ORIGINAL ARTICLE

MATERNAL SAFETY OF SYRIAN REFUGEES IN SOUTHEAST TURKEY

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Abstract

Objective: *Immigrants are exposed to many health risks during and after immigration. The impact of immigration on women is greater. The impairment of the women's mental health and barriers to accessing health services bring about many risks associated with pregnancy. In this study, it was aimed to reveal the state of using safe motherhood services among the women aged between 15-49 year old who immigrated from Syria.*

Methods: *In this cross-sectional descriptive study, the data were obtained from Syrian women aged between 15-49 age living in Mardin city center and Kızıltepe in 2016 and agreeing to participate in the study. The sampling size was calculated 384, and the study was carried out among 363 women.*

Results: *The average age of the participants is 28.06 ± 8.39 years and 38.0% is in the 25-34 age group. The rate of those who stated that they did not have any problems when applying to healthcare facilities is 42.3%. Out of 363, 180 (49.6%) women got pregnant after arriving in Turkey. While 162 (90.0%) pregnant women stated that they were examined by health personnel at least once during pregnancy, the rate of those who underwent adequate follow-up (≥4 follow-up) was 46.7%. Of the women, 47.2% who had pregnancy in Turkey were vaccinated against tetanus at least once.*

Conclusion: *Although they found health services to be complicated, the level of benefiting from safe motherhood services was moderate. Despite these positive findings, it is suggested that health care facilities should be tailored for intercultural communication.*

Key words: *Emigrants and immigrants, Maternal health, Syria, Women's health, Pregnancy*

Introduction

During humanitarian emergencies resulting from war or conflicts, immigration is the most tragic phenomenon and people who were made refugees are the most vulnerable group among those affected by unusual circumstances (1). When this issue is considered in terms of social indicators, the main challenges with regard to the refugees are almost invariably education, teaching, health care, accommodation, adaptation to urban life and cultural needs (2). Immigration has a great impact on health. Immigrants are exposed to many health risks during and after immigration. The individual's previous health problems, age, gender, and the duration of the stressors may increase the severity of these challenges. Difficulties in adaptation to the culture of the immigrated country can be a decisive factor in deterioration of the health problems (3-5).

It is an incontestable fact that individuals can not benefited enough from health services due to many factors such as financial issues, lack of health insurance, inability of local authorities to meet the needs of the immigrants, being a foreigner, laws and regulations, economic problems, transportation, for working women being unable to find babysitters, working hours and language barriers as well as inadequacy of health services. Immigrant individuals do not even make use of basic health services forming the core of health care, and these services, which must be provided equally to everyone in society due to the principle of social equality, can not be adequately delivered to the immigrants (4,6).

Immigrants' health is closely associated with their gender, sociocultural and ethnic characteristics, knowing the

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language of the immigrated country, working conditions, legal status, access to health and transport services. International reports indicate that immigrant women often have to bear a greater burden as women and immigrants than others (7,8).

Health problems are much more prevalent among those women who have to immigrate due to war or conflicts than other women living in the immigrated country. Even in the most organized refugee camps, it has been shown that women have a particularly high rate of reproductive health problems (9,10).

After the civil war in Syria, there has been a massive influx of immigrants to neighboring countries including Jordan, Lebanon, Turkey, Iraq and Egypt (11). Due to geographical and strategic position throughout history, Turkey has been the last destination of immigration movements in a broad sense, hosting millions of immigrants and refugees (12).

The impact of immigration on women is substantial. The impairment of the women's mental health and barriers to accessing health services bring about many risks associated with pregnancy (13-15).

The studies conducted in regions where immigrants live show that immigrant women can not access to prenatal care services adequately and the rates of birth in the hospital are quite low due to socio-cultural and psychological factors such as economic problems, environmental pressure, fear, familiarity are low whereas the birth rates without health personnel at home are quite high. It is a known fact that births delivered under non-hygienic conditions by non-professionals affects parental health and increases mortality rates (14,16). In a study evaluating women's attitudes towards family planning in a region inhabited by the immigrants, 110 babies of 462 women died at birth and 75-80% of women aged between the 25-34 lost at least one of their children (4).

The province of Mardin is located in the southeastern part of Turkey. It has been an ideal place for the immigrants since the local population can speak Arabic well. In this study, it was aimed to reveal the state of using maternal safety services among the women aged between 15-49 year old who immigrated from Syria to Mardin.

Methods

In this cross-sectional descriptive study, the data were obtained from Syrian women aged between 15-49 age living in Mardin in 2016 and agreeing to participate in the study. Research were conducted on visiting from house to house and women accidentally encountered.Since the number of Syrian women living in the province of Mardin was not known and the frequency of service use could not be estimated, 5% margin of error (d), a confidence level of 95% and a possible frequency of 50.0% were accepted and a sample size of 384 women was calculated and a total of 363 women could be surveyed. Surveys were administered by visiting women and making face-to-face interviews with women who were randomly selected around their neighbourhood. The questionnaires were administered by internship nursing school students in the 4th grade who could speak Arabic and Kurdish. Ethical permissions were obtained from the Ethics Committee of Mardin Artuklu University and the Provincial Health Directorate for the research (03.30.2016/1110). Oral approval was obtained from participants by researchers during questionnaire. Statistical analyses were performed using SPSS (Version 20). Tables show with numbers and percentages. For statistical analyzes using Chi-Square and significance level of α=0.05 (two-tailed) was applied for all p values.

Results

363 Syrian women were included in the study. Some demographic characteristics of the sample are shown on Table 1. The average age of women is 28.06±8.39 years and 38.0% of them are aged between 25-34 years. 76.6% of the women interviewed were married. 12.9% of them immigrated to our country less than 1 year ago, and 32.3% of them had been living in our country for more than 4 years.

When the employment status of the women in the study is reviewed, it is seen that the Syrian immigrants are employed in various jobs and positions. The most common jobs included construction worker (34.9%), temporary work (11.3%), various types of employment like doorman, hairdresser, butcher, chauffeur, guard, grocery shop, marble worker, builder/plasterer, green grocer, school janitor, street vendor and shop assistant (17.9%). Thirteen women (3.6%) stated that no family member was working at home, living up under the guard of relatives or other aids (Table 2).

345 of the participants (95.0%) stated that they were admitted to the health care facilities for any reason upon arriving in Turkey. The answers regarding communicative problems with health staff given by 345 women admitted to the health facilities for any reason are shown on Table 3. The rate of those who stated that they did not have any problems when applying to health facilities is 42.3%. Half of the immigrant women stated that they had a language and communicative problems with health staff.

49.6% of 363 women became pregnant after arriving in Turkey. The distribution of receiving antenatal care, pregnancy aid and postnatal care for these women is presented in Table 4. While 162 (90.0%) pregnant women stated that they were examined by health personnel at least once during pregnancy, the rate of those who underwent adequate monitoring (≥4 monitoring) was 46.7%. 47.2% of women who had pregnancy in Turkey were vaccinated against tetanus at least once. 81.7% of deliveries occurred in the hospital. 68.9% of of the puerperants received post-partum examination. 85.6% of newborn babies were put into vaccination schedule

When the living duration of the immigrant women in Turkey and the case of having problems in health care facilities were evaluated during their pregnancy problem living conditions, it was observed that the problems gradually decreased while receiving adequate monitoring rates during their pregnancy increased (Table 5).

Table 1. Some demographic characteristics of Syrian women

Demographic characteristics of Syrian women	n	%
Age groups (years)		
15 – 18	41	11.3
19 – 24	99	27.3
25 – 34	138	38.0
35 – 44	67	18.5
≥ 45	18	4.9
Marital status		
Married	278	76.6
Single	83	22.8
Widow	2	0.6
Period of living in Turkey (years)		
≤ 1	47	12.9
2 – 3	199	54.8
≥ 4	117	32.3
Total	**363**	**100**

According to the report prepared by Disaster and Emergency Management Authority (AFAD) in 2014, the age groups of the immigrant women in Turkey in and out of the refugee camps are between 19-54 years (42.4% and 44.3% respectively) (19). This indicate that the majority of the immigrant women are in the fertility age range. The rate of married women in the same report was found as 66.7%. In our study group, this rate was found as 76.6%, which can be considered similar to that of the report.

In a study on immigrant women in Istanbul, it was found that Syrian immigrant women had a high level of fertility rate due to socio-cultural and regional features and this case is still valid in Turkey with an average number of 3.44 calculated for pregnancies (20). Three-fourth of the women in our study group was married and 62.7% of married women stated that they became pregnant in Turkey. It has also been reported that Syrian immigrant women gave birth at younger ages according to the studies conducted on the birth records of hospitals (21,22). It can be argued that the case of fertility continues in the same way among Syrian women who settled down in Mardin province.

Although 95.0% of the study group (n=345), a great majority of the sample, was admitted to any health care facility after arriving in Turkey, more than half of the women stated that they had problems when they wanted to receive healthcare services. The most common problems are language and communicative problems (50.8%). In the literature, it has been shown that language barriers negatively affect the quality of health and patient satisfaction, as well as causing unwillingness among the women to benefit from health services (14,23). The language problem is not limited only to the patient's side, but also poses a problem for patient-physician communication for doctors who do not know the language of the patients (24). To solve this problem, it is proposed that brochures should be prepared in the women's mother tongue, interpreting services that can be reached at any time should be provided, and cultural differences should be addressed (17). The second most common problem was ranked as technical problems, and there are problems including medical processes perceived by the women as complicated and the distance of health care service providers. One out of every 10 people stating that they had problems reported that they experienced them due to the negative attitudes of health staff. Similarly, in another relevant study on the problems faced by refugees in health care, it was found that the immigrants encountered similar negative attitudes from health staff (25). When the living duration in Turkey and experiencing problems in health care services were compared, it was shown that the rate of having problems decreased while the duration of living in Turkey increased. This may be a sign that immigrant women have adapted themselves socially over the years, especially by developing solutions to overcome language barriers and adapting to healthcare delivery procedures. By integrating Syrian immigrants into the general health insurance system Turkey has provided

Table 2. Distribution of the jobs done by the the father or the income earners of Syrian women

	n	%
Construction worker	127	34.9
Doorman, hairdresser, butcher, chauffeur, guard, grocery shop, marble worker, builder/ plasterer, green grocer	65	17.9
Temporary or seasonal work	41	11.3
Working in a restaurant, teahouse, patisserie, bakery, steward	32	8.8
Field and gardening work	28	7.7
Working in textile factory, furniture workshop, industrial welder, other factory, car mechanic	26	7.2
Having relatives support, husband sending money from abroad, begging, living with other aids	13	3.6
Tailoring	12	3.3
Marketing	10	2.8
Porter	9	2.5
Total	**363**	**100**

free health care for them in certain circumstances (26). This is at least an anticipated fact due to the lack of financial problems encountered.

While physicians examined about 90% of the women at least once during their pregnancy within the scope of maternal safety services, about half of them had adequate monitoring. In Syria before civil war, the rate of adequate antenatal care is around 63.7%, and it can be assumed that Syrian women are not aware of this issue and have received no training (20). In a study conducted in Lebanon, 63.8% of Syrian immigrants received prenatal care at least once (27). It was also found that the increasing duration of living in Turkey has increased the rate of adequate prenatal care. Refugees' problem is not about one country, it is one of biggest problem of humanity. Thus, it is necessary to improve the results by collaborating together with international organizations (28).

Table 3. The language and communicative problems experienced by the Syrian women

	n	%
Problems in the health facilities (n=345)		
Not having problems	146	42.3
Having problems	199	57.7
Types of problems (n=199)		
Language and communicative problems	101	50.8
Technical problems	72	36.2
Negative attitudes of the health staff	19	9.5
Financial problems	7	3.5
Have you managed to ask all the questions related to your health? (n=345)		
Yes	202	58.6
No	143	41.4
Have you understood the answers given to your problems? (n=345)		
Yes	196	56.8
No	149	43.2
Have the answers given been satisfying for you? (n=345)		
Yes	192	55.7
No	153	44.3

Table 4. The distribution of antenatal care, and postnatal care among the refugees Syrian women who became pregnant after coming to Turkey

Distribution of receiving antenatal care, pregnancy aid and postnatal care among the immigrant Syrian women	n	%
Having had at least one visit to the physician during pregnancy	162	90.0
Having Adequate monitoring during pregnancy (≥4 follow-ups)	84	46.7
Those having had tetanus vaccination during their pregnancy	85	47.2
Those giving birth at hospital	147	81.7
Having had examination by health staff in post-natal period	124	68.9
Those whose baby was vaccinated	154	85.6

Table 5. Women having problem in health care services and antenatal care status by duration of living in Turkey

	The duration of living in Turkey				
	<1 year	2-3 years	>3 Years	X^2	p
Having problems in health services					
Yes	14 (34.1)	73 (38.2)	59 (52.2)	6.97	0.031
No	27 (65.9)	118 (61.8)	113 (47.8)		
Monitoring status during pregnancy					
Adequate	2 (16.7)	47 (45.6)	35 (53.8)	5.73	0.057
Inadequate	10 (83.3)	56 (54.4)	30 (46.2)		

Conclusion

The findings of the study indicate that a majority of Syrian refugees have lived in Turkey for a long time. It can be said that although the women stated that they had communicative problems while receiving health care and the hospital services were complicated, the level of benefiting from maternal safety services was moderate. A large proportion of women stated that they could see a doctor at least once in the prenatal period during their pregnancy. It has been understood that a significant number of the births take place in the hospital. Despite these positive findings, institutions/ facilities and healthcare professionals need to be trained in such a way that communication between cultures can be more convenient. It is thought that there is a need for extensive studies to be carried out in the region.

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