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Policy Brief

Refugee Women's Experiences of Maternal Healthcare Services in Türkiye

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Abstract

We live in times of unprecedented mass migration at the international level. The cross-border movements of people take a form of forced migration which is a humanitarian and human rights issue. Forced displacement of people creates challenges and increases vulnerabilities as a result of humanitarian needs. The basic needs of refugees, such as healthcare, are compromised by the absence of capabilities to access and/or receive care in the host countries. The root causes of this issue are multi-faceted and may stem from the refugees' status, cultural background, societal positioning and structure of the host country's health system. The ecological model to analyse the experiences of refugee women's healthcare system demonstrates the challenges produced within a mixture of interactions at macro, meso and micro levels of social and political determinants. A precarious and temporary legal status of refugee women coupled with a lack of economic means impacts their spatial interactions with host institutions for receiving health care in the host countries. The Brief sheds light on this issue through an intersectional empirical study of refugee women's lived experiences of maternal care arguing that it is a complex process comprising a multilayered form of relationship with primary, secondary and tertiary health services. The policy brief provides an analytical and methodological framework for: addressing the negative impacts of forced migration on refugee women; and uncovering the significance of the 'rights' and 'entitlements' (or 'lack of') of refugee women in the eyes of healthcare professionals in receiving basic healthcare in Türkiye. The Policy Brief transcends temporary solutions and explains why refugee women's access to health care should also be framed within human rights and an ecological model for robust management of health provision to refugees; and why long-term structural solutions can benefit both vulnerable refugee populations and host societies. The Brief develops recommendations for improving strategies to tackle the societal and structural challenges that hinder maternal care access and provision for refugees. The proposed recommendations aim to enhance quality health provision by breaking the barriers between refugees and health providers; a holistic model of integration of refugees whether it is temporary or permanent; and generating space for interactions to increase the health literacy of refugee women.

Keywords: *refugee women; right to health; maternal care; policy; ecological model*

Overview

We live in times of unprecedented mass migration at the international level. The cross-border movements of people take a form of forced migration which is a humanitarian and human rights issue. Forced displacement of people creates challenges and increases vulnerabilities as a result of humanitarian needs. The basic needs of refugees, such as healthcare, are compromised by the absence of capabilities to access and/or receive health care in the host countries. The root causes of this issue are multi-faceted and may stem from the refugees'

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status, cultural background, societal positioning and structure of the host country's health system.

The ecological model to analyse the experiences of refugee women's access to healthcare system demonstrates the challenges produced by a mixture of interactions at macro, meso and micro levels of social and political determinants. A precarious and temporary legal status of refugee women coupled with a lack of economic means impacts their spatial interactions with host institutions for receiving health care in the host countries. The Brief sheds light on this issue through an intersectional empirical study of refugee women's lived experiences of maternal care arguing that it is a complex process comprising a multilayered form of relationship with primary, secondary and tertiary health services. The policy brief provides an analytical and methodological framework for: addressing the negative impacts of forced migration on refugee women; and uncovering the significance of the 'rights' and 'entitlements' (or 'lack of') of refugee women in the eyes of healthcare professionals in receiving basic healthcare in Türkiye.

The Policy Brief transcends temporary solutions and explains why refugee women's access to health care should also be framed within human rights and an ecological model for robust management of health provision to refugees; and why long-term structural solutions can benefit both vulnerable refugee populations and host societies. The Brief develops recommendations for improving strategies to tackle the societal and structural challenges that hinder maternal care access and provision for refugees. The proposed recommendations aim to enhance quality health provision by breaking the barriers between refugees and health providers; a holistic model of integration of refugees whether it is temporary or permanent; and generating space for interactions to increase the health literacy of refugee women.

A Human Rights-Led Approach to Healthcare Needs

Migrant populations, especially refugees are considered as vulnerable groups who are on the margins of the host societies and disproportionately experience poor health (Ahonen et al., 2007). The fragile transnational legal positioning coupled with social exclusion further exacerbate the marginalisation of these group. Refugee women are more vulnerable to health inequalities due to their gender, temporary legal status, cultural alienation, and structural issues. Their social and legal positioning in the host country creates barriers and social exclusion that deprive these women of living a life in 'dignity' with the absence of one or more aspects of 'health'. Human dignity is the 'ultimate value' that a human possesses (Hasson, 2003, p.83) which automatically and intrinsically makes one worthy and deserving of respect (Donnelly, 2013, p.29).

A human rights-led approach provides a holistic lens to recognise vulnerability and health inequality as it encompasses all fundamental needs such as shelter, food, economic well-being, and education for a human being to have a healthy life. The humane approach creates a pathway to transition social exclusion to social inclusion (temporary or permanent) with the provision of fundamental rights that are multifaceted. In this case, a recognition of the interdependence of rights is crucial to reach good health (Tuncer, 2021, p.14). The WHO Constitution also emphasises the holistic approach and defines health as *'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'* (1948). For refugee women to be in 'good health' necessitates good physical health which means one's ability to use full physical potential; good psychological health to cope with stress and anxiety; and

social health to communicate with others and socialise within the society (Erdil, 2023, p.67-68). Thus, the right to health incorporates other entitlements such as *'the right to control one's health, informed consent, bodily integrity, and participation in health-related decision-making'* (WHO, 2024a). These entitlements transforms an invisible vulnerable group who are described mere statistics who cross transnational borders to visible human beings with bodily integrity and social identity who posses equal basic needs with the citizens. International Law suggests that all individuals under international protection should have the right to have good standards of physical and psychological health (Erdil, 2023, p.99). The Universal Declaration model incorporates the Bill of Human Rights would guide us to fundamental principles of human rights such as 'right to life' (UDHR, Article 3; ICCPR Article 9), 'freedom of movement and residence' (UDHR, Article 13; ICCPR Article 12) and 'right to health care and social services' (UDHR, Article 25; ESCR Article 12).

This Brief considers the maternal care of refugee women as a health status that automatically locates women in a vulnerable group in the host countries. By 'maternal care' we mean women who are pregnant or in postnatal health status. Maternal care is studied as a part of 'reproductive health' which is defined ash as '*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes'* (WHO, 2024b). It is important to emphasise that this definition includes women's capability to reproduce and to have the freedom to decide if, when and how often to have children. These capabilities and freedoms usually compromised by a 'refugee status' which is laden with social and cultural meanings to a wider host society. Moreover, this freedom is often undermined by a lack of power and self-esteem due to the precarious social and economic status of refugee women. Socioeconomic position is the proxy of the status within a social hierarchy and one's gender role or legal status is relevant to the degree of the power and capabilities exercised in the host country. The absence of these capabilities especially due to preventable and avoidable reasons such as access to health facilities will lead to health inequities as a result of weakening social power.

Structural mechanisms such as legal status, ethnicity, social class, gender and education impact refugees' physical, mental and social health resulting in unequal distribution of health-related resources (Christie-de Jong, 2018), These structural mechanisms can be described as social determinants of health inequities (WHO, 2010) in the host or migrant receiving countries. The first step to eradicating health inequalities is when policy frameworks recognise social determinants as producing inequities in health provision. This will lead to structural mechanisms to take necessary action and implement practical solutions to address the vulnerability of refugee women with maternal care needs. This process will create an equity agenda that explicitly recognises the vulnerabilities of socially marginalised populations in the host country which aims to empower refugee women with remedial policy action that leads to temporary or permanent integration. To enable 'quality maternal care for all' it is necessary for (local and central) institutions of health, migrant management, family and social services, and civil society organisations to collaborate in designing and implementing an equity agenda.

Intersectionality Approach to Study Vulnerabilities

Intersectional theoretical approach (Crenshaw 1989; 1991) and methodology is increasingly used to analyse social problems concerning public health, poverty, education and employment (Berger and Guidroz, 2009; Collins, 2019, p.21; Dill and Zambrana, 2009; Sabik et al. 2021).

It is a powerful concept that enriches our understanding of the social world through an analysis of socially constructed aspects of difference such as race, gender, nationality and class that are interacting (Anthias 2013; Choo and Ferree, 2010; Collins and Bilge, 2016; Glenn 2009; Ken 2008; McCall 2005; Misra et al., 2020) and produces social inequalities.

Intersectional research finds its place in the interdisciplinary realm (Collins, 2019, p.22) enabling researchers to incorporate power and oppression as central concepts (Misra et al., 2020, p.9) for understanding social inequalities that are intersectional. In intersectional inquiry, the researchers recognise the methodological traits including oppression, complexity, relationality, context, comparison and deconstruction (ibid). These tenets remind us that we cannot describe and understand peoples' lives by taking into account a sole category as human lives are complex and multi-dimensional, thus, peoples' lived experiences are shaped by different factors and social dynamics (Wyatt et al. 2022, p.863). In this perspective, we make sense of 'peoples' vulnerabilities' through multiple marginalised intersections in the social context of power, privileges and inequalities.

In this research, I use intersectionality as a method for studying the lived experiences of refugee women's maternal care beyond focusing on merely two or more social statuses (e.g. gender, ethnicity, education, legal status) which would be an oversimplification of the study that only focuses on micro and meso levels of their experiences. Rather, this study uses a more complex form of intersectionality to examine how larger systems of power at the macro level embedded in social structures such as the economy and institutions such as healthcare intersect individuals' identities and, thus, influence their lives (Wyatt et al. 2022, p.869; Conagham, 2009; Yuval-Davis, 2006). In this research, I recognise the complexity of the social inequalities which enabled this research to avoid a Western-centric epistemology of organising the world based on binaries such as citizen versus migrant and men versus women and emphasise that these seemingly dichotomous identities are interlinked and relational which culturally and structurally operate within various structures of power. By embracing the complexities of social groups, I recognise the social and cultural characteristics of refugee women within the contexts that are dynamic such as political and economic shifts in the host countries. Thus, inequality and oppression are experienced in different ways which reflect privilege and power (Misra et al. 2020) and "where the salience of race, class, gender and other statuses vary according to time, space and place" (Browne and Misra, 2003; Collins and Bilge, 2016). When analysing refugee women's lived experiences of maternal care in Türkiye, I not only focus on their complex characteristics and identities such as legal status, gender, social or economic class, and culture, but I also examine their relationship with structural factors that impact their health. Their access to maternal healthcare and experiences in the Turkish health system are determined according to their migration status, legal and social (non)acceptance in the host country and how they negotiate power within external structures such as health institutions.

Intersectionality as a method enables the researchers to study the marginalised groups in a society in two ways: relational articulation; and interconnectedness of ideas and society. The former enables the researchers to analyse society through a series of moving parts within an overall structure where the relationship with power is dynamic and varied according to social contexts. The latter focuses on the interrelated ideas and ideological elements; and the way in which they cohere. When combining the intersectional articulation of society and vulnerabilities in the Human Rights discourse, we do not treat the categories such as gender

and social status through the logic of segregation but we analyse the marginalised groups through a combination of various aspects and patterns.

The ecological model (Thursten and Vissandjee, 2005) encompasses these complexities of categories and enables the researcher to analyse the marginalised groups' lived experience incorporating their identities (i.e. gender and legal status) through their relationship with power at meso and macro levels of the health system. With the intersectional approach (ecological model), we are able to ask crucial questions (Sabik 2021, p.3) to generate an understanding of refugee women's experiences: what are their common social and cultural characteristics? What is the degree of the role of power and inequality in understanding their access to maternal care? What are the differences in their experiences? How do structural factors impact their health? In this inquiry, we not only address these questions but also attempt to generate solutions to social inequalities.

Research Methods

Qualitative research design and an inductive approach are employed in this study which used a set of methods to inform the results. The inductive approach enabled the study to build on existing knowledge and to further our understanding of refugee women's experiences of maternal care including challenges, barriers in health provision and practical solutions for overcoming these challenges.

The ecological model (Thursten and Vissandjee, 2005) is employed that inform the interview questions and the analysis of the themes that are intersectional. The ecological model enabled the research to conduct an inquiry at the macro (the state, governance, international agencies, social and public policies), meso (health institutions, civil society and other institutions, and micro (refugee women) levels. In an intersectional ecological inquiry, the interviews with both refugee women and health professionals incorporate various individual categories (gender, legal status, culture, socioeconomic status and education) and processes (migration, integration, temporariness) to make sense of their rights/entitlements and social inequalities in the context of maternal health. When incorporating these categories in this inquiry, I do not take a binary approach, thus, I recognise the dynamism of the categories that are shaped based on cultural context, space and time. For instance, legal status can be a master category for a refugee woman when negotiating power and well-being in accessing hospitals; whereas this may shift to gender and culture roles when social inequalities stem from the community hierarchies.

In 2023/24, I recruited 28 refugee women with maternal care health status (prenatal or postnatal) in the cities of Bursa and Istanbul in Türkiye for semi-structured interviews. Interviews of refugee women took place in family health centres, migrant health centres, hospital maternity, breastfeeding and maternity intensive care units, and health NGOs. The majority of refugee women were of Syrian origin and a few were of Turkic origin, most of whom had the legal status of Temporary Protection (the few had residence after Temporary Protection status). The majority of women were of average or poor economic status and lived in neighbourhoods with a high refugee population.

In the same period, I conducted semi-structured interviews with 40 professionals in the health sector such as nurses, midwives, GPs, social workers, and health managers (34); migrant management institutions (5); and academia (1). These interviews took place in health

institutions, hospitals, family health centres, migrant health centres, NGO headquarters, and online platforms. The majority of the health professionals were of Turkish origin, and 8 health professionals were of non-Turkish background including Syrian refugees on Temporary Protection.

Participant observations were also conducted in 2 family health centres, 2 migrant health centres, and 1 hospital's breastfeeding unit, maternity unit and maternity intensive care unit. The observations were overt style and included informal interviews with the individuals on the sites. I participated in informal meetings with health professionals in informal settings such as breakfast, lunch and staff meetings which informed the observational data further.

The adoption of intersectional inquiry and an ecological model informed the design of interview questions and analysis of the themes that emerged from the field data. Intersectional inquiry is embedded in the methodological design process continuously. Thus, the intersectional guiding premises routinely appear in this inquiry which include (a) relationality; (b) power; (c) social inequality); (d) social context); (e) complexity; and (f) social justice (Collins and Bilge, 2016, p. 25-30, 194-204). The analysis included 'open coding' (based on the participants' unique life experiences) and 'selective coding' (based on the common structural interactions and shared categories) in various stages before the theory stage.

Fieldwork Results

The study highlighted that the refugee women's experiences of maternal care incorporate a mixture of positive stories as well as challenges stemming from causes that are multifaceted including their status (gender, ethnicity, legal status, economic class, and culture), health literacy, structural variables, social attitudes and impact of migration processes. This analysis illustrates the complexities of the relational interactions of these categories in a healthcare context that is interconnected to refugee women's lives and encompasses various stages of their lives (i.e. pre-migration, migration and post-migration). The qualitative data also shows that these women are in constant negotiation with power structures and their social position in the host society. Through their lived stories we make sense of their own account of vulnerabilities due to power imbalance at meso (i.e. health institutions) and macro level (i.e. state and policy level) structures.

The inquiry of the healthcare professionals' perceptions suggested the complexity of the healthcare provision including some overlapping challenges and other social and structural issues. To understand the impact of transnational movements on refugee women's health and well-being in Türkiye, it is also crucial to hear health professionals' and stakeholders' accounts that enable us to make sense of the other spectrum of power relations. There is an interconnectedness of the ethics and position of power where the constant negotiation between a humane (Human Rights) approach and a legal positivist approach with a binary Western-centric approach to refugee women's entitlements. At the centre of the research, we address the key barriers to the reception of maternal care to refugee women and the provision of care by health providers. By evaluating these challenges, the policy paper offers recommendations for migration policy and practice which incorporates the cooperation of key stakeholders and institutions.

Refugee Women's Experiences

The demographical data of the 28 refugee women who were interviewed on maternal care are important in this study in explaining the root causes of some of the challenges in receiving healthcare in Türkiye. The majority of refugee women are educated in secondary school (14 of them) or primary school (5 of them) or none (1) whereas the remaining 8 refugee women who are interviewed have high school diplomas (5 women) or diplomas in higher education (3 women). The education level becomes an important variable for refugee women in terms of determining their economic and social integration and the level of health literacy in the host country. The data shows that there is a connection between higher education level and integration which generates refugee women's confidence in understanding their entitlements in healthcare. According to the interview data, refugee women with a diploma in high school or an undergraduate degree learn Turkish more easily and have better health literacy. By improving their health literacy, these women navigate in Turkish health system better via communicating with health professionals easier. During the interviews, women with higher education levels were more confident in answering the questions and telling their stories as well as communicating with the health professionals easily. However, the observational and interview data suggest that education level is not a mere determinant for indicating high literacy and positive experience of healthcare. For instance, the quotation from a refugee woman who has a higher education degree and who is fluent in Turkish, English and Arabic illustrates the complexity of their experiences of maternal care:

> *"Everything is very good…. There are very good people here, thank God, they helped us a lot. But, I want to ask something. Once, when I was pregnant, I made an appointment at …City Hospital, for my condition. There was a female doctor there, she behaved very badly. She behaved very badly because I am Syrian, the way I looked….She didn't explain anything, she said 'talk to the translator'. I was very upset, I cried a lot when I came home."* (PNRW1, a refugee woman, Syrian, aged 42).

This refugee woman describes her experience as starting with a 'feeling of appreciation' which was about the maternal care provided by the health professionals from the Family Health Centre (FHC). During the interview, a nurse was also present at times, and the refugee woman started telling the latter part of the story when we were alone in the room which shows a power imbalance impacted her confidence in telling her story. She expressed her negative experience expressed about a hospital appointment where her ethnicity and legal status also became a determinant that impacted communication with the health professional. I had more than 3 refugee women who told me that despite their good Turkish level, they had communication barriers:

> *"Yes, I tried, I said I have such a situation. They said they don't do the ultrasound until the appointment comes, I asked if you can do the ultrasound. They said no…They behaved badly. I said I understand you, I said my Turkish is good. Then they called the translator right away to take me out, they said you will make an appointment. I said okay I will make an appointment…"* (PNRW2, a refugee woman, Syrian, aged 21, FHC).

There multiple variables such as power imbalance, prejudice, and cultural and social context negatively impact the communication between refugee women and health professionals. These cultural barriers can stem from real cultural differences as well as socially constructed

versions of 'difference'; the former stems from the refugee women's cultural identity and practices different than Turkish culture whereas the latter is about the construction of differences to distinguish their maternal needs from the dominant culture. During the interview, this refugee woman was confident in talking about her experience and she was fluent in Turkish, however, she had minimum health literacy which was evident from the lack of knowledge about contraceptive methods that she asked the nurse for information.

The majority of refugee women expressed their frustration about their experience in the hospitals some of whom indicated that they avoid hospitals unless it is completely necessary such as during childbirth or for ultrasound whereas the majority of women expressed positive experience in family health centres which is also evident from the observational data. The communication barriers between refugee women and health providers transcend a lack of language proficiency to deeper causes as described by a refugee woman after she told her experience in a maternity unit:

> *"…no one hears us. Even if we raise our voices and say it... It's not that there was a misunderstanding because of language, they're covering up the (real issue) incident, yes. They pass it off.*" (PNRW22, a refugee woman, Syrian, aged 29, NGO).

When considering the multiple variables such as language barriers, pressure on some hospitals in the areas with high refugee populations, political shifts, economic issues, social tensions and cultural context, the root cause of the experience of this refugee woman may stem from her identity (i.e. refugee status, gender and socioeconomic position), structural issues (i.e. pressures in the health system) and cultural context (i.e. high number of childbirth among Syrian refugee women, young marriages). There are, however, existing prejudices and social exclusion against the Syrian refugee population who usually (prefer) living in the same neighbourhoods having parallel lives with the native Turkish population. Although the health system in Türkiye does not discriminate between Turkish citizens and refugees under Temporary Protection, these social pressures reinforce miscommunication in the hospitals, thus impacting the quality of care.

The economic status of these women is equally important for improving integration, especially learning Turkish which improves their health literacy and social integration. The interview data suggest that 8 out of 28 women worked in various sectors in Türkiye (textile, education, or food industry) before giving birth and taking a break from work (not a maternity leave). These women demonstrated confidence in communicating with the health providers and navigating the health system in the Turkish cities they recited, thus expressing positive experiences:

> *"For example, I came to this hospital, all the nurses and doctors are very good. They did not discriminate at all. They also come and look after my baby every two hours. The doctor came in the morning, he was very good."* (PNRW15, Refugee woman, Syrian, aged 24, Maternity Unit at a state hospital).

> *"In the beginning it was really hard, because of the language problems…after that I started to learn living in the country, the language. Also, children went to school, they needed to talk to the teachers and I learned from them. Series, cartoons, etc. after that everything was better."* (PNRW1, a refugee woman, Syrian, aged 42).

These 8 refugee women who worked before leaving their employment integrated into the host society better and were fluent in Turkish during the interviews. Thus, this study suggests that education and economic status impact refugee women's confidence in communicating with health providers, their awareness of the health system, the level of health literacy and integration in the host country. The observational data also demonstrates a positive interaction and communication between refugee women and health providers as a result of economic and social integration which increases the quality of health.

Positive Experience:

The data from interviews also suggest positive experiences of refugee women about the Turkish health system and the maternal care that they receive from the health providers. All refugee women who were interviewed stated their gratitude to Türkiye for the provision of healthcare in their health centres and hospitals. Most women stated that the health system is better in Türkiye in comparison to their home country. The positive experience of health provision was predominantly in the family health centres, migrant health centres and breastfeeding centres of the hospitals.

Image Source: Taken from a Breastfeeding Centre in Bursa with permission (2024).

The 20 out of 28 interviewees had minimum or no language skills in Turkish which had a grave impact on their understanding of the health system, and hindered their communication with health providers as they were dependent on a translator (usually from a family member), and thus this negative experience prevented many refugee women to avoid health visits in especially hospitals as mentioned above. These challenges coupled with high workload pressure on the hospital staff in the areas with high refugee populations resulted in either refugee women having minimum or no health visits until giving birth. Moreover, as a result of poor communication with health providers and negative experiences in hospitals, refugee women with financial means consulted with private health institutions (legally they are not permitted to do so), health NGOs and unlicenced health centres for maternal care and child delivery. The interviews with health managers and health providers suggest that a lack of

health visits during pregnancy may put women's and unborn babies' health at risk such as premature births, a lack of detection of preventable diseases, vitamin deficiencies and health risks of the babies. A few interviewees from NGO practitioners also raised a rising number of disabled babies among refugee populations due to mothers' health problems, early marriage, lack of economic means and low health literacy.

Refugee women narrated experiences of healthcare in Türkiye through a mixture of 'feelings' comprising of both 'senses of appreciation and satisfaction' and 'senses of neutrality and despair'. This study revealed that the biggest challenge the refugee women face is 'the language barrier' which impacts their experience in navigating the health system, their relationship with health professionals and their physical/psychological wellbeing. However, the analysis of other variables such as refugee women's (especially Syrian refugees) gender identity and roles within their refugee communities, the level of patriarchal hierarchies and social pressure also impact their health and well-being as a result of a high number of early marriages, forced marriage, close-kin marriage, teenage pregnancy, and high fertility rate (SIHHAT, 2018). The interview and observational data also suggest these gender roles as the majority of women who were interviewed were aged between 18-29, and 12 of them had 3 and more children. Young interviewees were planning to have more children. Studies suggest that cultural expectations and gender roles affect refugee women's accessing sufficient healthcare, such as patriarchal family structure and dependence on their husbands to go out, lack of practical knowledge of the Turkish language and lack of knowledge of the system (Tuncer Unver and Baykal, 2020 cited in Sonmez Efe, 2025).

As stated above, education level and employment status are two determinants that impact refugee women's language skills, however, many women stated that they do not mix with the locals due to their social status and they feel that there is prejudice against them. The fieldwork data suggests the need for a better understanding of refugee women's experiences of maternal care which is linked to their migration stories (pre-migration, migration and post-migration) as the interview data demonstrates levels of PTSD in these women. According to studies, "psycho-sociological health of refugee women is usually not good because they experience harsh migratory experiences, witness difficult situations and are away from their homes and families" (Sonmez Efe, 2025). Refugees' health status deteriorated after migration from Syria to Türkiye, as 85% of refugees stated being in good health pre-migration, which decreased to 62% post-migration (SIHHAT, 2018, p.55). Thus, many refugee women *'experience feelings of anxiety and sadness, hopelessness, difficulty sleeping, fatigue, irritability, anger or aches and pains… depression and post-traumatic stress disorder (PTSD)'* (WHO, 2022). According to a study, the depression level among refugee women is too high, as one in 10 women commit suicide (Yurdagul and Aytekin (2018). Thus, these variables illustrate the complexities of the health determinants and other categories (legal status, gender, ethnicity, socio-economic status) that need to be taken into account when analysing refugee women's experiences of maternal care and addressing social inequalities in accessing healthcare. The recognition of the complexity of the data is crucial for policy and practical solutions.

Refugee women who could speak Turkish also showed confidence in coping with the prejudice although they also mentioned a degree of negative public attitude towards them especially in the hospitals. Thus, a high number of women described facing forms of prejudice and negative attitudes towards them especially in hospitals, which was not as significant in family health centres or migrant health centres. The interview data suggests that all refugee

women have experienced a difficult migration journey and expressed the psychological implications on their mental and physical well-being as mentioned above. The data showed various coping mechanisms to overcome the negative impact of the migration journey such as a sense of denial, focusing on family life, and sometimes work (rarely education). All refugee women illustrated a sense of 'new life and hope' with their pregnancy and childbirth which is considered a 'coping mechanism' for their migrant status in the host country. The study also identified a cultural approach to marriage and childbirth at an early age and having many children which was the case for nearly all refugee women who are interviewed. The data also suggest that educated refugee women prefer fewer children and request birth control methods despite social pressure within their communities.

Thus, the interview data with refugee women identified key challenges impacting their maternal care which are lack of language skills, no or minimum health literacy, lack of social integration, negative public attitude towards refugees and prejudice against these women. The analysis of the interview data and participant observation also identified one of the major challenges for refugee women is the lack of 'health literacy' and knowledge of the 'health system' in Türkiye which are intertwined with the challenges mentioned above.

Health Providers' Views

The interviews with 40 professionals illustrate the challenges and perceptions through the experiences of healthcare providers (GPs, midwives, nurses, senior government officials, social workers, and psychologists). Refugee women's access to maternal care is considered and emphasised to be a 'human right' by all interviewees and healthcare providers in hospitals and family health centres. They emphasised that despite the heavy workload and barriers they do not discriminate against any patient based on ethnicity when providing care to women in their wards/centres. However, all interviewees stressed the language barrier as the most significant challenge in providing maternal care which is perceived as a cultural and gender-based issue among refugee women. The health providers stated that a lack of health literacy, integration and family planning impacts health provision and the workload of professionals. Healthcare providers in hospitals had negative opinions about refugee women such as high reproductivity, some cultural practices, patriarchal family style, lack of language skills and lack of health literacy. Although health providers in the family health centres and migrant health centres mentioned similar issues attributed to the refugee women, interviews and observational data suggest more tolerance towards these challenges by health providers as they were more supportive and understanding about the same barriers.

The data from interviews of the health providers suggest a 'lack of language skills' among refugee women and thus 'lack of communication' as the biggest hurdle for the provision of basic maternal care which undermines the quality of care. The health providers predominantly blamed the refugee women for a lack of will to learn Turkish which was stated by all health providers (i.e. nurses, and midwives). The interview data illustrated a 'sense of frustration' among health providers in terms of increased workload due to communication issues, the need for translation services, and problems with the translation processes. Although one of the reasons for these challenges is stated to be a 'lack of integration' of refugee women, by the same token health providers saw refugees' presence in the country as temporary due to their belief that they may return to their home country when the war is over. Thus, although the data showed 'mixed feelings and opinions' about the refugee population's status in

Türkiye, the health providers thought the 'refugees are here to stay', therefore they suggested that the state needs to generate solutions to these challenges.

The interviews with the senior health officials and stakeholders emphasised some of the same challenges mentioned above. However, the issue of 'informal health centres' run by refugees/irregular migrants who do not have licences is stated to be the biggest challenge from the institutional point of view. These unlicensed health centres/clinics are stated to be a risk to the refugee women's health as well as to the entire population. The health institutions' inspecting bodies work tirelessly (as stated by senior health managers) to tackle this issue, however, they also mention the persistence of this problem as the number of such health clinics is mushroomed. Similar to the health providers, senior health professionals/managers also emphasised the lack of language proficiency among refugees as being one of the biggest challenges for the quality of care, but they also stressed the existence of a sufficient number of translation services in Türkiye and language courses for refugees provided by the local municipalities. The interview data and observations suggest the difference between young and older refugees in terms of language proficiency as the former usually are fluent in the Turkish language.

All health professionals and stakeholders also agree that health care is a 'human right' and refugee women are granted this right in Türkiye regardless of their legal status. Despite some of the health providers' prejudiced views about the refugee population mentioned above and the challenges they encounter in hospitals, all health providers showed a degree of *'empathy'* towards refugee women and their migrant status in Türkiye and stated that they provide maternal care the same as Turkish citizens without discrimination once they are in the health centres and hospitals. The interview and observation data suggest the need for some improvements for better health provision to refugee women some of which stem from the health system and others should come from the refugee population's participation in the health initiatives.

Suggested Improvements

The research findings aim to make a positive change in improving health provision to refugee women in Türkiye. The research data enables refugee women to voice the challenges they experience in maternal care facilities in Türkiye as well as health providers' experiences of health provision in terms of addressing their concerns and frustrations. The interview questions enabled the interviewees to put forward suggestions for possible improvements to tackle these challenges. However, the refugee women predominantly addressed their concerns and challenges in the health facilities without explicitly generating suggestions. The policy recommendations (see the box below) also incorporate an interpretation of the refugee women's concerns. Thus, the suggestions below reflect health professionals' views on the improvement of health provision:

- State health institutions are suggested to be the principal source for the provision of health and produce solutions to the challenges (NGOs might be supporting the state institutions).
- Migrant Health Centres are good alternatives for the provision of primary and (some aspects of) secondary care for refugee women.
- There is a need for better policies for improving the health literacy of refugee women including understanding and use of family planning methods.

- An introduction of incentives for language courses for refugee women.
- Policies to improve the distribution of refugee population within the cities to prevent heavy workload in populated areas.
- A generation of better refugee management and return policies

Policy Recommendations

- The study has increased understanding of the impact of the key barriers to quality care raised by both refugee women and healthcare providers and the role of the state and non-state bodies of networks in addressing the challenges and generating incentives to overcome issues:
  - Health policies, plannings and programmes should have a multicultural perspective. In this regard, budget to be allocated for needs analysis pilot programmes to respond to the health needs of vulnerable groups
- It has produced evidence for a potentially stimulating policy debate about health risks for refugee women stemming from various determinants i.e. a lack of health literacy, the impact of mutual prejudice for receiving/provision quality care, language barrier, and the root causes of persistence of this issue:
  - To allocate budget to increase health literacy training for refugee populations in the family and migrant health centres
  - To allocate incentives for online Turkish courses for refugee women who can't attend face-to-face courses in state public language centres
- It aims to make suggestions around how learning from the study could be applied to practical solutions i.e. a co-production of Toolkits for refugees and healthcare providers to break the barriers, raise awareness, improve mutual knowledge, and enhance quality care in a safe environment:
  - To initiate/increase programmes for a co-creation of toolkits for refugees with inclusion of state and non-state stakeholders
- It aims to co-produce principles for 'inclusive narratives' within health institutions for the use of institutions' training services aimed at both refugees and service providers.
  - To take concrete measures for staff training programmes for health providers to raise awareness about refugee populations that creates social inclusion
  - To consider Equality Diversity and Inclusion regulations in health sector that revise/recognise protected characteristics and marginalised populations.

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