People and services in transit: a scoping review on access to sexual and reproductive healthcare for refugees in camps and informal settlements in the WHO European region

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2021/22

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People and services in transit: a scoping review on access to sexual and reproductive healthcare for refugees in camps and informal settlements in the WHO European region

A thesis submitted in partial fulfilment of the requirement for the degree of Master of Science in International Health

By

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Master of International Health
February 2021 – February 2022
KIT (Royal Tropical Institute)/Vrije Universiteit Amsterdam
Amsterdam, The Netherlands

February 2022

Organised by:

KIT (Royal Tropical Institute)
Amsterdam, The Netherlands

In co-operation with:

Vrije Universiteit Amsterdam (VU)
Amsterdam, The Netherlands

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4 ABBREVIATIONS

ANC	Antenatal Care
BRF	Boat Refugee Foundation
CSO	Civil Society Organization
EU	European Union
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning
HIC	High-Income Country
HIV	Human Immuno-Deficiency Virus
HRW	Human Rights Watch
IAWG	Inter-agency Working Group on Reproductive Health in Crises
IDPs	Internally Displaced Persons
IOM	International Organization for Migration
IRC	The International Rescue Committee
IUD	Intra-Uterine Device
LMICs	Low- and Middle-Income Countries
MDM	Médecins du Monde
MeSH	Medical Subject Heading
MH	Maternal Health
MSF	Médecins sans Frontières
NGO	Non-Governmental Organisation
RIC	Reception and Identification Centre
SDG	Sustainable Development Goal
SGBV	Sexual and Gender Based Violence
SOGIESC	Sexual Orientation, Gender Identity and Expression, and Sex Characteristics
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UAMs	Unaccompanied Minors
UHC	Universal Health Coverage
UN	United Nations
UNHCR	United Nations High Commissioner on Refugees
WHO	World Health Organisation
WRC	Women’s Refugee Commission

5 ABSTRACT

5.1 Introduction

Reviews addressing access to sexual and reproductive health (SRH) services for refugees are either limited to low- and middle-income countries (LMICs) or focus on countries of destination. In order to strengthen SRH responses for refugees residing in formal camps and informal settlements in the WHO (World Health Organisation) European region, this scoping review summarizes the evidence on (the factors influencing) their access.

5.2 Methods

EMBASE, MEDLINE and Web of Science were systematically searched for quantitative, qualitative and mixed-methods studies published from 2012 onwards, supplemented with grey literature. From 1951 screened records, 41 studies across 12 countries were included: 24 peer-reviewed and 17 grey literature. Data was extracted using standardized templates and charted using qualitative content analysis. Barriers and facilitators were mapped onto Levesque et al.'s (2013) ten-dimension framework (five supply-side dimensions and five demand-side abilities).

5.3 Results

Unmet family planning (FP) needs and inadequate use of ante- and postnatal care indicate poor access, but studies are limited to Turkey. 246 barriers and 19 facilitators across predominantly the supply-side domain of Levesque's framework emerged. Important barriers include absence of gender-sensitive services, staffing challenges and language barriers. Poor leadership and coordination result in ad-hoc services that are inadequately transitioning to comprehensive care. Refugees in transit prioritise reaching their final destination over their immediate health needs. Lack of trust in the healthcare system and poor health literacy further reduce access. An adapted version of the framework, incorporating the overarching themes of language and the refugees' transient nature, is better suited for this population.

5.4 Conclusion

The SRH landscape for refugees in the WHO European region is characterised by a fragmented system of emergency services provided to a population who prioritise reaching their country of destination. My strong conviction is that by strengthening the availability, continuity and quality of the 'in transit' services, we will sufficiently lower the threshold for the 'population in transit' to receive their entitled care.

5.5 Key words

Sexual and reproductive health
Access
Refugees [MeSH]
Refugee Camps [MeSH]
Europe [MeSH]

5.6 Word count

12996

6 PROLOGUE

This column, titled 'Gepruts op Hoog Niveau' (Institutional Clumsiness), was previously published in the NTvG (Dutch Journal for Medicine) in February 2021.[1] I translated it to English for the purpose of this thesis:

'It seemed as if some clumsy healthcare worker had been too lazy to remove the old one before inserting a new one. But she insisted: 'I've never had an implant, doctor.' Disbelief in my voice: 'Then what is it?' Wide eyes: she didn't know. Her friend was more outspoken: this swelling was the cause of her pain and sleepless nights, something had to be done. I palpated again - perhaps they had not had a surgical kit available in Congo? Or maybe they hadn't wanted to remove the old one without adequate anaesthesia?

Elisa was one of the many patients we regularly received in our clinic with psychological problems: unexplained abdominal pain, suicidal thoughts, insomnia. She was here with her daughter, having fled sexual violence and other misery in her home country. The lockdown had not been particularly conducive for her mental health. Nor had the threat of corona. Or the fire that destroyed all of Moria[i] in September.

One would expect that the accumulation of all these tragedies would finally motivate Europe to adopt a more humane asylum policy. For a moment we were hopeful; petitions were signed, demonstrations held, newspaper articles written. The EU held meeting after meeting and the Netherlands was to receive 50 unaccompanied children. But soon attention shifted back to other - equally important - matters. For institutional discrimination does not halt at the border of Europe,[ii] the lockdown causes unrest in the Netherlands too and our own children are struggling with psychological problems just as much.

And thus Elisa still finds herself on Lesbos. In the new camp, where conditions are many times worse than in the old one. Fortunately, I am told, she is in less pain, her eyes are less dull and she sometimes even smiles - we removed a bullet from her arm back then.

'No more Morias' was the promise in September.[iii] Agreements were made regarding an accelerated asylum procedure, more solidarity between EU member states, the decriminalization of sea rescues. But what was not discussed was the pertinent question of why people like Elisa reside in such miserable camps in the first place. What should have been a 'fresh start' turned out to be more of a sour wind: the debate loiters on whether we should accommodate two or 50 children. Hence, the bullet may have been removed, but no one wonders how it got there in the first place.'

[i] Moria RIC (Reception and Identification Centre) situated on the Greek island of Lesbos, was Europe's largest formal refugee camp before it was destroyed by fires in September 2020.

[ii] The Dutch 'childcare benefits scandal' (in Dutch: *toeslagenaffaire*) is a political scandal concerning false allegations of fraud by the Tax and Customs Administration (in Dutch: *Belastingsdienst*). The affair has been critiqued for its discriminatory approach.

[iii] Recognising that the poor conditions were at least partly responsible for the developments which led to the fire in Moria, European Commission (EC) Home Affairs Commissioner, Ylva Johanson, proclaimed there would be 'no more Moria's' on the 24th of September 2020.

7 INTRODUCTION

As a physician of Global Health and Tropical Medicine I recently spent six months on Lesbos as the medical coordinator of the Boat Refugee Foundation (BRF), a Dutch Non-Governmental Organisation (NGO) providing medical and psychosocial care to the refugees on the Aegean islands. I remember walking through the main 'market' of camp Moria and seeing fruit and veggie stalls, restaurants, barber shops, bakeries and kiosks lining the street - all unheard of in 2016 when I was there last. The contrast between the refugees' resilience and the unintended permanence of the camp disconcerted me. What did it mean for the ad-hoc humanitarian response we were still providing five years down the line?

I remember Sarah,[i] who had come to our clinic on various occasions requesting replacement of her intrauterine device (IUD); it had been six years since her current one had been placed in Syria. She was 23 years old and had three children to take care of. The NGO usually providing gynaecological services had left camp due to recent violence and an inability to recruit staff because of the COVID lockdown. When it became clear to me that they would not return any time soon, I began collecting the necessary material to deliver basic SRH care and invited Sarah back to the clinic. Crammed in a corner, with only a flimsy curtain guaranteeing her privacy, no gynaecological chair and poor mobile phone lighting we managed to replace her IUD. It wasn't long before the news of my make-shift 'gynae-box' had spread and woman after woman was lining up with complaints ranging from severe vaginal blood loss to chronic lower abdominal pain.

I also vividly remember James,[ii] a young man from Burkina Faso. He presented with rectal haemorrhoids and seemed relieved when I explained I spoke some French and asked the interpreter to give us our privacy. It was only after I had reassured him over and over again that our conversation was confidential, that he confided he had been repetitively sexually abused in a detention centre in Libya. I referred him to a sister NGO who was able to take on SGBV (Sexual and Gender Based Violence) cases. "He will have to wait," I was told. There was a three-month waiting list, and since the event had not occurred less than 72 hours ago, he could not be prioritised.

The SRH needs in Moria were painfully evident. However, what was even more painful was our inability to adequately meet them. I often pondered the quality of our service delivery, deliberated the accessibility of our care and wondered how other camps in Europe were tackling this issue. With this thesis I hope to shed light on some of these pressing questions.

[i] For confidentiality purposes, this is not her real name.
[ii] For confidentiality purposes, this is not his real name.

8 BACKGROUND

At least 100 million people worldwide fled their homes during the last 10 years. Europe experienced a spike in asylum requests in 2015,[i] with more than 450,000 Syrian refugees crossing the Mediterranean Sea to Greece.[2] As the war in Syria intensified, conflicts in Iraq and Afghanistan worsened and the situation in refugee-hosting countries deteriorated,[3] the number of people seeking protection in Europe increased considerably: a reported 6,570,500 refugees sought asylum in the European Union (EU) at the end of 2019.[4] Of these, approximately 19% are children (one third of which unaccompanied) and 25% women.[4]

Refugees use three main routes to reach Southern Europe: the *Eastern Mediterranean* to Greece, the *Western Mediterranean* to Spain, and the *Central Mediterranean* route to Italy. From Southern Europe the *Western Balkan* route is typically used to travel further North. Alternatively, refugees sometimes opt to travel to the United Kingdom from Italy through France.[3] Annex A provides a more detailed description of the routes, including the demographic profile of the refugees using them.

Data on refugee camps and settlements in the WHO European Region is fragmented[5] and asylum procedures differ between countries making it complex to draw generalised conclusions.[6] Of the 12 million people of concern to the UNHCR in the region, nearly one third live in Turkey, which remains the largest refugee-hosting country with 3.7 million refugees accounting for 63.4% of all Syrian refugees globally.[7] Most of these refugees live in informal settlements integrated into the host community.[8] Countries bordering the Mediterranean, such as Greece, Italy and Spain, contain Reception and Identification Centres (RICs) or 'hotspots', where refugees are identified and referred to asylum or return proceedings.[6] En route, refugees are subsequently accommodated in intermediate-stay reception centres before eventually residing in asylum seeker centres in the country of final destination.[9] Average stays in the centres vary: 28 days in transit camps in Slovenia[10] compared to 10.3 months in RICs in Greece[11] in 2019 for example. Annex B provides an overview of the different types of camps and the organisation of healthcare in the countries covered in this thesis.

Refugee health is complex. Newly arrived refugees in the WHO European region often present with accidental injuries, hypothermia, burns, pregnancy and birth complications, untreated non-communicable diseases, and problems related to sexual violence and mental health.[12] Many of these health outcomes are reflective of exposure to conflict in the country of origin, violence and inhumane living conditions during perilous journeys, interrupted routine healthcare and an increased susceptibility to infectious diseases.[12] However, it is difficult to draw general conclusions on the health status of refugees due to the diversity of the population, incongruent use of definitions and a historic focus on mainly communicable diseases.[12]

The WHO defines SRH as "a state of physical, emotional, mental and social well-being in relation to sexuality, and not merely the absence of disease, dysfunction or infirmity."[13] SRH encompasses the prevention, detection, and management of SGBV, sexually transmitted infections (STIs) and infertility as well as the choice to safe and effective contraception, abortion and maternal healthcare services.[14] Refugees in the WHO European region show poorer pregnancy outcomes than the host population, including increased induced abortions, caesarean sections, instrumental deliveries and complications during childbirth.[15] Evidence on STIs is limited and demonstrates conflicting findings, with both higher[16] as well as equal[17] prevalences compared to the host community. SGBV is a grave problem, occurring while journeying to Europe,[18, 19] as well as during transit and in the country of destination.[20]

Minimum standards for healthcare are outlined in the Common European Asylum System, which was established in 1999 to improve coordination and solidarity between EU member states.[21] In practice, all countries ensure that emergency care is made available to refugees, but further access to services varies from country to country and fundamental differences exist in the implementation of the agreed strategies.[12] Likewise, the call for action in the 2015 WHO Strategy and Action Plan for Refugee and Migrant Health, informed by Health 2020,[22] has also

[i] The displacement of mostly Syrian, Afghan and Iraqi refugees crossing the Mediterranean Sea to the EU is classically referred to as the European Refugee Crisis. In this thesis, I have consciously decided to avoid this term. I believe it is not an objective depiction of the situation and that framing the displacement of refugees as a 'crisis' contributes to decreased access to care. I explain this in more detail in the discussion section of the thesis.

been inconsistently answered.[23] For SRH, the IAWG (Inter-agency Working Group on Reproductive Health in Crises) developed the Minimum Initial Service Package (MISP) in 2015. It denotates priority life-saving services to be implemented at the onset of every emergency.[24] Key areas include the prevention of unintended pregnancy, maternal death and SGBV as well as the transition to comprehensive services.[24] Implementation of the MISP has not been evaluated in the European context, making the theme of this thesis even more relevant.

9 PROBLEM STATEMENT, JUSTIFICATION AND OBJECTIVES

9.1 Problem statement

The problem this thesis addresses is the knowledge gap on access to SRH services for refugees in camps and informal settlements in the WHO European region. Systematic reviews exploring SRH interventions in humanitarian and conflict settings from 2015,[25] 2018[26] and 2020[27] focus explicitly on LMICs. Similarly, retrospective analysis of reproductive health indicators in the United Nations High Commissioner for Refugees (UNHCR) post-emergency camps 2007–2013 exclude camps from the European Union (EU).[28]

In Europe, systematic reviews conclude adverse pregnancy outcomes of asylum seekers and undocumented migrants.[29] In turn, barriers to accessing care have been examined.[30, 31] However, these studies were conducted among refugees who had reached their country of destination, or were staying in longer stay refugee centres and thus cannot inform us about (the determinants of) access for refugees *transiting* through Europe.

A review of the existing literature is warranted to gain a more comprehensive understanding of this specific geographical context. A preliminary search of PROSPERO, MEDLINE and the Cochrane Database of Systematic Reviews showed no current or in-progress scoping or systematic reviews on the topic.

9.2 Justification

Migration is considered a major social, political and public health challenge for the WHO European Region.[32] Residence in temporary and overcrowded shelters is associated with severe disease burden and is taxing on the local healthcare sector.[33] Investing in migrant inclusive health systems has economic advantages,[34-36] is beneficial for social cohesion,[37] and imperative to public health: contrary to popular belief, migrants rarely introduce communicable diseases to host populations, whereas denying them treatment may pose risks.[38, 39]

But the most important reason to ensure inclusive health policies is because health is a human right for which the EU holds a social and ethical responsibility.[i] Nearly 25 years have passed since the 1994 International Conference on Population and Development in Cairo acknowledged SRH as a human right.[40] Yet significant inequities in its delivery still exist, with global gaps in access to services prevailing amongst the most marginalised.[41] In attempting to comprehend the factors influencing access to SRH services, this thesis thus contributes to the United Nations (UN) Sustainable Development Goal (SDG) call to 'leave no one behind' and promote Universal Health Coverage (UHC) by 2030.

9.3 Objectives

9.3.1 General objective

To examine the evidence describing access to SRH services for refugees residing in formal camps and informal settlements in the WHO European region in order to guide future research, strengthen existing responses and aid policy makers in determining priorities for interventions.

9.3.2 Specific objectives

a) To describe to what extent services meet the SRH needs of refugees residing in formal camps and informal settlements in the WHO European region;

[i] This has been recognized by member states in various binding and non-binding conventions and treaties, including: the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Convention of the Rights of the Child (CRC), the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), the Constitution of the World Health Organisation (WHO), the Declaration of Alma-Ata, the Ottawa Charter for Health Promotion and the Bangkok Charter for Health Promotion in a Globalised World.

b) To describe the supply-side barriers[i] and facilitators[ii] affecting access; and
c) To describe the demand-side barriers and facilitators affecting access.

[i] See Annex C for the operational definition of 'barrier'.
[ii] See Annex C for the operational definition of 'facilitator'.

10 METHODS

10.1 Study design

A scoping review was chosen to answer the above research questions since it is excellent at mapping existing evidence in complex topics.[42-44] The review is written in line with the Preferred Reporting Items for Systematic Reviews and Meta-analysis Extension for Scoping Reviews (PRISMA-ScR) and follows the guidelines outlined by Arksey and O'Malley,[43] Levac, Colquhoun and O'Brien[45] and the Joanna Briggs Institute.[46]

10.2 Theory and framework

Levesque's patient-centred framework[47] depicted in figure 1 served as the conceptual framework. Supply-side dimensions of *approachability*, *acceptability*, *availability/accommodation*, *affordability*, and *appropriateness* of the health system are coupled with supply-side dimensions of an individual's ability to *perceive*, *seek*, *reach*, *pay* and *engage* in healthcare. As opposed to other frameworks, such as those by Andersen[48] and Peters,[49] Levesque's framework places the *process* of seeking care at the centre of the analysis and is therefore particularly useful in identifying facilitators and/or barriers. Considering the often-limited agency of refugees, I also appreciate the equal emphasis on the demand-side of access.

To my knowledge, no frameworks exist examining access to healthcare for refugees specifically. However, Levesque's has a good track-record: it has successfully been deployed in studies exploring maternal healthcare[50] as well as access to care for refugees and asylum seekers in Malaysia, the Netherlands and Germany.[50] To what extent it can be applied to the extremely specific context of transient refugee settlements in Europe has yet to be determined. Thus, this review provides opportunities to further explore the framework's generalizability.

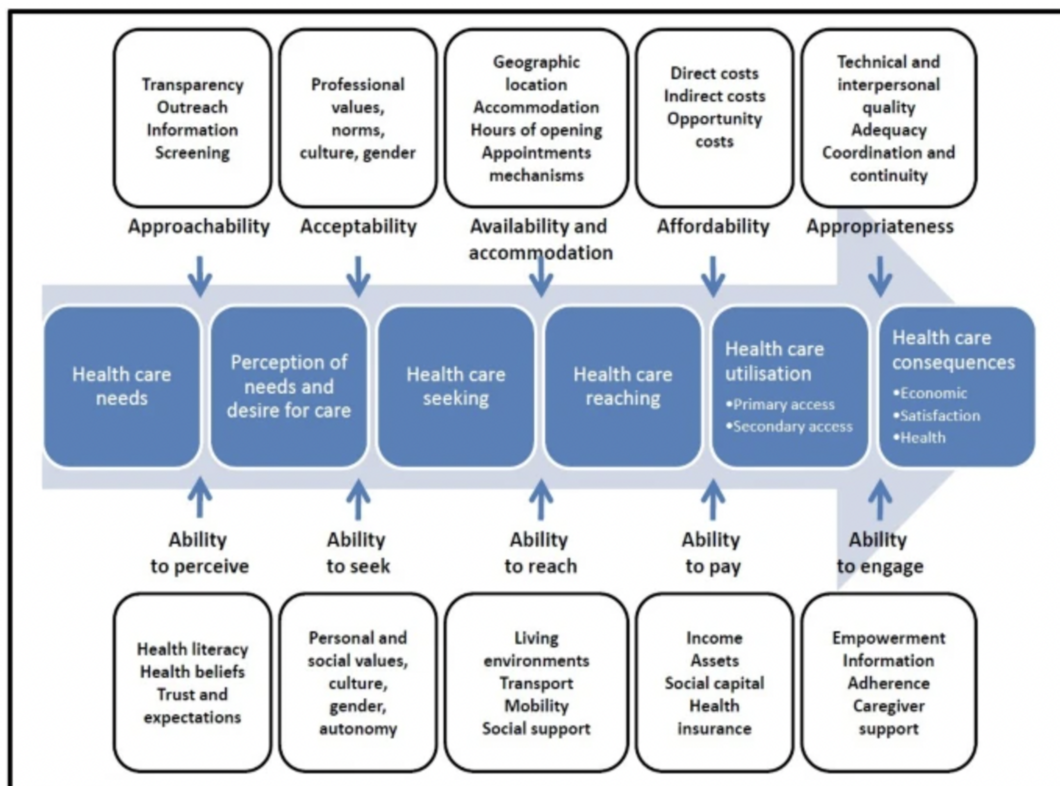

Figure 1. Levesque's conceptual framework of access to healthcare

Source: Levesque J-F, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. Int J Equity Health. 2013;12(1):18.

10.3 Search strategy

Peer-reviewed literature was retrieved from Embase, Medline and Web of Science. The search strategy was built in four steps using controlled vocabulary and free-text following the formula: (*refugees*) AND (*SRH* OR *general health*) AND (*refugee camps*) AND (*Europe*). Annex C explains the key terms in more detail. Annex D contains the full search history across all three databases. The search was supplemented by snowball literature by examining references.

First, I identified five key publications depicting SRH knowledge gaps. Thereafter, I reviewed the results of the database search and deployed the Boolean operator NOT to test the search mechanism. This allowed for finetuning of the search strategy: I added terms such as *"reception"[tiab]* and removed *"refugee"* from *"refugee cent*"[tiab]* for instance. I also decided to incorporate general health terms into the search formula since not all publications included SRH-related terms specifically in their title or abstract. Searching on SRH alone risked excluding articles reporting on SRH as part of broader studies pertaining to general health.

A list of 25 of the most well-known European refugee camps[5] were initially searched by name. Only the ones yielding significant results (namely: Moria, Calais, Chios, Samos and Lampedusa) were subsequently included as unique search terms. Searching on WHO European countries alone excluded articles that only stated the specific name of the above camps in their title or abstract.

Sources of unpublished studies and grey literature included organisations active in the field of refugee health in the EU, namely: the UNHCR, the WHO, the International Organization for Migration (IOM), the IAWG, Médecins sans Frontières (MSF), Médecins du Monde (MDM), Human Rights Watch, The International Rescue Committee (IRC) and the Women's Refugee Commission (WRC). I systematically hand-searched the resources section of their official websites.

10.4 Selection criteria

After removing duplicates, I uploaded 1951 unique records into the online software Rayyan and screened these against the inclusion and exclusion criteria as outlined in table 1. Figure 2 illustrates the steps in the initial screening process. Publications with ambiguous titles, non-existent abstracts, unclarity regarding the explicit mention of SRH or indeterminate answers to any of the screening questions were subjected to full-text review. If any systematic reviews were identified, relevant individual papers were extracted and analysed separately. 162 full-text publications were subsequently assessed for eligibility, resulting in 41 final inclusions. Figure 3 summarises the selection process.

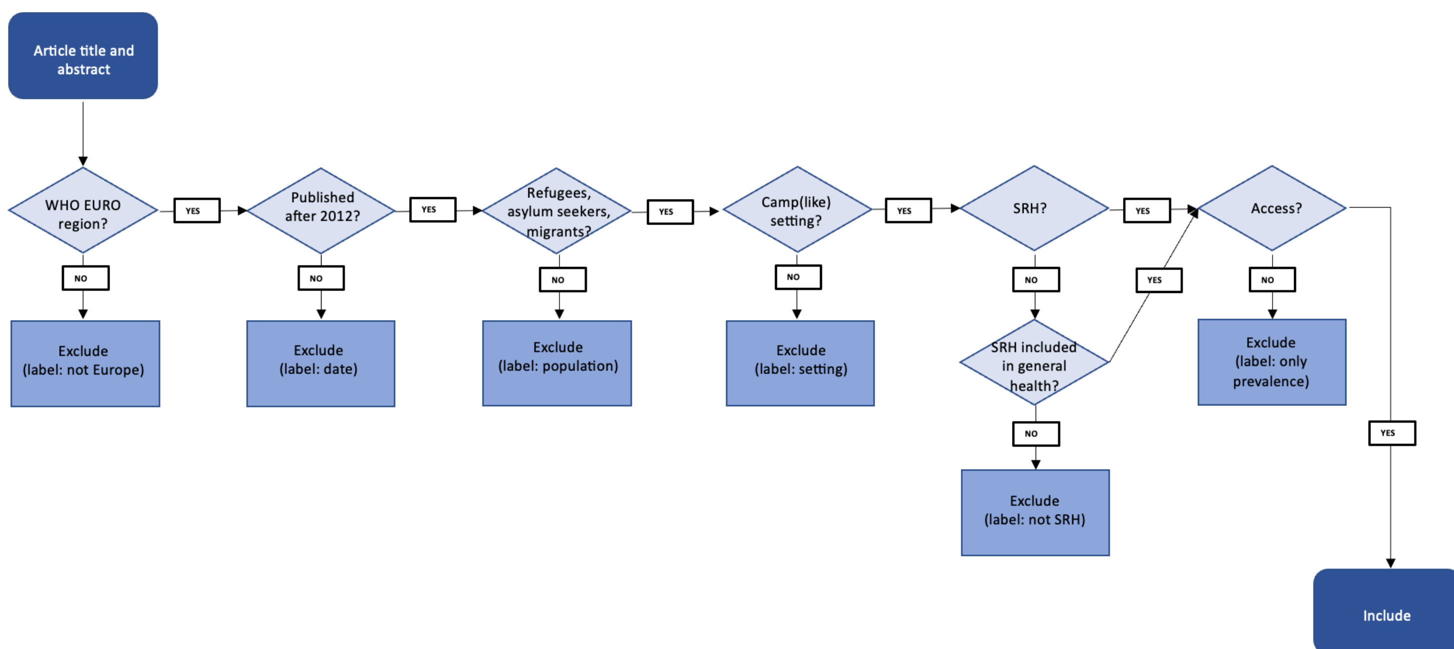

Figure 2. Flowchart illustrating the first stage of the screening process

Table 1. Inclusion and exclusion criteria

Topic	Inclusion	Exclusion
Population of interest	Refugees residing in camps or alternative settlements. In line with classifications used by UNHCR, alternative settlements include spontaneous temporary settlements in the host population, as well as alternative arrangements, such as urban refugees living independently amongst host populations.[33] Four types of accommodation were identified reflecting the journey refugees make through the EU before reaching their final destination in the host country: 1) informal settlements integrated into the host community; 2) first reception/hotspot centres; 3) transit centres and 3) intermediate-stay reception centres.	Refugees who have been resettled to a third country, asylum seekers residing in long-term asylum seekers centres in the country of final destination, IDPs (Internally Displaced Persons), immigrants and migrants, migrant workers.
Context	WHO European Region Member States. This includes Turkey.	Countries that are not WHO European Region Member States. Israel was excluded due to its geographical location and moreover not serving as one of the main destinations for refugees displaced after the Syrian and Libyan revolutions in 2012.
Concept	Accessibility, utilisation, availability, affordability, acceptability, appropriateness and quality of SRH services. Barriers and facilitators to receiving and delivering care. Studies examining health care workers' perception on SRH services for the above population of interest were also included.	Studies reporting on prevalence of SRH outcomes alone without mentioning access to services or any of the other concepts listed in the inclusion criteria.
Study type and design	Quantitative, qualitative and mixed-methods studies. Systematic literature reviews were only included for deduction of relevant studies.	Case reports of single patients, editorials, commentaries, first-person narratives, newspaper and magazine articles, opinion pieces, guidelines.
Publication date	After 2012, correlating to the beginning of the Syrian and Libyan revolutions accompanied by an increase in the flow of migrants towards the EU.	Before 2012.
Language	English.	Other languages.

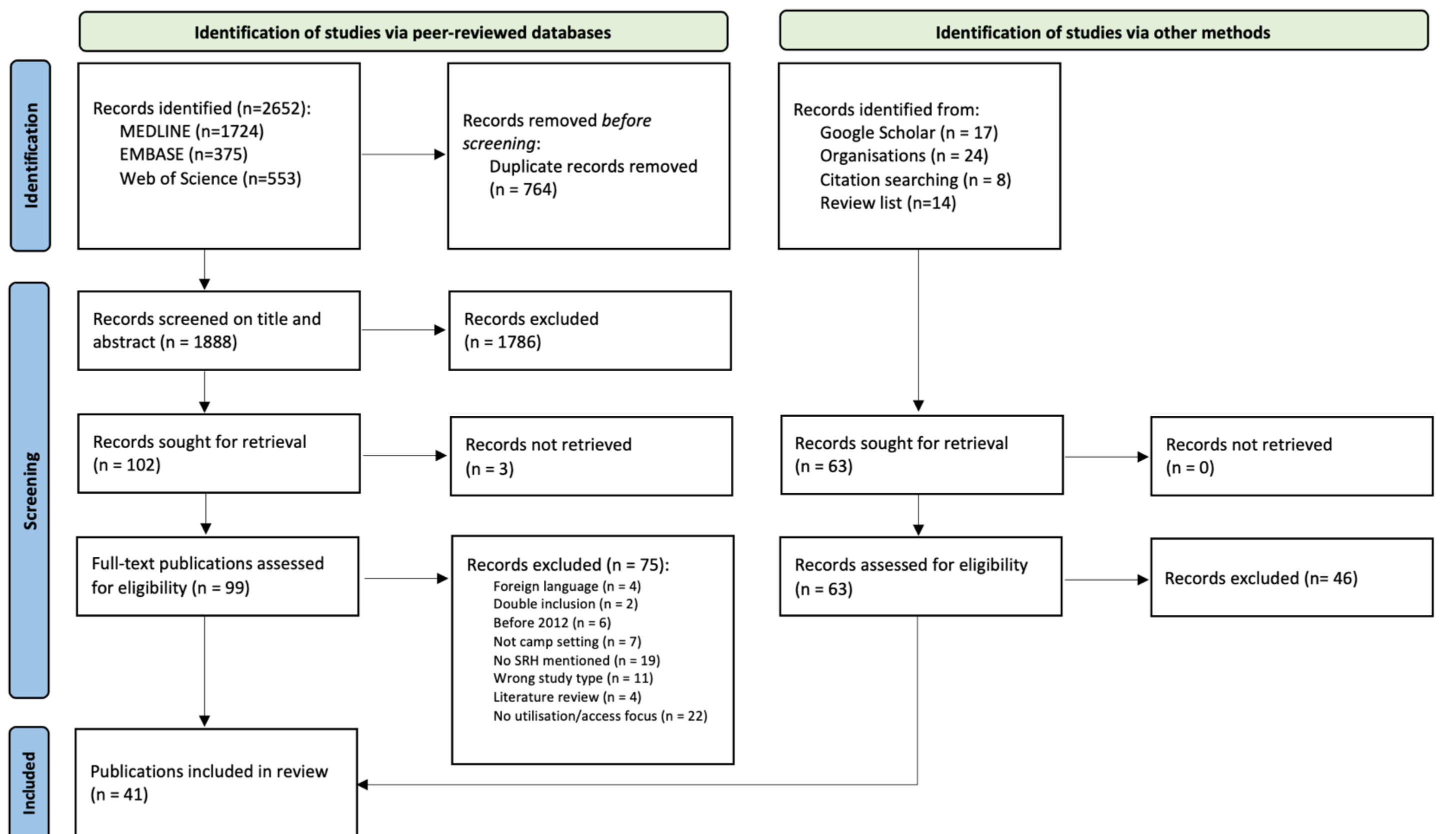

Figure 3. PRISMA flow diagram of the scoping review process

Adapted from: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71.

10.5 Data extraction

The 41 included studies were charted using a standardized form - annex E shows an example. To facilitate the coding process and for oversight purposes, I subsequently organized the finding by SRH themes established by the IAWG Field Manual on Reproductive Health in Humanitarian Settings for SRH in crisis settings,[51] namely: maternal health (MH), FP, SGBV, STIs and female genital mutilation/cutting (FGM/C).

10.6 Data analysis

Owing to the heterogeneity of the selected studies, I initially deployed an inductive analysis and examined the charted data without pre-determined categories, in accordance to the principles of thematic analysis in qualitative research as described by Patton.[52] I then used the conceptual framework to deductively place the codes which had emerged into context. For each code, I extracted illustrative citations from the relevant studies. The below table shows an example:

Table 2. An example of the coding process

Citation	Condensed meaning	Code	Subcategory	Category
"In our experience people were not only in transit physically, but also mentally. Their determination to reach their destination and find safety was understandable, but provided significant challenges when attempting to refer cases to secondary care."[53]	Priority lies with continuing travels as opposed to seeking medical care	Transient nature of stay	Living environments	Availability to reach
"Therefore, the doctor and the team of nurses (several of whom have worked in the CETI for years) know many of the residents, and particularly pregnant women, by name."[54]	Familiarity of healthcare workers with the target group due to being present for many years	Long presence	Trust and expectations	Ability to perceive

10.7 Quality assurance

Contrary to systematic reviews, no critical appraisal of the quality of included articles is required for scoping reviews.[42, 55] Nonetheless, the quality of the included articles was considered for the analysis and conclusion of the thesis. The initial methods for screening, study selection and data charting were outlined in a research protocol which was submitted for feedback to the thesis advisor and three other experts in the field of refugee and global maternal health (Professors Maria van den Muijsenbergh, Thomas van den Akker, Malabika Sarker). I consulted a medical librarian (Elmie Peters) to review the search strategy and syntax. To mitigate for the lack of a second researcher to screen and code the publications, I ensured these processes were as standardized and transparent as possible, as illustrated by figure 2 and table 2. Furthermore, the analysis was thoroughly discussed with the thesis advisor.

10.8 Ethical and safety considerations

Ethical clearance was not required since there was no collection of primary data.

11 RESULTS

11.1 Characteristics of the included publications

Annex F shows the characteristics of the 24 peer-reviewed and 17 grey literature sources. Twenty-eight publications employed a qualitative, nine a quantitative and five a mixed methods design. All but two Turkish household surveys[56, 57] reported on barriers and facilitators. Eleven studies,[53, 56-64] predominantly conducted in Turkey, quantified healthcare access and compared it to SRH needs.

Annex G illustrates how the number of studies found per country reflect the most common migration routes: approximately 60% (n=26) of the studies were conducted in Greece and Turkey,[53, 54, 56-61, 63-79] 30% (n=12) in Italy[54, 59, 62, 69, 70, 77, 80-84] and Malta[85] and two in Spain.[54, 70] Most of the selected studies were conducted in formal camps (either first reception, transit or intermediate stay camps). Studies in informal settlements were predominantly conducted in Turkey and in France; again, reflective of migration patterns.

Fifteen publications studied only refugees,[53, 56, 57, 60-63, 69, 72-75, 80, 86, 87] 16 both refugees and service providers (healthcare providers, NGO staff, government representatives)[54, 58, 59, 64, 70, 76, 77, 79, 84, 85, 88-92] and 10 only service providers.[65-68, 71, 78, 81, 83, 93, 94] Of the 31 conducted with refugees, 17 included men in their research population and two studies conducted by the same research group were specific to male refugees,[77, 82] portraying an encouraging trend to involve men in SRH discussions. Echoing the call by the IAWG[95] to recognize the unique SRH needs of adolescents, nine articles[56, 57, 60, 62, 63, 76, 82, 87, 88] included adolescents (defined as individuals aged 10 to 19 years) in their study population. However, none stratified results by age, making it impossible to capture potentially differing outcomes or specific barriers or facilitators in this vulnerable group. The study by Digidiki et al.[65] formed an exception: the authors interviewed service providers working with sexually exploited children.

The majority of the studies focused on MH (n=14),[54, 56-58, 60, 63, 68-70, 74, 77, 78, 80, 94] SGBV (n=8)[62, 65, 75-77, 82, 89, 90] and FP (n=7).[53, 56, 60, 61, 71, 72, 86] Five out of the eight articles on SGBV came from the grey literature, whereas most of the articles on MH and FP were peer-reviewed. STIs were discussed in four papers[57, 58, 60, 76] and FGM/C in one.[81] Sixteen studies reported on SRH in its totality, as part of larger projects on the general health of refugees.[53, 59, 64, 66, 67, 71, 73, 78, 79, 83-85, 87, 91-93]

11.2 Healthcare needs and access

Inadequate access to ANC, high proportions of hospital deliveries, unmet FP needs and suboptimal utilisation of SGBV services stood out in the 11 studies quantifying healthcare access. In Istanbul, Torun et. al[58] conducted a household survey with 891 refugee women and report that more than one third of pregnant women had not received ANC. Similar figures were found in Sanliurfa in the south of the country: of the 961 women included in Simsek et al.'s[60] study, 16% were pregnant and 26.7% had not received ANC. The WHO's conclusions were even more alarming: 71.9% of the women in their cohort of 4584 Syrian households had not received regular ANC while pregnant.[57] All three studies were conducted in similar informal camp settings during the same year. A possible explanation for the higher unmet need found by the WHO is the use of a different case definition - the WHO report defined 'regular ANC' as consultations at least every month, whereas the other two studies did not state an operational definition.

In Greece, ANC data is fragmented with inconsistencies in service delivery. Shortall et. al[53] describe routine data of a ferry clinic between January and March 2016 and report that 60% of the pregnant women presented after their first trimester without previously having seen a health professional. This illustrates an ANC need which is only partially being met in the first reception centres. Ben Farhat et al.[63] found ANC utilisation to differ between camps and Blitz et. al[59] report that of the 14 pregnant respondents in their survey, only one had received counselling.

The route to safe delivery is smoother: of the 300 included women residing in informal settlements in Istanbul, Coskun et al.[56] found that 12.3% had delivered their last child at home without professional help. This finding corresponds with Torun et al.[58] who conclude that 85.0% of the 26 deliveries in their cohort had taken place in

state hospitals. However, postnatal care is lacking: the majority of mothers and children (54.6%) in the household survey by the WHO had not received medical examinations in the two years after birth.[57]

Studies in Turkey reveal unmet FP needs. Simsek et al.[60] calculated an unmet need of 37.8% (56.9% unmet need for modern contraception) and Coskun et al.[56] conclude that 43.6% of women had conceived their last child unwillingly. Ozsahin et al. [61] investigated the fertility behaviours and contraceptive use among 223 Syrian refugees in western Turkey and found a more modest 13% (n=29) being at risk of unwanted pregnancy. The necessity for contraception was emphasized by the Turkish family physicians interviewed by Baser et al.[71] They regarded family planning a priority intervention.

There is suboptimal access to SGBV services. Bronsino et al.[62] included 2,484 refugee women residing in a first reception centre in Northern Italy and observed an unexpectedly low prevalence of SGBV (1.85%). The authors argue that this finding is indicative of underreporting and suggest stigma and fear could explain the discrepancy. However, these are speculations, since the study did not deploy a qualitative component.

11.3 Barriers and facilitators

11.3.1 Overview

As illustrated in figures 4 and 5, supply-side barriers and facilitators were reported three times more often than demand side factors (202 supply-side factors versus 63 demand-side factors). This is striking as it does not reflect the ratio of studies focusing on service users (31 in total) to those focusing on service providers (25 in total). The discrepancy can be indicative of two things: either the health system is truly showing more significant faults in ensuring access, or researchers are yet to properly investigate the demand side of service delivery.

Especially the *appropriateness* of service delivery stands out: the 25 studies reporting no fewer than 98 barriers and 4 facilitators mark it as the most substantial factor determining access to SRH services. Contrasting this were the four studies highlighting just four barriers and two facilitators across the domain of *affordability* of services and the refugees' *ability to pay*. The fact that healthcare is delivered free of charge for refugees might explain this but requires further exploration.

In the following sections I synthesise the findings on the barriers and facilitators conform the five steps of Levesque's conceptual framework, aggregating where possible by main SRH outcomes. The pre-determined subcategories (as defined by Levesque et al.) are indicated in **bold**. Exemplary citations justifying the subcategories can be found in Annex H. Additionally, figure 6 provides an overview of the main deduced topics under each subcategory.

Figure 4. Number of individual studies mentioning barriers and/or facilitators per category of Levesque's framework

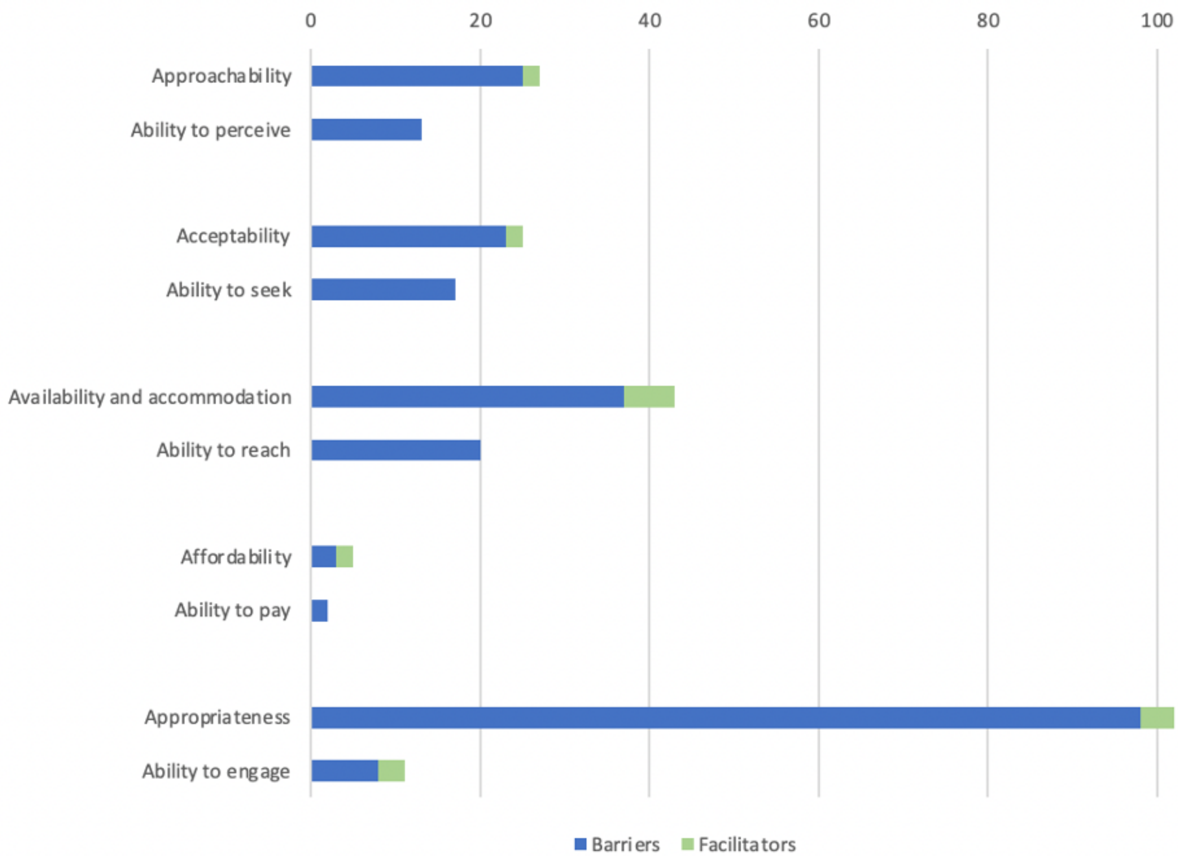

Figure 5. Total number of barriers and facilitators mentioned per category of Levesque's framework

11.3.2 Supply-side factors

11.3.2.1 Approachability

The *approachability* of services entails refugees with SRH needs can identify services and recognise that these can potentially benefit them.[47] An important associated barrier is inadequate **information delivery**: 15 studies explain how absent or limited information regarding the right to (free) healthcare [58, 69, 77, 84], existence of available services [59, 64, 66, 76, 77, 79, 85, 90] and pathway to care [59, 61, 66, 76, 77, 89] impede access. Particularly for MH, misinformation (on possibilities regarding the termination of pregnancy for example) results in poorer health outcomes.

Health education has the potential to combat misinformation, but needs to be tailored to the target population. Malakasis et al.[74] illustrate how flyers on epidurals were distributed in Athens in different languages but proved ineffective due to the rate of illiteracy amongst the refugee community. Verbal explanation is more successful: in the medical centres for refugees in Turkey health education sessions increased uptake of FP services.[72]

Acknowledgement of the unique vulnerability of refugees results in either enhanced or reduced access to services. Hesitation to actively engage in **outreach** activities is a striking barrier identified in Turkey.[64] Since refugees are known to have poorer health outcomes, family physicians deter from encouraging them to register in their practice out of fear that this might affect their performance results. In Spain however, the opposite is true: Grotti et al.[54] found that mere residence in refugee camps 'produced an administrative acknowledgement of pregnant women's health-related vulnerability'(p.12) and prompted doctors to accelerate their access to care 'based on personal moral and ethical motivations' (p.10). Another facilitator in this setting is the sustained presence of healthcare providers, who reportedly know many of the residents 'and particularly the pregnant women, by name'[70](p.16) aiding in outreach. In neither of the above contexts however, is vulnerability officially recognised. The UNHCR report on SGBV emphasizes this concern, stating that the absence of uniformly applicable vulnerability criteria translates to uneven access to services.[76]

Three studies reported on factors relating to the subcategory of **transparency.**[59, 76, 82] A lack of physical visibility of service providers negatively affects access to care in Greece, Italy and Macedonia.

11.3.2.2 Acceptability

Acceptability describes the cultural and social factors influencing the possibility for people to accept services.[47] I found **gender** to be the most important determinant of acceptability. Seven studies across the fields of MH,[58, 68, 69, 88] SGBV[89] and general SRH[66, 67] report a lack of female healthcare providers and interpreters to be a deterrent for women to seek care. But for men too, disregarding gender sensitivity in healthcare planning results in reduced acceptability of services. For example, male survivors of SGBV in Italy are reluctant to access care through women-oriented service points.[82] Such policies probably stem from a historically blind spot to male victimisation and consequently a structural lack of funding for male victims and/or survivors with diverse SOGIESC (Sexual Orientation, Gender Identity and Expression, and Sex Characteristics).[77]

Professional values, such as a friendly and respectful attitude of healthcare providers promotes the acceptability of care but was only identified by one article.[69] On the other hand, overt racism and discrimination were highlighted in as many as six studies,[58, 64, 68, 77, 82, 85] with national hospital staff being the main perpetrators. To what extent this is perceived or real hostility was interpreted differently in the studies: Scott et al.[68] analyse that general anti-migrant politics in Greece combined with a frustrating financial environment could explain the negative attitudes. Grotti et al.[54] share this sentiment, explaining how 'well-meaning caregivers [in Italy] were often fatigued and exasperated'(p.15). The IOM Malta report[85] however, explains how refugees perceived racism after being denied a consultation or desired treatment. They argue that the problem therefore lies in structural resource constraints as opposed to having a human cause.

The *acceptability* of care is compounded by **norms** including scarce treatment options and the application of medicine which contrasts to that which the target population is used to in their countries of origin. Dissatisfaction amongst refugees was reported in three studies,[63, 67, 84] with high thresholds for both referrals and antibiotics prescription forming the main grievances. As Ben Farhat et al.[63] state:

> 'The participants reported that they do not receive proper treatment but are told to drink water or given a few painkillers and therefore do not go there.' (p.64)

This is a challenging barrier to tackle, especially since none of the articles conducted a root cause analysis – why are doctors only prescribing painkillers? The question thus remains what the dissatisfaction is driven by: an absolute absence of options (secondary to resource constraints), or a differing **healthcare culture**? Either way, training in transcultural communication could offer a promising solution and was well received by service providers in Malta.[85] Other authors echo the need for more cultural education of the healthcare staff.[67, 77]

11.3.2.3 Availability and accommodation

Availability and accommodation refer to the physical existence of services with sufficient capacity to deliver timely care.[47] A lack of available services,[89, 90, 94] absence of medication,[64, 89, 92] limited number of translators[64, 68, 74] and low numbers of medical personnel[53, 64, 67, 76, 77, 83, 84, 93] all classically contribute to unmet health needs. Especially the lack of staff stands out and has ramifications for **opening hours**.[59, 70, 84] Task-shifting could offer solutions. Borsari et. al[80] describe how a mobile-Health system for ANC was deployed in a reception centre in Sicily and allowed trained low-skilled personnel to perform standardised visits while being remotely supported by medical staff.

A need specific to SRH are safe spaces where pregnant women and SGBV survivors 'feel safe to disclose their story confidentially'[89](p.9). These spaces are well appreciated where available[90] and mentioned as a clear barrier where not installed[68, 76, 88, 89] by refugees and service providers alike. Moreover, besides providing dignity, safety and social cohesion, they provide opportunities for health education:

> 'In camps where safe space for women was limited, this posed a challenge in creating both the space to educate women and the space for them to form social networks that would prevent social isolation during pregnancy.'[68](p.117)

Failing **appointment mechanisms**, secondary to a lack of know-how, language barriers, and bureaucracy are an important frustration for maternal healthcare providers in particular.[58, 67, 73, 74] This is only logical since strong referral systems and good collaboration between primary and secondary care are cornerstones of safe motherhood – the NGOs providing ANC to pregnant refugees are often dependent on hospitals for blood examinations, specialized ultrasounds, prenatal screenings, and labour. De Paoli et el[73] account how NGO's attempted to tackle the language barrier by hiring Greek speaking staff who could liaise with their colleagues in the hospitals. Another facilitator is flexibility of hospital staff who 'encourage migrant patients to stop by the screening department and either book their appointment in person or undergo an examination on the spot.'[74] (p.15). Albeit commendable, these practises were not consistent and thus structural improvements are vital.

Healthcare does not exist in a vacuum. Particularly for SGBV, national **legislation** influences service delivery both positively and negatively.[77, 82, 88-90] For example, in Macedonia, restrictive laws prevent gynaecologists from providing medical interventions to SGBV victims before a forensic report has been commissioned.[89] In Italy on the other hand, the fact that sexual violence is defined as being gender neutral is an important facilitator in providing care to male victims.[77]

Finally, the **geographic location** of the refugees' accommodation is crucial to access. Five studies reported remoteness from services as a clear barrier for refugees.[59, 67, 74, 77, 90] But physical location also has implications for service providers, with NGO's voicing ethical concerns or principally refusing to offer care there where refugees are housed in military or detention centres.[90] Similarly, service provision can potentially be jeopardised by security concerns, as for instance on the border of Turkey.[78]

11.3.2.4 Affordability

Affordability reflects economic capacity for healthcare expenditure and is determined by direct, indirect and opportunity costs.[47] In line with European legislation prohibiting refugees from working, opportunity costs were not mentioned in any of the 41 studies. SRH services are provided without a fee-for-service in all the settings researched. As explicitly mentioned in two studies conducted in Italy and Turkey[64, 75] this serves as a clear facilitator to access.

Two studies[64, 75] identified **direct costs** of services (namely sanitary pads and medication respectively) impeding access to care. The **indirect cost** of transport was mentioned in one article: Joseph et. al[67] describe how refugees

in Greece are dependent on taxis since private transport is often unavailable and language affects the ease of public transport use. The above effectively illustrates how the different barriers to access (in this case pertaining to *affordability*, *availability and accommodation*) are interconnected and strengthen barriers across the other dimensions (such as the *ability to reach*).

11.3.2.5 Appropriateness

Appropriateness expresses the relationship between services and needs and includes components such as technical and interpersonal quality, adequacy, and coordination and continuity.[47] With 25 studies reporting no fewer than 98 barriers and 4 facilitators (for details see Annex H) this domain of Levesque's framework has the most significant impact on access.

The most important challenge is **technical and interpersonal quality**. Staff often need to work with deficient or absent equipment[53, 64, 92] in understaffed centres[67, 77, 79, 83, 89, 92] with suboptimal infrastructure.[66] The result is a strained workforce: low work morale,[67] stress, [53, 79] impatience,[65] burn-out,[64, 67, 79] disappointment,[79] anxiety,[79] distress,[79] fatigue,[54] and exasperation[54] negatively affects the quality of care, illustrated for instance through poor post-operative management.[68]

Staff competence also deserves attention – twelve studies mentioned quality care being jeopardised by insufficiently trained healthcare workers.[64, 65, 76, 77, 79-81, 85, 88-91] The lack of expertise, experience and training is particularly evident for SGBV. Caroppo et. al[81] examined knowledge about FGM/C among healthcare workers in refugee centres in Italy and found that only 7.3% of respondents felt comfortable identifying the condition and 70.7% declared to have never met or assisted a woman with FGM/C. Considering the high WHO estimation of prevalence of FGM/C in the countries the refugees originated from this finding is suggestive of an alarming knowledge-gap among staff.

In line with the above, two studies[64, 70] mentioned high staff turnover impeding the delivery of appropriate care: the complexity of providing healthcare in refugee settings requires healthcare workers to 'transcend their regular practice'[70](p.15) and offer tailored care. However, this specific expertise is quickly lost due to frequent changes in staff, often secondary to disproportionately high work burdens and little financial compensation.[64]

The **adequacy** of healthcare delivery is negatively influenced by a lack of sufficient time[53, 64, 69, 84, 88-90] as well as its timeliness.[58, 63, 67, 68, 85] Language barriers are detrimental and ten studies reported on absent or fragmented use of interpreters causing delays in care, suboptimal consultations or the undermining of patient privacy.[64, 68, 69, 71, 75, 79, 83-85, 93] Additional barriers to the adequacy of care are a lack of effective triage systems causing strain on emergency services[53] and absence of accountability mechanisms ensuring compliance with minimum standards.[77]

Poor **coordination** – manifested by a lack of leadership,[76] unclear roles[76, 94] and deficient communication between service providers[67, 76-79, 83, 88, 91] – impedes access to care. Challenges exist at three levels: between the different healthcare actors in camp, between medical and non-medical service providers (for example border police and public health authorities) and between primary and secondary care. Lack of communication results in duplication of and/or gaps in services and inadequate referral pathways impede continuity of care.[65, 70, 75, 77, 79, 82, 83] Further undermining continuity is absent or poor implementation of standard operating procedures,[53, 65, 76, 77, 79, 82, 83, 89] coupled with incomplete documentation or absent patient files.[64, 69, 70, 79, 83] The authors argue that poor planning[78, 90] resulted in countries such as Greece and Turkey to remain inappropriately providing emergency care to refugees instead of transitioning to comprehensive services. The latter is also influenced by a failure to collect essential (epidemiological) data regarding health needs – a shortcoming highlighted in six studies.[53, 64, 77, 79, 84, 88]

The mHealth intervention described by Borsari et al.[80] was designed to tackle precisely the above barrier. The system facilitated the 'continuity of care for a population undergoing frequent relocations'(p.1) by placing ownership of the electronic patient record with the pregnant refugee. At the same time, it increased healthcare providers' adherence to ANC recommendations and guidelines. The WRC Balkans report[89] highlights a second good practice example where a civil society organization (CSO) in Serbia connected SGBV survivors to sister CSOs in Germany. Other facilitators include the use of mobile technology to share information on refugees with special needs across borders.[89]

The role of civil society is interesting. Certain studies claimed medical care delivered by NGOs results in fragmentation and the creation of unconstructive parallel health systems.[59, 67] Other studies however, stressed the instrumental contribution of NGOs and felt the 'traditional humanitarian aid architecture'[89](p.10) has the skills and capacity to add value and had unjustly been side-lined by governmental institutes in Greece[90] and the Balkans.[89]

11.3.3 Demand-side factors

11.3.3.1 Ability to perceive

The *ability to perceive* need for care is influenced by **health literacy**.[47] Especially for FP and SGBV, refugees either do not appreciate they have a need for care (coming to seek care only when more specific somatic problems existed),[62] have a poor understanding of health (for example that the violence they suffered constituted SGBV)[61, 82, 87, 91] or lack knowledge on the possible treatment options (for example the efficacy of contraceptives or existence of post-exposure prophylaxis for HIV).[82, 86]

Low formal health-seeking behaviour compounds low health literacy. Chynoweth et al.[82] explain how male victims of SGBV often preferred to seek care from traditional healers, community leaders and religious figures instead of accessing conventional medical services in Italian camps . Although the link was not made directly by the authors, this could stem from a lack of **trust** in the SRH services offered in Europe. Scepticism regarding the effectiveness of treatment or mistrust in the abilities of healthcare personnel were namely identified in four different studies.[58, 69, 77, 82] Additionally, as Joseph et al.[67] add, discrepancies between refugees' **expectations** of healthcare and the actual delivery of services could fuel the above sentiment.

11.3.3.2 Ability to seek

The ability to express the intention to obtain healthcare is determined by factors such as **personal and social values**.[47] Perhaps the most illustrative is the population's desire to obtain healthcare conflicting with the wish to continue traveling.[69, 77, 88, 89, 93] Refugees, especially the ones in transit centres in the Balkans and Italy, express delaying health treatment in the interest of continuing their onward journey. In some cases, national legislation magnifies this desire, where in the case of domestic violence for instance, women are hesitant to seek care out of concern that this could jeopardise their partner's asylum claim.[90] In other cases, the ability to seek care is affected by social pressure to keep on moving.[88] Either way, at all times, the priority lies on obtaining asylum in the final country of destination.

Cultural barriers including fear of social stigma deters male refugees from seeking SGBV care: sexual exploitation brings with it feelings of shame and self-blame, often founded in religious emphasis on heterosexuality and social perceptions of masculinity.[82] For women, care-taking responsibilities and household chores prevents them from accessing services.[75]

Autonomy influences one's ability to seek care[47] and is closely linked with health literacy. Refugees' knowledge about their entitlement to health[87] as well as their knowledge regarding different healthcare options[69, 72, 96] affect their decision to seek care. Mistrust and scepticism are barriers which re-emerge here too: four different studies reported on refugees rejecting care due to doubt regarding confidentiality, the quality of healthcare or the attitudes of the providers.[64, 77, 85, 93]

11.3.3.3 Ability to reach

Ability to reach healthcare is determined by factors enabling one to physically reach service providers.[47] Levesque argues it is influenced by personal mobility, the availability of transportation, social support, occupational flexibility, and knowledge about health services. Noteworthy is that – with the exception of one study on SGBV[88] - all factors relating to the ability to reach emerged in studies conducted on MH. Once again, this is probably reflective of the criticality of secondary care for safe motherhood.

Similar to how it affects the ability to seek care, the **living environment** and priority with travel also influence refugees' ability to *reach* services. The transient nature of refugees' stays challenges continuity of care[53, 64, 71, 76, 83, 88]. As Shortall et. al[53] explain:

> 'In our experience people were not only in transit physically, but also mentally. Their determination to reach their destination and find safety was understandable, but provided significant challenges when attempting to refer cases to secondary care.'[53](p.277)

The UNHCR report[76] raised a rather alarming point, namely that humanitarian actors do not even attempt to deliver certain SRH services because they believe refugees would not use them given the speed and urgency of their travels. Although this notion is confirmed in other qualitative studies exploring the views of the refugees themselves[69] it is a rather risky assumption for service providers to make.

Transport is an important determinant of refugees' ability to reach services. Joseph et. al[67] explain how on the islands of Greece most refugee camps are situated a considerable travel distance from tertiary care and transport is either not available, expensive or limited. Other studies in Greece confirm this finding.[63, 74] Malakasis et al.[74] add how unfamiliarity with public transport, compounded by language barriers, complicates transport there where it is available. Further hampering timely access are logistical barriers concerning emergency transport, with ambulances not making the trip to camps out of hours.[53, 73, 74, 94]

With regards to the **mobility** of refugees, legal rulings in particular impede access. Grotti et al.[54] describe how helicopter transfers from Lampedusa to tertiary care on the mainland are exclusively offered to women in their final months of pregnancy, resulting in refugees wanting to terminate their pregnancy before three months being exposed to a risky journey by bus and boat. Similarly, de Paoli et al.[73] report that in Greece, refugees are prohibited from using private NGO cars until they are issued certain documentation and are thus dependent on public transport. Besides creating a financial barrier to reach care, this legislation also results in health risks for vulnerable refugees such as pregnant women.

Social support is another determinant of the ability to reach care. Navigating care spaces is often impossible for refugees without the help of a local companion, especially to overcome language barriers.[63, 74, 90]

11.3.3.4 Ability to pay

One study in Greece reported on refugees' *ability to pay* for SRH services.[63] The authors explored refugees' sources of **income** and describe how they would sometimes have to use their monthly UNHCR cash transfer or borrow money to buy medication. Often this is because medication prescribed in the local hospital is not available in camp, highlighting yet another example of poor coordination between primary and secondary service providers.

11.3.3.5 Ability to engage

Factors affecting *engagement with healthcare* were disproportionately underrepresented in the literature, with only eight studies – of which the majority of the 11 factors were deduced from anthropological accounts – honing in on refugee's participation and involvement in healthcare decisions.

Most of the studies examining refugees' **agency** were conducted in MH. The inability to adequately communicate wishes stood out.[68, 71, 74, 80, 85, 88, 90, 93] Scott et al.[68] for instance, describe multiple accounts of women unable to provide informed consent before undergoing procedures such as caesarean sections. Language barriers are key causes, but prejudices and high work burdens amongst healthcare staff also contribute, as illustrated below:

> 'Most midwives and doctors did not interact with migrant patients long enough to be able to detect the agency that women exercised within their culturally conditioned gender roles. […] we argue that this orientalist perception of Syrians as women who have passively surrendered their reproductive agency to the authority of their husbands was reinforced by the almost complete lack of linguistic interpretation in Greek hospitals, where patients stood voiceless in front of over-worked medical personnel scrambling to get their history or symptoms.'[54](p.11)

Having said this, Grotti et al.[54] beautifully narrate how pregnant women are able to voice their concerns and take decisions despite language barriers disempowering them. The women interviewed exercised their **autonomy**, for instance by refusing that pregnancy deterred their onward travels in Spain, clearly requesting an

abortion in Italy, or refusing a caesarean section in Greece. But besides the strong personalities of the women, little insight is given into what contributed to this solid ability to engage. Community representatives play an important role in strengthening agency in Italy.[84] Another facilitator is the graphic interface of the mHealth application evaluated by Borsari et. al [80] which did not require language and thus enabled women's interaction with their maternal health.

11.3.4 Overarching factors inspiring an adjusted framework

Language is neither mentioned nor categorised by Levesque et al.[47] In this review however, it emerged as a crucial determinant affecting every step of a refugee's pathway to care. Certain dimensions like health education (*approachability*) and autonomy (*ability to engage*) are undisputedly affected by the ability to communicate in a common language. But language extends beyond the obvious. For example: already complex appointment mechanisms (*availability and accommodation*) are additionally complicated by language barriers, both on the part of the refugee (unable to understand the signs in the hospital for instance) as well as the service provider (NGO staff unable to organise referrals for example). The affordability of care is similarly affected by language as refugees are unable to navigate the public transport system and thus resort to expensive taxis (*ability to pay*). Even the timeliness of services is jeopardised by language due to crucial interpreting services often being unavailable (*appropriateness*).

A second overarching theme is the transient nature of refugees in Europe. Refugees prioritise reaching their country of final destination over their healthcare needs, which influences their *ability to seek* and *ability to perceive* care. But this population-specific characteristic has a far more profound impact on service delivery, venturing beyond only the demand-side of access. The temporary nature of refugees' stay results in the establishment of what I term 'services in transit', i.e.: services that are transient (inconsistent delivery, lack of continuity, varying implementation of SOPs) and not adequately transitioning to comprehensive care (focus on emergency care, heavy dependence on NGOs, scattered research). An illustrative example is how humanitarian actors abstain from delivering certain SRH services because they believe refugees would not use them given the speed and urgency of their travels.[76]

Figure 6 provides an overview of all the barriers (symbolised by a red minus sign) and facilitators (symbolised by a green tick) identified in this review, classified by subcategory (in bold font) of Levesque's framework. I added two additional horizontal arrows to illustrate how language is a cross-cutting theme which affects all five supply-side dimensions and five demand-side abilities. Furthermore, the dotted circle depicts how the patient-specific characteristic of their journey through Europe also affects both axes, in particular the last four steps required to access care.

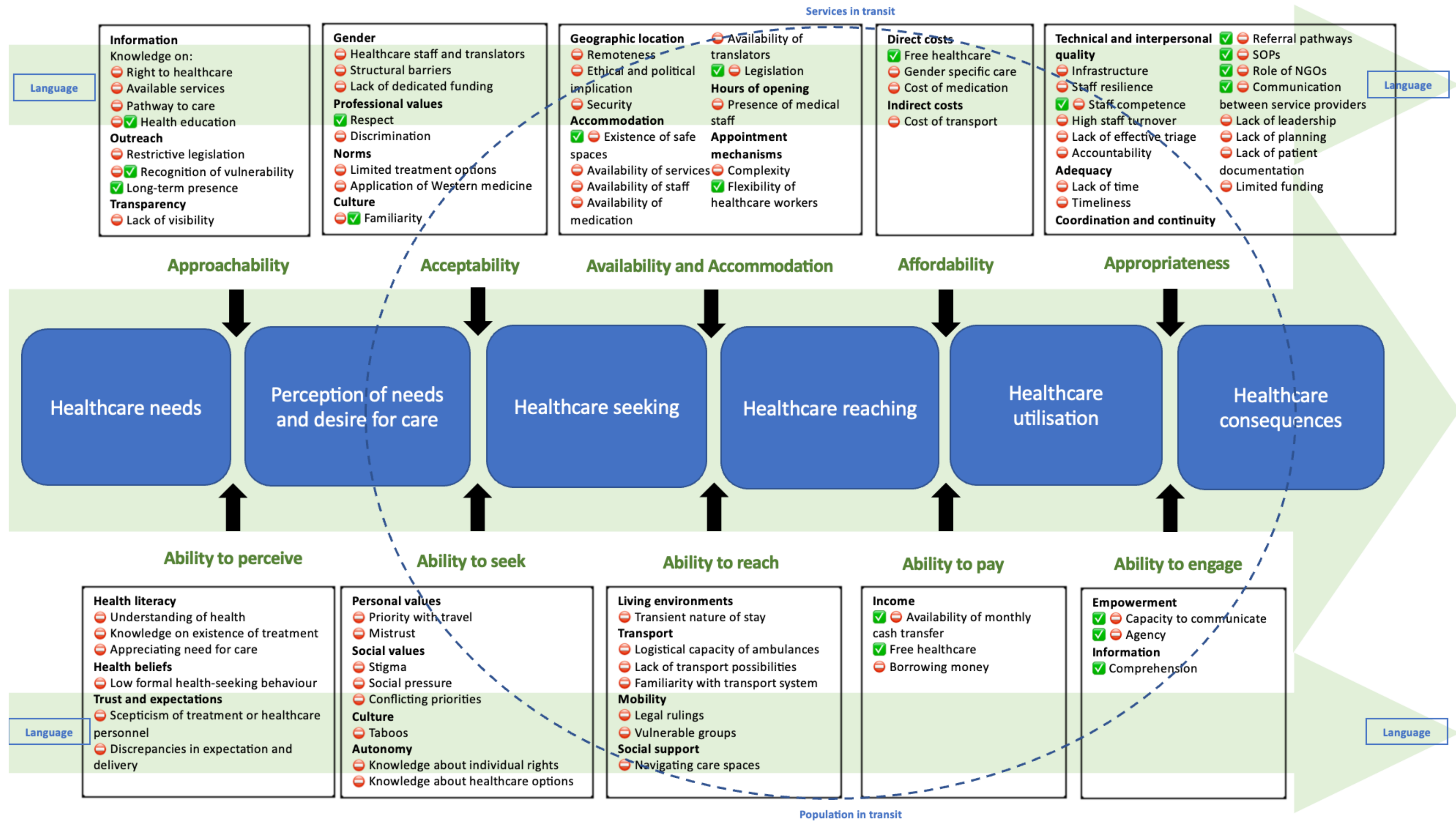

Figure 6. Levesque's framework adapted to show the barriers (-), facilitators (√) and overarching themes found in the review

12 DISCUSSION

12.1 Discussion of key findings

12.1.1 Cautious conclusions due to profound research gaps

The studies – mainly household surveys – quantifying access were almost exclusively conducted in Turkey. Conclusions regarding unmet FP needs and suboptimal access to ante- and postnatal care thus cannot be generalised to the rest of Europe. The focus on Turkey could stem from a greater sense of urgency seeing the large numbers of refugees the country hosts. The population in Turkey is also less mobile than those transiting through Europe, removing logistical barriers for research. However, all household surveys were conducted over an average timespan of a couple of months (and none exceeded one year), demonstrating how similar research initiatives in Europe are not impossible.

The Turkish setting resembles that of Jordan and Lebanon. These countries also host large numbers of Syrian refugees[4] and research on access to SRH services mirrors my findings: little is known about STIs and SGBV, access to ANC is suboptimal and unmet FP needs exist.[97-100] For FP, refugees in Turkey experience similar barriers to those in Jordan and Lebanon,[98] notably misconceptions of the different contraceptive methods and unawareness regarding free services and where to access these. The suboptimal ANC rates identified across the included studies similarly indicate barriers to access, especially since they contrast with the 87.7% coverage in Syria pre-conflict.[99] Concordant with findings from Lebanon,[99] barriers such as transport and lack of female healthcare workers reduce access. An interesting determinant requiring further investigation is the difference between formal and informal camp settings; in Jordan the unmet need is predominantly found in the latter.[99, 101] All five household surveys in Turkey were conducted in informal settlements, but there is reason to believe that access to SRH services might also be higher in formal camps: in a 2013 household survey with 550,000 refugees in Turkey, 60% of non-camp refugees were able to access general healthcare services, compared with over 90% of camp-based refugees.[102]

It is astonishing that the studies in Turkey did not mention SGBV since the brunt of sexual violence occurs during refugees' journey *to* Europe.[18, 19] For example: in a study examining the routine data of 215 SGBV victims in a clinic on Lesbos, half of the incidents (118) had occurred in transit, mainly in Turkey.[103] For refugees entering Europe through the Central Mediterranean route, Libya is infamously risky.[104, 105] The research gap may be due to stigma surrounding SGBV. Indeed, the eight studies examining this sensitive topic constituted predominantly grey literature and were conducted by NGOs who could probably build on existing networks and relationships of trust. Their conclusion is not pretty: the healthcare system is poorly equipped to deal with the high burden of SGBV. Meagre implementation of international guidelines, limited use of SOPs, low competency amongst staff and restrictive laws are the main supply-side barriers to offering care. Safe spaces, particularly for women and adolescents, emerged as important facilitators. Recognizing the pertinence of the problem, the WHO published a technical guide in 2020 on violence and injuries among refugees and migrants in the WHO European Region.[106]

A worrying, yet not unexpected, outcome is the omittance of adolescents in the literature. Only nine articles (of which the majority quantitative household surveys with women aged 15 to 49) included adolescents in their study population. Qualitative research is sparse and none of the publications present disaggregated data. This finding is not new: despite youth under 18 years of age constituting an estimated 30% of all refugees worldwide,[4] they have historically been side-lined in public health programmes and their health has only recently been placed on the global research agenda.[107] The urgency is clear though: adolescents have unique needs, especially regarding contraception and safe abortion,[107] and access health services in different ways than their adult counterparts, with embarrassment, shame, and fear of being judged restricting access.[108] Adolescents who are also refugees are at increased risk of sexual violence.[25, 109] The global community has recognized these unique vulnerabilities and developed guidelines and toolkits for humanitarian actors.[95, 110] Research into health seeking behaviour is still patchy however. Tirado et al.[109] recently published a scoping review on the barriers and facilitators to SRH for refugees aged 10 to 24 years globally. In line with my findings, they found only limited publications and none that focused on refugees in Europe.

What may explain the overall limited evidence base? First of all, it is difficult conducting research in refugee settings with insecurity, limited human and financial resources and a mobile population. Research might also be discouraged since it can be perceived as scepticism to the noble humanitarian cause.[111] Finally, there exists a dissonance between the academic community and humanitarian sector. On the one hand, NGOs do not share their routine operational data with policy makers.[112] On the other hand, evidence from researchers does not reach humanitarian professionals. This is a true shame, for – as this review highlights – the lack of essential (epidemiological) data on health needs hinders effective programme planning and management.

12.1.2 Inadequate supply or insufficiently examined demand?

Despite approximately three quarters of studies exploring refugees as service-users, I identified three times more supply-side than demand-side barriers. The discrepancy can indicate one of two things: either the health system is truly showing more significant faults in ensuring access, or researchers are yet to properly investigate the demand side of service delivery.

On the one hand, the descriptive analyses in the selected (grey) literature, combined with my personal experience on Lesbos, give reason to believe that the health system is indeed failing to meet demand. On the other hand, researchers tend to place more emphasis on the supply dimensions of access.[50] For example, in a scoping review analysing all empirical studies that applied Levesque's framework, questions on *appropriateness of care* outweighed those pertaining to the service *user's ability to engage*.[50] In the WHO European region, the abilities of refugees may have been less thoroughly researched due to time-constraints, language barriers, an inability to accurately comprehend cultural nuances and the complexity of conducting sound qualitative research. Researchers may also feel they are not in a position to draw conclusions on behalf of the refugees. Indeed, only the ethnographic accounts of anthropologists ventured onto the more complex themes of autonomy and agency. Lastly, researcher's ideological motivations coupled with a perceived advocacy role may subconsciously prompt them to focus their attention (and subsequent critique) on the health system. Contrasting this is the interesting difference in tone of the articles conducted in Turkey: authors were less outspoken in pinpointing healthcare gaps and overtly praised the response of the Turkish government.

The truth probably lies in the middle: services are indeed unable to meet the needs of the population, but demand side factors are insufficiently examined. It is precisely for this reason that mixed-methods forms of research are gaining more traction.

12.1.3 A people and system under stress

Despite revealing similar barriers to SRH services as other humanitarian contexts,[109] the WHO European region distinguishes itself by a unique combination of a population in transit accessing services that are a) not comprehensive and b) fragmented, the combination of which results in what I term 'services in transit'. In the following paragraphs I explain how these context-specific characteristics (indirectly) cause the main barriers to access, starting from the individual, zooming out to the service providers and finally honing in on the healthcare system as a whole.

The refugees transiting through Europe are a unique group of service users. They do not speak the same language, come from a different cultural background and demonstrate conflicting expectations of healthcare and perceptions on gender as service providers. Low health literacy, especially for FP and SGBV, means refugees do not appreciate they have a need for care, poorly understand health and lack knowledge on treatment options. Most importantly, the population is focused on reaching the country of final destination, foregoing their immediate health needs. The above factors impact the entire scale of access, from the *ability to perceive* to the *ability to engage* in care. The void between the refugees and service providers contributes to low formal health-seeking behaviour – fuelled by scepticism regarding the effectiveness of treatment, a lack of trust in healthcare personnel and doubts regarding confidentiality. Finally, the inability to adequately communicate their wishes (caused by language barriers but also induced by orientalist prejudices and high work burdens amongst staff) prevents refugees from engaging with their own SRH.

The workforce providing SRH care to refugees face challenges classical for a system which is predominantly run by NGO volunteers in Europe and underpaid civil servants in Turkey. In Greece for instance, when the National Health System was found insufficiently equipped to handle the influx of refugees in 2015, volunteer movements began to fill the gaps. To date, various NGOs, as well as many local ad hoc grassroots organisations and individuals continue to play crucial roles in the healthcare provision for refugees.[113-115] But the system is under stress: high staff turnover and understaffing affect the *availability* and *appropriateness* of services and the dearth of female healthcare workers and translators negatively impacts services' *appropriateness* and refugees' *ability to seek* care. Organisations dependent on volunteers often cannot afford to implement stringent quality control. But investment in cultural sensitivity and staff competence are paramount, especially for SGBV and FGM/C. Attention for occupational health is similarly lacking. Previous studies report poor mental health of staff working with refugees[116, 117] and this review only emphasizes the extent of stress, burn-out and compromised wellbeing of service providers, resulting in poorer *appropriateness* of care and arguably also contributing to the perceived discrimination on the part of the refugees. Lastly, dependence on civil society impacts the *availability* of services since NGOs may refuse to work in certain locations (like detention centres or military bases) due to ethical reservations.

The SRH services available to refugees residing in European refugee camps and informal settlements are far from comprehensive. Although this review was not designed to evaluate the MISP, the included publications indicate poor realization of certain components, notably: ensuring the availability of contraceptives, preventing and managing the consequences of SGBV, providing culturally appropriate menstrual protection and planning for comprehensive SRH services. MISP assessments in refugee camps in Lebanon show similar implementation gaps.[118-120] The scarce *availability* of services in turn affects the *acceptability* of care since discrepancy between refugees' expectations and actual SRH delivery leads to feelings of dissatisfaction and perceived discrimination. What is causing the failure to adequately transition to comprehensive services? As I explain in the following sections, the European political climate and dependence on NGOs play important roles. Additionally, a lack of funding and absence of dedicated research inhibits planning for comprehensive services. Furthermore, this review highlights a lack of coordination, leadership and accountability as important factors. This is in line with the IASC's (Inter-Agency Standing Committee) 'Transformative Agenda', which calls for a change of attitudes in the above three areas in order to strengthen humanitarian responses.[121]

Where available, the delivery of SRH services is inconsistent and continuity of care compromised. Fragmentation is caused predominantly by organisational weaknesses: complex appointment mechanisms hindering referrals, a lack of standardised SOPs and ineffective communication between medical, non-medical, primary and secondary service providers resulting in poor *appropriateness* of care. The absence of uniform vulnerability criteria and differing national legislation affects SGBV services in particular. The discrepancies between camps can be explained by differences in management and varying presence of NGOs. What causes the disparities between countries is less well understood. The presence of an existing asylum structure in a country such as Italy might explain why it was better equipped[59] to handle the influx of refugees than Greece for instance, which was also in the midst of an economic crisis.[122]

12.1.4 The contested role of civil society

The transition into comprehensive and integrated SRH services may unintentionally be hindered by civil society. On the one hand, NGOs are instrumental in addressing refugee SRH needs. They often fulfil a multifaceted role, venturing beyond pure service delivery to research, advocacy and policy advice. Often this is ex gratia of them being non-political actors building on trust gained by a population who notoriously fear government officials.[123] However, this review also highlights how competition, scant collaboration and funding insecurity of NGOs causes service delivery gaps and duplication of efforts. Many have been found to be 'out of sync'[124](p.3) with the government, replicating public services and undermining both state responsibility as well as refugee agency.[124] Furthermore, conflict between the state and NGOs can reinforce refugee marginalization.[125] A personal example: when the state tightened regulations on foreign institutions on Lesbos[126] and tensions between camp management and aid workers rose, refugees were caught between dependency on our NGO and limited power to advocate for themselves.

What then, is the position of humanitarian actors in a wealthy Europe? In my opinion, the key is to improve governance, harmonise services and ensure a bridging of the humanitarian-developmental nexus. It is widely

recognized that humanitarian, development and peacebuilding actions should be implemented simultaneously, focusing on common goals.[127] In 2016, the international community made a commitment to strengthen the relationship between the three activities in order to facilitate the transition from reactive responses to more sustainable, long-term solutions. This 'New Way of Working'[127] was developed for fragile and conflict-affected countries, but based on the outcomes of this review, I argue it urgently needs to be applied to the WHO European region too.

12.1.5 A perpetual culture of emergency

One cannot analyse SRH access for refugees without placing it within its larger context. Xenophobic rhetoric is currently part and parcel of European politics[128] with migration being depicted as 'an exceptional circumstance to be responded to as a short-term emergency'(p.40).[123] The advent of refugees to Europe since 2011 has been coined a 'crisis' both in terms of numbers as well as the perception that these numbers strain the host countries' already tight resources.[70]

The above narrative has consequences for the health of refugees. First of all, public debates and academic research have traditionally focused on the assumed economic impact of migration streams[129] and potential public health risks, foregoing individual health needs and seeing refugees as 'external' to health systems.[123] This is particularly detrimental for SRH, where the rights-based approach is progressively recognized as a crucial component of service delivery. Secondly, the term 'crisis' has resulted in a perpetual culture of emergency; a situation in which exceptional measures – which, as illustrated in this review, may well be subpar – are normalised, accepted and deter structural change. This may explain why, 25 years after the development of the MISP and 10 years after the first refugees arrived on European shores, delivery of comprehensive SRH services integrated into primary healthcare remains a challenge. Thirdly, the anti-migration discourse may be the cause of the discrimination experienced by refugees. It is noteworthy that the perceived racism was consistently identified in relation to the local hospital staff and not NGO workers. Humanitarians historically hold more left-wing political views and often work with refugees to offer a rebuttal to the mainstream xenophobic rhetoric.[130]

In summary, this review depicts a daily climate of emergency with underfunding, staff shortages, overtaxed personnel, inconsistent services and failing infrastructure. Structural racism compromises appropriate services since it guides research, influences health system organisation and gives rise to social ideologies that wear off on staff. I can only agree with Christopoulos who advocates for a recognition of the non-transient and non-exceptional character of refugees in Europe, and subsequent allocation of resources towards their reception and integration.[131]

12.1.6 Promising openings

The frequency of factors may indicate significance, but should not be assumed. With less than 10% of the in total 246 identified factors comprising facilitators, SRH services for refugees seem exceptionally difficult to access. Identifying barriers or facilitators offers a practical means to arrive at recommendations: barriers must be overcome and facilitators promoted. However, the complex phenomenon of access to care in the even more complex refugee setting of Europe cannot be reduced to a quantitative evaluation of barriers and facilitators.[132] By only examining the frequency of factors, likely explanations for the recurrence of certain concepts are disregarded, such as the influence of popular discourse,[132] relative ease of formulating known barriers,[132] and accumulation of evidence within specific research groups. For example: Grotti and Malakasis contributed to three, and Chynoweth to two of the 41 included studies.

Facilitators have meaningful impact, despite their infrequency. Health education, especially when tailored to the target population, substantially increases access. Friendly and respectful attitudes of healthcare providers promote the *acceptability* of care and cultural training fosters understanding between service providers and users. For refugees, social support from service providers, especially in navigating unfamiliar care spaces increases their *ability to reach* healthcare. Close collaboration with national staff mitigates for language barriers during referrals and community representatives are key in strengthening agency. These facilitators to SRH delivery echo those found in conflict settings in LMICs.[27, 133] A crucial facilitator not mentioned in other contexts but emphasized in this review are safe spaces – fundamental for the provision of gender-sensitive and culturally appropriate services.

For the mobile population in the WHO European region, technology offers novel openings. The ANC mHealth application researched in Italian refugee camps is an example of a promising intervention that capitalises on the above facilitators.[80] The system effectively collects clinical data, identifies high-risk pregnancies and encourages healthcare providers' adherence to guidelines. Furthermore, the graphic interface stimulates patient engagement and facilitates retention of health education. The application thus presents a solution to tackling the language barriers, low health literacy, limited patient engagement, workforce shortages, poor coordination between healthcare providers and limited use of SOPs identified in this review. In transit centres in Serbia and Slovenia CSOs also innovatively use technology to combat the lack of formal case management for survivors of SGBV. Informal networks between CSOs in neighbouring countries were developed and maintained through mobile communication so that refugees with special needs would be appropriately accommodated as they moved across borders. This offers a solution to the principal barriers of poor coordination and inadequate continuity of care.

12.2 Strengths and limitations

To my knowledge, this is the first study to provide an overview of the barriers and facilitators affecting access to SRH services for refugees residing in camp and camp-like settings in the high-income WHO European Region. Given that displacement to Europe is only expected to increase in the future (not least due to climate change), the topic is not only timely, but also answers a societal need for research which can inform service-providers and improve the health of service-users.

The review has various strengths. Firstly, it was based on sound methodological reasoning. The search strategy and associated syntax were meticulously thought-out and including broader studies on general health ensured that potential articles referring to SRH but not denoting this in the title or abstract were not omitted. A rich base of grey literature sources was consulted yielding valuable results. While it was sometimes challenging to meaningfully synthesize findings due to the inherently different methodologies, including quantitative, qualitative and mixed-methods forms of research provided a comprehensive overview of a sparingly researched domain. Levesque's framework brought structure to the analysis and guaranteed none of the supply- or demand-side factors were missed. The inductive analysis granted me a profound understanding of the – often complex – themes. Realising that the relevance and significance of barriers and facilitators are context-dependent,[132] I attempted to not only identify the most 'frequent' and in turn 'important' factors, but examined their interdependence, viewed them in light of broader social phenomena and developed theoretical explanations of the dynamics causing these barriers and facilitators. Furthermore, I undertook measures to enhance the quality of data collection and analysis through consultations with the thesis advisor as well as external experts.

However, the study also has limitations. Despite the extensive search in both peer-reviewed and grey literature, it is always possible that studies were overlooked. A major problem in sourcing evidence stems from the wide variation in the definition of refugees and asylum seekers and its inconsistent use in the WHO European Region. Additionally, time and practical constraints meant a second researcher could not validate the data collection process, including the coding and thematic analysis. I was also unable to aggregate the data by type of residence or SRH field owing to the limited number of studies and the heterogeneity in outcomes. Caution must furthermore be exercised in generalising the review's findings since these might not always provide an accurate representation of the diverse and dynamic field. First of all, only English studies were included. Secondly, European and national policies regarding refugees have changed over the years, as have countries' responses to their health needs. Thus, the identified barriers and facilitators to services can rapidly become historical. Important to take into consideration too is my personal bias: experiencing the daily frustrations of offering SRH care in a refugee camp could have coloured my conclusions. However, to mitigate, I ensured the analysis was as standardized and transparent as possible, and methodically discussed outcomes with the thesis advisor.

12.3 Evaluation of Levesque's framework

Levesque's clear and comprehensive depiction of the route to access provided a valuable structure for this review's analysis. None of the included studies used the framework to guide their research, but I was

nevertheless able to place outcomes in both the demand as well as the supply axes of the model. Perhaps using the framework proactively would encourage researchers to incorporate both aspects of access into their studies and in doing so, diminish the overemphasis on supply-side factors.

However, the framework also presented challenges. In line with experiences of colleagues,[50] there were repeated instances where factors belonged to more than one dimension or ability. For example, the remoteness of refugee camps could either be placed under the *availability* dimension when regarding it in the context of *geographic location*, or under *affordability* if *indirect costs* were taken into account. Another example is discrimination, which could be a deficit in *interpersonal quality of care* categorized under *appropriateness*, a lack of *professionalism* affecting the *acceptability* of care, but also a factor influencing refugees' *ability to engage.* Having said this, this 'flaw' in the framework may present an important conclusion to the research objectives, namely that we must continue to look at access holistically and recognise the interdependence of factors. Only targeting specific factors will ultimately delay sustainable solutions. The patient-centeredness of the framework had its disadvantages too: it was particularly difficult to categorize the perceptions and abilities of healthcare workers. For example, I categorised staff resilience under the subheading of *technical and interpersonal quality* within the dimension of *appropriateness* but feel this does not do justice to the impact it has on access.

In conclusion, the inherent complexity of access coupled with the inherent complexity of a mobile population journeying through a dynamic health system makes it challenging to clearly demarcate certain dimensions and abilities of access. While chosen for its broad application, it was exactly this lack of specificity which turned out to be a major drawback of Levesque's framework. I believe that in order to adequately analyse access to health for marginalized groups such as refugees, one needs to incorporate into the framework aspects unique to the population (such as language and their mobile nature) as well as elements unique to the setting (such as the political backdrop and structural discrimination). My adapted version (figure 6) is an attempt thereof.

13 CONCLUSION AND RECOMMENDATIONS

13.1 Conclusion

Despite increased attention for the SRH of refugees in the WHO European region, the field is still poorly researched: studies quantifying access are limited to Turkey, adolescents are not accounted for and studies on SGBV are restricted to mainly grey sources. The lack of a solid evidence base may explain why health responses to date are failing to meet the SRH needs of refugees transiting through Europe. Refugees demonstrate unmet FP needs and limited use of ante- and postnatal care. Access is influenced most significantly by supply-side barriers. Most noteworthy are flaws in the provision of gender-sensitive services, language barriers and staffing challenges. With regards to the workforce, strained resilience, high turnover and low expertise (especially in the fields of SGBV and FGM/C) impede the delivery of appropriate care. Important demand side factors include poor health literacy, language barriers and a lack of trust in the offered services.

While refugees in the WHO European region experience similar barriers to those in LMICs, access to SRH services is complicated by the unique European context. The refugees are a mobile population 'in transit', prioritising reaching their country of final destination over their healthcare needs. The temporary nature of their stay creates a culture where providers focus on emergency care, with heavy dependency on the often-fragmented services of NGOs. Poor coordination between service providers as well as the absence of uniformly applied vulnerability criteria and SOPs causes duplication of efforts, gaps in services and jeopardized continuity of care. Xenophobic European politics compromises appropriate service delivery since it deflects essential research, influences health system organisation and gives rise to social ideologies that wear off on staff. The result are scattered services that are 'in transit' and not adequately transitioning along the humanitarian-development nexus.

The outcomes of this review – highlighting the importance of language as well as the unique characteristic of the refugees as a mobile population – resulted in a proposed revised version of Levesque's framework. This has the potential to resonate in other refugee settings. Furthermore, the results offer important target areas for service providers, camp managers, policy makers and researchers alike. Refugees are entitled to the same universal human rights as all people. Capitalising on the main supply-side facilitators of health education, cultural training for staff and the creation of safe spaces in addition to the important demand-side facilitator of collaboration with community representatives, can offer a valuable first step towards equitable SRH access and UHC.

13.2 Recommendations

Following from the above conclusions, it is evident that the SRH landscape for refugees in the WHO Europe region needs to adapt to an increasingly complex reality. Below I outline the recommendations that can be made on the basis of this review, organised per sector. The focus is on strengthening the quality, accessibility and continuity of the 'services in transit' in the hope that - despite refugees still prioritising their journey – this will lower the threshold to access. The recommendations target each of the six building blocks of health systems (service delivery, health workforce, health information systems, access to essential medicines, financing and leadership/governance).[134]

Overall, the recommendations for service providers have the potential to have an instantaneous effect and are expected to be the easiest to realise; thus there is no reason to postpone implementation. The recommendations for camp managers and researchers will require funding and more robust planning and therefore may not be immediately implementable. Finally, the recommendations meant for policy makers and governing bodies – albeit arguably the most crucial factors determining sustainable change – will require first and foremost political will. It is my hope that this review has illustrated the urgency of such a culture change.

13.2.1 Recommendations for service providers

1. **Deliver culturally appropriate health information tailored to the needs of the population**

In order to promote access to SRH services, refugees need to be aware of their entitlements and healthcare options. Verbal sessions and health education programmes hold preference over written information.

Trust is crucial for refugees to feel they can access services. Such relationships can be built by showing interest, respect, empathy and acceptance of differences in sexual orientation or gender identity. Furthermore, it is important to stress confidentiality, discuss healthcare expectations, and be transparent about the availability of services.

2. **Pay attention to gender-sensitive care**
   The presence of female interpreters and medical personnel facilitate access for women refugees. Professional interpretation is a priority which is critical for the provision of appropriate, timely care and promotion of refugee agency. Interpreting services should be made available for appointments and referrals to secondary services as well, to aid refugees in navigating these often unfamiliar and administratively complex spaces.

   For male survivors of SGBV it is important to establish special access points. Service providers should advocate for dedicated safe spaces that are built and staffed in a gender-sensitive manner, with adequate resources (space, equipment, medication). Safe spaces for both sexes have the potential to increase the acceptability of care and can provide opportunities for health education.

3. **Invest in occupational health and staff capacity building**
   The physical and mental health of staff working with refugees in challenging contexts should not be underestimated. Vitality plans need to be implemented and psychological aid made available so as to ensure a healthy and resilient workforce who are able to deliver quality services.

   Cultural training is often well appreciated by healthcare staff and can improve the acceptability of services. Furthermore, intercultural mediation has proven effective in the delivery of people-centred care.[135] Training on refugee specific healthcare needs such as SGBV and FGM/C is pertinent. A set of national core competencies for staff working with refugees and continuous professional development plans can be considered.

   Staff shortages and high turnover can be tackled by investing in strategies to retain workforce, such as providing financial incentives and investing in capacity building. This is key to ensuring access since long-term staff presence improves trust in the refugee community, prevents inconsistencies in service delivery, protects against disproportionate work burden and helps combat the loss of institutional memory.

13.2.2 Recommendations for camp managers

1. **Engage with the refugee community**
   A participatory approach, including regular communication with community representatives and involving them in decision making processes, increases the population’s agency and empowers them to be active participants of their own SRH. Camp managers should ensure information sessions are organized informing refugees about their entitlements to healthcare and the existent pathways to services. For refugees residing in informal settlements, outreach campaigns should be undertaken.

2. **Develop and institute standardized systems of care and ensure continuity**
   Clear and strong referral pathways are crucial to ensuring access. Camp management also plays an important role in coordinating the development and implementation of uniform SOPs that all medical actors adhere to. Furthermore, uniform vulnerability criteria should be developed and standardized to ensure that all actors are able to identify, prioritize and respond to individuals who have heightened SRH risks. To reduce financial and logistical barriers to accessing care, transport to and from services should be arranged, for instance through voucher systems.

3. **Demonstrate leadership, promote coordination and implement accountability mechanisms**

In promoting conducive communication between medical actors in camps, between medical actors inside and outside camps and between medical and non-medical actors, camp management should take a coordinating and leading role. It is only then that efforts will not be duplicated and the whole range of necessary SRH services can be offered.

It is the responsibility of camp management to ensure that minimum standards of service delivery are being adhered to. Appointing SRH coordinators that ensure all elements of the MISP are in place is a suitable first step. When the state is unable to provide the necessary SRH services, subcontracting NGOs can form an option.

Transparency and accountability are important components of governance and improve the technical and interpersonal quality of care. Although accountability for SRH in humanitarian settings is challenging to achieve, effective strategies are open-ended feedback from the refugee population, quality improvement cycles, and practical application of standards.[136]

13.2.3 Recommendations for policy makers

1. **Tackle the humanitarian-development divide**
   To support the transition from the MISP to comprehensive SRH programmes it is imperative to bridge the divide between the acute emergency response and long-term strategic planning. This can be achieved by following the steps as outlined in the WHO Guide to Implementing the Humanitarian-Development-Peace Nexus for Health[127] and 'undertaking a joint assessment, agreeing on collective outcomes, developing and implementing a joint multiyear plan, harmonizing resources and financing, and monitoring and evaluating both the nexus process and its outcomes.'(p.4).[127]

2. **Improve multilateral coordination by deploying the WHO's 'Whole of Society' approach**
   'Working with society' has become a signature strategy for the WHO European Region. Health 2020, the new European policy for health and well-being for the 21st century, promotes intersectoral, interdepartmental, collaborative governance which extends beyond the state and includes the private sector, civil society, communities and individuals.[124] For refugee SRH, this approach is essential in ensuring comprehensive services, especially when attempting to guarantee continuity of care across borders. Policy makers should increase interagency collaboration, establish cross-border mechanisms where they do not exist (including case management and referrals) and encourage the academic community to collaborate with humanitarian organisations.

3. **Adapt the legislative framework**
   The absence of uniformly applicable vulnerability criteria translates to uneven access and restrictive national legislation can negatively affect service delivery for SGBV in particular. It is therefore imperative that uniform vulnerability criteria are established and national SRH policies and strategies are implemented into existing legislation.

13.2.4 Recommendations for researchers

1. **Collaborate with humanitarian actors, evaluate service delivery and conduct implementation research**
   Recent systematic reviews have found that the absence of quality data on women's, children's and adolescents' health in emergencies hinders the design and implementation of sustainable interventions[111] and undermines the monitoring and evaluation of humanitarian health activities.[137] It is imperative that the international community adopt a more scientific approach to monitoring and evaluating programmes such as the MISP so that impact can be assessed and implementation gaps targeted.

   Systematic data collection by NGOs should be shared with policy makers in order to inform strategy development. In turn, researchers need to actively reach out to NGOs with their results so that humanitarian programming can be supported by much needed evidence.

2. **Conduct health needs assessments**

   Individual preferences of donors have historically been the primary drivers influencing the implementation of SRH interventions in humanitarian settings.[138] However, tailored healthcare can only be accounted for if the needs of a population group are understood. To support evidence-informed policy planning and development, accurate and relevant data is thus paramount. Health needs assessments can provide valuable information in ensuring a systematic approach is deployed through which a comprehensive understanding of priorities for intervention can be gained.[139] Furthermore, by deploying a mixed methods approach, researchers can consciously include the demand-side of access into their models. SGBV and adolescents require conscious attention.

14 EPILOGUE

In line with the theme of transit outlined in this scoping review, writing this thesis has been a journey for me too. At the end of 2020 I returned from Lesbos exhausted, eager to embark on the Master's programme in the comfort of the online classroom and to engage with the material from a safe distance. Now, less than a year later, equipped with new knowledge, skills and enthusiasm, I am just as eager to go back.

I followed modules on humanitarian crises, studied the intricacies of global SRH, learned how to analyse disrupted health systems and got introduced to quality management. This thesis was a chance to consolidate all of the above. Writing it was an educational, intriguing but also distressing journey. The quantitative data was often shocking and the qualitative accounts brought tears to my eyes on more than one occasion. At the same time, the confrontation with the current evidence base fuelled my desire to conduct more research. The module on Mixed Methods research in International Health convinced me of the value of this methodology and this is what I hope to do next: to use this scoping review as a stepping board to conduct further research on the SRH needs of refugees in Europe.

Tragically, the migration streams into Europe are showing little sign of ceasing. But beyond the politics of what is driving the displacement and semantics of what a 'crisis' entails, lies the fundamental human right to ensure quality healthcare for all. I dream of a Moria where I walk in the main market street and see refugees taking ownership over their own health. Where NGO initiatives are seamlessly integrated into state efforts and where we are not still providing ad-hoc humanitarian assistance five years down the line. Where Sarah is able to obtain an IUD in a dignified manner and where James receives the mental health support he needs.

It is my hope that this thesis will help motivate and inform concrete action. It is time we start investing in sustainable solutions for the health of refugees, working towards medical programmes that are tailored to the needs of the target population and generating data that our politicians can no longer ignore.

15 ANNEX A. Migration routes to the WHO European region

Figure 7. Map showing the main migration routes into the WHO European region

Source: Border Violence Monitoring Network, 2020[140]

15.1 The Western Mediterranean route

The Western Mediterranean route is a historic crossing point between North Africa and Spain and includes a maritime as well as terrestrial route to the Spanish enclaves of Melilla and Cueta which share land borders with Morocco.[141] Indeed Moroccans, mostly young men, have been the most common nationality making use of this route.[142] In 2018, the Western Mediterranean route was the most frequented entry point into Europe, following an increase in refugees traveling to Europe from Sub-Saharan countries.[143] Overall, after Moroccans, the most common nationalities seen are Guineans, Malians and Algerians.[143]

15.2 The Central Mediterranean route

The Central Mediterranean route describes the overseas crossing from North Africa to Italy and Malta and is both the most common as well as dangerous route into Europe.[142] Other points of entry include the islands of Lampedusa, Linosa, Lampiona, Sicily and Sardinia.[141] Most refugees depart from Libya, which is a transit as well as departure country.[142] However, recent years have demonstrated an increase in departures from Tunisia, Egypt and Algeria too.[142] In 2018, two thirds of all refugees using this route were Tunisians and Eritreans.[143] Of the children traversing the Mediterranean to Italy and Malta in 2019, 76% and 85% respectively were unaccompanied, coming mainly from Somalia, Sudan, Eritrea, and Tunisia.[141]

15.3 The Eastern Mediterranean route

The Eastern Mediterranean route describes the route which is used by mainly Syrians, Iraqis and Afghans to cross from Turkey to Greece and, to a lesser degree, Cyprus and Bulgaria.[141] After a peak in 2015, the number of refugees using this rout dropped sharply in March 2016 after the implementation of the EU–Turkey agreement.[142]

15.4 The Western Balkans route

The Western Balkans route describes the route from Greece or Bulgaria to Hungary through North Macedonia, or to the Western European countries via Serbia, Bosnia and Herzegovina and/or Croatia.[142] Use of this route reached a peak in 2015, and decreased after the abovementioned EU-Turkey deal, but continues to be regularly frequented by mainly Afghani, Pakistani and Iranian refugees in 2018.[141]

15.5 Other noteworthy crossings

From the port of Calais in France, people have attempted crossing the channel to the United Kingdom since the 1990s.[142] Typically, this route was risked by young men, but recent statistics of 2020 portray an increase of unaccompanied children and families as well.[142]

16 ANNEX B. Overview of the refugee camps in the WHO European region and organisation of healthcare

Country	Camps	Access to healthcare
Croatia	In Croatia there are two reception centres or which the average length of stay was 3 months in 2018; it is estimated that more than 70% of refugees leave the country a few weeks after having lodged their application for international protection.[144]	Refugees are entitled to emergency health care.[144]
France	In France, despite the increase in reception capacity and creation of new centres, a number of regions continue to face severe difficulties providing housing to asylum seekers: only 51% of asylum seekers eligible for material reception conditions were accommodated at the end of 2020. In Paris, several informal camps still exist as of early 2021, despite many dismantlement operations by the authorities. In Calais, regular dismantlement operations have been carried out since 2015, but hundreds of migrants still live in makeshift camps in the area. In some other cities (Nantes, Grande Synthe, Metz) asylum seekers also often live on the streets.[145]	Asylum seekers have access to health care thanks to the universal healthcare insurance (PUMA) system.[145]
Greece	Six RICs or 'hotspots' exist in Fylakio, Lesvos, Chios, Samos, Leros and Kos. The average processing time at first instance was reported to be 10.3 months in 2019. The closure of the Western Balkan route in March 2016 resulted in an unprecedented burden on the Greek reception system. Thirty temporary camps were subsequently created on the mainland in order to increase accommodation capacity. In December 2019, a number of 24,110 persons were accommodated in mainland camps and an additional 21,620 people were accommodated under the UNHCR accommodation scheme (ESTIA). However, due to the ongoing lack of sufficient capacity, refugees continue resorting to makeshift accommodation in urban areas of (primarily) Athens and Thessaloniki.[11]	Health care is offered free to all refugees; a PAAYPA (Foreigner's Temporary Insurance and Health Coverage) number is issued to asylum seekers together with their asylum seeker's card. With this number, asylum seekers are entitled free of charge access to necessary health, pharmaceutical and hospital care.[11]
Hungary	In Hungary, there are two reception centres and one home for unaccompanied minors (UAMs).[146]	Access to health care covers essential medical services and corresponds to free medical services provided to legally residing third-country nationals: treatment by general practitioners is thus free, but all specialised treatment conducted in policlinics and hospitals is free only in case of emergency and upon referral by a general practitioner.[146]

Hungary	In Hungary, there are two reception centres and one home for unaccompanied minors (UAMs).[146]	Access to health care covers essential medical services and corresponds to free medical services provided to legally residing third-country nationals: treatment by general practitioners is thus free, but all specialised treatment conducted in policlinics and hospitals is free only in case of emergency and upon referral by a general practitioner.[146]
Italy	In Italy, by the end of 2020, four First Aid and Reception Centres (CPSA) were operating in Apulia (Taranto) and Sicily (Lampedusa, Pozzallo, and Messina). In case of unavailability in the first reception centres, Emergency Reception Centres (CAS) are used. The CAS system, originally designed as a temporary measure to prepare for transfer to second-line reception, expanded in recent years to the point of being entrenched in the ordinary system. The SAI (System of Accommodation and Integration) subsequently accommodates refugees in apartments. In addition to the abovementioned reception centres, there is also a network of private accommodation facilities which are not part of the national reception system, provided for example by Catholic or voluntary associations.[147]	Asylum seekers are required to register with the National Health Service and enjoy equal medical rights to Italian citizens.[147]
Slovenia	In Slovenia, asylum seekers are accommodated in the Asylum Home in Ljubljana and its three branch facilities. The turnover of people in the reception facilities is high; the average duration of accommodation in 2020 was 28 days.	Asylum seekers have the right to emergency medical care. Children and students up to the age of 26 are entitled to the same healthcare as their Slovenian counterparts.[10]
Spain	In Spain, accommodation during the first phase of reception can take place in either Refugee Reception Centres (CAR) or reception facilities managed by subcontracted NGOs. There are a total of 4 CARs on the Spanish territory and two Migrant Temporary Stay Centres (CETI) in the autonomous cities of Ceuta and Melilla. This type of centre hosts any migrant or asylum seeker that enters the Spanish territory undocumented, either by land or by sea and arrives in the Ceuta and Melilla enclaves.[148]	Spanish law foresees full access to the public health care system for all asylum seekers.[148]
Turkey	The government takes the lead role for implementing assistance through the Prime Ministry of Disaster and Emergency Management Authority (AFAD). The only Reception and Accommodation Centre is in Yozgat and has a modest capacity of 100 places.[7] As of 2021, seven government-run refugee camps exist but only 1.4% of Syrian refugees live in these camps; the rest are dispersed throughout the country.[8]	As of 2013, Turkey introduced universal health coverage to its citizens, including Syrian refugees. Healthcare services are provided free of charge through primary healthcare centres, medical emergency stations, and tent hospitals. Refugees also have access to Ministry of Health run hospitals.[149]

17 ANNEX C. Key domains and operational definitions

Domain	Term	Operational definition
Population of interest	Refugees	Someone who has been forced to flee their country of origin due to conflict, persecution, or violence, and who cannot return to their home country, as defined by the UNHCR.[150]
Geography	Europe (countries of transit and arrival)	Europe as defined by the WHO, referred to as the WHO European region.[151]
Setting	Formal and informal settlements	As defined by the CCCM (Camp coordination and camp management) Handbook by the UNHCR[152]: Formal camp: a site intentionally built or modified to host people. The government formally recognises its site and is responsible for its administration, often supported by humanitarian organizations for its management. Government and humanitarian organizations provide basic services, infrastructure, and assistance. Informal settlement: Congregations of five or more households, living outside a formal camp, and either within 1) the same shelter, 2) a shared boundary, or 3) a similar shelter typology.
Area of interest 1	Sexual and reproductive health	"A state of physical, emotional, mental and social well-being in relation to sexuality, and not merely the absence of disease, dysfunction or infirmity" as defined by the WHO,[13] which encompasses the prevention, detection, and management of SGBV, STIs and infertility as well as a choice to safe and effective contraception, abortion services and maternal healthcare.[14]
Area of interest 2	Access to healthcare	Acknowledging that there is no universally accepted definition for access, I opted to use Levesque et. al's definition: "the opportunity to reach and obtain appropriate health care services in situations of perceived need for care."[47] Key words include the five A's of affordability, availability, accessibility, accommodation, and acceptability, as coined by Penchansky et. al.[153]
	Barrier	Conditions or obstacles preventing individuals from accessing care.
	Facilitator	Conditions or obstacles promoting individuals to accessing care.

18 ANNEX D. Full search history

18.1 MEDLINE

18.1.1 Search terms (MeSH and free text)

Term 1: refugees (population)	
MeSH	"Refugees"[Mesh]
Free text	"Refugees"[Title/Abstract] OR "refugee"[Title/Abstract] OR "migrant"[Title/Abstract] OR "migrant"[Title/Abstract] OR "immigrant"[Title/Abstract] OR "immigrants"[Title/Abstract] OR "transient"[Title/Abstract] OR "transients"[Title/Abstract] OR "displaced person*"[Title/Abstract] OR "asylum seek*"[Title/Abstract]
Term 2: SRH (domain)	
MeSH	"abortion, induced"[MeSH Terms] OR "abortion, spontaneous"[MeSH Terms] OR "abortion, threatened"[MeSH Terms] OR "Contraception Behavior"[MeSH Terms] OR "Contraception"[MeSH Terms] OR "Family Planning Services"[MeSH Terms] OR "Gender-Based Violence"[MeSH Terms] OR "genital diseases, female"[MeSH Terms] OR "genital diseases, male"[MeSH Terms] OR "HIV"[MeSH Terms] OR "Maternal Health Services"[MeSH Terms] OR "Maternal Health"[MeSH Terms] OR "Maternal Welfare"[MeSH Terms] OR "Rape"[MeSH Terms] OR "Pregnancy Complications"[MeSH Terms] OR "Reproductive Behavior"[MeSH Terms] OR "Reproductive Health Services"[MeSH Terms] OR "Reproductive Health"[MeSH Terms] OR "Reproductive Medicine"[MeSH Terms] OR "Reproductive Techniques"[MeSH Terms] OR "Sex Offenses"[MeSH Terms] OR "sexual dysfunction, physiological"[MeSH Terms] OR "sexual dysfunctions, psychological"[MeSH Terms] OR "Sexual Health"[MeSH Terms] OR "Sexual Trauma"[MeSH Terms] OR "Sexually Transmitted Diseases"[MeSH Terms] OR "Women's Health Services"[MeSH Terms] OR "Women's Health"[MeSH Terms]
Free text	"abortion*"[Title/Abstract] OR "contracepti*"[Title/Abstract] OR "family planning"[Title/Abstract] OR "Gender-Based Violence"[Title/Abstract] OR "genital disease*"[Title/Abstract] OR "HIV"[Title/Abstract] OR "maternal health*"[Title/Abstract] OR "Maternal Welfare"[Title/Abstract] OR "Rape"[Title/Abstract] OR "reproductive behavi*"[Title/Abstract] OR "reproductive health*"[Title/Abstract] OR "sex offen*"[Title/Abstract] OR "sexual dysfunction*"[Title/Abstract] OR "sexual health*"[Title/Abstract] OR "sexual trauma*"[Title/Abstract] OR "sexually transmi*"[Title/Abstract] OR "women's health*"[Title/Abstract]
Term 3: General health (domain)	
MeSH	"Personal Health Services"[MeSH Terms] OR "Delivery of Health Care"[MeSH Terms] OR "Health Status"[MeSH Terms:noexp] OR "Health Status Disparities"[MeSH Terms]
Free text	"healthcare"[Title/Abstract] OR "health care"[Title/Abstract] OR "health service*"[Title/Abstract] OR "Health Status"[Title/Abstract]
Term 4: Refugee camps (context)	
MeSH	"Refugee Camps"[MeSH Terms]
Free text	"camp*"[Title/Abstract] OR "hotspot*"[Title/Abstract] OR "settlement*"[Title/Abstract] OR "cent*"[Title/Abstract] OR "shelter*"[Title/Abstract] OR "Moria"[Title/Abstract] OR "Calais"[Title/Abstract] OR "Chios"[Title/Abstract] OR “Lampedusa” [Title/Abstract] OR “Samos” [Title/Abstract]
Term 5: Europe (context)	
MeSH	"Europe"[MeSH Terms] OR "Turkey"[MeSH Terms]
Free text	"Albania"[Title/Abstract] OR "Andorra"[Title/Abstract] OR "Armenia"[Title/Abstract] OR "Austria"[Title/Abstract] OR "Azerbaijan"[Title/Abstract] OR "Balkan"[Title/Abstract] OR "baltic states"[Title/Abstract] OR "Belgium"[Title/Abstract] OR "Bosnia"[Title/Abstract] OR "Herzegovina"[Title/Abstract] OR "Bulgaria"[Title/Abstract] OR "channel island*"[Title/Abstract] OR "Croatia"[Title/Abstract] OR "czech republic"[Title/Abstract] OR "Denmark"[Title/Abstract] OR "England"[Title/Abstract] OR "europe*"[Title/Abstract]

	OR "Finland"[Title/Abstract] OR "France"[Title/Abstract] OR "Georgia"[Title/Abstract] OR "Germany"[Title/Abstract] OR "Gibraltar"[Title/Abstract] OR "Greece"[Title/Abstract] OR "Hungary"[Title/Abstract] OR "Iceland"[Title/Abstract] OR "Ireland"[Title/Abstract] OR "Italy"[Title/Abstract] OR "Kazakhstan"[Title/Abstract] OR "Kosovo"[Title/Abstract] OR "Kyrgyzstan"[Title/Abstract] OR "Liechtenstein"[Title/Abstract] OR "Luxembourg"[Title/Abstract] OR "Macedonia"[Title/Abstract] OR "Mediterranean"[Title/Abstract] OR "Moldova"[Title/Abstract] OR "Monaco"[Title/Abstract] OR "Montenegro"[Title/Abstract] OR "Netherlands"[Title/Abstract] OR "Norway"[Title/Abstract] OR "Poland"[Title/Abstract] OR "Portugal"[Title/Abstract] OR "Belarus"[Title/Abstract] OR "Romania"[Title/Abstract] OR "Russia"[Title/Abstract] OR "san marino"[Title/Abstract] OR "scandinav*"[Title/Abstract] OR "nordic countries"[Title/Abstract] OR "Scotland"[Title/Abstract] OR "Serbia"[Title/Abstract] OR "Sicily"[Title/Abstract] OR "Slovakia"[Title/Abstract] OR "Slovenia"[Title/Abstract] OR "Spain"[Title/Abstract] OR "Sweden"[Title/Abstract] OR "Switzerland"[Title/Abstract] OR "Transcaucasia"[Title/Abstract] OR "Turkey"[Title/Abstract] OR "Ukraine"[Title/Abstract] OR "united kingdom"[Title/Abstract] OR "USSR"[Title/Abstract] OR "Uzbekistan"[Title/Abstract] OR "Moria"[Title/Abstract] OR "Calais"[Title/Abstract] OR "Samos"[Title/Abstract] OR “Lampedusa” [Title/Abstract] OR “Chios” [Title/Abstract]

18.1.2 Full search stream results 21/07/21

#	Search	Hits
#1	Search: "Refugees"[Mesh] OR "Refugees"[Title/Abstract] OR "refugee"[Title/Abstract] OR "migrant"[Title/Abstract] OR "migrant"[Title/Abstract] OR "immigrant"[Title/Abstract] OR "immigrants"[Title/Abstract] OR "transient"[Title/Abstract] OR "transients"[Title/Abstract] OR "displaced person*"[Title/Abstract] OR "asylum seek*"[Title/Abstract]	354,257
#2	Search: "abortion, induced"[MeSH Terms] OR "abortion, spontaneous"[MeSH Terms] OR "abortion, threatened"[MeSH Terms] OR "Contraception Behavior"[MeSH Terms] OR "Contraception"[MeSH Terms] OR "Family Planning Services"[MeSH Terms] OR "Gender-Based Violence"[MeSH Terms] OR "genital diseases, female"[MeSH Terms] OR "genital diseases, male"[MeSH Terms] OR "HIV"[MeSH Terms] OR "Maternal Health Services"[MeSH Terms] OR "Maternal Health"[MeSH Terms] OR "Maternal Welfare"[MeSH Terms] OR "Rape"[MeSH Terms] OR "Pregnancy Complications"[MeSH Terms] OR "Reproductive Behavior"[MeSH Terms] OR "Reproductive Health Services"[MeSH Terms] OR "Reproductive Health"[MeSH Terms] OR "Reproductive Medicine"[MeSH Terms] OR "Reproductive Techniques"[MeSH Terms] OR "Sex Offenses"[MeSH Terms] OR "sexual dysfunction, physiological"[MeSH Terms] OR "sexual dysfunctions, psychological"[MeSH Terms] OR "Sexual Health"[MeSH Terms] OR "Sexual Trauma"[MeSH Terms] OR "Sexually Transmitted Diseases"[MeSH Terms] OR "Women's Health Services"[MeSH Terms] OR "Women's Health"[MeSH Terms] OR "abortion*"[Title/Abstract] OR "contracepti*"[Title/Abstract] OR "family planning"[Title/Abstract] OR "Gender-Based Violence"[Title/Abstract] OR "genital disease*"[Title/Abstract] OR "HIV"[Title/Abstract] OR "maternal health*"[Title/Abstract] OR "Maternal Welfare"[Title/Abstract] OR "Rape"[Title/Abstract] OR "reproductive behavi*"[Title/Abstract] OR "reproductive health*"[Title/Abstract] OR "sex offen*"[Title/Abstract] OR "sexual dysfunction*"[Title/Abstract] OR "sexual health*"[Title/Abstract] OR "sexual trauma*"[Title/Abstract] OR "sexually transmi*"[Title/Abstract] OR "women’s health*"[Title/Abstract] OR "Personal Health Services"[MeSH Terms] OR "Delivery of Health Care"[MeSH Terms] OR "Health Status"[MeSH Terms:noexp] OR "Health Status Disparities"[MeSH Terms] OR "healthcare"[Title/Abstract] OR "health care"[Title/Abstract] OR "health service*"[Title/Abstract] OR "Health Status"[Title/Abstract]	3,379,458

#3	Search: "Europe"[MeSH Terms] OR "Turkey"[MeSH Terms] OR "Albania"[Title/Abstract] OR "Andorra"[Title/Abstract] OR "Armenia"[Title/Abstract] OR "Austria"[Title/Abstract] OR "Azerbaijan"[Title/Abstract] OR "Balkan"[Title/Abstract] OR "baltic states"[Title/Abstract] OR "Belgium"[Title/Abstract] OR "Bosnia"[Title/Abstract] OR "Herzegovina"[Title/Abstract] OR "Bulgaria"[Title/Abstract] OR "channel island*"[Title/Abstract] OR "Croatia"[Title/Abstract] OR "czech republic"[Title/Abstract] OR "Denmark"[Title/Abstract] OR "England"[Title/Abstract] OR "europe*"[Title/Abstract] OR "Finland"[Title/Abstract] OR "France"[Title/Abstract] OR "Georgia"[Title/Abstract] OR "Germany"[Title/Abstract] OR "Gibraltar"[Title/Abstract] OR "Greece"[Title/Abstract] OR "Hungary"[Title/Abstract] OR "Iceland"[Title/Abstract] OR "Ireland"[Title/Abstract] OR "Italy"[Title/Abstract] OR "Kazakhstan"[Title/Abstract] OR "Kosovo"[Title/Abstract] OR "Kyrgyzstan"[Title/Abstract] OR "Liechtenstein"[Title/Abstract] OR "Luxembourg"[Title/Abstract] OR "Macedonia"[Title/Abstract] OR "Mediterranean"[Title/Abstract] OR "Moldova"[Title/Abstract] OR "Monaco"[Title/Abstract] OR "Montenegro"[Title/Abstract] OR "Netherlands"[Title/Abstract] OR "Norway"[Title/Abstract] OR "Poland"[Title/Abstract] OR "Portugal"[Title/Abstract] OR "Belarus"[Title/Abstract] OR "Romania"[Title/Abstract] OR "Russia"[Title/Abstract] OR "san marino"[Title/Abstract] OR "scandinav*"[Title/Abstract] OR "nordic countries"[Title/Abstract] OR "Scotland"[Title/Abstract] OR "Serbia"[Title/Abstract] OR "Sicily"[Title/Abstract] OR "Slovakia"[Title/Abstract] OR "Slovenia"[Title/Abstract] OR "Spain"[Title/Abstract] OR "Sweden"[Title/Abstract] OR "Switzerland"[Title/Abstract] OR "Transcaucasia"[Title/Abstract] OR "Turkey"[Title/Abstract] OR "Ukraine"[Title/Abstract] OR "united kingdom"[Title/Abstract] OR "USSR"[Title/Abstract] OR "Uzbekistan"[Title/Abstract] OR "Moria"[Title/Abstract] OR "Calais"[Title/Abstract] OR "Samos"[Title/Abstract] OR "Lampedusa" [Title/Abstract] OR "Chios" [Title/Abstract] OR “Lesbos” [Title/Abstract]	2,005,635
#4	"Refugee Camps"[MeSH Terms] OR "camp*"[Title/Abstract] OR "hotspot*"[Title/Abstract] OR "settlement*"[Title/Abstract] OR "center*"[Title/Abstract] OR "centre*"[Title/Abstract] "shelter*"[Title/Abstract] OR "Moria"[Title/Abstract] OR "Calais"[Title/Abstract] OR "Samos"[Title/Abstract] OR "Lampedusa" [Title/Abstract] OR "Chios" [Title/Abstract] OR "reception" [Title/Abstract] OR “Lesbos” [Title/Abstract]	2,384,544
#5	#1 AND #2 AND #3	8,030
#6	#1 AND #2 AND #3 AND #4	1,724

18.2 EMBASE Ovid

18.2.1 Search terms (Emtree and free text)

Term 1: refugee camps (context)	
Emtree	Refugee camp/ or (refugee* adj2 (camp* or hotspot* or settlement* or centre* or center* or shelter* or Moria or Calais or Samos or Lampedusa or Chios or reception)).ti,ab,kw.
Free text	
Term 2: Europe (context)	
Emtree	exp Europe/ or
Free text	Albania.ti,ab,kw. or Andorra.ti,ab,kw. or Armenia.ti,ab,kw. or Austria.ti,ab,kw. or Azerbaijan.ti,ab,kw. or Balkan.ti,ab,kw. or baltic states.ti,ab,kw. or Belgium.ti,ab,kw. or Bosnia.ti,ab,kw. or Herzegovina.ti,ab,kw. or Bulgaria.ti,ab,kw. or channel island*.ti,ab,kw. or Croatia.ti,ab,kw. or czech republic.ti,ab,kw. or Denmark.ti,ab,kw. or England.ti,ab,kw. or europe*.ti,ab,kw. or Finland.ti,ab,kw. or France.ti,ab,kw. or Georgia.ti,ab,kw. or Germany.ti,ab,kw. or Gibraltar.ti,ab,kw. or Greece.ti,ab,kw. or Hungary.ti,ab,kw. or Iceland.ti,ab,kw. or Ireland.ti,ab,kw. or Italy.ti,ab,kw. or Kazakhstan.ti,ab,kw. or Kosovo.ti,ab,kw. or Kyrgyzstan.ti,ab,kw. or Liechtenstein.ti,ab,kw. or Luxembourg.ti,ab,kw. or

	Macedonia.ti,ab,kw. or Mediterranean.ti,ab,kw. or Moldova.ti,ab,kw. or Monaco.ti,ab,kw. or Montenegro.ti,ab,kw. or Netherlands.ti,ab,kw. or Norway.ti,ab,kw. or Poland.ti,ab,kw. or Portugal.ti,ab,kw. or Belarus.ti,ab,kw. or Romania.ti,ab,kw. or Russia.ti,ab,kw. or san marino.ti,ab,kw. or scandinav*.ti,ab,kw. or nordic countries.ti,ab,kw. or Scotland.ti,ab,kw. or Serbia.ti,ab,kw. or Sicily.ti,ab,kw. or Slovakia.ti,ab,kw. or Slovenia.ti,ab,kw. or Spain.ti,ab,kw. or Sweden.ti,ab,kw. or Switzerland.ti,ab,kw. or Transcaucasia.ti,ab,kw. or Turkey.ti,ab,kw. or Ukraine.ti,ab,kw. or united kingdom.ti,ab,kw. or USSR.ti,ab,kw. or Uzbekistan.ti,ab,kw. or Moria.ti,ab,kw. or Calais.ti,ab,kw. or Samos.ti,ab,kw. or Lampedusa.ti,ab,kw. or Chios.ti,ab,kw. or lesbos.ti,ab,kw.
Term 3: SRH	
Emtree **Free text**	exp induced abortion/ or exp abortion/ or exp contraception behavior/ or exp contraception/ or exp family planning/ or gender based violence/ or exp genital system disease/ or exp human immunodeficiency virus/ or exp obstetric delivery/ or exp pregnancy/ or maternal welfare/ or maternal mortality/ or maternal health service/ or exp maternal care/ or exp rape/ or exp reproductive behavior/ or reproductive health/ or exp health service/ or sexual health/ or women's health/ or sexual crime/ or sexual trauma/ or exp sexually transmitted disease/ or abortion*.ti,ab,kw. or contracepti*.ti,ab,kw. or family planning.ti,ab,kw. or gender-based violence.ti,ab,kw. or genital disease*.ti,ab,kw. or genital system disease*.ti,ab,kw. or HIV.ti,ab,kw. or maternal health*.ti,ab,kw. or maternal welfare.ti,ab,kw. or rape.ti,ab,kw. or maternal mortality .ti,ab,kw. or reproductive behavi*.ti,ab,kw. or reproductive health*.ti,ab,kw. or sex offen*.ti,ab,kw. or sexual crime*.ti,ab,kw. or sexual dysfunction*.ti,ab,kw. or sexual health*.ti,ab,kw. or sexual trauma*.ti,ab,kw. or sexually transmi*.ti,ab,kw. or women$ health*.ti,ab,kw. or miscarriage*.ti,ab,kw.
Term 4: general health	
Emtree **Free text**	exp health status/ or exp health disparities/ or exp health care access/ or exp health care delivery/ or exp health service/ or health status.ti,ab,kw. or health disparit*.ti,ab,kw. or healthcare.ti,ab,kw. or care access.ti,ab,kw. or care delivery.ti,ab,kw. or health care delivery.ti,ab,kw. or health service*.ti,ab,kw. or personal health*.ti,ab,kw.
Term 5: Refugees (population)	
Emtree **Free text**	exp Refugee/ or Refugees.ti,ab,kw. or refugee.ti,ab,kw. or migrant.ti,ab,kw. or migrants.ti,ab,kw. or immigrant.ti,ab,kw. or immigrants.ti,ab,kw. or transient.ti,ab,kw. or transients.ti,ab,kw. or displaced person*.ti,ab,kw. or asylum seek*.ti,ab,kw.

18.2.2 Full search stream results 22/07/21

#	Search	Hits
1	exp Refugee/ or Refugees.ti,ab,kw. or refugee.ti,ab,kw. or migrant.ti,ab,kw. or migrants.ti,ab,kw. or immigrant.ti,ab,kw. or immigrants.ti,ab,kw. or transient.ti,ab,kw. or transients.ti,ab,kw. or displaced person*.ti,ab,kw. or asylum seek*.ti,ab,kw.	438939
2	Refugee camp/ or ((refugee* or asylum or seeker*) adj3 (camp* or hotspot* or settlement* or centre* or center* or shelter* or Moria or Calais or Samos or Lampedusa or Chios or reception)).ti,ab,kw.	2328
3	exp health status/ or exp health disparities/ or exp health care access/ or exp health care delivery/ or exp health service/ or health status.ti,ab,kw. or health disparit*.ti,ab,kw. or healthcare.ti,ab,kw. or care access.ti,ab,kw. or care delivery.ti,ab,kw. or health care delivery.ti,ab,kw. or health service*.ti,ab,kw. or personal health*.ti,ab,kw.	6209008
4	exp induced abortion/ or exp abortion/ or exp contraception behavior/ or exp contraception/ or exp family planning/ or gender based violence/ or exp genital system disease/ or exp human immunodeficiency virus/ or exp obstetric delivery/ or exp pregnancy/ or maternal welfare/ or maternal mortality/ or maternal health service/ or exp maternal care/ or exp rape/ or exp reproductive behavior/ or reproductive health/ or exp health service/ or sexual health/ or women's health/ or	7855092

	sexual crime/ or sexual trauma/ or exp sexually transmitted disease/ or abortion*.ti,ab,kw. or contracepti*.ti,ab,kw. or family planning.ti,ab,kw. or gender-based violence.ti,ab,kw. or genital disease*.ti,ab,kw. or genital system disease*.ti,ab,kw. or HIV.ti,ab,kw. or maternal health*.ti,ab,kw. or maternal welfare.ti,ab,kw. or Rape.ti,ab,kw. or maternal mortality.ti,ab,kw. or reproductive behavi*.ti,ab,kw. or reproductive health*.ti,ab,kw. or sex offen*.ti,ab,kw. or sexual crime*.ti,ab,kw. or sexual dysfunction*.ti,ab,kw. or sexual health*.ti,ab,kw. or sexual trauma*.ti,ab,kw. or sexually transmi*.ti,ab,kw. or women$ health*.ti,ab,kw. or miscarriage*.ti,ab,kw.	
5	exp Europe/ or Albania.ti,ab,kw. or Andorra.ti,ab,kw. or Armenia.ti,ab,kw. or Austria.ti,ab,kw. or Azerbaijan.ti,ab,kw. or Balkan.ti,ab,kw. or baltic states.ti,ab,kw. or Belgium.ti,ab,kw. or Bosnia.ti,ab,kw. or Herzegovina.ti,ab,kw. or Bulgaria.ti,ab,kw. or channel island*.ti,ab,kw. or Croatia.ti,ab,kw. or czech republic.ti,ab,kw. or Denmark.ti,ab,kw. or England.ti,ab,kw. or europe*.ti,ab,kw. or Finland.ti,ab,kw. or France.ti,ab,kw. or Georgia.ti,ab,kw. or Germany.ti,ab,kw. or Gibraltar.ti,ab,kw. or Greece.ti,ab,kw. or Hungary.ti,ab,kw. or Iceland.ti,ab,kw. or Ireland.ti,ab,kw. or Italy.ti,ab,kw. or Kazakhstan.ti,ab,kw. or Kosovo.ti,ab,kw. or Kyrgyzstan.ti,ab,kw. or Liechtenstein.ti,ab,kw. or Luxembourg.ti,ab,kw. or Macedonia.ti,ab,kw. or Mediterranean.ti,ab,kw. or Moldova.ti,ab,kw. or Monaco.ti,ab,kw. or Montenegro.ti,ab,kw. or Netherlands.ti,ab,kw. or Norway.ti,ab,kw. or Poland.ti,ab,kw. or Portugal.ti,ab,kw. or Belarus.ti,ab,kw. or Romania.ti,ab,kw. or Russia.ti,ab,kw. or san marino.ti,ab,kw. or scandinav*.ti,ab,kw. or nordic countries.ti,ab,kw. or Scotland.ti,ab,kw. or Serbia.ti,ab,kw. or Sicily.ti,ab,kw. or Slovakia.ti,ab,kw. or Slovenia.ti,ab,kw. or Spain.ti,ab,kw. or Sweden.ti,ab,kw. or Switzerland.ti,ab,kw. or Transcaucasia.ti,ab,kw. or Turkey.ti,ab,kw. or Ukraine.ti,ab,kw. or united kingdom.ti,ab,kw. or USSR.ti,ab,kw. or Uzbekistan.ti,ab,kw. or Moria.ti,ab,kw. or Calais.ti,ab,kw. or Samos.ti,ab,kw. or Lampedusa.ti,ab,kw. or Chios.ti,ab,kw. or lesbos.ti,ab,kw.	2466181
6	3 OR 4	8209507
7	1 AND 2	2191
8	5 AND 6 AND 7	375

18.3 Web of Science

18.3.1 Search terms and full search stream results 22/07/21

#	Search	Hits
1	TS= (Europe OR Turkey OR Albania OR Andorra OR Armenia OR Austria OR Azerbaijan OR Balkan OR "baltic states" OR Belgium OR Bosnia OR Herzegovina OR Bulgaria OR "channel island*" OR Croatia OR "czech republic" OR Denmark OR England OR europe* OR Finland OR France OR Georgia OR Germany OR Gibraltar OR Greece OR Hungary OR Iceland OR Ireland OR Italy OR Kazakhstan OR Kosovo OR Kyrgyzstan OR Liechtenstein OR Luxembourg OR Macedonia OR Mediterranean OR Moldova OR Monaco OR Montenegro OR Netherlands OR Norway OR Poland OR Portugal OR Belarus OR Romania OR RussiaOR "san marino" OR scandinav* OR "nordic countries" OR Scotland OR Serbia OR Sicily OR Slovakia OR Slovenia OR Spain OR Sweden OR Switzerland OR Transcaucasia OR Turkey OR Ukraine OR "united kingdom" OR USSR OR Uzbekistan)	
2	TS=(abortion* OR contracepti* OR “Delivery of Health*” OR “family planning” OR “Gender-Based Violence” OR “genital disease*” OR “Health Status” OR healthcare OR HIV OR “maternal health*” OR “Maternal Welfare” OR “Personal Health Service*” OR “Pregnancy Complication*” OR Rape OR “reproductive behavi*” OR “reproductive health*” OR “Reproductive Medicine” OR “Reproductive Technique*” OR “sex offen*” OR “sexual dysfunct*” OR “sexual health*” OR “sexual trauma*” OR “sexually	

	transmi*” OR “womens health*” OR “Women's Health*” OR "health care" OR "health service*" OR "Health status")	
3	TS=(("Refugee Camps" OR camp* OR hotspot* OR settlement* OR "refugee cent*" OR shelter* OR Moria OR Calais OR Samos OR lesvos OR “registration cent*” OR “reception cent*”) AND ("Refugee Camp*" OR refugees OR refugee OR migrant OR migrants OR immigrant OR immigrants OR transient OR transients OR "displaced person*" OR "asylum seek*"))disparit*.ti,ab,kw. or healthcare.ti,ab,kw. or care access.ti,ab,kw. or care delivery.ti,ab,kw. or health care delivery.ti,ab,kw. or health service*.ti,ab,kw. or personal health*.ti,ab,kw.	
4	1 AND 2 AND 3	553

19 ANNEX E. Data extraction form: two examples

Title	**Maternity care for refugees living in Greek refugee camps: What are the challenges to provision?**
Author	Scott, Wallis
Year of publication	2020
Study period	May 2017
Country	Greece
Setting	Five refugee camps in Greece: Lesvos, Malakasa, Eleonos, Skaramagas, Schisto. Latter 4 are around Athens.
Study objectives	To explore the barriers perceived by health care providers in providing maternal care to refugees living in Greek refugee camps.
Study type	Qualitative study comprising of observation and semi-structured interviews.
Population characteristics	Fifteen interviews with healthcare providers working with pregnant refugees: 12 participants were interviewed alone, and nine in three groups. All participants were female. A range of disciplines were represented: nine midwives, seven health visitors, three cultural mediators, two safe space providers. The length of their experience in the camps ranged from less than one month to two years with a median of 1-6 months experience.
Characteristics of available SRH interventions	All camps had one or more midwives employed by non-governmental organizations to provide assessments within the camps. Most camps could provide bedside investigations such as urinalysis or blood pressure monitoring. For antenatal ultrasounds, more complex investigations, and for delivery, women were taken by ambulance to the tertiary hospitals outside of the camp.
Reported barriers	Difficult cross-cultural communication: • Translation frequently occurred on an ad hoc basis, making it difficult for care providers to plan ahead and often caused service delivery delays. • Women preferred female translators and, in some cases, refused treatment if only a male translator was available. • Translation services were limited in the tertiary hospitals. • Multiple reports of women undergoing caesarean births without a translator to explain the procedure or obtain informed consent. • Varied availability of translators for particular languages created inequity in provision for certain groups. Limited availability of female only safe spaces: • Two camps had no formal safe spaces, one had safe spaces with limited opening hours and facilities, and two had safe spaces with no restriction on hours of use. Where safe spaces were available, health care providers felt they were beneficial and had a positive impact on providing maternity services. Overburdened Greek public health system: • Capacity of the hospitals was failing to meet the needs of the population, demonstrated by long waiting times and difficulties securing hospital appointments. • Overburdened health system was given as the cause for a high rate of caesarean birth and poor post-operative management after caesarean birth. • Frustration with the situation in Greece overlaid with adverse feelings toward immigrants had, in some cases, led to hostile relationships and even overt racism in health settings.
Reported facilitators	Value of safe spaces: education, prevention of domestic violence, social networks and prevention of isolation.

Quantitative data on utilisation of services	None mentioned.
Implications for policy	The camp community generates an opportunity for recruitment of cultural mediators; however, there is a need for appropriate training for the role and issues surrounding confidentiality and neutrality.
Identified research gaps	Unable to include the voice of women refugees and determine if their experiences correlate with the findings, need to incorporate their voices into research.

Title	**Shifting vulnerabilities: gender and reproductive care on the migrant trail to Europe**
Author	Grotti, Malakasis, Quagliariello, Sahraoui
Year of publication	2018
Study period	July 2016 to August 2017
Country	Athens, Greece; Sicily and Lampedusa, Italy; and Melilla, Spain.
Setting	Camps, squats, and NGO-run hotels and apartments
Study objectives	To examine the experiences of pregnant migrant women during their journey into Europe and their stay in EU borderlands through a conceptual lens that offers a critical and reflexive approach to the concept of vulnerability.
Study type	Ethnographic research with rescue and care services catering to pregnant women arriving in Greece, Italy, and Spain.
Population characteristics	Greece: • Observation of the medical consultations and labour in an independent Mother-Baby Centre in downtown Athens, a satellite clinic of a major transnational health NGO and the out- patient department and labour ward of a major public maternity clinic. • Ethnographic interviews with five Syrian women. Italy: • Observations of reproductive health consultations in the maternity health service. • Document analysis: processing of medical records from 2013 to 2017. • Fifteen interviews with migrant women. • Ten interviews with health professionals (three gynaecologists, three general doctors and four nurses) at the Lampedusa health facility. Spain: • Ten interviews with healthcare professionals and 17 migrant residents in the Centre for the Temporary Stay of Immigrants (CETI) and the public hospital.
Characteristics of available SRH interventions	Greece: • Largely provided by a network of NGOs in the humanitarian sector (in their own premises or via mobile units) who refer women to public hospitals for diagnostic tests (NT scan, B-mode or Doppler ultrasound, etc.), as well as blood and urine tests. Italy: • Lampedusa health service: pregnancy ultrasounds and consultations and the possibility of terminating pregnancies resulting from sexual violence during the journey. • Health records, made by the doctors in Lampedusa and mainland Sicily guarantee medical care beyond first reception. • After initial health checks performed by local obstetric gynaecologists, pregnant patients are transferred by medical helicopter or by boat (and then

	by bus) to other hospitals in Sicily, either in Palermo or in Agrigento. The helicopter transfer takes an hour, and is only offered to migrant women in their final months of pregnancy. The rest are offered transfer by boat (and then by bus), which takes about 12 hours. Spain: • CETI residents are entitled to the same care as Spanish citizens.

Reported barriers	Italy:
	• Hypermedicalisation and 'defensive medicine' where doctors perform additional tests to assess maternal and foetus risk in the absence of information obtained directly from patients (also due to language barriers).
	• Access to voluntary termination of pregnancy (VTP) not always possible due to legal and logistic barriers:
	  ○ According to the Italian law, the request for VTP must be communicated to the gynaecologists before the end of the third month of pregnancy. Therefore, a request for an abortion is only possible for migrants who arrive in Italy before this deadline.
	  ○ VTP for migrants who arrive in Lampedusa with a pregnancy of less than 3 months is endangered by 12-hour boat and bus transfers to Sicily.
	• Lampedusa's outpatients' clinic did not have a delivery room, nor a neonatal intensive care unit or operating room for surgical terminations.
	
	Spain:
	• Language barriers impacting the continuity of care.
	
	Athens/Lampedusa/Melilla:
	• Language barriers, lack of interpreter services.
	• Well-meaning caregivers are often fatigued and exasperated.

Reported facilitators	Italy:
	• Sympathetic attitude care providers:
	  ○ Perception of African women as victims of gendered exploitation such as sexual trafficking. Doctors' feelings relating to pity and compassion and seeing the women not only as 'gynaecological patients', but also as persons who had lived through an extremely difficult journey and were at the risk of ending up in the prostitution market in Europe.
	  ○ Defensive medicine exemplifies the desire to provide the best possible care, the broadest possible protection and support.
	Spain:
	• CETI residence produced an administrative acknowledgement of pregnant women's health-related vulnerability.

Quantitative data	Not applicable
Implications for policy	None mentioned
Identified research gaps	Not mentioned

20 ANNEX F. Characteristics of the included publications

LEGEND: * = part of a larger study on general health, grey box = factors mentioned
ABBREVIATIONS: SRH = general sexual and reproductive health, MH = maternal health, FP = family planning, SGBV = sexual and gender-based violence, STI's = sexually transmitted infections, FGM/C = female genital mutilation/cutting, KIIs = key informant interviews, IDIs = in-depth interviews, FGDs = focus group discussions

Author, year	Country	Type of camp	Study population	Study design	SRH field	Reports on service utilization and access	Supply					Demand				
							Approachability	Acceptability	Availability and accommodation	Affordability	Appropriateness	Ability to perceive	Ability to seek	Ability to reach	Ability to pay	Ability to engage
Peer-reviewed literature																
Baser, 2021	Turkey	Informal settlements	Service providers	Qualitative: IDIs	SRH*											
Blitz, 2017	Greece, Italy	First reception/hotspot centres	Service providers, refugee men and women	Mixed methods: household survey, IDIs, KIIs	SRH*	Access to ANC and psychosocial care for pregnant women										
Borsari, 2017	Italy	First reception centre	Refugee women	Quantitative	MH											
Bronsino, 2020	Italy	First reception centre	Refugee women	Quantitative	SGBV	Underreporting of SGBV										

Caroppo, 2014	Italy	First reception centre	Service providers	Quantitative: survey	FGM/C/C											
Chynoweth, 2020	Italy	First reception centre	Refugee men	Qualitative: document review, KIIs, FGDs	SGBV											
Coşkun, 2020	Turkey	Informal settlements	Refugee women	Quantitative: household survey	MH, FP	Unmet needs for maternal health and family planning										
Digidiki, 2017	Greece	First-reception centres	Service providers	Rapid assessment: observation and KIIs	SGBV											
Döner, 2021	Turkey	Informal settlements	Refugee men and women	Qualitative: IDIs	FP											
Finnerty, 2016	France	Informal camp	Service providers	Qualitative: observation and KIIs	SRH, MH, FP											
Grotti, 2018	Greece, Italy, Spain	First reception centres, informal settlements, NGO-run hotels and apartments	Service providers, refugee women	Qualitative: observations, document analysis, IDIs	MH											
Grotti, 2019	Greece, Italy, Spain	First reception centres, informal settlements, NGO-run hotels and apartments	Service providers, refugee women	Qualitative: observations, document analysis, IDIs	MH											

Hémono, 2018	Greece	First reception centres and alternative accommodation facilities	Service providers	Qualitative: IDIs	SRH*											
Inci, 2020	Germany	Intermediate stay	Refugee women	Quantitative: survey	FP	Unmet family planning need										
Joseph, 2020	Greece	First-reception centres	Service providers	Qualitative: KIIs	SRH*											
Marek, 2018	Hungary	First reception centre	Refugee men and women	Quantitative: survey	SRH*											
Matsumoto, 2019	Italy	First reception centre	Service providers	Qualitative: KIIs	SRH*											
Özşahin, 2021	Turkey	Informal settlements	Refugee women	Quantitative: household survey	FP	Unmet contraception need										
Scott, 2020	Greece	First reception and transit centres	Service providers	Qualitative: IDIs	MH											
Shortall, 2017	Greece	First-reception centres	Refugee men and women	Mixed: descriptive quantitative of routine data, qualitative descriptive	SRH*	Unmet need in maternal health and family planning										

Şimşek, 2018	Turkey	Informal settlements	Refugee women	Quantitative: household survey	MH, FP, STIs	Access and use of ANC, unmet contraception need										
Torun, 2018	Turkey	Informal settlements	Service providers, refugee women	Mixed methods: household survey, IDIs	MH, STIs	Utilisation of ANC, iron/vitamin D/folic acid supplements, hospital delivery										
Van Loenen, 2018	Greece, Croatia, Slovenia, Hungary, the Netherlands, Italy, Austria	First reception, transit, intermediate stay and long-term centres	Refugee men and women	Qualitative: FGDs	MH*											
Zagar, 2019	Croatia, Slovenia	Transit centre	Service providers	Qualitative: IDIs	SRH*											
Grey literature																
Amnesty International, 2018	Greece	First reception centres and UNHCR accommodation	Refugee women	Qualitative: FGDs and IDIs	SGBV, SRH											
Ben Farhat, 2017	Greece	First reception centres, refugee accommodation	Refugee men and women	Mixed methods: survey and IDIs and FGDs	MH*	ANC										
Botsi (IOM), 2013	Greece	First reception centres	Service providers, refugee men and women	Qualitative: site visits, KIIs, IDIs, FGDs	SRH*											
Chynoweth (WRC), 2019	Italy	First reception centres	Service providers, refugee men	Qualitative: KIIs, FGDs	SGBV											

De Paoli, 2018	Greece	First reception centres, informal settlements	Refugee men and women	Qualitative: Observational	SRH*											
Hersh (WRC), 2016	Serbia, Slovenia	Transit centres	Service providers, refugee men and women	Qualitative: IDIs, KIIs	SGBV											
Kurt (TMA), 2016	Turkey	Intermediate stay centres	Service providers, refugee men and women	Mixed methods	SRH*	MH, SRH										
Malakasis, 2020	Greece	First reception centres, informal settlements, NGO-run hotels and apartments in Athens	Refugee women	Qualitative: obervations, IDIs	MH											
Ozcurumez, 2017	Turkey	Intermediate stay centres, informal settlements	Service providers	Qualitative	SRH*											
Petrov (IOM), 2015	Bulgaria	First reception centres	Service providers, refugee men and women	Qualitative: site visits, IDIs	SRH*											
Puthoopparambil (IOM), 2013	Malta	First reception centres	Service providers, refugee men and women	Qualitative: site visits, IDIs, KIIs	SRH*											
UN Women, 2016	Serbia, fYR Madeconia	First reception and transit centres	Service providers, refugee men and women	Qualitative: site observations, KIIs, IDIs	MH, STIs											
UNHCR/UNFPA/ WRC, 2016	Greece, Madeconia	First reception and transit centres	Service providers, refugee men and women	Qualitative: site observations, FGDs, IDIs, KIIs	SGBV											

Urso (IOM), 2013	Italy	First reception centres	Service providers, refugee men and women	Qualitative: site visits, stakeholder meetings, IDIs, FGDs	SRH*											
Vidovic (IOM), 2014	Croatia	First reception centre/detention/pre-removal centres	Service providers, refugee men and women	Qualitative: site visits, KIIs, IDIs	SRH*											
WHO, 2019	Turkey	Informal settlements	Refugee men and women	Quantitative: household survey	MH, STIs	Maternal health and STI service utilisation										
WRC, 2016	Greece, Turkey	First reception centres	Service providers, refugee women	Qualitative: desk research, site visits, KIIs, IDIs	SGBV, FP, MH											

21 ANNEX G. Number of studies included per country

The arrows on the map in figure 8 depict the main migration routes into Europe. The size of the circles represent the number of studies per country found in this review. The graph in figure 8 shows the number of migrants entering Europe through the main migration routes from 2015 to 2021. Although proportions have fluctuated over the years, cumulatively the Eastern Mediterranean route is the most common entry point into Europe, followed by the Central and then the Western route. This trend is reflected in my data: approximately 60% (26/41) of the studies were conducted in Greece and Turkey, 12 in Italy and Malta and two in Spain. Other countries included Slovenia (3), Croatia (2), Hungary (2), the former Yugoslavian Republic of Macedonia (2) and Bulgaria (1), reflecting the continuation of refugees' journeys across the Balkan. France (1 study) and Germany (1 study) are countries where refugees are known to transit before traveling further North to the United Kingdom or the Scandinavian countries.

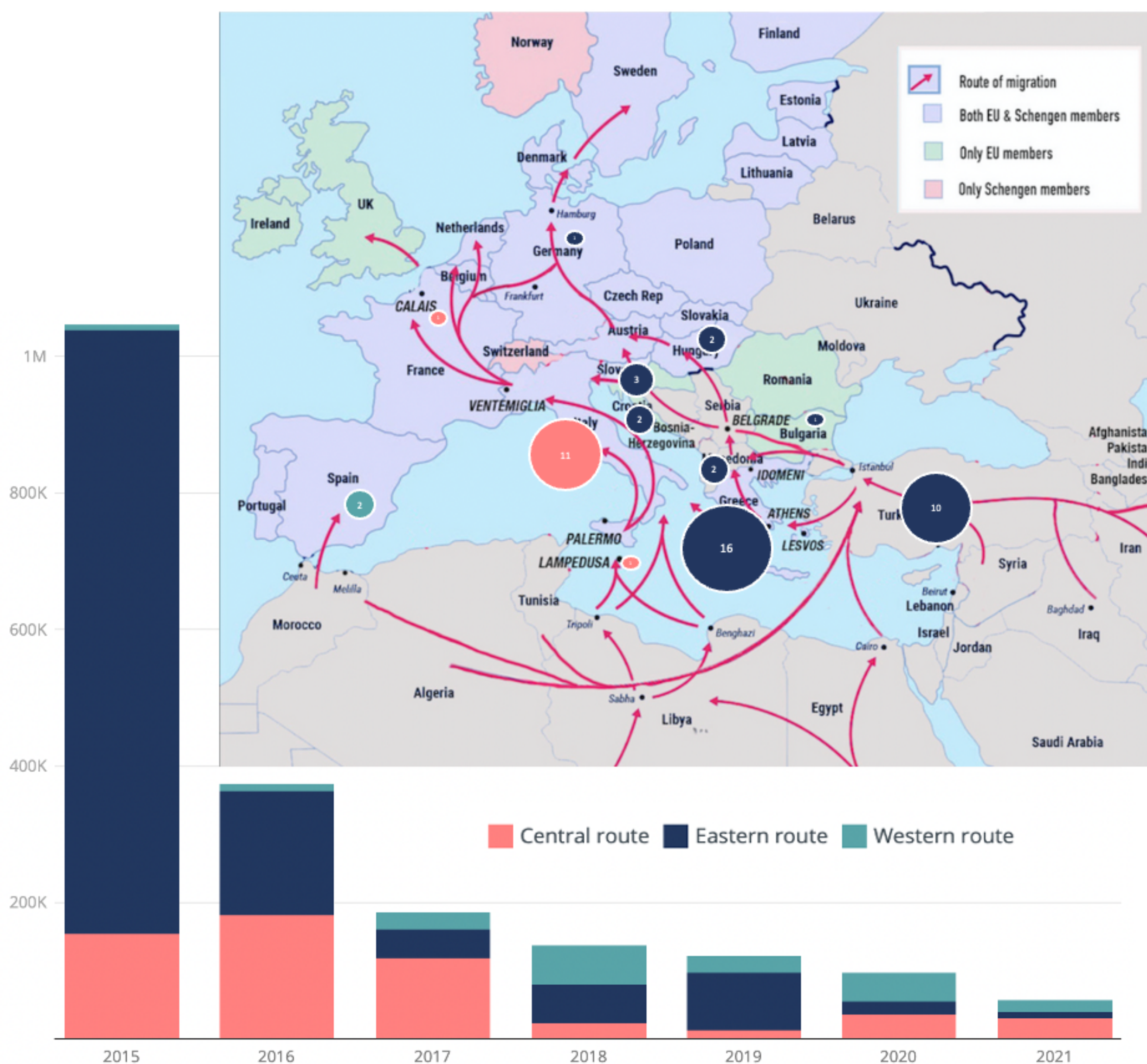

Figure 8. Graph showing number of migrants entering Europe from 2015 – 2021 through the three most common migration routes compared to map illustrating the number of studies reviewed by country
Source graph: Frontex, 2021.[154] Source map: Border Violence Monitoring Network, 2020[140]

22 ANNEX H. Barriers and facilitators in accessing SRH services

LEGEND: (-) = barrier, (+) = facilitator
ABBREVIATIONS: SRH = general sexual and reproductive health, MH = maternal health, FP = family planning, SGBV = sexual and gender-based violence, STI's = sexually transmitted infections, FGM/C = female genital mutilation/cutting

Category	Subcategory	Code	SRH Category	Number of studies	References	Example
Approachability	Information	Information provision regarding right to free healthcare (-)	SRH, MH, SGBV	4	58, 69, 77, 84	"Almost half (49.6%) of the interviewed women did not know about free health care rights for Syrians."[58] "CSOs have raised, in particular, the risks associated with misinformation regarding the possibility of access to the national health system for the voluntary interruption of pregnancy. In the absence of this information the women resort to other means, with high risks to their health."[84]
		Information provision regarding available services (-)	SRH, MH, FP, SGBV	8	59, 64, 66, 76, 77, 79, 85, 90	"Pregnant women interviewed by WRC were unsure of where they could give birth and whether they could access a hospital."[90] "There is a lack of clarity among the service providers and migrants on various provisions and assistance available to migrants. Lack of clarity in regulations creates discrepancies in services provided, thereby resulting in further marginalization of migrants."[85]
		Information provision regarding healthcare pathway (-)	SRH, MH, FP, SGBV, STIs	6	59, 61, 66, 76, 77, 89	"…there was a tendency for centres to be run in a top-down manner and those housed in centres therefore relied on a chain of relief workers to provide critical information."[59]
		Health education (-) (+)	FP, MH	2	72, 74	"The program wherein information related to epidurals was distributed to migrant women in a pamphlet in many languages was not accessible to all since not many women were not literate enough to understand it."[74]
	Outreach	Legislation (-)	SRH	1	64	"Family doctors have concerns about reaching and communicating with Syrian families, conducting pregnancy and child monitoring. So they are unwilling to record/add them to their patient lists because of worry about a decrease in their performance scores."[64]
		Recognition of vulnerability (-)(+)	MH, SGBV	2	54, 76	"A key aspect of this challenge is the lack of uniformly applicable vulnerability criteria that all actors on the ground, government and humanitarian, are aware of. Such criteria would allow for the screening, identification and prioritization of persons with specific needs, in particular those at risk, with the aim of responding and preventing SGBV."[76] "(…) residence produced an administrative acknowledgement of pregnant women's health-related vulnerability."[54]
		Long-term presence (+)	MH	1	70	"Therefore, the doctor and the team of nurses (several of whom have worked in the CETI for years) know many of the residents, and particularly pregnant women, by name."[70]
	Transparency	Visibility (-)	SRH, SGBV	3	59, 76, 82	"Although some services for male survivors were available in the study sites, many providers did not advertise as such and awareness of the available services was poor."[82] "Lack of visibility and thus accessibility of personnel, hindering refugees and migrants from easily identifying whom they could approach for information and support."[76]

Ability to perceive	Health literacy	Understanding of health (-)	SRH, FP, SGBV	4	61, 82, 87, 91	"Service providers reported that male survivors were often unaware that their mental distress was linked to sexual victimization. Many male survivors reportedly did not realize that the violence they had experienced constituted sexual violence"[82]
		Knowledge on existence of treatment (-)	FP, SGBV	2	82, 86	"Focus group participants (male and female) were largely unaware of the benefits of seeking care, and many did not know that medicine such as post-exposure prophylaxis to minimize HIV transmission existed."[82]
						"Gap in knowledge regarding the efficacy of different contraception methods."[86]
		Appreciating need for care(-)	SGBV	1	62	"Women were willing to overcome the barriers of reticence and to talk about the suffered violence almost exclusively when they have some specific and related healthcare need."[62]
	Health beliefs	Low formal health-seeking behaviour (-)	SGBV	1	82	"Refugees may prefer to seek help from traditional healers, religious leaders, elders, or community leaders."[82]
	Trust and expectations	Discrepancies in expectation and delivery (-)	SRH	1	67	"Some refugees also accustomed to lower prescription thresholds or less regulated medication dispensing systems, in particular for antibiotics; this led to frustration as antimicrobial stewardship was stricter in Greece than in their countries of origin."[67]
		Scepticism of treatment/healthcare personnel (-)	MH, SGBV	4	58, 69, 77, 82	"Some refugees expressed scepticism that services would be helpful or that recovery was possible."[82]
Acceptability	Gender	Staff (healthcare workers and/or translators) (-)	SRH, MH SGBV	7	58, 66-69, 88, 89	"Several participants emphasized the difficulties in addressing sexual and reproductive health, family planning and GBV for male healthcare providers due to gender sensitivities."[66]
		Structural (-)	FP, SGBV	3	77, 82, 94	"Across settings, research participants reported that there were few designated entry points for male survivors to access services. Key informants said that male survivors were reluctant to access care through women-oriented service points."[82]
						"The existing networks of post-sexual violence service providers are oriented to women and girls and, in general, are not equipped to respond to male survivors."[77]
						"There is free access to male condoms by NGOs and volunteers but not to female condoms."[94]
		Funding (-)	SGBV	1	77	"There is also a dearth of targeted financial support for male survivors, survivors with diverse SOGIESC, and at-risk men and boys, in addition to scarce support for women and girls."[77]
	Professional values	Respect (+)	MH	1	69	"Most important for all refugees was a friendly and respectful attitude of the healthcare workers."[69]
		Racism, discrimination, negative attitudes (-)	SRH, MH, SGBV	6	58, 64, 68, 77, 82, 85	"Refugees frequently cited negative attitudes by service providers and staff as a key deterrent to service use, including discrimination, disbelief, lack of empathy, and humiliating comments (…) Focus group participants said that racism and xenophobia were particularly harmful and deterred refugees from accessing any kind of services, including post- sexual violence care."[82]
	Norms	Treatment options (-)	SRH	1	63	"The fact that there are no health services in the camp at night were repeatedly mentioned as something that made people feel insecure. They did not trust that in case of an emergency, an ambulance would arrive in time." (Ben Farhat)
		Western medicine (-)	SRH	3	63, 67, 84	"At all the sites, the perception of the quality of health care services in the camps were low and unsatisfactory, which in some cases might also have had an impact on the utilization of these services. The participants reported that they do not receive proper treatment but are told to drink water or given a few painkillers and therefore do not go there."[63]
						"…as to therapy they claim to receive *"always the same pill"*- usually pain killers."[84]
	Culture	Familiarity (-)(+)	SRH, SGBV	3	67, 77, 85	"Religious traditions and customs (…) were unfamiliar to many Greek healthcare workers."[67]

						"Whenever health professionals participated in cultural training programmes, they expressed full satisfaction. However, these types of trainings were reported not to be regular, but high in demand."[85]
						"Few staff are trained in transcultural communication and how to sensitively support and work with communities from different cultures."[77]
Ability to seek	Personal values	Priority with travel (-)	MH, SGBV	5	69, 88-90, 93	"Greek law states that all GBV crimes must be reported to police to get post-rape medical care. However, refugee women are reluctant to do so because of fear, language and cultural barriers, uncertain legal status, and in the case of domestic violence, concern it would jeopardize a partner's asylum claim or result in arrest."[90]
						"Women may delay health treatment in the interest of reaching their country of destination in Western Europe. This has led in some cases to medical complications, including miscarriages."[88]
		Mistrust (-)	SRH, SGBV	4	64, 77, 85, 93	"Sceptical of confidentiality processes, they were concerned that victimization would become known to their communities and families, especially in their home country."[77]
						"As a result of their traumatic experiences, refugees may adopt negative attitudes, develop fear of being discriminated against, not examined well and given proper treatment."[64]
	Social values	Social stigma (-)	SGBV	1	82	"Research participants underscored that fears of social stigma and social sanctions by family and community members were significant barriers for male survivors seeking services."[82]
		Social pressure (-)	SGBV	1	88	"For those women traveling in groups, pressure to keep moving (…) may mean that they defer seeking urgent medical attention."[88]
		Conflicting priorities (-)	SGBV	1	75	"Even when they know about the existence of the services, many women living in flats told Amnesty International about the difficulties they face finding the time to seek these services because they have to take care of children and the elderly or have other household responsibilities."[75]
	Culture	Taboos (-)	SGBV	1	77	"Research participants reported that medical concerns might prompt a survivor to seek care. Otherwise, shame, fear of stigmatization, religious taboos, and worries about not being believed hinder survivors from seeking services."[77]
	Autonomy	Knowledge about healthcare options (-)	MH, FP	3	58, 69, 72	"All participants mentioned they received insufficient information about the rules and procedures in the centres and about the organization and location of healthcare services. They had difficulties finding a doctor at busy border crossings, but also in long-term reception centres and difficulties in finding their way through the local customs of the healthcare system and administrative problems hampered accessibility."[69]
						"A significant proportion of the women in the current study did not know that there were free methods and free consultation services or how to access these."[72]
		Knowledge about individual rights (-)	SRH	1	87	"The survey results demonstrated a low level of knowledge related to entitlements to health services."[87]
Availability and accommodation	Geographic location	Remoteness (-)	SRH, MH, SGBV	5	59, 67, 74, 77, 90	"Sites on the mainland tend to be in remote areas where there are limited GBV services for the host community."[90]
		Ethical and political implication (-)	SGBV	1	90	"The movement of refugees into military sites and detention centres means NGOs are not allowed to provide aid, or won't for ethical reasons."[90]
		Security (-)	SRH	1	78	"On the part of the NGOs, the security concerns of the personnel, particularly in the southeast, challenge the continuity and the quality of the services provided, despite local personnel performing to the best of their ability."[78]
	Accommo-dation	Existence of safe spaces(+)(-)	MH, SGBV	5	68, 76, 88-90	"There is a dearth of dedicated safe spaces for women and girls, including spaces for confidential interviews with service providers."[76]

						“One encouraging development is that some humanitarian organizations have been allowed to establish women’s safe spaces, which refugee women praise as an important measure to increase their safety.”[90]
		Availability of services (-)	FP, SGBV	3	89, 90, 94	“Sexual and reproductive healthcare for adults and for adolescents is also not available in sites, nor are comprehensive family planning services.”[90]
						“Women have to travel to Calais for contraception.”[94]
		Availability of staff (-)	SRH, SGBV	8	53, 64, 67, 76, 77, 79, 83, 93	“Despite increased populist opposition to migration, there are remarkable civil society-based efforts across the country: numerous dedicated NGOs, associations, cooperatives, and community-based organizations are working to assist refugees and migrants in their communities.”[77]
		Availability of medication (-)	SRH	3	64, 89, 92	“Medical supplies are limited, thus making it impossible for migrants to follow up treatment if they do not have the funds to buy their own medications, this being very often the case.”[92]
						“Post-rape and other emergency reproductive health kits are not pre-positioned.”[89]
		Availability of translators (-)	SRH, MH	3	64, 68, 74	“Varied availability of translators for particular languages created inequity in provision for certain groups.”[68]
		Legislation (+)(-)	SRH, SGBV	5	77, 82, 88-90	“Gynaecologists in fYR Macedonia fearful of using medical kits due to a national protocol on sexual violence that dictates that medical treatment is not to be provided to survivors until a forensic assessment is carried out.”[88]
						“Supportive legislation for male sexual violence survivors: sexual violence is broadly defined in the Italian Criminal Code and is gender neutral, encompassing both male victims and female perpetrators.”[77]
						“Without proper papers, medical facilities, shelters and even humanitarian actors have been unable to help GBV survivors.”[90]
	Hours of opening	Presence of medical staff (-)	SRH, MH	3	59, 70, 84	“…gynaecologists come to Lampedusa from mainland Sicily only once a week.”[70]
	Appointment mechanisms	Complexity (-)	SRH, MH	4	58, 67, 73, 74	“NGOs provided with little information as to how to refer into secondary care and often had to make their own links to develop pathways.”[67]
						Making appointments with the local hospitals, particularly in the case of international NGOs which had no Greek speaking staff. These difficulties were overcome by hiring Greek-speaking social workers who made the appointments by liaising with the social workers of the hospitals.”[73]
		Flexibility of healthcare workers regarding bureaucratic constraints (+)	MH	2	73, 74	“Staff at the outpatient department would encourage migrant patients to stop by the screening department and either book their appointment in person or undergo an examination on the spot.”[74]
Ability to reach	Living environments	Transient nature of stay (-)	SRH, SGBV	6	53, 64, 71, 76, 83, 88	“In our experience people were not only in transit physically, but also mentally. Their determination to reach their destination and find safety was understandable, but provided significant challenges when attempting to refer cases to secondary care.”[53]
						“Misconceptions on service use: when the assessment team inquired about the availability of SGBV services such as CMR, some humanitarian actors explained that refugees would not use such services, given the speed and urgency of their migration.”[76]
	Transport	Logistical capacity of ambulances (-)	SRH, MH	4	53, 73, 74, 94	“There is access to 24 h emergency newborn and obstetric care. It is, however, difficult to access out of hours as ambulances will not always drive into the camp.”[94]
		Lack of transport possibilities (-)	SRH, MH	3	63, 67, 74	“On the islands, most refugee camps were located at a distance away from the main towns, whereas hospitals were centrally placed. Refugees might have to travel 1–2 h to reach a large

						hospital, which was difficult as transport may not be available and language affected the ease of public transport use."[67]
		Familiarity with transport system (-)	MH	1	[74]	"Physical access to hospitals hindered by: unfamiliarity with the Athens transport system, residence in camps beyond the range of the city's public transportation system, no transport arranged for transfers, ambulances transport women to hospitals in case of emergency, but do not return them to their place of residence."[74]
	Mobility	Legal rulings (-)	MH	2	[54, 73]	"The helicopter transfer takes an hour, and is only offered to migrant women in their final months of pregnancy. The rest are offered transfer by boat (and then by bus), which takes about 12 hours. Thus, VTP (voluntary termination of pregnancy, red) for migrants who arrive in Lampedusa with a pregnancy of less than 3 months is endangered by bureaucracy."[54]
		Vulnerable groups (-)	MH	1	[73]	"Transport was always an issue as well: until the refugees were issued International Protection Cards, according to the Greek law, they were not allowed to be transported on private means of transport; therefore, NGOs would not take the responsibility to drive refugees to the hospital. Bus tickets were issued, but only in those camps where a bus stop was in the vicinity and only for relatively healthy refugees; in the case of fragile people, heavily pregnant women or small children, this means of transport was not ideal."[73]
	Social support	Navigating care spaces (-)	SRH, MH	3	[63, 74, 90]	"One women's health group explained to WRC that refugee women can deliver in public hospitals but often lack support in doing so."[90]
						"In their interactions with local hospitals, people often mentioned the inability to communicate with the health care personnel as a barrier to receiving the needed care: "I had severe pain in my stomach, so I went to the hospital. I could not find anyone that could speak Farsi, and after walking around for hours, I gave up and came back. I was in big pain still after a week". (Woman from Afghanistan)"[63]
Affordability	Direct costs	Free healthcare (+)	MH, STIs	2	[58, 77]	"Only one person had to pay for the delivery."[58]
		Gender specific care (-)	SRH	1	[75]	"Women also have to spend their limited cash on sanitary pads which are not always provided."[75]
		Cost of medication (-)	SRH	1	[64]	"Since there are problems in AFAD's reimbursement to pharmacies, there are cases when pharmacies ask patients to cover the full cost of medicine prescribed."[64]
	Indirect costs	Cost of transport (-)	SRH	1	[67]	"As a result, refugees could be forced to rely on more expensive forms of transport including taxis."[67]
Ability to pay	Income	Borrowing money for healthcare (-)	MH	1	[63]	"Some emphasized how they borrowed money or used the monthly cash transfer on health services or medications that were not offered to them in the camp."[63]
		Availability of monthly cash transfer (-)	MH	1	[63]	"In Samos, where people do not receive cash transfer, some participant reported how they were not able to obtain the medication that had been prescribed to them at the local hospital, as it was not available in the camps."[63]
Appropriateness	Technical and interpersonal quality	Equipment (-)	SRH	3	[53, 64, 92]	"Lack of proper medical equipment for the functioning of the medical room was also reported by the staff interviewed."[92]
		Infrastructure (-)	SRH	1	[66]	"Infrastructure and limited access to private spaces in clinics were highlighted as barriers to providing quality care."[66]
		Staff resilience (-)	SRH, MH, SGBV	6	[53, 54, 64, 65, 67, 79]	"We have worked on trauma for many years now, but this is completely different. Supporting children's resilience requires time, patience, and a protective environment. We have no time, a risky environment, and no one has patience. Even for very experienced people, this is a challenge."[65]
						"The need for services was high and staff were often overwhelmed with sudden influxes of service users."[53]

						"Well-meaning caregivers were often fatigued and exasperated."[54]
		Staff competence (+) (-)	SRH, MH, SGBV, FGM/C	12	64, 65, 76, 77, 79-81, 85, 88-91	"All staff working with migrants expressed the need for increased cultural awareness and competence, while at the same time reporting the lack of training in migrant-related topics."[85]
						"Staff do not always have sufficient expertise to properly evaluate a case of abuse, while higher-ups in the chain of command may also lack necessary knowledge."[65]
						"In for example the CARAs in Italy, where the shortage of trained medical personnel has hindered the provision of adequate healthcare to the growing number of people in need, the system offered the possibility of task-shifting, saving costs without compromising the quality of care."[80]
		High staff turnover (-)	SRH	2	64, 70	"Complexity requires medical personnel to transcend their regular practices, by offering assistance more extensive than what they usually provide to local women. Eleonora, a gynaecologist at the Lampedusa maternity service: "To take care of migrant women, our skills related to pregnancy are not enough, you must have a good knowledge also in general medicine, internal medicine, dermatology, and infectious diseases. The clinical problems these women present are not only gynaecological, so you have to know a little of everything." High staff turnover, loss of localised expertise."[70]
		Lack of effective triage (-)	SRH	1	53	"Lack of effective triage in densely populated camps and centres, with increased strain on emergency services in these areas."[53]
		Language barrier (-)	SRH, MH, SGBV	10	64, 68, 69, 71, 75, 79, 83-85, 93	"Translation frequently occurred on an ad hoc basis, making it difficult for care providers to plan ahead and often caused service delivery delays."[68]
						"Patient privacy is also undermined when health services are not delivered in the native language of patients or when there is no translator."[64]
		Accountability (-)	SGBV	1	77	"Accountability mechanisms to enforce compliance with minimum standards in sexual violence prevention and response in reception facilities are lacking."[77]
	Adequacy	Lack of time (-)	SRH, MH, SGBV	7	53, 64, 69, 84, 88-90	"Lack of time and privacy to build trust with women, combined with limited numbers of trained personnel, and the rapid movement of populations, make case identification, referral and service provision (including providing a continuum of care across multiple countries along the route) extremely challenging."[88] "Health workers at hospitals state that their work burden has increased after the refugees, working hours became longer and time allocated to each patient got shorter."[64]
		Timeliness, long waiting lists (-)	SRH, MH	5	58, 63, 67, 68, 85	"Capacity of the hospitals was failing to meet the needs of the population it is serving, demonstrated by long waiting times and difficulties securing hospital appointments."[68]
	Coordination and continuity	Referral pathways (+)(-)	SRH, MH, SGBV	8	65, 70, 75, 77, 79, 80, 82, 83	"Poor referral systems that for local women would depend on their own communication skills to mitigate the fragmentation: the collaboration between the hospital and the first reception centre located on the island is extremely weak, failing to build an effective network of care."[70]
						"The system facilitated the continuity of care for a population undergoing frequent relocations."[80]
		SOPs (+)(-)	SRH, MH, SGBV	9	53, 65, 76, 77, 79, 80, 82, 83, 89	"Even when male survivors sought care, functioning referral systems for male survivors were not in place in the study sites. In Italy, national standard operating procedures on responding to sexual violence had not been operationalized, including the establishment of standardized referral systems and processes were informal."[82]
						"The application's digital format increased health providers' adherence to antenatal-care recommendations: the application enabled caregivers to follow a structured guideline of ANC recommendations, devoting adequate time to all sections, like for example the counselling, which tends to receive less attention."[80]

		Role of NGOs (+)(-)	SRH, SGBV	4	59, 67, 89, 90	"NGOs often initiated additional medical interventions. Medical provision was therefore uneven and access uncertain."[59]
						"Grassroots women's organizations are an untapped resource to address women's protection concerns and GBV, and are prepared to play an active role in service delivery. Many of these CSOs are currently denied access to transit centres in Serbia and Slovenia."[89]
		Communication between service providers (+)(-)	SRH, SGBV	9	67, 76-79, 83, 88, 89, 91	"Coordination issues resulted in duplication of services and some gaps in required healthcare."[67]
						"During our field visits, the team observed lack of initial health screening of new arrivals and limited cooperation between border police and public health authorities."[91]
		Lack of leadership (-)	SRH, SGBV	2	76, 94	"Lack of clearly established leadership and clear definition of roles and responsibilities of all actors at the local level. Government-led efforts to establish roles and responsibilities, including referral and reporting structures, will ensure harmonized response efforts at the local and national level among government agencies and humanitarian actors."[76]
		Lack of planning (-)	SRH, SGBV	2	78, 90	"As the presence of SuTP is still perceived as temporary and urgent, the approach of the governmental agencies and NGOs is also mostly oriented towards immediate problem-solving rather than long-term planning and investment in almost all services, including health services."[78]
		Data collection (-)	SRH, SGBV	6	53, 64, 77, 79, 84, 88	"Lack of epidemiological data regarding health needs, impacting upon the planning of appropriate interventions."[53]
						"Qualitative data on women and girls as well as other vulnerable groups is limited, and it is not clear whether or how existing disaggregated data is being used for contingency planning and operations."[88]
		Lack of information/ documentation/ patient files (-)	MH, SRH	5	64, 69, 70, 79, 83	Lack of continuity of care was a crucial issue. This is related to the lack of information on previous treatment (no personal health record, or only in local language), difficulties in obtaining medication during the journey and lack of knowledge among healthcare workers about care available in the 'next' country."[69]
						"The current minimal health record documentation presents major complications with continuity of care especially since providers are constantly changing."[83]
		Costs, limited funding (-)	SRH, SGBV	6	67, 77, 79, 83, 89, 92	"Funding for health services is overstretched."[83]
						"The agency hired a medical doctor originally from the Syrian Arab Republic but educated in Bulgaria with a right to practice in the country. Unfortunately, due to limited funding, he is only employed part-time (four hours per day)."[92]
Ability to engage	Empower-ment	Capacity to communicate (+)(-)	SRH, MH, SGBV	8	68, 71, 74, 80, 85, 88, 90, 93	"Multiple reports of women undergoing caesarean births without a translator to explain the procedure or obtain informed consent."[68]
						"The graphic interface facilitated women's engagement and retention of the health education received."[80]
		Autonomy/Agency (+)(-)	MH	2	54, 84	"In the three contexts explored, pregnant women voiced their concerns and took decisions against the background of different opportunity structures, even if a shared linguistic challenge tended to disempower them in the medical interaction."[54]
						"A good initiative as mediation and communication within the centre and between staff and migrants is the creation in the CARA Mineo of a community of elected representatives and spokespersons from the various nationalities in the centre."[84]
	Information	Comprehension (+)	MH	1	80	"The easy-to-use and easy-to-understand graphic interface of the application facilitated the communication between the CHWs and the pregnant women, overcoming most language and literacy barriers."[80]

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