De Maio, 2010; Gagnon et al, 2009; Bollini et al, 2009; Villalonga-Olives et al, 2017). There is a meta-investigation of low birth weight(< 2500 g) among womenwho are migrant dwelling in European nations that indicated essentially expanded affiliation contrasted and women in the European host nations (OR 1.42, 95% CI 1.42–1.44) (Bollini et al, 2009). There was a critical lessening of low birth weight when investigations balanced for age, equality and level of usage of incorporation approaches ($p < 0.001$); frail execution brought about an expanded affiliation (aOR

1.77, 95% CI 1.63–1.92) and solid usage diminished the affiliation (aOR 1. 08, 95% CI 1.03–1.13), in spite of the fact that the affiliation remained essentially expanded contrasted and results for non-transient women(Bollini et al, 2009). Then again, a meta-analysis of global information that is not limited to women living in Europe demonstrated a diminished aOR for low birth weight and small for gestational age among transient women with marginal noteworthiness (aOR 0.92, 95% CI 0.85–1.00) (Gagnon et al, 2009). Furthermore, based on a meta-investigation by transient cause indicated expanded chances among women conceived in African and Asian nations and decreased chances among European, Latin American and North African-conceived women, albeit no sub-collection of meta-examinations arrived at noteworthy statistical outcomes(Gagnon et al, 2009).

Incomprehensible healthy transient impacts with correspondence to decreased danger of low birth weight and small for gestational age, despite the fact that there were some revealed conflicting discoveries, have been mentioned by De Maio (2010) and Villalonga-Olives et al. (2017). In addition, the systematized surveys by De Maio (2010)discuss about how the examples of diminished risk among transients contrasted and women in the host nations are affected by maternal financial status, nation of starting point and maternal training, where migrantwomen with depleted degrees of instruction have better results and there is an expanded danger of small for gestational

age and low birth weight among migrantwomenwho have advanced educational levels(De Maio et al, 2010). How the apparent healthy transient impact in the United States, where migrant populaces regularly have better results contrasted to non-migrant populaces, is differentiated by the wellbeing disparities in Europe, where the affiliations are switched as stated by Villalonga-Olives et al. (2017). Furthermore, in the United Statesit is considered to show a decreased danger of low birth weightand small for gestational age among Latina transients. This outcome is in spite of the fact that this does not reach to Black and Puerto Rican migrants, who in turn have expanded dangers, as well as Asian womenwho show no distinction in risk contrasted with host nation women (Villalonga-Olives et al, 2017). Interestingly, except for concentrates from 2 nations that being Spain and Belgium, there is an absence of a healthymigrant impact in Europe (Cebolla-Boado & Salazar, 2016). Nonetheless, information from these nations is additionally clashing, demonstrating that results contrast by migrant causes i.e. expanded risk among transients from Morocco and Turkey and furthermore by the seriousness of result i.e.women in receiving nations have an increased danger of moderate low birth weight, though transient womenhave an expanded danger of major low birth weight(Villalonga-Olives et al., 2017).

Preterm birth

There have been 3studiesthat have announced preterm birth results (De Maio, 2010; Gagnon et al, 2009; Bollini et al, 2009). Bollini et al. (2009) meta-investigation

recognized a higher chance of preterm birth representing less than thirty-seven weeks growth among transient women in Europe (OR 1.24, 95% CI 1.22–1.26). In addition, after the results it is observed that there was a noteworthy weakening when examinations balanced for age, equality and degree of execution of joining approaches ($p < 0.001$); solid execution arrangement diminished the chances (aOR 1.18, 95% CI 1.14–1.22) and frail usage brought about expanded chances of preterm delivery (aOR 2.88, 95% CI 2.50–3.32) (Bollini et al, 2009). Gagnon et al. (2009)conducted meta-investigation discovered contrasts in danger of preterm birth by transient starting point. However, in contrast receiving nations women had higher chances for migrantwomen from Asia (aOR 1.14, 95% CI 1.06–1.21) and Africa (aOR 1.29, 95% CI 1.04–1. 60); a decreased chance for Latina transient women (aOR 0.83, 95% CI 0.72–0.95); and no distinction for Europeanand North Africanmigrantwomen(Gagnon et al, 2009). An examination on the healthy migrant impact for preterm delivery results in being affected by maternal training and duration of living arrangement in the host nation conducted by De Maio (2010). It has been noted that transients with less than five years of living arrangements had a reduced predominance of preterm deliveryas opposed to host nations women which is 4.7 percent versus 6.2 percent. In addition, those dwelling less than fifteen years had the most elevated occurrence (7.4%) (De Maio, 2010). Further on, a five-year increment long, which was conceivably affected by maternal pressure and segregation, of living

arrangement altogether expanded the chances of preterm delivery among transient women (aOR 1.14, 95% CI 1.10–1.19), (De Maio, 2010).

Congenital anomalies

There are 2 studies that have highlighted congenital peculiarities (Gagnon et al, 2009; Bollini et al, 2009). It has been observed that migrantwomen had an essentially expanded danger of a pregnancy influenced by an innate inconsistency contrasted with receiving nation women (OR 1.61, 95 percent CI 1.57–1.65). In the studies, ithas beenshown that there was a noteworthy lessening of inherent peculiarities when investigations balanced for age, equality and degree of execution of combination approaches ($p < 0.001$) notably when there was operation that was weak, a critical expanded affiliation remained (aOR 1.20, ninetyfive percent CI 0.95–1.52). However, though having a solid actualize arrangement brought about an altogether lower chances of innate inconsistencies among migrantwomen (aOR 0.87, 95 percent CI 0.78–0.95) (Bollini et al, 2009). Gagnon et al. (2009) consolidated intrinsic irregularities with other newborn child dreariness, (for example, neonatal emergency unit affirmation and low Apgar score) and reported that sixty-two and a half percent of the sixteen investigations brought together for their audit detailed inferior results

for migrantwomen contrasted and receiving nations women. In addition, no examinations saw this result as better result for transient women.

Additional morbidities

There are 3 studies which detailed extra maternal or baby morbidities (De Maio, 2010; Bollini et al, 2009). Bollini et al. (2009) researched maternal baby blues discharge, however no synopsis information was accounted for. De Maio (2010) distinguished a healthymigrant impact for danger of not proper function of the placenta among women dwelling in Ontario, Canada, for less than five years that has been affected by duration of living arrangement: the most minimal chances were for thoseliving less than three months (OR 0.53, 95 percentCI 0.47–0. 61), which expanded the more drawn out the span of living arrangement whereby they were living forty-eight to fifty-nine months (OR 0.82, 95 percent CI 0.77–0.87). In any case, the OR continued to be lower in comparison towomen in the host nation for all terms of residency. Moreover, composite result for maternal wellbeing which counting yet not restricted to mortality, depression related to pregnancy, broadened durationof delivery, perineotomy and had announced that half of their thirty-twoincluded examinations demonstrated more regrettable results for transient women, almost twenty two percent indicated results that were better and the rest of the investigations were blended or revealed no distinctionas stated in Gagnon et al. (2009). Investigators had likewise revealed maternal and newborn child

contaminations such as HIV, sexually transmitted diseases, toxoplasmosis and rubella seronegativity to be more regrettable among migrantwomen in over sixty-three and a half percent of systematic studies and better for over nine percent (Gagnon et al., 2009). In addition, the rest of the examinations demonstrated blended outcomes (Gagnon et al, 2009). Furthermore, admission to a Newborn Intensive Care Unit(NICU) or unique consideration was higher among posterity of transient womenGagnon et al. collected confirmation for their composite result for baby morbidities, as detailed in Gagnon et al. (2009) and Bollini et al. (2009).

Prevalence of perinatal mental health disorders

Perinatal mental health amongst women with asylum seeker or refugee status

Included in the research spectrum there are 9 systemized studies whichhave revealed detailed information for haven searchers and exiles (Anderson et al, 2017; Fellmeth et al, 2017; Alhasanat & Fry-McCormish, 2015; Collins et al, 2011; De Maio, 2010; Tobin et al, 2018; Higginbottom et al, 2019; Balaam et al, 2013; Higginbottom et al, 2015)which refer to eleven unique investigations (Stewart et al, 2008; Gagnon et al, 2013; Merry et al, 2011; Kurth et al, 2010; Kennedy et al, 2003; McLeish, 2005; Briscoe & Lavender, 2009; Illadi, 2008; Matthey et al, 1999; Edge, 2006; Reynolds & White, 2010).The 5 surveys referred to information from Stewart et al. (2008)whonoted that levels of depression in the postnatal period were

notablyincreased among women with displaced person and refugee searcher status (25.7% and 31.1% individually) contrasted and women in the host nation of Canada (8.1%, p = 0.008). They likewise reported essentially expanded chances of scoring at least ten on the Edinburgh Postnatal Depression Scale (EPDS) for displaced people (OR 4.80, 95% CI, 1.57–14.69) and refugee searchers (OR 3.06, 95% CI, 1.06–8.82) (Anderson et al, 2017; Alhasanat & Fry-McCornish, 2015; Collins et al, 2011; De Maio, 2010; Higginbottom et al, 2012). Comparative rates were accounted for in an orderly audit by Fellmeth et al. (2017); 37.3 percent of displaced people and 41.8 percent of refugee searchers living in Canada went through indications of gloom, somatization or tension and fundamentally expanded chances for the commonness of any depression (OR pervasiveness 0.25, 95% CI 0.21–0.29) as detailed in Gagnon et al. (2013). Furthermore, as stated in Gagnon et al. (2013), expanded predominance for PTSD were accounted for, where women seeking asylum had the most noteworthy commonness which was represented at over 48 percent over the cut-off, followed by displaced people which showed thirty-three-point eight percent and migrants showing a fifteen percent representation (Anderson et al, 2017; Fellmeth et al, 2017). In addition, in an observation in Higginbottom et al. (2015) it had been announced that of fifty pregnant refugees who got a home visit at four months postpartum depression, twenty-six were found to have indications of post birth anxiety, as stated in Merry et al. (2011). In addition, in Balaam et al. (2013), information from unique

investigations solely on women with shelter searcher or displaced person status (Kurth et al, 2010; Kennedy et al, 2003; McLeish; 2005; Briscoe & Lavender, 2009; Illadi, 2008; Reynolds & White, 2010) were utilized in a meta-synthesis and added to the discoveries that pressure and low confidence were normal, and that women had emotional wellness issues, i.e. depression, sentiments of dejection and seclusion and communicated trouble, powerlessness and uneasiness together with serious sickness.

Risk factors for the development of perinatal mental health disorders

In total there are threeorganisedstudies that announcerisk factors for the advancement of perinatal emotional wellness issue explicitly applicable to shelter searchers and displaced people (Fellmeth, 2016; Collins et al, 2011; De Maio, 2010). Fellmeth et al. (2017) revealed information from Matthey et al. (1999) which demonstrated measurably noteworthy relationship among uneasiness and the quantity of premigration traumatic incidents lived or seen. However, there is no relationship with nervousness or PTSD and history of having lived in an evacuee camp before resettlement. Collins et al. (2011) and De Maio (2010) introduced information from Stewart et al. (2008) which reported that displaced people and shelter searchers had essentially less social help compared towomen in the receiving nation of Canada ($p < 0.001$), this includes familysupport, companions, gatherings and frameworks, just as close to home, enthusiastic and instrumental social help. Womenthat were exiles ascribed their downturn to social factors, for example, family issues or financial

difficulties as opposed to organic variables as stated byTobin et al. (2018) in Edge (2006).

Infant mortality amongst women with asylum seeker and refugee status

Offspring Mortality

There are 2organisedsurveys (Hadgkiss & Renzaho, 2014; Gissler et al, 2009) that have revealed infant mortality among women who were displaced people utilizing information from nine unique investigations (Kurth et al, 2010; Lalchandani et al, 2001; Essen et al, 2000; Schlpen et al, 2001; Vangen et al, 2002; Kuvacic et al, 1996; Nedic et al, 1999; Goosen et al, 2009; Rogstag & Dale, 2004). Moreover, in European examinations ofwomen who were enlisted outcasts or begun from exile source nations at the hour of appearance taking into consideration sub-Saharan Africa, Africa, Romania, Kosovo and Russia (Gissler et al, 2009). These countries had an altogether expanded danger of intrauterine death (RR 2.01, 95% CI 1.41–2.06), early infant mortality (RR 2.77, 95% CI 1.85–4.13) and mortality during the perinatal period (RR 1.71, 95% CI 1.41–2.06) contrasted with women in the host nations of Norway, Sweden, Ireland and the Netherlands as revealed in Gissler et al. (2009). Be that as it may, women from Vietnamese foundations had more decreased mortality than Norway as the host nation of women(Gissler et al, 2009). Previously evident, Yugoslavia demonstrated that displaced women had expanded danger of early infant

mortality (RR 3.66, 95% CI 1.92–6.99) and perinatal mortality (RR 3.07, 95% CI 2.05–4.62) yet no distinction in danger of intrauterine death (RR 1.19, 95% CI 0.56–2.50). Furthermore, it has been reflected that passings credited to inherent abnormalities, pregnancy entanglements or intrauterine development limitation were comparatively appropriated among exiles and receiving nation women.

Birth weight amongst women with asylum seeker and refugee status

There are 2 organisedstudies(Hadgkiss & Renzaho, 2014; Villalonga-Olives et al, 2017)that have detailed information for low birth weight (LBW) and intrauterine development impediment utilizing information from five unique examinations (Kurth et al, 2010; Lalchandani et al, 2001; Small et al, 2008; Reed et al, 2005; Kelaher &Jessop, 2002). Villalonga-Olives et al. (2017) revealed no distinction in low birth weightamong exile populaces in Ireland or undocumented Latina migrants in the United States and receiving nation women as stated inLalchandani et al. (2001) and Kelaher and Jessop (2002). Somali displaced people in Belgium, Canada, Finland, Norway and Sweden had lower paces of low birth weightcontrasted towomen in the host nations as stated in Small et al. (2008). Furthermore, it has been found byHadgkiss and Renzaho (2014) the predominance of intrauterine development limitation to be one of the most pervasive results among women who were looking for haven, seven percent of the populace information from Kurth et al. (2010). In this study no examination information were accounted for women in the host nations.

Live birth and abortion

There was extra information pertinent to infant mortality for womenwho were asylum seekers or refugees that were not announced in the migrant women'sfindings. Hadgkiss and Renzaho (2014) revealed that refugee searchers had an increased occurrence of rape, undesirable pregnancies and actuated fetus removal to-live birth proportion contrasted and women in the host nations (1:2.5 versus 1:7.5) as stated in Goosen et al. (2009), Kurth et al. (2010) and Rogstad and Dale (2004). Refugee searchers with longer term of remain in contrast with and those showing up in the past a half year) had a decreased live birth and premature birth rate (2014) as stated in Goosen et al. (2009).

Mode of Delivery amongst women with asylum seeker and refugee status

For this section there have been 3organized studies(Merry et al, 2016; Hadgkiss et al, 2014; Merry et al, 2013)that detailed cesarean delivery for exile and refugee searcher women utilizing information from four unique investigations (Gagnon et al, 2013; Kurth et al, 2010; Gagnon et al, 2007; Kandasamy et al, 2014) with clashing outcomes. Merry et al. (2013) and Hadgkiss and Renzaho (2014) detailed information from 2 examinations (Kurth et al, 2010; Gagnon et al, 2007) which found no critical contrast in cesarean delivery rates among refugee searchers contrasted with local conceived women (OR 0.93, 95% CI 0.74–1.17) as stated in Gagnon et al. (2007). Be that as it may, Merry et al. (2016) revealed that evacuees and refugee searchers were

at a diminished danger of a crisis cesarean contrasted and monetary and understudy migrants as stated in Gagnon et al. (2013). However so, an expanded riskhad been evident in women in Canada as the host nationas stated in Kandasamy et al. (2014).

Preterm birth amongst women with asylum seeker and refugee status

In this section there are 2 methodical surveys (Hadgkiss et al, 2014; Gissler et al, 2009) detailed preterm birth among women who were displaced people utilizing information from 2 unique investigations (Kurth et al, 2010; Nedic et al, 1999). It had been found in Hadgkiss and Renzaho (2014)that untimely laborwas one of the most predominant results in women looking for haven at fifteen percent of the populace as stated in Kurth et al. (2010). Furthermore, Gissler et al. (2009)revealed that women who were dislodged from the previous Yugoslavia had increased preterm birth rates compared towomen in the host nation as statedin Nedic et al. (1999).

Additional morbidities amongst women with asylum seeker and refugee status

There had been 2 orderly surveys that had been undergone. What's more 6 unique investigations had been accounted for of maternal morbidities. The extra morbidity rate had expanded to a more noteworthy amountin comparison to 2organisedstudies(Hadgkiss et al, 2014; Balaam et al, 2013) detailed extra maternal morbidities and information from six unique examinations (Kurth et al, 2010; Kennedy et al, 2003; McLeish, 2005; Goosen et al, 2009; Rogstad & Dale, 2004; Va

Hanegem et al, 2011). The extra grimness results revealed for women with haven searcher and displaced person status (eclampsia, maternalbleeding and diseases) are like those detailed for migrantwomen (improper function of the placenta, baby blues drain and maternal contamination). There was extra information detailed unequivocally for women with shelter searcher and evacuee status that were not revealed for transient women (counting haven searchers and exiles) indicating expanded danger of extreme intense maternal depression (SAMM), gestational diabetes, iron deficiency and rupture of the uterus. There was an absence of information expressly for asylum seeker and refugee women and infantinfection and admission to neonatal intensive care units (Kurth et al, 2010; Kennedy et al, 2003; McLeish, 2005; Goosen et al, 2009; Rogstad & Dale, 2004; Va Hanegem et al, 2011).. Hadgkiss and Renzaho (2014) detailed that shelter searchers confronted a scope of complicated obstetric issues including maternal haemorrhage, gestational diabetes, frailty, four and a half occasions higher rate of SAMM compared to the general obstetric populace (31.0 versus 6.8 per 1000 births), rupture of the uterus (15 versus 8.4%) and eclampsia (27.5 versus 9.1%); however lower rate of obstetric drain (42.5 versus 63. 3%) as presented in Kurth et al. (2010), Goosen et al. (2009), Rogstad and Dale (2004), Van Hanegem et al. (2011)). Baalam et al. (2013) revealed unforeseen weakness among women with shelter searcher and displaced person status which caused entanglements for the women and the infants, including contaminated injuries,

HIV and hepatitis as presented in Kennedy and Murphy-Lawless (2003) and McLeish (2005).

Perinatal healthcare access and experiences amongst women who are migrants

Access to perinatal healthcare amongst women with asylum seeker and refugee status

The boundaries to getting to mind are abridged here under the topics of auxiliary and hierarchical obstructions, social hindrances and individual and social obstructions.

Seven organisedstudies revealed basic or hierarchical boundaries for women with haven searcher and exile status to get to perinatal medicinal services (Mangesha et al, 2016; Winn et al, 2017; Higginbottom et al, 2012; Balaam et al, 2013; Downe et al, 2009; Small et al, 2014; Higginbottom et al, 2015) including information from fifteen unique examinations (Merry et al, 2011; Kurth et al, 2010; Kennedy et al, 2003; McLeish, 2005; Briscoe & Lavender, 2009; Iliadi, 2008; Reynolds & White, 2010; Gagnon et al, 2007; Harper et al, 2002; Herrel et al, 2004; Dartnall et al, 2005; Riggs et al, 2012; Redwood-Campbell et al, 2009; Carolan & Cassar, 2007; Carollan & Cassar, 2010). Furthermore, results identifying restricted capacity to communicate in

the host nation’slanguage or comprehend the verbal or composed data provided(Mengesha et al, 2016; Higginbottom et al, 2012; Balaam et al, 2013; Small et al, 2014) were like the outcomes for the general transient populace, as were difficulties exploring, and an absence of nature with, the medicinal services frameworks and lacking data about what bolster administrations exist (Mengesha et al, 2016; Winn et al, 2017; Balaam et al, 2013; Downe et al, 2009; Small et al, 2014; Higginbottom et al, 2015). Extra information important to shelter searchers and displaced people incorporated an absence of information about accessibility of help administrations which prompted sentiments of social disengagement (Higginbottom et al, 2015). There were suspicions among haven searchers and evacuees that they would need to pay for perinatal human services when they were qualified with the expectation of complimentary consideration (Mengesha et al, 2015; Downe et al, 2009). There had been a question of social insurance experts who were seen to be a danger to the passionate and physical wellbeing of refugee searchers who didn't draw in with antenatal consideration (Downe et al, 2009). Higginbottom et al. (2012) additionally detailed that women did not feel they needed to study the host nation’s language, and that the malesof the family unit participated in language training while the women remained home.

A total of 6 organised surveys detailed social boundaries to getting to perinatal human services (Schmied et al, 2017; Mengesha et al, 2016; Winn et al, 2017; Balaam et al, 2013; Higginbottom et al, 2014; Higginbottom et al, 2015) including information from twelve unique examinations (Merry et al, 2011; Kurth et al, 2010; Kennedy et al, 2003; McLeish, 2005; Briscoe et al, 2009; Illadi, 2008; Herrel et al, 2004; Riggs et al, 2012; Hill et al, 2012; Kulig, 1990; O'Mahony et al, 2013; Allotey et al, 2004). A significant number of the social hindrances to getting to or proceeding with perinatal medicinal services were like those for transient populaces, for example, an absence of funds, transportation, problems with lodging and an absence of relatives and companion systems (Schmied et al, 2017; Mengesha et al, 2016; Winn et al, 2017; Balaam et al, 2013; Higginbottom et al, 2014; Higginbottom et al, 2015). Be that as it may, these troubles were portrayed in the methodical study to be especially trying for women with shelter searcher or exile status because of impermanent and dubious status, not being allowed to employment in their host nations and the effect of these variables on accessible assets and having a 'typical way of life' (Schmied et al, 2017; Higginbottom et al, 2015). For instance, Higginbottom et al. (2015) portrays postnatal exiles skipping suppers in view of an absence of assets. In Balaam et al. (2013) it had been noted that a few types of settlement for displaced people and refugee searchers are confined by fixed eating times which forced pragmatic difficulties with adaptability to go to arrangements. Mengesha et al. (2016) announced that home visits

by displaced person wellbeing attendants were decidedly gotten, and Balaam et al. (2013) detailed that labor was a basic achievement towards a superior economic wellbeing, and that the child spoke to a fresh start and a wellbeing asset.

Five systematizedstudies detailed individual and social obstructions to getting to perinatal medicinal services (Aubrey et al, 2017; Tobin et al, 2018; Higginbottom et al, 2012; Balaam et al, 2013; Higginbottom et al, 2014) including information from eleven unique investigations (Kurth et al, 2010; Kennedy et al, 2003; McLeish, 2005; Briscoe & Lavender, 2009; Iliadi, 2008; Redwood-Campbell et al, 2008; Kulig, 1990l Carroll et al, 2007; Murray et al, 2010; Beine et al, 1995; Huster et al, 2013). The organizedstudy revealed comparative outcomes to those for migrants according to an absence of social comprehension of postnatal sadness and an inclination for female wellbeing experts. Further setting was given on sexual orientation inclination to haven searchers and exiles. Aubrey et al. (2017) revealed that higher paces of cesarean birth among Syrian displaced women came about because of shirking in looking for antenatal consideration because of the absence of female wellbeing experts and the way that lone five out of eighteen African outcast women in the United states would not have a problem being treated by a male healthcare provider. In any case, these discoveries were in struggle with different investigations in their survey which announced that African outcast women getting to obstetric consideration in Australia,

and Somali women in the United States, would not have a problem being treated by a male healthcare providerin a crisis (Aubrey et al, 2017).

Experience of perinatal healthcare amongst asylum seekers and refugees

The subjects distinguished in the organized surveys regarding understanding of care identified with negative correspondence and discrimination, relationship with wellbeing experts, social conflicts, and clinical perinatal consideration are condensed underneath.

There have been severalorganised surveys that have revealed negative correspondence and segregation information for shelter searcher and evacuee women(Mengesha et al, 2016; Winn et al, 2017; Higginbottom et al, 2012; Ballam et al, 2013; Small et al, 2014; Wikberg & Bondas, 2010; Higginbottom et al, 2015) detailing information from twelve unique examinations (Merry et al, 2011; Kurth et al, 2010; Kennedy et al, 2003; McLeish, 2005; Briscoe & Lavender, 2009; Iliadi, 2008; Harper Bulman, 2002; Herrel et al, 2004; Riggs et al, 2012; Redwood et al, 2008; Carolan & Cassar, 2007; Allotey et al, 2004). Furthermore, there were comparable negative correspondence encounters to the outcomes for migrantwomen, remembering dependence for mediators and experience of separation. Moreover, be that as it may, these negative

encounters were all the more broadly spoke to in the information explicit to women with shelter searcher and exile status than for general migrant populaces (Merry et al, 2011; Kurth et al, 2010; Kennedy et al, 2003; McLeish, 2005; Briscoe & Lavender, 2009; Iliadi, 2008; Harper Bulman, 2002; Herrel et al, 2004; Riggs et al, 2012; Redwood et al, 2008; Carolan & Cassar, 2007; Allotey et al, 2004). Announced that displaced and refugeewomen were hardly ready to express their needs and wishes as stated in Balaam et al. (2013). Furthermore, it had been found that information identifying with dependence on translators spoke to an insufficiency of administration arrangement prompting deferred care, women's dependence on non-verbal communication and outward appearances to convey, however also that their necessities not being met and the womennot being able to communicate their interests (Merry et al, 2011; Kurth et al, 2010; Kennedy et al, 2003; McLeish, 2005; Briscoe & Lavender, 2009; Iliadi, 2008; Harper Bulman, 2002; Herrel et al, 2004; Riggs et al, 2012; Redwood et al, 2008; Carolan & Cassar, 2007; Allotey et al, 2004). Furthermore, there was a revealed requirement for progressively reliable expert deciphering assistance for women with haven searcher or exile status including coordinated administrations, congruity of able mediators and improving of wellbeing experts' information on when deciphering administrations are required (Mengesha et al, 2016; Higginbottom et al, 2012; Balaam et al, 2013; Small et al, 2014; Higginbottom et al, 2015).

Moreover, it had been found that thesystematized surveys revealed that the most defenseless women with shelter chasing or displaced person status had the most troublesome circumstance and adverse experiences with wellbeing experts including straightforwardly bigot and biased consideration, social shame, disregard, threatening vibe, stereotyping, and being treated as 'crude individuals' (Mengesha et al, 2016; Balaam et al, 2013; Small et al, 2014; Wikberg et al, 2010). In addition, encounters explained are exhibited in a statement from an investigation that was included revealed in the methodical audit by Wikberg and Bondas (2010): "An African lady requested assistance when she got a contamination yet was not met with deference: She saw me like this and stated, 'You are OK'.. . She said to another birthing assistant, 'These Africans. .. they come here, they eat pleasant nourishment, rest in a decent bed, so now she wouldn't like to move from here!'. .. At the point when she said this, I didn't utter a word, I just cried… she doesn't have any acquaintance with me, who I am in my nation."Also, the other birthing specialist said 'What's up with them, these Africans?' and some of them they chuckled" as stated in from McLeish (2005). Women detailed that these cooperation's were impacted by the colour of their skin, their language capacity and correspondence issues, and that they needed strong, non-unfair consideration (Balaam et al, 2013; Small et al, 2014).

Relationship with wellbeing experts' 4 organised surveys revealed information on the connections between wellbeing experts and women with haven searcher and exile status (Mengesha et al, 2016; Winn et al, 2017; Balaam et al, 2013; Small et al, 2014) from 10 unique investigations (Kurth et al, 2010; Kennedy et al, 2003; McLeish, 2005; Briscoe et al, 2009; Iliadi, 2008; Reynolds & White, 2010; Harper Bulman et al, 2002; Herrel et al, 2004; Carolan & Cassar, 2007; Hill et al, 2012). There were comparative discoveries to the outcomes for by and large migrant populaces according to the significance of a steady relationship with wellbeing experts, negative encounters, for example, feeling wellbeing experts were too occupied and an absence of certainty to talk about their issues with wellbeing experts (Mengesha et al, 2016; Balaam et al, 2013; Small et al, 2014). Positive connections were reported when healthcareproviders had regard for rehearses from the nation of inception or were of a similar ethnicity or religion, and positive help expanded trust in posing inquiries and acknowledgment of the new medicinal services framework and practices (Winn et al, 2017; Balaam et al, 2013).

There are 5 organisedstudiesthat revealed social conflicts in perinatal medicinal services understanding among women with shelter searcher and outcast status (Mengesha et al, 2016; Winn et al, 2017; Balaam et al, 2013; Higginbottom et al, 2014; Small et al, 2014), announcing information from five unique examinations

(Harper-Bulman et al, 2002; Herrel et al, 2004; Riggs et al, 2012; Hill et al, 2012; Kulig, 1990). All datarelated to women with refugee and asylum seeker status recreate the data of the general population of migrantwomen, for example, strains between wanting to adjust to native clinical practices and women'sneed to maintaintraditional practices linked to their culture or religion. There was no new data related particularly to refugee or asylum seeker women.

The 6organisedstudies revealed concerns linked to the clinical healthcare refugee and asylum seeker women received during their pregnancy, labour, delivery, and the postpartum period(Mengesha et al, 2016; Tobin et al, 2018; Balaam et al, 2013; Higginbottom et al, 2014; Small et al, 2014; Higginbottom et al, 2015) detailing information from 15 unique examinations (Merry et al, 2011; Kurth et al, 2010; Kennedy et al, 2003; McLeish, 2005; Briscoe et al, 2009; Iliadi, 2008; Gagnon et al, 2007; Harper et al, 2002; Herrel et al, 2004; Riggs et al, 2012; Carolan & Cassar, 2007; Kulig, 1990; Allotey et al, 2004; O'Mahony et al, 2012). In addition, few similitudes with the outcomes for transient women identifying with negative encounters among women with shelter searcher and displaced person status, wellbeing experts indicating an absence of information and sensitive approachregarding with Female Genital Mutilation, women accepting inadequateinformationon care an absence of conversation of available choices,

insufficient assessment and recommendation for further investigation for depression during the postnatal period, an over-dependence on innovation and practices of the West World which were culturally insensitive(Mengesha et al, 2015; Balaam et al, 2013; Higginbottom et al, 2014; Small et al, 2014; Higginbottom et al, 2015). Extra discoveries in the information for women with haven searcher and outcast status incorporate the accompanying: results being better among women who had the option to show versatility and alter and change their social convictions; frustration and absence of groundwork for the absence of down to earth postnatal assistance and backing; suggestions for support or connection laborer plans; and the requirement for socially fitting wellbeing educationalsupplies on labour and delivery and the provision of educationfor healthcare providers on Somali exile women's way of life, customs, qualities and desires (Ballaam et al, 2013; Small et al, 2014). The methodical study inconsistencies regarding the subject of care groups for depression during the postnatal period in the studiesinvolved, as of Tobin et al. (2018) detailed further that one investigation revealed constrained use for outcast women who favored individual treatment because of security, classification and a social disgrace identified with the condition, while another investigation found that long range interpersonal communication and care groups were significant in encouraging assistance chasing and the recuperating procedure.

3 Methodology

The intention of the presentthesis is to analyze the perinatal experiences of refugee, migrant, and asylum seeker women in the context of the implementation of the ORAMMA project at the Hospital of Leros. As a means to provide a more thorough understanding of the ORAMMA project and the assistance offered to women during the period of the perinatal experience,a survey will be presentedbelow. The study involved seven women who were treated at Leros' Hospital under the ORAMMA program. The women were all migrants living on the island. In the present work they answered questionsregarding their experience and their satisfaction with the program. The answers they gave were important for the future of the ORAMMA project and the changes that need to be made to make it even more effective.

Qualitative research

There are two types of research methods, qualitative and quantitative(Glesne, 2016). Even if both methods allow the researcher to approach a research field and focus on it, they differ in the way it is done, but in the subject of investigation, depending on the methodused (Noble&Smith, 2015).

Qualitative research involves an extensive scope of objectives and approaches, which develop from the type of research itself. However, a quantitative study may follow the explanatory qualitative research in order to delve deeper into the resulting trends(Rahman, 2017). For the analysis of the research question, the qualitative research method was used, through the process of qualitative interviews (Glesne, 2016).

This paper examines the views of migrant women who gave birth at the hospital of Leros. The aim is to find in-depth analysis of the emotions and experiences they experienced during the birth and the care they received from the midwives of the hospital. In order to be able to record the specific views, the quality method was chosen, so that each participant could give the answer she wanted according to her experiences. In quantitative research the answers are predetermined while in qualitative ones not as each participant gives the answers that correspond to their experiences and character(Rogers, 2018). In this way it will be understood whether the ORAMMA program that was implemented had the expected results or if changes need to be applied.

Participants

In the present research, the strategy of deliberate sampling was applied, i.e. the sample was actively and deliberately selected in order to best serve the purposes and questions of the research(Wicks, 2017). To achieve this, women with specific characteristics were selected at the researcher's discretion. All participants had to be refugees and havegiven birth at least once at Leros' Hospital under the ORAMMA project. This means that they would have had the experience they needed to answer the interview questions about the project and their personal experience. A total of 7 women were selected, a sufficient number of participants for a qualitative study (Janesick, 2015).

Interviews

The interview is defined as an organized discussion and its results allow a systematic use of the time of a research. It is an interview-discussion aimed at scientific elaboration. The interview should meet certain technical needs that lead the researcher to pose the following two problems: a) what are the different forms of interviews and b) what are the problems created by the interviewer's and the respondent'srelationship?(Amankwaa, 2016).

As can be seen from the definition of the interview given, there are several forms of interview, which is determined by the purpose for which it is intended. Interviews are

separated in: structured or unstructured, direct or indirect, repetitive, clinical and in-depth.(Wicks, 2017).

In structured interviews, the interviewee is requested to respond to a series of questions, where their number, order and content are determined by the interview form. In contrast, in non-structured interviews, however, the discussion that takes place is freer. It varies depending on the nature of the discussion and the greater or lesser degree of freedom lies in its construction. At this point lies the distinction between non-structured interviews and localized ones. An identified interview aims to draw attention to a specific experience, the results of which have provoked certain stimuli. This type of interview is stricter than free interviews(Roger, et all, 2018). Even if he allows the interviewer to ask the questions in the order he wants, the style and the sentence that serves him, he is obliged to gather all the necessary information on the subject that has been put to study. Even if the freedom of the interlocutors is limited by the scope of the research, the interviewee has the opportunity to share his or her experience in the way he or she wishes, helping the interviewer to gather the information he or she needs (Saldaña, 2015).

The difference between direct and indirect interviews lies in the way the researcher receives his answers. While in direct interviews, the questions, as well as the answers are clear with clear content, in the indirect ones, the real value of the discussion becomes clear from the information given by the interviewee, without directly

targeting his behavior or views. The repeated interview is done in groups of people and is called a Panel, because it requires constant repetition in order to gather the necessary data for analysis. This method allows analysts to focus on the evolution of the group's behaviors regarding the social phenomenon to be studied. At the same time, there are stimuli that can affect individuals. The main disadvantage is that the respondents, knowing the subject of the research, think about what they will say to the researchers, reducing the degree of neutrality or objectivity. In addition, the in-depth interview enables the researcher to define the scope of the research, but also to direct the discussion to where he wants, just as the respondent has the ability to direct the way in which he will respond(Amankwaa, 2016). Finally, the clinical interview is conducted in the context of psychiatry and psychoanalysis, emphasizing the psychology of the individual and having a therapeutic purpose (Woods, 2006).

In the present work, structured interviews were selected. Participants had to answer predetermined questions that were directly related to the topic of the study. The interviews were individual as each participant gave her own answers without knowing the answers of the others. The interviews were immediate as the participants could easily understand their purpose and the information the researcher wanted to extract from them.

Interviewprocess

The present study selected refugee women who had their baby at the Hospital of Leros. This was a prerequisite for participation. The women's names were found in the hospital's files, and the researchers then contacted them. The participants had limited knowledge of the Greek language, which is why during their approach, the conversation with them and the interviews, aninterpreter, who participated as an Arabic-speaking interpreter and worked in NGOs, was present. 7 women from 7 different countries were selected for a greater variety of answers and to attain more data on the birth and care mothers receive in these countries, so that it couldbe compared with the Greek health system and specifically with the ORAMMA project. The women receivedcomplete care from a group of doctors and midwives during their pregnancy and during and after childbirth.

All participants were asked 15 questions about the program and their satisfactionon it. The questions as well as the answers given were translated with the help of the interpreter. All the women answered the questions without facing any problem or not understanding the question. Each interview was conducted after consultation with each participant and lasted for an average of 30 minutes.

Moral issues

Because of the personal character that the process of the research frequentlyacquires, it is essential to be aware of any forms of discomfort that the research might cause(Rogers, 2018). The researcher also needs to make sure thatparticipants remainanonymous, avoiding their potential identification, confidentiality and protection of the personal data that will be given during the process of the research (Glesne, 2016). It is necessary to ensure and prevent or minimize the discomfort of participants during the interview in questions related to sensitive and traumatic issues (Varga-Dobai, 2012).

In the present study, there was complete anonymity of the participants. No personal or demographic data were recorded other than their country of origin and their parity. The anonymity of their details was clear from the beginning. The researcher with the help of the interpreter made sure to assure them of this and they consented.

4 Presentation of Results

Seven women from different countries who arrivedin Greece as migrants were selected and participated in this study. The study looked at whether the ORAMMA project helped women during pregnancy, childbirth and during their visits and hospital stay in Leros. Participants from different countries were selectedin order to have a variety of answers. Specifically, the women came from Syria, Palestine, Somalia and Congo. All the questions asked were about the ORAMMA project in which they participated and the experiences they gained from it. A total of 15 questions were answered, the answers of which will be grouped and analyzed below.

The first question was referring tohowsatisfied they felt with the care provided to them and how long they were cared for by the doctors and midwives who participated in the program and who cared for them throughout pregnancy. The question that was asked was general and could hardly be answered with very detailed and detailed answers. That is why the participants responded in one word and did not provide further information about their care, incidents that did not occur, nor did they refer to the behavior of doctors and midwives. All the answers given were one word and the answer given was "Enough". This shows that all the services provided to them were adequate and appropriate. However, the fact that no one said they were very satisfied or did not use another word indicates that the services of the program could be better.

However, the fact that no one said they were unhappy shows that the program provided decent health services and that it cared for all women equally. Therefore, the effectiveness of the program was good and had a positive impact on the women who participated in it.

Then the questions became more specific and specific. The women were asked about the situations, events and services they received during pregnancy and the ones they liked and which ones they did not like. At this point the participants had to specify the answer they initially gave and talk about the experiences they had in the program. This caused them to shrink even with the existence of the interpreter and so the answers they gave were not detailed. The participants presented the main characteristics of the events without expanding.

Regarding the things that all the women liked, they stated that the provision of care made them feelsatisfied as well as the attention they received from the doctors and the hospital staff. These women left their country to find better living conditions in a foreign country, such as Greece. They have taken a lot during their transportation and many of them have been exploited and brutally abused. In addition, pregnancy in a woman is one of the most important and precious time in her life and needs special care. So, the fact that they received health benefits and the doctors treated them as unique personalities and actual human beings made them thank the doctors and feel happy.

However, there were many things that bothered women during their treatment, as different views were obtained through the answers. The language issue was the one that was mentioned the most. These women do not know any language other than their mother tongue, nor do they have basic knowledge of the English language. This means that there had to be an interpreter with them throughout the time they were in the hospital and receiving services. However, as they stated, there was not always aninterpreter, as a result of which there were communication problems. The issue of communication is key and especially in health matters as the doctor should be aware of the exact condition of the patient and the patient in turn should be aware of her health condition as well as be able to understand information about the treatments and services provided to them.

Another problem reported by two participants was the caesarean section. The women found the procedure painful and although it was necessary for their own and their baby's best interest, they stated they did not like it.

One participant cited late appointments as a major problem. A large number of refugee women participated in the program, so it was difficult to make an immediate appointment for all of them. The goal was for all women to become cannier and better cared for as much as possible. With the means available and the number of staff and doctors, it was reasonable to have small delays. However, this situation filled women with uncertainty about their baby's health and their own. Finally, one participant

stated that she did not like the fact that the doctor who examined her was male and stated that she would prefer to have a female doctor. This applies to the culture that exists in refugees' countries of origin where it is considered shameful for a male doctor to examine a woman. This culture comes from religion, which is just as strict. However, this problem could not be solved as most doctors were male and the examinations that had to be done were done only by the doctor and not the midwives.

Knowing the differences in the culture of refugee women, they were then asked about their feelings during their examination by women, like midwives. The expected response was that participants felt better and more comfortable with women than with men. Moreover, this implied a participant in the previous question that was analyzed above. Indeed, all participants reported feeling more comfortable with the midwife and would like to receive perinatal care from their midwives rather than gynecologists. One participant reported that both she and her husband wanted the tests to be done mainly by women and not by men. This answer shows that in their country, the prevailing culture makes men decide and even have highly feminine issues such as pregnancy. However, the health of women and babies was above all for the doctors, parents and those in charge of the program and so all the prejudices that existed were overcomed.

The questions then focused on the sensitive issue of research, namely whether pregnant refugee women were satisfied with the care and services of the midwife.

Specifically, they were asked to report two things they liked and two things they did not like about being cared for by midwives. So, starting with those who really liked the interest midwives showed for them and the baby, all the women gave similar answers and this shows that the midwives took care of each pregnant woman separately and gave her the proper importance. This made women feel safe during the exams. Even the persistence of the midwives and their willingness to explain the resultsof the exams but also techniques about breastfeeding and caring for the newborn were two of the most important and best things for those women to remember from the care received by midwives. According to the answers given by the women, they did not mention any problems with the midwives and the care they received from them. The problems mentioned in this question also concerned the difficulty in communication due to the lack of aninterpreter and the fact that they were also examined by men when they did not want to. The fact that they had repeatedly told doctors and staff that they wanted to be examined by midwives on ultrasound and vaginal examinations while this was not taking place caused them irritability and discomfort.

At the hospital where the program took place, there was always an interpreter to serve in the translations and to make all the procedures easier. From the answers given, it seems that the existence of a physician was necessary in all processes as the majority of refugees speak Arabic and very few of them speak English. However, as they

stated, there was not always an interpreter present at the hospital. This is a problem as the organizers of the program had to select a larger number of interpreters and always be available at the hospital. However, many women did not feel comfortable with the presence of a maleinterpreter to discuss about their gynecological symptoms. This shows that women felt uncomfortable with any man they had to interact with, whether he was a doctor or an interpreter. However, their fear and insecurity worked to the detriment of the baby's health. Still, all the women report that the presence of the interpreter was necessary and that it helped them a lot in understanding the results of the exams and in matters related to the care of the newborn.

The interpreter's nationality did not seem to bother the women. All they wanted was to help them communicate better with the hospital staff. However, although they spoke the same language as them, they did not feel comfortable because the interpreters were male. It was difficult for women to describe to the interpreterssymptoms and issues related to their health, even serious ones related to pregnancy. From the answers it seems that there were no female interpreters as they did not mention anyat their answers. However, the fact that the interpreters were male seems to have made it difficult for them and that they were a negative and unpleasant factor. The above states that women in Arab countries do not feel comfortable with any man around them except for their husband, who is involved and has a saying in everything.

In general, it seems that women were happy with the care they received. Many reported that care was overstretched and more than they thought they would have. However, as they say, they would like to see changes in the program to improve the services they have been offered and to be equal to their needs. There were more staff than most women mentioned. The incompetent staff were responsible for the delay in the appointments, resultingin, as one participant stated, visitingthe doctor only 3 times during the whole pregnancy and could not solve basic questions. Even the lack of interpreters was another major problem as they could not communicate properly with the doctors. However, the answers given showed that their greatest demand was the existence of female doctors or midwives during the examinations as they feel uncomfortable with men.

Last but not least, the refugee women answered questions about their previous pregnancies and their experience from public hospitals. For all the participants, the birth in the hospital of Leros was the first they had in Greece. For many of them it was their first birth while the rest have given birth of their previous children at their home country. These women stated that there is a difference in the health system of Greece with that of their country. In Greece it is necessary to perform more tests and ultrasounds that do not take place in their country. This made them feel that Greece's health system is complex and more difficult than their own. However, they felt that

health care professionals were paying more attention to them which made themfeel more secure.

However, the fact that caesareans are performed in Greece whenever there is a need displeased them. The participants stated that in the event of a subsequent pregnancy, they would trust the public hospitals but would like to give birth vaginally and have a female doctor. These are the two main priorities for giving birth in a Greek hospital as they do not seem to have another problem. Finally, the women mentioned that they shared the experiences from their births and the care they receivedat the hospital with the other women in the camps where they live. Everyone claimedthat they faced similar problems. Even because of the conditions under which they live, which are difficult and uncertain, they seem to be hesitant of a future visit to the country's hospital.

5 Conclusion

The current investigation meant to outline the current proof base of perinatal wellbeing results and perinatal human services among women with the status of shelter searcher and displaced person. Albeit every included survey joined information for women with shelter searcher or displaced person status so as to be qualified for consideration, the information detailed explicit to this populace were constrained. In the research projects that were presented in the literature review, just one included orderly survey was solely focused on refugee, and the rest of the information for asylum seeker and exile women were gathered alongsidethe ones for heterogeneous transient populaces or other powerless women in the proof combinations. It wasnoticed that various perinatal wellbeing results were worst for refugeewomencompared tonative women, involving psychological wellness issues, maternal mortality, preterm delivery and inherent peculiarities(Heaman, Bayrampour, Kingston, Blondel Gissler Roth Alexander & Gagnon, 2013).

The study looked at whether the ORAMMA project helped women during pregnancy, childbirth and during their visits and hospital stay in Leros. Participants from different countries were selected in order to have a variety of answers. The question that was asked to them was general and could hardly be answered with very detailed and detailed answers. All the services provided to them were adequate and appropriate.

However, the fact that no one mentioned they were very satisfied or did not use another word indicates that the services of the program could be better. However, the fact that no one said they were unhappy shows that the program provided decent health services and that it cared for all women equally. Therefore, the effectiveness of the program was good and had a positive impact on the women who participated in it. Moreover, the women stated that they feltcontent with the care the healthcare professionalsprovided to them and the attention they received from the doctors and the hospital staff. These women left their country to find better living conditions in a foreign country, such as Greece. They have taken a lot during their journey and many of them have been exploited and brutally abused.For the women, the prevailing culture in their country allows men to decide for them, even for highly feminine issues such as pregnancy. However, the health of women and babies was above all for the doctors and those in charge of the program and so all the prejudices that existed were overcome(O'Mahony, Donnelly & Bouchal, 2013).

From the literature review, the subjective and quantitative proof explicitly important to women with shelter searcher and exile status proposes that they have worst results and encounters contrasted with the proof from more extensive transient populaces (counting haven searchers and outcasts) and to women in the host nation, especially identifying with complex obstetric issues (for example SAMM, uterine crack, eclampsia), psychological well-being, posterity mortality, rape and undesirable

pregnancy, FGM, irresistible malady and iron deficiency. In any case, similitudes in populace risk between shelter searchers, displaced people and more extensive migrant populaces were watched for some perinatal wellbeing results, for example, cesarean delivery. The healthytransient impact was accounted for in a portion of the orderly surveys, especially identifying with LBW where the risk was like or superior to that for women in the host nations (Kurth, Jaeger , Zemp, Tschudin & Bischoff, 2010). This was accounted for by certain creators just like a clarification for better results. The proof recommends that the solid transient impact is setting explicit and doesn't decipher over all migrants from all nations of starting point or getting nations. Systematizedstudy announced a solid migrant impact among explicit populaces which had been principally in Latina transients that were in the USA whereby results would in general would be improved contrasted and women in the host nation, this was either local conceived or other transient gatherings. Be that as it may, wellbeing imbalances were accounted for among transient populaces from other starting point or potentially have nations and among displaced person and shelter searchers who, for specific results, fared more terrible than both other migrantwomenandnative women. The diversityamongmigrant, haven searcher and outcast populace drives us to additionally scrutinize the propriety of categorizing transient populaces in research, practice and arrangement. Joining populaces might veil the genuine contrasts in perinatal wellbeing results and care prerequisites, and in the absencethis information

the improvement of focused mediations to forestall antagonistic results is upset(Mengesha, Dune & Perz, 2016).

In spite of the absence of organized study solely focusing on women with shelter searcher and displaced person status, there were a few information on these populaces accessible to investigate perinatal medical problems among these gatherings of women. Most of the writing which explicitly focused on women with displaced person and shelter searcher status investigated access to and experience of perinatal social insurance. This information demonstrated comparable boundaries to access and utilization of perinatal social insurance with respect to more extensive migrant populaces. Notwithstanding, extra profundity of information applicable to haven searcher and exile women included social detachment coming about because of boundaries to mind, doubt of wellbeing experts and budgetary concerns and neediness; the last hindrances were especially testing because of the failure to be employed and transitory and questionable residency situation. Women's encounters of healthcare provision likewise demonstrated likenesses to those for more extensive transient populaces however with evidently expanded difficulties with language and correspondence obstructions and progressively broad experience of prejudice, segregation, disgrace and generalising in experiences with health services and healthcare providers during the perinatal period. The current examination proposes various territories that justifyadditional research. There is restricted proof for

womenwith shelter searcher and displaced person status on specific results during the perinatal period, for example, maternal mortality, obstetric inconveniences, for example, drain and diseases and innate peculiarities(Kandasamy, Cherniak, Shah, Yudin & Spitzer, 2014). There is, likewise, a lack of investigation into the probable causal pathways amongmigrant statuses and negative wellbeing results. Migrants, shelter searchers and evacuees are explicit populaces; examining wellbeing results for these gatherings when they are consolidated presents difficulties for advancing examination just as for approach and practice(Bergesen, Parmann & Thommessen, 2018). At the point when it was conceivable to look at migrant populaces including haven searchers and evacuees with shelter searchers and outcasts right now, had the option to exhibit some comparable discoveries for specific wellbeing results yet in addition extraordinary and more regrettable results, which are veiled when gatherings are joined. We couldn't investigate information explicit to shelter searchers and explicit to outcasts. We just distinguished one systematized survey explicit to refugee searchers, which proposes that further research is required. Our organized survey explicitly looked for organizedstudy on haven searchers and outcasts, however concentrates on different gatherings of powerless women, for example undocumented and migrant laborers, are likewise required. The advancement of successful mediations to help these women won't be conceivable if heterogeneous gatherings

keep on being consolidated for investigate(Higginbottom, Safipour, Yohani, O'Brien, Mumtaz, Paton., ... & Barolia, 2016).

The literature discoveries on the medicinal services encounters of women with haven searcher and exile status have suggestions for training. Associations with medicinal services experts were a long way from ideal, with correspondence, segregation and stereotyping announced. Given the discoveries of this survey on dangers of maternal emotional well-being and obstetric confusions, the arrangement of psychological wellness administrations and assistance of access to prenatal care on time is basic for this group of women. Social insurance chiefs ought to likewise have an away from of neighborhood needs with the goal that suitable administrations can be arranged. Executing these suggestions into training and giving socially explicit preparing to wellbeing experts can possibly lessen a portion of these negative encounters for women and furthermore for wellbeing experts.

Proof demonstrate a positive relationship between deficient wellbeing education and MAR women' antagonistic perinatal results (Hill et al, 2012; Kulig, 1990). Wellbeing education is characterized as "social assets required for people and networks to get to, comprehend, evaluate and use data and administrations to settle on choices about wellbeing" (Essen et al, 2000). Wellbeing proficiency is imperative to guarantee compelling human services training and fruitful commitment of networks in their own

social insurance arranging (Small et al, 2014). Blemish women ought to be given suitable, modern and effectively reasonable data. They ought to know about the accessible administrations and to be offered training to be dynamic accomplices in their own social insurance dynamic procedures. Furthermore, the ORAMMA project's approach reports that migrant, asylum seeking, and refugeewomen and their families will be supplied with data and counseling on different parts of pregnancy, delivery and parenthood experience that will be upheld by conversations with the maternity specialist. An assortment of instructive materials and data sources which includes booklets, recordings, applications, introductions, that werelikewise given, as per the women's language, proficiency level and social foundation. By raising wellbeing education whereby giving information, aptitudes and skills it is ORAMMA that attemptedtries to assistmigrant, asylum seeking and refugee women and their families to effectively take part in their own human services, follow up on the variables that influence their wellbeing and increment their possibility for better perinatal results. Wellbeing instruction will likewise empower women to comprehend the need of maternity care and the significance of standard registration.

In summary, it is obvious that in the hospital of Leros and on the basis of the ORAMMA project, the doctors and midwives, in cooperation with the interpreters, provided excellent services to the refugee women during their pregnancy. However,

the lack of staff and the presence of male doctors are two important problems for women and they need to be dealt with to fully meet their needs.

References

Alhasanat D, Fry-McComish J. Postpartum depression among immigrant and Arabic women: literature review. J Immigr Minor Health. 2015;17(6):1882–94.

Allotey P, Manderson L, Baho S, Demian L. Reproductive health for resettling refugee and migrant women. Health issues. 2004;78:12–7.

Amankwaa, L. (2016). Creating protocols for trustworthiness in qualitative research. *Journal of Cultural Diversity*, *23*(3).

Anderson FM, Hatch SL, Comacchio C, Howard LM. Prevalence and risk of mental disorders in the perinatal period among migrant women: a systematic review and meta-analysis. Archives Women's Mental Health. 2017;20(3):449–62.

Anderson, K., Ryan, B., Sonntag, W., Kavvada, A., & Friedl, L. (2017). Earth observation in service of the 2030 Agenda for Sustainable Development. *Geo-spatial Information Science*, *20*(2), 77-96.

Aubrey C, Chari R, Mitchell BFP, Mumtaz Z. Gender of provider—barrier to immigrant women's obstetrical care: a narrative review. J Obstet GynaecolCan. 2017;39(7):567–77.

Balaam MC, Akerjordet K, Lyberg A, Kaiser B, Schoening E, Fredriksen AM, Ensel A, Gouni O, Severinsson E. A qualitative review of migrant women's perceptions of their needs and experiences related to pregnancy and childbirth. J Adv Nurs. 2013;69(9):1919–30.

Bawadi, H., Al-Hamdan, Z., & Ahmad, M. M. (2020). Needs of Migrant Arab Muslim Childbearing Women in the United Kingdom. *Journal of Transcultural Nursing*, 1043659620921219.

Beine K, Fullerton J, Palinkas L, Anders B. Conceptions of prenatal care among Somali women in San Diego. J Nurse Midwifery. 1995;40(4):376–81.

Bergesen, H. O., Parmann, G., & Thommessen, O. B. (2018). United Nations Population Fund (UNFPA). In *Year Book of International Co-operation on Environment and Development* (pp. 227-227). Routledge.

Black, R. E., Levin, C., Walker, N., Chou, D., Liu, L., Temmerman, M., & Group, D. R. A. (2016). Reproductive, maternal, newborn, and child health: key messages from disease control priorities 3rd edition. *The Lancet*, *388*(10061), 2811-2824.

Bollini P, Pampallona S, Wanner P, Kupelnick B. Pregnancy outcome of migrant women and integration policy: a systematic review of the international literature. Soc Sci Med. 2009;68(3):452–61.

Briscoe L, Lavender T: Exploring maternity care for asylum seekers and refugees. Br J Midwifery 2009, 17(1):17–23.

Carolan M, Cassar L. Antenatal care perceptions of pregnant African women attending maternity services in Melbourne, Australia. Midwifery. 2010;26(2): 189–201.

Carolan M, Cassar L. Pregnancy care for African refugee women in Australia: attendance at antenatal appointments. Evidence-Based Midwifery. 2007;5(2):54–9.

Carroll J, Epstein R, Fiscella K, Gipson T, Volpe E, Jean-Pierre P. Caring for Somali women: implications for clinician–patient communication. Patient Educ Couns. 2007;66(3):337–45.

Cebolla-Boado, H., & Salazar, L. (2016). Differences in perinatal health between immigrant and native-origin children: Evidence from differentials in birth weight in Spain. *Demographic Research*, *35*, 167-200.

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

Cheng, I. H., Drillich, A., & Schattner, P. (2015). Refugee experiences of general practice in countries of resettlement: a literature review. *Br J Gen Pract*, *65*(632), e171-e176.

Collins CH, Zimmerman C, Howard LM. Refugee, asylum seeker, immigrant women and postnatal depression: rates and risk factors. Archives Women's Mental Health. 2011;14(1):3–11.

Danieli, Y., Stamatopoulou, E., & Dias, C. (2018). *The universal declaration of human rights: Fifty years and beyond*. Routledge.

Dartnall L, Ganguly N, Batterham J. Access to Maternity Services Research Report. London: COI and Department of Health; 2005.

De Leon Siantz, M. L. (2013). Feminization of migration: a global health challenge.

De Maio FG. Immigration as pathogenic: a systematic review of the health of immigrants to Canada. Int J Equity Health. 2010;9(1):27.

Directive 2011/95/EU on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted, 2011/95/EU.

Downe S, Finlayson K, Walsh D, Lavender T. 'Weighing up and balancing out': a meta-synthesis of barriers to antenatal care for marginalised women in high-income countries. BJOG Int J Obstet Gynaecol. 2009;116(4):518–29.

Edge D: Perinatal depression: its absence among Black Caribbean women. Br JMidwifery 2006, 14(11):646–652.

Essén B, Hanson BS, ÖStergren PO, Lindquist PG, Gudmundsson S. Increased perinatal mortality among sub-Saharan immigrants in a city-population in Sweden. Acta Obstet Gynecol Scand. 2000;79(9):737–43.

European Commission. (2016). *Refugee crisis in Europe*. Available at: http://ec. europa.eu/echo/refugee-crisis.

Falah-Hassani K, Shiri R, Vigod S, Dennis C-L. Prevalence of postpartum depression among immigrant women: a systematic review and meta-analysis. J Psychiatr Res. 2015;70:67–82.

Fellmeth G, Fazel M, Plugge E. Migration and perinatal mental health in women from low-and middle-income countries: a systematic review and meta-analysis. BJOG Int J Obstet Gynaecol. 2017;124(5):742–52.

Gagnon AJ, Dougherty G, Wahoush O, Saucier J-F, Dennis C-L, Stanger E, Palmer B, Merry L, Stewart DE. International migration to Canada: the post-birth health of mothers and infants by immigration class. Soc Sci Med. 2013;76:197–207.

Gagnon AJ, Merry L, Haase K. Predictors of emergency cesarean delivery among international migrant women in Canada. Int J Gynecol Obstet. 2013; 121(3):270–4.

Gagnon AJ, Stanger E, Dougherty G, Oxman-Martinez J, Platt RW, Saucier J-F, Wahoush O, Merry L, George A, Stewart DE. Refugee and refugee-claimant women and infants post-birth: migration histories as a predictor of Canadian health system response to needs. Can J Public Health. 2007;4:287–91.

Gagnon AJ, Zimbeck M, Zeitlin J. Migration to western industrialised countries and perinatal health: a systematic review. Soc Sci Med. 2009;69(6):934–46.

Gissler M, Alexander S, Macfarlane A, Small R, Stray-Pedersen B, Zeitlin J, Zimbeck M, Gagnon A. Stillbirths and infant deaths among migrants in industrialized countries. Acta Obstet Gynecol Scand. 2009;88(2):134–48.

Glesne, C. (2016). *Becoming qualitative researchers: An introduction*. Pearson. One Lake Street, Upper Saddle River, New Jersey 07458.

Goosen S, Uitenbroek D, Wijsen C, Stronks K. Induced abortions and teenage births among asylum seekers in The Netherlands: analysis of national surveillance data. J Epidemiology Community Health. 2009;7: 528–33.

Hadgkiss EJ, Renzaho AMN. The physical health status, service utilization and barriers to accessing care for asylum seekers residing in the community: a systematic review of the literature. Aust Health Rev. 2014; 38(2):142–59.

Harper Bulman K, McCourt C. Somali refugee women's experiences of maternity care in west London: a case study. Critical Public Health. 2002; 12(4):365–80.

Hayes, I., Enohumah, K., & McCaul, C. (2011). Care of the migrant obstetric population. *International Journal of Obstetric Anesthesia*, *20*(4), 321-329.

Heaman M, Bayrampour H, Kingston D, Blondel B, Gissler M, Roth C, Alexander S, Gagnon A. Migrant women's utilization of prenatal care: a systematic review. Matern Child Health J. 2013;17(5):816–36.

Herrel N, Olevitch L, DuBois DK, Terry P, Thorp D, Kind E, Said A. Somali refugee women speak out about their needs for care during pregnancy and delivery. J Midwifery Women's Health. 2004;49(4):345–9.

Higginbottom G, Bell AS, Arsenault J, Pillay J. An integrative review of experiences of maternity services for immigrant women in Canada. Diversity Equality Health Care. 2012;9:253–66

Higginbottom GMA, Hadziabdic E, Yohani S, Paton P. Immigrant women's experience of maternity services in Canada: a meta-ethnography. Midwifery. 2014;30(5):544–59.

Higginbottom GMA, Morgan M, Alexandre M, Chiu Y, Forgeron J, Kocay D, Barolia R. Immigrant women's experiences of maternity-care services in Canada: a systematic review using a narrative synthesis. Systematic Reviews. 2015;4(1):13.

Higginbottom, G. M., Safipour, J., Yohani, S., O'Brien, B., Mumtaz, Z., Paton, P., ... & Barolia, R. (2016). An ethnographic investigation of the maternity healthcare experience of immigrants in rural and urban Alberta, Canada. *BMC pregnancy and childbirth*, *16*(1), 1-15.

Higgins, A., Morriss, W. W., Gelb, A. W., Makasa, E. M., Gore-Booth, J., Vasco, M., & Mellin-Olsen, J. (2020). 72nd World Health Assembly, Geneva, Switzerland, 2019. *Anesthesia & Analgesia*, *130*(3), e92-e94.

Hill N, Hunt E, Hyrkäs K. Somali immigrant women's health care experiences and beliefs regarding pregnancy and birth in the United States. J Transcult Nurs. 2012;23(1):72–81.

Huster KMJ, Patterson N, Schilperoord M, Spiegel P. Cesarean sections among Syrian refugees in Lebanon from December 2012/January 2013 to June 2013: probable causes and recommendations. Yale J Biology Medicine. 2014;87(3):269.

Iliadi P. Refugee women in Greece: a qualitative study of their attitudes and experience in antenatal care. Health Sci J. 2008;2(3):173–180

IOM. (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*. Available at: http://migration.iom.int/docs/FMS_CT_Analysis_male%20female_Central_Eastern_2017.pdf.

Janesick, V. J. (2015). *" Stretching" exercises for qualitative researchers*. Sage Publications.

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*. Gent: Academia Press.

Kandasamy T, Cherniak R, Shah R, Yudin MH, Spitzer R. Obstetric risks and outcomes of refugee women at a single centre in Toronto. J Obstet Gynaecol Can. 2014;36(4):296–302.

Kelaher M, Jessop DJ. Differences in low-birthweight among documented and undocumented foreign-born and US-born Latinas. Soc Sci Med. 2002; 55(12):2171–5.

Kennedy P, Murphy-Lawless J. The maternity care needs of refugee and asylum seeking women in Ireland. Fem Rev. 2003;73(1):39–53.

Keygnaert I, Guieu A, Ooms G, et al. (2014). Sexual and reproductive health of migrants: does the EU care? *Health Policy*;114:215–25.

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*.

Knight, M., Kenyon, S., Brocklehurst, P., Neilson, J., Shakespeare, J., & Kurinczuk, J. J. (2017). Saving lives, improving mothers' care: lessons learned to inform future maternity care from the UK and Ireland confidential enquiries into maternal deaths and morbidity 2009-2012.

Kulig JC. Childbearing beliefs among Cambodian refugee women. West J Nurs Res. 1990;12(1):108–18.

Kurth E, Jaeger FN, Zemp E, Tschudin S, Bischoff A. Reproductive health care for asylum-seeking women—a challenge for health professionals. BMC Public Health. 2010;10(1):659.

Kuvacic I, Skrablin S, Hodzic D, Milkovic G. Possible influence of expatriation on perinatal outcome. Acta Obstet Gynecol Scand. 1996;75(4):367–71.

Lalchandani S, MacQuillan K, Sheil O. Obstetric profiles and pregnancy outcomes of immigrant women with refugee status. Ir Med J. 2001;94(3):79–80.

Lesueur, F. E. K., Sutter-Dallay, A. L., Panico, L., Azria, E., Van der Waerden, J., Vauvillier, N. R., ... & Melchior, M. (2018). The perinatal health of immigrant

women in France: a nationally representative study. *International Journal of Public Health*, *63*(9), 1027-1036.

Lewicka, I., Kocyłowski, R., Grzesiak, M., Gaj, Z., Oszukowski, P., & Suliburska, J. (2017). Selected trace elements concentrations in pregnancy and their possible role—Literature review. *Ginekologia Polska*, *88*(9), 509-514.

Martin, R., Fryers, K., Schlüter, M., Barbosa, A. L., Iglesias-Campos, A., Arévalo-Torres, J., ... & Domisch, S. (2017). Scenario Development. Deliverable 7.2, AQUACROSS, European Union's Horizon 2020 Framework Programme for Research and Innovation Grant Agreement No. 642317.

Matthey S, Silove D, Barnett B, Fitzgerald MH, Mitchell P. Correlates of depression and PTSD in Cambodian women with young children: a pilot study. Stress Health. 1999;15(2):103–7.

McLeish J: Maternity experiences of asylum seekers in England. Br J Midwifery 2005, 13(12):782–785.

Mengesha ZB, Dune T, Perz J. Culturally and linguistically diverse women's views and experiences of accessing sexual and reproductive health care in Australia: a systematic review. Sex Health. 2016;13(4):299–310.

Merry L, Small R, Blondel B, Gagnon AJ. International migration and caesarean birth: a systematic review and meta-analysis. BMC Pregnancy Childbirth. 2013;13:27.

Merry L, Vangen S, Small R. Caesarean births among migrant women in highincome countries. Best Practice Res Clin Obstet Gynaecol. 2016;32:88–99.

Merry LA, Gagnon AJ, Kalim N, Bouris SS. Refugee claimant women and barriers to health and social services post-birth. Can J Public Health. 2011;4: 286–90.

Moher D, Liberati A, Tetzlaff J, Altman DG, PRISMA Group. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. PLoS Med. 2009;6(7):e1000097.

Murray L, Windsor C, Parker E, Tewfik O. The experiences of African women giving birth in Brisbane, Australia. Health Care Women Int. 2010;31(5):458–72.

Nedić B, Loncar S, Ravić J, Komazec J. Deliveries in the outpatient birthing facility in Ruma during 1989 and between 1992 and 1995. Med Pregl. 1999; 52(1–2):53–6.

Nilaweera I, Doran F, Fisher J. Prevalence, nature and determinants of postpartum mental health problems among women who have migrated from South Asian to high-income countries: a systematic review of the evidence. J Affect Disord. 2014;166:213–26.

Noble, H., & Smith, J. (2015). Issues of validity and reliability in qualitative research. *Evidence-based nursing*, *18*(2), 34-35.

O'Mahony JM, Donnelly TT, Bouchal SR, Este D. Cultural background and socioeconomic influence of immigrant and refugee women coping with postpartum depression. J Immigr Minor Health. 2013;15(2):300–14.

O'Mahony JM, Donnelly TT, Bouchal SR, Este D. Barriers and facilitators of social supports for immigrant and refugee women coping with postpartum depression. Adv Nurs Sci. 2012;35(3):E42–56.

Pedersen GS, Grøntved A, Mortensen LH, Andersen A-MN, Rich-Edwards J. Maternal mortality among migrants in Western Europe: a meta-analysis. Matern Child Health J. 2014;18(7):1628–38.

Rahman, M. S. (2017). The Advantages and Disadvantages of Using Qualitative and Quantitative Approaches and Methods in Language" Testing and Assessment" Research: A Literature Review. *Journal of Education and Learning*, *6*(1), 102-112.

Redwood-Campbell L, Thind H, Howard M, Koteles J, Fowler N, Kaczorowski J. Understanding the health of refugee women in host countries: lessons from the Kosovar re-settlement in Canada. Prehospital and Disaster Medicine. 2008;23(4):322–7.

Reed MM, Westfall JM, Bublitz C, Battaglia C, Fickenscher A. Birth outcomes in Colorado's undocumented immigrant population. BMC Public Health. 2005;5(1):100.

Resolution 1509 (2006): human rights of irregular migrants. Strasbourg: Council of Europe; 2006 (http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=17456&lang=EN

Resolution 70/1. Transforming our world: the 2030 Agenda for sustainable development. Resolution adopted by the General Assembly on 25 September 2015. New York: United Nations; 2015 http://www.un.org/ga/search/view_doc. asp?symbol=A/RES/70/1&Lang=E

Resolution WHA61.17. Health of migrants. In: Sixty-first World Health Assembly, Geneva, 16–24 May 2008. Geneva: World Health Organization; 2008 http://apps.who.int/iris/bitstream/handle/10665/23533/A61_R17-en.pdf;jsessionid=CC5E570EABCC5AD0E653539039737FF0?sequence=1

Reynolds B, White J. Seeking asylum and motherhood: health and wellbeing needs. Community Practitioner. 2010;830(20):3.

Riggs E, Davis E, Gibbs L, Block K, Szwarc J, Casey S, Duell-Piening P, Waters E. Accessing maternal and child health services in Melbourne, Australia: reflections from refugee families and service providers. BMC Health Serv Res. 2012;12:117

Roger, K., Bone, T., Heinonen, T., Schwartz, K., Slater, J., & Thakrar, S. (2018). Exploring identity: What we do as qualitative researchers. *The Qualitative Report*, *23*(3), 532-546.

Rogers, R. H. (2018). Coding and Writing Analytic Memos on Qualitative Data: A Review of Johnny Saldaña's The Coding Manual for Qualitative Researchers. *The Qualitative Report*, *23*(4), 889-892.

Rogstad KE, Dale H. What are the needs of asylum seekers attending an STI clinic and are they significantly different from those of British patients? Int J STD AIDS. 2004;15(8):515–8.

Saldaña, J. (2015). The coding manual for qualitative researchers. Sage.

Schmied V, Black E, Naidoo N, Dahlen HG, Liamputtong P. Migrant women's experiences, meanings and ways of dealing with postnatal depression: a meta-ethnographic study. PLoS One. 2017;12(3):e0172385.

Schulpen TWJ, Van Steenbergen JE, Van Driel HF. Influences of ethnicity on perinatal and child mortality in the Netherlands. Arch Dis Child. 2001;84(3):222–6.

Sekeris, P., & Vasilakis, C. (2016). The Mediterranean refugees crisis and extreme right parties: Evidence from Greece.

Shafiei, T., & Flood, M. (2019). Perinatal mental health needs of immigrant and refugee women: Care provider's perspective. *Women and Birth*, *32*, S22-S23.

Small R, Gagnon A, Gissler M, Zeitlin J, Bennis M, Glazier RH, Haelterman E, Martens G, McDermott S, Urquia M. Somali women and their pregnancy outcomes postmigration: data from six receiving countries. BJOG Int J Obstet Gynaecol. 2008;115(13):1630–40.

Small R, Roth C, Raval M, Shafiei T, Korfker D, Heaman M, McCourt C, Gagnon A. Immigrant and non-immigrant women's experiences of maternity care: a

systematic and comparative review of studies in five countries. BMC Pregnancy Childbirth. 2014;14:152.

Stewart DE, Gagnon A, Saucier J-F, Wahoush O, Dougherty G. Postpartum depression symptoms in newcomers. Can J Psychiatry. 2008;53(2):121–4.

Strategy and action plan for refugee and migrant health in the WHO European Region. Copenhagen: WHO Regional Office for Europe; (2016) EUR/RC66/8; http://www.euro.who.int/_data/assets/pdf_file/0004/314725/66wd08e_ MigrantHealthStrategyActionPlan_160424.pdf.

Stroup DF, Berlin JA, Morton SC, Olkin I, Williamson GD, Rennie D, Moher D, Becker BJ, Sipe TA, Thacker SB. Meta-analysis of observational studies in epidemiology: a proposal for reporting. Meta-analysis Of Observational Studies in Epidemiology (MOOSE) group. JAMA. 2000;283(15):2008–12.

Taran P. The Sustainable Development Goals and migrants/migration. Regarding the UN 2030 Sustainable Development Agenda: a work in progress, version 3. Geneva: United Global Migration Policy Associates; 2016 http://www. un.org/en/development/desa/population/migration/events/coordination/14/ documents/backgrounddocs/GMPA_14CM.pdf

Taylor, S. J., Bogdan, R., & DeVault, M. (2015). *Introduction to qualitative research methods: A guidebook and resource*. John Wiley & Sons.

The Joanna Briggs Institute. The Joanna Briggs Institute reviewers' manual 2014: methodology for JBI umbrella reviews. Adelaide: The Joanna Briggs Institute; 2014.

Tobin CL, Di Napoli P, Beck CT. Refugee and immigrant women's experience of postpartum depression: a meta-synthesis. J Transcult Nurs. 2018;1:84–100.

Tunçalp, Ö., Pena-Rosas, J. P., Lawrie, T., Bucagu, M., Oladapo, O. T., Portela, A., & Gülmezoglu, A. M. (2017). WHO recommendations on antenatal care for a positive pregnancy experience-going beyond survival. *BJOG*, *124*(6), 860-862.

UNHCR. (2018). *Global trends: forced displacement in 2017*. Available at: http:// www.unhcr.org/statistics/unhcrstats/5b27be547/unhcr-global-trends-2017.html.

United Nations Population Fund, International Organization for Migration. (2006). Female migrants: bridging the gaps throughout the life cycle. New York: United Nations Population Fund; 2006 UNFPA–IOM Expert Group Meeting; https:// publications.iom.int/system/files/pdf/female_migrants.pdf

Van Hanegem N, Miltenburg AS, Zwart JJ, Bloemenkamp KWM, Van Roosmalen JOS. Severe acute maternal morbidity in asylum seekers: a twoyear nationwide cohort study in the Netherlands. Acta Obstet Gynecol Scand. 2011;90(9):1010–6.

Vangen S, Stoltenberg C, Johansen REB, Sundby J, Stray-Pedersen B. Perinatal complications among ethnic Somalis in Norway. Acta Obstet Gynecol Scand. 2002;81(4):317–22.

Varga-Dobai, K. (2012). The Relationship of Researcher and Participant in Qualitative Inquiry: From. Qualitative Report, 17, 93.

Villalonga-Olives E, Kawachi I, von Steinbüchel N. Pregnancy and birth outcomes among immigrant women in the US and Europe: a systematic review. J Immigr Minor Health. 2017;6:1469–87.

WHA 70.15. Promoting the health of refugees and migrants. In: Seventieth World Health Assembly, Geneva, 22–31 May 2017. Geneva: World Health Organization; 2017 (https://www.iom.int/sites/default/files/our_work/DMM/MigrationHealth/WHA_RES_70.15-Promoting-the-health-of-refugees-and-migrants.pdf

Wicks, D. (2017). The coding manual for qualitative researchers. Qualitative research in organizations and management: an international journal.

Wikberg A, Bondas T. A patient perspective in research on intercultural caring in maternity care: a meta-ethnography. Int J Qual Stud Health Wellbeing. 2010;5(1):4648.

Winn A, Hetherington E, Tough S. Systematic review of immigrant women's experiences with perinatal care in North America. JOGNN. 2017;46(5):764–75.

Wittkowski A, Patel S, Fox JR. The experience of postnatal depression in immigrant mothers living in Western countries: a meta-synthesis. Clin Psychology Psychotherapy. 2017;24(2):411–27.

Woods, P. (2006). Successful writing for qualitative researchers. Psychology Press.

Appendix

Interview Questions:

1. How satisfied are you with the care during pregnancy?

2. Tell me something you liked about the care they gave you during pregnancy. Why did you like it?

3. Tell me something you did not like about the care they gave you during pregnancy. Why did not you like it?

4. How did it feel to be examined by women during the visits (referring to midwives)?

5. Can you tell me 2 things you liked (from midwifery care)?

6. Can you tell me 2 things you did not like (from the care of the midwives)?

7. Did it help that there was always an interpreter in the hospital every time you came to visit?

8. Did the interpreter at the hospital help you understand more about your pregnancy, childbirth and baby care?

9. Did you have the same nationality as the interpreter? If so, how did you feel about it?

10. Would you like something more than what they provided you?

11. What do you think could improve the care you received?

12. Have you given birth to another child in Greece? If so, was there a difference between that time and this time? Was it better or worse?

13. Do you think that the care you received helped you understand how the health system works in Greece? Do you feel confident visiting a public hospital if you become pregnant again and are in Greece?

14. Did you share some of the information you learned about pregnancy and how to be examined in Greek hospitals with other pregnant women (e.g. friends, relatives, etc.)?

15. Would you like to share something else?