Pure

Bangor University

MASTERS BY RESEARCH

Refugee Women Experiences of Reproductive Care Provision Focusing on Syrian Women Experiences of Reproductive Care in Transit and Temporary Settings

Khoury, Sonia

Award date:
2021

Awarding institution:
Bangor University

Link to publication

General rights
Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal ?

Take down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Download date: 16. May. 2022

Refugee Women Experiences of Reproductive Care Provision

Focusing on Syrian Women Experiences of Reproductive Care in Transit and Temporary Settings

Dr Sonia Khoury

June 2020

Bangor University

Yr wyf drwy hyn yn datgan mai canlyniad fy ymchwil fy hun yw'r thesis hwn, ac eithrio lle nodir yn wahanol. Caiff ffynonellau eraill eu cydnabod gan droednodiadau yn rhoi cyfeiriadau eglur. Nid yw sylwedd y gwaith hwn wedi cael ei dderbyn o'r blaen ar gyfer unrhyw radd, ac nid yw'n cael ei gyflwyno ar yr un pryd mewn ymgeisiaeth am unrhyw radd oni bai ei fod, fel y cytunwyd gan y Brifysgol, am gymwysterau deuol cymeradwy.

I hereby declare that this thesis is the results of my own investigations, except where otherwise stated. All other sources are acknowledged by bibliographic references. This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree unless, as agreed by the University, for approved dual awards.

CONTENTS

Declaration and Consent i

Contents ii

Index of Figures vi

Index of Tables vii

Acknowledgements viii

Dedication ix

Summary 1

Structure of theses 4

A Reflexive Account 6

Chapter 1: Purpose Chapter Set of the Scene: Background and Context 12

1.1. Introduction: 12

1.2 Background 12

1.3 Women as refugees and asylum seekers: The international context 13

1.3.1 Clinical Context 13

1.3.2. Social Context 14

1.4 The National (Syrian) Context 15

1.5 Summary 17

Chapter 2: Methodology, methods and Study Design: Scoping Review, Secondary Analysis 18

2.1. Introduction 18

2.2. Phase 1: Scoping Review, A discussion of the approach to scoping: 18

2.2.1. Study Design - Stages of the scoping review framework: (Figure 2) 19

2.2.1.1 Stage 1: Formulate the research questions, the rationale for the scoping the literature: 19

2.2.1.2. Stage 2: Identify relevant studies 21

2.2.1.3. Stage 3: Selecting studies 22

2.2.1.4. Stage 4: Chart Themes and subthemes: 24

2.2.1.5. Stage 5: Summarise and discuss findings 24

2.3 Phase 2: Secondary Analysis of Qualitative data, secondary but not primary: 24

2.3.1. Study Design - Secondary Analysis of Qualitative data 25

2.3.1.1. Stage 1. Develop the research questions: 26

2.3.1.2. Stage 2. Identify Dataset/studies: 28

2.3.1.3. Stage 3. Analyse selected studies 28

2.3.1.4. Stage 4. Chart themes and subthemes, summarise and discuss findings 28

2.4. The Thematic Analysis in qualitative research 29

2.4.1. Data familiarisation 31

2.4.2 Generation of initial codes 31

2.4.3. Identification of themes /Data synthesis 31

2.4.4. Review of themes 32

2.4.5. Themes definition and naming 32

2.4.6. Report writing 33

2.5. Summary 37

Chapter 3 Scoping Review Results: Refugee Women's experiences of Reproductive Care Provision Globally and in the UK 38

3.1 Introduction 38

3.2. Background 38

3.3. Results 39

3.3.1. The provision of the reproductive health care and maternity services for women refugees and asylum seekers 53

3.3.2. Communication barriers and the interpretation services 61

3.3.3. Relations of women refugees and asylum seekers with their health providers, expectations and perspectives 65

3.3.4. Adolescents' reproductive health care and maternity services 67

3.3.5. Reproductive health care and maternity services for women refugees and asylum seekers facing sexual and gender based violence..69

3.3.6. Reproductive health care and maternity services in refugee and transit camps 69

3.4. Synthesis..70

3.5. Summary 74

Chapter 4: Secondary Data Analysis Results Syrian Refugee Women Experience of Reproductive Care in Transit and Temporary Settings..75

4.1. Introduction 75

4.2. Background 75

4.2.1. Syrian Refugees in Neighbouring Countries 76

4.2.2 Syrian refugees in transit camps while travelling to Europe 77

4.3. Results and findings 77

4.3.1. Syrian refugees experiences of reproductive care in Neighbouring countries 83

4.3.1.1. Provision of reproductive care in camps settings...................................87

4.3.1.2 Provision of reproductive care in out of camps settings 88

4.3.1.3. Provision of reproductive care for victims of gender based and sexual violence 90

4.3.1.4 Provision of reproductive care for young adolescents in humanitarian settings. 91

4.3.2 Syrian refugees' experiences of reproductive care in transit camps while travelling to Europe 92

4.3.2.1. No adequate gender sensitivity in transit sites including gender sensitive access to information...93

4.6.2.2 Lack of reproductive care..94

4.6.2.3. Lack or no Gender based violence services 94

4.7 Synthesis..95

4.8 Summary 98

Chapter 5: Discussion and Recommendations 99
5.1. Introduction 99
5.2. Novel contribution 99
5.3 Reflections on the findings 101
5.3.1. The provision of reproductive care in temporary and camps settings 101
5.3.1.1. The provision of reproductive care in Neighbouring countries 101
5.2.1.2. The provision of reproductive care in transit camps while travelling to Europe 105
5.4. Researcher Reflection and insights 107
5.5. Research challenges 110
5.5.1. Strengths points 110
5.5.2. Weaknesses and challenges 110
5.6 Recommendations 111
5.6.1. Syrian refugees in Neighbouring countries: 111
5.6.2. Syrian refugees in transit camps on the route to Europe: 113
5.7. Conclusion 115
References (APA Style) 117
Appendices 128
Appendix A: Table of terms used for the Scoping research and the Secondary Qualitative Data research 128
Appendix B: Presenter at Talking Health Care for Refugees Seminar, Welsh Red Cross July 2019 131

INDEX OF FIGURES

Figure (1) Internal and External displacement figures of Syrian Refugee (UNHCR Syria, 2018) 16

Figure (2) Stages of Askey`s framework of the scoping review 19

Figure (3): the literature flow PRISMA 24

Figure (5) Factors affected the development of the study question 27

Figure (6) Stages of Thematic Analysis (B& C) 30

Figure (7) Mapping women and girls' journeying: Surfacing the experiences of Reproductive Health Care & Maternity Services in the scoping review 73

Figure (8) The Distribution of Syrian Refugees by Host Country, July 2017 (Migration Policy Institute, 2017) 76

Figure (9) Secondary Qualitative data sources 78

Figure 10 Women and girl's experiences: Absence, dissonance and vulnerability in provision, awareness and power 97

INDEX OF TABLES

Table (1) SPICE Tool: 20

Table (2) Inclusion and exclusion criteria for the Literature review: 22

Table (3): Experiences and perspectives of women seeking asylum and refuge regarding the reproductive health care provided to them 40

Table: (4) Syrian refugees' women experiences of reproductive care in Neighbouring 84

Table (5) Syrian refugee women experiences of reproductive care in transit camps while travelling to Europe 92

ACKNOWLEDGEMENTS

This thesis is the end of a long-term journey of ups and downs, exactly as my life was during the last decade and since the start of the Syrian war. As I am finalising this journey; I would like to express my sincere gratitude and appreciation to few people who selflessly helped me through this time.

First, I am proud to be a Post Graduate student of Bangor University, the School of Health care Sciences.

I am deeply grateful and indebted to my supervisor Dr Sion Williams for his priceless and consistent support, advice, directions and patience trough this journey. I will never forget his words “we will finally get there”. Thank you Sion, I couldn`t have done it without you.

I highly appreciate the administrative support I got from the team of the School of Health care Sciences. I am greatly thankful to Ms Nyree Hulme for her amazing support, especially when the final but technical touches might be highly needed.

A big hug to my parents whom I have not seen since 7 years, but they always have been with me day by day.

A huge thank you to my husband Emanuel and my daughter Zein who had all the patience to listen about this work all over the years.

Thank you all

.

DEDICATION

I dedicate this small piece of work to all the Syrian women, mothers, daughters, wives, and sisters. Your pain and losses will create freedom and victory

In my heart, I hold Syria tight and dear

Refugee Women Experiences of Reproductive Care Provision

Focusing on Syrian Women Experiences of Reproductive Care in Transit and Temporary Settings

SUMMARY

Refugee Women Experiences of Reproductive Care Provision, Focusing on Syrian Women Experiences of Reproductive Care in Transit and Temporary Settings

As a result of wars and conflicts, the recent years have witnessed a noticeable inflation of people who left their homelands seeking protection and new life in other countries. The vulnerability of those newcomers had imposed additional load on the hosting health systems. Precisely, women and teenage girls in such circumstances are to be at increased risk of poverty and sexual persecution.

The 9 years of the Syrian war had resulted of more than 5 Million of Syrian refugees been internally and externally displaced in the neighbouring countries (Turkey, Lebanon, Jordan, Iraq, and other North African countries) of which 49.8 % are Both Turkey and Lebanon are accommodating 2,727,000 and 1,033,513 individuals respectively. In camps-population constitutes 493,633 (10%) individuals of the above, 49.2% are females. Moreover, 1,120,432 individuals claimed asylum in European countries between April 2011 and July 2016, 64% were claimed in Germany only. (UNHCR, 2016).

The thesis is essentially influenced by two main factors that are:

- The scoping literature review that analysed experiences and perspectives of women refugees and asylum seekers regarding the reproductive car provision. It had informed the second focus of the research as it highlighted a ‘gap’ in women experiences of reproductive care in transit and temporary settings.
- As a Syrian migrant and a medical professional, the researcher was prompted to further explore he nature of the ‘gap’ in the evidence on women experiences of reproductive care in transit and temporary camps. In particular, the researcher focused on Syrian women displaced with their families in neighbouring countries or during temporary positioning in transit camps, while trying to reach a safe haven in Europe. Hence, the second part is an analysis of qualitative secondary data that explores

perspectives and experiences of Syrian Refugee women regarding the reproductive health care provision in transit and temporary camps/settings

The study questions:

The literature review answered the below question.

1. What are perspectives and experiences of women refugees and asylum seekers about the reproductive care provided to them during their journey?

As stated above, the literature review influenced the second focus of the research which was supposed to answer the below two questions.

2. What are experiences and perspectives of Syrian refugees' women of reproductive care provision in temporary camps of Syria neighbouring countries?
3. What are experiences and perspectives of Syrian refugees` s women of reproductive care provision in transit camps as part of their journey to Europe?

Methods

. The first part of the study centred on the completion of a scoping review of the evidence. As part of the study design, a scoping review of the literature provided the platform for an analysis of the secondary qualitative data. Combined these two approaches were used to answer the research questions. Secondary data consisted of research, projects/services evaluation reports and surveys produced by International and local None Governmental Organisations NGOs. At the core of the analytic process was subjecting the evidence from both sources to thematic analysis prior to a synthesis. Manual line-by-line coding was implemented in order to specify potential themes and subthemes.

Results presentation:

Aiming at reaching some applicable and realistic recommendations, results of Syrian refugee women experiences of reproductive care in transit and temporary camps were compared against similar global perspectives. As part of the key findings, it was clear that the lack of knowledge regarding the availability and the accessibility of health services in countries of

final destinations had adversely affected women experiences and perspectives of reproductive care provision. Importantly, relations with health professionals affected the attendance of antenatal care appointments in both ways. While women felt that they were stereotyped and less respected by the health professionals, other highly appreciated the genuine empathy shown. The financial hardships, language barriers, and female professional's availability also affected seeking the services when needed. Family male dominance and patriarchy that were embraced in war zones was seen as an essential reason of restricting women of seeking the reproductive care they need such as contraceptives or antenatal care. Women and girls were of a higher vulnerability to all sorts of sexual exploitation and gender-based violence.
Syrian women refugees in transit camps on the route to Europe had a poor experience. During their stay in transit camps. Syrian asylum seekers, including women heading households, or single women and young girls experienced inadequate services that did not suitably consider gender and cultural issues in these temporary settings, including no access to gender sensitive information nor adequate reproductive care provision. Transit camps lacked also gender based violence services when and as needs be.

The results highlighted that improving women refugees experiences of reproductive care provision and reducing their vulnerability in general could be achieved not only by increasing the access and the availability of such services but also by ensuring that such services are adequately and sensitively provided. It is indeed by enhancing women empowerment to take care of their own health and wellbeing to be able to seek the health service as and when they need it.

STRUCTURE OF THESES

Introduction

This thesis consisted of two essential parts. The literature review explored perspectives and experiences of women refugee and asylum seekers regarding the reproductive health care provision during their journey of seeking safe haven in the UK and globally. This review had informed the second focus of the research as it showed a gap in women experiences of reproductive care in transit and temporary camps. Being a Syrian migrant myself, was an added factor to investigating further the above gap particularly among Syrian women and their families displaced in neighbouring countries or stayed temporarily in transit camps while trying to reach a safe haven in Europe. Hence, the second part explored perspectives and experiences of Syrian Refugee women regarding the reproductive health care provision in transit and temporary camps on route to Europe.

A Reflexive Account

In this chapter, the researcher provided the contextual landscape to position the study with the focus on the Syrian civil war. It highlighted how personal and professional identities, experiences and interests shaped the development of the research.

Chapter 1: Purpose Chapter Set of the Scene: Background and Context

This chapter introduced the thesis structure and illustrated international and Syrian refugee's dilemmas given that the researcher is a Syrian immigrant herself. It briefed about the international social, clinical and political contexts of being a female refugee / asylum seeker. The international and national (Syrian) contexts were explained. It also outlined the main scopes of the two essential components of this thesis and its rationale.

Chapter 2: Methodology, methods and Study Design: Scoping Review, Secondary Analysis

This chapter detailed the approaches and methods used to undertake this study. It mapped the steps followed and the criteria adapted to select or exclude the research materials and content for both (Chapter 3) the scoping review of the literature and the secondary analysis of Syrian

women refugees experiences of reproductive care during transit and temporary camps (Chapter 4). It identified the research questions and the rationale of the content analysis as the approach chosen in evidence synthesis.

Chapter 3: Scoping Review

This chapter reviewed the literature relevant to women`s refugees experiences and perspectives of the reproductive care provision during their journey and the final destination. The outcomes from the scoping review of the literature was thematically analysed to inform the subsequent phase of exploring the position in the secondary data regarding the experiences of Syrian women refugees of reproductive care provision to in temporary and transit camps.

Chapter 4: Secondary Analysis: Mapping the experiences of Syrian Refugee Women Experiences of Reproductive Care in Neighbouring Countries and in Transit Camps

In this chapter reviewed the experiences and perspectives of Syrian refugees' women of reproductive care provision in neighbouring countries, temporary and transit camps were reviewed. Secondary data, including research reports were analysed. Results were presented based on two essential focuses that are: (i) Experiences and perspectives of Syrian refugee women displaced in Syria neighbouring countries (Lebanon, Jordan, and Turkey). The second focus is on (ii) the experiences and perspectives of Syrian women refugees in temporary/transit camps while on route to Europe.

Chapter 5 Discussion and Recommendations

This chapter discussed the findings of Chapter 4 and Chapter 3 implied by the global of perspectives of the literature. The chapter included a series of recommendations, reflecting on the research, policy and practice implications of the global approach and attitudes towards immigration

A REFLEXIVE ACCOUNT

Introduction:

This chapter reflected on the researcher's personal insights with regard to her Masters by Research based study to explore further the Syrian refugee experiences of reproductive health care provision in transit and temporary camps. As a reflexive piece, it is narrated in the first person.

Syria is my homeland, I am a medical doctor and I am a Syrian refugee in the UK. The above factors had influenced the focus of my theses. In this reflexive account, I briefly highlighted the important role of the Syrian civil war in shaping my biography and the development of the thesis and its underpinning study. It sought to illustrate how my personal and professional identities, experiences and interests influenced the shape of the thesis and the overarching views of the research.

Background context: The Syrian Civil War

The almost 9 years of the Syrian war had resulted of around 6 Million of Syrian refugees been internally and externally displaced in the neighbouring countries (Turkey, Lebanon, Jordan, Iraq, and other North African countries) of which 49.8 % are females and 29% are aged between 12-59 years. Both Turkey and Lebanon are accommodating 2,727,000 and 1,033,513 individuals respectively. In camps-population constitutes 493,633 (10%) individuals of the above, 49.2% are females and 27% are aged between 12-59 years. Moreover, 1,120,432 individuals claimed asylum in European countries between April 2011 and July 2016, 64% were claimed in Germany only. (UNHCR, 2016). Whilst official camps had been established by governments to accommodate Syrian families in Jordan and Turkey, the Lebanese government had refused that option. Families needed to privately rent, live with relatives or stay in tents provided by international non-governmental organisations NGOs.

Other Syrians had risked their lives and been smuggled trying to cross borders and reach safe haven in Europe. During this transit journey, Syrian asylum seekers including women heading households, or single women and young girls stayed in temporary centres near European countries borders such as Hungary and Serbia. As so many European states are struggling to

afford the basic but different human needs of those refugees, research efforts to identify health needs and practices were not a priority.

Evidence found in the literature showed that whilst the asylum journey itself could induce high levels of stress and anxiety in general; women and children are of a higher vulnerability due the effects and the re-traumatisation of violent events such as sexual abuse and exploitation. Importantly, the reproductive care networks are disrupted in temporary camps settings or/and the neighboring countries.

Medical Doctor and then Syrian immigrant

The dilemma refers to the overlap and the connection between my professional identity and my personal identity and life experiences since. I am a Syrian woman that needed to start a new life with her teenage daughter in the UK.I am the eldest daughter of a professional Syrian family, my mother was the head teacher of a secondary school in Damascus and my father was a professor of Economics and had several senior positions in different Syrian Universities. Although he had his education in different countries, he insisted to come back to Damascus, live and spend all of his life in Syria as his motherland. My sisters and I were brought up with 3 dominating concepts; 1) Education is the most strengthening tool especially for women and girls, 2) we should be so proud being females,3) we should be so proud to be Damascene girls as we are from the first inhabitant capital in the world .

I had graduated from the School of Medicine, Damascus University and had my internal medicine training for 4 years, worked in emergency and intensive care units of two Public Hospitals in Damascus; I ended up practicing as a primary care doctor in different primary care facilities in Damascus. After almost 10 years of clinical practice I wanted to have a better and a holistic understanding of health system functioning, health care planning and provision; I therefore had specialised in health systems management and got a Diploma from Liverpool School of Tropical Medicine. As a new training member of the Liverpool Collaboration Centre, the Centre of Strategic Health Studies I came to the UK to study a Master in Health Management Planning and Policy in the University of Leeds. My Master thesis was about enabling greater participation of Syrian women to utilise and make decision relevant to reproductive health care provision in Syria. Collecting and analysing data for my thesis had enriched my knowledge about the role of women empowerment and how socio-economic contexts can awfully influence the decision capacity of women and young girls to seek a service or not. Hence, I had a personal dream to discover further those links and obtain a PhD

in this domain. After returning from the UK on the year 2008, I have been appointed as the head of the Health Policy unit in the Ministry of Health in Syria. My role included taking decisions regarding the establishment of primary and secondary health facilities based on population demographic needs and other health indicators. It also involved setting the 5-year health plan in coordination with senior nationals and international stakeholders. This role had better introduced me to the conflicting political powers that influenced the health policies and priorities in my country.

Following that role, I wanted to experience working with an international none governmental organisations. I worked as the national coordinator for the International Organisation for Migration IOM Syria office, the project aimed at empowering Iraqi Refugee Women heading households and survivors of human trafficking. My role included commissioning vocational training providers for women to help them generate micro income for their families, raising awareness about human trafficking across urban and rural suburbs of Syria, supervising the shelter for human trafficking survivors and assessing their health needs and the care provision accordingly. In this role, I learned how women and children could be the most vulnerable groups in wars when human trafficking and sexual abuse are major risks they face. I also learned that generating an income even if it little can be quite empowering and a pride raiser. However, my best work experience in Syria was as a Technical officer for the health systems strengthening programme in the World Health Organisation WHO Country office. This essentially allowed me to contribute with colleagues in the Ministry of Health, Ministry of Higher Education, Ministry of Interior, local NGOs such as the Syrian Red Crescent and variable stakeholders in setting comprehensive and responsive health plans. Having worked previously with the Ministry of Health supported me in this position, as I was familiar with strengths and challenges facing the Syrian Health system. Sadly, enough, the health system in Syria, mortality, morbidity and the population health had dramatically been affected due the war. However, furthering my career by obtaining a PhD was a dream that wanted to embrace, and maybe this was the good tome for it. At that time 1,500,000 of Iraqi Refugees had been displaced in Syria, which imposed a major pressure on the Syrian health services, and we were as WHO team working closely with UNHCR medical team , the Syrian Red Crescent and the national colleagues to ensure that health care provision was as adequate as possible. Again, women and girls were the first to be affected by the tightness of services. Hence, my previous master thesis, my work with Iraqi refugee women and survivors of human trafficking and been a member of WHO team contributed in my choice of the PhD subject of

reproductive health care provision for Iraqi refugees in Syria. I therefore started searching and corresponding with UK Universities and I got my offer to do my PhD in Bangor University. I came to the UK, North Wales on October 2011. Due to the conflict having started in Syria, it was agreed with my supervisor that the focus of my PhD could be to explore the experiences and perspectives of Syrian refugee women refugees in neighbouring countries and in temporary transit camps. During my first supervision meeting, it was suggested that primary data maybe collected from Refugees camps for Syrians. However, as the conflict heightened completing fieldwork and collecting primary data for the research became unsafe and impossible in addition to few personal obstacles as a single mother of a teenaged girl , I had suspended my PhD and I returned back to do an Masters by Research degree.

Following the suspension of my PhD, I was in need of a full time work. Hence, I have joined BAWSO Women `s Aid to support women of families of ethnic minorities BME facing all sorts of gender based violence (Domestic violence, human trafficking, forced marriage and female genital mutilation FGM) I also led the Sanctuary project in coordination with Oxfam Cymru. In both roles, the aim of the support provided was to help women becoming independent, integrated and champions in their communities. I have met with women from different cultural background, they all shared common needs of dignity and respectfulness taking into account the severe vulnerability they have faced and their extra ordinary power to cope, survive and start again. Meanwhile, I had participated in lobbying for the Syrian Resettlement Programme in the UK, which resulted of the kind commitments of the UK government to resettle 20000 most vulnerable Syrian refugees in the next 5 years. My journey to further my career had passed through several pathways, from working for the Care Quality Commission, Wokingham Borough Council Public Health team, the Healthy Working team of Public Health Wales and currently as a Patient and Service User Experience manager for North Wales Central Counties.

My background as a Syrian woman, a clinical and health management professional and an immigrant that worked with refugees influenced my perspectives and understanding of the data collected and analysed. As a health professional, I was able to understand the efficiency, limitations and challenges faced when providing health care in transit and refugee camps settings. As a Syrian immigrant, I could understand maybe some of the trauma faced by women refugees, their losses and their resilience.

Being Syrian by origin and given that quiet a limited research is available about reproductive health care in transit settings; influenced me to analyse the experience of Syrian refugee women of reproductive health care provision in transit settings. This was undertaken by the secondary analysis of qualitative data was the only possible tool for me to explore experiences and perspectives of this particular groups of Syrian refugees. Due to safety concerns and logistic capacities, and being the single parent of a teenaged daughter; I was not able to neither travel to Syria neighbouring countries (Jordan, Lebanon and Turkey) nor visit other temporary transit camps where Syrian refugees had been temporarily accommodated.

Local/ University and jobs stories

In this section, I explained how the transformation of my study and the need to work full time resulted in transferring my PhD to a Masters by Research. However, the focus was retained as well as my passion for exploring perspectives and experiences of women refugees and asylum seekers about the reproductive health care with particular focus on Syrian refugees in neighbouring countries and transit camps.

On November 2011, I had started my PhD as a full time self-funded international student. The plan was to complete my systematic review, and undertake my primary data piece of work by meeting women refugees from different nationalities, this was planned to be facilitated by BAWSO Women`s Aid and the Welsh Refugee Council, Wrexham offices. After almost two years; and due to the implications of the war in Syria I needed to work full time to meet the needs of my household. I therefore suspended my PhD and started my work. When I returned to my study; I realised that a PhD was untenable as a full time working and single mother; my school and supervisors approved the transformation of the study to Masters by Research.

I was also keen to start a work in Public Health and I was offered a role in Wokingham Public Health team as a Public Health officer in Wokingham Borough Council, Berkshire, at the South of England where I needed to relocate. Luckily, I was recently able to return home to North Wales to work for Public Health Wales, as a Public Health Practitioner. I am currently the Patient and Service User Experience Manager Central for Betsi Cadwaldar University Health Board BCUHB.

Summary

This reflexive account attempted to position both myself as the researcher and the study into a context of conflict and adjustment. It sought to illustrate how my personal identity influenced my research interests and the methodology chosen to undertake this research.

A Syrian woman lived in Syria for 40 years, moved to the UK, and needed at some stage to accept that she cannot return home, a health professional that had previously occupied clinical and health management roles, worked with and supported BME and refugee women.

The research journey spanned a period of time that involved overcoming the dilemmas of homesickness, the feeling of guilt that I was safe and my home people were not, with the observation that my country and my past memories were systematically destroyed and taken from me and leading to the global vulnerability of millions of my people.

CHAPTER 1:

PURPOSE CHAPTER SET OF THE SCENE: BACKGROUND AND CONTEXT

1.1. Introduction:

This chapter introduced the structure of the thesis and its chapters; it provided a background about international refugees and asylum seekers dilemma including the clinical and the social contexts. The Syria conflict was outlined as part of setting the scene for the forthcoming chapter. The conceptual framework is also introduced.

1.2 Background

As a result of wars and conflicts, the recent years have witnessed a noticeable inflation of people who left their homelands seeking protection and new life in other countries (UNHCR, 2018). The vulnerability of those newcomers had imposed additional 'load' on the hosting health systems (Matlin *et al,*2018*)* Precisely, women and teenager girls in such circumstances are at increased risk of poverty and sexual persecution (UNHCR, 2018). Significant reproductive care needs maybe required at all stages of their asylum journey, transit and temporary accommodation where maternal morbidity and mortality can be of an extreme raise; and tailored care will affect positively the health and living conditions of the above population. (Matlin *et al,*2018*).*

Asylum seekers and refugees are groups of people that leave their countries of origin and ask for protection in another country due to fear of persecution in their homelands. They are highly heterogeneous groups faced difficult and variable circumstances before, during and after their arrival their last destinations. They are men, women and children in all ages with different cultural, socio economic and educational backgrounds, only fear and suffers had unified them and forced them to move and search for new life of dignity and protection. (Matlin *et al,* 2018*)*

The refugee person is the "*'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country*" Article 1, 1951 Convention Relating to the Status of Refugee. The asylum seeker is the person who had applied to stay and remain in the destination country and still awaiting the outcome of his application (the governmental decision).Refused asylum seeker is a person who failed to obtain asylum. Part of the refused asylum seekers return home voluntarily, some will be deported by the government, (Refugee Council RC, Unknown) and others will be living in the UK with no access to any welfare system or the ability to be work or continue their higher education. In the UK Asylum applications had dramatically increased during the last 2 decades. The total number of refugees, people in refugee-like situations and asylum seekers are estimated to be 253,235 according to UNHCR statistical yearbook 2010. 30% of asylum applicants were female on the year 2010 (Blinder, 2011).

1.3 Women as refugees and asylum seekers: The international context

The purpose of this section is to contextualise the different factors that may affect the health status of women refugees and asylum seekers. It explicated both the international clinical and social contexts, with the focus of the Syrian national context.

1.3.1 Clinical Context

Adding to the fact, that maternal mortality is higher by six times amongst refugees and asylum seekers women comparing with the UK childbearing women; different factors contribute in increasing pregnancy and labour complications and the deteriorated reproductive health amongst women refugees and asylum seekers worldwide. Having left their conflicted countries, most of the asylum seekers faced torture, assault, arrest, rape and the loss of their family members. Health services in such conditions are unlikely able to meet their overwhelming health needs. During the transition period and before reaching the final destination, refugees and asylum seekers do also struggle with insecurity, dangerous accommodations, and less hygienic conditions, which therefore increase the incidence of threatening life diseases. Women, girls and children are of the most vulnerability where sexual violence and exploitation might result of HIV/AIDS and sexual transmitted infections (STI). Given that reproductive health care may not be seen as a priority, antenatal care is

inadequately available and women might give unattended birth in unhealthy conditions (Matlin,*et al,*2018; Heselhurst *et al,*2018). Consequently, women arrive at the final destination with a worsened health situation especially if they survived a sexual abuse, rape or any kind of gender-based violence when pregnancy may add to the risks. Even the abortion in such conditions can be either illegal or unsafe (Lehmann, 2002).

In the UK, refugees and their dependants are eligible of full NHS care. They should receive a welcoming pack of how to access health services and they should be registered with GPs and dentists (Burnett &Fossil, 2000). However, it is reported that asylum seekers are facing many developed health problems due to difficulties in accessing needed health services, they struggle with problems in registering with a GP and accessing primary care and community services. Language barriers and lack of system awareness are also problematic (Faculty of Public Health FPH, 2008). Furthermore, health providers may not know the medical history of the patient or feel unfamiliar with some medical conditions such as Haemophilia or cultural practices such as Female genital mutilation FGM that is practiced to millions of African and Asian women. (Van Hangem *et al,*2011; Cottingham *et al*,2007;Kerimova *et al*,2003;Gassar *et al*,2004;Clifford,2008;McKay,1998;Johnson *et al,* 2004; Haynes and Cardozo,2000)

As per pregnancy among refugees and asylum seekers in the UK whilst arrival to the UK; National Collaborating Centre for Women's and Children's Health, 2010 stated in their guideline that although there was no accurate statistics about pregnancy rate among this specific group; direct and indirect maternal mortality had been doubled and tripled during the last 18 years from 4/1000 in 1997-1999 to 12/1000 in 2000-2002 and 36/1000 in 2003-2005.

1.3.2. Social Context

The social components of seeking asylum and refuge impose additional pressures on women life conditions and consequently their health wellbeing. When women leave their homelands to seek refuge, they are in many situations the only carers of the households where men are either killed or arrested. In transit/refugees' camps, women are required to afford the household basic needs of food, clothing and fuel for heating. Sexual favour could be therefore the price of these needs. Besides, camps are male dominant; women with their families are most likely accommodated in less quality and isolated tents, their security and safety are compromised; and they are threatened by rape and sexual abuse when perpetrators can be insiders, outsiders, or even humanitarian workers (Women`s Commission for Women and Children,2008) .

This socioeconomic insecurity may result of enforcing adolescent girls to accept early marriage. To reduce the households' financial pressures and protect girls of "potential shame" they may bring to the family early marriage is seen as a desired solution. This can cause increased and early reproductive health care needed where adolescents' awareness about such needs is limited and their empowerment to seek health care is restricted by patriarchy and male dominance, added to the fact that reproductive health care and maternity services are already limited in the camps context (Okanlawon et al, 2010; Benner.*et al*, 2010; Kulig,1995).

At the arrival at the final destination, ethnic differences and the new social contexts will influence seeking and receiving the reproductive care. (Lewis, 2007) stated that women with coming from different cultural contexts are less likely to seek antenatal care. (Mcleish, 2002) found that women refugees and asylum seekers felt that they were treated with rudeness, indifference and racism by their health professionals. Some women were less/ not involved in their care and treatment. The need to tailored maternity services that suit the particular social and cultural contexts of the targeted women was also mentioned. Although health providers were aware that that women refugees and asylum seekers are entitled to reproductive care when needed; in many cases midwives were unable to provide the adequate care to pregnant women as they know nothing about their medical history, social and psychological needs. Communication problems are challenging between the services providers and recipients. Interpretation services were costly and they were not always available. This resulted of the inadequate provision of reproductive care (Gaudion & Allotey, 2008; Kottegoda.et al, 2008; M.Henttonen.et al, 2008; Cottingham.et al, 2007; Beyani, 1995; Hynes and Lopescardozo, 2000;Hammoury et al,2009; Hans,2008;Campbell,2003;Haynes and Cardozo,2000 ; Keygnaert et al,2012;Kottegoda et al,2008)

1.4 The National (Syrian) Context

As the focus of chapter fife is to explore the experience of Syrian refugees and asylum seekers of the reproductive care in temporary settings and transit camps, hence a highlight the Syrian dilemma had been briefly explained here.

The 2011 uprising that was extended to be a nine year ongoing civil war had resulted of over 5.4 Million people fleeing Syria and seeking safety in the neighbouring Countries in Lebanon, Turkey, Jordan and beyond to Europe (UNHCR,2016) As part of this movement of people fleeing conflict approximately 50% were females (Figure 1).

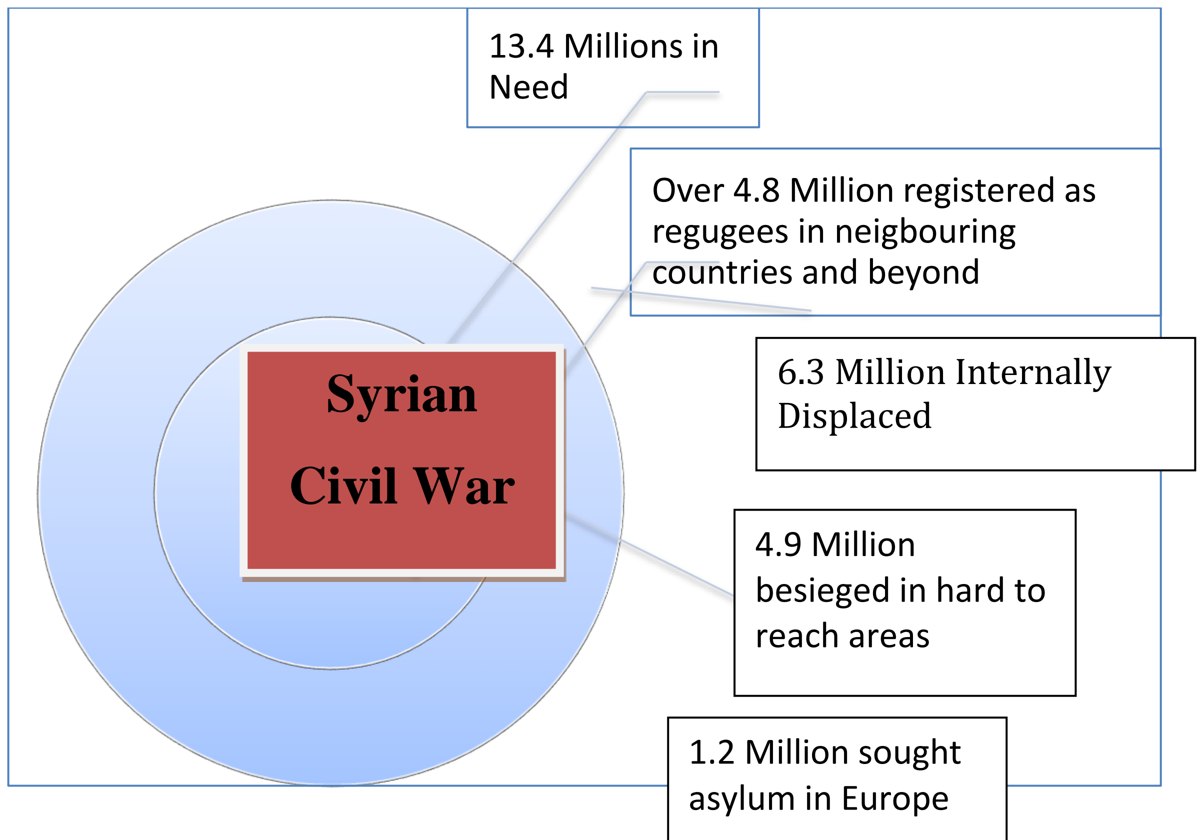


Figure (1) Internal and External displacement figures of Syrian Refugee (UNHCR Syria, 2018)

The situation in Syria in not getting any better despite the international players in the field, in fact this had dramatically added to the complexity of the conflict. While the Northern area of Syria had been occupied and controlled by different actors such as the Kurds, the Turkish , American and other troops fighting against each other with the Syrian regime and its Russian allies attacks; displacement particularly from the Northern Area is becoming a major humanitarian dilemma (Mercy Corps,2020)

1.5. the Conceptual Framework

While this theses explored the experience of refugees' women and girls regarding a health reproductive health care provision, conceptually, it is assumed that findings are not only influenced by the health services provision and providers. Women and girls positioned in a particular vulnerability, patriarchy and gender power that are steadily shaping the decision, the ability and the accessibility of seeking health care in general and reproductive care in particular.

Refugees escaping war zones and fleeing torture and prosecution are all vulnerable with no exemptions. After they have lost their homes, jobs and securities and left with their families to become internally or externally displaced, they are made powerless and incapable.

However, in societies that are culturally positioning male members of the families (fathers, husbands and brothers) in an upper position as honours guards and bread earners, women and girls can be seen as potential threats and additional economic burdens. Powerless, and dominated by males patriarchy, females are therefore of specific vulnerability where their gender is the main factor it.

Conceptually, findings of both the scoping review and the secondary data analysis does reflect the above.

1.5 Summary

This chapter set the scene of the following chapters; it provided a brief background about the international refugees' dilemma and some of its international aspects such as the clinical and social contexts. It also briefed about the Syrian current conflict and its impact of the global influx. Finally this chapter introduced the conceptual framework anticipated to be found in the following chapters.

CHAPTER 2:

METHODOLOGY, METHODS AND STUDY DESIGN: SCOPING REVIEW, SECONDARY ANALYSIS

2.1. Introduction

This chapter introduced the study design methods used to undertake both the literature review, and the secondary data analysis of the Syrian refugee women experiences of reproductive care in transit and temporary settings. It explained the completion of a scoping review of the literature and the secondary analysis of qualitative data. Thematic analysis was undertaken to synthesise data as appropriate. The three phases undertaken in this thesis have been detailed.

2.2. Phase 1: Scoping Review, A discussion of the approach to scoping:

The Scoping review is defined as a mapping tool that helps in determining the available volume and type of literature underpinning a complex topic of research. It identifies the emerged evidence, its depth and comprehensiveness and most importantly contributes in clarifying potential gaps of a complex context (Levac *et al*, 2010; Arksey&O`Malley,2005; Peterson *et al*,2017). Scoping the literature gave a detailed but holistic overview of the nature and the context of the relevant literature, it helps increase understanding and formulate consequently research questions and the targeted samples and informs gaps that require further investigation. (Munn.et *al*,2018) .

2.2.1. Study Design - Stages of the scoping review framework: (Figure 2)

Askey`s framework was used for the scoping review, five stages were followed as below.

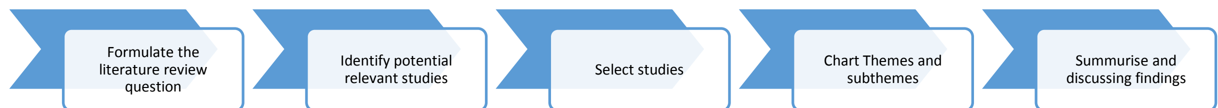


Figure (2) Stages of Askey`s framework of the scoping review

2.2.1.1 Stage 1: Formulate the research questions, the rationale for the scoping the literature:

A wide approach of research had been adopted to inform the scope and the excessiveness of the literature coverage. Undertaking a literature review is the first and the essential step that introduces the comprehensive evidence of a particular subject (Centre for Reviews and Dissemination CRD, 2009). This may inform policy makers to take evidence-based decisions and notify gaps that require future research and improvements.

Forced immigration resulted of wars and conflicts is imposing major challenges for both refugees and hosting countries. Woman, girls and children are of a particular health and social risks, and their particular health needs are unlikely to be met and reproductive health care and maternity services are not prioritised during all periods of the refuge journey. Scoping the literature contributed in identifying " what is known (Arksey&O`Malley,2005) with regards to essential issues experienced by women refugees such as the provision of reproductive and maternity care, barriers and tools of communication, women expectations toward health

providers and the appropriateness of the services especially when particular health and social needs exist. To further understand the subject of reproductive care of women refugees and asylum seekers, the researcher started her search using Google and Google Scholar search in addition to the official related websites such as the Refugee Council, Welsh Refugee Council, UNHCR and the Refugee Action websites. Found articles and research reports were in majority articles that highlighted challenges, circumstances and health needs faced by asylum seekers and refugees in general, women, and children in particular. International and national charities documents related to projects that assess the needs and evaluate the reproductive health care and maternity services provision to women seeking asylum and refuge were also collected and reviewed.

To formulate the literature review question, SPICE tool was applied. The tool defined Settings, Perspective, Intervention or Phenomenon of Interest, Comparisons and Evaluation.

This helped in creating an answerable question; particularly when the review is reliant mainly on secondary data (Booth & Brice, 2004). (Table 1)

Table (1) SPICE Tool:

Setting	Perspective	Phenomenon of interest	Comparison	Evaluation
Women seeking asylum and refuge aged between 15-50 years in any global context.	Perspectives of women seeking asylum and refuge.	Experiences of women seeking asylum and refuge regarding reproductive health care and maternity services provision during the different stages of their journey	Comparison undertaken across the different contexts Comparison was also undertaken with findings of the Syrian refugee women (Chapter 5)	Narrative comparison of experiences of women seeking asylum and refuge regarding reproductive health care and maternity services provision.

Given that the literature review explored services users' experiences and perspectives regarding the services provided to them and that beneficiaries are of a particular vulnerability and consequences, qualitative data facilitated going beyond the appeared conceptions, it was the tool to generate a profound knowledge of what is not ordinarily clear (Miles and Huberman, 1994). Reproductive health for women refugees and asylum seekers is a wide topic; hence scoping the literature improved the general knowledge of the topic, helped formulating the question of the literature review and influenced the focus of the following chapter.

The literature review question focused on: "What are perspectives and experiences of women seeking asylum and refuge regarding the reproductive health care and maternity services provided to them during their journey, globally and in the UK".

The gap identified by the literature influenced the secondary data analysis of Syrian refugee women experience of reproductive care in transit and temporary settings. (Chapter four)

The questions were:

1. What are experiences and perspectives of Syrian refugees' women of reproductive care provision in temporary camps of Syria neighbouring countries?
2. What are experiences and perspectives of Syrian refugees` s women of reproductive care provision in transit camps as part of their journey to Europe?

2.2.1.2. Stage 2: Identify relevant studies

To identify relevant studies, articles and research papers, Databases such as CINHAL, Web of Knowledge, ASSIA, and OVID were searched. International and National NGOS related research projects were also collected. For instance, published projects reports of Maternity Action, United Nations High Commissioner for Refugees UNHCR , International Organisation for Migration IOM and the Women`s Commission for Women and Children were also utilised. References list were screened as well to identify potential additional studies. (Appendix A).

2.2.1.3. Stage 3: Selecting studies

When undertaking the literature review and to avoid a substantial volume of literature that may not be specifically relevant; inclusion and exclusion criteria had been applied with relevance to the literature review question (Table 2). Hence, the number of included studies for the literature review was reduced from 107 articles to 47. The researcher stopped also when narrative became repeated with no new themes and subthemes emerged. (Please see Figure 3 the PRISMA Literature Flow)Table (2) Inclusion and exclusion criteria for the Literature review:

	Inclusion Criteria	Exclusion Criteria
Setting: Women asylum seekers and refugees aged between 15-50 years in any global context.	Experiences and perspectives of women asylum seekers and refugees regarding reproductive health care and maternity services provision after leaving their countries of origin and during all stages of their refuge journeys	Experiences and perspectives of women regarding reproductive health care and maternity services in their countries of origin
Perspectives: Perspectives of women asylum seekers and refugees	Age 15-50 years Women faced sexual violence during their refuge journeys. Single teenagers seeking asylum and refuge Different ethnic minorities Different socioeconomic contexts. Studies in English, Studies between1985-2018.	Women not seeking asylum and refuge. Women asylum seekers and refugees who did not receive maternity care. Men or other family members. Studies before 1985.
Phenomenon of interest : Experiences of women asylum seekers and refugees regarding reproductive health care and maternity services provision during the different stages of their journey	Qualitative studies and surveys of perspectives and experiences of women asylum seekers and refugees regarding reproductive health care and maternity services provision.	

Comparison: Comparison undertaken across the different contexts. Comparison will also be taken with the perspectives and experiences of Syrian refugees women (results of chapter 4)	Comparison conducted for reproductive health care and maternity services provision to women asylum seekers and refugees across the different contexts.	.
Evaluation: Narrative comparison of experiences of women asylum seekers and refugees regarding reproductive health care and maternity services provision.	Comparison conducted for reproductive health care and maternity services provision to women asylum seekers and refugees across the different contexts	

To ensure that all relevant literature is analysed, no quality appraisal had been undertaken

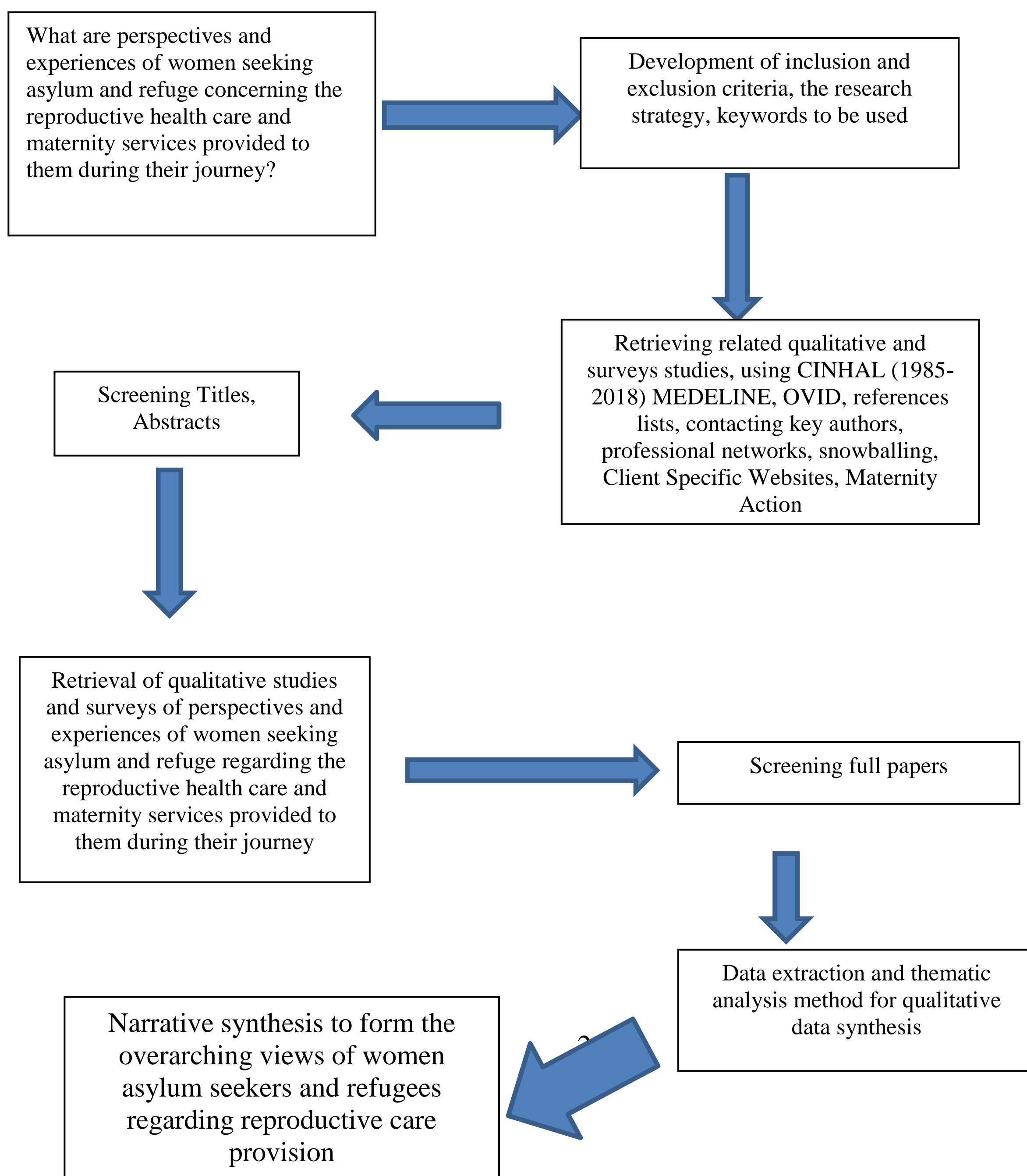


Figure (3): the literature flow PRISMA

2.2.1.4. Stage 4: Chart Themes and subthemes:

Prior to discussing results of the scoping review (Chapter 3), key findings had been displayed in tables as themes and subthemes where the referencing studies were sited next to them. Presenting qualitative data in tables and other visualised graphic figures for instance simplifies reading data reading and the connection with the relevant sources (Verdinelli &Scagnoli, 2013).Qualitative data charting is a technique to review and interpret the found results. (Richie & Spencer, 1994). Therefore, the main themes/subthemes that are affecting women refugees' experiences of reproductive care provision had also been displayed in figures in both the scoping review chapter and the secondary analysis of qualitative data. These figures surfaced the experiences and perspectives, potential overlaps and interactions.

2.2.1.5. Stage 5: Summarise and discuss findings

In the literature review chapter, themes and their relevant subthemes had been explained further. Similarities and contradictions had been analysed and discussed. Comparisons were made between the wide experience of women refugees explored in the literature review and the specific experience of Syrian refugees' experiences of reproductive care during their stay at neighbouring countries (Lebanon, Jordan, and Turkey) and in transit camps while crossing the borders to Europe. In the discussion chapter (Chapter five) results of the scoping review had been further discussed and compared with findings of the secondary analysis of the qualitative data (Chapter four).

2.3 Phase 2: Secondary Analysis of Qualitative data, secondary but not primary:

Secondary analysis of qualitative data is the "re- use" of previously existing data resulted of formerly undertaken research studies (Bishop &Kuula-Luumi, 2017). Heaton, (2008) described it as"reworking "with qualitative data. Analysing the secondary data collected and produced by another researcher as part of a primary research, can provide alternative tools when different factors may restrict the ability to undertake the primary research, particularly in an area where a wealth of studies had been already implemented. (Johnston, 2014; Irwin &Winterton, 2011).

This approach may be applied when the researcher aims at exploring a sensitive area such as women refugees and reproductive care and hindering barriers restrict undertaking the primary work directly with the above specific population (Long-Sutehall *.etal,* 2010). Utilising secondary analysis of qualitative data by an independent researcher may have an added value as additional focus would be originated from the original piece of work (Heaton, 1998). Qualitative data facilitates going beyond the appeared conceptions, and generates a profound knowledge of what is not ordinarily clear (Miles & Huberman, 1994). For instance, while international organisations tried to explore refugee women experiences and perspectives of reproductive care in camps; the researcher in this thesis was keen to explore in particular the experiences and perspectives of Syrian women in temporary settings such transit camps on their route to Europe. The researcher was not able to undertake a primary research due to safety concerns, travel restrictions and most importantly the challenging circumstances of establishing contacts with such vulnerable yet specific groups of refugees. Hence, analysing secondary qualitative data contributed in discovering further the specific interest of the study.

2.3.1. Study Design - Secondary Analysis of Qualitative data

Heaton, (2008) described the secondary analysis of qualitative data as "revisiting" qualitative findings that are explored and published by other researchers. Functions of this method may include answering new questions or/and analysing in depth previous results. In this study, the researcher tried to answer questions related to the gap identified by the scoping review, with a specific focus on the Syrian refugee's women in temporary and transit camps only. It was indeed revisiting similar researched questions but for a very specific groups and settings.

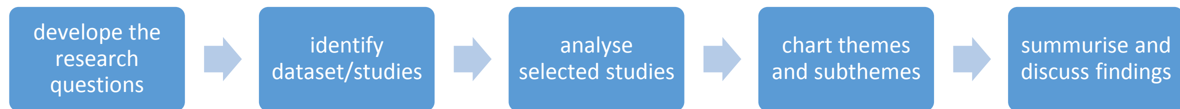


Figure (4) the process of Secondary Analysis of Qualitative data:

2.3.1.1. Stage 1. Develop the research questions:

The starting point of the Secondary Data Analysis is to have an acceptable theoretical knowledge of the researched area (Johnston, 2014).The scoping review had equipped the researcher with the initial platform of knowledge about experiences and perspectives of women refugees regarding the reproductive care. Most importantly, it informed a gap in such experience in temporary and transit camps settings. After 9 years of the Syrian civil war, the influx of displaced population is still imposing present and quite acute humanitarian obstacles.

Based in the above research questions had been identified. (**Figure 5**)

1. Experiences and perspectives of Syrian refugee's women of reproductive care provision in temporary camps in Syria`s neighbouring countries.
2. Experiences and perspectives of Syrian refugee' women of reproductive care provision in transit camps as part of their journey to Europe.

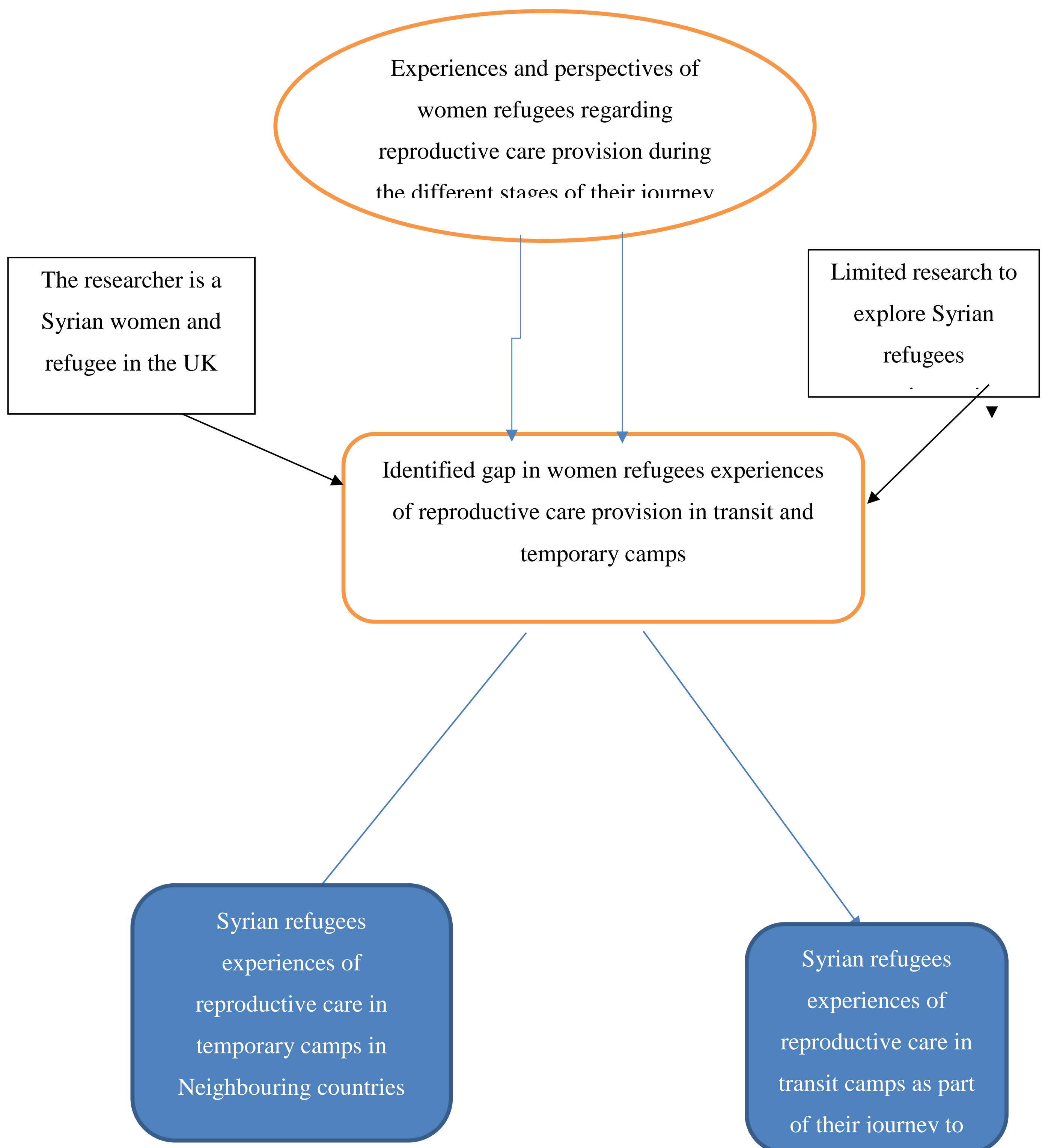


Figure (5) Factors affected the development of the study question

By identifying the specific questions, the researcher was able to select the relevant studies for the secondary data analysis phase.

2.3.1.2. Stage 2. Identify Dataset/studies:

Having the questions in hand, informed the dataset/studies used for chapter four. Projects and services evaluation reports undertaken by local and international Non-Governmental were included. Nonetheless, only articles that explored the Syrian women experiences during their stay at Refugees camps and neighbouring countries (Lebanon, Jordan, and Turkey) and in transit camps while crossing the borders to Europe were included had been analysed.

The researcher applied her subjective judgment in appraising the quality of materials found to ensure that no relevant evidence is missed as only few reports can be found for Syrian refugees in transit camps for instance. (Appendix A)

2.3.1.3. Stage 3. Analyse selected studies

Thematic analysis had been used to analyse the Secondary Qualitative studies. To ensure that no potential theme and subtheme are being missed, the researcher analysed the research materials manually and line by line. When reviewing the selected articles, the scoping review findings had influenced themes and subthemes of the Secondary Qualitative studies. Although similarities were clearly noticed between the global related context and the Syrian context, some specific findings were highlighted. (Braun & Clarke, 2006; Boyatzis, R. E., 1998; Nowell. *et al,* 2017; Maguire& Delahunt, 2017)

2.3.1.4. Stage 4. Chart themes and subthemes, summarise and discuss findings

Similarly to the literature review, themes and subthemes emerged after analysing the Secondary qualitative studies had been presented in charts with their relevant studies. Figures had also been used to easily illustrate Syrian refugee women experiences in temporary and transit camps. (Verdinelli &Scagnoli, 2013). Findings were explained, discussed and compared in line with the scoping review findings.

Recommendations had been drawn up accordingly.

2.4. The Thematic Analysis in qualitative research

Thematic analysis is the tool to identify process, analyse and come up with emerged themes/patterns from the qualitative data (Boyatziz, 1998). Data can be described and richly detailed for interpretation and synthesising; aiming at answering the research questions. Braun &Clarke (2006) argue that although the thematic analysis is the foundation of the qualitative research analysis; it should be seen as a distinguished method by itself.

This method provides the researcher the tool to synthesise rich, detailed yet complex qualitative data (Austin&Sutton, 2014). An emerged theme catches data that is raising an important but relevant answer to the asked questions; it may formulate a meaning taken from the data set. It is up to the researcher judgement to decide what a theme could be, and the "size/space "of it. (Braun & Clarke, 2006). In other words, analysing the data was based on the "theoretical "thematic analysis; as the researcher analytical interests had influenced the themes emerged and analysed. In the study, only themes that are relevant to the research question were included and fully explained. In this instance, themes that describe perspectives and experiences of women refugees and asylum seekers about reproductive care provision globally and in the UK are to be included in the literature review while themes that describe Syrian refugees' experiences of reproductive care provision in Syria neighbouring countries and temporary camps during their journey to Europe are to be included. Found articles may report other relevant themes that are not going to be interpreted and analysed if it does not answer the main questions. For example, experiences of male refugees or women refugees for other than reproductive care, or none Syrian refugees (Chapter 4) are not analysed in this research.

While the constructionist approach in thematic analysis is looking at producing and reproducing themes; the realistic/ essentialist approach explores and describes real experiences. As the research questions are looking to explore and describe experiences; the realist/essentialist thematic analysis is applied when identifying and analysing themes. (Braun & Clarke, 2006). Analysing the experience of Syrian refugee women in temporary and transit camps is a lived experience; it is real, vivid and long standing.

Thematic analysis is an effective method when exploring experiences and perspectives of variable settings of people. It highlights similarities and differences. It is also useful when a large amount of data is analysed. Thematic analysis is flexible and simple to apply which will

help the researcher to adequately structure the report and clearly present the data (Nowell *et al*,2017). Both social and psychological interpretation of data can be facilitated by adapting the thematic analysis (Braun & Clarke, 2006; King, 2004; Nowell. *et al,* 2017).

Both the scoping review and the secondary analysis of qualitative data chapter aimed at exploring experiences of groups of high level of vulnerability. In addition, a huge sum of the literature was collected. Hence, thematic analysis simplified the narrative analysis of the data. It also highlighted interesting and unanticipated insight when exploring the experiences of women globally, in the UK and for Syrian refugees in temporary settings.

Thematic analysis allowed a systematic and structured narrative analysis. However, in order to ensure trustworthiness of a good thematic analysis; the data had been coded to a fair level of details with equal attention given to each theme (Nowell *et al*,2017). Synthesised themes had been coherently identified, discussed and compared against each other (Please see Table 2 and Table 3)

The stages utilised in analysing the data were based on Braun & Clarke (Figure 6).

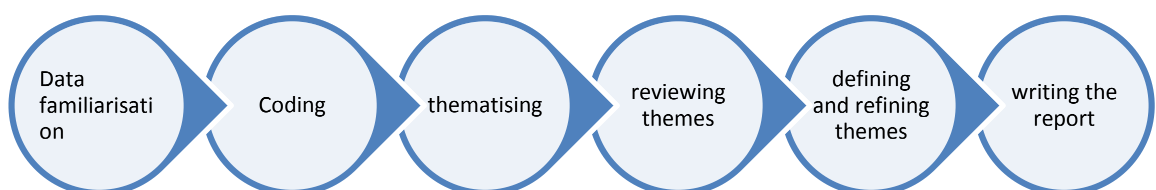


Figure (6) Stages of Thematic Analysis (B& C)

2.4.1. Data familiarisation

In order to familiarise herself with the subject and understand further what to focus on with regard to the reproductive care provision for refugees and asylum seekers women ; the researcher started by searching: *Google and Google Scholar*, *International and local None Governmental Organisations NGOS such as the UNHCR, the Refugee Council, the World Health Organisations*. This pre-search highlighted challenges, circumstances and difficulties faced by women and girls. Scoping the literature crystallised the researcher understandings of the dilemma faced by women and girls as results of displacement and wars. It contributed to deciding what to focus on, and how in depth the data would be analysed. Most importantly, it informed a gap in experiences of women refugees needing to receive reproductive care but in transit and temporary settings.

Influenced by her personal interest as a Syrian immigrant herself as well; the researcher had read in details all collected articles and had therefore established clearer thoughts of what and how deeply her themes are to be identified and then analysed.

2.4.2 Generation of initial codes

Coding is the identification of data features that are "interesting" for the researcher. It is the process of arranging and sorting the data into meaningful groups. Following this step, all data may be assembled on the base of relevancy to each code. (Nowell.*et al,*2017)

It is important to recognise that codes here are not themes. Where a group of codes may formulate one theme, another code can be a theme by itself, or a sub theme. Themes start appearing when the data is consequently interpreted. (Nowell.*et al,*2017)

The researcher had manually coded the data. Line by line, all details had been given equal attention with the aim of recognising the interesting and relevant sets of data that may formulate a repeated theme / pattern. Codes were not pre-set, there were developed as the researcher was reading and working through her materials
(Braun&Clarke,2006;Maguire&Delahunt,2017).

2.4.3. Identification of themes /Data synthesis

After capturing the list of codes; thematising is to sort variable codes into themes, it is really mapping the data and gathering those that are relevant to each theme together.
(Braun &Clarke, 2006; Nowell.et al, 2017) The researcher in this stage analysed the extracted

data and categorised them as themes or subthemes. When coding and thematising the scoping review data, the researcher tended to include as much sources of data as possible with regards to women refugees and asylum seekers experiences in the UK and Globally. Coding such a significant lot of collected materials had helped in informing the focus of secondary of qualitative data analysis and its questions that need exploring (chapter 4)

2.4.4. Review of themes

In this stage, the researcher would have reviewed and refined the final themes and their supporting data. (Nowell,*et al*,2017). For instance, some themes might have too little data to support them so they can formulate a subtheme rather than a separate one; others are too loaded and can be considered as more than one theme (Braun&Clarke, 2006). Nonetheless, checking whether the thematic mapping has accurately represented the data depends strongly on the theory, question or phenomenon of interest (Boyatziz,1998). When the refined data is no more adding value on the existing overarched themes, analysis can be then completed (Braun&Clarke,2006).

2.4.5. Themes definition and naming

Following the completion of refining themes and subthemes, the researcher explained what each theme is about (Braun&Clarke, 2006). Naming themes is giving a" hint of the story "that they are telling (Nowell, *et al*,2017). It is also defining the subthemes within each theme; should the data in the theme are complex. (A subtheme is a theme within the theme).

Due to the wealth of the data collected, extracted and analysed for the scoping review, in order to exploring a wide question (Experiences and perspectives of women refugee and asylum seekers regarding the reproductive care provision Globally and in the UK) many themes and subthemes had been synthesised and identified.

To explore experiences of Syrian refugee women of reproductive care in temporary and transit camps during their journey to Europe (The secondary analysis of qualitative data chapter 4) and due to the limited found sources; fewer themes had been identified and emerged. When using the work "emerged theme" it is essential to remember that themes only appear on the base of the researcher aim and the theory to be explored (Nowell et al,2017;Braun & Clarke, 2006).

2.4.6. Report writing

Writing the report was telling the story of the data collected and extracted, it aimed at showing the validity and the worth of the analysis. The story telling in the report needs to be holistic, comprehensive, interesting and succinct where repetition is to be avoided (Braun & Clarke, 2006;Nowell et al,2017). The report did not only introduce the data extracted and the sufficient evidence linked, it provided a narrative analysis that exceeded data description and presented an interesting argument. (Braun & Clarke, 2006; Boyatzis, R. E., 1998; Nowell. *et al,* 2017; Maguire& Delahunt, 2017).

Meta Ethnography, Synthesising Qualitative Studies

Meta Ethnography is one of the most utilised but influential approaches in synthesising multiple primary qualitative studies, (Noblet& Hare,1988; France *et al,* 2019), It conceptualises data and goes beyond the individual synthesis of primary studies to interpreting evidence and creating a new model/theory. Most importantly Meta Ethnography may highlight how individuals or users of health care and social care visualise their experiences (France *et al*, 2019)

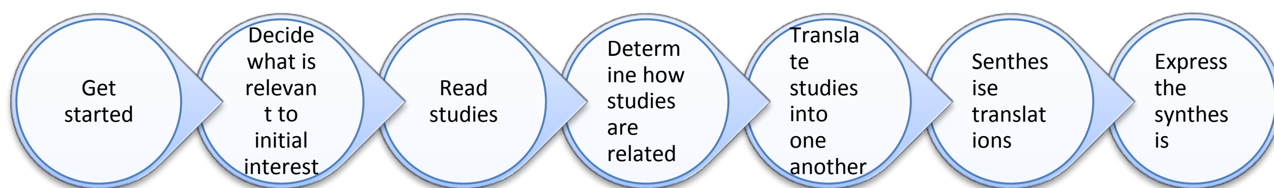
Although, Noblet and Hare had not standardised methods of synthesising qualitative studies, Meta Ethnography facilitates the personal contribution of reading, understanding and translating the data upon the individual perspectives of the researcher.

On other words, data emerged from studies is interpreted across and synthesised by being directly compared against similarities and contradictions (Britten.*et al*, 2002; France *et al*, 2019)

Scoping the literature and thematically analysing the secondary data highlighted the urgency and the need to specifically focus on exploring the experience of refugees in transit camps for instance. Meta Ethnography of the qualitative research studies allowed the researcher to interpret her understanding to explore the particularities of this group of people, Syrian women refugees that are externally displaced either in neighbouring countries or in transit camps as part of their journey to Europe for a safe but final destination.

Comparing with the scoping review, being refugees and displaced in other countries might not appear as unique, however uniqueness comes out of being Syrians , most importantly being

accommodated in transit and short term camps while travelling to Europe , alone or with children , it is the temporariness that influences experiences, highlights or hinders needs, strengths and weaknesses.



Get Started:

Figure (5) showed how the Scoping review had equipped the researcher with the initial platform of knowledge about experiences and perspectives of women refugees regarding the reproductive care. Precisely, it informed a gap in such experience in temporary and transit camps settings.

Nobilt and Hare said" 'identifying an intellectual interest that qualitative research might inform'(Noblit & Hare,1988 p 26-27).   Considering that the Syrian war is still continuing to be a huge humanitarian problems ; and given that the researcher is positioned in such a crucial era where exploring further the experience of Syrian refugees in neighbouring countries and short term transit camps became an initial stimulator for narratively analyse the available qualitative and related research work.

Decide what is relevant to initial interest

Based on the researcher initial interest of exploring the experiences of Syrian refugees' women. Projects and services evaluation reports undertaken by local and international Non-Governmental were included. Nonetheless, only articles that explored the Syrian women experiences during their stay at Refugees camps and neighbouring countries (Lebanon, Jordan, and Turkey) and in transit camps while crossing the borders to Europe were included and had been analysed.

The researcher applied her subjective judgment in appraising the quality of materials found to ensure that no relevant evidence is missed as only few reports can be found for Syrian refugees in transit camps for instance. (Appendix A).

Although grey literature might have been included with the possibilities of reports findings to be driven by the NGOs and local third sector organisations interests and agendas, themes and subthemes were similar and compliant with the scoping review findings. When trying to find further articles exploring women refugees experiences in transit camps, studies did not specify whether these camps were long or short term camps. Nonetheless, no studies about Syrian refugees in short term camps were found apart of the three synthesised projects reports. As mentioned, findings were logical, hypothetically relevant to the settings and harmonised with the scoping literature review themes.

Read studies

In order to identify main concepts, studies had been carefully read. (Britten.*et al*, 2002; France. *et al* , 2019) Nablit and Hare, 1988 stated that the more the researcher is familiar with the concepts, the deeper are the interpretation and the extraction of themes. (Atkins et al, 2008) . 14 articles had been read and extracted (Table 3 explains the features of the selected studies)

Determine how studies are related

Meta Ethnography was used to answer the below two questions:

- Experiences and perspectives of Syrian refugee's women of reproductive care provision in temporary camps in Syria`s neighbouring countries.

- Experiences and perspectives of Syrian refugee' women of reproductive care provision in transit camps as part of their journey to Europe.

Studies that were related to exploring the experience of Syrian women refugees displaced in Syrian Neighbouring countries had been "put together" , analysed, compared and synthesised. The same was also applied on studies and projects reports that explored in particular the experience of Syrian women refugees staying in transit and short term camps while travelling to Europe to seek safety.

This was applied by implying a " Key Judgmental Call" (Nablit &hare,1988;Britten *et al,* 2002;Atkins et al, 2008; France et al, 2019)

- Comparing similarities within articles that are directly related
- Stating differences and none agreeability, although articles are exploring similar experiences.
- Drawing conclusions out of similarities and arguments accordingly

Translate studies into one another

To explore experiences of Syrian refugee women of reproductive care in Syrian Neighbouring countries, research/projects reports and articles that were implemented in Lebanon, Jordan, and Turkey had been studied and linked with each other. Findings were presented in a table

Nonetheless, Syrian women experience in temporary settings and transit camps were analysed and also presented in a table. When using the work "emerged theme" it is essential to remember that themes only appear on the base of the researcher aim and the theory to be explored (Nowell et al,2017;Braun & Clarke, 2006).

It is important to highlight that at all stages, attention had been given to linking assumptions and findings of what knowledge the researcher had established. (France.*et al*, 2019)

Synthesise translation

When themes had been influenced by a specific concept (vulnerability, patriarchy and gender power) Synthesising the interpreted data is to go beyond the clear findings of each study, it is formulating and overarching synthesis by comparing what was found in each article against

the others in preparation of expressing them accordingly . (Atkin et al, 2008;France et al, 2019).

Express synthesis

It is expected that the targeted audience of presented synthesis are Academics and qualitative researchers, Third Sector , national and international NGOs, Policy makers (Health, Border agencies ,,) It is indeed communicating the findings applying convenient tools.
The researcher had already presented the findings in North Wales Red Cross , as they are supporting Syrian refugees as part the Syrian Resettlement Programme in the UK

It is aimed that findings can be published and relevant national and international conference will also be targeted

.2.5. Summary

This chapter introduced methods used to undertake this thesis. It explained the scoping review steps, the secondary analysis of qualitative data, Meta Ethnography of qualitative data and the thematic analysis approaches. Factors influenced the selection of these methods had been also explained in addition to the phases followed.

CHAPTER 3

SCOPING REVIEW RESULTS:

REFUGEE WOMEN'S EXPERIENCES OF REPRODUCTIVE CARE PROVISION GLOBALLY AND IN THE UK

3.1 Introduction

This chapter introduced the background of the scoping review. Main findings were presented as a series of themes and relevant subthemes. The main six themes consisted of: **1**.the provision of the reproductive health care and maternity services for women refugees and asylum seekers. **2.** The communication barriers and the interpretation services. **3**. Relations of women refugees and asylum seekers with their health providers' expectations and perspectives. **4.** Adolescents reproductive health care and maternity services.5. Reproductive Health Care for Refugees, Asylum seekers women facing sexual, and gender based violence.**6.**Reproductive health care and maternity services in refugee and transit camps. A Synthesis Model had mapped the overall results.

3.2. Background

According to United Nations High Commissioner for Refugees UNHCR, the United Kingdom is ranked to be the seventh country of destination for many countries of origin such as Zimbabwe, Afghanistan, Iran, Syria, Eritrea, Pakistan, Sri Lanka, Somalia, Iraq and other African Countries (UNHCR, 2011). In the UK,. The total number of refugees, people in refugee-like situations and asylum seekers are estimated to be 152,623 according to UNHCR statistical yearbook 2017.

Although Refugees and asylum seekers are eligible of full NHS care with their dependants, it is reported that they are facing many developed health problems and they are classified as part of the most vulnerable and excluded groups (Faculty of Public Health FPH, 2008; Department of Health, 1999). As per the pregnancy among refugees and asylum seekers in

the UK, no accurate data is available, however, it is stated that 13% of women seeking asylum arrived to the UK in Kent were pregnant (Le Feuvre *et al*., 1999).
The UK national maternity care standards are ideally taking into considerations the vulnerability and the specific needs of refugees and asylum seekers (The Royal College of Obstetricians and Gynaecologists RCOG,2008), even though mortality rate among refugee women and asylum seekers is reported to be higher than white UK women; it is six times higher amongst Black African women. Caribbean and Middle Eastern new arrivals are also experiencing significant differences in morbidity and mortality comparing with women of UK origin (Lewis, 2007). Given that medical pre-existing conditions among the above groups might be influencing the reported higher maternal morbidity and mortality, factors related to the maternity care provision after arriving to the UK and during the different stages of their dispersal until their final settlement are also contributing in the poorer outcome and increased related health risks (Knight.*et al*, 2009).

Based on the above, scoping the existing qualitative studies that describe experiences and perspectives of women asylum seekers and refugees either in the UK or internationally may assist in better understanding the actual health needs and requirements of those group of specific needs and higher vulnerability and highlight any existing gaps of refugee women experience of reproductive care in transit and temporary settings.

3.3. Results

Evidence was synthesised from 44 articles. Qualitative articles and project reports were thematically analysed. Results had been presented as ***6*** main themes. Each theme has its grouped subthemes explained accordingly. Table (3) listed all themes, their relevant subthemes and the relevant scoped articles.

The identified themes were:

1. The provision of the reproductive health care and maternity services for women refugees and asylum seekers
2. The communication barriers and the interpretation services.
3. Relations of women refugees and asylum seekers with their health providers' expectations and perspectives.

4. Adolescents' reproductive health care and maternity services.

5. Reproductive Health Care for Refugees, Asylum seekers women facing sexual, and gender based violence

6. Reproductive health care and maternity services in refugee and transit camps.

The table was followed by explaining findings in details as appropriate.

Table (3): Experiences and perspectives of women seeking asylum and refuge regarding the reproductive health care provided to them

Themes	Subthemes
The provision of the reproductive health care and maternity services for women refugees and asylum seekers	**Women awareness about the available services and the health system in the country of settlement.** - Lack of knowledge about how, when and where reproductive care is provided. (Carolan and Cassar, 2008), (Campbell et al,2007), (Merry.*et al*,2011).(Carolan,2010), (Norredam *el al*,2005),(Murray.et al, 2010), (D`Souza and Garcia,2004), (Beecher Bryant,2011),(Alzate,2007),(Donelle and Harrison,2004), (Gannan et al,2004),(Downe et al,2009), Mengesha.*et al*,2017), (Sudbury & Robinson, 2016), (Asif *et al*,2015), (Heslehurst *et al*,2018) - Difficulties in booking for antenatal and postnatal care (Norredam *el al*,2005) (D`Souza and Garcia,2004), ,(Ascoly et al,2001), (Reynolds and White,2010),(Caroll et al,2007) - Differences and complexities of the new health systems. (ILiadi,2008),(Gurnah et al,2011), (Norredam *el al*,2005) (Murray.et al, 2010), ,(Ascoly et al,2001), (Sadbury & Robinson, 2016), (Heslehurst *et al*,2018) - Lack of awareness about what reproductive care is available for women,(ILiadi,2008), (Norredam *el al*,2005), (Murray.et al, 2010) ,(Beecher Bryant,2011) ,(Ascoly et al,2001) (Reynolds and White,2010), (Chynoweth,2008), (Alzate,2007) (Downe et al,2009)., - (Mengesha.*et al*,2017), (Heslehurst *et al*,2018)

	- The need of the health visitors to accompany women to the health facilities for receiving the services. (Dernnan and Joseph,2005)
	The geographical access to reproductive health care and maternity services. - The geographical barriers restrict women from accessing the reproductive and maternity care when needed and as appropriate (Bosmans.*et al*, 2008) (Carolan,2010), ,(Kottegoda.et al, 2008) - Women are not able to access the go to seek the health service from the health facility without the permission of her husband or mother in law.(Furuta and Mori,2006). - Women not being able to access hospitals when they are in labour due to insecure situation (Bosmans.*et al*, 2008),(Purdin et al,2009),(Wayte. et al,2008) - Health providers cannot attend women when they are giving birth at camps. (Bosmans.*et al*, 2008) - Newly arrived women are not geographically familiar with the locations of health facilities. (Carolan,2010)
	Women perspectives regarding the need of antenatal, postnatal care and family planning. - Women form some African backgrounds cannot recognize the need and the importance of antenatal care(Liampittong Rice and Naksook,1998),(Futura and Mori,2006), ,(Carolan and Cassar, 2008), (Beecher Bryant,2011), (Mengesha.*et al*,2017) , (Heslehurst *et al*,2018) - The concept of pregnancy as a normal and essential role of women ((Liampittong Rice and Naksook,1998),(Futura and Mori,2006), ,(Carolan and Cassar, 2008) ,(Beecher Bryant,2011). - Basic needs in the new lives such as safety, food, work are prioritised until a serious health problem is noticed,(Carolan and Cassar, 2008),. (Carolan,2010), (Dernnan and Joseph,2005) ,(Beecher Bryant,2011), (Mengesha.*et al*,2017) - Due to the unstable migration status, women avoid seeking RHC for themselves. (Merry.*et al*,2011) (Carolan,2010), (Dernnan and Joseph,2005), ,(Ascoly et al,2001), (Asif *et al*,2015)

	- Screening services during the pregnancy are unusual and not required. (Pavlish et al,2010), (Mengesha.*et al*,2017) - Antenatal, postnatal and the continuity of care are highly evaluated comparing with RHC at home.(Liampittong Rice and Naksook,1998), (ILiadi,2008), (Straus et al, 2007). (Herrel et al,2004), (Correa-Velez and Ryan,2011) - Contraceptives are not accepted due to religion believes, pregnancy is a privilege and the children are gift especially when thousands are killed (Gurnah et al,2011), (Bosmans.*et al*, 2008), (Chynoweth,2008) or - The use of contraceptives is mandatory due to fears of losing the governmental support. (Gurnah et al,2011) - Decisions related to contraceptive use need the approval of husbands (Gurnah et al,2011), (Morrison,2000), (Campbell et al,2007), (Alzate,2007),),(Kottegoda.et al, 2008) , (Mengesha.et al,2017) - Contraceptives are highly required but not adequately available in refugee camps when poverty, unemployment and sexual assault are challenging conditions.(Benner.et al, 2010) - Insufficient knowledge about contraceptives methods and misconceptions about their impacts, utilisation and side effects.(Kulig,1988), (Wayte. et al,2008).
	Women perspectives regarding reproductive care provided in the community health centres - Midwives and nurses were supportive, sympathetic and none judgemental in the community centres. This increases the attendance and the continuity of care,(Carolan and Cassar, 2008), (Gurnah et al,2011), (Herrel *et al*.2004), (Sulliavan.et al,2004),(Tsianakas and Liamputtong,2002) (Nabb,2006), - Higher antenatal appointment attendance as women enjoyed meeting women from their communities and communicating with them using their own languages (Carolan and Cassar,2008). - Women can be subject of racism; midwives therefore separated refugees of the other attendees. (Carolan,2010), (Nabb,2006) - The preference to be seen by the same midwife (Carolan and Cassar, 2008), (Straus et al, 2007). (Correa-Velez and Ryan,2011) (Murray.et al, 2010), - Midwives were unfamiliar with FGM and incapable of dealing with this special medical need, women therefore

	were evaluated as high risk cases (Murray.et al, 2010). (Upvall.*et al*,2008), - Midwives were not familiar with contraceptive tools in Thai camps community centres. - Worries about the side effects of the different contraceptives restrict women of seeking these tools. (Okanlawon et al, 2010). - The preference of obtaining contraceptives from the community centres rather than the mobile clinics due to the sensitivity and the privacy preference. (Wayte. et al,2008)
	women perspectives regarding reproductive care provided in the hospitals - Women were treated with no respect, stereotyped and their needs were ignored in hospitals ((Liampittong Rice and Naksook,1998), (Herrel *et al*.2004), (Carolan,2010) (Murray.et al, 2010),(Tebid.et al,2011). ,(Ascoly et al,2001),(IOM,2011) (Kennedy and Lawless,2003),(Gannan et al,2004), (Chalmers and Hashi,2000). (Heslehurst *et al*,2018) . - Feeling isolated and lonely (Carolan and Cassar, 2008), (Pavlish et al,2010), (Murray.et al, 2010) (Tebid.et al,2011)., (Kennedy and Lawless,2003) - Health providers; including midwives are sympathetic and supportive especially in the postpartum stay in the hospital. (Correa-Velez and Ryan,2011), (Murray.et al, 2010), (Nabb,2006) (Kennedy and Lawless,2003), - Women trust more physicians rather than midwives (Liampittong Rice and Naksook,1998), (Reynolds and White,2010), (Gannan et al,2004). - Women are unfamiliar and /or confused with some medical practices such as midline episiotomies, pain management and ultrasound. (Carolan and Cassar, 2008), (Herrel *et al*.2004) (Correa-Velez and Ryan,2011), (Pavlish et al,2010), (Murray.et al, 2010), (Upvall.*et al*,2008), (Chalmers and Hashi,2000). - Fears of death due the caesarean section (Essen.et al,2010), (Amersekere.et.al,2011),(Vangen et al,2003). - CS is more performed to Somali women, late attendance to the hospital for giving birth due to fears of CS (Essen.et al,2010), (Herrel *et al*.2004), (Amersekere.et.al,2011), (Murray.et al, 2010), (Chalmers and Hashi,2000).

	- CS is performed only because women have FGM for Somali women (Essen.et al,2010), (Amersekere.et.al,2011) - Cs was performed due to labour complications, women were informed by the health providers (Liampittong Rice and Naksook,1998), (Amersekere.et.al,2011) - Induced abortion was the result of the inappropriate use of contraception (Straus.*et al*, 2011), (Alzate,2007) - A longer postpartum stay in the hospital was always seen as problematic for the household. (Murray.et al, 2010) - Women request further antenatal education and about hospital services and departments.(Norredam. et al,2005), (Correa-Velez and Ryan,2011), (Murray.et al, 2010) (Tebid.et al,2011)., (Tsianakas and Liamputtong,2002) - Time given to women during the antenatal care in the hospital was not adequate and they could not have all the information they need. (ILiadi,2008), (Pavlish et al,2010), (Murray.et al, 2010), (Tebid.et al,2011). - Long waiting time when attending hospitals appointments. (Correa-Velez and Ryan,2011) - Confidentiality in getting the information and the treatment of HIV in hospitals (Anderson and Doyle, 2004).
	The need for transportation and baby care during services provision. - Affording the transportation to attend antenatal care is problematic among refugees and /or failed asylum seekers who are not receiving any financial support. (Merry.*et al*,2011), (Correa-Velez and Ryan,2011), ,(Beecher Bryant,2011),(Kennedy and Lawless,2003) (Alzate,2007), (Kottegoda.et al, 2008) (Caroll et al,2007), , - Providing baby care when attending the antenatal and postnatal care is required. (Merry.*et al*,2011), (Correa-Velez and Ryan,2011). (Kennedy and Lawless,2003) - Prioritising domestic and family responsibilities might restrict women to attend antenatal appointments. (Tsianakas and Liamputtong,2002) (Downe et al,2009)., (Sadbury & Robinson, 2016), (Mengesha, et al, 2017)
	The impact of dispersal on the continuity of reproductive health care and maternity services provision - Routine antenatal screenings such as ultrasound and routine blood tests are missed. (Nabb,2006)

	- Continuity of antenatal and postnatal care or HIV treatment for HIV patients- is affected by the continuous movement (Straus.*et al*, 2011),),(Merry.*et al*,2011), (Dernnan and Joseph,2005) ,(Beecher Bryant,2011), ,(Ascoly et al,2001) (Reynolds and White,2010), - The connection with women could be missed in the new place. (Dernnan and Joseph,2005) (D`Souza and Garcia,2004), ,(Beecher Bryant,2011), (Reynolds and White,2010) - Difficulties in building trust with health providers when women are seen by changeable health staff or even for health visitors,(Ascoly et al,2001) - Dispersing women just before or after giving birth affects adversely women and new-borns health(Dernnan and Joseph,2005), (Reynolds and White,2010) (Nabb,2006), - The temporary dispersal accommodation is not healthy, basic needs such as nappies, baby clothes, and sterilisation are not afforded for many women ,(Beecher Bryant,2011) (Reynolds and White,2010), (Nabb,2006), (Kennedy and Lawless,2003) (Anderson and Doyle, 2004), - Difficult life conditions when sharing life with strangers. (Reynolds and White,2010), (Kennedy and Lawless,2003), (Kennedy and Lawless,2003) (Anderson and Doyle, 2004),
	Financial restrictions and women eligibility - Women entitlement of free reproductive and maternity depends on the resettlement countries and the stage of asylum seeking process. (Norredam *el al*,2005), (Beecher Bryant,2011) ,(Ascoly et al,2001), - Failed or undocumented asylum seekers might not seek antenatal , postnatal routine care and contraceptives due to financial difficulties (ILiadi, 2008), (Kurth et al,2010), (Carolan,2010), (D`Souza and Garcia,2004) ,(Beecher Bryant,2011) ,(Ascoly et al,2001),(IOM,2011), ( Asif *et al*,2015) - NGOs support the provision of RHC&MS. (ILiadi,2008), (Norredam *el al*,2005), ( Women`s Commission for Women and Children,2008),(UNFPA,2008),(Henttonen et al,2008) (Anderson and Doyle, 2004),.

	- Antenatal appointments can be refused if residency documents are not introduced to administrative staff (Norredam *el al*,2005) (Alzate,2007) , - Unsafe abortion can be performed if women cannot afford to have it in private clinics. (Kurth et al,2010) (Alzate,2007) ,
	Psychological support provision - Loosing families members, torture and sexual violence are reasons of the postpartum depression (Dernnan and Joseph,2005),(Beecher Bryant,2011) - The asylum seeking process, the insecurity and the isolation experienced in the new place can be reasons of induced abortion (Kurth.*et al,*2010) (Reynolds and White,2010) (Asif *et al*,2015), (Heslehurst *et al*,2018) - Insufficient psychological support and expertise was reported by resettled asylum seekers. (ILiadi,2008), (Campbell et al,2007), (Straus et al, 2007). (Merry.*et al*, 2011), (Carolan,2010), (Norredam *el al*,2005), (Dernnan and Joseph,2005),(Gannan et al,2004). - Anxiety; stigma, low self-esteem and fear of death are all described by women. (Reynolds and White,2010) (Kennedy and Lawless,2003), (Anderson and Doyle, 2004), (Heslehurst *et al*,2018)
Communication barriers and the interpretation services	**The availability of interpretation services** - The availability of the adequate interpretation services is essential for women and health providers as well. (Kennedy and Lawless,2003) (Liampittong Rice and Naksook,1998),(ILiadi,2008), (Correa-Velez and Ryan,2011) (Murray.et al, 2010), (IOM,2011). (Kennedy and Lawless,2003), (Asif *et al*,2015), (Heslehurst *et al*,2018) - Inadequate interpretation services affected negatively women attendance of antenatal care or seeking contraceptives (Straus.*et al*, 2011), (Heslehurst *et al*,2018), (ILiadi,2008),(Gurnah et al,2011). (Campbell et al,2007),). (Merry.*et al*,2011) (Carolan,2010), (Norredam *el al*,2005), (Murray.et al, 2010) ,(Beecher Bryant,2011) ,(Ascoly et al,2001), (Gannan et al,2004) (Downe et al,2009). - Available interpretation services encourage women to attend the antenatal appointments (Carolan and Cassar, 2008) (Caroll et al,2007), - Inadequate available interpretation services in hospitals. (Liampittong Rice and Naksook,1998), (Carolan and Cassar, 2008), (Gurnah et al,2011), (Straus et al, 2007), (Murray.et al, 2010) (Carolan,2010), (Correa-Velez and Ryan,2011), (Pavlish et al,2010), (Murray.et al, 2010)

	The need of female interpreters - Women feel embarrassed of discussing and sharing such symptoms with stranger males. (Gurnah et al,2011), (Correa-Velez and Ryan,2011) (Caroll et al,2007), - Women avoid involving their partners in related conversations. - Female interpreters are essential to obtain RHC&MS (Kulig,1988). (Upvall.*et al*,2008),
	The impact of communication and language barriers on exchanging the medical information and interpreters capacity - Women were unable in many situations to understand what their health professional told them even with the interpretation assistance. (Gurnah et al,2011) (Upvall et al, 2008), (Pavlish et al,2010), (Murray.et al, 2010) ,(Ascoly et al,2001), (Asif *et al*,2015) - Women felt embarrassed of repeating questions or asking for further explanations regarding health instructions to be taken or prescriptions given especially when special condition is existed such as FGM(Gurnah et al,2011). (Upvall et al, 2008), (Pavlish et al,2010) (Murray.et al, 2010), - Interpreters were not familiar with the medical terms which affected the accuracy of the health and medical instructions (Straus et al, 2007), (Correa-Velez and Ryan,2011), - The language of the interpreters was not the same spoken language. (Gurnah et al,2011),
	Friends and family members as interpreters - The need of friends and other family members to interpret during antenatal appointments (Liampittong Rice and Naksook,1998), (Murray.et al, 2010) (Nabb,2006), - Partners and children as interpreters restrict women of telling everything about their body and reproductive health. (Upvall et al, 2008), (Murray.et al, 2010), ,(Ascoly et al,2001), (Mengesha.*et al*,2017) - Friends and the same community members as interpreters threaten the privacy and the confidentiality of women. (Murray.et al, 2010), (MacFarlane et al, 2009) ,(Ascoly et al,2001), - The adequacy of shared information is not ensured in most cases as friends and family members are not

	familiar with the medical terminology. (MacFarlane et al, 2009). - The informal relation between women and their interpreters might result of interfering in the discussion and not sending the same message told by women to their health providers or vice versa. ,(Ascoly et al,2001)
	Inferiority feelings - Interpretations services were provided without considering the actual need or the choice of women. (Herrel *et al*.2004) (Pavlish et al,2010), (Asif *et al*,2015), (Heslehurst *et al*,2018) - Indirect communication between women and their health providers caused inferiority feelings among women. (Gurnah et al,2011). (MacFarlane et al, 2009)
	Adequate communication, preference of oral communication and body language and communication different tools - Direct oral communication and sympathy shown by health staff are highly appreciated for some backgrounds (Straus et al, 2007), (Sulliavan.et al,2004), (Pavlish et al,2010) (Vangen et al,2003), (Caroll et al,2007) - GPs and physicians are seen as the direct source of information (Liampittong Rice and Naksook,1998), (Herrel *et al*.2004), (Sulliavan.et al,2004), (Amersekere.et.al,2011), (Pavlish et al,2010), (MacFarlane et al, 2009) - Direct body contact is not always preferable(Tsianakas and Liamputtong,2002) - Male GPs, Gynaecologists and obstetricians should make attention to their body language and direct touch particular groups due to religion contexts. (Tsianakas and Liamputtong,2002) - Phone calls as a tool to remind women about their antenatal appointments encouraged them to attend. (Herrel *et al*.2004) - Translated leaflets that provide health information with the women languages are effective, but the direct contact by the staff is more preferable. (Herrel *et al*.2004), (Straus et al, 2007), (Sulliavan.et al,2004). (Vangen et al,2003) (Caroll et al,2007), - Bilingual workers and the availability of adequate interpretation services increase the access to maternity services in the UK. (Hobbs et al,2012), (Nabb,2006)
Relations of women refugees and asylum seekers with their health providers,	**Stereotyping and racism faced** - Health professionals are treating women with sympathy and respect. (Liampittong Rice and Naksook,1998),

expectations and perspectives	(Sulliavan.et al,2004), (Murray.et al, 2010), (D`Souza and Garcia,2004) (Nabb,2006), (Kennedy and Lawless,2003), (Asif *et al*,2015), (Heslehurst *et al*,2018) - Women treated as unintelligent with racism and stereotyping. (Upvall et al, 2008), (Herrel *et al*.2004) (Carolan,2010), (Pavlish et al,2010) ,(Tebid.et al,2011). ,(Ascoly et al,2001), (Tsianakas and Liamputtong,2002), (Kennedy and Lawless,2003)
	Women trust in health providers, their capacity and knowledge about their special needs. - Health care providers are not adequately able to understand and deal professionally with FGM (Upvall et al, 2008), (Straus et al, 2007). (Murray.et al, 2010) ,(Ascoly et al,2001),(Vangen et al,2003), (Chalmers and Hashi,2000). (Caroll et al,2007) , (Asif *et al*,2015) - Caesarean section was highly performed; (Essen.et al,2010), (Straus et al, 2007).(Herrel et al, 2004). (Pavlish et al,2010), (Murray.et al, 2010) - Midwives assumed that giving birth with FGM especially with the third degree (infibulation) is extremely difficult. (Murray.et al, 2010),(Vangen et al,2003) - Women might not trust health visitors or providers due to their previous home fears from the officials or considering them sent by the home office. (Dernnan and Joseph,2005),
	Cultural competency and sensitivity of RHC&MC provision - Cultural acceptance increases antenatal and postnatal care attendance and enhance contraceptive utilisation (Carolan and Cassar, 2008), (Caroll et al,2007), (Heslehurst *et al*,2018) - **Health** professionals are not adequately aware about women social and cultural needs ((Liampittong Rice and Naksook,1998), (Norredam *el al*,2005), (Correa-Velez and Ryan,2011), (Pavlish et al,2010). ,(Tebid.et al,2011), (Ascoly et al,2001), (Tsianakas and Liamputtong,2002), (Alzate,2007), (Gannan et al,2004),(Chalmers and Hashi,2000), (Chalmers and Hashi,2000), (Downe et al,2009). (Sadbury & Robinson, 2016) , (Heslehurst *et al*,2018) . - Women preference of female health professionals (Gurnah et al,2011), (Liampittong Rice and Naksook,,1998), (Kulig,1988). 1998),(ILiadi,2008), (Upvall et al, 2008), (Murray.et al, 2010). (Tsianakas and Liamputtong,2002), (Caroll et al,2007),

	- Women with FGM were treated culturally insensitive by health professionals (Upvall et al, 2008) (Vangen et al,2003), (Chalmers and Hashi,2000). (Caroll et al,2007) - Health professionals were surprised or disgusted with FGM.(Upvall et al, 2008) (Vangen et al,2003), (Chalmers and Hashi,2000). . - The need for culturally sensitive health education materials (Herrel et al,2004). (Caroll et al,2007)
	Women involvement in decision making - Women felt uninvolved in decision making related to their health and wellbeing especially for the need of Caesarean Sect ion(Straus et al, 2007) (Herrel *et al*.2004), (Pavlish et al,2010) (Murray.et al, 2010), (Tebid.et al,2011), (Chalmers and Hashi,2000) (Caroll et al,2007),. - Women felt uninvolved in pain management tool(Murray.et al, 2010) - women with FGM are unable to discuss their special needs and concerns with health professionals, (Upvall et al, 2008) (Pavlish et al,2010), (Murray.et al, 2010) (Caroll et al,2007), (Tebid.*et al*,2011),
Adolescents reproductive health care and maternity services	**the availability of RHC&MS for adolescents and their related awareness** - Early forced marriage, intimate partner violence, insufficient education and unemployment constitute major problem amongst refugees communities. (Benner.*et al*, 2010). (Kottegoda.et al, 2008) - Adolescents accept the fact that sexual and gender based violence is acceptable among couples. (Benner.*et al*, 2010) - Contraceptive access and use are problematic for particularly unmarried adolescents (Okanlawon et al, 2010), (Benner.*et al*, 2010). - Adolescents are inadequately aware about the different tools they can use for protect themselves against the sexual transmitted diseases or unwanted pregnancies (Benner.*et al*, 2010). (Alzate,2007) - Adolescents are aware about the risk of unintended pregnancy and the unprotected sex (Okanlawon et al, 2010) (Benner.*et al*, 2010),. - Difficulties in accessing these tools if available (Okanlawon et al, 2010), (Benner.*et al*, 2010), (Alzate,2007) - Feeling embarrassed to seek condoms or other tools is leading to the inadequate use

	- Misconceptions about contraceptive impact and side effects. (Okanlawon et al, 2010). (Benner.*et al*, 2010), (Kulig,1995) - The inadequate use of contraceptives caused the high pregnancy rate among adolescents. (Alzate,2007) - Information related to the sexual life is obtained inaccurately from mothers and friends (Pavlish et al,2010), (Benner.*et al*, 2010) - Parents feel that it is inappropriate to share sexual conversations between mothers and teenage girls(Pavlish et al,2010) ,(Kulig,1995).. - The need for adequate information that can be obtained from professional health workers. (Pavlish et al,2010), (Benner.*et al*, 2010)
	Health providers attitude toward the need and provision of RHC&MS - Adolescents do not need or should use contraceptives - Health providers do not provide the related counselling and family planning for this specific group. ((Morrison,2000) - Health professionals are not always familiar that sexual and reproductive services are guaranteed for adolescents. (Alzate,2007)
	Community attitude toward needs and provision of Reproductive care - Adolescents' communities and families do not acknowledge their reproductive health needs (Okanlawon et al, 2010). - Information related to sexuality and reproduction should not be provided and discussed with single adolescents (Kulig,1995), - Adolescents do not seek the reproductive health care including the contraceptive advice when needed (Morrison,2000)
Reproductive Health Care for Refugees, Asylum seekers women facing sexual, and gender based violence	- In some communities using contraceptives was forbidden by husbands thinking that these tools will encourage women of having additional sexual relations; this resulted of higher sexual and domestic violence. (Kottegoda.et al, 2008) (Mengesha.*et al*,2017) - Women are raped by their husbands without the ability to refuse the sexual intercourse (Morrison,2000) - Higher complications are resulted of unsafe abortions amongst adolescents who have not been treated adequately following rape and sexual abuse. (Women`s Commission for Women and Children,2008)

	- Inadequate health care provision. (Women`s Commission for Women and Children,2008), (Wayte. et al,2008) - Adolescents survivors of sexual and GBV are inadequately treated. ( Women`s Commission for Women and Children,2008) - Although preventive treatments for survivors of sexual violence and rape were available in some camps; the demand for these treatments was limited. (Women`s Commission for Women and Children,2008) - Staff working in RHC&MS clinics in Jordan denied providing emergency contraceptives to rape survivors and antenatal care for pregnant women that did not provide marriage certificates.(Chynoweth ,2008)
Reproductive health care and maternity services in refugee and transit camps.	- Women are not aware about delivery kits available in refugee camps and distributed by UNFPA(UNFPA, 2011) - Women recognise the importance of contraceptive and family planning tools to protect them for unwanted pregnancies resulted of rape and the sexual exploitation they may face.(Morrison,2000) - Although women prefer spacing in child bearing; a little demand of family planning is reported as women prefer having more children and it is against god (Futura and Mori,2006) - Women accept FGM as a normal practice for “the social belonging” (Futura and Mori,2006), (Okanlawon et al, 2010),. - Women prefer home delivery attended by the visitor midwife although they are not easily accessible.(Futura and Mori,2006). - FGM is performed for girls near to marriage. (Futura and Mori,2006) - Women cannot use contraceptives without their husbands’ permission. (Morrison,2000), - Women recognise the need to use contraceptives in camps ,even though misconceptions about the side effects, or embarrassed to ask for (Morrison,2000) - Women show reservations to give contraceptive to unmarried women (Cambodians) ,(Morrison,2000) - The location of the camp imposed barriers to access contraceptives for adolescents ((Okanlawon et al, 2010). - Transportation is not accurately available for pregnant women who show pregnancy risks and need immediate attention and hospitalisation. (Women`s Commission for Women and Children,2008)

	- Psychosocial support was provided mainly from the humanitarian bodies. (Women`s Commission for Women and Children,2008)

3.3.1. The provision of the reproductive health care and maternity services for women refugees and asylum seekers

Evidence synthesised had shown that multiple factors can affect the provision of reproductive health care to women asylum seekers and refugees and during the different stages of their refuge journey. The above factors were categorised following the narrative synthesis of the evidence as below:

- **Women awareness about the available services and the health system in the country of settlement**: women who arrived recently to the country of settlement lack the required knowledge of the available reproductive and maternity care. (Carolan & Cassar, 2008; (Campbell et al,2007; Merry.*et al*,2011;(Carolan,2010; ;Norredam *el al*,2005;Murray.et al, 2010; D`Souza and Garcia,2004; Beecher Bryant,2011; Alzate,2007;Donelle and Harrison,2004;(Gannan et al,2004;Downe et al,2009). They are not aware about how and when the services are provided; therefore booking for their antenatal or postnatal care will be difficult (Norredam *el al*,2005; D`Souza and Garcia,2004;Ascoly et al,2001;Reynolds and White,2010; Caroll et al,2007;Mengesha.*et al*,2017;Sadbury & Robinson, 2016;Asif *et al*,2015; Heslehurst *et al*,2018).

- The difference and the complexity of the new health systems restrict them from seeking the needed care, most women seeking asylum are coming from countries where health systems are irresponsive and dramatically affected by the chronic conflicts (ILiadi,2008;Gurnah et al,2011;Norredam *el al*,2005;Murray.et al, 2010; Ascoly et al,2001;Sadbury & Robinson, 2016).This new position had weakened women who are already in a burden position. On the other hand, effective partnership among women and health providers can be described when health visitors who visit women seeking asylum in South London needed to explain the system of the maternity care provision. They added that they sometimes needed to accompany women to the medical practice and their contribution affected positively women awareness about the new system ,(ILiadi,2008;Norredam *el al*,2005;Murray.et al,

2010; Beecher Bryant,2011;Ascoly et al,2001;Reynolds and White,2010; Alzate,2007;Downe et al,2009;Dernnan and Joseph,2005; Heslehurst *et al*,2018) .

- These findings are globally common, for instance; in Colombia internal displaced refugees women are not aware about the available reproductive care for them. In Jordan, Iraqi refugee women lacked also the knowledge that maternity care is available for them free of charge (Chynoweth,2008).

- **The geographical access to reproductive health care and maternity services**: It is found that the geographical barriers restrict women from accessing the reproductive and maternity care when needed and as appropriate (Bosmans.*et al*, 2008; Carolan,2010; Kottegoda.et al, 2008). Refugee camps are most likely located near the borders of the conflicted countries, accessing the health facility therefore will impose potential risk on women safety. Wars and armed conflicts result of women not being able to access hospitals when they are in labour, similarly, health providers cannot attend women when they are giving birth at camps (Bosmans.*et al*, 2008;Purdin et al,2009;Wayte. et al,2008) . Besides, as the newly arrived women are not geographically familiar with the locations of health facilities, they are reluctant and unable to obtain the required services when needed (Carolan,2010). Adding to the fact of the geographical barriers, women capacity to seek the maternity care required was restricted by the patriarchy of husbands and mothers in law. This finding is not particularly associated with seeking asylum and refuge situation; it is related more to the social position of women and the patriarchal inferiority. .(Furuta and Mori,2006; Asif *et al*,2015)

- **Women perspectives regarding the need of antenatal, postnatal care and family planning**: Previous home experiences and perspectives regarding the need for early routine antenatal care influence women behaviour when arriving to the country of settlement. (Liampittong Rice and Naksook,1998; Futura and Mori,2006; Carolan and Cassar, 2008; Beecher Bryant,2011; Mengesha.*et al*,2017) . Women form some African backgrounds cannot recognise the need and the importance of antenatal care. They are raised with the concept of pregnancy as a normal and essential role of women where such a pre-labour care is a luxury, basic needs in their new lives such as safety, food, work are prioritised until a serious health problem is noticed (Carolan and Cassar, 2008; Carolan,2010; Dernnan and Joseph,2005; Beecher Bryant,2011) .

Women used to categorise themselves under the role of household carers and child bearers, therefore it was unusual for them to receive health care for normal duties such as pregnancy and prenatal care. (Merry.*et al*,2011;Carolan,2010; Dernnan and Joseph,2005; Ascoly et al,2001; Mengesha.*et al*,2017)

- Screening services during the pregnancy, blood tests, ultrasounds performed are also seen as unusual and not required (Pavlish *et al*,2010). Meanwhile and when they were in the position to decide; other groups of pregnant women highly evaluate the antenatal and postnatal care provided to them when they compare the level and the quality of care with their previous home experiences. Somali women in the USA consider that antenatal care prevents them from pregnancy complications and therefore they are keen to have the entire regular test needed, postnatal care was also given a high preference .(Liampittong Rice & Naksook,1998; ILiadi,2008; Straus et al, 2007; Herrel et al,2004; Correa-Velez and Ryan,2011). As per the family planning and contraceptives use, multiple factors affected the decision and the ability of women from different backgrounds to seek contraceptives.
- Women do not accept the use of contraceptive tools. they are raised with the concept of children seen as god gifts and birth should not prohibited for any reason especially when conflicts and wars resulted of thousands killed (Gurnah et al,2011;Bosmans.*et al*, 2008; Chynoweth,2008) sometimes the use of contraceptives could be obligatory in order not to lose the governmental support (Gurnah et al,2011). On the other hand, as many women living in refugee camps and may be victims of sexual assault, or due to poverty and hardships, they prefer to use contraceptive tools but they cannot access the effective contraceptive counselling, or tool provision .In many communities, utilising contraceptives is basically influenced by husbands permission (Gurnah et al, 2011;Morrison, 2000; Campbell *et al*,2007; Alzate,2007; Kottegoda.et al, 2008; Mengesha.*et al*,2017)
- Additionally, the Insufficient knowledge about contraceptives methods and misconceptions reported regarding the side effects of each tool contribute also in the insufficient utilization of contraception tools (Benner.et al, 2010;Kulig,1988;Wayte. et al,2008). In some refugee communities, women are forbidden of using contraceptives as their husbands think that women will be encouraged of having extra sexual relationships. This resulted of less protection against sexual transmitted

diseases and HIV/AIDS. As noticed, women position in the communities they came from influenced their perspectives and experiences toward the need and the utilisation of the reproductive health care and maternity services.

- **Women perspectives regarding reproductive care provided in the community health centres**: partnership between health professionals particularly midwives and women varied depending on the community and health providers. This partnership affects either negatively or positively on women attendance and perspectives of reproductive care. (Carolan and Cassar, 2008; Gurnah et al,2011; Herrel *et al.*2004 :Sulliavan.et al,2004 ;Tsianakas and Liamputtong,2002; Nabb,2006). For instance, African women in Melbourne preferred community health centres for obtaining the required reproductive and maternity care. They described midwives and nurses as supportive , sympathetic and not judging them if they were unfamiliar with the system or having particular medical needs such as Female Genital Mutilation, and they enjoyed meeting women from their communities and communicating with them using their own languages. This positive experience encouraged women who do not prioritise antenatal care to attend the clinic and accept the new health system basics. However, midwives in some clinics in the UK noticed that women visiting a community medical practice can be subject of racism shown by other UK attendees and they are consequently been separated of the other attendees (Carolan,2010;Nabb,2006)..

- Being seen by the same midwife during the antenatal care improves the attendance in the UK. This supports the fact that effective partnership between midwives and women improve women perspectives toward the services provision (Carolan & Cassar, 2008;Straus et al, 2007; Correa-Velez and Ryan,2011; Murray.et al, 2010). Notably, the mentioned partnership was not enhanced in many situations. Many studies stated that women felt as midwives were unfamiliar with FGM and inadequately capable of dealing with this special medical need, and therefore women were evaluated as having a high risk pregnancy (Murray.et al, 2010; Upvall.*et al*,2008).

- With regard to the contraceptive and family planning tools, women in Thai refugee camps found midwives as not experts of providing the appropriate contraceptive tools or the suitable related counselling. Worries about the side effects of the different

contraceptives were restricting women of seeking these tools although they needed them for the unwanted pregnancy protection (Okanlawon et al, 2010). In Timor East women preferred obtaining contraceptives from the community centres rather than seek them from the mobile clinics due to the sensitivity and the privacy preference (Wayte. *et al*,2008). In Jordan, the staff working in a RHC&MS clinic denied providing emergency contraceptives to rape survivors and antenatal care for pregnant women that did not provide marriage certificates (Chynoweth,2008).

- **Women perspectives regarding reproductive care provided in hospitals**: Women in many studies reported different and contradicted experiences during their maternity hospitals visits for antenatal routine ultrasounds, giving birth or during their postpartum stay. Women needs and particular circumstances were not always met in the hospitals, partnership between the women and health providers also varied. Being treated with no respect, stereotyped and ignored was mentioned, besides are feelings such as being isolated and lonely (Liampittong Rice and Naksook,1998; Herrel *et al*.2004;Carolan,2010; Murray.*et al*, 2010; Tebid.*et al*,2011;Ascoly et al,2001; IOM,2011; Kennedy and Lawless,2003; Gannan et al,2004; Chalmers and Hashi,2000; Carolan and Cassar, 2008; Pavlish et al,2010; Murray.et al, 2010; Heslehurst *et al*,2018) .Midwives in other studies were described as sympathetic and supportive especially in the postpartum stay in the hospital (Correa-Velez and Ryan,2011; Murray.et al, 2010; Nabb,2006; Kennedy and Lawless,2003) . Misconceptions regarding the role of midwives was noticed, trust was highly given to gynaecologists particularly in giving birth and this was inherited of the previous home experiences (Liampittong Rice & Naksook, 1998; Reynolds and White,2010; Gannan et al,2004).

- Talking about their birth experiences, Somali women were unfamiliar with some medical practices such as midline episiotomies as it is less practiced in Somalia. Fears of death due the caesarean section were described (Carolan and Cassar, 2008; Herrel *et al*.2004; Correa-Velez & Ryan,2011; Pavlish et al,2010;Murray.et al, 2010; Upvall.*et al*,2008; Chalmers and Hashi,2000). To avoid CS women were lately attending the hospital which resulted of higher birth complications. According to Somali women perspectives, CS is more likely to be performed because they do have FGM (Essen.*et al*,2010;Amersekere.*et.al*,2011;Vangen *et al*,2003;Essen.et al,2010; Herrel *et al*.2004; Amersekere.et.al,2011; Murray.et al, 2010; Chalmers and

Hashi,2000; Essen.et al,2010; Amersekere.et.al,2011; Liampittong Rice and Naksook,1998), (Amersekere.*et.al*,2011). A longer postpartum stay in the hospital was always seen as problematic for the household (Murray.et al, 2010). Women were also unfamiliar about pain management during the labour. In such conditions when women are experiencing medical and social contexts that hugely differ to what they used to have in their homelands, women will feel misunderstood and unable to control their body and their own life. Therefore enabling greater partnership among women and their health providers; women perspectives of reproductive provision in hospitals would be improved. Moreover, further antenatal education particularly about hospital services and departments was required. (Norredam. *et al*,2005; Correa-Velez & Ryan,2011; Murray.*et al*, 2010; Tebid.*et al*,2011; Tsianakas & Liamputtong,2002). Many women reported that the time given to them during the antenatal care in the hospital was not adequate and they could not have all the information they need. (ILiadi,2008; Pavlish et al,2010; Murray.et al, 2010; Tebid.*et al*,2011). Long waiting time was also reported when attending hospitals appointments (Correa-Velez and Ryan,2011) . Sub-Saharan women with HIV positive need particular care when arriving to the final destination. Although HIV is highly occuring in many African and Sub-Saharan countries, the majority of these women got the disease due to sexual exploitation they faced during their transitional travel or from their partners. Experiencing Stigma feelings and their worries of meeting people from their communities was expressed, even though they described the hospital as a safe environment and an effective source of the relevant information. They were keen to attend their appointments where their confidentiality is ensured and the continuity of the therapy was maintained (Anderson and Doyle, 2004)

- **The need for transportation and baby care during services provision**: In order to attend for antenatal and /or postnatal care, women mentioned the need to afford their transportation; as financial difficulties often existed, particularly among failed asylum seekers who are not receiving any financial support. (Merry.*et al*,2011; Correa-Velez & Ryan,2011; Beecher Bryant,2011;Kennedy and Lawless,2003; Alzate,2007; Kottegoda.et al, 2008; Caroll et al,2007) . Providing baby care was also asked by women when attending the antenatal and postnatal care (Merry.*et al*,2011; Correa-Velez & Ryan,2011; Kennedy & Lawless,2003). Prioritising domestic and family

responsibilities might restrict women to attend antenatal appointments (Tsianakas and Liamputtong,2002; Downe et al,2009).,

- **The impact of dispersal on the continuity of reproductive health care and maternity services provision**: When arriving at the final destinations; women asylum seekers and refugees are subject of dispersal where they are not given any choice regarding the new accommodation and services providers. Routine antenatal screenings such as ultrasound and routine blood tests will be missed (Nabb, 2006). Continuity of antenatal and postnatal care is therefore affected as the connection with women could be missed in the new place.

- The need to move temporary and change different accommodations, areas and consequently GPs; resulted of women being seen by different health professionals. Building the effective partnership between women and their health providers is not possible at this stage and women needs were not adequately taken into consideration. (Straus.*et al*, 2011;Merry.*et al*,2011; Dernnan & Joseph,2005; Beecher Bryant,2011; Ascoly *et al*,2001; Reynolds &White,2010). In the UK; pregnant or recently delivered women might be dispersed just before or after their birth which affects adversely mothers, unborn or neonatal babies (Dernnan and Joseph,2005; D`Souza and Garcia,2004;Beecher Bryant,2011;Reynolds and White,2010; Nabb,2006) The temporary dispersal accommodation is not healthy as well.

- Health visitors who visit women seeking asylum during their postpartum period in their temporary accommodation and hostels stated that they are facing difficulties related to building the trust between with these women in south London (Ascoly et al,2001). In a short time, they need to explain the health system and obtain information from women who will be moving in a short time where they need to start such procedures again in a different area. Basic needs such as nappies, baby clothes, and sterilisation are not afforded for many women in the temporary residency,(Beecher Bryant,2011;Reynolds & White,2010;Nabb,2006; Kennedy and Lawless,2003; Anderson and Doyle, 2004) . Temporary accommodation and the dispersing of women with HIV positive had adversely affected the continuity of care for this specific group of women in the UK. Adding to their major and daily difficulties they do face as asylum seekers with HIV AIDS, women asylum seekers need to visit periodically hospitals and to follow special medicines and food diet

where sharing accommodation with strangers might restrict them of following these regimes to avoid being recognised (Reynolds and White, 2010; Kennedy and Lawless,2003; Anderson and Doyle, 2004),

- **Financial restrictions and women eligibility**: Women entitlement of free reproductive and maternity care is depending on the resettlement countries health systems and policies; it depends also on the stage of seeking asylum process. (Norredam *el al*,2005;Beecher Bryant,2011;Ascoly et al,2001). In the UK, maternity care is considered as an emergency care and should not be restricted for any reason, however, asylum seekers might not seek antenatal or postnatal routine care due to financial difficulties that inhibit them to use transportations especially those who are not supported by any party such as failed asylum seekers (ILiadi, 2008;Kurth et al,2010;Carolan,2010; D`Souza and Garcia,2004; Beecher Bryant,2011;Ascoly et al,2001;IOM,2011; Asif *et al*,2015; Heslehurst *et al*,2018) In other countries as Greece, maternity care is provided free of charge to documented asylum seekers. Undocumented asylum seekers need to pay some charges unless they are covered by the involved NGOs. Although the services charge might not be expensive, it will reduce the ability of women to seek the required reproductive and maternity care (ILiadi,2008;Norredam *el al*,2005; Women`s Commission for Women and Children,2008;UNFPA,2008;Henttonen et al,2008; Anderson and Doyle, 2004).

- Women in the Governmental Hospital in Johannesburg, South Africa mentioned that antenatal appointments were sometimes refused if residency papers are not with them (Norredam *el al*,2005; Alzate,2007). In Colombia, although internally displaced women are entitled of reproductive care, administrative staff in hospitals restricted them from receiving such services if they do not pay. Poor internally displaced women in Colombia were unable to afford the safe abortion which is performed in private clinics which increased morbidity and mortality (Kurth *et al*,2010; Alzate,2007). It is clear that financial difficulties imposed additional challenges and restrictions on the women choice of obtaining the required health care.

- **Psychological support provision:** Women, who left their conflicted countries, lost children or relatives, witnessed and experienced highly traumatic occurrences such as torture, rape and kidnapping will be subject of major mental and psychological disorders. Following their arrival at the countries of resettlement, women face major

difficulties related to the asylum seeking process. The insecurity and the isolation experienced in the new place contribute also in the mentioned psychological distress (Dernnan & Joseph,2005;Beecher Bryant,2011; Kurth.*et al,*2010;Reynolds and White,2010;Asif *et al*,2015; Heslehurst *et al*,2018).

- Health visitors who provided the maternity care for refugees and asylums seekers in South London mentioned the endless crying after giving birth and the postpartum depression. They contributed in helping the women to obtain some psychological support either by the NHS or through NGOs. Thus, the psychological support should be provided concurrently with the maternity care, even though insufficient psychological support and expertise was reported by resettled asylum seekers (ILiadi,2008;Campbell et al,2007; Straus *et al*, 2007; Merry.*et al*, 2011; Carolan,2010; Norredam *el al*,2005; Dernnan & Joseph,2005; Gannan *et al*,2004).
- Postnatal depression is notably increased among these groups of women. Women with HIV positive constitute another group of high psychological needs as anxiety; stigma, low self-esteem and fear of death are all described, in the UK, NGOs act and effective role in providing the psychological support. The Culturally sensitive social support provided by the medical staff can contribute in reducing the symptoms and the incidence of the postpartum depression among women refugees and asylum seekers. Notably, women psychological needs are not met, effective partnership is not achieved in this regards (Reynolds and White,2010; Kennedy and Lawless,2003; Anderson and Doyle, 2004) .

3.3.2. Communication barriers and the interpretation services

It was clear that barriers in the adequate communication between women seeking asylum and there health providers were not only due to the availability of the interpretation services. Besides, the need of female interpreters, the professional capacity of the interpreters , the assistance of friends and family members as interpreters, the inferiority feelings experienced by women themselves, the adequate communication and the preference of oral communication , body language and the different communication tools were all subsidised factors that affected the adequacy and the accuracy of the communicating needed information.

- **The availability of interpretation services**: the availability of the adequate interpretation services is essential for women and health providers as well. Women asylum seekers are coming from variable backgrounds, and they are not expected to speak the language of the final destination country (Kennedy and Lawless,2003; Liampittong Rice & Naksook,1998; ILiadi,2008;Correa-Velez & Ryan,2011;Murray.*et al*, 2010;IOM,2011; Kennedy and Lawless,2003) .However, the adequate availability and utilisation of such services was challenging in most resettlement countries. This affected negatively women attendance and their ability to obtaining and using the services (Straus.*et al*, 2011;ILiadi,2008; Gurnah *et al*,2011; Campbell et al,2007; Merry.*et al*,2011;Carolan,2010; Norredam *el al*,2005; Murray.et al, 2010; Beecher Bryant,2011; Ascoly et al,2001; Gannan et al,2004; Downe et al,2009; Asif *et al*,2015; Heslehurst *et al*,2018) .Women asylum seeker and refugees in many hosting European countries, Canada, Australia and the USA, mentioned this problem.

- While most African who received antenatal services in Brisban Maternity hospital in Melbourne complained from the shortage of the interpreters to help them communicate with the health staff; women who visited Women`s clinic for antenatal care were encouraged to attend as the needed interpretation services were available. (Carolan & Cassar, 2008; Caroll *et al*,2007). In the UK, Somali women who gave birth also lacked interpretation support during their hospital stay (Liampittong Rice & Naksook,1998), (Carolan & Cassar, 2008; Gurnah et al,2011; Straus et al, 2007;Murray.et al, 2010; Carolan,2010;Correa-Velez & Ryan,2011; Pavlish *et al*,2010; Murray.*et al*, 2010).

- **The need of female interpreters**: It was clear that the availability of interpretation services is neither sufficient nor appropriate. Due to the sensitivity of reproductive health and maternity care issues; women feel embarrassed of discussing and sharing such symptoms with stranger males, they even avoid involving their partners in related conversations. Given that women seeking asylum and refuge are coming from different social and religion contexts, this sensitivity might be challenging them not to seek the services if no available female interpreters. Women from different backgrounds who seek asylum in different countries mentioned the need for female interpreters to facilitate sharing their reproductive health and pregnancy concerns with health providers and confirmed that the availability of female interpreters encouraged

them to attend their maternity appointments. (Gurnah *et al*,2011; Correa-Velez and Ryan,2011; Caroll et al,2007; Kulig,1988; Upvall.*et al*,2008),

- **The impact of interpreters' professional capacity in exchanging the accurate medical information**: Exchanging the medical information between health professionals and women was described as challenging. Trying to explain their experiences in this regard, women said that they were unable in many situations to understand what their GPs and midwives told them even with the interpretation assistance (Gurnah et al,2011; Upvall et al, 2008; Pavlish et al,2010; Murray.*et al,* 2010; Ascoly et al,2001). They felt embarrassed of repeating questions or asking for further explanations regarding health instructions to be taken or prescriptions given. Therefore, missing important information or using inaccurately a prescribed drug was reported (Gurnah et al,2011; Upvall et al, 2008;Pavlish et al,2010; Murray.et al, 2010; Asif *et al*,2015). Somali refugees in Minnesota, USA found that in many situations interpreters were not familiar with the medical terms and therefore health information and instructions were not accurately provided(Straus *et al*, 2007;Correa-Velez and Ryan,2011) . More than one official language are spoken in many African countries, interpretation services were in many cases provided only for only one language which is not the used language among the asylum seeking women. Consequently, meeting the specific language and communication needs was not always possible (Gurnah *et al*,2011). Professional interpretation services are requested to ensure effective communication with women seeking asylum and refuge.

- **The assistance of friends and family members as interpreters**: As a result of the unavailable or inadequate interpretation services, women needed to ask the assistance of their friends and other family members such as children and partners in acting as interpreters when attending for their pregnancy appointments (Liampittong Rice & Naksook,1998; Murray.*et al*, 2010; Nabb,2006) . When describing their perspectives, women said that they avoid speaking about reproductive or pregnancy problems when their partners are the interpreters and it is not appropriate to involve their children in such sensitive conversations (Upvall et al, 2008; Murray.*et al*, 2010;Ascoly *et al*,2001; Mengesha.*et al*,2017) . As friends are members of the same communities, women assumed that asking the assistance of their friends as interpreters can lead to their privacy being breached among their communities' members (Murray.*et al*, 2010;MacFarlane *et al*, 2009; Ascoly *et al*,2001) . Assuming that friends and family

members were used as interpreters, adequacy of shared information is not ensured in most cases as those are not familiar with the medical terminology (MacFarlane *et al*, 2009). Besides, the informal relation that link between women and their interpreters in such a situation might result of interfering in the discussion and not sending the same message told by women to their health providers or vice versa (Ascoly *et al*,2001).

- **The inferiority feelings:** The existence of the interpreters was not always supportive. Women in some situations reported that these services were provided to them just because they are coming from different ethnic minorities and health professionals assumed automatically that they are not capable to communicate. In Minnesota USA, Somali refugee women proposed that interpretation services should be given to them only upon their choice as some of them can speak English(Herrel *et al*.2004;Pavlish et al,2010; Heslehurst *et al*,2018). Having experienced the need of interpreters to intermediately communicate their conversations with their health providers, women felt as they are less capable to communicate and therefore they are seen as inferiors (Gurnah *et al*,2011; MacFarlane *et al*, 2009).

- Adequate communication, preference of oral communication, body language and communication different tools:

- Direct oral communication and sympathy shown by health staff toward women during their antenatal appointments and when they were in labour were highly appreciated among Somali women in the UK (Straus *et al*, 2007:Sulliavan.*et al*,2004 ;Pavlish *et al*,2010;Vangen et al,2003;Caroll et al,2007). GPs were also seen as the direct source of information (Liampittong Rice & Naksook,1998; Herrel *et al*.2004; Sulliavan.*et al*,2004; Amersekere.*et.al*,2011; Pavlish *et al*,2010; MacFarlane *et al*, 2009).Being attended by GPs or midwives that keep writing and avoid eyes contacts was described as unsympathetic. On the other hand, women coming from other backgrounds might consider that direct body contact is not always preferable even if it is expressed by female staff (Tsianakas and Liamputtong,2002). Considerations should be given to male GPs, Gynaecologists and obstetricians with regard to the body language and direct touch with Muslim women that will not accept such behaviour due to their religion context. Women also in many studies said that having received phone calls to remind their about their antenatal appointments encouraged them to attend .Translated leaflets that provide health information with the women

languages are effective, but the direct contact by the staff is more preferable. (Herrel *et al*.2004;Straus et al, 2007; Sulliavan.et al,2004 ;Vangen et al,2003;Caroll *et al*,2007). Bilingual workers and the availability of adequate interpretation services increase the access to maternity services in the UK. (Hobbs et al,2012; Nabb,2006) .

-

3.3.3. Relations of women refugees and asylum seekers with their health providers, expectations and perspectives

Women refugees and asylum seekers are coming from variable ethnicities and backgrounds that vary with their health providers, they have particular reproductive and maternity health needs and they are coming to seek better life and wellbeing in the new country of resettlement. This affects what they expect from their health providers. Likewise, health professionals who are providing the reproductive care to these particular groups are most likely unfamiliar with their specific needs. Evidence obtained from the literature showed that women expectations and relations with their health providers affect strongly the health care demand and the appointment attendance. Stereotyping and racism faced, women trust in health providers, their capacity and knowledge about their special needs, the cultural competency and sensitivity of reproductive care provision and women involvement in decision making were the emerged subthemes.

- **Stereotyping and racism faced:** women refugees and asylum seekers expressed contradicted experiences regarding the behaviour of the staff. Where some women described the health professionals as sympathetic and welcoming (Liampittong Rice & Naksook,1998;Sulliavan.*et al*,2004;Murray.*et al*, 2010; D`Souza & Garcia,2004; Nabb,2006;Kennedy & Lawless,2003). Somali women who gave birth in the UK felt that doctors, midwives and nurses were dealing with them as unintelligent. Health professionals assumed that women were unaware about childbirth and family planning methods as they have many children. They reported stereotyping and racist behaviours (Upvall *et al*, 2008; Herrel *et al*.2004;Carolan,2010; Pavlish *et al*,2010;Tebid.*et al*,2011; Ascoly et al,2001;Tsianakas & Liamputtong,2002; Kennedy & Lawless,2003; Asif *et al*,2015;Heslehurst *et al*,2018),
- **Women trust in health providers, their capacity and knowledge about their special needs:** Speaking about their experiences during the giving birth, women with

Female genital mutilation had the feeling that their health care providers are not adequately able to understand and deal professionally with their condition (Upvall *et al*, 2008;Straus et al, 2007; Murray.*et al*, 2010;Ascoly *et al*,2001;Vangen *et al*,2003;Chalmers and Hashi,2000; Caroll et al,2007; Asif *et al*,2015) . In order the birth complications either for mothers and new-borns; surgical procedures were needed before and after giving birth (Essen.*et al*,2010;Straus *et al*, 2007;Herrel *et al*, 2004;Pavlish *et al*,2010;Murray.*et al*, 2010) . According to women the; caesarean section was highly performed as midwives assumed that giving birth with FGM especially with the third degree (infibulations) is extremely difficult (Murray.*et al*, 2010;Vangen *et al*,2003). Health visitor nurses who visit women in their temporary accommodation in South London during their postpartum period reported that they do need to explain that they are not related to the Home Office. Obtaining the women trust was problematic following their experiences either with their nationals' health providers or the Home Office (Dernnan & Joseph,2005). Based on the above findings, health professionals did not show effective understanding and partnership with women regarding their particular health and social conditions, this can affect dramatically the ability of women to be actively represented and capable.

- **The cultural competency and sensitivity of reproductive care provision:**

Evidence collected had shown that reproductive care provision that is culturally sensitive increases women commitment to attend antenatal and postnatal care and to seek family planning methods (Carolan & Cassar, 2008; Caroll .*et al*,2007). Being treated culturally insensitive was reported by women seeking asylum when receiving the reproductive in the new resettlement countries. Health professionals were unable to understand their specific cultural needs. (Liampittong Rice & Naksook,1998; Norredam *el al*,2005; Correa-Velez & Ryan,2011; Pavlish *et al*,2010;Tebid.et al,2011;Ascoly et al,2001; Tsianakas & Liamputtong,2002; Alzate,2007; Gannan *et al*,2004; Chalmers & Hashi,2000; Downe *et al*,2009;Sadbury & Robinson, 2016; Heslehurst *et al*,2018). For instance, Somali women with female genital mutilation described that midwives were highly surprised when examining them and diagnose FGM, showing disgust was also stated (Liampittong Rice & Naksook,1998;Norredam *el al*,2005; Correa-Velez & Ryan,2011; Pavlish *et al*,2010; Tebid.*et al*,2011; Ascoly *et al*,2001), (Tsianakas &Liamputtong,2002; Alzate,2007;Gannan *et al*,2004;Chalmers & Hashi,2000; Chalmers and Hashi,2000; Downe et al,2009;Upvall

et al, 2008;Vangen et al,2003). Women from different background also mentioned that female professionals were preferred and trustful as they can be opened and comfortable with them (Gurnah *et al*,2011;Liampittong Rice & Naksook,1998; Kulig, 1998;ILiadi,2008;Upvall *et al*, 2008; Murray.*et al*, 2010; Tsianakas & Liamputtong,2002; Caroll *et al*,2007)

- **Women involvement in decision making:** Women asylum seekers and refugees reported that they felt uninvolved in decision making related to their health and wellbeing. Somali Women in many studies mentioned that a Caesarean Section was performed to them without taking their consent (Straus *et al*, 2007;Herrel *et al*.2004;Pavlish *et al*,2010; Murray.*et al*, 2010; Tebid.*et al*,2011; Chalmers and Hashi,2000; Caroll et al,2007). Even in pain management tools, women in the Governmental Hospital in Johannesburg, South Africa stated that they were not given any pain relief during their labour although they requested that (Murray.*et al*, 2010). Female genital mutilation is a medical practice that is performed to millions of women all over the world. Females from such communities are subject to female circumcision as a social practice that makes women socially acceptable and marriageable. When arriving to the new countries of settlement where such a practice is seen as an invasion of women bodies and sexuality,   health professionals were not also familiar or expecting such a practice. Women with FGM felt that they were not able to discuss their special needs with their health providers who found that so strange, and sometime disgusting (Upvall *et al*, 2008; Pavlish *et al*,2010; Murray.*et al*, 2010; Caroll *et al*,2007)

-

3.3.4. Adolescents' reproductive health care and maternity services

Reproductive health needs are not usually considered and met in many communities. The provision of reproductive care for adolescents during the conflict and the forced displacement conditions is challenged by three main subthemes emerged from the literature. The availability of such care for adolescent and their awareness about these services, health providers attitude to the need and the provision of reproductive care, the community attitude towards the need and the provision of reproductive care.

- **The availability of reproductive care for adolescents and their awareness about these services**: Girls under 18 are at a higher risk of sexual and gender based violence. To avoid the sexual stigma or due to the socio economic difficulties, early forced marriage and consequently intimate partner violence constitute major problem amongst refugees communities (Benner.*et al*, 2010; Kottegoda.*et al*, 2008) . Contraceptive access and use seem to be problematic for particularly unmarried adolescents living in refugees camps. (Okanlawon *et al*, 2010; Benner.*et al*, 2010). Adolescents are inadequately aware about the different tools they can use for protect themselves against the sexual transmitted diseases or unwanted pregnancies (Benner.*et al*, 2010; Alzate,2007) . Difficulties in accessing these tools if available were mentioned by Burma refugees' adolescents living in camps (Okanlawon et al, 2010; Benner.*et al*, 2010; Kulig,1995). Feeling embarrassed to seek condoms or other tools is leading to the inadequate use as well. In Colombia, adolescent girls do not use adequately family planning methods which resulted of being responsible about the highest pregnancy rate (Alzate,2007). Information related to their sexual life is obtained inaccurately from mothers and friends in most situations taking in mind that such discussions are mostly limited as parents feel that it is inappropriate to share those conversations between mothers and teenage girls (Pavlish *et al*,2010; Benner.*et al*, 2010). Therefore the need for adequate information that can be obtained from professional health workers was mentioned.,(Kulig,1995;Pavlish *et al*,2010; Benner.*et al*, 2010)

- **Attitude of Health Providers toward the need and the provision of reproductive care:** Assuming that adolescents do not need contraceptives and they should not have any sexual activities, health providers did not provide the related counselling and family planning for this specific group. Health professionals in Colombia were not familiar that sexual and reproductive services were guaranteed for adolescents. (Morrison,2000;Alzate,2007).

- **The community attitude towards the need and the provision of RHC&MS:** Similar to the health providers attitude; adolescents reproductive health needs were not acknowledged by the community either in camps or among the adolescents families as well. This fact restricted adolescents of seeking the reproductive health care including the contraceptive advice when needed, unsafe abortion and numerous

complications were therefore resulted of adolescents fears and being embarrassment of seeking the required advise. (Okanlawon et al, 2010; Kulig,1995).

3.3.5. Reproductive health care and maternity services for women refugees and asylum seekers facing sexual and gender based violence

Evidence synthesised from the literature showed that Sexual violence, Gender based violence including domestic violence increase dramatically during conflicted areas, refugees' camps, and the transitional period and in the resettled destinations. Rape as weapon of war was reported historically, sexual exploitation or /and sexual relations for affording basic needs was also used my women in camps as a favour payment for food or money for the households. As a result of the instability of leaving the conflicted countries, rape and domestic violence were also occurring in households. In some refugee communities in Sri-Lanka, using contraceptives was forbidden by husbands thinking that these tools will encourage women of having additional sexual relations; this resulted of higher sexual and domestic violence (Kottegoda.et al, 2008; Morrison,2000). In Sri-Lanka, higher complications were seen as results of unsafe abortions amongst adolescents who have not been treated adequately following rape and sexual abuse. (Women`s Commission for Women and Children,2008). Inadequate health care respond to sexual and gender based violence is reported by health professionals for refugees camps and communities in Timor-East (Women`s Commission for Women and Children, 2008;Wayte. et al,2008) . Adolescent girls were the target for sexual exploitation (Women`s Commission for Women and Children,2008). In Kenya, essential treatments related to preventing survivors of sexual violence and rape of HIV and sexual transmitted diseases were available but the demand for these treatments was limited (Women`s Commission for Women and Children,2008). In Jordan staff working in RHC&MS clinics denied providing emergency contraceptives to rape survivors and antenatal care for pregnant women that did not provide marriage certificates.(Chynoweth ,2008).

3.3.6. Reproductive health care and maternity services in refugee and transit camps

Notably, studies related to experiences and perspectives of women seeking asylum and refuge regarding reproductive care provided to them during their stay in refugee camps were not sufficient and comprehensive compared to the evidence available regarding the experiences

of reproductive care in the final destination countries. In the found studies, camps were not always described whether they are long term or transit camps. A gap in exploring experiences and perspectives of women refugees and asylum seekers regarding reproductive care is therefore reported as an essential finding of this review. Living in transit camps is imposing particular dangerous conditions. Beside difficulties in accessing the water, food, and secure shelter, lack of safety and security are extremely challenging. Women, girls and children are of a higher risk of sexual violence and exploitation, either by facing rape or by sexually exploited to afford their basic needs. Security and safety procedures to protect women and girls from sexual violence are not accurately taking place in the camps. Therefore it was essential to secure basic Reproductive health care. Delivery kits were available in Kenya refugee camp and distributed by UNFPA for women who might need to deliver outside, in the tent or bus, even though women stated that they never knew about such kits (UNFPA, 2011). Women recognised the importance of contraceptive and family planning tools to protect them for unwanted pregnancies resulted of rape and the sexual exploitation they may face even though they do not use these tools as appropriate and husband permission is essential.(Morrison,2000) . As per home delivery, women prefer to deliver at home attended by the visitor midwife although this is not always accessible (Futura & Mori,2006). Transportation is not accurately available for pregnant women who show pregnancy risks and need immediate attention and hospitalisation (Women`s Commission for Women and Children, 2008). Psychosocial support was provided mainly from the humanitarian bodies. (UNFPA,2011).

3.4. Synthesis

Synthesis of themes and subthemes emerged from the scoping review (figure 7) showed that although six wide themes where reached; there is a clear overlap between them.

The first theme emerged from the scoping review covered the aspects of accessing the health care required. Whether they were hospital or community setting facilities, women awareness of what is available for them, their ability to geographically access these services added to their cognizance of their health care needs, all these subthemes influenced the seek and the provision of the health care required in the country of final destination. However, available and culturally adequate interpretation services and communication tools in addition to the relationships with the health practitioners providing the reproductive health care (Nurses, doctors, midwives) both large themes overlap and affect the experience and the perspectives

of women and asylum seekers either way. Despite the emerging separate themes, they are still fully overlapped and influenced by each other.

Nevertheless, reproductive health care for women refugees and asylum seekers that are facing different sorts of gender based violence was not adequately or suitably provided. The same applied for reproductive care provision to adolescents were tangibly missing and inappropriate. Cultural aspects including the attitude of health practitioners contributed strongly and in most cases negatively on the availability and the provision of reproductive care. For instance, young adults and unmarried girls may not be able to seek contraceptives. Victims of wars sexual abuse and rape were also not able to get the emergency contraceptives, as they were not married. Again, overlaps were strongly noted.

Figure 7 below presents the overlapping themes, the concept of vulnerability, gender power and patriarchy can`t be ignored at all themes.

When travelling to access health care, women may be not allowed to go alone for instance. Accompanied by their partners, they will not be able to disclose any information such as any exposure to partner abuse. Women health in the family is not prioritised when financial burdens are faced.

Decisions that are related to contraceptives and family planning are also highly influenced by the male dominance in the family. Sadly enough, this patriarchy and gender power exceed family members in some occasions to the wider society, an example of that is the restriction applied by health care professional over the distribution of emergency contraceptives for women and girls that are not married even if they were rape victims. Vulnerability is only enhanced.

Adolescent girls may also not be able to access the adequate reproductive care and advice.

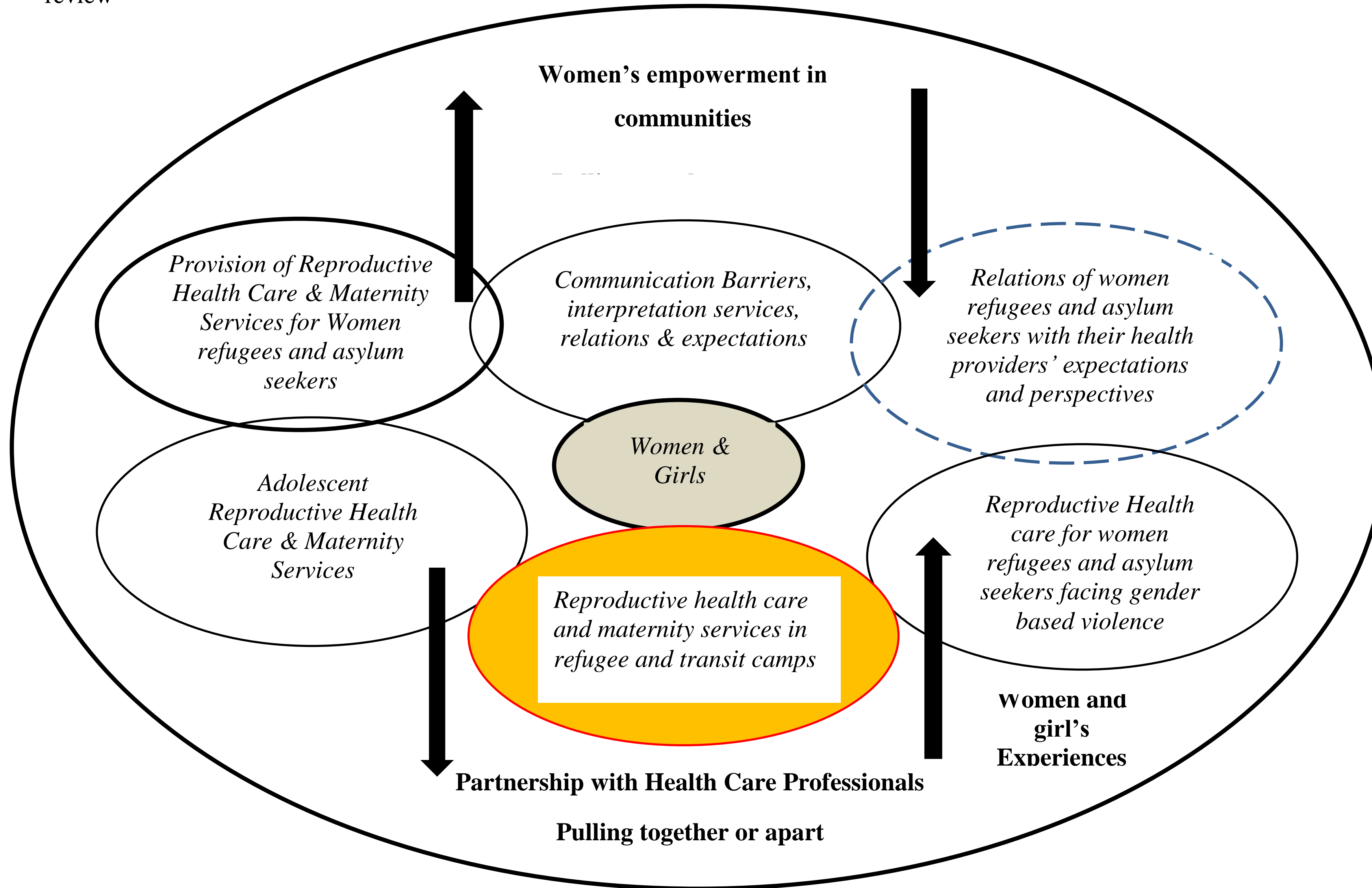
Camps settings increase women and girls vulnerability again when male members are able to get better tents and better food, while women may face sexual exploitation for feeding their households.

Reflecting on that, while both men and women possibly struggling to access the health care they need for instance, women and girls can easily be restricted by their men who act as upper guardians in their families. It is the concept of vulnerability crystallised by male power obtained by their position in their family and community patriarchy

Precisely, evidence synthesised had shown that women experiences and perspectives of reproductive care provision were crucially influenced by women empowerment in their communities and the partnership between them as care users and their health professionals particularly midwives.

However, the scoping review had informed a noticeable gap about refugees and asylum seekers experience and perspectives of reproductive care in transit and temporary settings/camps. Therefore, the next chapter tried to explore in particular Syrian refugee and asylum seekers women in temporary and transit camps, both in neighbouring countries and during their journey to Europe.

Figure (7) Mapping women and girls' journeying: Surfacing the experiences of Reproductive Health Care & Maternity Services in the scoping review



3.5. Summary

The literature review chapter aimed at exploring perspectives and experiences of women refugees and asylum seekers regarding the reproductive care provided to them during their journey, globally and in the UK. Scoping the literature and the thematic analysis methods had been used to analyse the evidence emerged. Synthesis shown that although large and separate themes had emerged, clear overlaps between them were clear. This chapter informed the focus of the next chapter as a gap in refugees' experiences and perspectives in transit camps was noticed

CHAPTER 4:

QUALITATIVE NARRATIVE REVIEW RESULTS

SYRIAN REFUGEE WOMEN EXPERIENCE OF REPRODUCTIVE CARE IN TRANSIT AND TEMPORARY SETTINGS

4.1. Introduction

This chapter introduced the background of the Syrian dilemma and its local and regional implications. It explained the rationale stimulated undertaking this chapter. Findings of the secondary analysis of qualitative data were presented and based on two main areas which are experiences and perspectives of Syrian refugee women of reproductive care provision in Syria neighbouring countries (Lebanon, Jordan and Turkey) , and their experiences in transit camps during their journey to Europe.

4.2. Background

On March 2020, the Syrian conflict had completed its 9th year. However; following the regime invasive efforts to get Damascus Superb (Eastern Ghoutta) back under its control; and the international players involved in Northern Syria , millions of Syrian had been victims of the adverse impact of this war. The Syrian civil war resulted of more than 13 Million people in need. These statistics included 6.3 Million internally displaced, 4.9 Million besieged in hard to reach areas inside Syria and Over 4.8 Million registered as refugees in neighbouring countries and beyond as around 1.2 Million sought asylum in Europe. (Figures 1 and 8). (UNHCR, 2018; Mercy Corps, 2020).

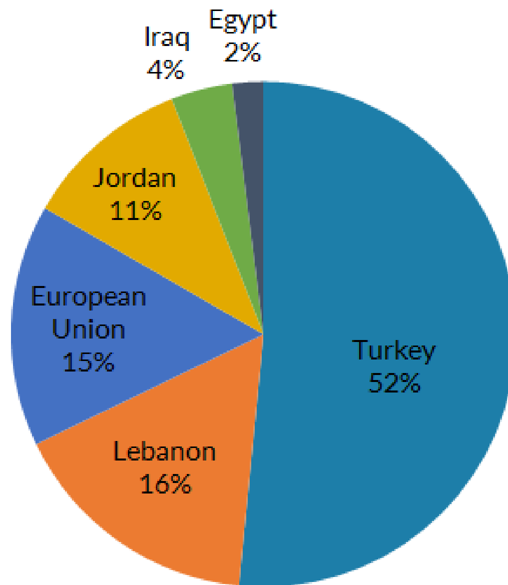


Figure (8) The Distribution of Syrian Refugees by Host Country, July 2017 (Migration Policy Institute, 2017)

As mentioned in the scoping review chapter, experiences and perspectives of women refugees and asylum seekers regarding the reproductive care in temporary and transit camps had been so limitedly addressed. While more studies dealt into health care in long-term camps, only few of them discussed the transit and temporary camps. Given that the researcher was not able to visit neither Syria countries not Europe refugees transit camps; primary data were inaccessible, the secondary analysis of qualitative data had been applied.

4.2.1. Syrian Refugees in Neighbouring Countries

At the beginning of the war, neighbour governments had generously hosted Syrian refugees escaping the conflict and crossing the borders, however borders started tightening and imposing hard and restrictive rules to reduce the numbers of refugees seeking sanctuary. Countries applied varied policies in accommodating and providing essential services to refugee families, which influenced consequently their living circumstances, social, economic and health statuses.

Syrian refugees had been living in non-camps settings in addition to refugees' camps, for instance in Jordan only 42% live in camps (USAID, 2016). Although the largest population

of Syrian refugees are hosted in Lebanon; the government had not allowed the establishment of official camps similar to camps in Jordan and Turkey, this led to refugees who are not able to afford renting or living with relatives to be using informal tents, buildings in constructions and abandoned buildings, even animals sheds. (Benage *et al*, 2015).

In Lebanon, Syrian refugees that are registered with the UNHCR are entitled to 4 covered antenatal care visits, the relevant laboratory tests, supplements and delivery. Family planning methods were also freely provided. However Due to them spreading to more than 1400 geographical locations; reproductive care was fragmentally and unequally provided; considering that unregistered women may need to fully pay for any care they receive.

Unequal access to services is reported for groups living inside and outside camps, with less attention given to women and girls living outside the camps and groups of higher vulnerability such as individuals with disabilities and individuals of different sexual orientation. (WRC, 2014).

4.2.2 Syrian refugees in transit camps while travelling to Europe

Based on the UNHCR Statistics, around 1.2 Million Syrian sought asylum in Europe. The number of women and girls travelling alone is increasing. They are lone women, female households, pregnant or breastfeeding, and unaccompanied adolescents that left one of the most dangerous conflicts areas to seek a safe haven in Europe particularly Sweden and Germany. To reach the country of their final destination they need to cross Countries in Balkans and Eastern Europe such as Greece, Serbia, Slovenia and Macedonia where they will be accommodate temporarily in transit camps and asylum accommodation centres in Sweden and Germany for instance. Although they are escaping wars and seeking safety, they will still subject to major risks during the above journey, where their gender is a burden by itself.

4.3. Results and findings

Findings of this chapter had explored two main streams. It covered the Experiences and perspectives of Syrian refugees' women in Lebanon, Jordan and Turkey as the major neighbouring countries and the first external displacement destinations for that left the country. Reaching articles and evaluations reports health care services provided for Syrian refugees either by the hosting governments or by the none governmental sector including international NGOs was not as hard as the second focus. The war had lasted long enough to

allow interested researchers and health providers to try and partially evaluate their care. 11 articles had been analysed. (please see table 3)

However, exploring experiences and perspectives of Syrian refugee women staying in temporary transit camps while travelling to Europe in particular was the most challenging part, but the most interesting and the "unique" interest of this stream. The short-term stay of women in such temporary settings does not mitigate nor facilitate a research work to discover perspective of such a hard but highly vulnerable group of individuals. Neither a priority nor an easy work for researchers. Therefore, only **3** project/services evaluation reports undertaken by the Women's Refugee Commission had been found and analysed. (please see table 3; Figure 9)

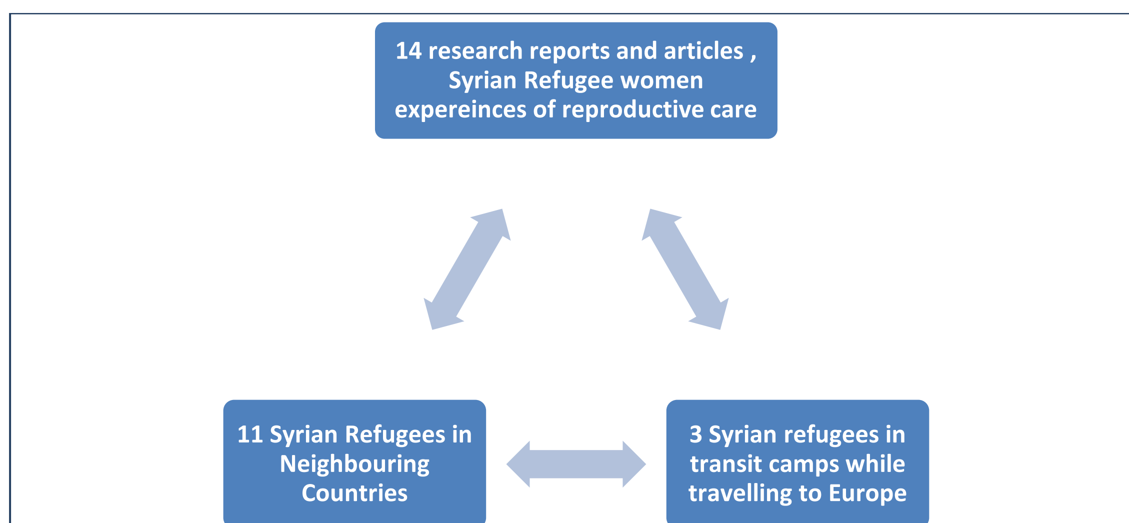


Figure (9) Secondary Qualitative data sources

Table 3 Features of Studies and Reports synthesised for the Qualitative Narrative Review

Source papers (14)	Country Setting	Participants	Sample origins	Data Collection
WRC,2014	Jordan	key informants, including staff and leaders from 25 COMMISSION REF U GEE W O MEN ' S 6 UN agencies, international NGOs (including religious based, emergency	UN Agencies Local Jordanian Organisations Syrian Refugees women and girls Zaatari refugee camp and in Amman, Zarqa, Irbid and Dhleil,	Literature review Field assessment in Jordan, including in-depth interviews, focus group meetings and observation. Two focus group meetings with

		response and development agencies) and local Jordanian organizations. Syrian Refugees women and girls		groups of Syrian refugee women and girls in urban settings were also conducted, as well as unstructured interviews with numerous refugees in urban and camp settings.41 Finally, site visits were conducted to five community and women's centers run by local and international NGOs in the Zaatari refugee camp and in Amman, Zarqa, Irbid and Dhleil,
Amiri.et al,2020	Jordan	PubMed, Medline/Ovid and Scopus for both quantitative and qualitative studies	PubMed, Medline/Ovid and Scopus for both quantitative and qualitative studies	Systematic Literature Review
Krause *et al*, 2015	Jordan	Sampling of health facilities included obtaining a list of health facilities that provided RH services in Zaatri Camp (n=15) and Irbid City (n=6). Participants in FGDs were recruited by partner agencies that selected a purposive sample of female youth (18-24 years of age) and older women (aged 25-49 years). In Zaatri Camp, the groups included those that lived near and farther away from health facilities, and newly arrived refugees (arrival within the past two months). In Irbid City, the groups were allocated	1 key informant interviews, 13 health facility assessments, and focus group discussions (14 groups; 159 participants) in two Syrian refugee sites in Jordan, Zaatri Camp, and Irbid City, respectively	formative evaluation approach 11 key informant interviews, 13 health facility assessments, and focus group discussions (14 groups; 159 participants) were conducted in two Syrian refugee sites in Jordan, Zaatri Camp, and Irbid City, respectively

		based on refugee registration status.		
Erenel *et al*.2016	Turkey	Comparative Study Demographic data, obstetrical history, clinical findings, obstetrical and neonatal outcomes	total of 600 singleton pregnancies who delivered at Sisli Hamidiye Etfal Training and Research Hospital were included in the study	Comparative study Demographic data, obstetrical history, clinical findings, obstetrical and neonatal outcomes were compared between 300 Syrian refugees and 300 control patients.
Rees Masterson *et al*, 2014	Lebanon	452 Syrian refugee women ages 18–45 who had been in Lebanon for an average of 5.1 (± 3.7) months.	452 Syrian refugee women ages 18–45 in six health clinics.	needs assessment in Lebanon, administering a cross-sectional Survey in six health clinics.
Yasmine & Moughlian, 2016	Lebanon	phone and face to face interviews with over 300 Syrian refugee Referrals made by local NGO that focuses on sexual and reproductive health and rights (SRHR), sexuality, and gender in Lebanon.	300 Syrian refugee Referrals made by local NGO that focuses on sexual and reproductive health and rights (SRHR), sexuality, and gender in Lebanon.	An observations of two Master's level graduates, in Sexual and Reproductive Health Research (RY) and Social Psychology (CM), who have worked for over the last two years within a local NGO that focuses on sexual and reproductive health and rights (SRHR), sexuality, and gender in Lebanon. phone and face to face interviews via the NGO's SRH referral hotline with over 300 Syrian refugee women,
Dejong .*et al*,2017	Lebanon, Jordan, Syria and Turkey	Istanbul , Ankara (NGOs , academics) Beirut, Lebanon, with stakeholders working with IDPs	NGOs working with Syrian refugees in Turkey and Lebanon	Medline, PubMed, Scopus, Popline and Index Medicus for WHO EMR (WHO Eastern Mediterranean Region) Meeting in Istanbul and Ankara with representatives of key non-governmental organisations and academics.

				Expert meeting was conducted in Beirut, Lebanon, with stakeholders working with IDPs or Syrian refugees from countries of interest (Syria, Lebanon, Jordan and Turkey)
Tayson,2016	Lebanon	Clinic /Service report written by a trainee participant		Clinic /service observation report Article published in Women`s Health
USAID,2016	Jordan	60 Published and unpublished reports from multiple sources within Jordan	60 Published and unpublished reports from multiple sources within Jordan	60 Published and unpublished reports from multiple sources within Jordan, including, MOH, the Ministry of Planning and International Cooperation (MOPIC), and the interagency Reproductive Health Working Group, supplemented by internet searches. These documents include needs assessments and national response plans, assessments of the situation of Syrian refugees throughout the nation or in specific localities,
Benage *et al*,2015	Lebanon	Female 420 self-identified pregnant Syrian refugee women	non-randomized sample of 420 self-identified pregnant Syrian refugee women	field-based survey 14 main geographic sites of refugee concentration.
UN, 2016	Jordan	Interviews with Health Sector partners and Actors, project/field staff Refugees	Interviews with Health Sector partners and Actors, project/field staff Refugees	Literature review (extracting both quantitative and qualitative information Health sector project documents UNHCR, UNICEF, MEDAIR, JHAS

				Key Informant Interviews (KIIs), and Focus group discussion (FGDs Health Sector partners and Actors, project/field staff Refugees
WRC, 2016 (1)	Germany and Sweden.	WRC interviewed refugee women in accommodation centers. The team also met with numerous relevant stakeholders in both countries, including: local and national government officials; nongovernmental organizations	Refugee women in accommodation centers. numerous relevant stakeholders in both countries, including: local and national government officials; nongovernmental organizations	Undertaken Assessments to understand women's and girls' access to humanitarian and legal protection throughout the European migration route. joint mission with the UN High Commissioner for Refugees (UNHCR) and the UN Population Fund (UNFPA) WRC interviewed refugee women in accommodation centers. The team also met with numerous relevant stakeholders in both countries, including: local and national government officials; nongovernmental organizations dedicated to promoting women's rights, human rights, and migrant rights; and accommodation center staff and volunteers.
WRC, 2016 (2)	Serbia and Slovenia.	Refugee women transit in accommodation centers. numerous relevant stakeholders in both countries, including: local and national government officials;	Refugee women in accommodation centers. numerous relevant stakeholders in both countries, including: local and national government officials;	Interviews with Refugee women in transit. The team meeting with other relevant stakeholders, including: government officials; border officials and police;

		nongovernmental organizations border officials and police	nongovernmental organizations border officials and police	international humanitarian actors, including staff at numerous UN agencies and local civil society organizations ; and transit center volunteers Belgrade, Presevo, Adasevci and Sid in Serbia, and to Ljubljana, Dobova and Sentilj in Slovenia
WRC, 2016 (3)	Macedonia	key informant interviews with representatives of coordinating disaster management systems (MoH and DRR Departments); relevant coordinating bodies for health, including UN agencies; and international and national implementing partners providing SRH services.		key informant interviews with representatives of coordinating disaster management systems (MoH and DRR Departments); relevant coordinating bodies for health, including UN agencies; and international and national implementing partners providing SRH services.

4.3.1. Syrian refugees experiences of reproductive care in Neighbouring countries

Evidence was synthesised from 11 research reports, research articles and services evaluations reports (Please see table 4) REF). The content of the above was thematically analysed line by line to identify emerged themes as appropriate. Identified themes identified were *The provision of reproductive care in camps settings, the provision of reproductive care in out of camps settings, provision of reproductive care for victims of gender based and sexual violence, and the provision of reproductive care for young adolescents in humanitarian settings.* Table **(4)** explained by details themes and subthemes and linked them with the relevant sources.

Table: (4) Syrian refugees' women experiences of reproductive care in Neighbouring countries

Themes	Subthemes
the provision of reproductive care in camps settings	- Women in Alzaatari camp were able to access reproductive health care provided by " in camps clinics" that are established by International Non Governmental Organisations such as UNHCR, UNFPA (WRC,2014) - women are also able to access care provided by out of camps clinics managed by the Jordanian Ministry of Health (WRC, 2014) - No adequate provision of the Minimum Initial Services Package MISP as clean delivery kits were not given to women due to concerned that these kits may promote home birth instead and increase possible complications (Amiri et al,2020; Jordan Krause *et al*, 2015;WRC,2014). - Women were not aware of the free services that they are available for them (WRC,2014;Amiri et al,2020;) - The shortage of female practitioners and gynaecologists may have restricted women of accessing the reproductive care needed unless in emergencies (WRC, 2014). - Women were not aware that contraceptive and family planning services are available free for them in Alzaatari Camp (Krause et al, 2015). - Women may try to self abort by heavy lifting should they become pregnant - Poor Sexual transmitted diseases and HIV Aids reporting and treatment (Krause et al. 2015; Amiri et al,2020) - Women involvement in service design and provision proven positive feedback, Operation Mercy at Alzaatari camp consulted women regarding what a hygiene kit should

	include. (Amiri et al,2020; WRC, 2014)
the provision of reproductive care in out of camps settings	- In a maternity centre in Istanbul, Turkey more than 40% of Syrian refugees women haven`t received any antenatal care during their pregnancy, their haemoglobin levels were lower than the other group. Syrian women are late in arriving to the hospital for labour (Erenel *et al*.2016) - In Irbid City of Jordan, Syrian refugee women were informed about the reproductive care from their relative and neighbours, lack of communication between the care providers. (Krause *et al*. 2015; WRC, 2014) - The cost of reproductive care for UNHCR unregistered Refugees women in Jordan hindered them of seeking the required care (Krause *et al*. 2015 - Syrian refugee women in Jordan and Lebanon were hesitant to seek reproductive care due to shortage of female practitioners ((Rees Masterson *et al*, 2014; Yasmine & Moughlian, 2016; Krause *et al*. 2015; WRC, 2014) - In Jordan, only one site was providing post rape contraceptives to victims for rape. (Krause *et al*. 2015) - Reproductive care was poorly provided to refugee women in Lebanon. (Reese Masterson *et al*,2014; Yasmine &Moughlian,2016; Dejong .*et al*,2017) - Syrian refugee women in Lebanon struggled to pay the cost of Caesarean section operations. (Tayson,2016; Yasmine &Moughlian,2016; Dejong .*et al*,2017)
The provision of reproductive care for victims of gender based and sexual violence	- Early marriages to senior men are increasing with poor legal marriages and newborn registrations. (WRC, 2014; Benage *et al*,2015; Yasmine

	&Moughlian,2016; Dejong *.et al*,2017Amiri et al,2020, USAID,2016). - Women unable to get their legal rights or report any abuse (WRDC, 2014; Benage *et al*,2015; Yasmine &Moughlian,2016; Dejong *.et al*,2017). - Women may be of a higher exposure to sexual exploitation in order to meet their household basic needs. (Krause et al. 2015; WRC, 2014) - Sexual abuse and rape incidences may not be reported due to fears of honour based violence Krause et al. 2015; WRC, 2014) - No protection measures in place to protect women and girls from all sorts of gender based and sexual abuse Krause et al. 2015; WRC, 2014) - Increased domestic abuse incidences with hesitance in reporting. (Krause *et al*. 2015; UN,2016: Yasmine &Moughlian,2016) - Increased pregnancy adverse complications affecting women and newborns due to the exposure to both the gender based violence in war areas or by their intimate partners. (Reese Masterson *et al*, 2014; Yasmine &Moughlian,2016) - Male dominance had hindered the women capacity to utilise the required health services.(UN,2016)
The provision of reproductive care for young adolescents in humanitarian settings.	- Early marriages are reported in all neighbouring in camps and out of camps settings (Benage *et al*, 2015; Yasmine &Moughlian, 2016Amiri et al,2020). - Poorer pregnancy outcome among young girls aged 12-19 years old in Istanbul , Turkey in comparison the same group of non-refugee women (Erenel *et al*.2016) - Young girls have limited access to reproductive health information and they may seek it from their mothers and older females in the family

	rather than visiting the primary care facility. (UN, 2016; Yasmine &Moughlian, 2016). - Young and /or unmarried girls are unlikely to seek reproductive care unless for emergencies.(Krause *et al*, 2015; Yasmine &Moughlian,2016)

The table was followed by explaining findings in details as appropriate

4.3.1.1. Provision of reproductive care in camps settings

While Syrian refugees had been accommodated in official refugees' camps in Jordan and Turkey, Lebanon restricted the establishment of such camps. This had resulted of different settings of health care provision in accordance to the country, in camps and out of camps residency.

In Jordan, Alzaatari camp had been established on the year 2012 by the United nations High Commissioner for Refugees UNHCR, it was the first camp in Jordan (WRC,2014). Reproductive health services are provided in camps through health clinics and hospitals established by involved international None Governmental Organisation NGOS (UNFPA, UNHCR, etc). However, women may still be able to access the care from out of camps clinics that are managed and supervised by the Jordanian Ministry of Health.

The Minimum Initial Services Package MISP in humanitarian setting is defined as the set of prioritised health activities that may contribute in reducing the excess morbidity and mortality among women and girls in particular. MISP implementation is to be managed by a lead organisation and provided by highly trained staff. MISP aims at supporting women in emergencies to manage potential implications of sexual abuse, help in home deliveries, and reduce HIV and STI transmission (Amiri et al,2010)). In their evaluation of the MISP implantation at Alzaatari camp (Jordan krause *et al*, 2015) found that clean delivery kits were not given to women as providers were concerned that these kits may encourage women to deliver at home and increase possible complications instead of seeking hospital care. Women added that organisations in the camp did not provide the adequate and direct advice with regard to what needed to do in emergencies. This finding was also confirmed by the

Women`s Refugee Commission Report (WRC, 2014) mentioning that women may use out of pockets for deliveries and services that are already available for them free of charge. Normal deliveries, newborn care, simple and basic obstetric care are provided at The Gynécologie Sans Frontières maternity clinic in the camps while more complicated emergencies for mothers and newborns are referred to the Morrocan Field hospital and transported by ambulances.

Moreover, the shortage of female practitioners and gynaecologists may have restricted the use of reproductive services for women refugees in camps unless in emergencies (WRC,2014).

As per family planning and contraceptive tools use in Alzaatari camp; half of women participated in the research clarified that they are not aware that they can get free family planning services although they were available for them; they might try to self-abort by heavy lifting should they become pregnant. However only male condoms were available. This reflects inadequate communication between providers and services users, which may result of additional risk factors. The same report highlighted poor Sexual transmitted diseases and HIV Aids reporting and treatment (Krause et al. 2015)

Although services had been designed and provided based on rapid needs assessments in order to respond to the rapid increase of refugee's influx and their complex needs; some positive experience was reported in engaging directly with women and involving them in services design. Operation Mercy at Alzaatari camp consulted women regarding what a hygiene kit should include. (WRC, 2014)

4.3.1.2 Provision of reproductive care in out of camps settings

In Turkey, comparing with a Turkish pregnant women group in a maternity centre in Istanbul Erenel *et al*.2016 stated that more than 40% of Syrian refugees women haven`t received any antenatal care during their pregnancy, and their haemoglobin levels were also lower than the other group. This may be due to language barriers, their socio economic statuses and the lack of awareness with regard to reproductive care availability and the entitlement to free services and distribution of Iron and Vitamin D supplement for those living around the refugee camps.

Adding to the above, cervical dilation for Syrian refugees when admitted for labour was significantly higher than the Turkish women group. Syrian women may be late in seeking the

required care or timely reaching the hospital; which will increase expected complications, maternal, neonatal morbidity and mortality.

In Irbid City of Jordan, Syrian women reported that they only learned about the reproductive health services available for them through their community members and neighbours, as there was no adequate communication from the provider agencies in this regard. Although women registered with the UNHCR were entitled to free services, they were reluctant to see the reproductive care they may need due to lack of female practitioners. (Krause *et al*. 2015; WRC, 2014). For unregistered refugees that sought the reproductive care with no UNHCR referrals; the cost of the care was equal to uninsured Jordanians; this will massively hinder them to receive the care they need considering their economic obstacles.

The lack of female practitioners contributed also on the poor reproductive care provision in general and antenatal care in particular for Syrian refugees in Lebanon (Rees Masterson *et al*, 2014; Yasmine &Moughlian, 2016)

Different contraceptive methods were available such as injectable methods, intrauterine devices and pills. The Jordanian Guidelines for emergency contraceptives advise that combined oral contraceptives can be given, but only one site was providing post rape contraceptives. (Krause *et al*. 2015)

Despite the evidence showing that adequate and culturally convenient antenatal care provision may largely reduce complexities expected to occur to pregnant displaced women to almost reach similar morbidity and mortality for none displaced; antenatal care for displaced and refugees women remains a challenging issue. The economic hardship and the inadequate refugees support experienced by the women and their families had contributed in the inadequate antennal care received during pregnancies and the poor birth outcome. Reproductive care was poorly provided to refugee women in Lebanon. (Reese Masterson *et al*,2014; Yasmine &Moughlian,2016; Dejong .*et al*,2017)

Nonetheless, the reliance on Caesarean Section deliveries became dominant among Syrian refugees in Lebanon, added to the complication that may occur; Syrian women found themselves under an increase financial implications if they couldn’t afford to pay the cost of the operation. (Tayson,2016; Yasmine &Moughlian,2016; Dejong .*et al*,2017)

4.3.1.3. Provision of reproductive care for victims of gender based and sexual violence

Women and girls continue to be the higher vulnerable groups that are subject to all sorts of gender-based violence and sexual exploitation .Cultural and socio economic contexts impose major implications over them. While men may not be able to find the appropriate work to afford their family's needs; early marriages for young girls may reduce the financial burdens and most importantly their families assume that they will be better protected by their husbands rather than bringing shame to the family when safety is hugely unmaintained in camps settings. The Syrian law allows Syrian girls to get married at 16 years old while it is 18 years old in Jordan; however, it was indicated that early marriages to senior men are increasing with poor legal marriages and newborn registrations. This had resulted of women unable to get their legal rights or report any abuse (WRDC, 2014; Benage *et al*,2015; Yasmine &Moughlian,2016; Dejong .*et al*,2017).

As households maybe headed by only females after the loss of men killed or arrested; women may be subject to sexual exploitation in order to meet their families' basic needs such as a good tent in the camp, clothing and food. However, women and girls in most cases may not report rape or sexual harassment due to fears of honour based violence as they brought he shame to the family. It is worth mentioning sexual abuse protection protocols and measures were not in place. In Jordan, emergency contraceptives are fully restricted to unmarried girls and women and only one side was providing them to victims of rape (Krause et al. 2015; WRC, 2014)

Few reports highlighted that women living in Alzaatari camp in Jordan felt insecure in many occasions, for instance going to toilets and bathrooms at nights may not be safe as lights are not enough. (Krause et al. 2015; WRC, 2014), this can be explained that the camp had been rapidly extended to meet the need of the comers influx.

Nonetheless, domestic abuse incidences increased in both camps and out of camps setting due to what families experience after leaving their country and trying to afford their basic needs in the new place. Women reported that they might be hesitant to report such incidences as they might be culturally stigmatised the male patriarchy is the term, and women should always obey family male members. (Krause *et al*. 2015; UN,2016: Yasmine &Moughlian,2016)

The exposure to both the gender based violence in war areas or by their intimate partners had increase dramatically pregnancy adverse complications affecting women and newborns. (Reese Masterson *et al*, 2014; Yasmine &Moughlian,2016)

It is worth mentioning that the male dominance had hindered the women capacity to utilise the required health services.(UN,2016)

4.3.1.4 Provision of reproductive care for young adolescents in humanitarian settings.

Early marriages are seen as one of the major social and economic implications of conflicts; as households assume that marriage may reduce the economic burden over the other members of the family and protect adolescent girls from potential sexual threats that will shame the family. Erenel *et al*.2016 found in their study aimed at comparing pregnancy outcome between Syrian refugees and Turkish none refugees women in a maternity centre in Istanbul that the percentage of pregnant young girls aged between 12-19 years is noticeably higher than the Turkish group.

Early and child marriages had also been confirmed among Syrian refugees in Jordan and Lebanon as well (Benage *et al*, 2015;Yasmine &Moughlian,2016). However, young girls have limited access to reproductive health information and they may seek it from their mothers and older females in the family rather than visiting the primary care facility. (UN, 2016; Yasmine &Moughlian, 2016). In Alzaatari camps in Jordan; facilities were open and welcoming for adolescents females; however it is not usual for young and /or unmarried girls to seek reproductive care unless an emergency is occurred.(Krause *et al*, 2015; Yasmine &Moughlian,2016)

4.3.2 Syrian refugees' experiences of reproductive care in transit camps while travelling to Europe

Considering the very limited research undertaken to understand the reproductive care provision in transit camps while refugees and asylum seekers may only stay for a short time; evidence was synthesised from three services evaluation reports.

Themes identified were: no adequate gender sensitivity in transit sites, lack of reproductive care, lack or no Gender based violence support services.

Table (5) Syrian refugee women experiences of reproductive care in transit camps while travelling to Europe

Themes	Subthemes
No adequate gender sensitivity in transit sites	- Women and girls facing additional risks in transit camps located in transit countries such as Greece, Serbia, Slovenia and Macedonia - Some camps did not offer dedicated and private places to women and families. - Single women may have shared accommodation with males which increased sexual abuse incidences - Many women were avoiding eating and drinking to reduce their needs to toilets. - Third sector workers in camps were not adequately capable of identifying females with higher vulnerability - Language barriers contributed in Women and girls lack of knowledge of what services are available for them including the health care [WRC, 2016 (1) ; WRC. 2016 (2) WRC,2016 (3)]
Lack of reproductive care	- Lack of reproductive care provided in transit camps - Not to delay their journeys, many pregnant or newly delivered mothers were hesitant to seek the required care as they need to go to hospitals out of camps - Minimum Initial Service package (MISP) recommended to be available in camps and at all times were not provided

	- Variations of the availability of the emergency post rape care including post exposure prophylaxis, emergency contraception and antibiotics were reported. [WRC, 2016 (1) ; WRC. 2016 (2) WRC,2016 (3)]
Lack or no Gender based violence support services.	- Government personnel and frontline workforce dealing with women and girls arriving to transit camps, lack the capacity to identify groups of a higher vulnerability and potential victims of rape, sexual violence or human trafficking. - Women were hesitant to disclose incidents of sexual abuse/rape - No standardised assessment followed to identify victims of gender-based violence. Assistance was reliant on workers individual judgement - Variations of the availability of the emergency post rape care/kits - No adequate referral pathways for victims of sexual abuse including the required legal, medical, psychological and judicial services [WRC, 2016 (1) ; WRC. 2016 (2) WRC,2016 (3)]

The table was followed by explaining findings in details as appropriate

4.3.2.1. No adequate gender sensitivity in transit sites including gender sensitive access to information.

While Syrian women and girls had fled one of the most dangerous conflict zones in recent years, they faced additional risks in transit camps located in transit countries such as Greece, Serbia, Slovenia and Macedonia. For instance, Dobova and Sentilj camps did not offer dedicated and private places to women and families. In Sweden, single women and lone females with children shared accommodation with single men at asylum accommodation centres which increased the reported sex crimes occurred at the above centres.

Nonetheless, third sector workers were not able to identify those of higher vulnerability due to overcrowded places and no private areas for females. Latrines and bathing facilities were

also shared between men and women, many women were avoiding eating and drinking to reduce their needs to toilets.

Many refugees reported that they have no idea what services are available for them including the health care; not aware of their rights, some of them did not know the borders they just crossed or the country they arrived to. Language barriers contributed to the described lack of knowledge. Relevant information was not provided in the spoken languages of refugees with no available translators as well. [WRC, 2016 (1) ; WRC. 2016 (2) WRC,2016 (3)]

4.6.2.2 Lack of reproductive care

the Women`s Refugee Commission noted in its assessments undertaken in transit camps that there was a huge number of pregnant and new mothers among the Syrian refuges. Women explained that they are referred to local hospitals outside the camps; but they were hesitant to go unless in emergencies as they were afraid of being separated from their families or relatives or causing delays to their journeys. This reflects that the Minimum Initial Service package (MISP) recommended to be available in camps and at all times were not provided.

The emergency post rape care including post exposure prophylaxis, emergency contraception and antibiotics were available in Sweden and Germany asylum accommodation centres. [WRC, 2016 (1) ; WRC. 2016 (2) WRC,2016 (3)]

4.6.2.3. Lack or no Gender based violence services

Government personnel were the first frontline workforce talking to women and girls arriving to transit camps, in most cases they are unlikely to be adequately experienced of identifying groups of a higher vulnerability and potential victims of rape, sexual violence or human trafficking. Cases may therefore be missed, as females will be hesitant to disclose such information when no experienced personnel are leading an effective conversation with them.

In Germany and Sweden, no standardised assessment was undertaken to identify victims of gender-based violence. Assistance was provided in reliance to the workers individual judgement. As mentioned previously; sharing asylum accommodation centres with men resulted of increased sex crimes occurrence with guards; volunteers and workers involved some times.

It was also noticed that post rape kits were not available to rape victims; such services are available in local hospitals. As victims of rape may not disclose the incidence to the police, the need to establish suitable referral pathways for victims of sexual abuse including the required legal, medical and psychological and judicial services and implemented by trained workforce. . [WRC, 2016 (1); WRC. 2016 (2) WRC, 2016 (3)]

4.7 Synthesis

Figure (10) shows how the experiences of Syrian women in their displacements regarding the reproductive care provision were hugely determined by many other factors such as the economic and the cultural factors. While language was not a barrier in Lebanon, Jordan; the poverty and the economic hardships had hindered women of seeking the required health care and resulted of them prioritising other members of their households. Added to the above, the males' patriarchy in the family had increased women and girls vulnerability. Hence, their capacity to seek the reproductive care was extremely restricted

Reflecting on that is drawn in Figure 10, vulnerability of women and their inferior position in their household and their community are affected by the listed themes. Gender based violence that increases in war times, family financial dilemmas, displacement and powerlessness. To sum it up, the concept of vulnerability is adding up to the impacts of the above issues, but it is also deepened by the elements of males' power upper status. A simple fact is that" this relationship between vulnerability and the synthesised themes is a two ways impact. If few changes can be made to reduce vulnerability the impact of the found themes can be minimised. (I hope it is rather possible to say say eliminate),

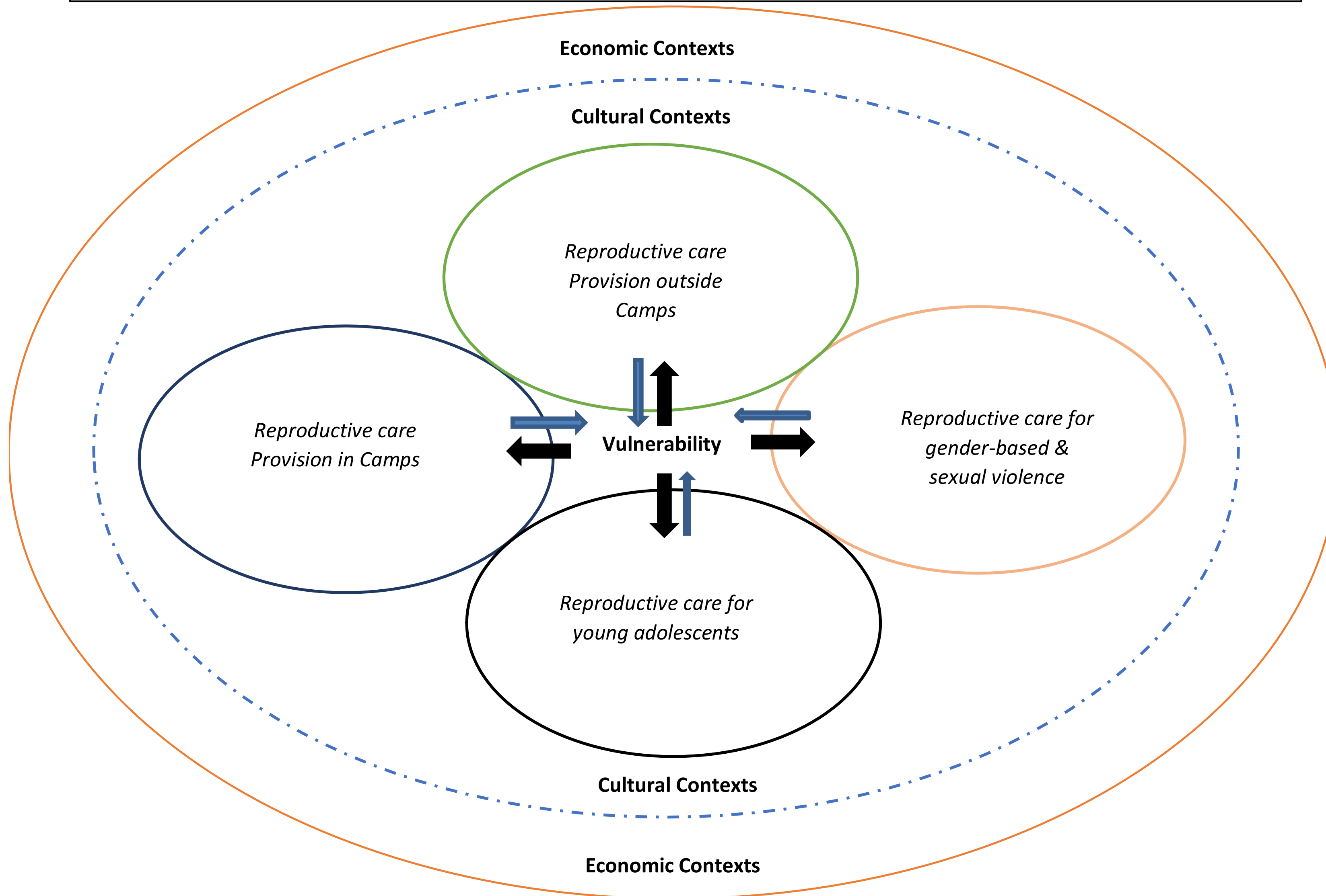
Nonetheless, women and girls on their way to Europe were subject to different sorts of vulnerability. These camps did not acknowledge their sexuality as women and girls. Settings were insensitive, indignifying and ignorant to their basic needs such as mixed sanitary and toilets. Their vulnerability was deeply enhanced by the absence of responsive care. For instance, women victims of rape were not able to disclose the faced sexual abuse to the camos none experienced immigration officers.

Although we are acknowledging that immigration is imposing financial and political challenged on governments, no signs of refugees influx stopping. The concept of women and girls vulnerability can be simple but positively impacted by minor changes made in these transit camps. Changes that are minor, do not cost much but sensitively respect gender and

sexuality of this particular group or people crossing borders to escape death and seek safety as a basic but so hard to reach need.

Whether they were in neighbouring countries or on their route to Europe, women experiences were hugely influenced by absence, dissonance and vulnerability in provision, lack of awareness and power

Figure 10 Women and girl's experiences: Absence, dissonance and vulnerability in provision, awareness and



4.8 Summary

The scoping review had identified a gap in the reproductive care provision in temporary and transit camps. In addition, the researcher has a deep interest in understanding the Syrian refugees' experiences in particular. Therefore this chapter explored experiences and perspectives of Syrian refugees resided in Syria neighbouring countries, in transit camps and asylum accommodation centres while they were travelling to seek the safe haven in Europe.

Secondary analysis of qualitative data had been utilised. Projects evaluations and research reports had been thematically analysed. Limited source of data was found.

Whether they were in camps or out of camps settings, in neighbouring countries or during their journey to Europe, Syrian women and girls were of a higher vulnerability of all sorts of gender based and sexual violence. No adequate reproductive care was s available for them; economic hardship and male patriarchy have hindered them of seeking the required reproductive care. Moreover, no adequate t information was provided as and when needs be. Early marriage has increased such vulnerability and contributed in poor birth outcomes. Contraceptives and family planning were available although unmarried females were refused such services even in rape cases. Results and findings are critically discussed and analysed in line with the literature review findings in Chapter five.

CHAPTER 5:

DISCUSSION AND RECOMMENDATIONS

5.1. Introduction

This chapter discussed results of the Syrian Refugee Women experiences of reproductive care provision in neighbouring countries, temporary and transit settings and compared them with the wider context of the Scoping literature review findings. It introduced the novel contribution of this thesis and highlighted the challenges faced while undertaking this research work. A spotlight on the researcher insights and reflection were also illustrated. Recommendations and conclusions have been covered in the last chapter of this thesis.

5.2. Novel contribution

Although the experiences of women refugees of the health care they receive was a subject that had been explored globally and by many researchers, the novelty of this piece of work is that it tried to explore the particularity of Syria women refugees of reproductive care in temporary and transit camps.

Scoping the literature was the first step in this research journey. It contributed in recognising the essential aspects of the reproductive care provision to women refugees and asylum seekers, and directed the researcher of what can be of a high influence to these experiences. Trying to discover all stages of their route to a safe haven, the literature materials included experiences of women refugees from variable nationalities, during different stages of their journeys, who settled in different countries of final destinations. International studies in addition to the UK studies helped in determining how ethnic and cultural variations can affect significantly the women experiences and perspectives of reproductive care. While seeking asylum and refuge is not limited to particular backgrounds, countries or ethnicities, any country that can provide safer and peaceful life conditions can be a county of resettlement. Nonetheless, in most situations, the refuge journey passes through multiple pathways where refugee camps can be either transitional or long-term residential camps.

Understanding the experiences of refugees in long-term refugee camps was so much easier than understanding such experiences in the transit and temporary settings camps. After few years, these long-term refugee camps become sort of a home to displaced people. On another hand, the short stay in transit camps does not allow nor give the health providers enough time and tools to understand further the impact of the care provided. Moreover, refugees and asylum seekers are not quite keen to give their opinions or get involved in such health care are they should be “leaving soon”.

Analysing the secondary qualitative data of Syrian refugees in Neighbouring countries that were not seen as long term home, and in transit camps on the route to Europe may be considered as an introduction to understand further this deep era of vulnerability.

To elaborate further, the main contribution of this theses is illustrated in understanding the experience of Syrian women refugees staying for a very short time in Transit camps while travelling to Europe. Government with their Borders Forces might not particularly focus on living conditions in temporary and transit camps, as this stay is “temporary”, attention will not be given to small details. My research had shown that No adequate gender sensitivity in transit sites, this is reflected by women and girls refugees sharing accommodation with men and no separation of latrines services. Making small but considerate and sensitive changes will tangibly improve the experiences of this vulnerable group. Educating Border forces individuals to run a sensible conversation with women and girls may encourage them to disclose potential sexual violence and enable them to seek the medical by emergency help such as emergency contraceptives.

As I researcher and if I have been given the chance to anecdotally speak to hosting governments that accommodate refugees in short term and transit settings, I will simply say:” when immigration is a global pain, and fund will not be prioritised for immigrants and refugees; wars are still there, people are still seeking safety and refuge, these people faced all sorts of torture, destitution and misery, especially if they are women and girls. Therefore, the small but affordable changes in transit camps such as latrines and accommodation separation, availability of hygiene female kits and staff that is able to run a sensitive conversation with a devastated woman will make a major changes in these troubled human beings short stay on their way to a safe heaven.

The model of mapping women and girls’ journeying and surfacing their experiences of reproductive care services in the scoping review introduced the overlapping themes and

subthemes that tangibly influenced such experiences. However, the secondary analysis of qualitative data model highlighted the impact of economic and cultural factors on hindering Syrian women capacity to seek the care they need. The above had helped in coming up with some recommendations to slightly improve such experiences by working in better involvement of care and maybe a positive championship of women refugees.

5.3 Reflections on the findings

In order to present the findings of the secondary analysis of the qualitative data of chapter 4 and reflect on them, the researcher focused on the findings of two main areas of Syrian refugees in Syria neighbouring countries and in transit camps on route to Europe. She compared and analysed them in line with the scoping review results. Although many similarities were noted, further insights had been discussed.

5.3.1. The provision of reproductive care in temporary and camps settings

Studies implemented in camps were few in comparison with those implemented in the final country of resettlement. Although some collected studies in the scoping review introduced aspects of women experiences and perspectives in the refugee camps, it was not clear whether these camps are for long-term residency or transitional and short-term stay camps where life conditions including health care provision may not be adequate nor prioritised.

Notably, living circumstances and the context of health care provision may crucially vary between long term displacements where refugees live for months and years and short term transit camp while travelling to Europe or waiting for the asylum meeting or their asylum application to be decided in one of the European countries. Hence, the experiences of Syrian refugees were explored separately in longer-term camps (Neighbouring countries) and transit camps (on route to Europe)

5.3.1.1. The provision of reproductive care in Neighbouring countries

It is worth noting that Syrian refugees in Jordan and Turkey had lived in both camps and out of camps settings where circumstances were not the same including the provision of health care.

In Lebanon, due to government restrictions, no official camps to accommodate Syrian refugees were established. Lebanon had a long-term and previous history of having

Palestinians refugees that lived in camps and ended up fully settled there with no intention nor possibility to be fair to return back home ; this experience may had influenced the decision not to establish camps to avoid the long term settlement of Syrians. However, this had resulted of Syrian families living in randomly, and in none official camps that are built by a family member with no minimum safety, hygiene or any normal living conditions.

Many similarities were noticed when comparing between the Syrian refugees experiences analysed from the secondary qualitative data and experiences of international refugees of the scoping review.

Examples of such similarities had risen when evaluating the provision of the Minimum Initial Services Package MISP in humanitarian setting; results showed that MISP were not adequately distributed to Syrian women living in camps. Clean delivery kits were not distributed in ALZaatari camp of Jordan as this might have encouraged Syrian women to give birth at home with all possible side effects, morbidities and mortalities of mothers and their babies. (Krause *et al*, 2015;WRC,2014). In the scoping review, the above kits were given to refugee women in a refugee camp in Nigeria knowing that home deliveries were preferred (UNFPA, 2011) with health visitors attending the home birth. Although the purpose of restricting the distribution of MISP kits in Alzaatari camp in Jordan was to limit home delivery, this practice may have resulted of a negative and contradicting impact. It did not stop Syrian women of having their babies at home with no clean kits or professional attendants with all the potential complications.

Moreover, whether it is camps or out of camps settings; Syrian refugee women flagged the fact that no adequate explanation was given to them about the reproductive health services available for them, their entitlements and where from to seek the required care. Hence, women were not receiving the services that are entitled for, paying more than what needed or not seeking the service at all. (Krause *et al*. 2015; WRC, 2014)

The above results matched the literature review findings, refugee women felt that they lacked the sufficient knowledge of how and where from they may seek the reproductive care they need. (Merry.*et al*,2011);Carolan,2010;Norredam *el al*,2005;Murray.et al, 2010;Mengesha.*et al*,2017;Sudbury & Robinson, 2016; Asif *et al*,2015; Heslehurst *et al*,2018)In most cases, these led of women not seeking the service at all or use the services at late stages .

In Turkey. Haemoglobin levels were lower in pregnant Syrian refugees when they reached their labour comparing with pregnant Turkish women. Cervical dilation was significantly higher when admitted for labour. (Erenel *et al*.2016)

The shortage of female practitioners in camps contributed in the inadequate provision of reproductive care. (Rees Masterson *et al*, 2014; Yasmine & Moughlian, 2016; Krause *et al*. 2015; WRC, 2014) Women were in many cases restricted by the men in their households to be seen by male professionals. The male dominance negatively affected the ability of women to decide when and how to ask for the health care they need.

The scoping review supported the above. Receiving the required reproductive care is challenging as utilising the services can be possible only when the permission of the husband is given. Seeking contraceptives tools is also a decision to be taken by men as women and girls have no control on their bodies. The cultural and religious factors controlled such behaviours. While variable contraceptives methods were available in camps for Syrians; restrictions again had been applied, only one side in Jordan was providing post rape emergency contraceptives. Single women and young girls were not allowed to have them at all. (Krause *et al*. 2015)

Syrian adolescents and young girls had similar experiences of reproductive care to evidence synthesised from the literature. Early marriages have been reported among Syrian young refugees in Jordan and Lebanon. In many cases, these marriages were not legally registered. Early marriages are a tool of protecting the "honour of the family", and reduce the economic pressure over the households that are already struggling to afford their basic daily needs. Adolescent girls who are not well educated and forced to follow the household head and accept the early marriage face, as a result, additional reproductive unmet needs when having the first sexual relation and during their antenatal and postnatal periods. In Istanbul the percentage of pregnant young girls aged 12-19 was significantly higher than Turkish group seen at the same medical centre. (WRDC, 2014; Benage *et al*, 2015; Yasmine &Moughlian, 2016; Dejong .*et al*,2017)

Similar to findings of the scoping review, Syrian women living in Alzaatari camp in Jordan reported feeling insecure and unsafe. During their residency in camps, women were less involved in decisions related to the camps design, tents distribution, kitchens, bathrooms or toilets locations. Given that men in camps are the main decision makers for such aspects, in most cases unaccompanied women and their households were located in the isolated places of

the camps where they need to walk a long distant in order to reach the kitchen and the hygiene supplements. This imposes major risks of being raped and sexually abused. Even for food distribution, women were less considered taking into account that women in such cases are the only carers for their households; sexual favours were provided for affording food and basic needs. Women and girls are also subject of human trafficking. In such contexts, sexual transmitted diseases, rape injuries, HIV/AIDS incidence, undesired pregnancies, and unsafe abortions can be the result of such life challenges. When reproductive health care packages are not adequately available or provided; meeting women and girls needs are unlikely to be achieved, pregnant women will struggle the most among women refugees and increased maternal and infant mortality will be reported.

Domestic abuse was a big dilemma. With all the socio-economic, cultural and financial hardships men became more abusive and women in most cases were quite hesitant to report such incidences. This may be influenced by their fears of being stigmatised among their peers (Family members and neighbours for instance). Women would be seen as not “good enough”, they might be afraid of being left, lost their family protection and become financially insecure. Most importantly, there is no trustful refuge and protection to seek out of their known context. On another word, there is no adequate support available to protect them should they reported such incidences.

The global literature evidenced that conflicts and wars may have contradicting impacts on fertility rates. While bearing children and affording their needs can be challenging for households in the complicated socio-economic conditions; families might consider reducing pregnancy and number of children. On the other hand, affected refugees communities prioritise the need to have more children and save races and ethnicities from potential extermination. Given that households displaced in camps need to afford their daily needs and taking into consideration that women and girls are less able to express their needs or opinions within a patriarchal communities.

Caesarean section was preferred by midwives and gynaecologists to avoid the normal birth complications on mother and new-borns, women reported less involvement in such a decision-making.

Language barriers were not as significant in hindering the provision of reproductive care among Syrian refugees. Arabic is spoken in both Jordan and Lebanon but not in Turkey.

While female genital mutilation created a huge health problem among other ethnic groups of refugees, FGM is not practiced in Syria. It was not reported nor mentioned at all in any of the reviewed source.

Reflecting on the findings emerged from the secondary qualitative data, and following the above comparisons with the scoping review; it is clear that the ability of Syrian women and girls to seek and receive the health care they need is highly controlled by many overlapping cultural and economic factors. This confirms models synthesised from both the scoping review and the Syrian refugees experiences analysed using the secondary qualitative data.

As stated previously, in Lebanon and Jordan, the language had never been a barrier to hinder seeking the care required. Being displaced in another country far from home can be by itself a huge cause of vulnerability. In the history time of peace, Syrians used to regularly visit Jordan and Lebanon due to similarities in the daily life and culture, however when the war started, displacement was another story. It flagged clearly that refugees are supressed, weakened and homeless. Most importantly, the daily life struggles and dilemma shadow all household members, but those who pay high are women and girls. Poverty deepens patriarchy and fears of family reputation for instance may enable more abuse toward women and young girls. Women inferiority in decision-making and the need to enable greater participation and empowerment are essential factors to ensure adequate protection, safety, dignity and better life conditions for the most vulnerable groups. Ensuring effective partnership between health providers and women receiving the services and considering that women are the centre of the care can result of the provision of responsive and culturally sensitive care.

5.2.1.2. The provision of reproductive care in transit camps while travelling to Europe

While the longer-term displacement of Syrian refugees in neighbouring countries allowed some projects research and evaluation to be undertaken, finding sources that explored Syrian women stories and experiences on the route to Europe was quite challenging.

Although, evidence was synthesised from three projects evaluation reports; findings were informative and impressive.

When analysing themes emerged; it is significantly important to remember that women and girls were in most cases travelling alone to Europe, they might have been pregnant or with

very young children with no partner or other part of the family accompanying them. Additionally, the transit camps or temporary accommodation allocated to them while they have been crossing the borders or waiting for an asylum claim were basic and less equipped than camps built in Syria neighbouring countries (Turkey , Jordan ..).

Some of Neighbouring countries camps, health care was managed and provided by both governmental bodies or long term existing NGOS such as the UNHC . Alzaatari camp in Jordan, for instance, had clinics and on site field hospitals. Oppositely, transit camps in Serbia, Slovenia and Macedonia did not have that, and refugees needed to seek the care outside the camp. This, in many, cases stopped pregnant women of leaving the camp and going out to seek the care unless in emergencies due to their fears of being separated of any relative travelling with (if they had any) or being delayed of their journeys.

Inadequate gender sensitivity was a huge issue in transit camps. Latrines and bathing facilities were shared with male refugees. Women mentioned that they tried to stop eating or drinking to avoid going to toilets. Risks of rape and sexual assaults imposed also a major risk. Governmental and NGOs workers dealing with women and girls were not fully capable of identifying those of higher vulnerability, taking into consideration that language barriers contributed in the limited disclosure of any sexual abuse they are facing or have faced before arriving to the camps. Women and girls were subject to sexual assaults by males sharing camps with them and in some cases by workers that are supposed to take care and safeguard them after they fled the war zone.

When disclosing information about gender based abuse (domestic or sexual), Syrian refugees in long term camps were hesitant to disclose domestic and gender based violence due to their cultural and honour based fears of being excluded from their community. Syrian women in transit camps were, on the other hand, hesitant to disclose that to frontline government personnel working with them as they were not able to run a sensitive conversation in this regard. This resulted of women with serious exposure to sexual risks or who had been sexually assaulted to be missed and remained unidentified. When post rapes kits were not available, and women are not aware what are the health services they can get and where from to seek them; health complications such as untreated sexual transmitted diseases STC , post rape pregnancies and trying to miscarriage intentionally with no health care provided will be overwhelming and may lead to death. It is the “deadly journey to the safe haven “

To sum up, services in transit camps were designed for refugees' short stay. It did not take into consideration women and girls higher vulnerability; in fact, it had exposed them to extreme risks instead of safeguarding them and trying to minimise their adverse experiences having lived and left the war zone and done the journey to Europe alone , pregnant or with very young children . Furthermore, improving their stay in the transit camps was not an "expensive" duty. It only needed basic but sensible approach when providing services. Whether separating males and females in latrines and bedroom, or equipping immigration officers with skills of undertaking a sensitive conversation with a potential victim of sexual abuse/rape, these simple functions would have slightly bettered women experiences and encouraged them to disclose vulnerability and seek the required care.

5.4. Researcher Reflection and insights

Being able to write my reflections and reaching this stage of reporting the study results is a delight that I did not assume I would get to at all. My journey to undertake this piece of work had gone through so many challenges and stages.

The idea of undertaking the research that explores experiences and perspectives of refugee women regarding the reproductive care provision started on the year 2010 when I applied to do my PhD at Bangor University and wrote my admission proposal. At that time; Syria had accommodated and helped more than one million of Iraqi refugees. As a previous health professional and UN/WHO member of Syria team, I was involved in planning and services delivery to Iraqi refugees. Nonetheless, the drive of the research had changed as soon as I arrived to the UK. It was agreed that the focus of the research will be reproductive care provision to Syrian refugees in the UK (although they were fewer in the UK then) or/ and camps that were established in Syrian neighbouring countries such as Jordan, Turkey and Lebanon. The first step of that research was to undertake the wide and large scoping literature review exploring the experiences of women asylum seekers and refugees from variable ethnic backgrounds and during different stages of their journey globally and in the UK. It was a huge literature review; but it widened my knowledge and understanding of the refugees' global dilemma. It also deeply affected me recognising how women from different nationalities who left their countries had been unified in becoming destitute; strangers and not always welcomed in other countries where they sought safety with their families.

It made me face the fact that Syrians including myself are passing through similar experiences; articles about Syrian refugees will be the material for other PhD and Master Researchers (This thought had left me in tears for a long period). I still remember that day when I went to the shop near the school to buy my lunch and found them fundraising for Syrian children. These emotions accompanied me for so long, but I ended up making peace with it

After almost 18 months of working on the literature review and thinking about the next step of the primary research; collecting data for the PhD was supposed to be implemented either by visiting Syrian camps in Jordan or by meeting Refugee women from different nationalities in Wales. To help taking my decision; I visited Amman, Jordan and met a UNFPA employee that gave me an idea about the complexity of visiting Alzaatari camp. The health and safety policy of Bangor University in addition to being a single mother to a teenage daughter; it was decided that I will undertake the research in Wales rather where BAWSO Women`s Aid and the Welsh Refugee Council may facilitate accessing and interviewing the refugee ladies.

I, therefore, started establishing some contacts with health professionals in Wales (health visitors, midwives) that were working with refugees and asylum seekers in particular. BAWSO Director Wanjiku Mbugua had very kindly offered to help in translating the transcripts and questionnaires to be used in data collection to all spoken languages. Despite the emotional pressure I was experiencing and my persistent worries about my parents living in Syria, my intentions were to complete my PhD as planned.

During the summer of 2013, I had no choice rather than suspending my PhD and find a full time work. PhD had been suspended on October 2013 and I started my full time job at BAWSO North Wales supporting BME women fleeing all sorts of gender-based violence.

During the following few years; I changed many jobs across England and Wales as I was furthering my career path. I worked for the Care Quality Commission, London as a Public Engagement Officer. I also worked as Public Health officer in Wokingham Borough Council, Berkshire England and appointed as the Director of BAWSO South West and Mid Wales and joined Public Health Wales team for which made me gladly return back home to North Wales. I am currently the Patient and Service User experience Manager (Central) BCUH Board.

In addition to crossing the country and changing many jobs; I had some health issues and my partner was diagnosed with Colon cancer and gone through a rough operation and treatment processes. All the above had affected my capacity to work and complete my research.

Nevertheless, I was still involved with the women refugees' stories, struggles and successes as well by raising awareness, raising funds and working with different third sector organisations and forums such as the Refugee Council, Christian Aid Cymru and the National Refugee Welcoming board in the UK. And I was honoured to be awarded the Women on the Move Award by the UNHCR and the Migrants organise in London on March 2015 and The Welsh Asian Women Award for Social and Humanitarian work in Wales WAWAA , April 2015.

By the time, the stories of my people crossing seas, drowned, survived, rejected or accepted by countries that supposed to be safe heaven, these stories had become part of my brain and heart. I am able now to return and read all the research and aid projects articles done about Syrian refugees without crying. With the hope of collecting their stories and maybe taking messages and lessons learnt to other listeners, to those that are able to make changes even if they are slight. I might help making the journey of my people particularly women and girls a tiny little bit easier. I hope.

It was a journey from a PhD to an MSc of Research. It started by scoping the literature and ended by analysing literature that focused on Syrian refugee women displaced in neighbouring countries and transit camps on the route to Europe. I admit though that the part that I was looking forward to explore further was the specific experience of Syrian women and girls crossing the borders to Europe. The novelty of this piece of work was that I specifically tried to understand further the particularity of Syrian women as refugees in short term and transit settings.

I am hoping that this small piece of work is going to highlight the specific difficulties and come up with some effective recommendations. I already started sharing the findings of my work in small venues (Welsh Red Cross, Appendix 2). I am looking forward to participating in related conferences and to sharing the insight with people that are in the decision area.

I am also keen to publish in relevant journals when possible. I am delighted that I have reached this stage; it was not easy but definitely worth it

5.5. Research challenges

The research journey had passed through many strengths and weaknesses. Nevertheless, it was a learning curve in every step of it.

5.5.1. Strengths points

Undertaking the scoping review was a great start as it allowed the researcher to have a better understanding of what the experience and perspectives of women refugees and asylum seekers in the international and the UK contexts. This also helped the researcher to identify her next focus. Using the scoping review provided a huge amount of literature to screen and analyse, so no relevant areas of knowledge were really missed.

The secondary analysis of qualitative data had also allowed the researcher to explore areas that could not be quantified. By reading women experiences, what they said, their shared thoughts and experiences made the researcher feels as if she became a "trustworthy" friend/allied of these women. Being Syrian herself enabled her to further understand the cultural aspects of their perspectives, and "where they were coming from ".

Most importantly, a very specific area of refugees' women experiences crossing the border and temporarily stayed in transit camps had been explored. This piece of work is only a start though.

5.5.2. Weaknesses and challenges

Added to the variable personal and life aspects that the researcher had gone through while undertaking the research and the need to transform the research from a PhD to an MSc of Research, few issues were also challenging.

The Scoping review was a great start indeed, but it produced a huge "lot" of literature that selecting from was not always easy. However, applying inclusion and exclusion criteria helped in reducing the amount to be analysed.

Being unable to undertake the primary research and relying mainly on secondary data may have limited the depth of the work. Nonetheless, the limitation of the relevant qualitative research that focused on women experiences in transit camps was another challenging point.

5.6 Recommendations

Recommendations had been separately presented for Syrian refugees in Neighbouring countries then for Syrian refugees' experiences in transit camps on route to Europe.

Evidence synthesised raised the need to enhance Syrian women empowerment and increase their involvement during all aspects of the refuge journey in order to ensure the protection and the dignity of the most vulnerable groups of refugees and asylum seekers.

Below are some recommendation that might positively affect refugee women experiences of reproductive care provision.

5.6.1. Syrian refugees in Neighbouring countries:

- Whether they are living in camps or out of camps settings, ensuring that information about the available health services, eligibility, how, and where from to access them are clearly provided to refugee women particularly the new comers .

- While language barriers may not be an issue in Jordan and Lebanon as Arabic is the spoken language; providing adequate interpretation in Turkey by female interpreters (if possible) will encourage women to seek the reproductive care they may need and enhance their knowledge of what are they eligible for and/ or existing limitations

- Given that international and local NGOs are involved in working with refugees in camps or out of camps settings; strengthening and effectively building the capacity of the above NGOs particularly local organisations may improve the service provision. Although these organisations may not the direct providers of health care; their support to women refugees and their families can positively contribute in women feeling for empowered and capable of seeking the health care they need. To illustrate more; some of local NGOs roles can be supporting women in their managing their everyday life details. When women are supported in other aspects, they might have more time to take better care of themselves including seeking the reproductive care as need be. An example of the support can be provided by explaining where is the health facility and how to access it, or in childminding other children..

- Ensuring that the Minimum Initial Services Package MISP is adequately distributed and the adequate supervision of health professional is available should women give

birth at home. To avoid the complications of home delivery; it is essential to raising the awareness of women about the importance of having their babies at hospitals in order to reduce possible complications. Moreover ensuring that adequate number of health professional is available at all stages.Although, suggestions such the above might sound theoretical and not easy to achieve; the cost of dealing with the health implications that might be resulted of the shortage of equipment and staff is highly overwhelming. When transportation to hospitals out of camps is not always available and women may need to pay even partially for the health service; giving birth at home might be the only options. Therefore ensuring the adequate distribution of MISP and under the supervision of adequate health professionals is safer and cost efficient for women and their new-borns.

- Ensuring that contraceptives methods are made available, and women are aware of the different options they can use. This essentially includes better access to emergency contraceptives for survivors of sexual assaults and rape.

- Enhancing a friendly reproductive care provision for young girls and raising their awareness about the importance of taking care of their own health. This may reduce the health implications of pregnancy and giving birth in young ages. On another word, if it was not possible to erase the harmful practice of early marriage and pregnancies; teaching young girls to seek the care when need be may reduce the negative health implications, morbidity and mortality.

- Engaging with Syrian women in longer terms camps, as they are the main users of the services. This needs to be achieved when assessing needs, planning the services and delivering them. Many international and local NGOs planned their services delivery based on rapid quick assessments and in most cases, the quick and overwhelming influx of refugees may restrict the ability to have an adequate needs assessment and consequently adequate response. However, given that the Syrian conflict is not solved and displaced families are more likely going to stay in the neighbouring countries (whether in camps or out of camps settings) for long period of time and their return home imposes major risks of torture and prosecution ; involving the community that uses the services can be achieved . Women can be at any stage involved in needs assessment, planning and delivery of reproductive care.

- Championing refugee women in their community and pioneering intellectuals among them. This does not mean selecting women with higher qualification for instance but working with those that present with commitment and acceptance by their peers. Those women can play crucial roles in setting positive example to others, discussing culturally sensitive issues and empowering them. Positive examples are more acceptable and accommodated when they come from the local members of the communities

- Targeting and involving male partners in awareness raising with regard to gender based violence, early and forced marriage implications and the importance of empowering their wives and daughters to seek the care they need

- Most importantly, relying on men that are key actors in their communities, and championing those that are decisions makers .These men will be able to positively influence others regard to harmful practices, gender based violence and how empowering women in their families can be protective and safer.

5.6.2. Syrian refugees in transit camps on the route to Europe:

With the entire global atmosphere toward immigration, and given that the stay of refugees in transit and temporary camps is supposed to be limited, improving living circumstances including the health care provision may not be seen as a priority for related governments and public bodies. But these human beings had left war zones, part of their lives, loved ones, life long memories behind and risked their own and their children lives to reach a safer place.

Improving their stay in transit camps require more focused but affordable efforts such as:

- Enhancing basic privacy of women and girls staying in transit camps by separating sleeping, toilets and bathing facilities. This will reduce possible sexual assaults exposures.

- Ensuring that government frontline workers working with women and girls and interviewing them are trained enough to conduct a sensitive conversation. This will help them disclose further vulnerability such as sexual incidences and consequently any required reproductive care. Trained female workers might encourage refugee

women to disclose sensitive incidences including any sexual disclosure or special needs.

- Ensuring that frontline workers whether they are government or voluntary workers are adequately able to identify those of particular vulnerability, so they can signpost them and safeguard them as appropriate.
- Ensuring that adequate interpretation is provided during interviews. This includes information about health care access, asylum process, legal eligibility or any other safeguarding information to be distributed in Arabic.
- Ensuring that emergency contraceptives, post rape services including mental health support are available on sites.
- Ensuring that safe reproductive care is provided on site for pregnant women (antenatal care for example), or reassuring them that no delays will occur if they received the care outside the camp. This may be possible for instance by having support workers that can accompany them to outside facilities when required.
- Applying strict disciplines on workers who abuse their duties and sexually abuse or risk women and girls that they are supposed to safeguard.
- Ensuring that female hygiene kits are available and distributed to women and girls as they may be embarrassed to ask about them.
- Despite their short stay, encouraging women and girls to express their needs and taking their opinions about the variable care they receive may slightly improve their experience in transit camps. Most importantly, it will improve the experience of women and girls that may follow them to these camps.

Sadly, the Syrian dilemma is not easing soon, millions that are displaced and thrown all over the world will remain unable to come back home. The global atmosphere toward immigrants is not helping at all. Nevertheless, I still assume that little may help.

Improving women refugees experiences of reproductive care provision and reducing their vulnerability in general; can be achieved not only by increasing the access and the availability of such services but also by ensuring it is adequately and sensitively provided . Most

importantly, enhancing women empowerment to seek the care they need, to take their own decisions and to be as involved as possible in decisions related to their own body.

5.7. Conclusion

This thesis aimed to explore experiences and perspectives of women refuges and asylum seekers of reproductive care with a significant focus in Syrian refugees' experiences in neighbouring countries and transit camps on the route to Europe. The thematic analysis method was used to analyse and synthesise evidence.

While the scoping review explored the experiences of women refuges of reproductive care globally and in the UK; analysing secondary qualitative data method had been used to explore experiences for Syrian refugees displaced in neighbouring countries and in transit camps on the route to Europe. Evidence emerged from the literature review showed that the provision of reproductive care was restricted by the inadequate knowledge and awareness about the new health systems in the country of settlement. The attitude and the relation with their health providers affected women attendance to the antenatal care either positively or negatively. Where many women mentioned that they were treated with racism and stereotyping; sympathy and non- judgmental attitude were highly appreciated. Health providers' awareness about the particular medical and cultural needs was not adequate. Financial restrictions and women entitlement of reproductive care inhibit women of seeking the needed services. Women dispersal affected extremely the adequate provision of reproductive care. In many situations, health providers loose the connection with the pregnant women, late antenatal care and major birth complications are reported therefore. The living conditions in the temporal accommodation are mostly so bad, as women share the accommodation with strangers; additional difficulties are added to the women daily life problems.

Women with FGM faced additional difficulties either during their antenatal and postnatal care or with the attitude shown by their health providers. Women involvement in decision making related to the reproductive care provision was not adequately achieved. The availability of adequate interpretation services was essential to ensure the accurate attendance and the effective communication between the providers and the women. This was not always accomplished which affected therefore the appropriateness of the health care provided and the information communicated with the women.

Adolescent reproductive health care was of a major concern, in many refugees communities, the needs of reproductive health care for such a group of population was ignored and therefore not adequately met. Neither the community nor the health providers admitted the adolescents' needs; this fact had resulted of adolescents more vulnerable of unprotected sexual activities, and unsafe abortion when they are victims of gender and sexual based violence.

Reproductive care in refugees and transit camps is not adequately available. When the direct emergency package should be available and provided; women might not be aware about the availability of safe delivery kits. Conflicts and insecurity impose additional restrictions in accessing the health care as need be.Furthermore, when sexual and gender based violence can be faced in camps, survivors might not seek the direct services due to the stigma. However, evidence that emphasises transitional and camps reproductive care is little. Added to the above factors, the patriarchy role and male dominance increased the restrictions faced by women to seek the health care they need and as appropriate.

The secondary analysis of qualitative data/chapter 4 explored Syrian women experiences of reproductive care in Neighbouring countries and transit camps. Evidence had been analysed and compared in line with the scoping review that explored experiences of women refugees of reproductive care provision globally and in the UK. While adequate reproductive care provision was not always available for those groups of higher vulnerability; marginalising them and hindering their capacity to take decisions relevant to the care they receive had significantly contributed on their everyday obstacles.

As per the experiences of Syrian refugees of reproductive care provision, whether they were in camps or out of camps settings, in neighbouring countries or during their journey to Europe, Syrian women and girls were of a higher vulnerability of all sorts of gender based and sexual violence. No adequate reproductive care was always available for them; economic hardship and male patriarchy have hindered them of seeking the required reproductive care where no adequate relevant information was provided. Early marriage has increased such vulnerability and contributed in poor birth outcomes. Contraceptives and family planning were available although unmarried females were refused such services even in rape cases.

The researcher insights and reflections were introduced in additions to research challenges faced. Recommendations were listed in reliance to the analysis undertaken.

REFERENCES

(APA STYLE)

Al Gasseer.N, Dresden.E,Keeney.G.B, Warren.N (2004) *Status of Women and Infants in Complex Humanitarian Emergencies.* Journal of Midwifery & Women`s Health 49(4) 7-13

Alzate.M M (2007) *The sexual and reproductive rights of internally displaced women: the embodiment of Colombia's crisis.* Disasters 32 (1): 131-148.

Ameresekere.M,Borg.R,Frederick.J, Vragovic.O,Saia.K,Raj.A (2011) *Somali immigrant women`s perceptions of caesarean delivery and patient-provider communication surrounding female circumcision and childbirth in the USA*. International Journal of Gynecology and Obstetrics 115: 227-230

Amir.M,El-Mowafi.I,Chahien.T,Youssef.H (2020) *An overview of the sexual and reproductive health status and service delivery among Syrian refugees in Jordan, nine years since the crisis: a systematic literature review*. Reproductive Health 17:166 https://doi.org/10.1186/s12978-020-01005-7

Anderson.J,Doyal.L (2004) *Women from Africa living with HIV in London: a descriptive study.* AIDS CARE 16 (1) 95-105

Atkins.S,Lewin.S,Smith.H,Engel.M,Fretheime.A,Volmink.J (2008) *Conducting a meta-ethnography of qualitative literature: Lessons learnt* BMC Medical Research Methodology 2008, **8**:21 doi:10.1186/1471-2288-8-21

Arksey, H. and O'Malley, L. (2005) *Scoping studies: towards a methodological framework,* International Journal of Social Research Methodology*, 8, 1, 19-32.*

Ascoly.N,Halsema .I.V.,Keysers.L (2001) *Refugee Women, Pregnancy, and Reproductive Health care in the Netherlands.* Journal of Refugees Studies 14(4).

Asif.S,Baugh.A,Jones.N.W (2015) *The obstetric care of asylum seekers and refugee women in the UK* TOG the Obstetrician and Gynecologist 17 (4) 221-298

Austin.Z,Sutton.J (2014) *Qualitative Research: Getting Started.* The Canadian Journal of Hospital Pharmacy 67(6): 436–440

Barnes.D.M,Harrison.G.L (2004) *Refugee Women`s Reproductive Health in Early Resettlement* Journal of Obstetric, Gynecologic & Neonatal Nursing 33(6) 723-728

Benage.M,Greenough.G.P,Vinck.P,Omeira.N,Pham.P (2015) *An assessment of antenatal care among Syrian refugees in Lebanon*. Conflict and Health 9(8)

Benner.M.T,Townsend.J,Kaloi.W, Htwe.K,Naranichakul.N , Hunnangkul.S, Carrara.V.I Sondor.E (2010) *Reproductive health and quality of life of young Burmese refugees in Thailand*. Conflict and Health 4(5)

Bernett.A,Fassil.Y (2000) *Meeting the health needs, of refugee and asylum seekers in the UK an information and resource pack for health workers* the UK Department of Health, Directorate of Health and Social Care Publication

Beyani.C (1995) *The needs of refugee women: A human-rights perspective,* Gender & Development 3(2) 29-35

Bishop.L,Kuula-Luumi.A (2017). *Revisiting Qualitative Data Reuse: A Decade On.* SAGE Open January-March 2017: 1–15

Booth.A, Brice.B, *Evidence Based Practice for Information Professionals: A Handbook.* London: Facet Publishing.[Online] Available on : http://ebliptext.pbworks.com/f/Booth+%26+Brice+2004+EBP+for+Info+Professionals+-+A+Handbook.pdf

Bosmans.M,Nasser.D,Khammash.U, Claeys.P,Tammerman.M (2008) *Palestinian Women`s Sexual and Reproductive Health Rights in Longstanding Humanitarian Crisis*. Reproductive Health Matters 16 (31):103-111

Boyatziz.R (1998) *Transforming Qualitative Information: Thematic Analysis and Code Development* (Book) SAGE Publications

Braun, V. and Clarke, V. (2006) *Using thematic analysis in psychology*. Qualitative Research in Psychology, 3 (2). pp. 77-101.

Britten.N,Campbell.R,Rope.C,Donovan.J,Morgan.M,Pill.R (2002) *Using Meta Ethnograohy to Synthesise Qualitative Research : a Worked Example.* Journal of Health Service,Research Policy Vol 7 No 4

Breecher Bryant. H (2012) *Improving Care for Refugees and Asylum Seekers: The Experiences of Midwives.* [Online] available on Asylum Aid , Women `s Asylum News (109) https://www.asylumaid.org.uk/wp-content/uploads/2013/02/WAN_March.pdf .

Campbell. S (2003) *Reproductive health interventions for displaced populations*. Primary Health Care 13 (3) 39-42

Campbell.L.R , Thind.H,Howard.M,Koteles.J,Fowler.N, Kaczorowski.J (2008). *Understanding the Health of Refugee Women in Host Countries: Lessons from the Kosovar Re-Settlement in Canada*. Prehospital and Disaster Medicine 23(4) :322-327

Carolan. M (2010) *Pregnancy health status of sub-Saharan refugee women who have resettled in developed countries: a review of the literature*. Midwifery 26 :407-414

Carolan.M, Cassar.L (2007) *Pregnancy care for African refugee women in Australia: attendance at antenatal appointments*. Evidence Based Midwifery 5(2):54-58

Chalmers.B, Hashi .K.O (2000) *432 Somali Women`s Birth Experiences in Canada after Earlier Female Genital Mutilation*. Birth 27(4):227-34.

Chynoweth.S.K (2008) *The Need for Priority Reproductive Health Services for Displaced Iraqi Women and Girls*. Reproductive Health Matters 16 (31):93-102

Clifford.C (2008) *Rape as a Weapon of War and it`s Long-term Effects of Victims and Society.* Conference paper .7th Global Conference Violence and the Contexts of Hostility Budapest, Hungary

Correa-Velez.I,Ryan.J (2012) *Developing a best practice model of refugee maternity care* Women and Birth 25, 13-22. Department of Health DH (1999) *Health Profile of England* . PDF

Cottingham.J, Garcia Moreno.C,Reis.C (2008) *Sexual and reproductive health in conflict areas:the imperative to address violence against women*. BJOG 115:301-303

D`Souza.L,Garcia.J (2004) *Improving services for disadvantaged childbearing women.* Child Care, Health & Development. 30 (6) 599-611

DeJong.J, Ghattas.H, Bashour.H,Mourtada.R,Akik.C,Reese-Masterson.A (2017) *Reproductive, maternal, neonatal and child health in conflict: a case study on Syria using Countdown indicators* BMJ Glob Health ;**2**

Dernnan.V.M & Joseph.J. (2005) *Health visiting and refugee families: issues in professional practice.* Journal of Advanced Nursing JAN 49 (2) 155-163

Donnelle.M.B, Harrison. C.L (2006*) Refugee Women's Reproductive Health in Early Resettlement.* Journal of Obstetric, Gynecologic & Neonatal Nursing JOGNN 33(6) 723-728

Downe.S, Finlayson.K, Walsh.D, Lavender.L (2009) *'Weighing up and balancing out': a metasynthesisof barriers to antenatal care for marginalised women in high-income countries.* International Journal of Obstetrics and Gynaecology BJOG 116(4)

Drennan.V.M,Joseph.J (2005) *Health visiting and refugee families: issues in professional practice*. Journal of Advanced Nursing 49 (2):155-163

Essen.B, Binder.P, Johnsdotter.S (2011) *An anthropological analysis of the perspectives of Somali women in the West and their obstetric care providers on caesarean birth.* Journal of Psychosomatic Obstetrics& Gynecology 32(1):10-18

Ernel.H, Mathyk.B,Sal.V,Ayhan.I,Karatas.S,Bebek.A,(2017) *Clinical characteristics and pregnancy outcomes of Syrian refugees: a case–control study in a tertiary care hospital in Istanbul, Turkey.* Archives of Gynecology and Obstetrics **volume 295**, pages45–50

Furuta.M,Mori. R (2008) *Factors Affecting Women`s Health –Related Behaviors and Safe Motherhood: A Qualitative Study From a Refugee Camp in Eastern Sudan.* Health care for Women International 29: 884-905

Erance.E,Uny.I,Turley.R,Maxwell.M,Duncan,E,Jepson.R,Roberts.R,Noyes.J (2019) *A methodological systematic review of meta-ethnography conduct to articulate the complex analytical phases* BMC Medical Research Methodology 19:35

Gannan.R, Sword.W,Black.M,Carpio.B (2012) *Influence of Maternal Birthplace on Postpartum Health and Health Services Use* . Journal of Immigrant and minority Health 14 223-229

Gaudion.A,Mcleish.J, Homeyard.C (2007) *Free care for the displaced*? MIDWIVES 10 (3)

Gurnah.K,Khoshnood.K,Bradley.E, Yuan.C (2011) *Lost in Translation: Reproductive Health Care Experiences of Somali Bantu Women in Hartford, Connecticut*. Journal of Midwifery & Women`s Health 56(4) : 340-346

Hammoury N, Khawaja M, Mahfoud Z, Afifi RA & Madi H (2009) *Domestic violence against women during pregnancy:the case of Palestinian refugees attending an antenatal clinic in Lebanon*. Journal of Women's Health 18, 337–345.

Hans.A (2008) *Gender, Camps and International Norms*. Refugee Watch 32:64-73

Haynes.M.L, Cardozo.B. (2000) *Sexual Violence against Refugee Women*. Journal of Women`s Health &Gender-Based Medicine 9 (8)

Heaton.J (2008) *Secondary Analysis of Qualitative Data: An Overview* Historical Social Research Vol.33 (125)

Henttonen.M, Watts.C, Roberts. B, Kaducu.F, Borchert. M (2008) *Health Services for Survivors of Gender Based Violence in Northern Uganda : A Qualitative Study*. Reproductive Health Matters 16 (31) : 122-131.

Herrel.N, Olvetich.L, DuBois.D.K, Terry.P,Thorp.D, Kind.E, Said.A (2004) *Somali Refugee Women Speak Out About Their Needs for Care During Pregnancy and Delivery*. Journal of Midwifery &Women`s Health 49 (4) 345-349

Heslehurst.N, Brown. H,Pemu.A,Coleman.H, Rankin.J (2018). *Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews* BMC Medicine (2018) 16:89

Iliadi.P (2008*) Refugee Women In Greece:-A Qualitative Study of Their Attitudes And Experience in Antenatal Care.* Health Science Journal 2 (3)

International Organisation for Migration IOM (2011) *An Analysis of Migration Health in Kenya* [Online] available on IOM Website https://publications.iom.int/books/analysis-migration-health-kenya

Irwin.S,Winterton.M (2011) *Debates in Qualitative Secondary Analysis: Critical Reflections* Economic &Social Research Council, A Timescapes Working Paper 4

Johnston.M.P, (2014*) Secondary Data Analysis: A Method of which the Time Has Come* Qualitative and Quantitative Methods in Libraries (QQML) 3:619 –626, 2014

Kennedy.P, Murphy-Lawless. J (2003) *The maternity care needs o refugee and asylum seeking women in Ireland*. Feminist Review 73(39).

Kerimova.J,Posner.S.F,Brown.T.Y,Hillis.S, Meikle.S,Duerr.A (2003) *High Prevalence of Self-Reported Forced Sexual Intercourse Among Internally Displace Women in Azerbaijan.* American Journal of Public Health 93(7):1067-1070

Keygnaert. I, Vettenburg. N, Temmerman M.(2012) *Hidden violence is silent rape: sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands.* Cult Health Sex. 14(5)

Kottegoda.S, Samuel.K, Emmanuel.S (2008) *Reproductive Health Concerns in Six Conflict-Affected Areas of Sri Lanka.* Reproductive Health Matters 16 (31):75-82

Krause.S,Williams.H, Onyango.M.A, Sami.S,Doesdens.W,Giga.N,Stone.E, Tomczyk.B (2015) *Reproductive health services for Syrian refugees in Zaatri Camp and Irbid City, Hashemite Kingdom of Jordan: an evaluation of thevMinimum Initial Services Package* Conflict and Health 9

Kulig.J.C (1988) *Conception and Birth Control Use : Cambodian Refugee Women`s Belief and Practices.* Journal of Community Health Nursing 5 (4) 235-246

Kulig.J.C (1995) *Cambodian refugees` s family planning knowledge and use*. Journal of Advanced Nursing 22:150-157

Kurth.E,Naeger.F.N, Zemp.E, Tschudin.S,Bischoff.A (2010) *Reproductive health care for asylum-seeking women- a challenge for health professionals*. BioMed Central BMC Public Health 10:659

Lehmann.A (2002) *Safe Abortion: A Right for Refugees?* Reproductive Health Matters 10 (19) 151-155

Levac.D,Colquhoun.H, O`Brien.K.K (2010) *Scoping studies:advancing the methodology.* Implementation Science 5:69

Liamputtong Rice.P, Naksook.C (1998) *The experience of pregnancy, labour and birth of Thai women in Australia.* Midwifery 14, 74-84

Long-Sutehall.T,Sque.M, Addington-Hall.J (2010) *Secondary analysis of qualitative data: a valuable method of exploring sensitive issues with an elusive population?* Journal of Research in Nursing 16 (4)335-334. The Royal College of Obstetricians and Gynaecologists RCOG (2008)

MacFarlane.A,Glynn.L.G, Mosinkie.P.I, Murphy. A.W (2009) *Responses to language barriers in consultations with refugees and asylum seekers; a telephone survey of Irish general practitioners*. *BMC Family Practice* **9**:68

Maguire.M, Delahunt. B (2017) *Doing a Thematic Analysis: A Practical, Step-by-Step Guide for Learning and Teaching Scholars.** AISHE-J: The All Ireland Journal of Teaching and Learning in Higher Education. 8 (3)

Masterson.A.R,Usta.J,Gupta.J,Ettinger.A (2014) *Assessment of reproductive health and violence against women among displaced Syrians in Lebanon.* BMC Women`s Health 14(25)

Matlin.S.A, Depoux.A, Schütte.S,Falhault.A,Saso.L (2018) *Migrants' and refugees' health: towards an agenda of solutions* Public Health Reviews (2018) 39:27

McKay.S (1998) *The Effects of Armed Conflict on Girls and Women*. Journal of Peace Psychology 4(4): 381-392

McLeish.J (2002) *MOTHERS IN EXILE Maternity experiences of asylum seekers in England* [Online] Available on Maternity Action Website: https://www.maternityaction.org.uk/wp-content/uploads/2013/09/mothersinexile.pdf

Mengesha ZB, Perz J, Dune T, Ussher J (2017) *Refugee and migrant women's engagement with sexual and reproductive health care in Australia: A socio-ecological analysis of health care professional perspectives.* PLoS ONE 12(7)

Mercy Corps (2020) *Syrian Refugee Crisis - What You Need to Know* [Online] available on the Mercy Corps Website: https://www.mercycorps.org/blog/quick-facts-syria-crisis

Merry.L, Gagnon.A.J, Kalim.N,Bouris,S.S (2011) *Refugee Claimant Women and Barriers to Health and Social Services Post-birth*. Canadian Journal for Public Health 102 (4) 286-290

Morrison.V (2000) *Contraceptive Need Among Cambodian Refugees in KHAOPHLU Camp*. International Family Planning Perspectives 26 (4):188-192

Munn.Z, Peters.M.D.J, Tufanaru.C, McArthur.A, Aromataris.E (2018) *Systematic review or scoping review?Guidance for authors when choosing between a systematic or scoping review Approach* BMC Medical Research Methodology (2018) 18:143

Murray.L, Windsor.C, Parker.E (2010) *The Experiences of African Women Giving Birth in Brisbane, Australia.* Health Care for Women International 31:458-472

Nabb.J (2006) *Pregnant asylum -seekers: perceptions of maternity services provision.* Evidence Based Midwifery 4(3): 89-95.

Noblit GW, Hare RD. Meta-ethnography: synthesizing qualitative studies, vol. 11. California: Sage Publications; 1988

Norredam.M, Mygind.A, Krasnik.A (2005) *Ethnic Disparities in Health. Access to health care for asylum seekers in the European Union- a comparative study of county policies.* European Journal of Public health 16 (3) :285-289

Nowell.L.S,Norris. J.M, White.D.E, Moules.M.J (2017) *Thematic Analysis: Striving to Meet the Trustworthiness Criteria* International Journal of Qualitative Methods 16: 1–13

OH.S.A, HOBSTETTER.M (2011) *Forced Migration and Adolescent Reproductive Health* Gender Perspectives 3(2).

Okanlawon.K, Reeves.M,Agbaje.O.F (2010) *Contraceptive Use : Knowledge, Perceptions and Attitudes of Refugee Youths in Oru Refugee Camp, Nigeria*. African Journal of Reproductive Health 14(4): 17-25

Oliver.S,Harden.A,Rees.R,Shepherd.J,Brunton.J,Garcia.J,Oakley.A (2005) *An Emerging Framework for Including Different Types of Evidence in Systematic Reviews for Public Policy* SAGE Journals 11(4)

Pavlish.C.L, Noor.S,Brandt.J (2010) *Somali immigrant women and the American health care system: Discordant beliefs, divergent expectations, and silent worries.* Social Science and Medicine 71: 353-361

Peterson.J, Pearce.P.F, Ferguson.L.A,Langford.C.A (2016) *Understanding scoping reviews: Definition, purpose, and process.* Journal of the American Association of Nurse Practitioners *29* (2017) 12–16

Purdin.S,Khan.T,Saucier.R.(2009) *Reducing maternal mortality among Afghan refugees in Pakistan* . International Journal of Gynecology and Obstetrics 105(1):82-5.

Reavy.K, Hobbs.J, Hereford.M, Crosby.K (2012) *A new clinic model for refugee health care: adaptation of cultural safety.* Rural and Remote Health 12:1826 [Online] availble on www.rrh.org.uk

Rees- Masterson.A,Usta.J,Gupta.J, Ettinger A.S (2014) *Assessment of reproductive health and violence against women among displaced Syrians in Lebanon* BMC Women's Health 2014, 14:25

Reynolds.B, White.J (2010) *Seeking asylum and motherhood: health and wellbeing needs.* Community Practice; 83(3):20-3

Straus.L,McEwen.A,Hussein.F,M (2009) *Somali women`s experience of childbirth in the UK: Perspectives from Somali health workers*. Midwifery 25: 181-186

Sudbury.H, Roninson.A (2016) *Barriers to sexual and reproductive health care for refugee and asylum-seeking women* British Journal of Midwifery 24(4)

Sullivan.T.M, Maung.C, Naw.S (2004) *Using Evidence to Improve Reproductive Health Quality along the Thailand-Burma Border*. Disasters 28 (3):255-268

Tebid.R,Du Plessis.D,Beukes.S,Niekerk.V,Jooste.K (2011) *Implications of nurse managers arising from immigrant women`s experience of midwifery care in a hospital*. Journal of Nursing Management 19: 967-975

Thomas J, Harden A, Oakley A, Oliver S, Sutcliffe K, Rees R, Brunton G, Kavanagh J (2004) *Integrating qualitative research with trials in systematic reviews: an example from public health*. British Medical Journal **328**: 1010-1012.

Tsianakas.V, Liamputtong.P (2002) *What women form Islamic background in Australia say about care in pregnancy and prenatal testing* . Midwifery 18:25-34.

Tyson,K (2016) *Maternity Care for Syrian Refugees in Lebanon.* Women`s Health 18:(2) 59-61

United Nations Populations Fund UNFPA (2011) *Report of UNFPA`s action In Tunisia-Lybia Border (1-10 April 2011).* [Online] available on UNFPA Website http://www.unfpa-tunisie.org/images/pdf/UNFPA_report_1_10_april_2011.pdf

United Nations Refugee Agency UNHCR (2016) *UNHCR Statistical Yearbook 2016.* [Online] available on the UNHCR Website: https://www.unhcr.org/uk/statistics/country/5a8ee0387/unhcr-statistical-yearbook-2016-16th-edition.html

United Nations Refugee Agency UNHCR (2018) *Global Trends: Forced Displacement in 2018.*[Online] available on UNHCR Website: https://www.unhcr.org/5d08d7ee7.pdf

United Nations Refugee Agency UNHCR (2018) Syria Emergency. [Online] Available on UNHCR Website: https://www.unhcr.org/syria-emergency.html

United Nations UN and Partners (2016) *Humanitarian Response for Syrian Refugees in Jordan Inter-Agency Task Force (IATF) Health Sector Gender Analysis Final Report.* [Online] Available on the UNHCR Website https://data2.unhcr.org/en/documents/download/40097

United States Agency International Department USAID (2016) Jordan Communication, Advocacy and Policy Activity *Family Planning among Syrian Refugees in Jordan.*[Online] available on https://docs.euromedwomen.foundation/files/ermwf-documents/6616_3.24.familyplanningamongsyrianrefugeesinjordan0.pdf

Upvall.M, Mohammed.K, Dodge.P.D (2009) *Perspectives of Somali Bantu refugee women living with circumcision in the United States*: A focus group approach. International Journal of Nursing Studies. 46:360-368

Vangen.S, Johansen. R.E.B, Sundby.J,Traeen.B, Stray-Pedersen.B.(2003) *Qualitative Study of perinatal care experiences among Somali women and Local health care professionals in Norway.*European Journal of Obstetrics & Gynecology and Reproductive Biology 112 29-35

Verdinelli.S,Scagnolli.N.I (2013). *Data Display in Qualitative Research*. International Journal of Qualitative Methods IJQM 12:359-381

Wayte.K, Zwi.A.B, Belton.S, Martins.J, Martins.N, Whelan.A, Kelly.P.M (2008) *Conflict and Development: Challenges in Responding to Sexual and Reproductive Health Needs in Timor- Leste*. Reproductive Health Matters 16 (31) :83-92.

Widmark.C,Tishelman.C,Ahlberg.B.M (2002) *A Study of Swedish midwives' encounters with infibulated African women in Sweden.* Midwifery 18 113-125

Women`s Commission for Women and Children (2008) *Reproductive Health Coordination Gap, Services Adhoc: Minimum Initial Service Package (MISP) Assessment in Kenya.* [Online] Available on Women`s Commission for Women and Children Website: https://www.womensrefugeecommission.org/images/zdocs/ken_misp.pdf

Women's Refugee Commission WRC (2014) *Unpacking Gender The Humanitarian Response to the Syrian Refugee Crisis in Jordan.* [Online] Available on the WRC Website UnpackingGender-WRC.pdf Women's Refugee Commission WRC (2016) *No Safety for Refugee Women on the European Route: Report from the Balkans* [Online] available on the WRC Website: https://www.womensrefugeecommission.org/images/zdocs/Refugee-Women-on-the-European-Route-Balkans.pdf

Women's Refugee Commission WRC (2016) *Building National Resilience for Sexual and Reproductive Health :Learning from Current Experiences* [Online] Available on the WRC Website https://www.womensrefugeecommission.org/srh-2016/resources/1318-disaster-building-resilience-srh

Women's Refugee Commission WRC (2016) *Falling Through the Cracks: Refugee Women and Girls in Germany and Sweden* [Online] available on the WRC Website: https://www.womensrefugeecommission.org/gbv/resources/1308-protection-germany-sweden

APPENDICES

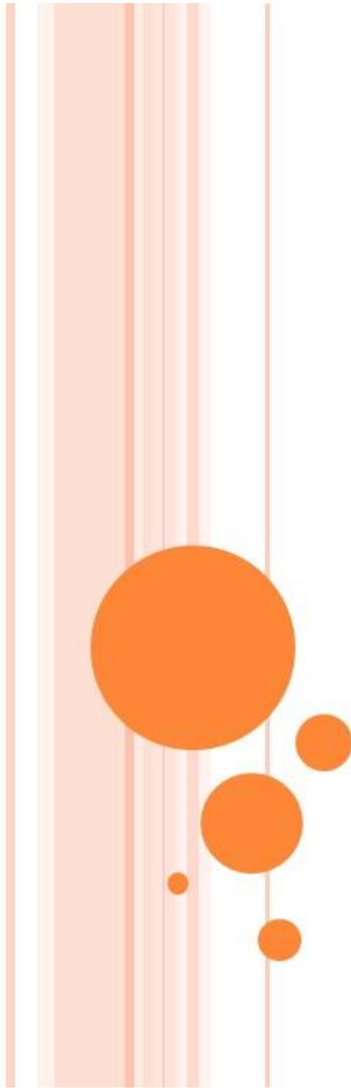
Appendix A: Table of terms used for the Scoping research and the Secondary Qualitative Data research

Terms used for the scoping review What are perspectives and experiences of women seeking asylum and refuge regarding the reproductive health care and maternity services provided to them during their journey, globally and in the UK?	Women refugees experiences/reproductive care Women refugees perspectives/reproductive care Women asylum seekers experiences/reproductive care Women asylum seekers experiences/reproductive care Women refugees experiences/ antenatal care Women refugees perspectives/antenatal care Women asylum seekers experiences/antenatal care Women refugees experiences/ postnatal care Women refugees perspectives/postnatal care Women asylum seekers experiences/ postnatal care Women asylum seekers perspectives/ postnatal care Refugee women/eligibility of health care /UK Refugee women/ access to health care/Europe Refugees women /access to reproductive care Asylum seekers women/access to reproductive care Pregnant refugees experiences/ antenatal care Pregnant refugees perspectives antenatal care Pregnant asylum seekers experiences/antenatal care Pregnant asylum seekers perspectives antenatal care Refugee women experiences/contraceptives Refugees women perspectives/contraceptives Asylum seekers experiences/contraceptive Asylum seekers perspectives/contraceptive

	Women refugees/Domestic abuse Women refugees/gender based violence Women refugees/FGM/pregnant Women asylum seekers /FGM/pregnant Women refugees/FGM/pregnant UK Women asylum seekers /FGM/pregnant UK Adolescent girls/refugees/contraceptives Adolescents girls asylum seekers/contraceptives Refugees/camps/reproductive care Refugees camps/pregnant Refugees camps/birth/
Terms used for the Secondary Analysis of Qualitative day Q1 What are experiences and perspectives of Syrian refugees' women of reproductive care provision in temporary camps of Syria neighbouring countries?	Syrian refugees/reproductive care /neighbouring countries Syrian refugees experiences/reproductive care/ Jordan Syrian refugees perspectives/reproductive care/ Jordan Syrian refugees experiences/reproductive care/ ALZaatari camp Syrian refugees experiences/antenatal care/Jordan Syrian refugees experiences/antenatal care /AlZaatari camp Syrian refugees experiences/giving birth/Jordan Syrian refugees experiences/giving birth/Alzaatari camps Syrian refugees experiences/contraceptives /refugee camps Syrian refugees experiences/contraceptives / Alzaatari camp

	Syrian refugees perspectives/reproductive care/ refugees camps Syrian refugees/ reproductive care/ sexual abuse Syrian refugees experiences/reproductive care/ Lebanon Syrian refugees experiences/antenatal care/Lebanon Syrian refugees experiences/ giving birth /Lebanon Syrian refugees reproductive care/Lebanon camps Syrian refugees experiences/reproductive care/ Turkey Syrian refugees experiences/reproductive care/ Turkey camps Syrian pregnant refugees experiences /Turkey Syrian pregnant refugees experience/ antenatal care Turkey
Terms used for the Secondary Analysis of Qualitative day Q2 What are experiences and perspectives of Syrian refugees` s women of reproductive care provision in transit camps as part of their journey to Europe?	Syrian refugees experience/reproductive care /transit camps to Europe Syrian refugees perspectives/reproductive care /transit camps Europe Syrian refugees experiences/reproductive care temporary camps Europe Syrian refugees perspectives/reproductive care /temporary camps Europe Syrian refugees experiences/refugee camps/Europe Syrian refugees perspectives/refugee camps Europe Syrian refugees /gender based violence/transit camps Europe Syrian refugees/sexual abuse /transit camps Europe Syrian refugees pregnant/ reproductive care/transit camps Europe

Appendix B: Presenter at Talking Health Care for Refugees Seminar, Welsh Red Cross July 2019



REFUGEE WOMEN EXPERIENCES OF REPRODUCTIVE CARE PROVISION FOCUSING ON SYRIAN WOMEN EXPERIENCES OF REPRODUCTIVE CARE IN TRANSIT AND TEMPORARY SETTINGS

Dr Sonia Khoury
Sonia.Khoury@wales.nhs.uk

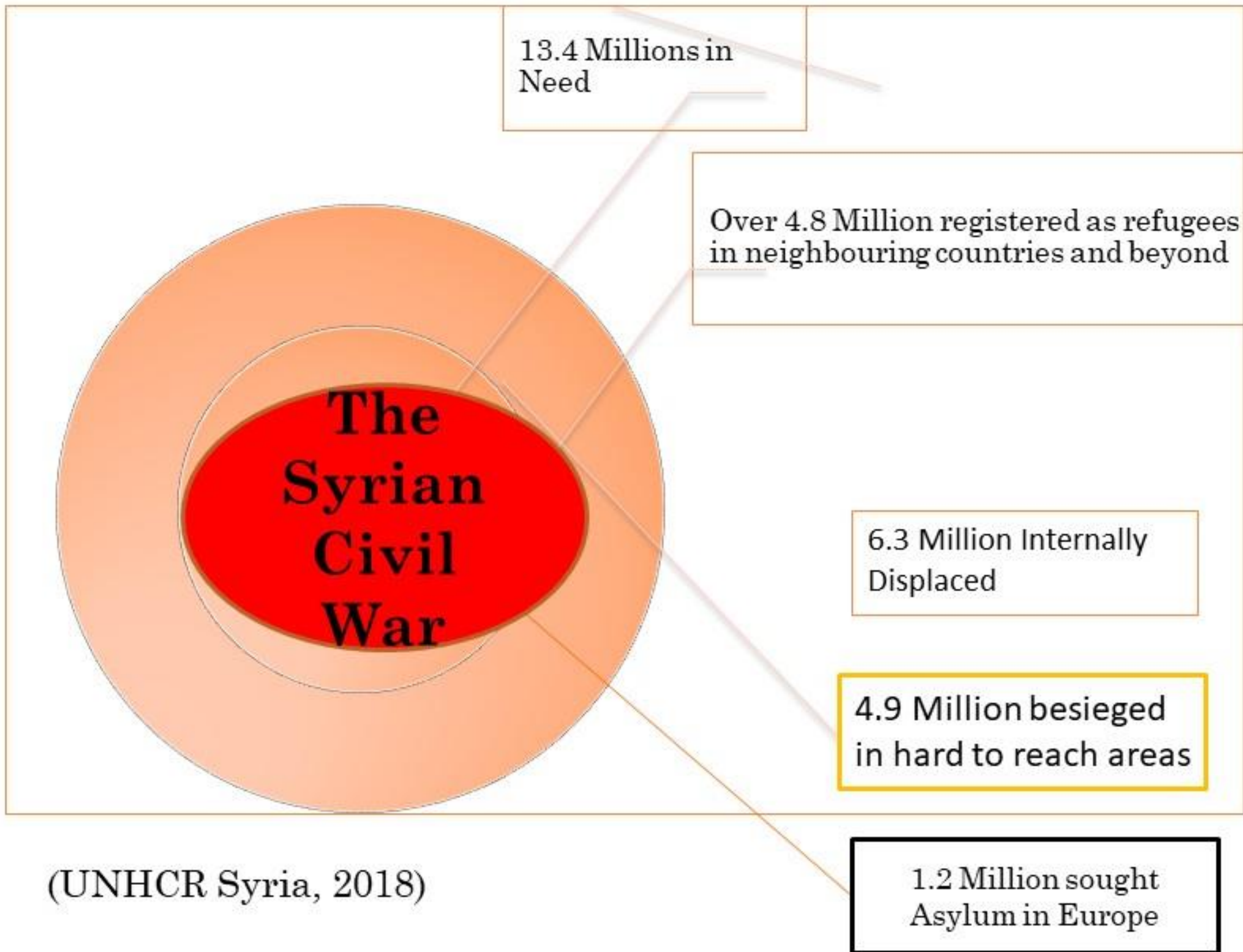
Context and Background

- As a result of wars and conflicts, the recent years have witnessed a noticeable inflation of people who left their homelands seeking protection and new life in other countries

- Additional pressure had been imposed on the hosting health systems in countries of final destinations

- Women and teenage girls in such circumstances are to be at increased risk of poverty and sexual persecution.

THE SYRIAN CONTEXT

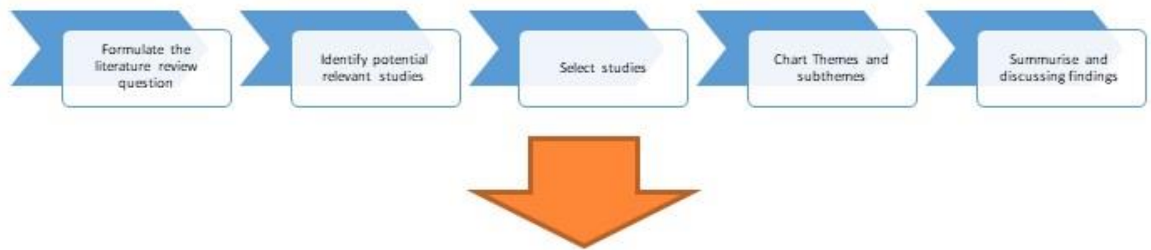


THESIS AIM

This thesis main aim is to explore experiences and perspectives of women refuges and asylum seekers of reproductive care with a significant focus in Syrian refugees' experiences in neighbouring countries and transit camps on the route to Europe

Aim of the Scoping Review

This thesis main aim is to explore experiences and perspectives of women refugees and asylum seekers of reproductive care with a significant focus in Syrian refugees' experiences in neighbouring countries and transit camps on the route to Europe.

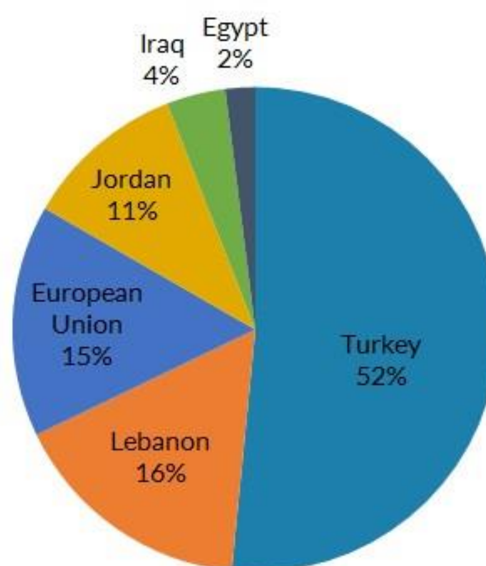


Identified gap in women refugees experiences of reproductive care provision in transit and temporary camps

Scoping review main findings

- the provision of reproductive care was restricted by the inadequate knowledge and awareness about the new health systems in the country of settlement.
- The attitude and the relation with their health providers affected women attendance to the antenatal care either positively or negatively.
- Health providers' awareness about the particular medical and cultural needs was not adequate.
- Financial restrictions and women entitlement of reproductive care inhibit women of seeking the needed services.
- Women dispersal affects extremely the adequate provision of reproductive care, as health providers loose the connection with the pregnant women, late antenatal care and major birth complications are reported
- Women with FGM faced additional difficulties either during their antenatal and postnatal care or with the attitude shown by their health providers.
- Women involvement in decision making related to the reproductive care provision was not adequately achieved. The availability of adequate interpretation services was essential to ensure the accurate attendance and the effective communication between the providers and the women.
- Adolescent reproductive health care RHC was of a major concern, in many refugees communities, needs of RHC for such a group of population was ignored and not adequately met.
- Neither the community not the health providers admitted the adolescents' needs; this fact had resulted of adolescents more vulnerable of unprotected sexual activities, and unsafe abortion when they are victims of gender and sexual based violence.

Syrians displacement in neighbouring Countries



Digram (6) shows the **Distribution of Syrian Refugees by Host Country, July 2017**

Source: Migration Policy Institute, 2017

THE FOCUS OF SYRIAN REFUGEES DISPLACED IN THE NEIGHBOURING COUNTRIES AND ON ROUTE TO EUROPE

- 1.What are experiences and perspectives of Syrian refugees' women of reproductive care provision in temporary camps of Syria neighbouring countries?

- 2.What are experiences and perspectives of Syrian refugees` s women of reproductive care provision in transit camps as part of their journey to Europe?

14 research reports and articles , Syrian Refugee women expereinces of reproductive care

11 Syrian Refugees in Neighbouring Countries

3 Syrian refugees in transit camps while travelling to Europe

Experiences and perspectives of Syrian refugees' women of reproductive care provision in temporary camps of Syria neighbouring countries

The provision of reproductive care in camps settings

- Women in Alzaatari camp were able to access reproductive health care provided by " in camps clinics" that are established by International Non Governmental Organisations such as UNHCR, UNFPA (WRC,2014)
- women are also able to access care provided by out of camps clinics managed by the Jordanian Ministry of Health (WRC, 201
- No adequate provision of the Minimum Initial Services Package MISP as clean delivery kits were not given to women due to concerned that these kits may promote home birth instead and increase possible complications (UNFPA,2018; Jordan Krau 2015;WRC,2014).
- Women were not aware of the free services that they are available for them (WRC,2014)
- The shortage of female practitioners and gynaecologists may have restricted women of accessing the reproductive care neede unless in emergencies (WRC, 2014).
- Women were not aware that contraceptive and family planning services are available free for them in Alzaatari Camp (Krau 2015).
- Women may try to self abort by heavy lifting should they become pregnant
- Poor Sexual transmitted diseases and HIV Aids reporting and treatment (Krause et al. 2015)
- Women involvement in service design and provision proven positive feedback, Operation Mercy at Alzaatari camp consulted regarding what a hygiene kit should include. (WRC, 2014)

the provision of reproductive care in out of camps settings

- In a maternity centre in Istanbul, Turkey more than 40% of Syrian refugees women haven`t received any antenatal care dur their pregnancy, their haemoglobin levels were lower than the other group. Syrian women are late in arriving to the hospita labour (Erenel *et al*.2016)
- In Irbid City of Jordan, Syrian refugee women were informed about the reproductive care from their relative and neighbours communication between the care providers. (Krause *et al*. 2015; WRC, 2014)
- The cost of reproductive care for UNHCR unregistered Refugees women in Jordan hindered them of seeking the required ca (Krause *et al*. 2015
- Syrian refugee women in Jordan and Lebanon were hesitant to seek reproductive care due to shortage of female practitioner ((Rees Masterson *et al*, 2014; Yasmine & Moughlian, 2016; Krause *et al*. 2015; WRC, 2014)
- In Jordan, only one site was providing post rape contraceptives to victims for rape. (Krause *et al*. 2015)
- Reproductive care was poorly provided to refugee women in Lebanon. (Reese Masterson *et al*,2014; Yasmine &Moughlian,20 Dejong .*et al*,2017)
- Syrian refugee women in Lebanon struggled to pay the cost of Caesarean section operations. (Tayson,2016; Yasmine &Moughlian,2016; Dejong .*et al*,2017)

The provision of reproductive care for victims of gender based and sexual violence

- Early marriages to senior men are increasing with poor legal marriages and newborn registrations. (WRDC 2014; Benage *et al*,2015; Yasmine &Moughlian,2016; Dejong .*et al*,2017).
- Women unable to get their legal rights or report any abuse (WRDC, 2014; Benage *et al*,2015; Yasmine &Moughlian,2016; Dejong .*et al*,2017).
- Women may be of a higher exposure to sexual exploitation in order to meet their household basic needs. (Krause et al. 2015; WRC, 2014)
- Sexual abuse and rape incidences may not be reported due to fears of honour based violence Krause et al. 2015; WRC, 2014)
- No protection measures in place to protect women and girls from all sorts of gender based and sexual abuse Krause et al. 2015; WRC, 2014)
- Increased domestic abuse incidences with hesitance in reporting. (Krause *et al*. 2015; UN,2016: Yasmine &Moughlian,2016)
- Increased pregnancy adverse complications affecting women and newborns due to the exposure to both the gender based violence in war areas or by their intimate partners. (Reese Masterson *et al*, 2014; Yasmine &Moughlian,2016)
- Male dominance had hindered the women capacity to utilise the required health services.(UN,2016)

The provision of reproductive care for young adolescents in humanitarian settings.

- Early marriages are reported in all neighbouring in camps and out of camps settings (Benage *et al*, 2015; Yasmine &Moughlian, 2016).
- Poorer pregnancy outcome among young girls aged 12-19 years old in Istanbul , Turkey in comparison the same group of non-refugee women (Erenel *et al*.2016)
- Young girls have limited access to reproductive health information and they may seek it from their mothers and older females in the family rather than visiting the primary care facility. (UN, 2016; Yasmine &Moughlian, 2016).
- Young and /or unmarried girls are unlikely to seek reproductive care unless for emergencies.(Krause *et al*, 2015; Yasmine &Moughlian,2016)

What are experiences and perspectives of Syrian refugees` s women reproductive care provision in transit camps as part of their journe Europe

No adequate gender sensitivity in transit sites

- Women and girls facing additional risks in transit camps located in transit countries such as Greece, Serbia, Slovenia and Macedonia
- Some camps did not offer dedicated and private places to women and families.
- Single women may have shared accommodation with males which increased sexual abuse incidences
- Many women were avoiding eating and drinking to reduce their needs to toilets.
- Third sector workers in camps were not adequately capable of identifying females with higher vulnerability
- Language barriers contributed in Women and girls lack of knowledge of what services are available for them including the health care

[WRC, 2016 (1) ; WRC. 2016 (2) WRC,2016 (3)]

Lack of reproductive care

- Lack of reproductive care provided in transit camps
- Not to delay their journeys, many pregnant or newly delivered mothers were hesitant to seek the required care as they need to go to hospitals out of camps
- Minimum Initial Service package (MISP) recommended to be available in camps and at all times were not provided
- Variations of the availability of the emergency post rape care including post exposure prophylaxis, emergency contraception and antibiotics were reported.

[WRC, 2016 (1) ; WRC. 2016 (2) WRC,2016 (3)]

Lack or no Gender based violence support services.

- Government personnel and frontline workforce dealing with women and girls arriving to transit camps, lack the capacity to identify groups of a higher vulnerability and potential victims of rape, sexual violence or human trafficking.
- Women were hesitant to disclose incidents of sexual abuse/rape
- No standardised assessment followed to identify victims of gender-based violence. Assistance was reliant on workers individual judgement
- Variations of the availability of the emergency post rape care/kits
- No adequate referral pathways for victims of sexual abuse including the required legal, medical, psychological and judicial services
- [WRC, 2016 (1) ; WRC. 2016 (2) WRC,2016 (3)]

Recommendations (1) : Syrian refugees in Neighbouring countries:

- Information about the available health services, eligibility, how, and where from to access them are clearly provided to refugee women particularly the new comers .
- While language barriers may not be an issue in Jordan and Lebanon as Arabic is the spoken language; providing adequate interpretation in Turkey by female interpreters (if possible) will encourage women to seek the reproductive care they may need and enhance their knowledge of what are they eligible for and/ or existing limitations
- Strengthening and effectively building the capacity of the above NGOs particularly local organisations may improve the service provision
- Ensuring that the Minimum Initial Services Package MISP is adequately distributed and the adequate supervision of health professional is available should women give birth at home. To avoid the complications of home delivery
- Ensuring that contraceptives methods are made available, and women are aware of the different options they can use. This essentially includes better access to emergency contraceptives for survivors of sexual assaults and rape.
- Enhancing a friendly reproductive care provision for young girls and raising their awareness about the importance of taking care of their own health. This may reduce the health implications of pregnancy and giving birth in young ages.
- Engaging with Syrian women in longer terms camps, as they are the main users of the services. This needs to be achieved when assessing needs, planning the services and delivering them. Women can be at any stage involved in needs assessment, planning and delivery of reproductive care.
- Championing refugee women in their community and pioneering intellectuals among them. This does not mean selecting women with higher qualification for instance but working with those that present with commitment and acceptance by their peers. Those women can play crucial roles in setting positive example to others, discussing culturally sensitive issues and empowering them. Positive examples are more acceptable and accommodated when they come from the local members of the communities
- Targeting and involving male partners in awareness raising with regard to gender based violence, early and forced marriage implications and the importance of empowering their wives and daughters to seek the care they need These men will be able to positively influence others regard to harmful practices, gender based violence and how empowering women in their families can be protective and safer.

Experiences and perspectives of Syrian refugees` s women of reproductive care provision in transit camps as part of their journey to Europe

Improving their stay in transit camps require more focused but affordable efforts such as:

- Enhancing basic privacy of women and girls staying in transit camps by separating sleeping, toilets and bathing facilities. This will reduce possible sexual assaults exposures.
- Ensuring that government frontline workers working with women and girls and interviewing them are trained enough to conduct a sensitive conversation.. Trained female workers might encourage refugee women to disclose sensitive incidences including any sexual disclosure or special needs.

- Ensuring that frontline workers whether they are government or voluntary workers are adequately able to identify those of particular vulnerability, so they can signpost them and safeguard them as appropriate.
- Ensuring that adequate interpretation is provided during interviews. This includes information about health care access, asylum process, legal eligibility or any other safeguarding information to be distributed in Arabic.
- Ensuring that emergency contraceptives, post rape services including mental health support are available on sites.
- Ensuring that safe reproductive care is provided on site for pregnant women (antenatal care for example), or reassuring them that no delays will occur if they received the care outside the camp. This may be possible for instance by having support workers that can accompany them to outside facilities when required.
- Applying strict disciplines on workers who abuse their duties and sexually abuse or risk women and girls that they are supposed to safeguard.
- Ensuring that female hygiene kits are available and distributed to women and girls as they may be embarrassed to ask about them.
- Despite their short stay, encouraging women and girls to express their needs and taking their opinions about the variable care they receive may slightly improve their experience in transit camps. Most importantly, it will improve the experience of women and girls that may follow them to these camps.

Table of amendments made as advised

Change made	Chapter	Page
The conceprual framework	Chapter 1	P 17
MetaEthnography , Synthesising qualitative studies	Chapter 2	P 33-37
Elaboration of synthesis (figure 7)	Chapter 3	P71
Table of Features of studies synthesised for the qualitative Narrative review	Chapter 4	P78-83
Elaboration of synthesis (figure 10)	Chapter 4	P95-96
Added arrows to figure 10	Chapter 4	P97
Elaborated the Novel Contribution	Chapter 5	P100