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Süreyya Sönmez Efe

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Ecological Model of Health in Understanding Refugee Women's Access to Maternal Care Services in Türkiye*

Süreyya Sönmez Efe**

Abstract

This paper analyses refugee women's experiences in accessing maternal care services in Türkiye. Using a human rights framework, it emphasizes the vulnerability of refugee women arising from their precarious legal status, social position, gender and health status which intersect in complex ways. The ecological model is employed as a methodological approach to illustrate the normative and practical complexities of interactions between maternal care, its determinants, and outcomes across three interrelated stages: the micro-level (refugees' interactions), the meso-level (healthcare clinics and centers), and the macro-level (state policies and international agencies). Drawing on fieldwork findings, the paper concludes that while refugee women receive maternal care within the Turkish health system without overt discrimination, there are persistent challenges that hinder access to high-quality maternal care.

Keywords : Refugee Women, Right to Health, Human Rights, Maternal Care, Intersectionality, Ecological Model

Türkiye'de Mülteci Kadınların Anne Bakım Hizmetlerine Erişimini Anlamada Ekolojik Sağlık Modeli

Özet

Bu makale, mülteci kadınların Türkiye'de anne bakım hizmetlerine erişim deneyimlerini analiz etmektedir. İnsan hakları çerçevesini kullanarak, mülteci kadınların kesişimsel olan güvencesiz yasal statüleri, sosyal konumları, cinsiyetleri ve sağlık durumları nedeniyle savunmasızlıklarını vurgulamaktadır. Ekolojik model; anne bakımı, belirleyicileri ve sonuçları arasındaki etkileşimlerin normatif ve pratik karmaşıklıklarını üç aşamada göstermek için yararlı olan bir metodolojik yaklaşım olarak kullanılmaktadır: mikro düzey (mültecilerin etkileşimleri), mezo düzey (sağlık klinikleri/merkezleri vb.) ve makro düzey (devlet politikaları/uluslararası kuruluşlar). Saha araştırması bulgularından elde edilen verileri sunan bu makale, mülteci kadınların Türk sağlık sisteminde ayrımcılık yapılmaksızın anne bakımı aldıklarını, ancak kaliteli anne bakımı almalarını engelleyen zorlukların da olduğu sonucuna varmaktadır.

Anahtar Kelimeler : Mülteci Kadınlar, Sağlık Hakkı, İnsan Hakları, Anne Bakımı, Kesişimsellik, Ekolojik Model

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** *Dr., Senior Lecturer in Politics and International Relations, University of Lincoln, School of Social and Political Sciences, Lincoln, United Kingdom.*

CONTACT *ssonmezefe@lincoln.ac.uk • Orcid: 0000-0003-0054-7041*

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Introduction

We are living in an era of unprecedented international mass migration, with cross-border movements taking various forms, including forced or involuntary migration. It is widely recognized that when the root cause of the migratory movement is involuntary, human capabilities over life decisions are compromised due to a lack of power and agency. In other words, forced migration or unlawful displacement of people from their homes creates a power dilemma for displaced individuals in negotiating their rights, vulnerabilities, spatial precarity, and sense of belonging. The causes of individual vulnerabilities among forced migrants are intersectional, encompassing their legal status, social and cultural position, and overall health and well-being. Displaced persons are often in a constant state of negotiation between statuses and vulnerabilities, which undermines their capacity to make meaningful decisions about their lives. They become disempowered as a result of institutional and structural constraints, spatial changes, and demands of adaptation processes.

A human rights-based approach provides a valuable lens through which we interrogate the concepts of displacement, consent, rights, well-being, right holders, and duty bearers in the context of forced migration. These concepts are explored in this paper through an analysis of refugee women's experiences with maternal care and their interactions with health institutions in Türkiye. Refugee maternal healthcare in Türkiye remains underexamined from both ecological and intersectional human rights perspectives. Therefore, this paper offers a significant contribution to literature.

Existing studies in the field of healthcare identify differential levels of prenatal care for refugee and native women in Türkiye (Demirci et al., 2022), the younger age of refugee women giving birth (Erenel et al., 2017), challenges in antenatal care among refugee women (Turkay et al, 2019), issues of migrant women face in accessing health services (Yucel et al., 2021). However, these predominantly large-scale, quantitative, and comparative studies focus on statistical differences and lack a more nuanced, rights-based account of the lived experiences of refugee women. Although they reveal a growing health crisis for this population, they fall short in fully illustrating this issue through a human rights lens. This gap underlines the need for a deeper exploration of how refugee women experience access to healthcare, including the barriers and enablers involved.

This study will explore the root causes of the lack of maternal care for refugee women, such as the legal loopholes, social inequalities, and practical issues that prevent them from receiving much-needed healthcare. It will also develop a uniquely holistic illustration of this issue by incorporating the role of governmental and non-governmental actors in facilitating healthcare to refugee women. The paper uses the ecological model (Thurston and Vissadjee, 2005) to illustrate the complexities of interactions between maternal care, its determinants, and outcomes. These interactions of networks

occur in three interconnected levels: 1) the micro-level (refugee experiences and their interactions.) 2) the meso-level (healthcare clinics and centers, community-level issues on health etc.) and 3) the macro-level (state policies and international agencies' regulations). Thus, this study addresses the limitations of existing literature by bridging policy framework to an ecological model of health through a holistic and intersectional methodological approach.

The paper starts with a section on definitions of migrant statuses at both international and national levels. It then outlines the human rights approach as the theoretical foundation for analyzing refugee women's right to maternal healthcare. Subsequent sections examine the ecological-intersectional model for understanding refugee women's vulnerability in healthcare systems, provide an overview of the Turkish health system for refugee women's access to maternal care; a discussion section on the fieldwork findings from participant observations conducted at national health centers that provide healthcare services; and a conclusion with recommendations for improving the quality of maternal care for refugee women in Türkiye.

Refugee Status in Turkish Law

International Legal Framework

Turkish law incorporates both the United Nations (UN) Refugee Convention and the European Commission (EC) legal frameworks when defining the status of refugees. EC defines forced migration as "…a migratory movement in which an element of coercion exists, including to a life or livelihood, whether arising from natural or man-made causes" (EC, n.d.). This definition encompasses refugees, internally displaced persons (IDPs), and those displaced due to natural, environmental, or chemical disasters or famine" (EC, n.d.). Similarly, the United Nations High Commissioner for Refugees (UNHCR) (n.d.) defines forced displacement as "…when individuals and communities have been forced or obliged to flee or to leave homes or places of habitual residence as a result of or in order to avoid the effects of events and situations such as armed conflict, violence, human rights abuses, natural or man-made disasters, and/or development projects". The UNHCR does this definition within the context of "internally displaced persons (IDPs) and in legal terms treats "internationally displaced persons" as a separate category with the status of "refugee". The term "refugee" is reserved for individuals who cross international borders, who are legally a distinct category that carries specific rights and protections under international law.

The term refugee is a legal concept recognized by states and International Law requiring protection at the state, regional, and international levels under customary law. Refugees are people forced to flee their own country and seek safety in another country

"owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality…" (UN Refugee Convention 1951). This definition initially applied only to people from Europe and legally recognized them as refugees. However, the Protocol Relating to Refugees and Stateless (1967) removed this geographical limitation.

Refugees and Temporary Protection in Turkish Legislation

This paper focuses on refugee women in Türkiye, who fall under the category of forced migrants. Turkish domestic law retains the geographic limitation of the legal definition of a refugee from the 1951 UN Refugee Convention, despite Türkiye being a signatory to the 1967 Protocol (Decree No:6/10266, 1968), which removes this restriction. Under Turkish law, only individuals fleeing from Europe are granted full refugee status (Law on Foreigners and International Protection - LFIP, 2013). Although Türkiye is a signatory to the Protocol (1967), Turkish Law (Decree No:6/10266, 1968) makes a distinction between the term "asylum seeker" and "refugee" based on geographical limitation. Some scholars consider asylum status as *de facto* refugee status[1] which encompasses the elements of refugee status, thus needs to be recognized as such *de jure* (Cicekli, 2011, cited in Yilmaz Eren, 2018, p. 33; Sonmez Efe, 2021).

Turkish legislation (LFIP, 2013) gives Temporary Protection (TP) only to Syrian people who has sought refuge in Türkiye fleeing the civil war since 2011. TP is "an exceptional measure to provide immediate and temporary protection in the event of a mass influx or imminent influx of displaced persons where the idea is to provide protection against non-refoulment and respect for fundamental human rights…" (EC, n.d.; Luca, 1994). There are currently 2,820,362 Syrian refugees under TP (PMM, 2025) and 9,009 applicants for International Protection (IP) applications, with the majority coming from Afghanistan (5,550) and Iraq (1,881) (PMM, 2024).

The UNHCR advocates TP and states that "it is not a protection scheme replacing existing international obligations…1951 Refugee Convention and/or its 1967 Protocol or Regional Refugee arrangements" (UNHCR, 2023). Rather, it is considered an effective tool for ensuring rapid access to protection and services in host countries. To be legitimate, TP arrangements must adhere to international refugee and human rights law standards, including the principle of non-refoulment and the discouragement of premature returns (UNHCR, 2023).

UNHCR Decree No 22 (1981) lays out key guidelines for protecting individuals

[1] A *de facto* refugee: "Person not recognised as a refugee (within the meaning of Art. 1A of the Geneva Refugee Convention and Protocol) and who is unable or, for reasons recognised as valid, unwilling to return to their country of origin or country of nationality or, if they have no nationality, to the country of their habitual residence" (European Commission, n.d.).

during situations of mass influx, offering a pragmatic tool for safeguarding those who may not qualify for formal refugee status but are nonetheless in need of protection under TP. Although this Decree does not have binding principles for the states, it creates a norm for the protection of people fleeing conflict (Yilmaz Eren, 2018, p.69). In line with International Law, Turkish legislation (LFIP, 2013; Regulation No.6883, 2014; Regulation No.8375, 2016) encompasses the following principles for people under TP: unconditional admittance into the country, enforcement of non-refoulment without exceptions, and stay arrangements/meeting basic needs (UNHCR Emergency Handbook, 2025).

This paper focuses on access of refugee women under the TP status to health services in Türkiye using the human rights framework. The HRs framework enables the paper to formulate and advance an ecological model to analyze the refugee women's experiences and in accessing maternal care. This approach facilitates a normative and humane understanding of their healthcare needs and rights, emphasizing the moral obligations of host states and institutions.

A Human Rights Approach to Refugee Women's Right to Maternal Health Care

The Right to Health in International Human Rights Law

Human rights are the rights that everyone possesses because they are human (Donnelly, 2013, p. 7). Human rights have 'humanity or human nature' as the source, which are different than legal rights that are enforced by legal frameworks (Donnelly, 2013, p. 13). According to the Universal Declaration of Human Rights (UDHR) (1948) and the World Health Organization (WHO) Constitution (1948), health is considered to be an intrinsic human right regardless of gender, race, nationality, or socio-economic status. A human rights approach to health is particularly crucial for refugee women who are a vulnerable group within host countries due to their precarious social and legal status.

Human rights are different from legal rights (positive rights) as individuals are entitled to the latter because they are legal members of a state. Hence, countries ought to recognize health as a human right and have legal obligations to have appropriate policies to allocate resources to guarantee this right without discrimination between groups of people (WHO, 2024a). However, this paper does not make a distinction between negative rights and positive rights (or between the generations of rights[2]), as the right to health encompasses other aspects of rights[3] that prevent us from making such a distinction.

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[2] French Jurist Karel Vasak advanced generations of rights: first generation rights (civil and political rights); second generation rights (economic, social and cultural rights); and third generation rights (solidarity rights) (Pierre Claude and Weston, 2006, p. 21).

[3] Refugee women's rights to maternal care include social, economic, physical and mental wellbeing.

The recognition of the interdependence of human rights means that an individual's right to life is the fundamental right for them to sustain their physical existence. To enjoy the right to life and other human rights, an individual ought to have "good health" (Tuncer, 2021, p.14). Thus, the right to health encompasses other entitlements, such as "the right to control one's health, informed consent, bodily integrity, and participation in health-related decision-making" (WHO, 2024a). The Universal Declaration model incorporates the Bill of Human Rights and guides us to the fundamental principles of human rights[4] including the 'right to health care and social services' (UDHR, Article 25, 1948; ESCR Article 12, 1966). WHO Constitution (1948) adopts a holistic approach to the definition of health which is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (1948).[5] WHO defines reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (2024c). This definition includes people having safe sex and the capability to reproduce, and have the freedom to decide if, when, and how often to have children regardless of their social and legal status.

Health Equity and Social Determinants for Refugee Women

Refugees are among the most vulnerable groups and thus disproportionately experience poor health as they are usually on the margins of the host societies (Ahonen et al., 2007). Structural mechanisms such as legal status, ethnicity, social class, gender and education are considered the social determinants of health inequities (WHO, 2010). An unequal distribution of health-related resources (Christie-de Jong, 2018) has a grave impact on refugees' physical, mental and social health in the host countries. Diagram 1 illustrates how social stratification generates inequalities in health. The left column shows the institutional and policy structures within governments that directly influence social hierarchies, and the next column summarizes the social structure. Societal values create social hierarchies (or social divisions) that impact government policies. Socioeconomic position indicators such as gender roles serve as proxies for social hierarchy, influencing individuals' access to power and resources in both political and economic domains. In this study, legal status is added as a crucial component alongside gender and ethnicity. It reflects an individual's positionality based on migratory status and legal recognition within the host country, which significantly impacts their access to healthcare and other basic rights.

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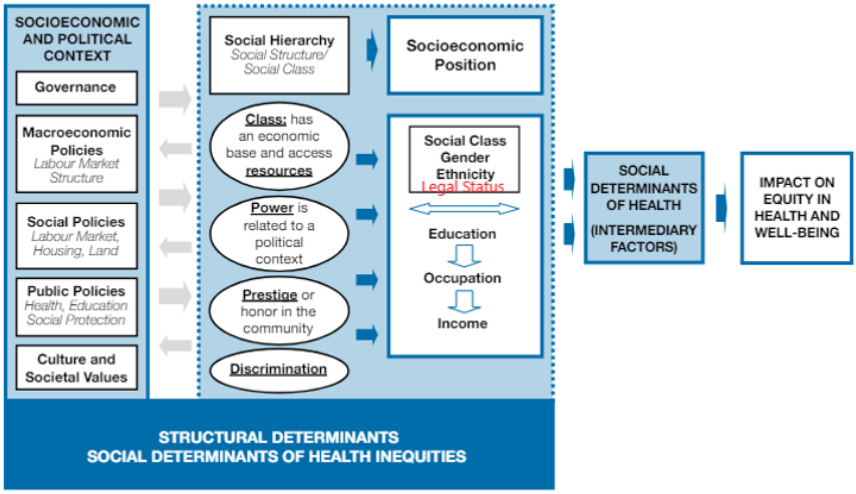
[4] Such as "right to life" (UDHR, Article 3, 1948; ICCPR Article 9), "freedom of movement and residence" (UDHR, Article 13; ICCPR Article 12, 1966)

[5] Physical health means one's ability to use full physical potential; psychological health allows individuals to cope with stress and anxiety and, thus, to conceive an environment with full potential; and social health enables one to communicate with others and socialize within the society (Erdil, 2023, p. 67-68).

Diagram 1: Structural Determinants: The Social Determinants of Health Inequalities



Source: WHO (2010), "A conceptual framework for action on the social determinants of health," p. 35 (with author's interpretation).

Legal Status and Structural Barriers to Accessing Maternal Care

Refugee women are susceptible to health inequalities in host countries because of the temporariness of their legal status. Their migration experience as a social determinant of health may also generate barriers to accessing healthcare. These barriers deprive refugee women of living a life in dignity with the absence of one or more aspects of health. Human dignity[6] is the "ultimate value" (Hasson, 2003 cited in Donnelly, 2009, p. 3), and the right to health automatically bestows refugee women with this value through the principles of worthiness and respect in the host society.

The concept of health equity explicitly recognizes the vulnerabilities of socially marginalized populations by advocating for fairness in health outcomes and empowering them with an equity agenda. WHO defines health equity as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically" (2005). Health inequalities are socially constructed issues which can be rooted in systematic processes that operate within different segments of the social hierarchies outlined in Diagram 1. Refugee women are positioned in these structural hierarchies in health systems which cannot be fully understood with merely their migration status and need to move beyond singular social categories (i.e. sex and gender)

[6] Human dignity is the foundation of the concept of international human rights law which gives coherence to human rights (Hasson, 2003, p. 83 cited in Donnely, 2009, p. 3). To claim 'human dignity' simply because being human fundamentally and intrinsically makes one worthy and deserving of respect (Donnelly, 2013, p. 29).

and determinants (i.e. immigration status, gender, indigeneity, age, and education) for a comprehensive understanding. Intersectionality (Bunjun, 2010; Collins, 1990; Crenshaw, 1989, 1991; Van Herk et al., 2010; 2011) enables the researchers and policymakers to engage in social hierarchies and encourages a critical reflection that allows researchers and decision-makers to study multiple forms of discrimination intersecting to shape refugee women's health outcomes (Hankivsky and Cormier, 2009; Hankivsky et al., 2014).

The human rights framework enables a robust conceptual framework for advancing health equity through action and implementation. International Law suggests that all individuals under IP should have the right to have good standards of physical and psychological health (Erdil, 2023, p. 99). Due to their political dominance in international order, states are the central institutions that have the responsibility for protecting and enhancing health equity in their jurisdictions (Donnelly, 2013, p. 34; WHO, 2010, p. 12). This moral and ethical debate is located within the "just governance" (Sen, 1999) argument where governments are held responsible for equitable distribution of health, which is considered as "special good" (Anand, 2001). Health is special good for two reasons: "a) it is directly constitutive of a person's well-being and b) it enables a person to function as an agent" (Anand, 2001).[7] Thus, for refugee women to reach their full potential and capability to become autonomous agents, government policies act as enablers or duty bearers of fair health policies and create systems that facilitate health equity. This paper argues that refugee women in maternal care need a special focus and empowerment due to the intersecting vulnerabilities they face within health systems.

Ecological Model in Studying Refugee Women's Access to Maternal Care

The migratory experience, including pre-migration, migration, and post-migration, is an important social and legal determinant in health research. One's legal status, culture, and gender are central to understanding migration and health through the ecological model of health (Ashcraft and Mumby, 2004; Thurston and Vissadjee, 2005). These determinants intersect with broader social determinants laid out by the WHO (2010) that act as proxies for social hierarchies, including power and class (see Diagram 1).

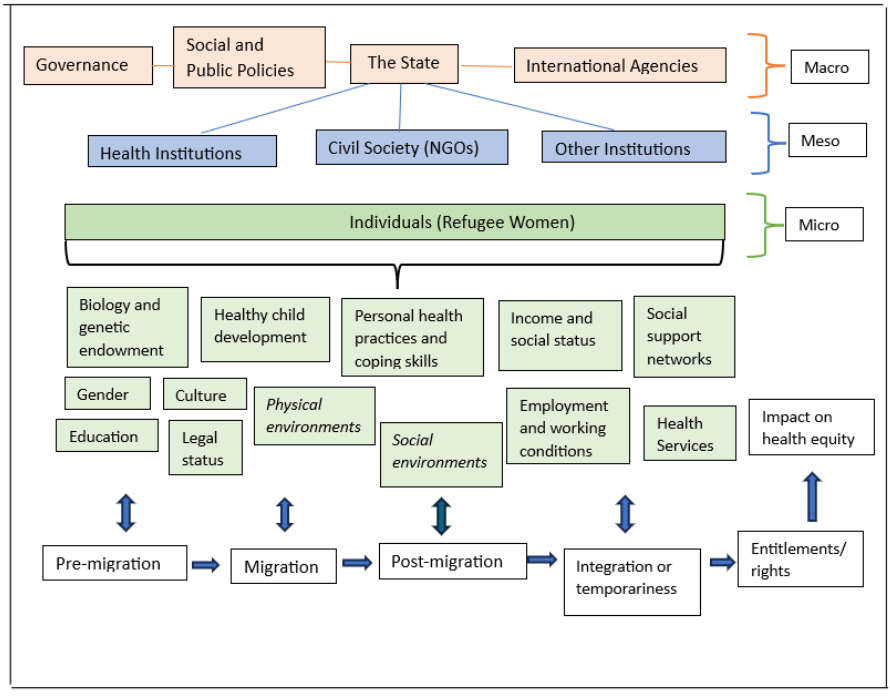
Thurston and Vissadjee (2005) argue that migratory experience is usually confused with culture; thus, they differentiate the two in their analysis. The ecological model was first introduced by Bronfenbrenner's (1986) systems theory, where he argues that to understand human development, we must consider the entire ecological system in which growth occurs. Other studies expand upon the ecological model, for instance, Howard and Hollander (1997) focus on gender, and Thurston and Vissadjee (2005) incorporate gender

[7] In this context, with the prevailing inequalities, people will not meet their full potential and capability to function, thus their freedoms and autonomy will be compromised because of their social position.

and culture in cognitive schemas to study the integration processes in a new locality over time. In this paper, I add another layer of themes to this schema, "migrant legal status" and "health determinants", to understand refugee women's access to health in host countries. I argue that it is the legal status that defines these women, thus, migration experience becomes an important social determinant to understand their access to health which is, according to feminist literature, a fundamentally gendered process (Ashcraft and Mumby, 2004, p. 31). Migrant status also impacts on these women's living and work conditions.

The diagram below illustrates the relationships and interactions of equally interdependent determinants in an open system. At the macro level, the state and symbolic institutions are in the same category, although, as mentioned before, states are the ultimate decision-makers, even though they are in constant interaction with other non-state institutions. These interactions can be an iterative process where some modes of structures incorporate a continuation across time and space. They may produce new forms of structures because of new dynamism stemming from internal or external determinants.

Diagram 2: Ecological Model in Studying Refugee Women's Experiences of Maternal Health Services in Türkiye



Source: Created by author with inspiration from "An Ecological Model for Understanding Culture as a Determinant of Women's Health" (Thurston and Vissadjee, 2005, p. 231, in Appendix 1)

Welfare institutions, institutional civil society, and economic institutions are kept separately in Diagram 2 to illustrate conceptual and practical differences within systems and structures. Their interactions with the state would vary based on the level of cooperation. Here, (migrant) legal status plays a crucial role in shaping individuals' interaction with systems and structures. Thus, migration experience has a grave impact on physical, social, economic, political, and cultural determinants and define their positionality within the systems and structures.

This paper advances the ecological model of health, as illustrated in Diagram 2, in three ways: 1)it will provide more clarity on institutions' behavior at the macro-level where the hierarchies shift based on the decision-making powers; 2)it adapts social and structural determinants to the context of the Turkish health system; and 3)it introduces new or additional health determinants with the inclusion of migration experience in shaping refugee women's health outcomes and their interactions with systems and structures.

Integrating Ecological Model to Understand Refugee Women's Health in Türkiye: Why are Refugee Women More Vulnerable?

Refugee Women's Health Profile in Türkiye

This paper refers to refugees as individuals under TP, as refugee status is granted in Türkiye only to people coming from Europe (see definitions section). Official data suggest that all migrants under TP in Türkiye are from Syria, who fled their country due to the civil war that started in 2011 (see introduction). Statistical evidence also suggests that of the total of 2,820,362 Syrian refugees, 1,365,892 are women (PMM, 2025). Moreover, nearly 50% of Syrian refugees in Türkiye are women, who are of reproductive age. According to a study by SIHHAT, the majority of Syrian refugee women in Türkiye are housewives (52%), students (19.9%) and have no profession (19.5%) (2018, p. 113). It is common for them to get married at a young age, such as 13, and give birth (Ciftci et al., 2016). The same survey, with a sample of 1280 refugees across 10 cities with a high refugee population, suggests that 83.9% of women aged 15-49 have children (SIHHAT, 2018, p. 115).

The most common health problems that refugee women under TP face are unwanted pregnancies due to lack of family planning (SIHHAT, 2018, p. 115), miscarriages (Karadağ and Altıntaş, 2010) and delivery-related complications (WHO, 2022). Moreover, the SIHHAT study also found that 54.4% of Syrian refugee women in Türkiye aged 15-49 do not use any contraceptive methods to prevent pregnancy (2018, p. 140). When asked why not, 47.7% among women aged 15-18 said "they wanted to have children"; similarly, 24.2% of women aged 15-24 indicated that they wanted to get pregnant (2018, p. 143).

Vulnerabilities and Barriers to Maternal Care

Women and children are considered the most vulnerable refugee group under TP who need special protection (Erdil, 2023). The vulnerability of women aged 15-49 derives from their gender roles and experiences of serious problems during pregnancy and childbirth (Ciftci et al., 2016). It is suggested that gender roles and expectations for Syrian refugee women influence their desire to have children at an early age. Refugee women are also vulnerable due to insufficient pregnancy monitoring, lack of information about maternal care clinics, giving birth in unhealthy conditions, and lacking the vitamins and minerals during and post-pregnancy (Özgülnar, 2016 cited in Türk Tabipler Birliği, 2016). Cultural expectations and gender roles also impact refugee women's accessing sufficient healthcare, including patriarchal family structures and dependence on husbands to go out of their homes, lack of practical knowledge of the Turkish language, and lack of knowledge of the Turkish healthcare system (Tuncer Unver and Baykal, 2020).

The psycho-sociological health of refugee women is usually low because they experience harsh migratory experiences, witness difficult situations, and are away from their homes and families. According to the SIHHAT study, refugees' health status deteriorated after migration from Syria to Türkiye, with 85% stating that they had been in good health prior to migration but declining to 62% after migration (2018, p. 55). Thus, many refugee women "experience feelings of anxiety and sadness, hopelessness, difficulty in sleeping, fatigue, irritability, anger or aches and pains… depression and post-traumatic stress disorder (PTSD)" (WHO, 2022). According to a study, depression levels among refugee women are high, with one in 10 women attempting to commit suicide (Yurdagul and Aytekin (2018). Studies (SIHHAT, n.d., p.11; Türk Tabipler Birliği, 2016; Gümüş et al., 2017) emphasize the reproductive health risks that Syrian refugee women usually experience as:

- Early marriage; forced marriage; short-term marriage; close-kin marriage; polygamy
- Teenage pregnancy; high fertility rate
- Violence-sexual violence
- Lack of usage of modern contraceptive methods
  - Lack of awareness and knowledge
  - Unwanted pregnancies
  - Unfulfilled contraceptive needs
- Insufficient prenatal care
  - Iron and vitamin deficiency (especially Vitamin D)
  - Poor obstetrics outcome (miscarriage, premature birth, DDA, and risky pregnancy)
- Mother and child mortality
- Unsafe miscarriage

- Lack of gynecological periodic checks
- CYBH/HIV (polygamy, torture, rape, sexual violence)
- Osteoporosis and cancer

Other social determinants of health are strongly related to refugee women's health, including gender, education, income, housing, culture, and employment. For instance, due to forced migration, Syrian refugee women may have reproductive health problems, such as attaining the desired number of children and accessing family planning services (SIHHAT, 2018, p. 119). Some determinants also create additional barriers for refugee women accessing reproductive health, including language, lack of awareness, communication issues with healthcare providers, sociocultural problems and lack of healthcare service (SIHHAT, 2018, p. 14).

Refugee Women's Access to Maternal Health Care in the Turkish Health System

Structure of the Turkish Health System

The Turkish health system provides primary (family health centers [FHCs]), secondary (hospitals) and tertiary (research hospitals) services for maternal care including antenatal and postnatal care. Primary and secondary maternal care is also provided in migrant health centers (MHC) and extended MHCs (E/MHCs) (for migrants only) directly by booking an appointment. Tertiary care is given by referral to university research hospitals or private health care providers in private hospitals or clinics. All three tiers in the Turkish health system ensure all women in maternal care needs are monitored and taken care of with services free of charge (see Table 2 (created by the author based on official and fieldwork data) in Appendix 2). Everyone, including documented and undocumented foreigners,[8] can benefit from emergency health services, facilities, and services to fight against infectious diseases and victimization (DGHC, 2022).

There are also 442 prenatal schools in healthcare facilities including public health centers, secondary and tertiary health institutions in Türkiye (MoH, 2023a, p. 92). They aim to prepare/inform pregnant women about a healthy pregnancy, childbirth and postnatal health, and raise awareness about vitamin D and iron deficiency[9] during and after pregnancy. Türkiye collaborates with WHO and UNICEF (2020) to tackle mother and baby mortality and implements high health standards by monitoring and providing transparent data sharing across institutions to meet WHO's 2010-2030 Sustainable Development Goals. Türkiye also initiated the Mother-Friendly Hospital Program in

[8] The term 'foreigner' is used here in line with Turkish Law.

[9] 92.6% of pregnant women have vitamin D deficiency.

2023 (MoH, 2023a, p. 81; 2023b, p. 126), with 121 hospitals named Mother-Friendly[10] (MoH, 2023b, p.81), and implemented the Baby-Friendly Hospital Initiative nationwide,[11] with 1,353 hospitals categorized as baby-friendly (MoH, 2023b, p. 83).

The Turkish health system accommodates refugee women in FHCs (until recently), MHCs, E/MHCs, and hospitals, all of which prescribe medicine that refugees can buy from the pharmacies that have agreements with state institutions. The health system has language facilities, including translation and information centers,[12] for all foreigners, which are crucial services for overcoming language or cultural barriers. Türkiye collaborates with the EU on the SIHHAT Project (Facility for Refugees in Türkiye [FRIT]; EC, 2024), which enables refugee women to receive basic health care, health education, health personnel development, reproductive health care, family planning, and mental health care (Sonmez Efe, 2025). Primary healthcare services for refugees[13] are provided through MHCs, E/MHCs,[14] mobile clinics, and polyclinics for foreigners, all of which are critical for refugee women's sexual and reproductive health.

Legal Rights and Entitlements under Temporary Protection

Refugees with TP and IP statuses benefit from primary, secondary, and tertiary health services in Türkiye. However, refugee women without TP and who cannot provide a TP identification document can only benefit from emergency health services, services that fight against infectious diseases, and victimization services (DGHC, 2022). All refugees without TP must register with the Provincial Directorate of Migration Management to receive full health services in the city of residence. According to the TP Regulation Article 27/(d),[15] refugees under TP cannot directly go to private health institutions, unless for

[10] Mother-Friendly Hospital Model (WHO and UNICEF, 2020) aims the creation of birth units for one person with privacy to promote natural birth and a comfortable environment for pregnant women to give birth (MoH, 2023b).

[11] It aims to train pregnant women and support them during the postnatal period for the skills for breastfeeding. There are currently 1,353 baby-friendly hospitals in 81 cities in Türkiye (MoC, 2023b). Refugee women with TP can benefit from these health services without discrimination.

[12] Communication Centre for Foreigners (YIMER) by calling 157, Ministry of Health Communication Centre (SABIM) by calling 184, and Ministry of Family and Social Politics Social Support Call via 183.

[13] Within the scope of the SIHHAT Project: primary health services, laboratory and imaging support in primary care, psychosocial support services in primary care, cancer screening program support, CBMHC (Community-Based Mental Health Center) services, mobile health services, provision of micronutrient and vitamin D. support, immunisation and vaccine follow-up services (Sonmez Efe, Unpublished Evidence Paper, HoC, 2025).

[14] SIHHAT projects currently support 190 MHCs and E/MHCs, where there are further specialised services such as gynaecology, internal medicine, paediatrics and dental care) (Sonmez Efe, Unpublished Evidence Paper, HoC, 2025).

[15] 'The cost of health services, including second and third step health services, shall not exceed the costs in the Health Budget Law [SUT] determined by the Presidency of Social Security Institution for beneficiaries of general health insurance' Article 27(c), 2013).

emergency procedures (2014). However, the interview data and fieldwork study suggest that refugees with TP benefit from the private hospital services only when they financially afford to do so. The Regulation (2014) takes a holistic approach to the provision of health services to refugees including psycho-social services in coordination with the Disaster Intervention Plan of Türkiye.

The regulation also lays out health services provided to refugees in Türkiye as Article 26 (1) as the following: "Foreigners under this Regulation may be provided with health, education, access to the labor market, social assistance, interpretation and similar services." Moreover, Article 27 gives control and responsibility to the Ministry of Health for the provision of health services to refugees under TP "inside and outside of temporary accommodation centers"[16]

Access to Maternal Health Services: FHCs, MHCs and Hospitals

As mentioned earlier, refugee women can access primary and secondary maternal care at FHCs, and since 2018, at MHCs, E/MHCs, Migrant Health Education Centers, and Migrant Health Units in the cities and provinces in which they are registered. Women registered in the FHCs before 2018 continue to receive health services and are monitored as a family; however, the FHCs transferred all refugees to MHCs in 2018. The fieldwork and the interview data suggest that in April 2025, the transfer process was completed. Both FHCs and MHCs provide care and monitoring services during pregnancy and post-natal care including refugee women:

Table 1: Prenatal and Postnatal Care Provided for Women in FHCs and MHCs in Türkiye

	During Pregnancy	**Post-natal**
Aim of the care	Prenatal care to minimize the risks of mother and baby mortality rates, diseases, and disabilities.	Postnatal care to minimize the risks of mother and baby mortality rates.
When	Women are advised to have four health visits: during week 14, weeks 18-24, weeks 24-28, and weeks 36-38 of the pregnancy.	Women are advised to have four health visits after childbirth: in the first 24 hours; between day 2 and 5, 13 and 17, 30-42, and after 42 days.

[16] Migration Board under the Presidency of Migration Management (PMM) is responsible for "determining Türkiye's migration strategies related to foreigners and following the coordination and implementation; and is chaired by the Minister of Interior and consists of representatives from ministries, institutions and establishments determined by the Ministry of Interior" (the Presidential Decree No. 1, 2018).

Health services provided	a) Iron and vitamin D tablets are distributed free of charge. b) Each health visit incorporates the following examinations: -Anamnesis -Physical and pregnancy examination -Weight, height, blood pressure monitoring and pregnancy week and fetus monitoring -Blood and urine tests -Risky pregnancies are determined and referred to the hospital. -Vaccination for pregnant women -Training for general hygiene procedures, breastfeeding techniques, sexual life, diet, and contraception methods.	a) Physical care after birth b) Support breast milk and breastfeeding c) Monitor unexpected health risks such as infection, and bleeding. d) Monitor vitamin D and Iron levels e) Consultancy on contraceptive methods f) Vaccination

Source: Created by the author using the information from the Ministry of Health (2023)

Refugee women receive secondary care in hospitals by booking appointments directly using the same system as Turkish citizens. Pregnant refugee women go to hospitals for ultrasound monitoring, childbirth, caesarean, and other postnatal and baby-related treatments. In E/MHCs, there may be a gynecologist and ultrasound facilities that permit refugee women to go in lieu of hospitals. However, the number of E/MHCs and Syrian gynecologists is quite low, so most refugee women go to hospitals for advanced monitoring and treatment.

Findings from Participant Observations of Maternal Care Centers/Units in Türkiye

Participant Observation as a Data Collection Method

This section discusses data from participant observations conducted in two FHCs, two E/MHCs, a hospital's breastfeeding support unit (BSU), a maternal unit (MU), and a caesarean intensive care unit (CICU) in Bursa, Türkiye. Bursa was chosen for the fieldwork study as it has one of the highest numbers of refugees, especially Syrian, at 162,928 (PMM, 2025). These health centers/units are in areas with high refugee populations from Syria or Turkic countries such as Azerbaijan (see Table 2, Appendix 2 for demographical data). The overt observations in closed non-public settings are planned strategically with consent[17] from the health centers to access these health facilities.[18] The carefully selected

[17] The consent is sought after negotiating with the health care professionals and management in each centre or department. This project is funded by the British Academy Leverhulme Small Grants. Favourable Ethical Approval was obtained from the Ethics Committee of the University of Lincoln (Ethics Reference: UoL2023_16174).

[18] There had been a challenge to gain access to some units which required rigorous negotiations with gatekeepers, but

settings fit with the research aims; thus, observations enable us to understand Turkish healthcare services providing maternal care to refugee women.

This study employed a multi-method ethnographic approach incorporating participant observation, semi-structured interviews, and photo elicitation technique (Hodkinson, 2002, cited in Bryman, 2012, p. 441; Gorli et al., 2012, p. 291, 302-304). This paper focuses on findings from observational data collected during fieldwork in December 2023 and January 2024 (see Table 2, Appendix 2). The participant observation followed the key stages as outlined by Dewalt and Dewalt (2002): "active looking, improving memory, informal interviewing, writing detailed fieldnotes, and patience" (p. vii, 18). Due to time constraints and the sensitive nature of healthcare settings, the researcher maintained minimal participation in core clinical activities (e.g., meetings and direct conversations with patients). Greater time was spent in FHCs, E/MHCs, and the hospital's breastfeeding unit, where the intensity of care provision allowed for extended observation. Conversely, time in high-intensity settings such as the MU and CICU was necessarily limited. Despite these constraints, the observations provided meaningful insights into the organizational culture and behavioral dynamics of healthcare settings. Using a sensory and contextual approach, the researcher created detailed "written photographs" [19] of the structures and environments under study (Erlandson et al., 1993). The observations aimed to understand the health care system and to observe the communication and interactions between the health care professionals and refugee women receiving maternal care.

The observational data is analyzed using thematic analysis and focused on two themes: a) the institutional practices in maternal care and b) interactions between refugee women and healthcare providers. These themes enable us to make sense of refugee women's experiences of maternal care at the meso-level (hospitals, health centers) and micro-level (refugee women) (Diagram 2). The writing style of the observations in these sections falls somewhere between "realist tales" and "structural tales." The former allows the writer to adhere to the strategy of realism through third-person accounts of behavior and culture (Van Maanen, 2011, p. 47), and the latter enables the researcher to link observation of everyday interactions and momentary practices to broader social, political, and institutional structures (Van Maanen, 2011, p. 166). By drawing these connections, the researcher incorporates interpretative analysis that situates behavior and institutional dynamics within the wider societal context.

as Bryman (2012, p. 435) describes "sheer perseverance pays off". The researcher used contacts from the healthcare sector and the health NGO for necessary permissions.

[19] The researcher preferred taking mental notes where it was not possible to take notes in the setting as well as taking written notes where it was possible as the recording was not allowed by the healthcare professionals due to privacy regulations of the patients and the healthcare providers.

Observations on Institutional Practices in Maternal Care

The observational data in health centers and hospitals corroborate the official document analysis (see Section 5), which outlined the maternal health care provision to refugee women within the Turkish health system. Observational data illustrates the provision of maternal care focusing on two system-based categories: primary care (FHCs and E/MHCs) and secondary care. The observations took place in the FHCs' maternity monitoring and baby monitoring rooms and vaccination rooms upon the healthcare providers' suggestions. In the MHCs, the researcher was immersed in the ultrasound admission unit and the examination rooms. Although the MHCs and FHCs are designed to serve as the initial point of contact for pregnancy care and monitoring, the observational data reveal a common pattern: many refugee women tend to bypass primary care facilities and seek care directly from hospitals once they receive a positive pregnancy test. One of the E/MHCs had a gynecologist who refugee women preferred for ultrasound examinations.

Observational data and informal discussions with healthcare professionals in the FHCs suggest that pregnant women, both Turkish and refugee, initially present at FHCs, while refugee women also utilize MHCs, for the following procedures: an initial health record including pregnancy status; health registration; routine health checks (i.e. blood count, tests for infectious diseases, height and weight, blood pressure, pulse, and baby's heartbeat); provision of comprehensive information about pregnancy and postnatal processes; starting on folic acid and training on the importance of the deficiency during pregnancy; first tetanus and flu vaccines; antenatal classes after 20 weeks of pregnancy to receive guidance about caring for a newborn, breastfeeding, staying healthy, making birth plans and information about health arrangements for labor and childbirth. All these procedures are compulsory including follow-up checks during antenatal and postnatal states.

One notable observation was the diligence of health providers in FHCs in monitoring women with both prenatal and postnatal health status. If a woman misses a routine appointment, the health providers – nurses and midwives – make every effort to contact these women and process health visits at home, if they continuously miss their appointments. During the observations, this process is recorded on many occasions, as toward the end of each workday the records for missed appointments are checked and women are called to arrange a new appointment or a home visit. Each health professional is responsible for monitoring a group of women. Pregnant women are required to visit the FHCs and MHCs four times during pregnancy and seven times if it is a risky pregnancy. Both Turkish citizens and refugees with TP and other legal statuses benefit from these health checks and procedures.

Both FHC and MHC facilities were spacious and well-equipped, allowing healthcare providers to deliver care in a comfortable environment. This spatial relationship reflects the high quality of interactions between health providers and care recipients. In both

FHCs, referrals to the hospitals were made when necessary. The following excerpt is from my fieldwork observations at FHC2:

> *"My observations took place in the immunization and pregnancy unit at FHC 2 which was well equipped with spacious rooms. In each room, there were two midwives and two nurses, computers for data entry and monitoring, an examination area, space for routine checks with equipment, and a desk and seating space for the midwives and women… a Syrian refugee woman, 21 weeks pregnant in her late 30s…came…was her second visit…the nurse carried out routine checks including drawing blood for tests (glucose tolerance test), weight and height records…arranged a follow-up appointment."* (FHC2, 2 January 2024, 9:00 am-11:30 am)

This process was carried out for all women regardless of their legal status, thanks to a centralized official approach managed by the Municipal Health Authorities appointed by the Ministry of Health. The health providers stated that if they have any missing records or when the authorities notice a lack of monitoring of a woman, there are financial repercussions on their salaries with fines. The central checks are carried out every month through a management system. I was permitted to analyze the online recording system, which was very intricate and detailed.

The health providers in MHCs also followed the same data entry/recording procedures for refugee women they monitored by using a separate online system, managed by the SIHHAT system which was ultimately overseen by the MoH. The health providers in MHCs were equally taking these procedures very seriously. Although MHCs are EU-funded centers, the Turkish health system is responsible for regulations/monitoring etc., where routine checks are carried out by the Municipal Health Authorities. This illustrates the hybrid management of MHCs by the EU and the Turkish national health system and the strong collaboration for quality maternal care for refugee women.

The hospital where the observations were conducted is located in a region with a high concentration of refugee populations. Observations were carried out in three hospital units, MUs, BSUs, and CICUs, during peak hours in the mornings and early afternoons. BSUs were established in most hospitals in Türkiye since 2022, including the one in which this fieldwork occurred. At the BSU, pregnant women or women in postnatal status visited the unit to receive support and training on breastfeeding and healthy maternal care/well-being:

> *"The BSU nurse provided support and training to a refugee woman in postnatal health status using a supplemental nursing system (SNS) device (which could be obtained from pharmacies) to support new mothers to teach effective breastfeeding especially babies with low weight. The nurse raised awareness*

> *about the health benefits of breastfeeding for women's bodies, hormone systems and well-being after birth."* (BSU, 25 December 2023)

Pregnant women and new mothers were also guided to hospital departments if the nurse identified a health problem with the mothers or babies. I witnessed three referrals (informally advised by the nurse) during my observations.

Observations at the MU suggest different spatial interactions from the BSU due to the type of health provision and structural setting. The MU in this hospital is one of the busiest in the city, receiving a high number of Syrian refugees. During the observations, in nearly every room in the MU with a capacity of two or four patients there was one or two refugee women. The interaction between the health providers and refugee women was minimal due to the language barrier and carried out via translation provided by family members or friends. Although the hospital had translation services (health providers said there were two translators in the hospital) for Syrian refugees, they usually did not call for the service, as the refugee women were accompanied by a family member who could help with translation. Some refugee women could speak Turkish and did not need translators.

Interactions Between Refugee Women and Healthcare Providers

The observational data suggest equal treatment of refugee women and native women receiving health services. Health providers at the FHCs where I conducted my observations take a holistic approach to the provision of maternal care to all women regardless of their legal status or ethnicity:

> *"I conducted observations in the vaccination and baby care room… I witnessed a well-equipped and inclusive environment for both Turkish and refugee women. During my observations, routine health checks provided to Turkish mothers and two Syrian refugee women, one pregnant and one in the postnatal stage. The healthcare professionals treated all women equally and with a positive attitude. One refugee woman inquired about IUD contraception and was referred to a nearby clinic, as such procedures are not carried out in FHCs. Overall, the atmosphere was respectful, and the service delivery appeared equitable across all patients."* (FHC 1, December 2023, 9:00 am-11:00 am)

The researcher observed similar scenes in both FHCs and the BSU:

> *"I was simultaneously conducting observations and conversing with health providers which indicated a relaxed atmosphere in this health space…two Syrian refugee women came, one of whom was 36 years old and five months pregnant…she spoke limited Turkish, and her teenage son accompanied her for*

> *translation. The nurse carried out routine procedures without any issue with communication with the refugee woman who expressed gratitude for the positive treatment."* (FHC 2, January 2024, 9:00 am-11:30 am)

Interactions between health providers and refugee women were positive despite the FHC 2 receiving a high number of Syrian and Turkic refugee women from Azerbaijan, Russia, and Turkmenistan, who are called 'Meskhetian Turks'.

A similar positive relationship between health providers and refugee women was observed in the E/MHCs, even though they were busier than FHCs due to having consultants such as a gynecologist and a pediatrician. E/MHCs seem to overcome cultural and language barriers as most healthcare professionals could speak Arabic, including the gynecologist, and there were translators. Thus, refugee women appeared to be pleased with the healthcare provided. Despite the busy corridors and examination rooms, there was a synergy and a feeling of ease in terms of interactions between refugee women and health professionals:

> *"…in a health reception of the E/MHC 1, two nurses recorded the refugee women in the system who came to see the gynecologist for pregnancy monitoring and ultrasound. The interaction of refugee women with the nurses was positive and straightforward, and I could see the exchange of jokes and comfortable conversations during the process. There was a male Syrian gynecologist with a very positive attitude toward the pregnant women... the atmosphere was extremely relaxed and inclusive in this space where refugee women seemed to feel safe and happy. Although the examination room was small and a bit packed with furniture, and there was a curtain that separated the room from the reception section, no one seemed to be uncomfortable about it."* (MHC, 1 January 2024, 9:00 am-4:00 pm).

The observations in the BSU suggest positive spatial interactions like the FHCs, which are more relaxed and accessible. The time spent by healthcare providers on each woman was longer than in the MU or CICU. Women who visit the BSU seem to have a positive interaction with the health provider (nurse) and the space that is accessible. During the observations, refugee women (mainly Syrian) and Turkish women (largely members of the hospital staff on maternity care) visited the unit.

I also observed cultural differences between refugee women (mainly Syrian) and Turkish women about family structure, gender roles, and expectations. All Turkish women came to the BMU with their husbands, who were present during the routine checks and breastfeeding training, whereas most refugee women came with a female family member or friend. One refugee woman who was seven months pregnant came with her husband, who waited outside the hospital, which was also the case during interviews. My observational

data notes collected in the field illustrate the spatial interactions in the BSU:

> *"A refugee woman (Syrian) with a newborn came with her friend (Syrian) who was helping with translation. The nurse carried out routine monitoring of the baby, i.e. weighing and recording the baby's development since the last visit. She was very caring when asking questions to the mother through a translator. I was impressed with the nurse's enthusiasm with each patient when providing support and training to mothers about breastfeeding techniques. The nurse treated the refugee woman as same as the native women who visited the unit."* (BSU, 25 December 2023)

The spatial interactions did not suggest a direct cultural stigma when the care was being provided. Although the health provider shared with me her concerns about the high fertility level among Syrian refugees and its implications for their well-being, this attitude did not affect the quality of the maternal care provided. However, the maternal health guidance and advice provided by the nurse included some cultural stigma (based on the difference) despite the positive attitude.

The observations emphasize two key barriers that undermine positive spatial interactions in the MU: the "language barrier" and the "(direct or indirect) stigma attached to the Syrian culture." The former stems from refugee women who could not speak Turkish, whereas the latter from the health providers (Turkish) or in some cases from both sides. The observational data coupled with the informal conversations with the refugee women and the healthcare providers suggest that these barriers increase workload and generate frustration for healthcare providers. Minimal interaction due to language barrier and a lack of understanding of the healthcare system impacted the refugee women's well-being and in receiving quality maternal care.

The barriers mentioned above are observed in the CICU, which was a small health setting, with a four-bed capacity and the presence of two nurses. Because the type of healthcare provision required intensive treatment and close monitoring, the researcher spent limited time in the CICU compared to the other two units. Two Syrian refugee women were in the CICU in post-op status, who had had caesarean operations one day earlier. I did not have any interaction with the refugee women but had informal conversations with the nurses. The spatial interaction was highly limited due to the type of care given, but the nurses were providing special care using sophisticated monitoring equipment.

During an informal conversation with the nurses, they described one full workday at the CICU. Their focus shifted to a heavy workload because of the high number of Syrian women giving birth, and their descriptions were laden with stigma about their (refugee women's) patriarchal culture and expectations. Two refugee women in the CICU were

conscious, and their communication with the consultants and nurses was extremely limited. These observations suggested that maternal care provision is affected by barriers that are multi-faceted such as lack of communication and cultural stigma. However, despite these barriers and the prejudice against these women, the nurses carried out the health provision without discrimination. The nurses described the same health concerns about the refugee women under their care within the CICU where the observations occurred.

Conclusion

The paper examined refugee women's access to maternal care services in Türkiye through qualitative data from participant observations and official document analysis. Methodologically, the study offers a novel contribution to the literature by integrating ecological and human rights-based frameworks to analyze maternal health among refugees in Türkiye. The human rights approach aimed to re-humanize this marginalized group by moving beyond statistical abstraction and affirming their dignity, worth, and agency within the context of quality maternal care. By placing health equity at the core of the normative argument for the right to health, the study underscores the moral and legal obligations of states toward refugees.

Simultaneously, the ecological model facilitated a holistic and intersectional examination of key determinants such as gender, social status, legal status, and culture background allowing for a nuanced understanding of refugee women's experiences across macro and meso levels of the health system. Through this approach, the study reveals how refugee women's intersecting identities shape their engagement with health institutions, challenging monolithic or stigmatized representations and instead highlighting their diverse needs and lived realities. In doing so, the paper contributes meaningfully to broader discourse on migrant rights and reproductive justice.

The paper highlights the heightened vulnerability of refugee women in host countries, stemming from their precarious legal and social position. It argues that the temporariness of their legal status exacerbates these vulnerabilities, limiting their ability to claim rights and entitlements in the healthcare system. Through in-depth qualitative data, the study illustrates rich data about social work practices through illustrating spatial interactions (at the meso-level and micro-level) between refugee women and healthcare providers. The findings reveal a spectrum of positive and challenging experiences that refugee women encounter while navigating the Turkish health system. Key challenges identified include:

- Language barriers, which hinder effective communication with healthcare providers;
- Cultural stigmatization and prejudice, particularly surrounding perceptions of high fertility among refugee women, which shape health providers' attitudes and public discourse;

- Systemic pressure on health services in regions with dense refugee populations, which contributes to negative public sentiment;
- Gendered roles and expectations within refugee communities, which influence women's reproductive decision-making and overall well-being.

The observational data suggest that the Turkish health system provides maternal and reproductive healthcare to refugee women under TP without discrimination. This suggests that the principle of health equity is embedded within the operational framework of the Turkish health system. Furthermore, official document analysis highlights a coordinated effort involving national (Türkiye Ministry of Health), regional (EU), and international (WHO and UNICEF) institutions to ensure the delivery of quality maternal and reproductive care for refugee women.

We acknowledge the limitations of the study in terms of geographical scope, sample size, and diversity of refugee backgrounds, which may constrain the generalizability of the findings. However, it offers a nuanced qualitative account of the maternal healthcare experiences of a marginalized population within Türkiye's national health system. The research contributes meaningfully to healthcare practice and informs policy development by highlighting both structural and interpersonal challenges faced by refugee women. The findings lead to several practice recommendations aimed at enhancing social inclusion and improving the quality of maternal care for refugee women:

- Sustain and strengthen collaborations between state and non-state health institutions providing maternal and reproductive care to refugee women.
- Increase investment in prenatal and postnatal education programs to improve the health literacy of refugees.
- Develop and implement training programs for health providers to enhance their cultural competence.
- Introduce structured educational and social integration programs for refugee women in FHCs, MHCs, and other public health facilities to increase health literacy, cultural competence, and social integration.

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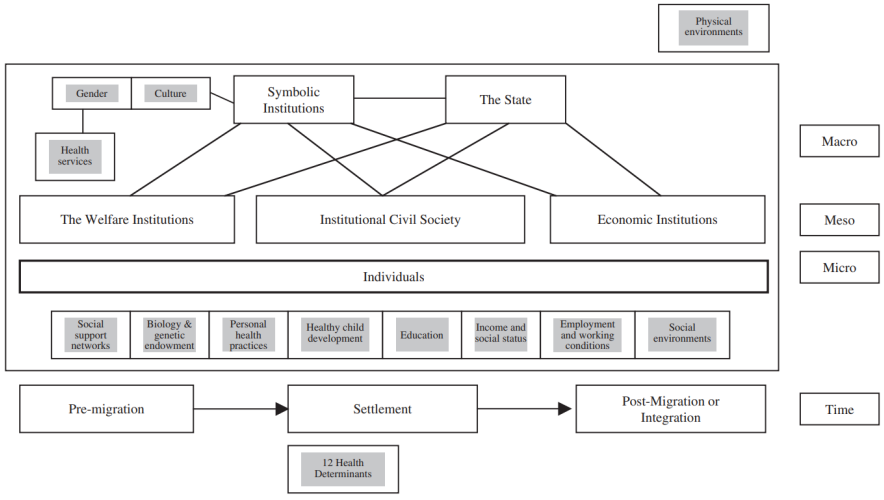
Appendix 1

Diagram 2: Ecological model of migration, gender and health



Source: 'An ecological model for understanding culture as determinant of women's health' (Thurston and Vissadjee, 2005, p.231)

Appendix 2

Table 2: Heatlh Centers/Units that are included in participant observation for this study.

The type of center/unit	The key services provided for women	Health professionals present during observations	Population receiving care in the centers during the observations	Time spent on observation
FHC 1	-Pregnancy care and monitoring -Prenatal vaccination -Provision of Vitamin D and Iron (free) -Postnatal care and monitoring -Consultation and education for family planning -Free blood and other tests -Referrals to hospital -Other pre-hospital health services	-Midwives -Nurses	-Turkish Women -Refugee women from Syria	1 Full day
FHC 2	-Pregnancy care and monitoring -Prenatal vaccination -Provision of Vitamin D and Iron (free) -Postnatal care and monitoring -Consultation and education for family planning -Free blood and other tests -Referrals to hospital -Other pre-hospital health services	-Midwives -Nurses	-Turkish Women -Refugee women from Syria -Migrant women from Turkic nations (Ahiska)	1 Full day
MHC 1	-Pregnancy care and monitoring -Prenatal vaccination -Provision of Vitamin D and Iron (free) -Postnatal care and monitoring -Consultation and education for family planning -Free blood and other tests -Gynecology consultancy -Referrals to hospital -Other health services including primary and secondary care	-Health administrators -Gynecologist -Interpreters	-Refugee women (all Syrians)	1 full day

MHC 2	-Pregnancy care and monitoring -Prenatal vaccination -Provision of Vitamin D and Iron (free) -Postnatal care and monitoring -Consultation and education for family planning -Free blood and other tests -Gynecology consultancy -Referrals to hospital -Other health services including primary and secondary care	-Health administrators -GPs -Interpreters -Midwives	-Refugee women (all Syrians)	Half day (afternoon)
Hospital Breastfeeding Unit	-Provide breastfeeding training to women before and after childbirth -To provide and/or advice on the breast bumps or breastfeeding methods -To monitor new mothers about breastfeeding progress -To monitor babies' health, and development on each training session i.e. measuring babies' height and weight -To keep a report of the data from the training, and monitoring of babies and mothers -To provide and facilitate mandatory educational training to hospital staff about breastfeeding	-Nurse	-Turkish women who are pregnant or on maternal care in the hospital -Turkish women discharged from hospital after childbirth (walk-in) -Health professionals who are pregnant or on maternal care -Refugee women who are pregnant or on maternal care in the hospital -Refugee women discharged from hospital after childbirth (walk-in)	2 Full days

Hospital Maternity Unit	-Admission of the pregnant women -Examination and monitoring of pregnant women in labour -Monitoring and caring women after childbirth -Providing breastfeeding training -Guidance on postnatal care including physical and emotional support	-Nurses -Midwives -Obstetricians	-Turkish women mostly postnatal care (who had either natural birth or caesarean section) -Refugee women mostly postnatal care (who had either natural birth or caesarean section)	3 days (2-3 hours each day)
Caesarean Intensive Care Unit of a Hospital	-Examination and Monitoring of women after caesarean operation	-Nurse -Midwife - Obstetrician (briefly came in to examine a patient)	-Turkish women who had caesarean delivery -Refugee women who had caesarean delivery	2 hours

Source: The content of the table is created by the author based on the primary data collected during the fieldwork studies between December 2023 and February 2024.