2023

Participatory Research on
SRHR on Lesbos, Greece

VENTURING BEYOND EMERGENCY CARE

MIXED-METHODS PARTICIPATORY ACTION RESEARCH ON THE SEXUAL AND REPRODUCTIVE HEALTH OF REFUGEE WOMEN OF REPRODUCTIVE AGE RESIDING IN THE MAVROVOUNI CAMP ON LESBOS, GREECE

PRELIMINARY RESULTS

2023

Participatory Research on
SRHR on Lesbos, Greece

VENTURING BEYOND EMERGENCY CARE

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A COLLABORATIVE EFFORT OF 4 INSTITUTES (NKUA, VU, RADBOUD, KIT)

A COMPREHENSIVE AND HOLISTIC RESEARCH DESIGN:

- **A HOUSEHOLD SURVEY** WITH 247 REFUGEE WOMEN OF REPRODUCTIVE AGE IN MAVROVOUNI CCAC.
- **6 FOCUS GROUP DISCUSSIONS** INVOLVING 48 REFUGEE WOMEN EXPLORING NEEDS, EXPECTATIONS, FACTORS INFLUENCING ACCESS TO HEALTH SERVICES
- **27 IN-DEPTH INTERVIEWS** WITH REFUGEE WOMEN
- **6 FACILITY ASSESSMENTS** WITH THE MAIN PROVIDERS OF SEXUAL AND REPRODUCTIVE HEALTH.
- **20 KEY-INFORMANT INTERVIEWS** WITH STAKEHOLDERS REPRESENTING ALL LEVELS OF THE HEALTHCARE SYSTEM.
- 24 HOURS OF SENSE-MAKING WITH THE CO-RESEARCHERS.




A DIVERSE TEAM:

10

10 CO-RESEARCHERS FROM THE REFUGEE COMMUNITY REPRESENTING 6 DIFFERENT LANGUAGE GROUPS (ARABIC, FARSI, SOMALI, AMHARIC, FRENCH/LINGALA, TIGRINYA)

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4 MASTER STUDENTS (UNIVERSITY OF BARCELONA, MCMASTER UNIVERSITY, UNIVERSITY OF AMSTERDAM, NATIONAL AND KAPODISTRIAN UNIVERSITY ATHENS)

1. Executive Summary


Household Survey


Facility Assessment


Focus Group Discussions and PEER Interviews


Key Informant Interviews

1.1. Research Design and Methods

This research report synthesizes the results from:

- A **HOUSEHOLD SURVEY** with 119 questions encompassing 9 different areas of sexual and reproductive health (Maternal Health, Family Planning, Menstrual Health, Sexually Transmitted Infections, Gyneacological Health, Abortion, Female Genital Mutalation (FGM), Gender-based violence (GBV) and Mental Health) conducted with 247 refugee women of reproductive age residing in Mavrovouni Closed-Controlled Access Centre (CCAC).
- Six **FOCUS GROUP DISCUSSIONS**, each lasting 3 hours, involving 47 refugee women exploring 3 main areas of healthcare: needs, expectations, and factors influencing access to services.
- 27 **IN-DEPTH INTERVIEWS** with refugee women.
- 7 **FACILITY ASSESSMENTS** with the main providers of sexual and reproductive health.
- 20 **KEY-INFORMANT INTERVIEWS** with stakeholders representing all levels of the healthcare system.

1.2. Main Preliminary Findings

1.2.1. General Demographics

- The breakdown of the respondents was as follows: 35% Afghanistan, 27% Eritrea, 12% Somalia, 7% Yemen, 5% Palestine, 5% Democratic Republic of Congo, 5% Other, 2% Sierra Leone, 2% Syria.
- The median age of the women is 24 years, with a range spanning from 15 to 48 years.
- The median estimated time displaced is 25 months, while median length of stay is 4 months.
- Roughly 75% are Muslim, and 25% are Christian.
- Only one respondent identified as being part of the LGBTQ+ community, highlighting the further invisibility of this population in camp.
- Diverse range of education levels within the group, with a significant portion having primary education or never having attended school, and a substantial proportion are highly educated.
- 28% of the women have received a negative response to their asylum request. Having a negative response is significantly associated with having clinically significant mental distress, and being denied medical care.
- 63% of women are single, 35% of single women have a child (unclear whether the child is with them in camp).

1.2.2. Information

- For each of the main SRH categories, women are largely not accessing information in the camp. While preference for information access varies by category, women generally tend to get their information from health care providers, and trained NGO volunteers or counselors.
- Most health care facilities do not perform outreach to provide information about the type of services offered. However, SRH information at the facilities are provided through health care professionals.
- Women residing in CCAC Mavrovouni consider information on sexual and reproductive health, as well as relevant services, important factors to experience autonomy, empowerment and safety; to prevent unplanned pregnancies; to combat existing lack of information; to decrease mental health problems; to improve health awareness and women's overall health status. In terms of information delivery, there is a need for direct, verbal, one-to-one outreach to camp residents; for pamphlets and brochures as well as non-text, visual materials such as cartoons and/or comics; to target new arrivals; to provide group sessions for women and set up women's communities; to engage religious leaders in information delivery; and to engage men in topics such as those related to family planning and sexually transmitted infections (e.g., couples' sessions on such topics). The preference for receiving information from medical personnel or trained health promoters was further expressed.
- Key informants expressed the importance of improving information delivery to refugee women on service delivery as well as culturally sensitive health awareness.

1.2.3. Maternal Health

- 7.5% of the respondents indicated that they were pregnant.
- There are 1.5 children per woman; fertility rate varies significantly by country of origin.
- Number of antenatal care (ANC) visits per month: 1.1; Number of postnatal care (PNC) visits per month: 0.25.
- 36% of pregnant women had a caesarean section with one woman who did not know why she received it, highlighting the need for more female translators.
- Women reported to have not received more or different food during and after pregnancy.
- Miscarriages and neonatal and child deaths are occurring at a low rate in camp.
- 2 women had a child under 18 die during their journey by land/sea to this camp.
- Women are exclusively breastfeeding for an average number of 3 months, and introduction of complementary feeding is occuring after 4.1 months.
- Provision of ANC exceeds the minimum recommendations set by the WHO with an average of 9 ANC visits per pregnant woman. One non-medical organization provides ~5 additional meals including fruits, vegetables, and pantry staples to pregnant women. Provision of PNC falls under the minimum recommendations set by the WHO with an average of 1 PNC visit per postpartum woman. 5 facilities provide ANC and 4 facilities provide PNC.
- Women's specific needs relating to maternal health include care needs (medication, check-ups, informed consent during delivery); needs pertaining to the living space (clean, private ISObox with sanitary facilities); material needs (clothes and hygiene products for pregnant women); nutritional needs (fruits, vegetables, and/or vitamins, as well as access to food in the hospital); and other needs (e.g., social support, physical activity, religion and prayer).
- Key informants unanimously agreed that post-partum care was challenging, especially under the current living conditions in camp.

1.2.4. Family Planning

- 74% of women want to prevent having a baby; no women are receiving fertility treatment, but over 25% would be interested in using treatment to get pregnant.
- Current contraception method as well as preference varies by origin country, and for all countries, use of contraceptives is dramatically different than that of preference.
- 11 women reported having used the emergency contraception pill in camp.
- 4 facilities provide family planning services. Most modern forms of contraception (i.e., condoms, pills, IUDs, tubal ligation) are provided by health facilities except injectables and implants.
- Women's needs in relation to family planning encompass care needs (access to contraception, especially anonymous access; support for fertility treatment; consultation and/or information); and social support.

1.2.5. Gynecological Health

- Almost half of respondents experienced gynecological symptoms in camp, of which the most prevalent were itchiness, unusual discharge, and burning pain during urination.
- Women felt factors contributing to the frequent symptoms of itchiness and burning urination included: shared and unclean sanitary facilities; distance to sanitary facilities; dust in camp; oneself or one's partner having an STI; engaging in intercourse with multiple partners; lack of underwear, toilet paper, hygiene products, adequate menstrual materials, and self-care. Other perceived reasons included not using contraception; experiencing stress; undergoing a C-section; and shared laundry machines (scabies). Women may be hesitant to seek care for these symptoms because of a lack of (female) interpreters, lack of awareness and information, as well as low expectations and trust in services.
- 16.7% of respondents had an STI test in camp AND received the results.
- 1 of 246 received cervical cancer screening.
- Two facilities provide gynecological services including passive cervical cancer screening. Four facilities provide sexually transmitted infections services. Two facilities provided human immunodeficiency virus-related services.
- Needs pertaining to gynecological health included care needs (medication for gynecological symptoms, urine tests, female interpreters) as well as clean and private sanitary facilities.
- Needs pertaining to STIs/HIV included care needs (treatment and medication for STIs and HIV, STI screenings, female interpreters) as well as the need for a loyal partner.
- Key informants mentioned how gyneacological complaints formed an important reason for women to seek SRH services.

1.2.6. Menstrual Health

- 84% have had a menstrual period since arriving in camp.
- Respondents had access to menstrual materials, but less than 20% were able to adequately manage their menstrual pain.
- Several factors of the toilets where most women changed their menstrual materials was assessed. 60% of women found them clean, 80% private, 77% safe, 96% said there was water and only 10% with soap.
- Women receive their menstrual materials at the Hygiene Office in camp, from EuroRelief or Because We Carry, as well as a local women's center outside of camp. However, 17% of women did not have enough menstrual materials and a few women mentioned buying menstrual materials themselves. While women expressed differing opinions about the quantity and quality of materials provided, a general need for access to hygiene products and/or menstrual materials and, importantly, for autonomy (i.e., not needing to register for materials) and choice in materials emerged.

1.2.7. Abortion

- Since arriving in camp, 2 out of 217 respondents had a pregnancy removed while living in camp, and 3 of 217 respondents did not want to respond.
- 4 cases of complications were noted, 2 of them did not seek care.
- Two facilities provide abortion-related services up to 12 weeks of pregnancy.
- Specific needs relating to abortion included care needs (access to medical professionals, follow-ups after the abortion, medication, mental health support); nutritional needs (vitamins and nutritious food after the abortion); and other needs (social support, partner support, initiative, housing outside of camp).

1.2.8. Female Genital Mutilation (FGM)

- Respondents from Somalia, Yemen, Sudan and Sierra Leone were most prominently impacted by FGM.
- The average age of experiencing FGM is 6 years old, with the range being 0 to 25.
- Over 85% of respondents who had experienced FGM did not get access to treatment.
- There are no official health care services to treat female genital mutilation. However, vulnerability certificates are provided by two health clinics for the asylum procedure.
- Specific care needs pertaining to FGM included proper informed consent procedures during vulnerability checks, medication, mental health support, reconstructive surgery, and treatment for complications and infections.

1.2.9. Gender-Based Violence (GBV)

- **Pushbacks:** 55% of women reported having experienced at least one pushback. Notably, there was a significant association between clinically significant mental distress, as defined by the Self-Report Questionnaire Item-20 as a score of 8 or higher out of 20, and having experienced a pushback.
- **Child marriage:** 28% of 243 respondents experienced child marriage.
- **Intimate Partner Violence (IPV)**: 11 of 247 respondents are IPV cases in camp.
- **Verbal abuse:** 74% of women have experienced verbal abuse in their lifetime; 48% in home country, 20% en route to Greece, 19% during pushback, 14% in camp now, 12% in detention centre, 9% in previous camp, 7% in another country.
- **Physical abuse:** 53% of women have experienced physical abuse in their lifetime; 36% in home country, 9% during pushback, 8% en route to Greece, 7% in another country, 4% in detention centre, 3% in camp now, 2% in previous camp.
- **Sexual abuse:** 36% of women have experience sexual abuse in their lifetime; 22% in home country, 7% en route to Greece, 6% in another country, 4% during pushback, 2% in detention centre, 1% in camp now, and 1% in previous camp.
- Most perpetrators for all types of GBV were authorities, neighbor/community members, family members, and partners/husbands.
- Two facilities provide services for GBV.
- Women's needs relating to GBV included care needs (medical attention and follow-ups, mental health support, female interpreters, well-functioning referral pathways); legal support (legal support and protection); information and education (awareness among men, awareness of rights); agency (resilience, confidence, consent for sexual intimacy); and other needs (security, community support for reporting GBV).
- Women felt unsafe due to the asylum procedures or their legal status (e.g., fear of rejection and deportation) and during night hours or in the dark (e.g., when accessing sanitary facilities, especially due to the distance to the sanitary facilities). They also expressed concerns about drunk people; stealing, trespassing, and harassment (e.g., men entering the tents at night); lack of information about SRH and available services; insects in the camp; and fights between communities. In contrast, women feel safer during daytime; in comparison to their country of origin; and when knowing their rights as an asylum-seeker in Europe. A divergence in safety perceptions of police and security presence in camp was observed. While police were perceived to increase security in camp due to patrolling, women mentioned long response times, a perceived bias between communities, and expressed a general mistrust of the police. Women reported perceived discrimination in their asylum procedures, when accessing health care (e.g., lack of interpreters for specific languages), or when interacting with the police.
- Multiple key informants voiced concerns about transactional sex occurring in camp.
- Key informants were of the opinion that the lack of a GBV focal point, clear referral pathways and dedicated meetings hindered the delivery of adequate GBV care.

1.2.10. Mental Health

- Out of 247 women surveyed:
  - The average SRQ-20 score was 10 (with a score of 8 considered high)
  - 13.4% of respondents had considered ending their life in the past 4 weeks
- Over half of the women experience clinically significant mental distress, as defined by the Self-Report Questionnaire 20-Item with a score of 8 or higher out of 20, yet do not seek care.
- Not seeking mental healthcare may be due to stigma and shame; cultural and/or religious beliefs about treating mental health issues; lack of mental health awareness and information about services; lack of interpreters and language barriers; long waiting times; distance from homes to services; lack of trust and low expectations of care (e.g., no support with the asylum procedures). Women further expressed that having to repeat one's story during psychological sessions may cause mental distress.
- Across all communities, we observed a pronounced need for clarity and stability as pertains to the asylum procedures and transfers, which cause a significant amount of mental distress. Further mental health needs included care needs (access to medical professionals, psychologists, social workers, lawyers, and external interpreters; timely treatment, medication, personal attention, well-functioning referral pathways, non-Western treatment techniques); the integrated provision of legal support (positive asylum, family reunification, receiving documents from psychological staff); information and education (mental health awareness); needs pertaining to the living space (privacy); and other needs (social support, partner support, women's space and/or activities, sexual intimacy for stress reduction, music, physical exercise, drawing books, religion and prayer, opportunities to express emotions).
- Mental health is a major concern for key informants, particularly against the backdrop of a reduced number of mental health actors in camp and an overburdened public sector.

1.2.11. Overarching SRH Needs

- A range of overarching SRH needs emerged. The biggest category comprises **needs related to healthcare and other services** such as care needs (e.g., 24-hour access to medical professionals, access to care and services for children, timely treatment), interpretation (e.g., external and female interpreters), legal support (e.g., family reunification), good nutrition (e.g., more nutritious food, improving the food line), and information and education (e.g., outreach).
- Women further expressed **needs related to the physical camp setting**, including the camp environment (e.g., shade, park/garden for children), sanitary facilities (e.g., clean, close, and private facilities), accommodation (e.g., clean and private accommodation, ISOboxes), and safety (e.g., during night, for single women and minors, related to the asylum procedures).
- Participants also mentioned **material needs** (e.g., electric wheelchair, necessities for their children, toilet paper) and **financial needs** (e.g., employment, bank card).
- **Community needs** included community relations (e.g., support for reporting GBV, activities for women) and support for single mothers (social support, particularly for childcare).
- **Interpersonal needs** included partnership needs (e.g., loyalty, support for abortion) and a satisfying sex life (e.g., privacy, consent).
- Finally, **other relevant needs** included agency (e.g., resilience, freedom, awareness of one's rights), justice (e.g., related to discrimination, pushbacks, and the asylum procedures), and stability and clarity (e.g., related to the asylum procedures, living conditions, and transfers).
- Key informants stressed the importance of food (including milk for newborns) and accommodation (ensuring privacy and silence, especially after childbirth) as prerequisites for health.

1.2.12. Expectations of Care

Women's expectations regarding care can be summarized in five key categories:

- Expectations regarding **treatment** (e.g., efficient medication, follow-ups, choice in contraceptive methods);
- Expectations regarding **mental health support** (e.g., encouragement, documents and support for asylum claims, looking ahead to the future);
- Expectations regarding **personnel** (e.g., experienced, knowledgeable healthcare professionals, able to speak English, female interpreters);
- Expectations regarding **interactions with healthcare providers** (e.g., kind, being taken seriously, calm tone of voice, clarification if unable to help, patience, personal attention, respect); and
- **General expectations**, going beyond immediate healthcare assistance (e.g., support for other needs such as accommodation, food, and the asylum process).

1.2.13. Barriers and Facilitators to Health Care Access

Women perceived a variety of supply-side and demand-side barriers and facilitators when accessing services and support for their SRH.

On the **supply-side:**

- ***Approachability*** of care was facilitated by information provision in English and community outreach by NGOs, while it was hindered by a lack of information, information provision in Greek, and, to a smaller degree, lack of visibility of services.
- ***Acceptability*** of care is impeded by gender issues (e.g., feeling uncomfortable with male interpreters), norms (e.g., feeling questioned by the psychologist), and perceived discrimination (e.g., by Greek doctors, by the police, at the hospital, and related to the lack of interpretation services).
- ***Availability and accommodation***: Perceived shortages in services (e.g., restricted access after midnight), staff, and medication impeded access to SRH care. Furthermore, limited availability of menstrual materials and/or hygiene products, legislative hurdles (e.g., time limits for abortion), the overcrowding of CCAC Mavrovouni, distance to services, road conditions in camp, and temperature during the summer negatively impact accessibility of care. While EuroRelief keeps appointment slips for women so that they do not miss appointments, overlapping scheduling creates inefficiencies. Apart from evening and weekend services offered by BRF, limited opening times constrain access to care.
- Free healthcare, free menstrual materials and/or hygiene products, free food and non-food distributions ensure ***affordability*** of services. However, both direct (e.g., treatment after receiving a rejection, medication when the pharmacy is out of stock) and indirect costs (e.g., transport) contribute to financial challenges in accessing healthcare.
- Women reported several barriers and a few facilitators in the ***appropriateness*** of care. Services and care exhibit deficiencies in adequacy (e.g., lack of proper informed consent during delivery and FGM vulnerability assessments, long waiting times and lines, lack of explanations at EODY facilities); coordination and continuity (e.g., perceived lack of interorganizational coordination, referral pathways); and quality (e.g., lack of personal attention, lack of effective triage). Facilitators for quality included, for example, choice in contraceptive methods, healthcare providers, and menstrual materials.

On the **demand-side:**

- The ***ability to perceive the need for care*** was aided by personal initiative, whereas it was hindered by a variety of barriers, including: limited health awareness; fear of side effects and consequences (e.g., in relation to contraception and abortion); normalization of gynecological symptoms; a mismatch between care and expectations (e.g., perception of not receiving sufficient medication, treatment, or support for their asylum claim); mistrust in healthcare professionals; rumors and misinformation circulating in the camp community; and a limited emphasis on personal hygiene and self-care practices due to stress.
- Women's ***ability to seek care*** was impeded by challenges in autonomy (e.g., gender dynamics in relation to decision-making on abortion, illiteracy), cultural factors (e.g., beliefs about abortion and mental health, care-taking and household responsibilities), stigma and shame (e.g., in relation to GBV, mental health, and contraception), as well as the experience of pronounced stress.
- Women's ***ability to reach care*** was negatively affected by restricted mobility (e.g., due to disability), the capacity of ambulances, and the absence of social support, in particular childcare facilities. On the other hand, information sharing within the community and partner support during abortion acted as facilitators in reaching care.
- Financial constraints (e.g., lack of income and/or money, unemployment, social isolation) limit women's ***ability to pay*** for services, whereas remittances and a monthly cash transfer by the Greek government - albeit perceived as insufficient - supported women's financial capacity.
- Issues of empowerment (e.g., limited capacity to communicate, self-respect and dignity) as well as stigma and shame (e.g., when engaging with interpreters from the camp community) hinder women's ***ability to engage*** with service providers.

1.2.14. Barriers and Facilitators to Health Care Delivery

71% of the health care professionals are female, including the part-time gynecologist, suggesting that the availability of female staff is sufficient.

Despite 49% of translators being female overall, there are insufficient female translation services. There are gaps in language coverage and female translators within some of the health care facilities.

Collaboration

- **Team and NGO Collaboration:** Positive teamwork within teams and between medical NGOs, but communication lapses may lead to duplicated efforts.
- **Medical and Non-Medical Collaboration:** Mixed opinions on collaboration, especially in GBV management.
- **NGO-Hospital Collaboration:** Challenges in trust, cultural understanding, and effective communication hinder optimal collaboration.
- **Authorities Collaboration:** Improved regional collaboration, but a perceived gap between fieldworkers and policymakers exists at both national and European levels.

Coordination challenges include:

- **Effort Duplication:** Parallel systems and resource wastage due to lack of coordination.
- **Information and Follow-up Issues:** Canceled meetings, accountability lapses, and inaccurate information impede efficient healthcare delivery.
- **Bureaucracy Barriers:** Administrative hurdles, such as delays in approvals, hinder effective care delivery.

Key informants expressed the following main challenges:

- **Interpretation Services:** Lack of gender-specific interpretation services hampers communication and fosters racism.
- **Human Resources:** Shortage of medical personnel due to NGOs leaving, denied access, and job insecurity.
- **Increasing Numbers and Lagging Registration:** Unregistered refugees and complex medical needs pose health risks and logistical challenges.
- **Funding**: Declining funding impacts medication provision and overall service delivery.
- **Accountability:** NGOs face a lack of response, and medical actors deal with responsibilities beyond their capacity.
- **Transportation**: Challenges in transporting patients to and from hospitals hinder adequate care.
- **Lack of Continuity and Experience:** High personnel turnover affects culturally sensitive services, emphasizing the need for continuity and specific skills in refugee healthcare.

Supplementary Sections

2. Supplementary Sections

2.1. List of Figures & Tables

2.2. Appendix

2.3. List of Abbreviations

ANC - Antenatal Care

BRF - Boat Refugee Foundation

BWC - Because We Carry

CCAC - Closed Control Access Center

EU - European Union

FA - Facility Assessment

FGD - Focus Group Discussion

FGM - Female Genital Mutilation

HIV - Human Immunodeficiency Virus

IUD - Intrauterine Device

NGO - Non-Governmental Organization

PAR - Participatory Action Research

PEER - Participatory Ethnographic Evaluation and Research

PLA - Participatory Learning and Action Research

PNC - Postnatal Care

RIC - Reception and Identification Center

SGBV - Sexual and Gender-Based Violence

SRH - Sexual and Reproductive Health

SRH - Sexual and Reproductive Health and Rights

STIs - Sexually Transmitted Infections

UNFPA - United Nations Population Fund

UNHCR - United Nations High Commissioner for Refugees

WASH - Water, Sanitation and Hygiene

WHO - World Health Organization

Introduction

3. Introduction

The intent of this study is to learn about the sexual and reproductive health (SRH) needs, health-seeking behaviour and factors affecting access to care of refugee women of reproductive age residing in Mavrovouni CCAC, so that workable solutions for the implementation of comprehensive services can be co-created.

Nearly 25 years since SRH needs were recognized as fundamental human rights (1), significant inequities in their fulfillment still exist, with global gaps prevailing amongst the most marginalised (2). Refugees in Europe show much poorer SRH outcomes than host populations, including worse pregnancy outcomes, with increased abortions, caesarean sections, instrumental births and complications (3, 4). Sexually transmitted infections (STIs) are also higher in several groups (5), and sexual and gender based violence (SGBV) is a serious problem, occurring before (6) and during transit (7) and in the country of destination (7).

Despite increasingly being recognized as an urgent and dire problem, unfulfilled SRH and rights among refugees in the European region are still poorly researched: studies quantifying health needs are mostly limited to refugees in Turkey, adolescents are not accounted for and demand-side factors are insufficiently examined (8). Moria RIC, situated on the island of Lesbos, was Europe's largest formal refugee camp before being destroyed by fires in September 2020. The only available SRH data describing SGBV in Moria came from a clinic run by Médecins sans Frontières (9). In the new Mavrovouni CCAC, 23% of residents are women (10). To date, not a single situation analysis of any European camp has been conducted. The lack of robust evidence to inform directed action may explain why health responses are failing to meet refugees' SRH needs. Indeed, the SRH landscape for refugees is characterised by a fragmented system of emergency services, inadequately transitioning along the humanitarian-development nexus (8).

Planning for comprehensive services and tailored healthcare is only possible if needs, capacities, values and aspirations of the population are understood. Traditionally, individual preferences of donors were the primary drivers of SRH interventions in humanitarian settings (11). In line with increased efforts to conduct people-centred research and decolonise healthcare programming, health needs assessments are a valuable tool to ensure a systematic approach is deployed by which an inclusive understanding of priorities is gained (12). Moreover, actively involving refugees as partners and collaborators in the research process has the potential to improve research quality, relevance, and impact (13). Through participatory methodologies - even with hard-to-reach groups such as refugees against the challenging backdrop of power asymmetries! - meaningful engagement can be achieved (14).

This research is justified for various reasons. Migration is considered a major social, political, and public health challenge for the WHO European Region (15). Residence in temporary and overcrowded shelters is associated with severe disease burden and

Figure 1: CCAC Mavrovouni at sunset.

taxing on the local healthcare sector. Investing in migrant-inclusive health systems has advantages in terms of healthcare costs (16), social cohesion (17), and public health. Contrary to popular belief, migrants rarely introduce communicable diseases, whereas denying them proper care may pose risks to refugees themselves and to the health sector at large (18, 19). However, the most important reason to ensure inclusive policies remains the fact that SRH is a fundamental human right, for which the EU holds social and ethical responsibility, and that counts for all residing within European borders. In attempting to comprehend the SRH landscape for refugees, this project thus contributes to the United Nations Sustainable Development Goal call to 'leave no one behind' and promote Universal Health Coverage by 2030.

The study answers the following research questions:

- What do refugee women of reproductive age residing in CCAC Mavrovouni consider their SRH needs?
- How do women seek SRH care and what are their preferences regarding professional and informal support?
- Which SRH services are available?
- Which factors do women find influence their access to SRH services?
- Which factors do service providers find influence the women's access to SRH services?
- Which factors influence service providers' delivery of care?
- According to refugees, service providers, and policy-makers, what would ideal SRH services in CCAC Mavrovouni look like, and which conditions must be met to realize these?

Research Design

4. Research Design

4.1. Study Setting

The study was conducted in Mavrovouni CCAC, Lesbos, Greece between June and November 2023. The Mavrovouni CCAC replaced Moria RIC, which was Europe's largest formal refugee camp after Moria was destroyed by fires in September 2020. According to the United Nations High Commissioner for Refugees (UNHCR), as of November 2023 4418 refugees and migrants reside on Lesbos, of whom 3990 are in the CCAC. The majority of the refugees are from Afghanistan (49%), Eritrea (17%), Palestine (10%), Syria (9%) and Sudan (4%).

4.2. Study Design

The study involved core team of a medical doctor with experiencing working on Lesvos, Master's students and refugees as co-researchers in a convergent mixed-methods design. The participatory design helped identify:

(A) refugees' perspectives (demand-side) through:

- **Quantitatively**: a household survey among women; and
- **Qualitatively**: focus group discussions and interviews.

(B) service providers' perspectives through:

- **Quantitatively**: assessments of primary and secondary SRH services; and
- **Qualitatively**: key informant interviews with local and international non-governmental (NGO) programme leads, SRH focal points, influential workers, government officials and community representatives.

Quantitative and qualitative data were merged for deeper understanding.

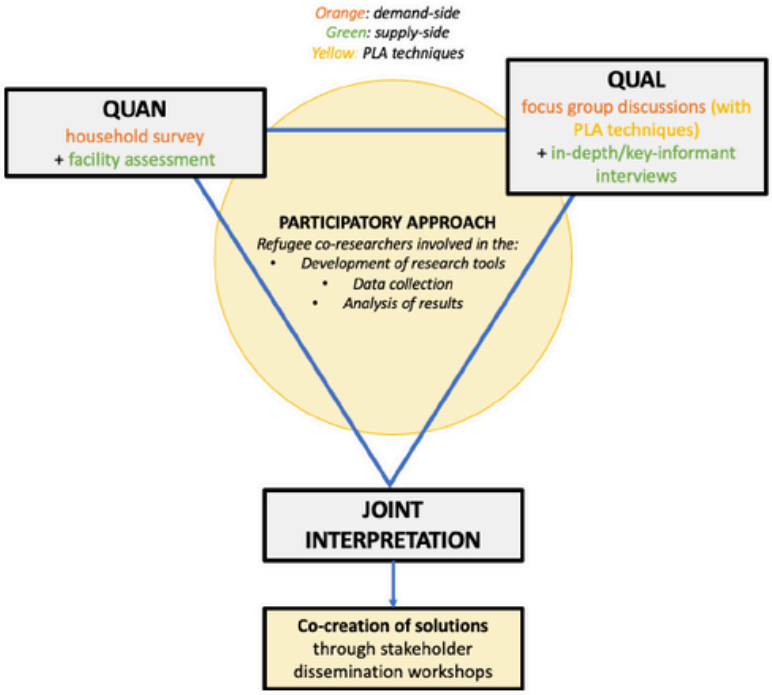


Figure 2: Triangulation mixed-methods design and participatory approach.

4.3. Participatory Action Research

Participatory action research (PAR) is “based on reflection, data collection, and action that aims to improve health and reduce health inequities through involving the people who, in turn, take actions to improve their own health” (20) This meant involving co-researchers that are refugees who have had lived experience of living on Lesbos as refugees in Moria RIC and/or Mavrovouni CCAC. The co-researchers were recruited from the major ethnic groups in Mavrovouni CCAC, including the Afghan, Arab, Congolese, Ethiopian, Eritrean, and Somali communities. They were integral to the research project as they knew their community well and were able to provide local contextualization. The co-researchers were all literate, spoke English, and shared the native language with their respective communities including Amharic/Tigrinya, Arabic, Farsi, French/Lingala, and Somali. They were involved in the development of the data collection tools (i.e. household survey, topic guides for the focus group discussions, and in-depth interviews), administering household surveys, facilitating focus group discussions, conducting in-depth interviews, assisting with sense-making of the results, and co-creating solutions.

Figure 3: First team picture in June 2023.

4.4. Ethical Considerations

Ethical approval for this study was provided by the Hellenic National Public Health Organization – NPHO (EODY) according to the no. 25298/23-12-2022 exact excerpt of the 7th Meeting of the Board of Directors on 28 December 2022.

In keeping in line with the WHO guidelines on conducting SRH research, we ensured the following aspects were stringently adhered to:

- **Inclusivity:** except for the French/Lingala-speaking community, the co-researchers were of the same gender as the participants. For the French/Lingala-speaking community this was not deemed necessary after consulting with three separate community members, of whom two had representatives roles in camp. All content of the questionnaires (for the household survey) and interview guides (for the IDIs and FGDs) were extensively discussed and developed with the co-researchers, as explained in more detail later in this report. Interviews were electronically filled in by the co-researchers so as not to burden non (digitally) literate participants. Methodologies in the FGDs were designed such that non-literate participants were also able to participate. Playful elements were introduced to engage with adolescent women. Each component was pre-tested to ensure language was comprehensible and terminology culturally appropriate.

- **Referral systems:** prior to finalising the research tools, we mapped the existing referral possibilities and ensured the research team was aware of these pathways. The facilities to whom we referred were informed of the study and could therefore anticipate new patients. The research team was trained on how to respond to emerging SRH needs should these arise during interviews.

- **Informed consent:** each participant in every component of the research was informed of the research purposes, the methodology used, the nature of the questions, the risks and benefits of participating and the means in which we safeguard their privacy and anonymity. Informed consent was a dynamic process in which the researchers rechecked consent continuously througout each research method.

- **Voluntary participation:** We explained that participation was voluntary and that respondents could at any time decide to terminate the interview, not answer a question or withdraw from the study. The nature and financial value of the 'tokens of appreciation' we provided respondents was considered carefully so as not to impede with this goal.

- **Confidentiality and anonymity:** Confidentiality was maintained at each step of data collection and data analysis. Interviews were held in participants' place of choice, there were visual and auditory privacy could be guaranteed. Online data was stored on password protected files. Only the principle investigator (JS) was able to link personally identifiable information with data – this was necessary in case we needed to conduct medical follow-up of respondents who were referred with SRH complaints.

- **Precaution and risk minimisation:** The safety of the respondents was of utmost importance. Especially when discussing sensitive subjects such as SGBV, the risk exists that if a perpetrator becomes aware of the topic of the study, he may inflict further violence. To minimise this risk, the survey was introduced to the community as a study of women's health and did not include specific details of the topics.

• **Safety, security and wellbeing of the research team:** It is important to ascertain a conducive working environment for the research team. Master students involved in the project received a security briefing prior to entering the CCAC and were informed of the socio-cultural-political context. As sensitive topics were part of the survey and difficult stories would be shared, group mental health sessions were scheduled on a monthly basis for the team with the IRC, and contact information for a mental health professional was provided for individual sessions for co-researchers. Daily group debriefing sessions and monthly check-ins with the principal investigator (JS) also served as a space to discuss difficulties. These measures prioritized the well-being of the team.

• **Professional competence:** The study was conducted by competent and qualified persons who acted with integrity, respect and cultural sensitivity. They received training on good interview techniques and were informed on all of the above ethical considerations to bear in mind throughout the research process. Additionally, this study builds on previously developed techniques and utilises research tools that have been tried and tested, and thus adheres to the principles of nonmaleficence and beneficence.

Household Survey

5. Household Survey

5.1. Methods

We employed a cross-sectional survey of **119 questions** to explore the perceived SRH needs of refugee women of reproductive age and their experiences in accessing services. The questionnaire consisted of nine sections: demographic characteristics and displacement characteristics (e.g., age, ethnic group, level of education, year of fleeing, experience with pushbacks, and duration of stay in CCAC Mavrovouni); and access to information and services of eight SRH topics including maternal health, family planning, sexually transmitted infections, menstrual and gynecological health, abortion, female genital mutilation, mental health, and gender-based violence.

5.1.1. Parallel Processes: SRH Training and Designing the Household Survey

Training sessions and activities with the co-researchers were held within the first three weeks of June 2023, which was coupled with co-creating and translating the household survey. The schedule involved a combination of team-building exercises, educational sessions on various SRH topics and research methodology, interactive activities, and practical research-related tasks. Here is a summary of the timeline:

Figure 4: Training session at Iliaktida

Training and Activities

Team Building (May 31, 2023)

- Ice-breaking activities, sharing motivations, strengths, and expectations.
- Establishing working agreements, logistics, and roles/responsibilities within the research team.

Research Training (June 1 - June 5, 2023)

- Understanding research methodologies and the purpose behind the SRH survey.
- Storytelling sessions to share personal experiences related to SRH.
- Brainstorming sessions to generate ideas and topics for the survey.
- Group discussions, games, and categorization of ideas.

Co-Creation of Survey Questions (June 1 - June 13, 2023)

- Covering specific SRH topics like STIs, abortion, family planning, maternal health, FGM, and others.
- Conducting various interactive sessions including quizzes, games, and discussions.
- Collecting feedback, reflecting, and adapting questionnaire content based on co-researcher input.

Translation of Survey (June 14 – June 19, 2023)

- Translation of finalized English survey to Amharic, Arabic, Farsi, French, Lingala, Tigrinya, and Somali, and back-translated to English

Interview Practice (June 19 – June 20, 2023)

- Practiced interviewing techniques through role-playing with the English version of the survey on laptops in a plenary style to encourage peer-peer feedback.

Reflection (June 21, 2023)

- A final focus group discussion reflecting on the entire training process and the conducted activities.

Inputting Translations into Software (June 22 – June 30, 2023)

- Troubleshooted software and supported co-researchers with computer skills development.

Overall, the schedule and activities during the first part of the research project were designed to equip the team with the necessary knowledge, skills, and understanding required to conduct sensitive research on sexual and reproductive health in Mavrovouni CCAC, while ensuring ethical considerations and the well-being of both researchers and participants.

5.1.2. Household Survey Development: Key Process Insights

The survey development process consisted of four main steps, which are:

1. Initial Generation, Sorting and Evaluation of Questions in The Question Bank;
2. Question Generation Through The Participatory Process;
3. Depth Subject Matter & Preliminary Questionnaire Review By Sections; and
4. Iterative Questionnaire Review & Translation (see **Table 1**).

The process involved sourcing, refining, and augmenting questions in the question bank, integrating participatory methods for question generation, determining inclusion conditions, and undergoing iterative reviews and piloting sessions leading to the final version of the survey, along with multilingual translations to ensure precision.

An overview of the process is illustrated in **Figure 5**.

The SRH themes that were decided upon were:

1. **Maternal health** (subthemes included: antenatal care, nutrition during pregnancy, labour, post-natal care and breastfeeding practices)
2. **Family planning** (including anticonception and infertility)
3. **Abortion**
4. **Menstrual health**
5. **Gynecological health** (including cancer)
6. **Female Genital Mutilation (FGM)**
7. **Gender-based violence** (including childhood marriage and pushback)
8. **Mental health**

Table 1: Steps to Survey Generation

01

Generation, Sorting, and Evaluation of Question Bank

A question bank was assembled using diverse resources including CDC and WHO toolkits, as well as other key literature focusing on SRH in conflict-affected women. (21-38) Divided into 9 WHO SRHR indicator categories, the bank underwent meticulous scrutiny by a core team. Questions were assessed for relevance, refined based on study context and discussions, and the bank was condensed to align with research needs. Subject matter experts then reviewed and refined the included questions, leading to adjustments, additions, or removals based on feedback.

02

Question Co-Creation

A collaborative approach was used to enrich the SRH question bank. Co-researchers shared personal SRH stories, noted themes on sticky notes, and brainstormed specific ideas. Card sorting organized notes into themes, which were categorized into Healthcare and SRH groupings. Participants added relevant questions related to assigned themes and identified key themes, topics, and questions for discussion. New questions were added to the question bank if not previously included.

03

Depth Subject Matter & Preliminary Questionnaire Review By Sections

During the development stages of the initial survey, 811 questions were curated into Version 1, which included 232 questions across various sections. Participants reviewed and refined one to two sections daily, analyzed questions individually and in pairs, and held group discussions. An ethics session was also held to prompt the drafting of consent statements in participants' languages. The Maternal Health section required more attention, and discussions on sensitive topics like Gender-Based Violence took longer.

04

Iterative Questionnaire Review & Translation

After receiving feedback on the preliminary questionnaire sections, Version 2 was developed, containing 114 questions. Participants reviewed and refined Version 2 individually and in pairs, contributing to group discussions for question adjustments and reordering based on collective input. Subject matter experts also provided feedback and the survey was piloted in practice sessions, leading to iterative revisions that culminated in Version 7, comprising 119 questions (excluding consent sections). The questionnaire was then translated into target languages.

Figure 5 is a visual summary of the household survey, which was mainly characterized by steps 1 through 4. Step 1 was carried out before arrival to the field, and did not include the participation of the entire research team. Steps 2 through 4 were participatory in nature. The Question Bank generated in steps 1 and 2 had 811 questions. There were 7 versions, or drafts of the household survey, with the inital number of questions being 232, and a final question number of 118.

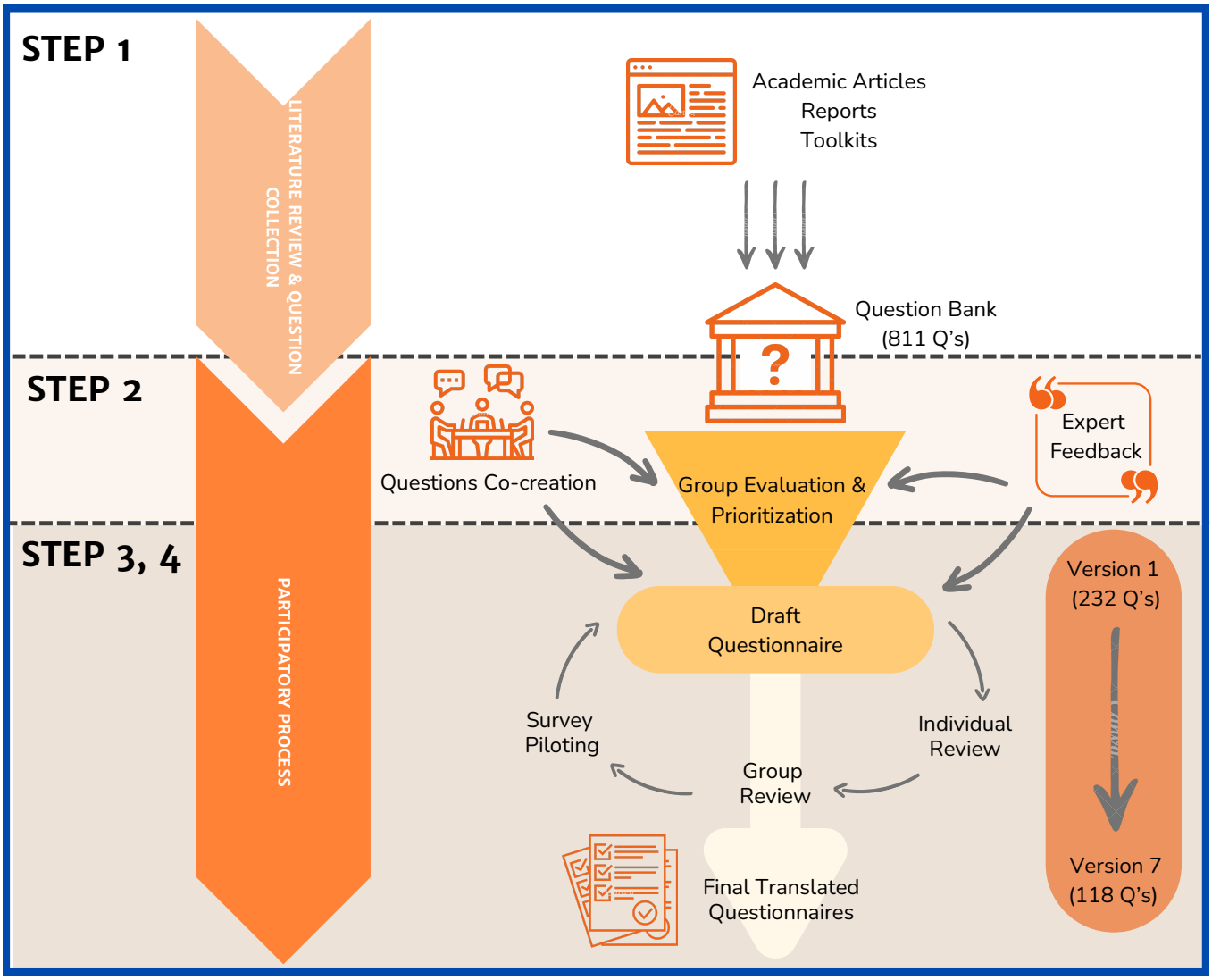


Figure 5: The household survey development process.

5.1.3. Sampling and Recruitment

We calculated a sample size of 258, which accounted for a 10% non-response rate, and managed to sample 247 refugee women of reproductive age, ages 15-49 as defined by the WHO. The sample size was calculated using Yamani's formula with a confidence level of 95% and a margin of error of 5%. Participants were recruited using random stratified sampling by country of origin. We obtained household lists from camp management which were numerically random, organized the list by country of origin, and went down the list to approach households. After several failed attempts to contact the woman or if she declined, we would continue down the list.

Data collection occurred from June to August 2023, where the sample's representation of individuals from various countries relied on the list of camp residents as of June 30, 2023. Co-Researchers were tasked with interviewing individuals based on their ability to converse in the primary language of the potential interviewee rather than their country of origin.

For instance, an Arabic-speaking researcher conducted interviews with participants from five distinct Arabic-speaking countries. Due to varying language representation in the camp, some co-researchers were assigned more interviews than others. For example, while one co-researcher was tasked with 42 interviews, another had 10 assignments. Co-researchers received randomized lists and were instructed to systematically approach candidates. If a candidate was unreachable, declined participation, or had been relocated, the subsequent candidate on the list was approached. Interviews were scheduled or conducted immediately based on the participant's preference.

Figure 6: Two co-researchers practicing good survey techniques in the BRF tent.

These interviews took place in examination rooms within the in-camp clinic or other private and comfortable settings, such as the participant's ISObox or tent. The interview process involved sequential questioning using KoboToolbox, consisting of personal ID-related queries followed by the actual survey questions. Co-researchers adhered to good interview practices, displaying sensitivity to discomfort, seeking consent before major survey sections, and duly noting any relevant information.

5.1.4. Data Analysis

The data retrieval process involved downloading an Excel file from the Kobotoolbox web application, after which Stata, a statistical software package, was utilized to extract and analyze descriptive statistics from the acquired results.

5.2 Results

5.2.1. Sociodemographic Characteristics

247 household surveys, stratified by country of origin, were conducted to assess the sexual and reproductive health needs of women. Data collection was conducted from June to July 2023. Participant age, estimated time displaced, and length of stay are summarized in **Table 2**.

Table 2: Participant Age, Estimated Time Displaced and Length of Stay

	n	Age (y)	ETD (months)	LOS (months)
Median	247	24	25	4
Range		15 - 48	2 - 369	0 - 58

Period of Displacement and Stay in Camp

Respondents have been displaced from their place of origin for a median time of **25 months**, or roughly **2 years**. The displacement period is relatively long compared to the median time period of stay in camp. It is important to note though that the length of stay in camp has a wide range, with a maximum of **58 months**, or almost **5 years** spent in camp.

Country of Origin

Figure 7 shows the distribution of respondents based on their origin country (n = 247). There was a relatively higher presence of participants from Afghanistan, Eritrea, and Somalia compared to other nations surveyed, in line with the camp demographics as presented to us at recruitment.

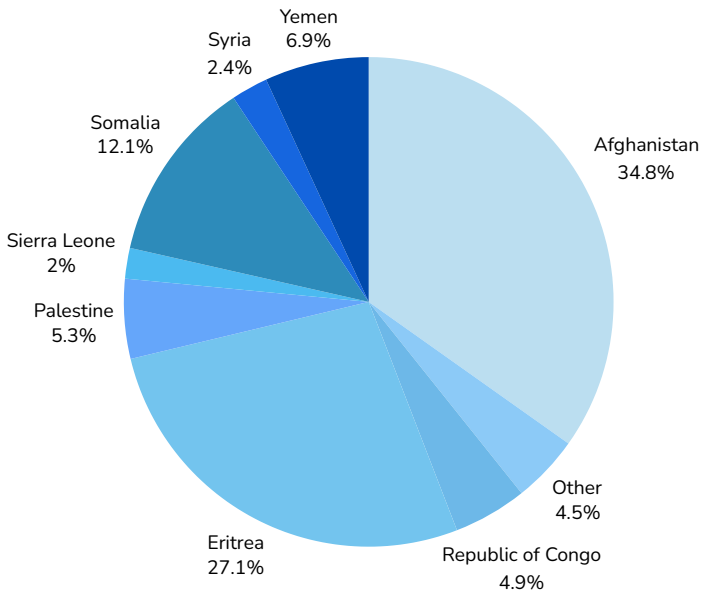


Figure 7: Proportion of survey participants by origin country.

Education, Religion & Sexual Orientation

There was a diverse range of education levels within the group, including **29.6%** who had never been to school, **32%** who had attended primary school, **17.8 %** who had completed some secondary schooling, and **30.6%** who are highly educated (i.e., high school diploma or attended university) (n = 247). The proportions of religious affiliations among the surveyed population were approximately **24.7%** identifying as Christian, **74.1%** as Muslim, and around **1.2%** falling into other religious categories (n = 247). Among the respondents, **1 of 246 individuals** self-identified as part of the LGBTQ+ community.

Domestic Circumstances

63.5% of 247 respondents said that they were not currently living with a partner or husband, while **36.4%** responded that they were. **35%** of women not living with a husband or partner in camp have a child, although it is unclear whether the child is with them in camp. Notably, the rates of cohabitation vary greatly across different countries; for instance, **Figure 8** shows that significantly more respondents from Afghanistan reported living with a partner or husband, whereas fewer from Eritrea or Somalia indicated living with a partner or husband.

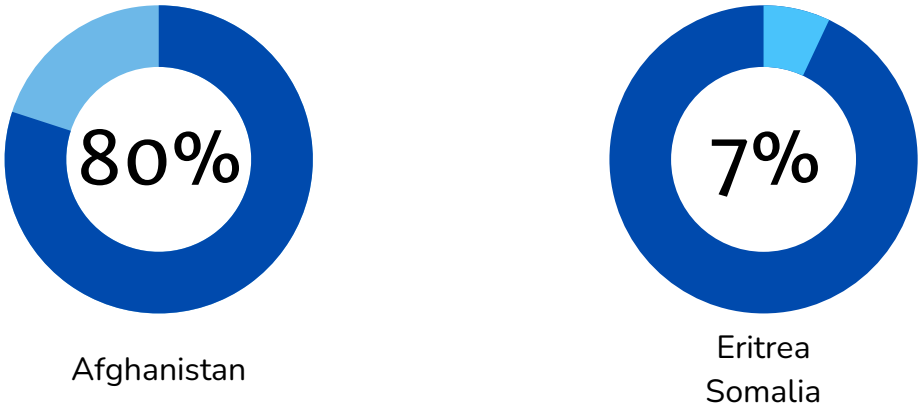


Figure 8: Percentage of respondents living with a partner or husband.

Reported Legal Status and Medical Care Denial

28% of 247 respondents have received a negative response to their asylum request. Of the respondents who reported being denied medical care due to their legal status, the breakdown by frequency of denial is as follows: Never (**78.9%**), Sometimes (**10%**), Often (**5.9%**), Rarely (**4.7%**), and Always (**2.4%**).

Figure 9 demonstrates the relationship between mental distress, healthcare denial perception and asylum request response. Notably, having a negative response is significantly associated with having clinically significant mental distress. Clinically significant mental distress was defined by the Self-Report Questionnaire Item-20 as a score of 8 or higher out of 20. A negative asylum response is also associated with the perception of being denied medical care.

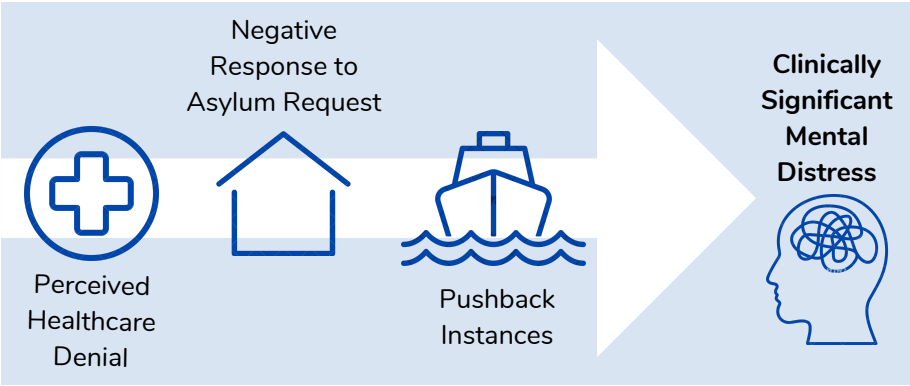
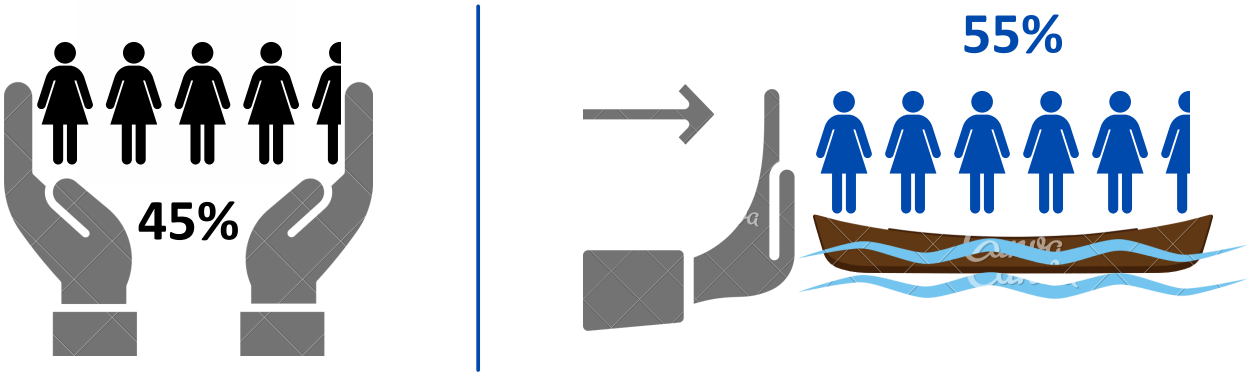


Figure 9: Legal Status, Healthcare Denial, Pushbacks and Mental Distress.

Instances of Pushbacks

55% of 244 respondents reported having experienced at least one pushback. The median number of pushbacks per respondent was **two**, with the range being from **0 to 42**. **Figure 9** illustrates the notable association between clinically significant mental distress and having experienced a pushback.



Information Receival and Preferences

Figure 10 presents the sources through which individuals obtain information on various health categories. Across all categories listed the majority of respondents indicated that they did not receive information through these sources, ranging from **41.67% to 87.73%**. Healthcare professionals were reported as a source of information in varying percentages across categories, with the highest being for Breastfeeding (**25.00%**) and the lowest for FGM (**1.36%**). Trained volunteers or counselors from NGOs contributed as a source of information, ranging from **4.09%** for FGM to **29.17%** for Breastfeeding. Online resources were reported as a minor source for obtaining information across most categories, with percentages ranging from **0.00%** for Breastfeeding to **2.78%** for STIs.

Figure 11 illustrates the preferred sources individuals choose for obtaining information across various health categories. Across all categories, the majority of respondents expressed a preference for obtaining information from healthcare professionals. Trained volunteers or counselors from NGOs were also a favored source. Online resources were a less preferred choice for information across these categories. The percentage of respondents who preferred not to receive information on these health topics ranged from **8.25% to 21.92%** across the different categories.

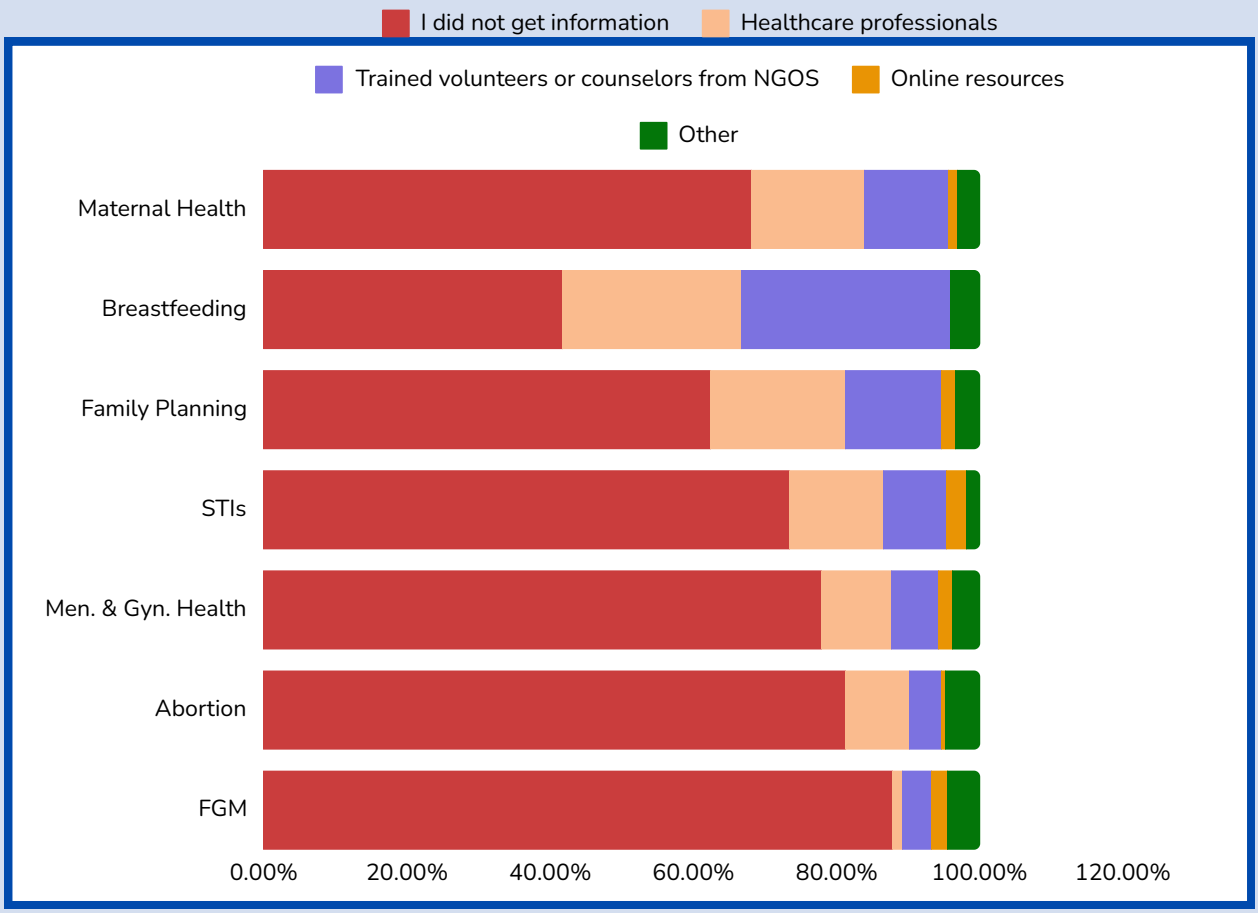


Figure 10: Where or from whom women are receiving information about various SRH topics.

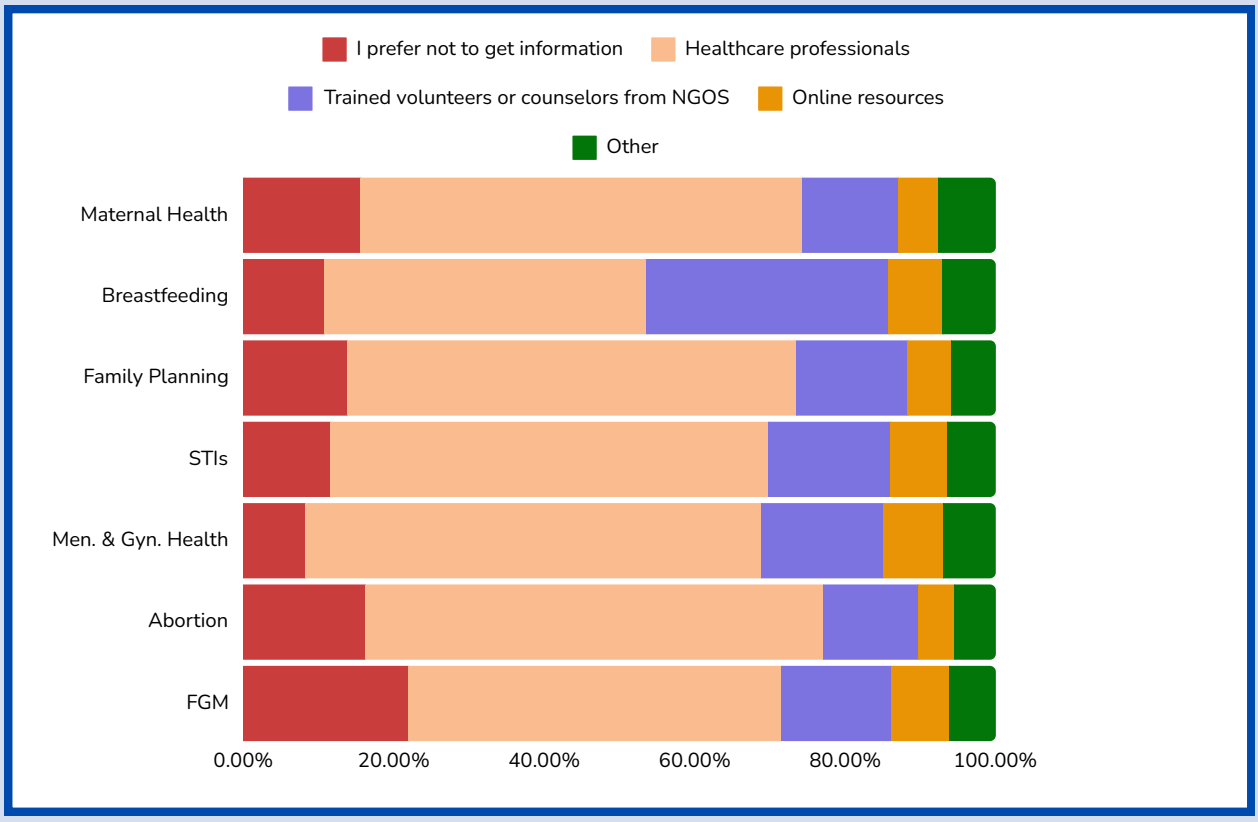


Figure 11: Where or who women would prefer to receive information about SRH topics from.

5.2.2. Maternal Health

7.5% of 239 respondents indicated that they were pregnant at the time of the survey. **Figure 12** displays the number of children per respondent, categorized by their origin country. The overall average number of children per woman is **1.5** (n = 239), but there are variations across different countries, with Syria, Somalia, Afghanistan, and Palestine having the highest average. Conversely, Eritrea, Ethiopia, Sudan, and Cameroon have the lowest average, ranging from **0.0 to 1.0 children per woman**. The differences in family size and circumstances among the respondents highlight the need for more contextual information to understand family dynamics and living situations within the CCAC.

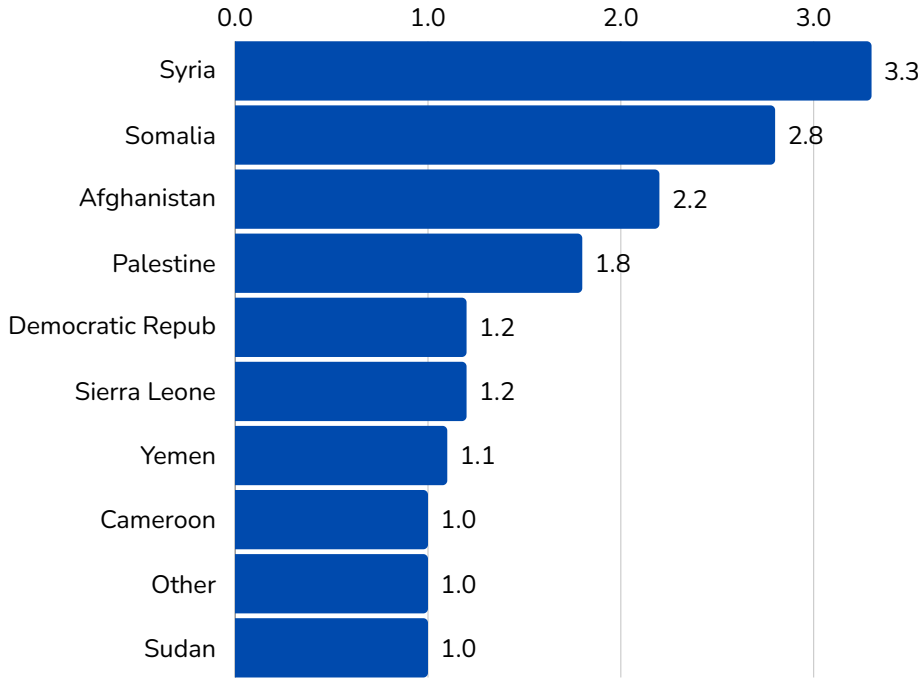


Figure 12: Number of children per woman stratified by origin country.

The data indicating the average months pregnant that each respondent was showed a normal distribution, with a mean of **4.17 months** (n = 18), underscoring the accuracy of our data collection. The mean number of prenatal visits per month pregnant is **1.1** (n = 25), with ultrasound screenings, access to supplements, blood pressure monitoring and blood tests being the most accessed prenatal care services. Of those who received access to care, prenatal care was overwhelmingly received in health clinics in camp. **Figure 13** shows prenatal care services perceived to have been received and where the services were obtained.

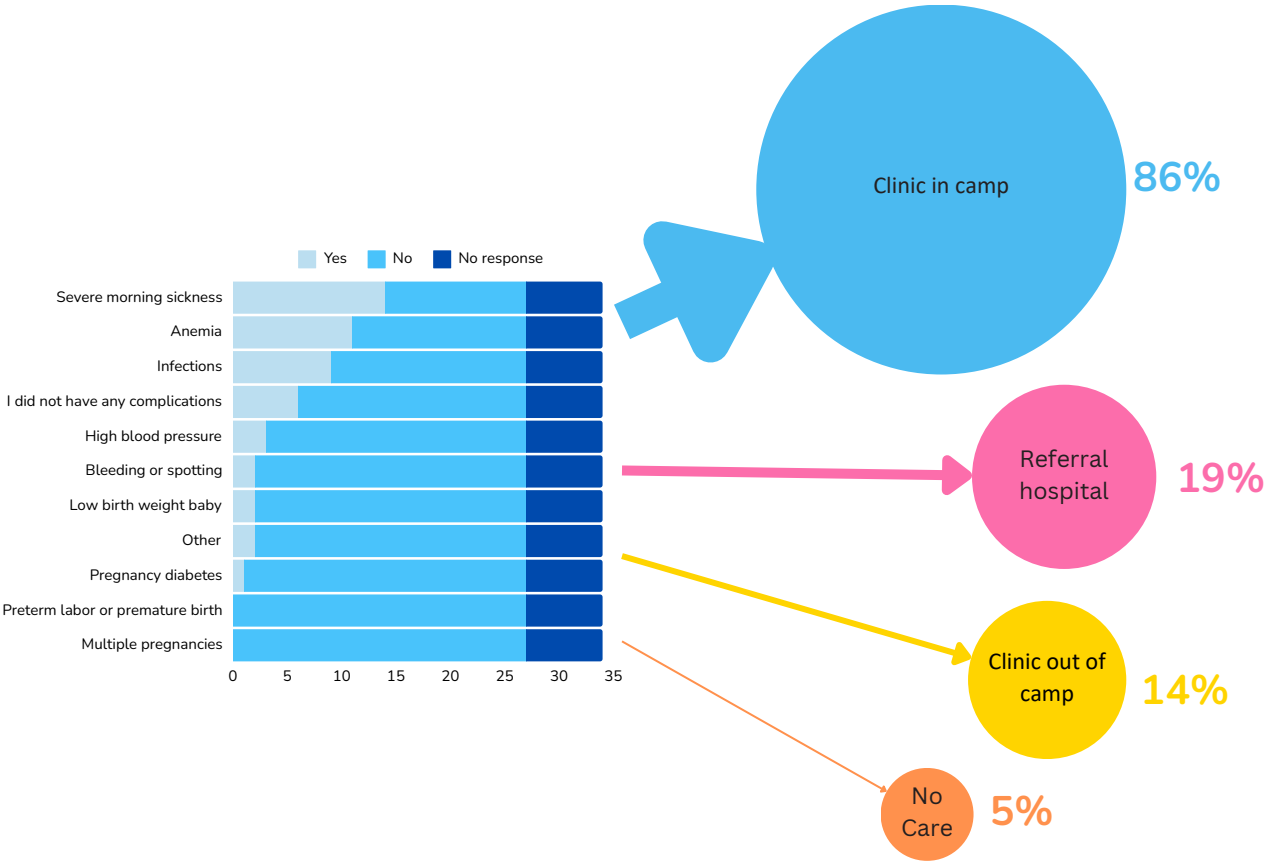


Figure 13: Prenatal care services perceived to have been received and where the services were obtained.

Considering nutrition during pregnancy, the majority of n = 29 respondents indicated that they never received different food than normal during pregnany (see **Figure 14**). Overall, a notable portion of participants reported consistently not receiving different food than their usual allocation.

Furthermore, **70.37%** of 29 respondents did not receive extra food during pregnancy (**Figure 15**).

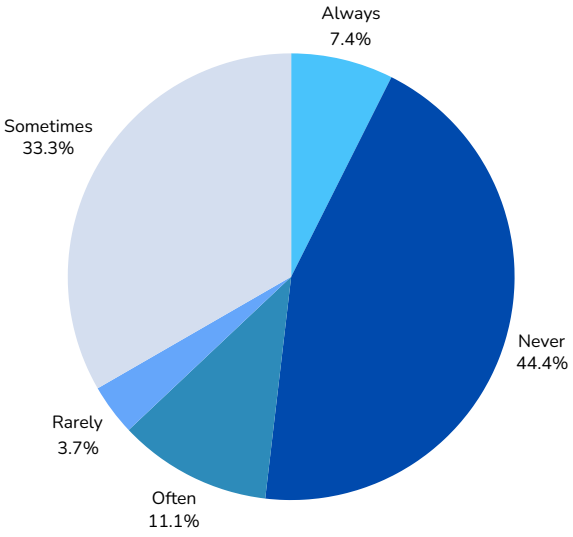


Figure 14: Number of times respondent received food different than normal.

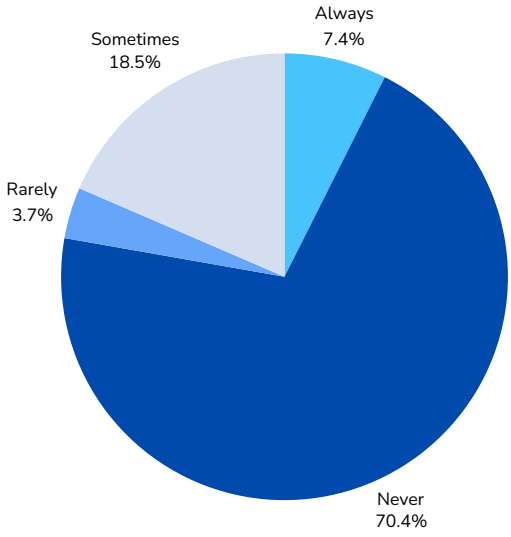
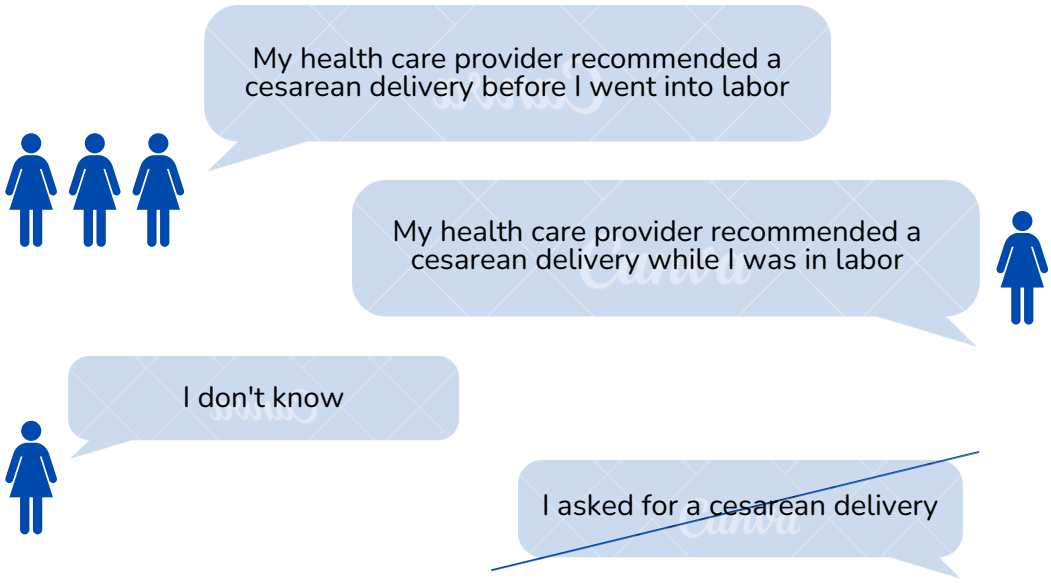


Figure 15: Number of times respondent received more food than normal during pregnancy.

All **fourteen** women who gave birth while living in camp had their births in the local hospital. Of these births, **five** of them were c-sections, and **nine** of them were delivered vaginally. Of women who reported having their labor induced, when asked why, **two** answered that it was due to complications, **one** said it was past their due date, **one** said the baby was not doing well, **one** said they didn't have energy and **one** didn't know.

36% of the **fourteen** births in camp were via c-section. When asked which statement best described the reason for receiving a c-section, one woman did not know why she received it.



The reported miscarriage instance were low, with only **two** reported miscarriages before the 6-month pregnancy mark (n = 240). There were **zero** miscarriages reported after the 6-month pregnancy mark (n = 241). Additionally, there were **zero** neonatal deaths within one hour or one month after birth (n = 242). However, **two** women reported that they had lost a child during the trip by land/sea (n = 242).

The median number of postpartum visits per month was **0.25** (n = 15), indicating that access to postpartum care is much lower than access to prenatal care. **Figure 16** shows the most common postpartum complications reported, which were painful urination, anxiety or depression, and hot, swollen painful breasts.

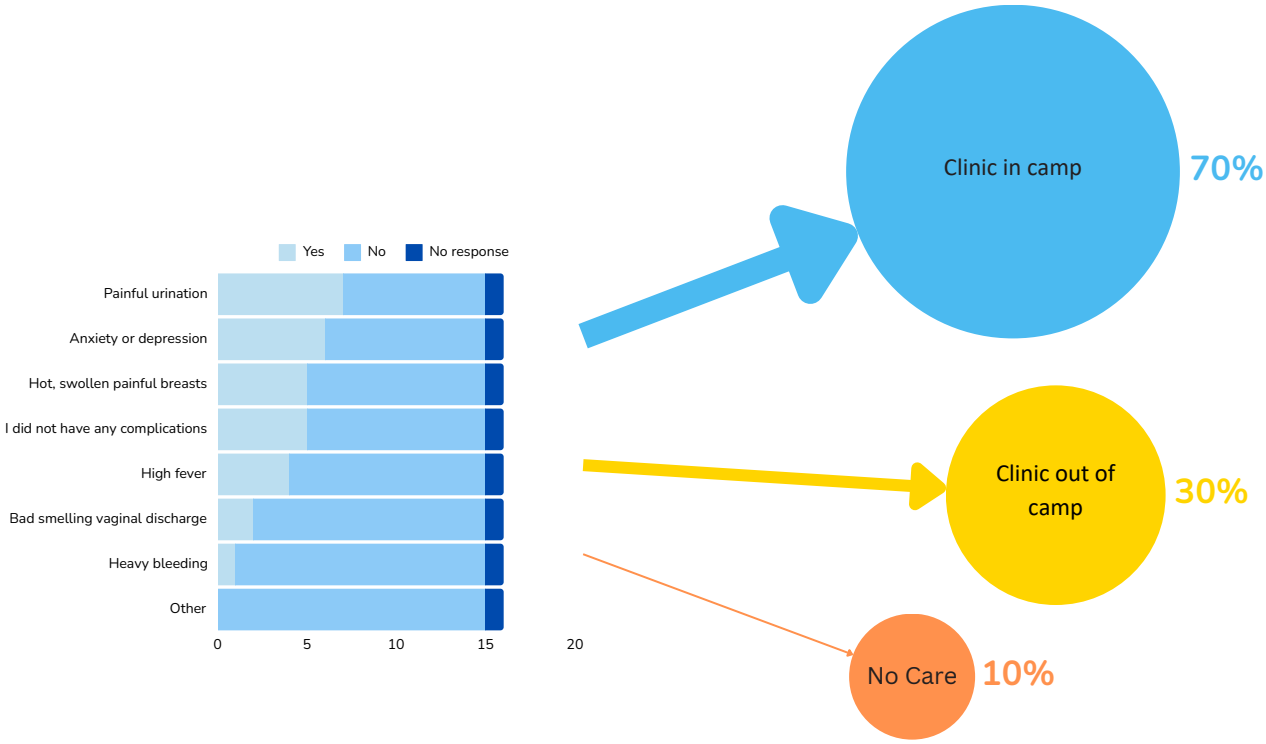


Figure 16: Postnatal care services perceived to have been received and where the services were obtained.

Of the **20 women** who were interviewed, the median number of months that they solely gave breastmilk to their baby was **three months.** 14 respondents gave food to their baby for the first time at a mean number of **4.1 months** (5 respondents were still only feeding breastmilk).

5.2.3. Family Planning

74% of 239 respondents wanted to prevent having a baby. Regarding the use of fertility treatment, none out of 65 respondents were receiving fertility treatment, but **26%** of which indicated that they were interested in receiving fertility treatment.

13 out of 247 reported using the emergency contraception pill. Of the 13 users, median use of the emergency contraception pill was high, with the median number of uses being **two**, with a minimum of **zero** and a maximum of **four** .

Figure 17 shows the reported use of contraception by women in the camp, stratified by origin country. Notably, the distribution of contraception use varies by country. Most contraception services are accessed at a clinic outside of camp.

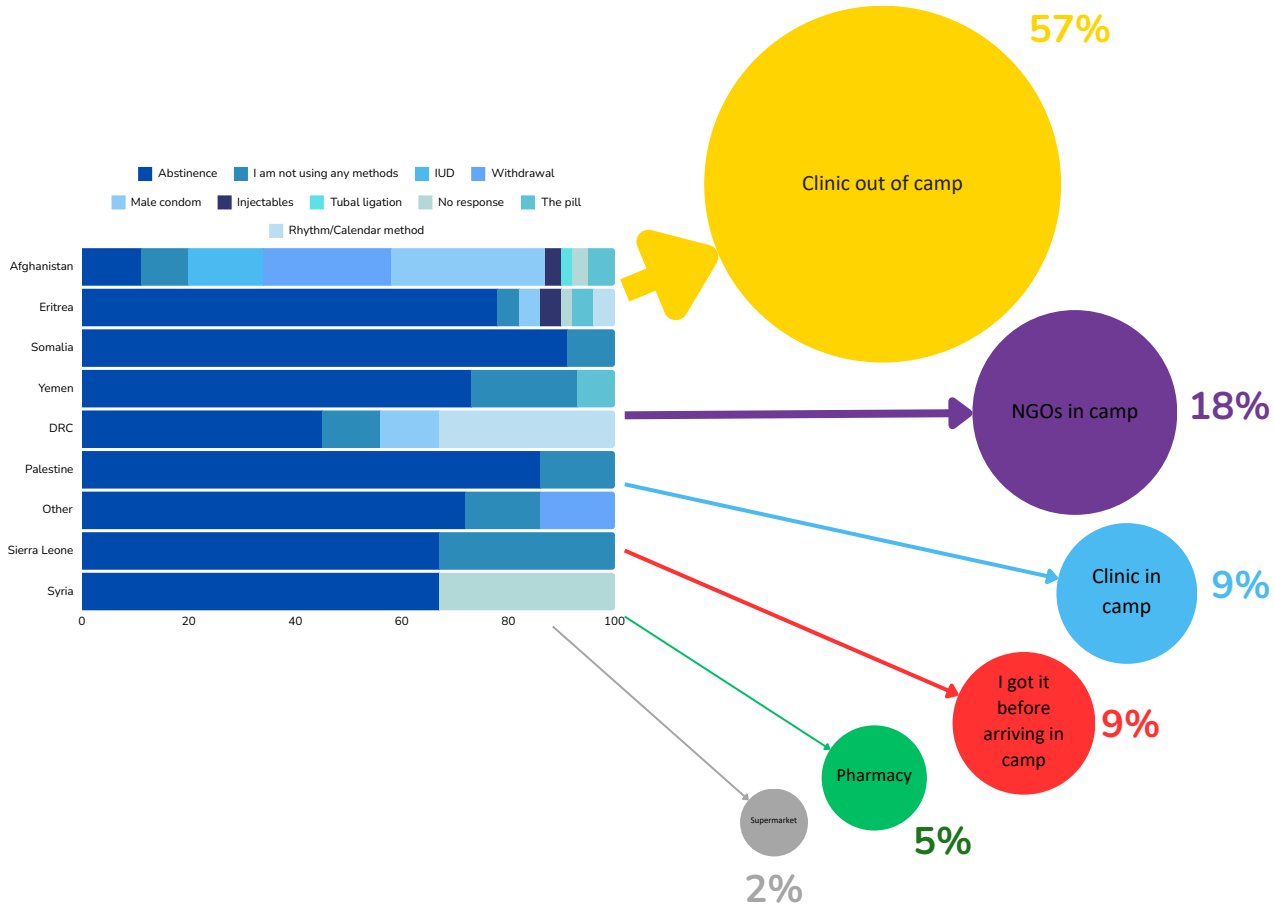


Figure 17: Contraception method use and where modern methods of contraception were obtained.

Figure 18 shows that contraception preference also varies greatly by origin country, Notably, respondents from Palestine, Syria, and Yemen overwhelmingly indicated that they had no preference for contraception method. Respondents from Afghanistan, Eritrea, and the Democratic Republic of Congo had a wide range of preferences compared to other countries. Reported use of contraceptives is dramatically different than that of preference.

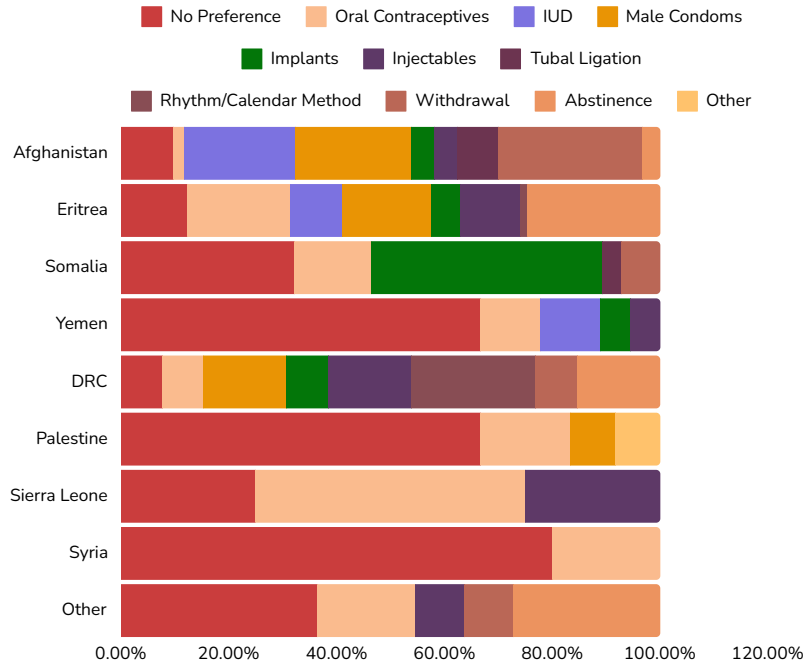
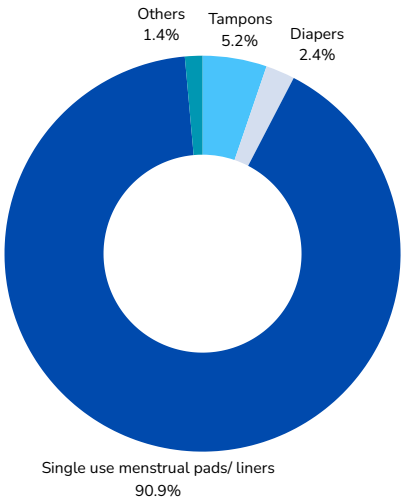


Figure 18: Contraception method preference by origin country.

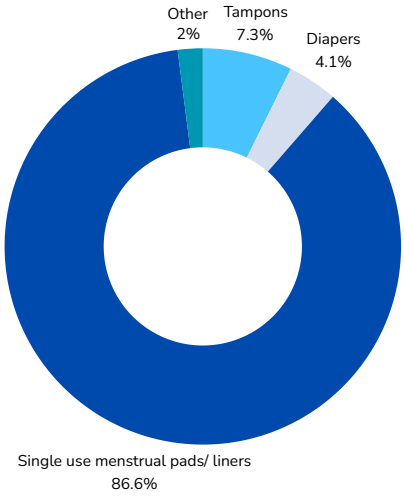
5.2.5. Menstrual and Gynecological Health

84% of 247 respondents reported having had their menstrual period since arriving in camp. Most respondents had access to their preferred menstrual materials (n = 211). However, less than **20%** of 210 were able to manage their menstrual pain adequately. Methods used mainly to manage pain were home remedies.

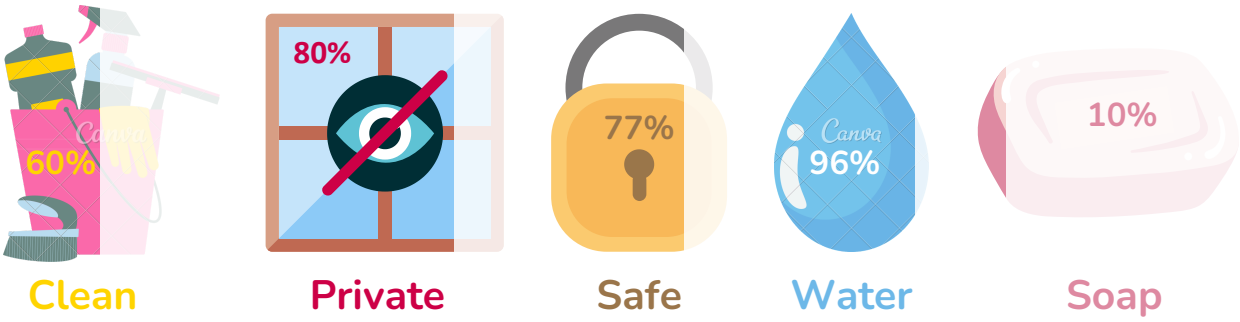
Materials **Mainly Used** During Last Menstrual Period



Preferred Materials for Menstrual Period



In the camp toilets where women mainly changed their menstrual materials, the percentage of 208 women who agreed with the following conditions of the toilets include:



17% of 240 respondents had gotten an STI test and received the results in camp. The majority of those tested, **68 percent** of 43 respondents, went to a health clinic outside of camp. Notably, only **1 respondent of 246** respondents had received cervical cancer screening.

Figure 19 shows that **almost half of 246 respondents** experienced gynecological symptoms in camp, of which the most prevalent were itchiness, unusual discharge, and burning pain during urination.

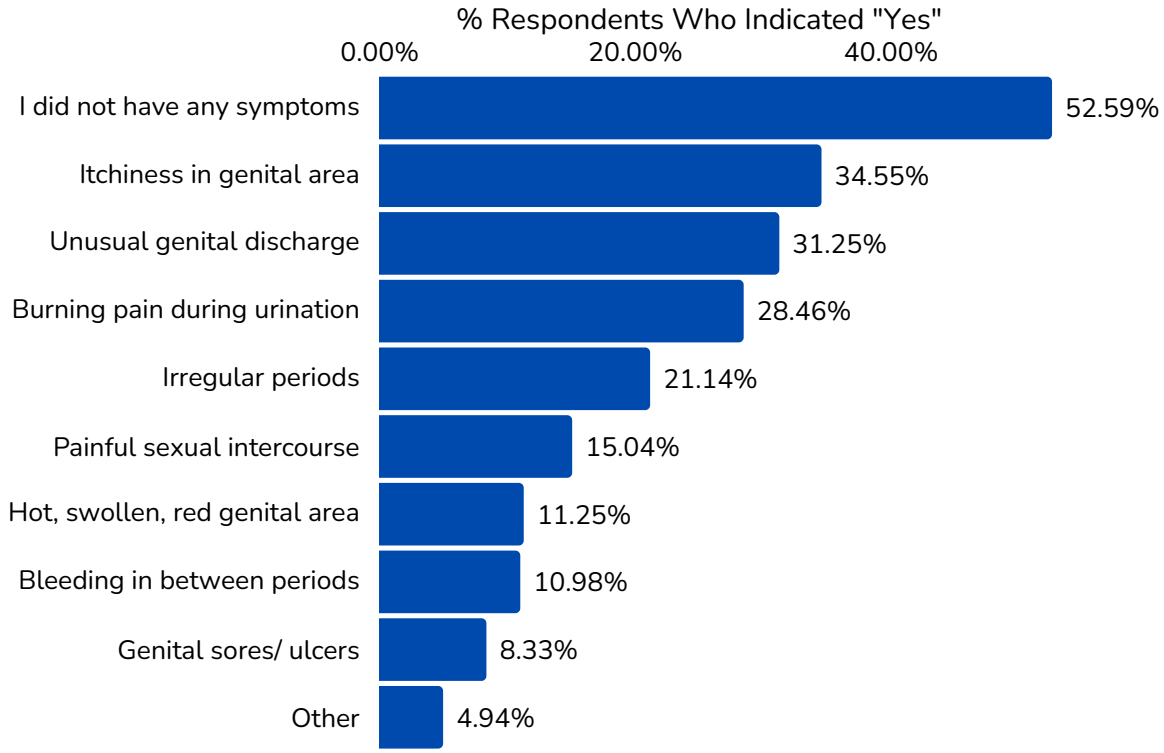


Figure 19: Reported gynecological symptoms in camp.

When asked about care seeking behaviors related to their symptoms, out of 140 respondents, **40%** went to a health clinic in camp, **35%** went to a health clinic outside of camp, and **35%** did not get any treatment.

5.2.6. Abortion

Since arriving in camp, **two out of 217** respondents had a pregnancy removed while living in camp, and **three of 217** respondents did not want to respond. **Four** cases of complications were noted, **two** of which did not get linked to care.

5.2.7. Female Genital Mutilation

Of 220 respondents, women from Somalia, Yemen, Sudan, and Sierra Leone were most prominently impacted by FGM (see Figure 20). Because of the population distribution in camp, this means that a large percentage of the population has been impacted by FGM.

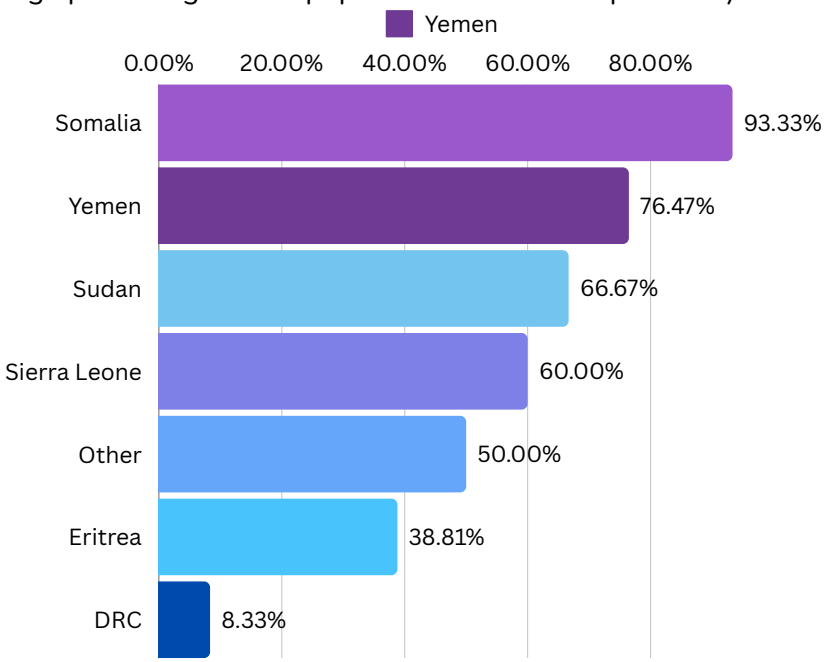


Figure 20: Rates of women in camp who have experienced FGM per country.

The average age of experiencing FGM is **6 years old** (n = 74), with the range being **0 to 25. Figure 21** shows how over **85%** of 77 respondents who had experienced FGM did not get access to treatment.

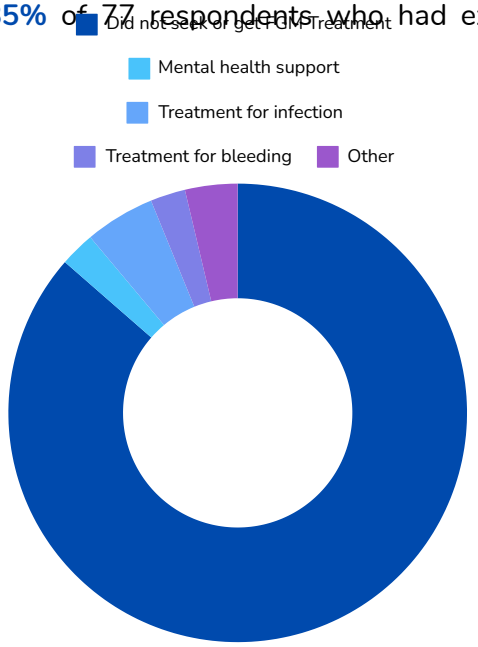


Figure 21: Access to FGM treatment in camp.

5.2.8. Mental Health

Out of 247 respondents, the average SRQ-20 score was **10**. Notably, **13.4%** of 247 respondents had thoughts of ending their life within the past four weeks of the survey.

5.2.9. Gender-Based Violence

Figure 22 illustrates the percentage of women in camp by country of origin who have experience gender-based violence in their life. We have defined gender-based violence as experiencing child marriage, verbal abuse, physical abuse, and/or sexual abuse.

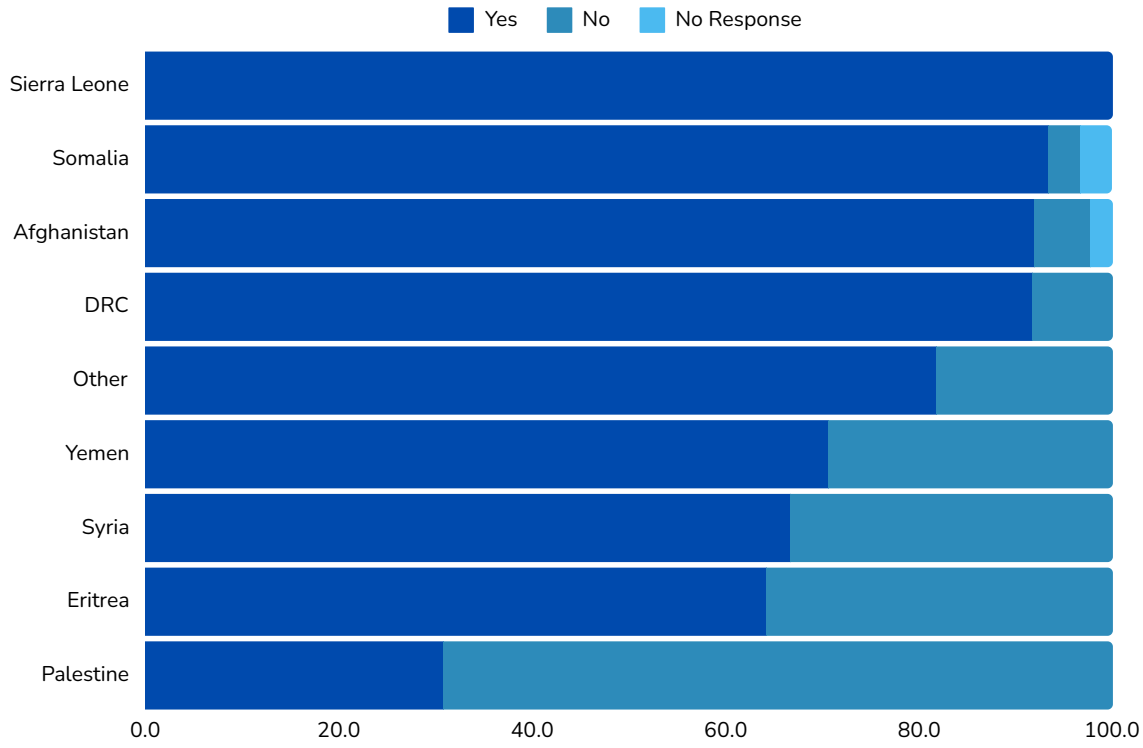


Figure 22: Percentage of women in camp who have experienced gender-based violence by country of origin.

Of 247 respondents, **74%** reported having experienced verbal abuse in their lifetime. **Figure 23** shows the percentage of **355 reported cases** that were carried out by perpetrator type. Of 247 respondents, **53%** reported having experienced physical abuse in their lifetime. **Figure 24** shows the percentage of **283 reported cases** that were carried out by perpetrator type.

Of 247 respondents, **37%** reported having experienced sexual abuse in their lifetime. **Figure 25** shows the percentage of **104 reported cases** that were carried out by perpetrator type.

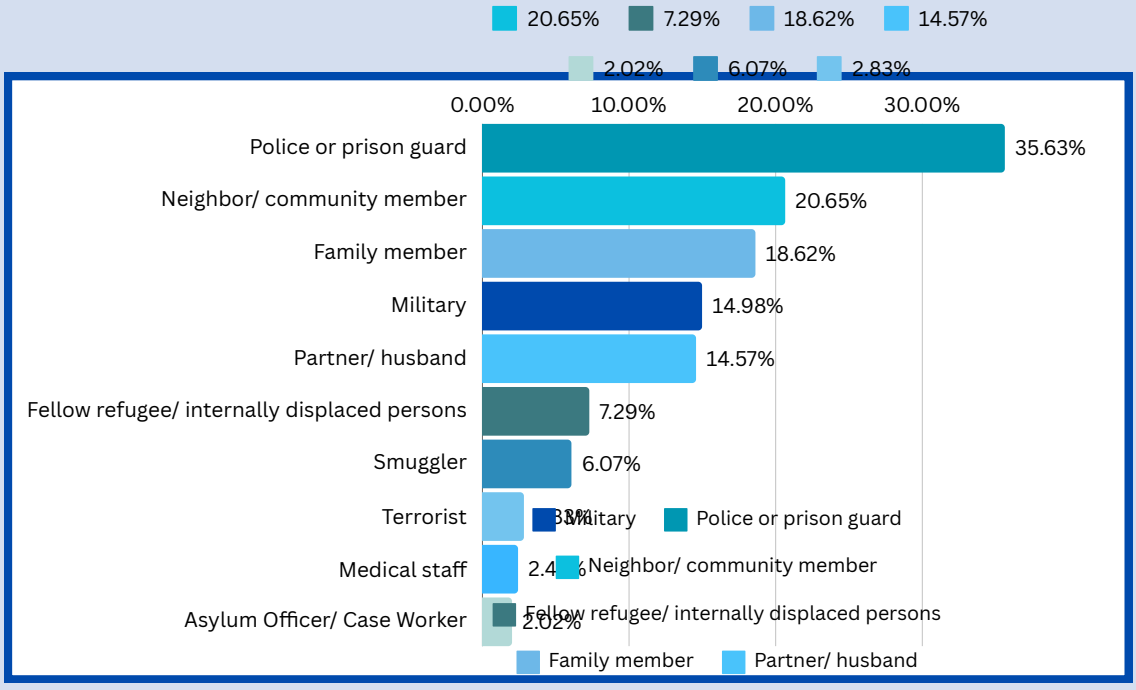


Figure 23: Percentage of Respondents Who Experienced Verbal Abuse, by Perpetrator

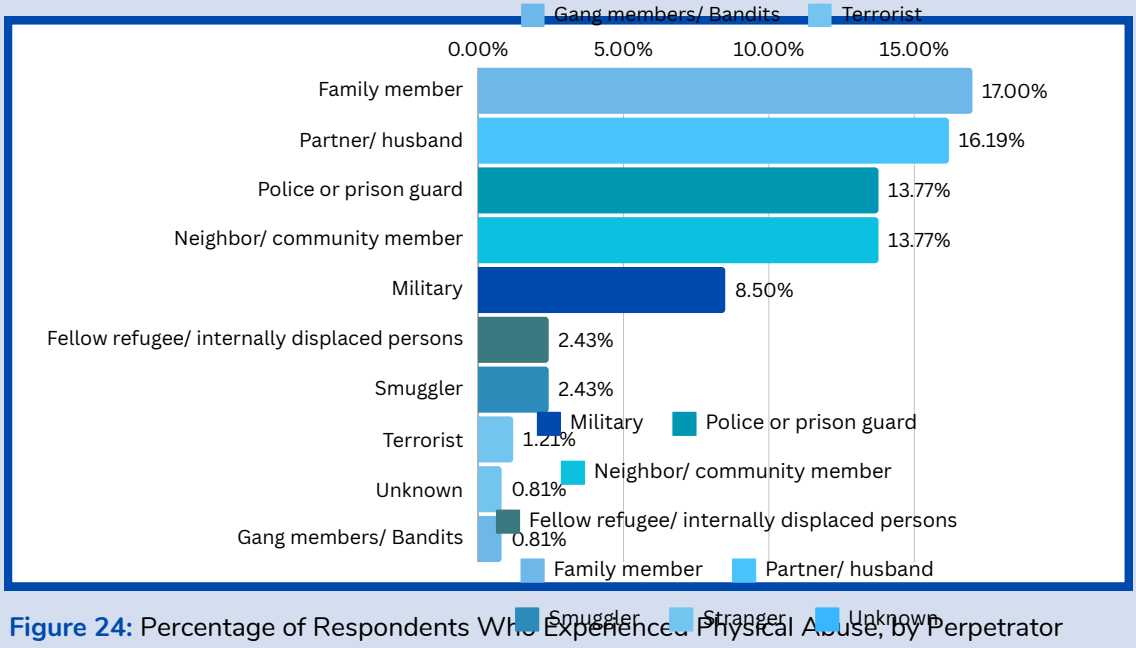


Figure 24: Percentage of Respondents Who Experienced Physical Abuse, by Perpetrator

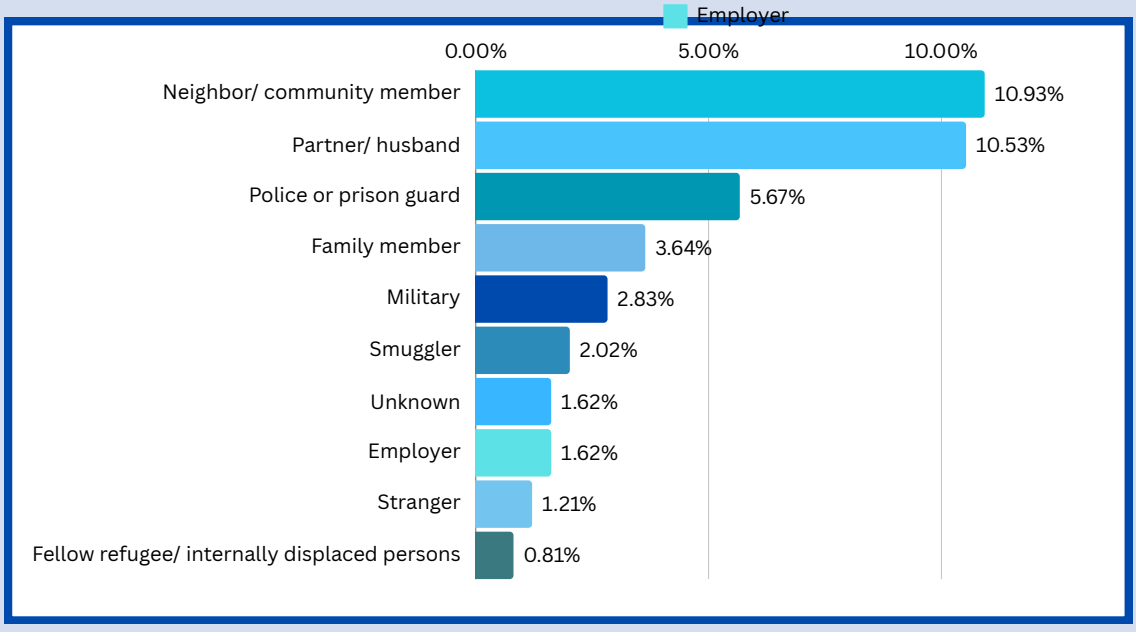


Figure 25: Percentage of Respondents Who Experienced Sexual Abuse, by Perpetrator

28% of 243 respondents experienced child marriage. **11 of 247** respondents are intimate partner violence cases in camp. The location of verbal (**A**), physical (**B**), and sexual (**C**) abuse during the participants lifetime was mapped.

A.

B.

C.

Of those who reported physical abuse, **80%** did not receive access to care for the abuse. Of those who reported sexual abuse, **63%** did not receive access to care for the abuse, however **28%** received treatment at a health clinic outside of camp.

Facility Assessment

6. Facility Assessment

6.1. Methods

We employed a cross-sectional facility assessment to explore the SRH services provided to refugee women residing in Mavrovouni camp. The questionnaire consisted of 18 sections: general questions (e.g., facility type, managing authority, and opening hours), maternal health services, blood transfusion, family planning, sexually transmitted infections, menstrual and gynecological health, abortion, female genital mutilation, mental health, gender based violence, human resources, translation, training, infrastructure, coordination, funding, patient legal status, and inclusion. The assessment's different parts were developed based on five validated tools: WHO Service Availability and Readiness Assessment (39), UNFPA Inter-Agency Emergency Reproductive Health Kits for Use in Humanitarian Settings (40), WHO recommendations on maternal and newborn care for a positive postnatal experience (41), WHO abortion care guideline (42), UNHCR Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons (43) along with contextualization from our household survey. Feedback from three previous medical actors who worked in Lesbos was integrated.

6.1.1. Sampling and Data Collection

Seven facilities inside and outside of camp were identified as providers of SRH services. The field and/or medical coordinator and health care providers from each facility were requested to participate.

Data collection was carried out in July 2023 by two master's students and the principal researcher. Data was collected using laptops and the questionnaire was deployed using the KoboToolbox application. Data collection was conducted at the facilities. Major stakeholders from the facilities, as well as relevant staff who were knowledgeable in certain areas were interviewed.

6.1.2. Data Analysis

Descriptive data analysis was completed using Microsoft Excel and data visualizations were created on Canva.

6.2. Results

Six health care facilities, four clinics in camp, one outside of camp, and one hospital, and one non-medical organization were interviewed to assess the SRH services provided to the women.

6.2.1 Overview of Available SRH Services

Most health care facilities do not perform outreach to provide **information** about the type of services offered. However, SRH information at the facilities are provided through health care professionals.

Five facilities provide **antenatal care**. **One** non-medical organization provides approximately **five** additional meals including fruits, vegetables, and pantry staples to pregnant women. On average, it was estimated that a pregnant woman in camp receives **nine** antenatal care visits.

One facility provides **childbirth services**.

Four facilities provide **postnatal care** visits. On average, it was estimated that a pregnant woman in camp receives **one** postnatal care visit.

Four facilities provide **family planning** services. Most modern forms of contraception including condoms, pills, intrauterine devices, and tubal ligation are provided by health facilities; however, injectables and implants are unavailable.

Two facilities provide **gynecological** services including passive cervical cancer screening. **Four** facilities provide **sexually transmitted infections** services. **Two** facilities provided **human immunodeficiency virus**-related services.

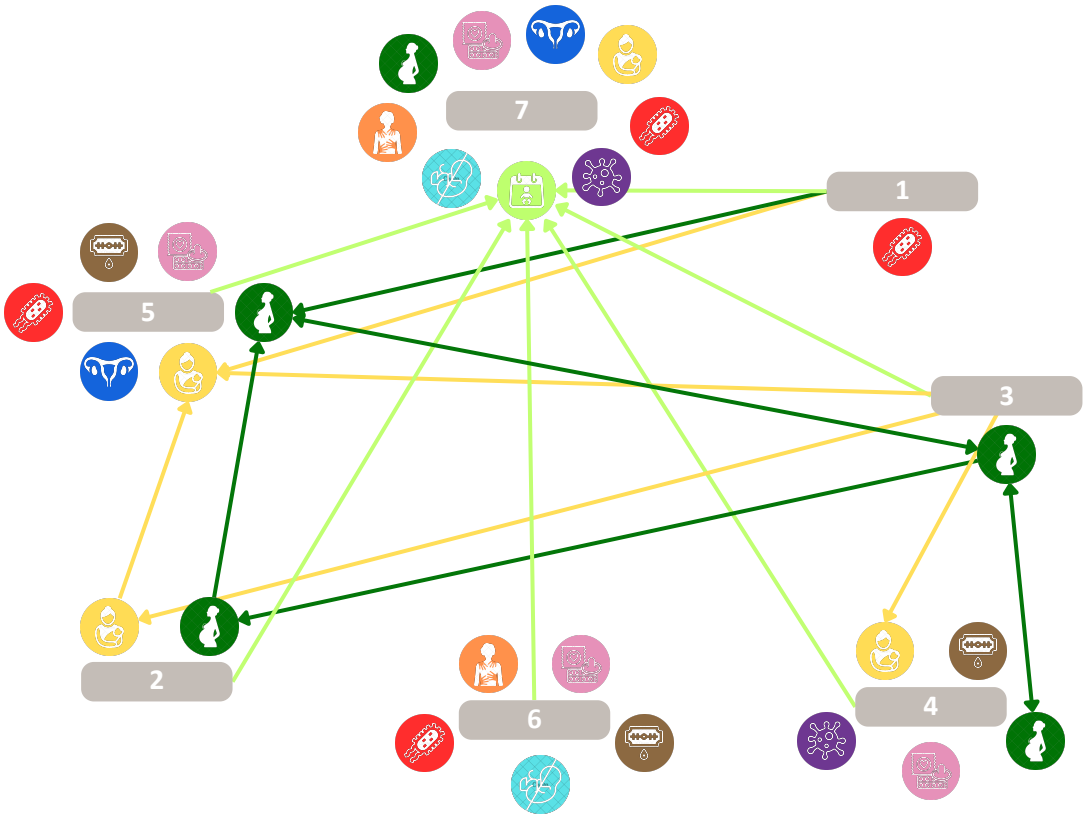
Two facilities provide **abortion services** up to 12 weeks of pregnancy.

There are **zero** official health care services to treat **female genital mutilation**. However, vulnerable certificates are provided by **two health clinics** for the asylum procedure.

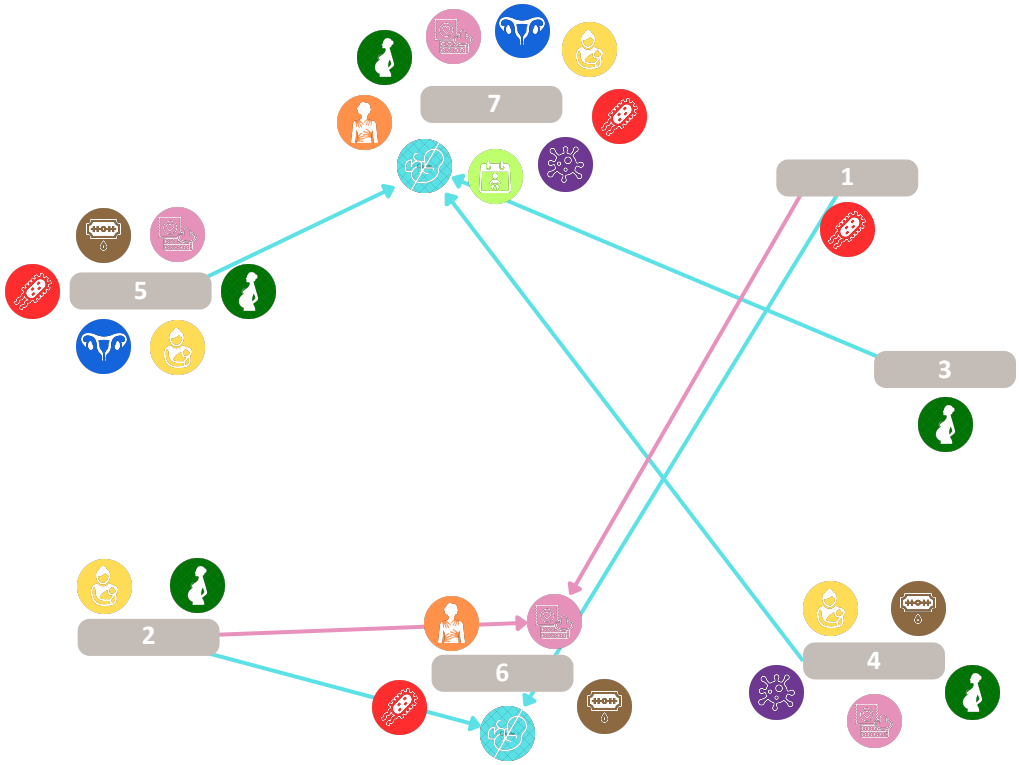
Two facilities provide services for **gender-based violence**.

6.2.2. Referral Pathways

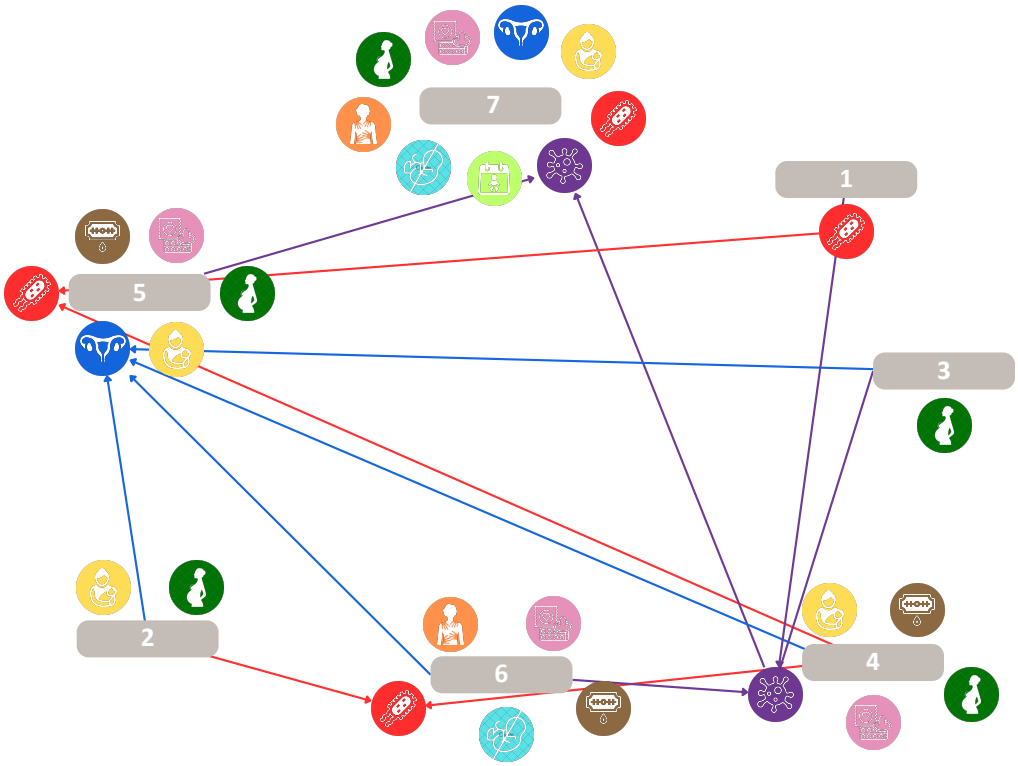
A. Referral pathway for antenatal care (green), childbirth (light green), and postnatal care (yellow)



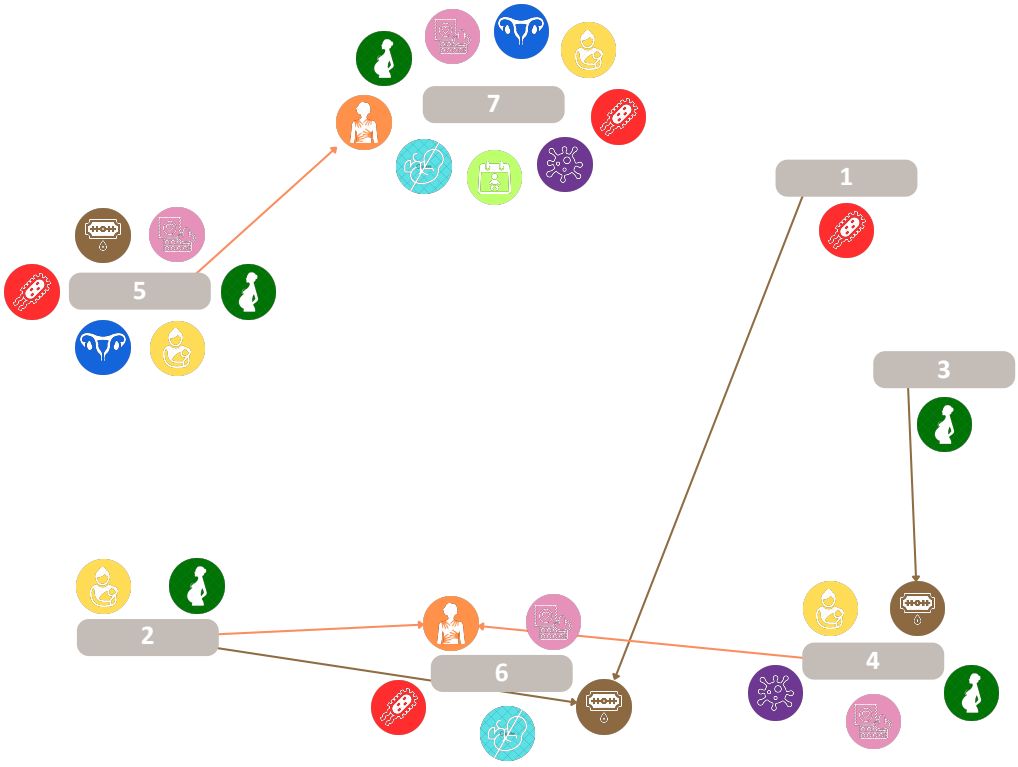
B. Referral pathway for abortion (teal) and family planning (pink)



C. Referral pathway for gynecological health (dark blue), sexually transmitted infections (red) and human immunodeficiency virus (purple)



D. Referral pathway for female genital mutilation (brown) and gender-based violence (orange)



Notably, while there is unofficial coordination between organizations for the provision of SRH services as seen in the referral pathways depicted above (A, B, C, and D), there is an absence of a designated SRH focal point.

6.2.3. Human Resources

71% of health care professionals are female, including the part-time gynecologist.

	1	2	3	4	5	6	7
Anesthesiologist							NR
General doctor							NR
Gynaecologist							NR
Health Promoter							NR
Lab technician							NR
Midwife							NR
Nurse							NR
Other specialist doctor							NR
Pharmacist							NR
Psychiatrist							NR
Psychologist							NR
Other							NR

Full-time female | Part-time female | Full-time male | Part-time male

49% of translators are female; however, there are gaps in language coverage and female translators within some of the health care facilities.

	1	2	3	4	5	6	7
Amharic							NR
Arabic							NR
Farsi							NR
French							NR
Lingala							NR
Somali							NR
Tigrinya							NR
Other							NR

Full-time female | Part-time female | Full-time male | Part-time male

6.2.4. Self-Evaluation: Provision of SRH Services

Workforce: Responses across facilities were evenly distributed with **two** reported being understaffed, **two** with limited staff, **two** with sufficient staff, and **one** facility that stated they did not officially provide SRH services.

Infrastructure: While **four** facilities responded that their infrastructure was well-maintained and sufficient, **one** stated adequate infrastructure, and **one** with limited infrastructure.

Equipment: **Three** facilities stated that they were fully equipped, **three** facilities reported that they were partially equipped, and **one** reported that they had limited equipment.

Medication: Responses were distributed with **three** stating they were well-stocked, **two** replying they had limited stock, and **two** reporting they were scarcely stocked.

Figure 26: First facility assessment with Doctors of the World (Médecins du Monde).

Focus Group Discussions & PEER Interviews

7. Focus Group Discussions (FGDs) and PEER Interviews

Concluding the data collection for the quantitative methods marked the initiation of another series of training sessions in preparation for the qualitative phase of the research project at the end of July.

7.1. Methods FGDs

Training sessions and activities covered qualitative and participatory research methodology, positionality, the co-creation of themes and topic guides, practice scenarios, and logistic considerations. Below follows a summary of the timeline:

1. Kick-Off: Qualitative and Participatory Research (July 23, 2023)

- Introducing qualitative and participatory learning and action research (PLA).
- Simulating group discussions using a fishbowl exercise.
- Flexible brainstorming sessions to generate relevant themes for the qualitative part.

2. Co-Creation of Questions and Practice Scenarios (July 24 - August 1, 2023)

- Practicing the facilitation of FGDs and interviewing techniques through role-playing.
- Reflecting on positionality through body mapping.
- Using discussions and the World Café method to co-create the topic guide.

3. FGD Simulation (August 2, 2023)

- Simulating a FGD, which included community mapping and PhotoVoice, with the co-research team.

4. Logistics of the FGDs (August 3 – August 9, 2023)

- Discussing the outline of the FGD and logistics (e.g., participant compensation).
- Training external notetakers and recruiting participants.

Data collection was carried out in August 2023. The semi-structured FGDs, deploying community mapping and PhotoVoice as participatory elements (see Section 14.1 for an outline), were focused on the following main themes: exploring **SRH needs**; **expectations of care**; and facilitators and barriers to **access to SRH care**. The co-researchers purposively recruited participants from six different language groups (Amharic, Arabic, English, Farsi, Lingala, and Somali) aiming for maximum diversity in age, marital status, children, education level, literacy, sexual orientation, disability and other characteristics. Finally, the six FGDs comprised 5 to 10 women each, with a total of 47 participants. In consultation with the co-research team, the FGDs were held inside the research office in camp. Oral informed consent and permission to audio-record was obtained at the beginning of each FGD. Lasting between three to four hours, participants were reimbursed for their time and contributions with 15 euros, in addition to being provided with lunch, snacks, and drinks.

Figure 27: Practicing the facilitation of group discussions in the backyard of BRF.

7.2. Methods PEER Interviews

Following the Participatory Ethnographic Evaluation and Research (PEER) method (see **Box 1**), which centers the community's social life, stories, and narratives (44), we conducted in-depth interviews with refugee women in camp to gain deeper insights into their SRH needs and perceptions of access to services. Addressing gaps from the quantitative results and the FGDs, the topic guide included questions on menstrual, gynecological, and mental health, family planning and abortion, community perceptions of safety and justice, as well as information provision related to SRH and available services. After providing feedback, adjusting the questions accordingly, and refreshing interviewing techniques, the topic guide was translated by the co-researchers.

Data collection took place between the end of August and mid-October 2023. A total of 27 in-depth PEER interviews were conducted. Eight co-researchers and one master's student each interviewed three women until theoretical saturation was reached. Oral informed consent was obtained at the beginning of each interview. The interviews were not recorded; however, interviewers took notes on dedicated data collection sheets. Each interview was debriefed with the project team, and the recordings of these debriefings served as data for analysis.

Box 1: Participatory Ethnographic and Evaluative Research (PEER) method

The PEER method is an action-oriented interviewing technique that strengthens the inclusion of hard-to-reach participants in research and is particularly useful when engaging with sensitive topics such as SRH (45, 46). Peer researchers from the community recruit "peers" in their social environment for in-depth interviews. Instead of recording interviews, data collection sheets are discussed in a recorded debrief meeting with researchers from the project team.

7.3. Analysis

Utilizing flexible brainstorming as a participatory technique, collective sensemaking sessions with the co-research team were conducted as the initial step in data analysis, addressing both the FGDs and the PEER interviews (see **Figure 26**).

All FGDs and debrief meetings were audio-recorded. The English FGD was transcribed ad verbatim by one of the master's students; the other FGDs were written up as condensed, paraphrased transcriptions including direct key quotations by the co-researchers. The debrief meetings were transcribed ad verbatim. Subsequently, the data underwent thematic analysis using Atlas.ti by the same master's student. SRH needs and care expectations were inductively coded. Facilitators and barriers influencing access to services were initially inductively coded and then deductively classified according to Levesque's patient-centered framework of healthcare access. In instances of uncertainty, coding decisions were discussed with the principal investigator. For this report, all six FGDs and 11 PEER interviews were fully coded. Due to time constraints, 16 additional PEER interviews are yet to be fully analysed. Instead, relevant themes from these interviews were extracted orally from the recordings.

As of the date of publication, visual materials such as PhotoVoice pictures and community maps are still undergoing analysis; however, they are included in this report for illustrative purposes.

Figure 28: Practicing interviewing techniques in the team's research office in camp.

Figure 29: Output from the Collective Sensemaking Session in August 2023

7.4. Results

The FGDs and PEER interviews explored three key aspects of sexual and reproductive health - SRH needs, expectations of healthcare, and access to SRH care and services. Below the preliminary findings for each of these key areas are presented.

7.4.1. SRH Needs

Women of reproductive age residing in CCAC Mavrovouni experience a variety of SRH-related needs, including:

Needs Related to Healthcare and Other Services

- **Care needs**: Women expressed a need for "good care" and "good treatment", aiming to improve the healthcare system in camp, particularly focusing on EODY. Their specific healthcare needs encompassed access to medical professionals, including gynecologists and mental health professionals; timely treatment and 24-hour availability of medical professionals; access to care and services for children; check-ups and follow-up communication; proper informed consent procedures (e.g., during delivery and vulnerability checks); medical documents supporting their asylum claims; sleeping pills and medication, particularly for mental health issues, abortion, FGM, STIs/HIV, and gynecological symptoms. Furthermore, there was a need for mental health support, especially concerning abortion, FGM, and SGBV, and a desire for personalized attention during treatment. Women also emphasized the importance of effective referral pathways, free transportation, and the potential for transfer to other facilities/places for specialized treatment. For **specific needs related to each SRH sub-domain**, please consult **Table 3**.
- **Interpretation**: A prevalent challenge encountered in accessing services was the absence of (suitable) interpreters (refer to Section 7.4.3). Consequently, a notable demand for interpreters arose, particularly in hospital, gynecological, and psychological settings. Female interpreters and individuals external to the camp community are essential due to considerations of shame and stigma. Specific language groups requiring interpretation encompassed French-Lingala, Creole (Sierra Leone, Guinea), and Somali.
- **Legal support**: Women additionally articulated a need for legal assistance, encompassing access to legal professionals, family reunification support, protection (particularly in cases of SGBV), and efficiently operating referral pathways.

"When we came they look our vagina but they didnt tell us why and what they look us" (two Somali women, 20 and 26 years, about the vulnerability assessment)

"I have a lot of diseases but despite of this I got rejection and everyone told me I lied that I'm sick and I told it just to get asylum and this affected on my mental health. I have hand shaking. I am waiting for a long time in waiting list of MSF to get psychologist." (Afghani woman, 48 years)

"But when we say out of rape that woman has to go to a doctor and talking freely about what happened and the health providers also should have a female translator." (Eritrean woman, 24 years)

"The protection of women and children and also provide lawyers" (Congolese woman, 33 years, about support for SGBV)

Table 3: SRH Needs per SRH Domain

SRH Domain	Associated Needs
Maternal Health	• **Specific care needs**: medication; check-ups; informed consent during delivery • **Living space**: clean and private accommodation (ISObox) with sanitary facilities • **Material needs**: clothes and hygiene products for pregnant women • **Nutrition**: fruits, vegetables, and/or vitamins; food in the hospital • **Others**: social support; physical activity; religion and prayer; shower; sufficient rest after delivery
Family Planning	• **Specific care needs**: access to contraception, especially anonymous access; support for fertility treatment; consultation/information • **Others**: social support
Safe Abortion	• **Specific care needs**: access to medical professionals; follow-ups after the abortion; medication; mental health support • **Nutrition**: vitamins and nutritious food after the abortion • **Others**: social support, incl. partner support; initiative; housing outside of camp
Menstrual Health	• **Material needs**: access to hygiene products and/or menstrual materials • **Agency**: choice in materials; no registration to receive materials
Gynecological Health	• **Specific care needs**: medication for gynecological symptoms (e.g., itchiness and burning urination); urine tests; female interpreters • **Sanitary facilities**: clean and private sanitary facilities
STIs & HIV	• **Specific care needs**: treatment and medication for STIs and HIV; STI screenings; female interpreters • **Others**: loyal partner
Sexual and Gender-Based Violence (SGBV)	• **Specific care needs**: medical attention and follow-ups; mental health support; female interpreters; referral pathways • **Legal support**: legal support and protection • **Information and education**: awareness among men; awareness of rights • **Agency**: resilience; confidence; consent for sexual intimacy • **Others**: security; community support for reporting SGBV
Female Genital Mutilation	• **Specific care needs**: informed consent during vulnerability checks; special care; medication; mental health support; reconstructive surgery; tetanus vaccinations; treatment for complications and infections
Mental Health	• **Specific care needs**: access to medical professionals, psychologists, social workers, lawyers, and external interpreters; timely treatment; medication; personal attention; referral pathways; non-Western treatment techniques • **Legal support**: positive asylum; family reunification • **Information and education**: mental health awareness; information • **Living space**: private accommodation (ISObox) • **Others**: social support, incl. partner support; women's space and/or activities; stress reduction (e.g., through sexual intimacy); music; physical exercise; drawing books; religion and prayer; opportunities to express emotions

- **Good nutrition**: There was a collective aspiration for a high standard of nutrition and for improvements in the food distribution system in camp. Ensuring optimal nutrition emerged as a priority, particularly for children, pregnant women, individuals with positive asylum decisions or rejections, and after an abortion. Women furthermore expressed a need for dietary options, improvements in the quality of hospital food, and access to clean water.
- **Information and education**: Addressing comprehensive awareness and education needs, women emphasized the importance of providing information about the available services and SRH information aligning with available services, covering specifically mental health, menstrual and gynecological health, abortion, family planning, FGM, as well as information on STIs/HIV. Other informational and educational needs encompassed promoting (mental) health awareness; raising awareness among men on issues related to SGBV and women's rights; offering targeted information for new arrivals; providing information on the rights of asylum-seekers; and conducting outreach efforts for information provision.

"Most importantly, as for me. One, we are refugee. Now, you see, you give me positive, right? Then when we have positive, you said that the people that have positive cannot even food, but at the same time you cannot prepare these people documents to leave." (Sierra Leonean woman, 26 years)

"And then she told me that, most of the women, they have a little bit information about the topics related to the (...), for example, women's and their gynecological health and most of the women, they prefer to know where they can go and get the services." (co-researcher about her interview with an Afghani woman, 24 years)

Needs Related to the Physical Camp Setting

- **Camp environment**: Women additionally communicated a desire for a clean camp environment with ample shade provided by trees. They expressed the need for recreational spaces such as gardens, parks, and/or play areas specifically designed for children. Additionally, women highlighted the importance of sports facilities, well-maintained roads, and reasonable speed limits for cars within the camp. They also emphasized the significance of active engagement and responsiveness from camp management.
- **Safety**: Women expressed concerns about safety, particularly at night. They emphasized the importance of well-lit areas during nighttime hours and proximity to sanitary facilities. Ensuring safety for minors, as well as for single women and girls, emerged as a priority. Confidence, safety pertaining to the asylum procedure, and security (particularly addressing issues related to SGBV) were underscored as essential elements of a safe environment.

"(...) it would be better to plant more trees to make comfortable for sitting outside because of the heat." (Eritrean woman, 20 years)

"And the other thing was about single mom and single girl, she told, we have single girl inside the camp. They live in a separate tent together. It is difficult for them because provide safety for them for 24 hours during the day, during the night, it's really difficult for them." (co-researcher about her interview with an Afghani woman, 24 years)

"it is difficult to go to the toilet 3 times per day after C-section." (Tajikistani woman, 25 years)

"I have made several complaints about this one, but since then, even the last time we are having tea, me and my husband, and not knowing that the bug is inside the cup. (...) they really, really need to do something about insects. There are so many!" (Guinean woman, 27 years, about cockroaches in camp)

- **Hygiene facilities**: Women highlighted the importance of clean, closely located, and private sanitary facilities. Specific requests included toilets equipped with seats for added comfort. Additionally, they expressed a need for a laundry service to ensure proper hygiene practices.
- **Accommodation/living space**: Women expressed a desire for a "good house" or "good home" with a strong emphasis on cleanliness, including considerations for roommates and shared spaces. Privacy emerged as a crucial aspect, particularly for couples, families, and pregnant women. Specific needs included separate rooms for children and parents, fostering compatibility among roommates who share the same language, and dedicated ISOboxes tailored for various needs, such as those designed for elderly individuals, individuals with mental health concerns, and pregnant and/or breastfeeding women.

Material and Financial Needs

"I'm disabled, I cant reach the health center. I would like to get electric weelchair to reach my SRH service." (Somali woman, 38 years)

"I need a bank card so that I can treat my children or at least go to the hospital. Everything needs money for my children and me for transportation." (Syrian woman, 29 years)

- **Material needs**: Women expressed essential needs for their children, including items such as a baby bathtub, stroller, baby towels, diapers, and wipes. Additional needs encompassed cleaning materials, maternity clothes, an electric wheelchair, menstrual materials and hygiene products, emphasizing the importance of having choices in these items. Basic necessities such as toilet paper and underwear were also highlighted.
- **Financial freedom**: Aspects related to financial autonomy encompassed the desire for a bank card, opportunities for employment, pursuit of financial independence, and the availability of financial resources such as money.

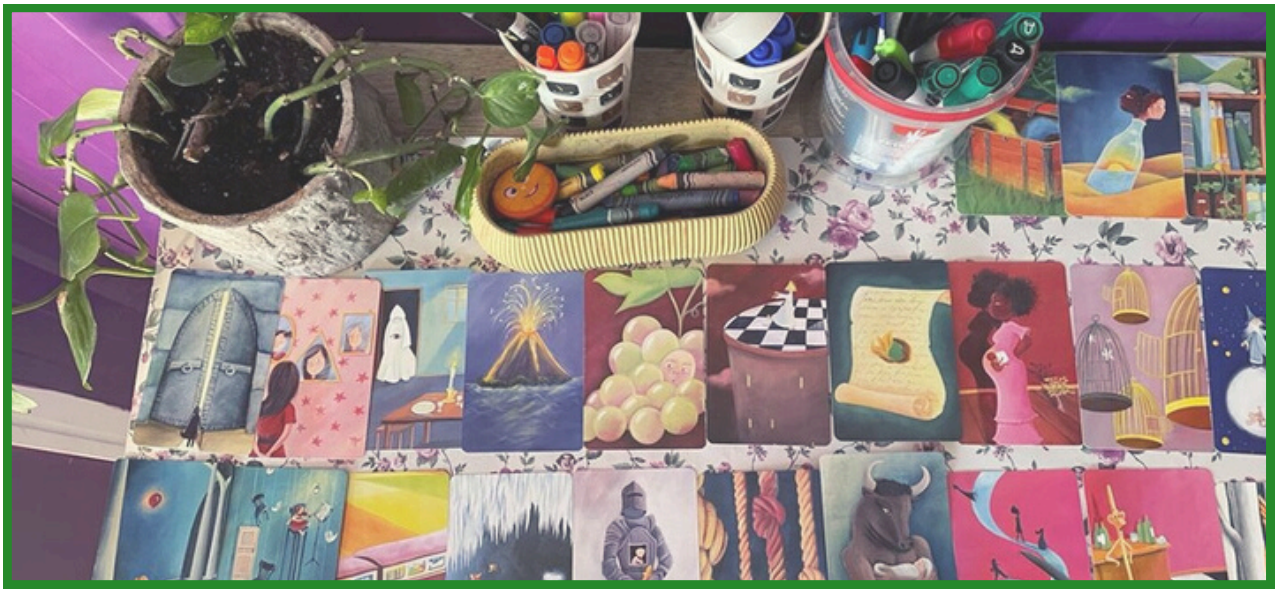


Figure 30: Dixit cards used during the flexible brainstorming session on SRH needs in each FGD.

Figure 31: Flexible Brainstorming Session on SRH Needs in the Arabic-Speaking FGD

Community Needs

- **Community relations**: In the realm of community dynamics, key elements included establishing social support networks, including assistance with childcare and babysitting; designating space, activities, and/or a community center tailored for women, which is accessible more than once a week and suitable for children; acknowledging the significance of religion and prayer; encouraging engagement in sports, positive interactions with roommates, and community support for the reporting of SGBV incidents.
- **Support for single mothers**: Addressing the needs of single mothers involves providing assistance with necessary documents; opportunities for employment; financial support; and social support, with a specific focus on assistance with childcare and babysitting.

"(...) there is a place for women and there is a place for children. We think that 'OK, now our children, they are playing in this place, this place is safe and good'. And we are in the place for women. We are doing something and we are speaking with other women and with this we can relieve our stress." (co-researcher about her interview with an Afghani woman, 27 years)

"For now, the most important thing, I need job. I'm already have the job but decide to leave my baby, it's difficult." (Sierra Leonean woman, 27 years, about being a single mother in camp)

Interpersonal Needs

- **Partner**: In the context of partnership, key considerations included partner support, especially during abortion; education about women's rights; and a commitment to being a loyal partner, particularly concerning issues related to STIs and HIV.
- **Satisfying sex life**: Factors contributing to a fulfilling sexual experience encompass being with one's partner and sharing accommodation; ensuring privacy, taking into consideration concerns about roommates and potential influence on children; prioritizing consent and mental peace for sexual intimacy; and recognizing sexual intimacy as a means of stress reduction.

"For me, if my partner agrees with me, I can do the abortion." (Congolese woman, 25 years)

"For example, inside the camp the way we are sleeping in the same room with the children, you cannot feel comfortable to fullfill the condition and feel comfortable with your sexual life, because the children are there. Maybe they can hear the noise." (Congolese woman, 33 years)

Other Relevant Needs

- **Stability and clarity**: Ensuring a sense of stability and clarity involves addressing concerns related to asylum processes, living conditions, future prospects, and potential transfers. Specific considerations include providing necessary documents for individuals with a positive decision and recognizing the substantial impact of asylum decisions and insecurity on women's mental health.
- **Justice**: Ensuring justice involves addressing various aspects related to discrimination, including concerns about accommodation, varying availability of interpreters across language groups, differential treatment by the police, disparities during distributions, and unequal healthcare experiences. A comprehensive approach to justice needs furthermore involves stopping pushbacks; creating clear and fair asylum procedures (e.g., abolishing the extra admissibility interview for certain nationalities); promoting women's awareness of their rights in this context; as well as considerations regarding health justice, for example, ensuring access to care, services, and nutrition for children.
- **Agency**: Women's self-perceived agentic needs involved fostering awareness of rights; self-confidence; patience; resilience and strength; freedom; commitment and motivation; self-hygiene/self-care practices; and ensuring consent for sexual intimacy. Women also valued the choice of menstrual materials without the need for registration as well as opportunities for expressing emotions.

For an overview of all overarching needs, please refer to **Table 4**.

"I lost my husband in Afghanistan. I arrived here with my two sons. I can't work here because I have to go to food line for a long time, three hours every day. So, I don't have income. We don't have access to good nutritions. We are waiting for our decision about eight months and it has bad effects on my mental health." (Afghani woman, 27 years)

"She said, they need medication and they need really real urine test, not this one that they are doing here. (...) There's nothing here. They consider us as a refugee. (...) she means that they don't give them the good quality as the people who are living here, they don't care for them." (co-researcher about her interview with a Palestinian woman, 22 years)

"It's important too to keep self-hygiene, its more important than medication." (Eritrean woman, 34 years, about treating gynecological symptoms in camp)

Figure 32: Co-researchers presenting the community maps to the whole research team.

Perceptions of Contraception and Family Planning

- **Perceptions of contraceptive methods**: Women's perceptions of contraceptive methods varied. Some women expressed being abstinent because of lack of knowledge, fear of childbirth, being in a long-distance relationship, and because being sexually active is not a priority in camp. Similarly, withdrawal is employed, stemming from a lack of knowledge, fear of childbirth, condom allergies, mistrust in healthcare professionals, or partner preferences (e.g., partner not wanting to use condoms). At the same time, condoms are favored for their easy accessibility, prevention of pregnancies and infections, and lack of side effects, despite their drawback of reducing sensation during intercourse. Birth control and morning-after pills serve to prevent pregnancy during unsafe sex but are accompanied by concerns such as weight gain or the risk of forgetfulness. Some women would like to use implants due to their discreet nature when unmarried, yet accessibility issues in the camp and fears of infertility deter their use. Similarly, some women prefer injections because they are low maintenance, hard to forget, not visible when unmarried, because they already have children, or are unsure about their partner, however, they also come with the fear of infertility. While IUDs are favored by some women for their absence of side effects, others harbor concerns about cancer, fear of pregnancy, and the long-term care burden. The calendar method is adhered to by some due to its perceived absence of side effects. Others mentioned not using contraception due to shame, or using paracetamol due to lack of knowledge.

> "Yeah, with the family planning, I mean with the contraception and abstinence. She told me that, I don't think so with abstinence (...) maybe they are using injections for three months or six months, injections, because (...) if they are taking the injections, just they are not married, so they can just have the injection once and then they can use it, she say. But, let's say, for example, also she mentioned the morning-after pill, also maybe they can forget it even. So, for that case, even if they are not sure, also they are not sure with their partners, she thinks they prefer to use the injections." (co-researcher about her interview with an Eritrean woman, 25 years)

- **Choice in family planning**: Reasons to conceive a child in camp included cultural and/or religious beliefs about contraception; benefits for the asylum case and/or for documents; considering Greece as one's final destination; receiving free services, accommodation, and materials in camp; concerns about one's menopause; having an unplanned pregnancy; or already being pregnant upon arrival in camp. On the other hand, many women recognized the unfavourable camp conditions and limited service situation as the major reason not to conceive a child in camp. Other reasons included existing parenthood; infertility; not having a partner; and experiencing excessive stress. Women also shared that Greece may not be their final destination such that a child would limit their mobility, personal freedom, and opportunities. Concerns also included that having a child would prolong the asylum procedures or that a possible rejection would affect their future child.

> "She said, they are afraid to give birth inside the camp, because the condition is not good for the baby, for the babies inside the camp. Like me, I cannot give birth inside the camp. I don't have residence yet. If I get rejection, my baby will be also rejected. (...) so, maybe she was afraid." (co-researcher about his interview with a Congolese woman, 25 years)

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Table 4: SRH Needs per Overarching Category

Category	Associated Needs
Needs Related to Healthcare and Other Services	Care needs; Interpretation; Legal support; Good nutrition; Information and education
Needs Related to the Physical Camp Setting	Camp environment; Hygiene facilities; Safety; Accommodation
Material and Financial Needs	Material needs; Financial freedom
Community Needs	Community relations; Support for single mothers
Interpersonal Needs	Partnership needs; Satisfying sex life
Other Relevant Needs	Agency; Justice; Stability and clarity

7.4.2 Expectations of Care

Women's expectations regarding care can be summarized in five key categories: expectations regarding treatment; regarding mental health support; regarding personnel and interactions with healthcare providers; and regarding general expectations, going beyond immediate healthcare assistance.

Treatment Expectations

Women's expectations in terms of treatment encompass:

- Receiving "good care" or "good treatment" - importantly, in a timely fashion;
- Receiving appropriate and efficient medication;
- Anticipating regular check-ups, particularly after abortion;
- Streamlining appointments to avoid multiple visits for a single health issue;
- Testing as needed (e.g., urine tests for gynecological symptoms);
- Being referred to the hospital when necessary and not experiencing rapid discharges from the hospital;
- Prioritizing special attention for children, the elderly, and individuals with health conditions such as diabetes;
- Being able to choose from various contraceptive methods and undergoing blood testing to match with suitable FP methods;
- Receiving internal examinations for gynecological symptoms;
- Emphasizing special care for issues related to FGM.

"I was using injections in Ethiopia and when I came here, I want to change and I went to MSF to ask and have another contraception. But they ask me which contraception I was using before and they gave the same. But my expectation was to test my blood, and telling me the options they have, explain which one good and telling me which one fits with me, but they do not." (Eritrean woman, 20 years)

Expectations Regarding Mental Health Support

Women's expectations for mental health support include:

- Overall mental health improvement, with stress reduction being an integral part of mental health support;
- Counselling, encouragement, advice and guidance on coping strategies;
- Prescription and use of medication;
- Regular check-ups and support with transportation if needed;
- Establishing a friendly and/or close relationship with the psychologist (e.g., engaging in various activities for mental stimulation such as going to the beach) and engaging in pleasant interactions (e.g., calm and pleasant tone of voice, authentic smile, personal attention, psychologists expressing emotions during interactions, forward-looking conversations);
- Assistance with documentation and support for asylum claims and support for living in an ISObox.

"She's like a sister to me. Let me just forget about the past and think about the future. (...) She usually used to call me, 'what is going on with you? What are you doing? What is happening with the babies? Are you OK? When you feel sick or when you want to go to town, please call me. I will provide ticket for you. Yes, or I will come and pick you with car. I will go'. Yeah, so. All that, all, all those things that she is doing, it helps you to forget about your stress (...) she is part of you to cure you. (...) That's what I think I need from psychology, all the time you have your attention to your patient, you calm him or her down, you talk to her good." (Sierra Leonean woman, 23 years, about her psychologist)

Expectations Regarding Personnel

"I went to gynecologist inside the camp and told her that I don't want the interns do my C-section, and the doctor said that if you don't want, do it at your own expense." (Tajikistani woman, 25 years)

Women's expectations regarding personnel include:

- Experienced, knowledgeable healthcare professionals;
- The presence of a specialist for gynecological health;
- The availability of female interpreters;
- The ability to speak English.

Expectations Regarding Interactions with Healthcare Providers

"A doctor has to behave good with patients and respect them" (Tajikistani woman, 25 years)

"If you don't have a way to help me, find me another way or tell me. I will do something." (Sierra Leonean woman, 26 years)

Expectations for interactions with healthcare providers involve:

- Demonstrating respect, kindness, friendliness, and patience throughout the interaction;
- Offering personal attention to individual concerns and ensuring that concerns are taken seriously;
- Providing thorough explanations and consultations;
- Offering clarification if assistance is not immediately possible;
- Active listening to understand the patient's needs;
- Maintaining a calm tone of voice during communication.

General Expectations

"The healthcare providers do not want to take responsibility for medical papers. They know the problem that we are passing through. We ask them to give us medical papers that can help us to get more help, like, here women are suffering from insect bites, we ask a lot, but no answer." (Eritrean woman, 42 years)

"Also, it's too far to go to the toilet from my home since I am pregnant. I expect to have a home near to toilet and water." (Eritrean woman, 25 years)

Expectations of care extended beyond immediate medical assistance to cover more comprehensive support for other essential needs such as accommodation, food, and asylum-related support. More general expectations involved:

- Availability of documents for additional support;
- Provision of ISOboxes, specifically for families, pregnant and/or breastfeeding women;
- Proximity of accommodation to WASH facilities;
- Provision of nutritious food for children, pregnant and/or breastfeeding women;
- Access to reliable transportation.

7.4.3. Access to SRH Services and Care

Access to healthcare is a critical aspect of ensuring the well-being of refugee populations. The results below delve into the demand-side and supply-side facilitators and barriers that refugee women in CCAC Mavrovouni encounter in their pursuit of healthcare services, categorized according to the Levesque model of patient-centered healthcare access.

Supply-Side Barriers and Facilitators

1. Approachability

Service approachability means that women with SRH needs can easily identify available services and understand their potential benefits.

- **1.1. Information**
  - **Information provision**: Refugee women often face challenges stemming from a lack of information about the healthcare system, including essential details such as the pathway to care and the array of available services. On the other hand, informative sessions by organizations like BWC to address specific SRH concerns facilitate women's access to care. Despite lacking much information, the information board in camp was also considered a facilitator in the process of seeking care.
  - **Information in Greek versus English language**: The language barrier further compounds approachability issues, as vital healthcare information is often provided in Greek. In contrast, information provided in English makes it easier for women to access SRH services.
- **1.2. Outreach**
  - **Community outreach**: Community outreach initiatives, for example, led by EuroRelief and BWC ease women's access to SRH support and services. Similarly, personalized patient support, such as psychologists picking patients up at the gate or their tents, is perceived as a supportive measure, fostering accessibility.
- **1.3. Transparency**
  - **Lack of visibility**: A lack of physical visibility of service providers has a negative impact on access to SRH care in CCAC Mavrovouni.

"(...) the language, if it's written in Greek, it makes me very difficult because I don't know Greek. So, it makes it very difficult for me to access maybe something. If I want something, I'll find someone who speak English and, you know, not all of them speak English. Some of them is purely Greek, so that one makes it difficult for me. But whenever I see it like this, it's written in English, you know, it makes easy for me." (Guinean woman, 27 years)

"BWC is very good for all the pregnant women and children under two years old. They are coming themselves and checking on us." (Tajikistani woman, 25 years)

"She said, I hear that there is a, there is a doctor there. A female doctor. (...) And then she said she hear from, from, from people, there is our, our BRF still have the gynecologist here. But when she's going, she cannot find her. She doesn't know what, where to go." (co-researcher about her interview with a Palestinian woman, 22 years)

"Yeah, she said, they can't talk about sensitive question. They're asking me, like, is there is a discharge, how it looks like, this stuff. And then she said, I can't talk about this for male interpreter. (...) She said, I'm not feel comfortable. (...) Then she said, I didn't tell anything, any more information." (co-researcher about her interview with a Somali woman, 38 years)

"Greek doctors have racist behaviors with patients. They do not consider us as a part of human beings at all. They think that we have to be treated like this. Even though they are doctors, but they are not responsible. (...) I like the behavior of BRF doctors, but I don't like the behavior of Greek doctors." (two Afghani women, 22 and 23 years)

"Like me, I'm a victim. (...) Like since I go FGM, I have stomach pain, too much stomach pain, yes. And then sometimes I feel my vagina is paining me. (...) For me, since I came in the camp, they didn't even told me about this FGM. They only ask if he go FGM or what. So, after I went, the midwife watch me if I go FGM, then she confirmed it and said yes. After from then, they don't give me any treatment." (Sierra Leonean woman, 23 years)

"The barrier is the negligence at the pharmacy, they do not have all the medicine that the organizations prescribe." (Congolese woman, 40 years)

2. Acceptability

Acceptability refers to the cultural and social factors that shape the likelihood of individuals accepting services.

- **2.1. Gender**
  - The shortage of female interpreters contributes to discomfort among women, particularly when engaging with male interpreters during healthcare interactions.
- **2.2. Norms**
  - Reluctance to engage extensively with psychologists is reported, with some women expressing discomfort when being questioned by psychologists, and revisiting past traumatic experiences during psychological sessions.
- **2.3. Perceived Discrimination**
  - Some women perceive discrimination due to a lack of interpretation services for specific language groups (i.e., Somali, French-Lingala, Creole (Sierra Leone & Guinea), inadequate accommodation, and perceived biases from Greek doctors. Experiences of perceived discrimination by the police and within hospital settings contribute to a sense of mistrust and hinder the acceptability of healthcare services.

3. Availability and Accommodation

Availability and accommodation encompass the presence of services equipped with adequate capacity to provide timely care.

- **3.1. Accommodation**
  - **Availability of services and staff**: While there exists access to healthcare professionals and social workers for women residing in camp, perceived shortages in staff (e.g., psychologists, interpreters) impede access to SRH healthcare. This holds equally for restricted access to healthcare professionals and hospitals after midnight. Insufficient availability of FGM care services creates barriers to addressing specific health needs. At the same time, some women positively reported that BRF offers specialized care for pregnant women.
  - **Availability of medication**: Similarly, while women perceived medication provided for abortion and gynecological symptoms as helpful, they also felt that essential medications were frequently lacking.

- **Legislation**: While Greek legal frameworks permit abortion facilitating women's reproductive choices, women are sometimes too far ahead in their pregnancy to seek abortion services.
- **Availability of menstrual materials and hygiene products**: Limited availability of menstrual materials and hygiene products further exacerbates health challenges.
- **Camp conditions**: Overcrowding within the camp hampers the overall living conditions (e.g., shortages in clean accommodation, mattresses, beds) and accessibility of healthcare facilities.

"OK, to bring her period material, sometimes she went to office, hygience office. (...) But she's not happy by them because she couldn't find them all the time. She went to go because... because of that, yesterday, she was on her period and she went to bring pad and it was locked. (...) She said, they have to be available all the time." (co-researcher about her interview with an Eritrean woman, 20 years)

- **3.2. Appointment Mechanisms**: While EuroRelief's service to keep appointment slips for women makes it easier not to miss appointments, overlapping scheduling (e.g., several appointments, during food distribution) creates inefficiencies, potentially causing delays and hindering women from receiving timely care.
- **3.3. Location**: The distance to services and sanitary facilities, combined with poor road conditions within the camp, poses significant challenges for access to healthcare. Fluctuating temperatures, both hot and cold during summer and winter, further impact the accessibility and comfort of healthcare facilities.
- **3.4. Opening Hours**: Limited opening times for healthcare facilities constrain access to essential services and support, whereas women deemed the weekend and evening services provided by BRF as a facilitator to care.

"And the other problem is, she said, I heard that the way for psychologist from BRF is far from the camp. They have the following session in Paréa and because the weather is warm sometimes and the other time weather is cold, they cannot go to Paréa. It is more difficult for women who has a pain in leg and the old women, they cannot go." (co-researcher about her interview with an Afghani woman, 24 years)

"EuroRelief is good because when I am not at home, I am going there and ask them if I had missed any appointment." (Afghani woman, 17 years)

Figure 33: PhotoVoice picture taken by one of the participants.

"We are thankful because they care about us and give us shelter, food, and clothes. Now, we are thankful because our basic needs are fulfilled. They bring us from a forests and give us this all for free, we are thankful for the NGOs for their free service and their treatments." (Eritrean woman, 34 years)

"You see this big tent (meaning EODY)? If they give you an appointment to go to the big hospital in Mytilene, they say, 'this is the appointment, go there'. They don't care if you have to use car, if you have to walk, they don't care. It's not good now. If I have my girls, I cannot, I can't walk. I don't have money to pay. How can I pay them?" (Sierra Leonean woman, 26 years)

4. Affordability

Affordability refers to direct and indirect healthcare expenses.

- **4.1. Direct Costs**: The provision of free services for asylum-seekers constitutes a major facilitator to healthcare access. However, other financial constraints associated with direct costs, such as medication when the camp's pharmacy is out of stock, sperm tests in case of infertility, and costs of treatment after receiving a rejection present hurdles to affordability.
- **4.2. Indirect Costs**: While food, menstrual materials and/or hygiene products, are freely available, they do not always meet the needs of women in terms of quantity, quality, or both. Indirect costs, encompassing expenses like purchasing food, hygiene products and/or menstrual materials, cleaning materials, and covering transportation costs, further contribute to the overall financial challenges women face in accessing care. Free transport, for example, offered by MSF can mitigate these hurdles.

5. Appropriateness

Appropriateness denotes the relation between services and needs, reflected in quality, adequacy, coordination and continuity.

"The biggest barrier for me in the Congolese community is the lack of interpreters in the medical sector because we suffer from certain discrimination. Because you go very early in the morning to have a good place but for lack of interpreters, you are obliged to leave very late, exhausted and discouraged." (Congolese woman, 31 years)

- **5.1. Adequacy**
  - **Waiting times and lines**: Prolonged waiting lines and extensive waiting lists, particularly for psychologists and hospital surgeries, contribute to inadequacies in timely access to essential healthcare services. Some women also reported quick discharges from the hospital, potentially contributing to inadequacies in post-treatment care.
  - **Informed consent**: Inadequacy is observed in the absence of proper informed consent procedures, notably during delivery and vulnerability assessments, raising concerns about patient participation in decision-making.
  - **Lack of explanations**: Deficiencies in providing explanations during treatment at one specific facility add to concerns regarding the adequacy of communication and understanding during healthcare interactions.

- **5.2. Quality**
  - **Interaction with healthcare professionals**: Unpleasant interactions with healthcare professionals (e.g., healthcare professionals not actively listening, perceived lack of personal attention, instances of receiving misinformation) contribute to concerns about the overall quality of patient-centered care. In contrast, the quality of healthcare interactions was perceived as elevated when women experienced pleasant exchanges with healthcare professionals.
  - **Language skills of healthcare professionals**: Limited English language skills create challenges in effective communication and information exchange.
  - **Lack of effective triage**: Concerns about the lack of effective triage, particularly the absence of prioritization for vulnerable groups like children, the elderly, and those with specific health conditions such as diabetes, highlight potential shortcomings in healthcare quality.
  - **Choice**: An array of menstrual materials and contraceptive methods promotes quality in reproductive healthcare by providing women with the ability to make informed choices tailored to their preferences and needs.

"Late appointment, asking for referrals, I even brought referrals for the Greek doctors (EODY) but they did not accept. They don't give medicine, behaving very bad, keep saying 'go, come back tomorrow', just giving 2 pills." (Afghani woman, 26 years)

"She told me that in WWBT, they put different types of pads and the ladies can go and choose it. That, it was very surprising for me. And she told like there are like pads for like during the day, night pads and everything. Then, the women can choose between them." (co-researcher about her interview with an Afghani woman, 24 years)

- **5.3. Coordination and Continuity**
  - **Interorganizational coordination and referral pathways**: Women perceived deficiencies in interorganizational coordination, for example, when it comes to referral pathways, potentially impacting the continuity of care.
  - **Follow-ups**: The absence of follow-ups, particularly in the context of abortion services, raises concerns about the continuity and completeness of healthcare provision.
  - **Police support during medical emergencies**: The perception of insufficient police support during medical emergencies raises issues related to the coordination between healthcare and law enforcement, potentially affecting the effectiveness of emergency response.

Figure 34: PhotoVoice picture taken by one of the participants.

Figure 36: Community Mapping Session on Camp Perceptions in the English-Speaking FGD

Demand-Side Barriers and Facilitators

1. Ability to Perceive Need for Care

The ability to perceive need for care is influenced by health literacy and beliefs, trust and expectations, and lack of self-care.

- **1.1. Health Literacy**
  - **Health awareness**: Limited awareness about prevalent health issues and available treatments poses a challenge to accessing care.
  - **Appreciating need for care**: Exerting initiative when dealing with health issues acts as a facilitator in accessing healthcare.
- **1.2. Health Beliefs**
  - **Fear and side effects**: Beliefs regarding the side effects of contraception can contribute to apprehension and reluctance to utilize such services. Similarly, fear of consequences associated with abortion acts as a barrier to seeking reproductive healthcare.
  - **Normalization**: Some women expressed that they do not seek care for gynecological symptoms, because they are perceived as normal.
- **1.3. Trust and Expectations**
  - **Mismatch between care and expectations**: There was a clear mismatch between care and expectations, with women reporting low expectations when seeking care, having received no or insufficient treatment or medication, and not receiving necessary medical papers for their asylum claim. Some women also perceived psychological care as ineffective, given the continuing uncertain nature of their stay in Greece and, by extension, Europe.
  - **Mistrust**: Mistrust in healthcare professionals is a prevalent barrier. Relatedly, one Afghani woman reported feeling like she was mistrusted by her psychologist.
  - **Rumors and misinformation**: Rumors and misinformation circulating within the refugee community further contribute to a climate of uncertainty and mistrust.
- **1.4. Lack of Self-Hygiene or Self-Care**
  - Limited emphasis on personal hygiene and self-care practices due to stress may result in gynecological symptoms.

"Lots of them do that (referring to abstinence) because of lack of knowledge, and some of them, they know but they are afraid of pills because if you take those pills a lot can make you infertile and you never give birth again, that's why people choose abstinence and if child grows up, you can start to have intercourse again." (Congolese women, 40 years)

"And she said, I didn't have enough support because I didn't have any ultrasound before and after abortion. Because I was bleeding, I needed some vitamin medicine from MSF, but they didn't give any medication for me, only they give some painkiller to me." (Afghani woman, 24 years)

"I like to use IUD, but in another country, not here, because the medical services are not good enough here and I can't trust doctors in this camp." (Afghani woman, 23 years)

2. Ability to Seek Healthcare

"They will ask for your partner if he is agreed to abort the pregnancy." (Sierra Leonean woman, 22 years)

"The place of service is far from the home and I don't have anyone to keep my children. I would like to get a home doctor to get my SRH service." (Somali woman, 33 years)

"Because we are afraid of judgment from another refugees." (Tajikistani woman, 25 years, about reasons why women do not seek psychological support)

The ability to seek care refers to expressing one's intention to access healthcare services.

- **2.1. Autonomy**: Challenges in autonomy arise from a lack of confidence, gender dynamics influencing decision-making (e.g., in relation to abortion), illiteracy, and a lack of necessary documents to access healthcare on the mainland.
- **2.2. Culture**: Cultural and religious beliefs, such as those surrounding abortion and mental health treatment, as well as care-taking and household responsibilities, influence women's ability to seek healthcare.
- **2.3. Stigma and shame**: Stigma and shame act as barriers to seeking healthcare, particularly concerning mental health, reporting SGBV, and accessing contraception. Engaging with interpreters from the camp community also contributes to this stigma.
- **2.4. Stress**: The presence of feelings of unwellness and excessive stress also hampers the ability to seek healthcare.

3. Ability to Reach Healthcare

"I feel very tired alone and my child was born in the camp and, during her birth, I wanted the ambulance to come to my house but no one responded. I was forced to walk from my home to the BRF clinic until I was transferred to the hospital for childbirth." (Syrian woman, 29 years)

"It is a culture in Afghanistan that after giving birth, some friends and relatives take care of the mother and newborn for a long time. In the camp, there is not any support during pregnancy and after delivery. It is really better if mothers can stay in the hospital for a few more days." (Afghani woman, 22 years)

The ability to access healthcare depends on factors that facilitate or hinder the physical reach to service providers.

- **3.1. Restricted mobility**: Restricted mobility, including disabilities and pain in the feet and/or legs, poses challenges for women in physically reaching healthcare facilities.
- **3.2. Capacity of ambulances**: The availability and capacity of ambulances plays a crucial role in determining the ability to access healthcare in a timely fashion.
- **3.3. Social and partner support**: The absence of social support and a lack of childcare facilities or babysitting options present additional barriers, hindering women's ability to reach healthcare facilities, particularly for those with family responsibilities. Partner support and agreement is essential, particularly in the context of reaching abortion services.
- **3.4. Informating sharing within the community**: Information sharing about relevant healthcare knowledge and resources within the community can act as a valuable facilitator in the process of reaching care.

4. Ability to Pay

The ability to pay refers to any financial means influencing women's capacity to cover costs for services.

- **4.1. Income**: Financial constraints arise from a lack of income and/or money, unemployment, and social isolation, creating barriers to accessing necessary healthcare services. A source of support, on the other hand, may be remittances received from family and friends elsewhere. While there is a monthly cash transfer in place, the amount is often perceived as insufficient.

"(...) where do women in the camp get their materials for their periods? And then she's telling me, 'buy'. (...) And then I asked, where do they get money? And then she say, they get money from the government. Every month, I think it's the man that they give refugees or the asylum seekers, the ones that don't have rejection because they always give them, like, €70 every 10th in the month." (co-researcher about his interview with a Congolese woman, 25 years)

5. Ability to Engage

The ability to engage involves women's capacity to interact with care providers.

- **5.1. Empowerment**: Limited capacity to communicate, coupled with a lack of confidence, affects women's empowerment in expressing their healthcare needs and preferences. Challenges in self-respect and dignity (e.g., being asked to wait multiple times) further impact women's ability to actively engage in healthcare decisions.
- **5.2. Stigma and/or shame**: Stigma and shame are associated with engaging with interpreters from the camp community, creating barriers to effective communication and potentially hindering women from expressing necessary information during treatment.

"I took my mom to the hospital. My English is not very good but they don't let me translate for her because I am under 18. Once, we had to wait three hours for the interpreter." (Afghani woman, 17 years)

"When I was pregnant, sometimes it was difficult for me to open up to the doctor because, me and my husband, we knew the interpreters. Sometimes, it was difficult to explain my female problems." (Congolese woman, 33 years)

Key Informant Interviews (KIIs)

8. Key Informant Interviews

8.1 Methods

For the KIIs an interview guide was developed following a) review of the literature and b) building on the preliminary analyses of the household survey, facility assessments, FGDs and PEER interviews. Topics included:

- SRH service provision (including client-refugee relations as well as coordination and collaboration between actors)
- Perceived health and social needs of refugee women
- Factors influencing women's access to SRH services
- Factors influencing the delivery of SRH care to refugee women
- Proposals for improvement

8.1.1 Sampling

Key informants were selected based on the following criteria:

- Experience working in the field of refugee health (either directly or indirectly); and/or
- Likely to add valuable insights into the opportunities and challenges in delivering SRH services to refugee women; and/or
- Likely to add insights into the preliminary results found in the household survey, facility assessments, FGDs and/or PEER interviews; and
- Representing various stakeholders. Therefore, care was taken to interview at least one representative from each of the following institutions:
    - Ministry of Migration and Asylum
    - Ministry of Health
    - National Public Health Organization (EODY)
    - UNHCR
    - European Commission
    - Local hospital offering SRH services to refugees
    - Local medical NGOs offering SRH services to refugees
    - Local non-medical actors offering GBV or safe spaces services to refugee women
    - Community representatives.

8.1.2. Recruitment and Data Collection

Key informants were approached through email or phone and interviewed in person or through Microsoft Teams in either Greek (by one of the master's students) or in English or Dutch (by the principal investigator). Verbal and/or written consent was obtained and interviews were recorded. Interviews were conducted between October and December 2023.

8.2. Analysis

For the purpose of this report, interviews were transcribed ad verbatim and underwent a thematic analysis. Both the principal investigator and one of the master's students coded both inductively as well as deductively following Levesque's patient centred framework of healthcare access. Due to time constraints, it was not possible to plan for a thorough discussion between the two coders. This will follow at a later stage. Relevant quotes were selected for the purpose of illustrating the findings.

8.3. Results

8.3.1. Coordination and Collaboration

Collaboration

a) **Within teams**

Teamwork was highly regarded. Various key informants stated how team-members working in refugee health were **"working from the heart and not the head"** (state actor) and **"we are not only a team of coordinators and colleagues, we are friends."** (medical actor inside camp)

> **"I have a good team, we are a good team. There is good cooperation, everyone wants to work. Everyone is running, especially with the new arrivals which have increased… We are seeing everyone, we are trying."** (medical actor inside camp)

b) **Medical NGOs and other medical NGOs**

Key informants unanimously agreed that collaboration between the different medical NGOs was extremely good, especially since the number of NGOs had reduced and therefore NGOs depended more on each other. However, sometimes a lack of communication between the medical actors meant that there was a duplication of efforts, as explained below:

> **"However, it has happened many times, a patient has given blood sample twice, for no reason. This is a collaboration issue."** (medical actor inside camp)

c) **Medical NGOs and non-medical actors**

There were differences in opinion regarding the collaboration between medical and non-medical actors. For mental health for instance, referrals were found to be effective with non-medical actors referring to the medical actors proactively. It was also noted how beneficial it was that for instance the WASH sector attended the medical meetings. However, especially when it came to the management of GBV, key informants were of the opinions that referral pathways were unclear, and that a lack of a GBV focal point jeopardized care.

d) **Medical NGOs and the hospital**

Overall, collaboration between medical NGOs and the hospital was not seen to be optimal. This was mainly due to:

> **"trust being broken by flagging everyone as emergency cases and not conducting proper triage"** (Non-medical actor outside camp)

Key informants also mentioned that some NGO volunteers have lacked understanding of the local sociopolitical context, with their stays being too short to really grasp and understand the circumstances their local colleagues were working in. Humility was seen as key:

> **"I'm talking about the volunteers and the people who come to work. They have not realised what it is living on an island, so they behave like we are in Amsterdam. He does not have the time to understand, he just comes in and says: "OK, this is very easy, why don't we do it like that?"** (state actor)
>
> **"Many times the referral that accompanies the woman who comes in the ER has nothing to do with reality. In other words, we are told that she is giving birth and from the examination she is not even pregnant.. And we examine her, take her record, all over again."** (Medical actor outside camp)
>
> **"Just writing papers and sending them to the hospital: that backfires. Then the circle of trust is broken"** (state actor)

When collaboration did go well, this was often because the NGO had a Greek doctor working for them who:

> **"know the doctors from the hospital and they know that we are here to filter the population and we try to not send them all without the criteria."** (medical actor inside camp)

Once again this highlights the importance of not overburdening the hospital with primary care cases.

e) Actors with regional/national authorities

Collaboration with regional authorities in Mytilini was seen to have improved over the years, with for instance GBV collaboration efforts with the Municipality and the police working well. However, NGO coordinators expressed that they often did not feel seen by their national superiors. As one of the key informants put it:

> **"There is a huge gap between the vest (referring to the fieldworker) and the suit and the tie (referring to the policy makers)."** (state actor)

Mutual understanding was emphasized from all parties.

> **"The person who has never worked in the field is in trouble - he cannot make the right decisions. He cannot prioritise the right things. But if a person with a vest has never gone through what the people with the suit and tie have to go through, he will not understand either."** (state actor)

f) Authorities within Europe

Similarly, the key informants from the ministries explained how they did not feel seen by the larger European political landscape.

> **"Do we get the support? We do not even get the understanding. It's not a matter of financial support."** (state actor)

Coordination

Where collaboration was generally seen to be going well, key informants were more critical of coordination efforts. The main challenges being:

a) Duplication of efforts

Multiple key informants mentioned how the lack of coordination resulted in the creation of parallel systems, for instance for patients going to the hospital for blood work, but also in the

> **"double case management. Double trainings. Waste of resources for no reason."** (non-medical actor)

b) Lack of information and follow-up

Although the medical meetings in camp were appreciated, the fact that they were often cancelled was seen as an important challenge. Moreover, key informants felt that the lack of accountability on action points as well as the lack of feedback mechanisms hindered the delivery of quality care. One key informant mentioned how information between medical actors in camp was not always accurate:

> **"Sometimes I receive referrals of things that we do not do, and have never done."**

When correct referrals between medical actors did take place, it was unfortunate that feedback on the referral did not always reach the healthcare worker. Moreover, changes (for example on opening hours, referral pathways etc.) were sometimes not adequately communicated to the respective teams. Additionally, the lack of data (showing trends for GBV or FGM for instance) was seen to impede interventions and adequate responses:

> **"Now, how can we advocate if we do not have the information? I am seeing people with trafficking but it is not officially being monitored. The same with FGM. Then we can adapt our training to it for instance."** (non-medical actor)

c) Bureaucracy and administrative barriers

Key informants noted how administrative barriers hampered the delivery of care through either blocking certain NGOs from working in camp, or suggestions for improvement or referral pathways taking long to approve at ministerial level.

8.3.2. SRH Needs

Main Needs

Amongst the main health needs, key informants identified needs similar as those expressed by the women in the FGDs, namely:
a) Food, including multivitamins and baby-milk for mothers with children;
b) Accommodation (especially after childbirth) ensuring privacy and silence;

"Living in such an unsafe space. Where there's never silence. Where the food is terrible. I think this is disastrous for mental health." (medical actor inside camp)

c) Information and health awareness;
d) Security: this included safe bathroom facilities, especially after dark;
e) Care for gynaecological infections;
f) Care for GBV.

Particular Concerns

Key informants mentioned the following specific concerns:

a) **Transactional sex**

Multiple key informants also voiced concerns about transactional sex occurring in camp.

"We are doing community outreach and have heard stories about transactional sex and this is very worrying. We have informed the camp manager, we have informed all the working groups, but we are not seeing many things going on." (non-medical actor)

b) Increased mental health needs

A number of key informants mentioned the increasing mental health needs of the women, coupled with social determinants of health, such as crowding and subsequent sleep deprivation, registration, but also complex grief due to loss in country of origin (Palestine for instance) or en route, as described below:

"We have had to bury 6 children this past year, of whom the parents did survive the crossing. That is not ok." (non-medical actor)

"They need to be referred and therefore, they need to be registered. So as long as people are not registered they cannot see a psychiatrist. And then there's a waiting list. This is this is something I am very worried about." (medical actor inside camp)

c) **Post-natal care**

Key informants unanimously agreed that post-partum care was challenging, especially under the current living conditions in camp. As one of the key informants put it:

"And within 3 days you have to return to the camp amidst the dust and the stench, where I go for 1-2 hours and then I take a bath to get the dust off of me. She must come back open, with the baby in her arms in the dust, inside the camp." (non-medical actor)

8.3.3. SRH Challenges

a) **Interpretation services**

By far, the greatest and most recurring challenge key informants mentioned was the lack of gender-specific interpretation services. Key informants felt that this would solve a multitude of challenges, including the lag in registrations, ability to offer quality services, but also foster understanding between healthcare professionals and refugees and decrease racism.

> **"One of the problems is fear of the unknown. And if things were easier with the communication, I don't think we would have this problem. The system pushes the racism."** (medical actor outside camp)

b) **Human resources**

Most key informants spoke extensively about the lack of capacity within their organization to meet the increasing number of health needs of women. This was seen to be secondary to NGOs leaving Lesbos, being denied access, or not having enough staff. As one of the key informants reflects:

> **"So back then we had doctors and we didn't have the equipment. Now we have equipment we do not have doctors."** (non-medical actor)

The low number of medical personnel in the public sector in particular are thought to be because working on the island is not considered attractive: due to the complexity of the healthcare problems, the challenging environment but also the job insecurity.

> **"Why? I can easily tell you why. First of all, it is difficult to practice medicine in an island because it is isolated. You are the doctor and you are supposed to take care of a child being born to an old guy who has cancer and he's dying. So you have to practice the whole spectrum of medicine there and you are completely alone. And there's these ideals of personal security, you know, and this is a temporary programme, so why should I invest into moving to the islands?" (non-medical actor)**

c) **Increasing numbers in camp, lagging registration, complexity of care needs**

Hand-in-hand with the above worry were the large numbers of unregistered refugees who could not leave camp for medical care. In some cases this posed serious risks to health, like for example the continuation of HIV treatment. Coupled with this were fast and sudden transfers which sometimes meant women were unable to obtain a vulnerability certificate after GBV. It was also mentioned how women often had complicated medical histories, for instance when they would come to the hospital for a C-section. Addionally, the legal status of women was an important barrier for the delivery of timely care, as one of the key informants explained:

> **"Due to the geographical restriction, they cannot move to the mainland for their treatment, even if the hospital provides them a medical certificate that certifies that she should go to a tertiary hospital in Athens. Very few women have been transferred to Athens for medical reasons." (medical actor outside camp)**

d) **Funding**

Many of the key stakeholders had seen a drop in funding over the years, which challenged their delivery of care, including the provision of medication. As one of the key informants put it:

"We need more help, more funds, more attention. Lesbos is not front-page news anymore. For that, a ship with 750 people needs to sink." (non-medical actor)

e) **Accountability**

Key informants from the NGO sector felt that there was a lack of response from their Greek colleagues:

"We tried to cover the gap, but as you know, we are not responsible for the whole camp, for the whole population and for the change of the situation. Our job is to help for a specific reason in a specific timeline." (medical actor inside camp)

Simultaneously, medical actors outside camp felt that they were also being made to accept responsibilities above their capacity:

"For example, there was a woman to whom a 5th or 6th caesarean section had to be done. hysterectomy is an operation with high mortality. we cannot deal with such a serious case in a small provincial hospital. There was a referral to a tertiary hospital in Athens, but the woman was not transferred, we had to do the surgery here with too much fear..."

f) **Transportation**

Transportation to and from the hospital in particular was seen as a major challenge for the delivery of adequate care, from both the perspective of the medical actors in camp as well as the hospital.

g) **Lack of continuity, capacity and experience of personnel**

Finally, the high turnover of personnel in both the medical as well as non-medical sector was seen to impede culturally sensitive services.

"If you see a woman with diabetes multiple times, you know her name and build a relationship then this helps against racism and discrimination as well." (medical actor outside camp)

"Not staff that have done 100 trainings but have not worked in the field and have not the experience how it is to work with cases of GBV. It is not only about the training." (non-medical actor)

"To work in a refugee camp takes a specific skill-set. You cannot just take someone from medical school and just drop them here." (non-medical actor)

Key informants mentioned how the work with this particular group of patients required a wide skillset from them, often outside their primary area of expertise. The following quotes are illustrative of this:

"I am not only a doctor, I am also a psychologist. If a woman has experienced rape, we sit and cry together." (medical actor inside camp)

"Yes, I also do psychological first aid at my legal appointments." (non-medical actor)

8.3.4. Access to SRH Services

The below sections summarise the demand, as well as supply-side barriers and facilitators that were mentioned by the key informants, organized as per Levesque's patient-centred framework:

Supply-Side Barriers and Facilitators

1. Approachability

1.1. Information: some key informants mentioned how "not everyone is aware of our services in camp." (medical actor in camp). Additionality, challenges in communication (often secondary to language barriers) meant that information was not always well delivered, as in the example below:

"Sometimes they come, we've made an appointment for blood and they probably haven't been informed properly and they ask me what I'm doing here? Why am I donating blood? So you explain, you're pregnant, for example, that's why." (medical actor in camp)

1.2. Outreach: three key informants explained how and why they would have preferred to do more community outreach had they had the resources to do so.

1.3. Transparency: to some extent key informants felt that the visibility of the services they were offering in camp was not always clear.

2. Acceptability

2.1. Gender: certain NGOs employed female healthcare professionals which was seen to ease access to care.

2.2. Professional values: key informants mentioned how some of their colleagues sometimes demonstrated discriminatory tendencies. Additionally, it was felt that the lack of ownership over case-management in the hospital in the Greek system, where private appointments with women often complemented the appointments in the hospital, were another reason women did not always receive optimal care. On the other hand, it was mentioned how a respectful and kind nature and taking one's time were conducive to access. Accompanying women to the hospital was also perceived as a facilitator.

3. Availability and Accommodation

3.1. Availability of services: key informants mentioned how the clinics in camp were not always ideal and how the absence of a safe space for women was unthought-of:

> **"There is no woman's space is camp, yet this is the most basic thing to have in each camp, I don't know why this camp is the exception in Greece."** (non-medical actor)

3.2. Opening hours: key informants recognized that the opening hours of services were not always in line with refugee women's preference or availability and noted how the presence of just police out of hours meant that unnecessary referrals to the hospital were often made.

3.3. Staffing: Various key informants spoke about the lack of experienced staff as a challenge. The high turnover of staff, as well as their relatively short stay meant staff did not always comprehend the system they were working in nor were they able to build trust with patients.

> **"I don't think everyone always feels as comfortable and it's very difficult to let people understand the topic (referring to GBV) if they're only here for three months. Or six weeks sometimes. And so this is the difficulty. How do you provide (your team) all the information in such a short period of time and they need to apply it straight away?"** (medical actor in camp).
>
> **"NGO's staff is constantly changing. The new staff is not properly informed about the procedure that we follow and it becomes a mess."** (medical actor in camp).

This was seen as a disadvantage, but at the same time key informants recognized that longer stays in the refugee camp under strenuous working conditions could be too taxing on the staff.

> **"But they need to calm their mind. To prioritise their health, their mental health."** (medical actor in camp).

Additionally, the safety of medical personnel could not always be guaranteed, as this doctor explains:

> **"In Moria, our lives were endangered several times. I had to resign because I had received threats by a minor addicted to substances. In CCAC, it is much better."** (medical actor inside camp)

3.4. Professionalism: key informants mentioned the importance of professional, clean and private waiting rooms and consultation rooms. In case these were present, they were seen to improve access to care. When absent, the opposite was experienced:

> **"It's difficult to go and wait in a waiting room where there are men, women, children, from all different cultures"** (medical actor inside camp)

4. Affordability

4.1. Direct costs: key informants mentioned how the free services they offered were a facilitator to women seeking care, but that it was not always clear that services were free of charge. Additionally, certain diagnostics or procedures were not offered for free and could impede access to healthcare, such as for intra-uterine devices or vaginal cultures:

> **"Vaginal fluid cultures are not done in the hospital, so all of them, Greeks and non-Greeks, have to go to private clinics."** (medical actor outside camp)

4.2. Indirect costs: the indirect costs of transport to and from the hospital was repetitively mentioned as a barrier to accessing care.

5. Appropriateness

5.1. Staff: key informants mentioned how staff sometimes lacked cultural sensitivity or awareness of the conditions that their patients lived in.

5.2. Timeliness: where long waiting lists were perceived by many key informants as a barrier to care, it is worth mentioning that having many medical services available in camp was also seen to be beneficent to women.

> **"A positive factor I would say is that everything is done here, most of them do not need to leave, to go to the hospital. They know that the midwives will open a medical file, check the pregnancy, they will do the tests, they don't even have to leave, go to the hospital, give blood, come back and go get the results. They know that there is a gynecologist for further check-up and again, there is no need to go to the hospital unless the gynecologist says so. So that's what I would say is a plus in terms of access, that you come to one place and you do almost everything."** (medical actor in camp)

5.3. Funding: lack of funds were perceived as one of the largest challenges to quality care.

> **"We don't have budget for this through the funds. Yes we have a small amount, let's say for medicines, but it is for 2000 people, not for 6000."** (medical **actor in camp)**

Demand-Side Barriers and Facilitators

1. Ability to Perceive Need for Care

1.1. Health literacy: key informants noted how some women had low levels of health literacy, for instance not being aware that they had had FGM in the past or about gynecological conditions. Similarly:

> **"Look, since many of the women are also victims of gender-based violence and have suffered some type of sexual abuse, either in the distant past, or during the journey, or inside the camp, there are a lot of such issues. There is a lack of information and many women do not even know that they should contact a special service."** (non-medical actor)

1.2. Health beliefs: certain health beliefs, especially pertaining to contraception, were seen to impede access to healthcare.

1.3. Trust and expectations: key informants also stressed the importance of trust in either forming a facilitator or barrier to access.

2. Ability to Seek Healthcare

2.1. Personal values: one key informant noted how women often gave priority to the health of their children or partners as opposed to themselves.

2.2. Social values: stigma surrounding abortion as well as GBV was mentioned as a barrier to care.

2.3. Autonomy: one key informant pointed out how women were not always aware of their right to healthcare and the available options, especially when it came to abortion. Also some key informants mentioned when it comes to married women, their husbands were involved in the decisions concerning the women's health and were "representing" the family during the dissemination of important information.

3. Ability to Reach Healthcare

3.1. Social support: key informants mentioned how women often did not have the social network to take care of their children while they sought care.

3.2. Legal hurdles: due to geographical restrictions, it sometimes occurred that women were unable to access healthcare on the mainland, despite referrals from the hospital.

> **"We always escort our cases to the hospital. So the visits will be with one of us. So it's hard for anyhing to go wrong with our presence."** (non-medical actor)

3.3. Transport: getting to and from the hospital was seen as a barrier. Some NGOs facilitated this for the women by accompanying them:

4. Ability to Pay

As mentioned previously, legal status was seen to impede access to healthcare since women who had received a rejection were expected to pay for healthcare themselves. Another economic barrier is to pay the tickets for the local bus to go to the hospital and get back.

5. Ability to Engage

5.1. Language: most importantly, the lack of gender sensitive translation was highlighted over and over again impeding women's ability to engage with healthcare.

Figure 36: Dissemination session with the actors in camp in September 2023.

Co-Creation of Solutions

9. Co-Creation of Solutions with the Co-Researchers

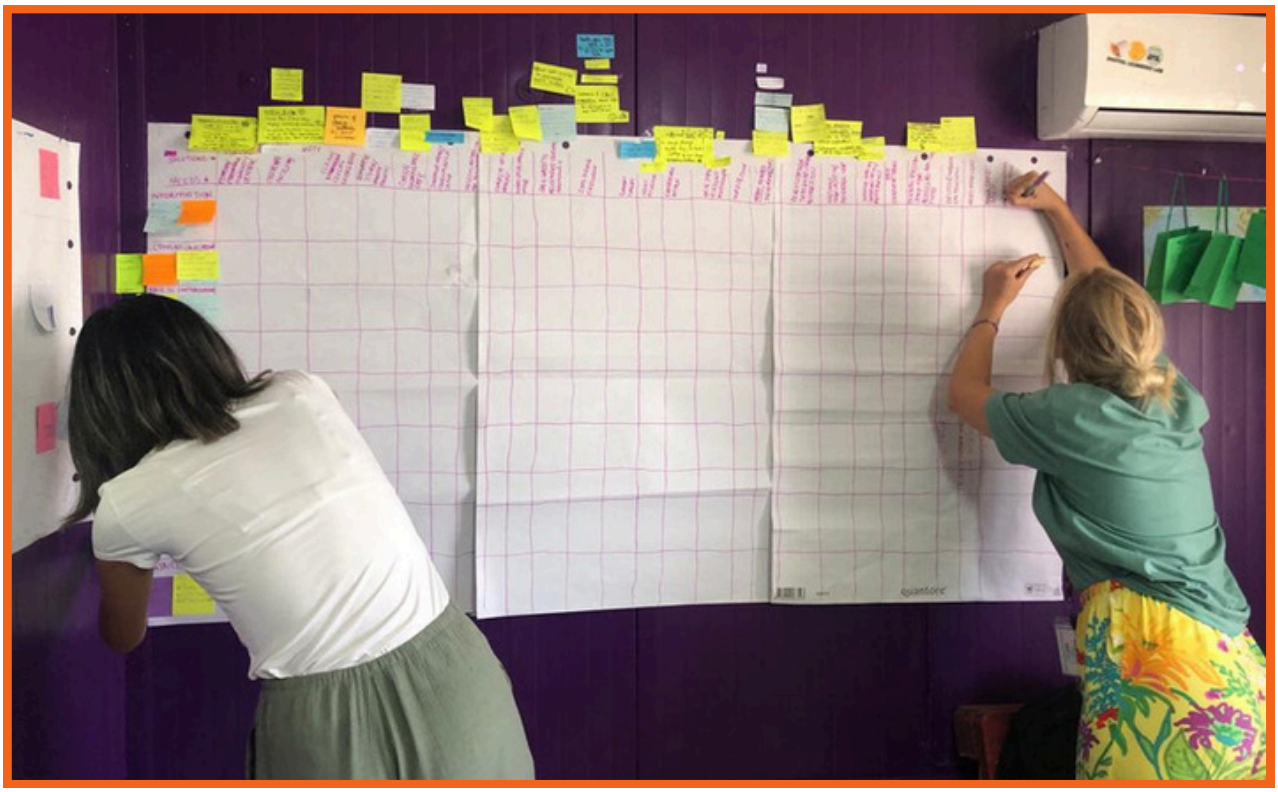

Figure 37: Generating a solutions matrix with the whole research team.

The co-creation workshop amoungst the team took place after the household surveys, focus group discussions, PEER interviews, and sense-making of results sessions. The co-researchers were asked to reflect on key themes that came up during the data collection process. A matrix is a grid-based diagram used in PLA to show correlation. As shown in Figure 32, the left-hand vertical axis are the needs and the top horizontal axis are the solutions. The co-researchers were first asked to write down the top three needs they identified through their reflection and similar needs were grouped together. The next step involved discussion of solutions for each corresponding need. Once the matrix was set up, each member of the research team was given 50 pins to vote on the needs that they thought were most important and the corresponding solution. This method thus allows to broaden one's perspectives as solutions that were not initially associated with a given need may actually be identified as an effective solution for multiple needs. This enables you to assess the effectiveness of a solution.

Top **seven** solutions identified by co-researchers out of the **45** co-created solutions:

1. More Female Interpreters
2. Proper Informed Consent for FGM Vulnerability Check
3. Make Legal Process Fair
4. Community Center
5. Sensitization Training for Greek Authorities
6. Increase Interorganization Communication / Referrals
7. Central Digital Space For Accessing Application Status

Discussion

10. Discussion

10.1. Main Findings

The data obtained from our study highlights crucial healthcare, mental health, and well-being challenges among women in CCAC Mavrovouni. Tailoring information dissemination strategies is essential, given the diverse preferences across different categories. Moreover, challenging stereotypes, acknowledging varying education levels among refugees, and empowering individuals to leverage their expertise for solutions are vital.

Safety concerns for women traveling alone to Greece as well as living alone in camps are high, due to potential violence, along with risks associated with intimate partner violence, and need to be addressed comprehensively. Access to healthcare remains problematic, with high perceptions of denial of care, dissatisfaction with treatment, and barriers like partner control and reproductive coercion requiring deeper examination.

Improving postpartum care, mental health support, and reproductive health services is crucial, considering high rates of postpartum complications, such as anxiety and depression. Flexibility in family planning initiatives is necessary, given varied contraceptive use and preferences across different populations.

Urgent attention is needed for fertility treatment, low STI and HIV testing rates, limited access to treatment for conditions like FGM and cervical cancer screening, and barriers to abortion access. Despite access to menstrual materials, challenges in obtaining them persist, alongside high rates of menstrual pain. Gynecological symptoms prevail significantly, demanding comprehensive interventions and improved access to gynecological care and screening services. The high rate of suicidal thoughts and mental health scores underscore the urgent need for enhanced mental health services.

The prevalent rates of verbal, physical, and sexual abuse among the women are concerning and warrant condemnation. Instances of such abuse exacerbate the already vulnerable situation of these women, further compromising their safety, well-being, and mental health. Addressing and combating this alarming trend of abuse is crucial to ensure the safety and dignity of these individuals. Comprehensive measures and policies must be implemented to prevent and respond to instances of abuse, offering protection and support to those affected while holding perpetrators - including the coast guard and law enforcement - accountable.

Implementing actions at camp, national, and EU levels - such as tailored information dissemination, increased number of SRH healthcare workers, increased number of female translators, improved safety measures, enhanced healthcare access, mental health resources, and policy changes - requires collaboration among NGOs, healthcare providers, policymakers, and community leaders to ensure comprehensive support for women living in refugee camps.

10.2. Strengths

Our research study stands out due to its robust and inclusive methodology, incorporating a participatory, community-owned approach that ensures the active involvement of key stakeholders throughout the research process. This approach not only fosters a sense of community ownership but also enhances the relevance and applicability of our findings.

The utilization of mixed-methods further strengthens the study by combining quantitative and qualitative data, providing a more comprehensive understanding of the phenomenon under investigation. Our study design addresses both the supply and demand aspects related to sexual and reproductive health for our study population, offering a holistic perspective on the subject matter.

The commitment to quality is evident in every aspect of our research, from data collection to analysis, with a strong validation process in place to ensure the reliability and accuracy of our results. The emphasis on methodological rigor and community engagement positions our research as a valuable contribution to the field, offering insights that are not only academically sound but also practically meaningful for the communities involved.

10.3. Limitations

Despite the strengths of our research study, it is essential to acknowledge and address certain limitations that arise from the dynamic nature of the environment in which our study is conducted.

The ever-changing landscape introduces challenges in maintaining a static and consistent research context, potentially impacting the reliability of our findings. During the period of our fieldwork in the camp, the camp population witnessed a substantial doubling in size from our initial arrival to the conclusion of our study. Specifically, during late July 2023, a phase characterized by significant transfers of individuals, it became increasingly challenging to locate and engage participants. Consequently, the selection process for participants became less random, relying more on the availability of individuals from specific origin countries due to the difficulty in finding willing participants amidst the camp's dynamic population changes.

In terms of the quantitative arm of the study, the underreporting of sensitive topics, such as abortion, gender-based violence, pushbacks, and education, poses a challenge to the comprehensiveness of our data. It is crucial to recognize and transparently address these limitations to ensure a nuanced interpretation of our study's findings and to inform future research endeavors in similarly dynamic and culturally sensitive environments.

The study had other limitations, including not systematically tracking the response rate, potential inconsistencies in age reporting, difficulty in counting time displaced from home, possible dishonesty regarding education background and pushbacks, and potential underreported response rate for the LGBTQ+ question.

Future studies should consider asking about partners and whether the children are living with them in camp, and be sensitive to individuals' hesitancy to share their experiences. It is also critical that future studies deliberately involve high representation of marginalized groups, such as those with disabilities and those who identify as LGBTQ+. It would have been helpful to allow respondents to indicate if they were still waiting on a response regarding their legal status and to clarify the definition of "legal status" for the question on being denied medical care.

Further suggestions include adding options for respondents who were unable to seek care, asking about the dignity of care, and adding questions about whether symptoms were treated. Due to a lack of hesitancy to consent certain sections in the survey, either due to lack of relevance or stigma, there was a selection bias in some of the sections, such as the FGM section, in which a notable proportion of the respondents are those who experienced FGM.

For future surveys, it is suggested to combine STIs and gynecological symptoms and to remove irrelevant answer choices related to reusable menstrual materials. Other improvements include asking about miscarriages on the route to Greece, access to the morning after pill and determining whether respondents are sexually active before asking family planning questions.

Additionally, for future studies it is recommended to asking about all FGM-related symptoms, including lack of pleasure and sensitivity, difficulties during menstrual period and difficulties during delivery. Additionally, questions about whether respondents wanted an abortion should be added, and the abortion complications question should be available for women who recently had an abortion before arriving in camp. The survey should also include questions about where respondents get their information and where they prefer to get information for the mental health and gender-based violence sections.

On the other hand, in terms of the qualitative arm of the study, the presence of a male co-researcher and notetaker who were rooted in the local community during Congolese focus group discussions revealed a gender-related limitation. Two women expressed reservations about discussing sensitive issues, specifically SGBV, due to concerns that the two men would tell the details to their husbands/partners. This limitation underscores the need for careful consideration of cultural nuances and power dynamics within the research team.

Conclusion

11. Conclusion & Next Steps

The design methods of this study proved revolutionary as it seamlessly combined qualitative and quantitative research, examining both the supply- and demand-sides of SRH in camps for women of reproductive age. This comprehensive method provided a vivid understanding of their needs, expectations, and the myriad factors influencing access to services. Additionally, it shed light on the available services, offering a complete picture of the SRH landscape.

The participatory approach wasn't just feasible; it was absolutely essential. It not only expanded the focus to encompass key determinants, but also amplified advocacy for best practices during research, especially concerning GBV sessions.

This study underscores the fact that addressing SRH transcends mere healthcare provision. It involves a multifaceted approach that considers care, material, and nutritional needs, as well as community support, social factors like religion and prayer, and various other components.

All of these efforts take place against the backdrop of escalating pushbacks and threats faced by migrants choosing the sea route to Europe. Simultaneously, Europe is leaning towards anti-migrant policies, creating additional challenges for refugees and displaced populations. Amidst these complex circumstances, it becomes even more imperative to center the voices of refugees and women in camps in decision-making processes concerning their SRH. By collaborating across sectors, we can advocate for comprehensive solutions that not only address healthcare but also encompass the broader spectrum of needs, fostering empowerment, equity, and dignity for all individuals, irrespective of their migrant status.

In realizing the holistic nature of sexual and reproductive health, it's time to amplify the voices of refugees and women living in camps. Their insights are invaluable in shaping inclusive strategies. Let's collaborate across sectors, involving communities, NGOs, and governments. By prioritizing their participation, we honor their dignity and empower them to create impactful solutions tailored to their needs. Together, let's champion a future where everyone has a say in decisions that affect their sexual and reproductive health, fostering empowerment, equity, and well-being for all.

Figure 38: Teamwork makes the dream work.

Together, let's champion a future where everyone has a say in decisions that affect their sexual and reproductive health, fostering empowerment, equity, and well-being for all.

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13. Appendix

13.1 Outline of the FGDs

Section 1: Exploring SRH Needs and Expectations of Care

Activities	Time
Introduction • Introduce yourself • Introduce the project (research) • Give a definition of SRH and introduce each SRH sub-topic • Introduce today's program (2 hours – lunch – 2 hours) • Informed consent and ask for permission to record! • "Are there any questions?" • Establish shared ground rules (e.g., no need to share anything that you do not feel comfortable with, no use of phones during the session, etc.)	15 minutes
Icebreaker • You can choose your own icebreaker – remember for it to be inclusive, to build trust, and for everyone to speak (e.g., everyone has a phone) • Example: Show your neighbor a) your most recent picture and b) a picture that means something to you	15 minutes
SRH Needs (Flexible Brainstorming) A) "What do you need to feel content with your sexual and reproductive health?" • Give participants time to think and write/draw • Post-its and/or Dixit pictures B) Sharing and discussion • One person starts sharing. Ask the group who has something similar. If no one answers, move to the next person. • Ask follow-up questions. Example follow-up questions: ◦ "What does X mean to you?" ◦ "Why does Y happen?" ◦ "How do you feel about Z?" C) Brief check-in with Jamilah and Greta • Questions from the topic guide	A) 10 minutes B) 40 minutes C) 20 minutes
Expectations of Care (Discussion) • What does "good quality care" mean to you? ◦ Follow-up questions: What does X (e.g., trust, respect) mean to you? Which characteristics in a healthcare professional encourages you to seek care? • What are aspects of care that you are satisfied with? Why? • What are aspects of care that you would like to improve? How? • Under what circumstances do women feel in control of their SRH (e.g., related to C-sections that women undergo but do not want)?	20 minutes

Section 2: Access to SRH Services and Care

Activities	Time
Perceptions of Camp (Community Mapping) A) "Draw your community and where women go to get services and support for their SRH" • They can use stickers, props, coloring pencils. • Give the participants time to draw and do not intervene in this process. Instead, observe and take notes. B) Afterwards, ask: "Could you explain to me what you have drawn?" • More example follow-up questions: ◦ "Why did you decide to draw A first?" ◦ "Why did you draw B bigger/smaller?" ◦ "Why did you leave C out of the drawing?"	A) 15 minutes B) 15 minutes
Access to SRH Services and Care (PhotoVoice) A) Walk around the camp and take one picture for each question: • "What makes it **easy** for women to get SRH services?" • "What makes it **difficult** for women to get SRH services?" • If the woman does not have a phone: encourage her to walk around and take mental pictures to speak about later. • Ask the women to send the pictures to the facilitator through WhatsApp. B) Sharing and discussion • Ask the women one by one to explain their two pictures • Remember to ask follow-up questions C) After all the pictures have been discussed, **probe** with the questions about different steps of access to care (see questions in the topic guide): 1. Understand that you have a health problem 2. Deciding to seek care 3. Reaching services (going) 4. Paying for services 5. Interacting with services Example probe: "We have spoken a lot about women's ability to reach services physically. What do you think are factors that make it easier or more difficult for women to understand/become aware that they have a health problem?"	A) 30 minutes B) 40 minutes C) 20 minutes

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