ANKARA MEDICAL JOURNAL

Research Article

Ankara Med J, 2022;(1):69-80// 10.5505/amj.2022.71677

THE KNOWLEDGE ABOUT SEXUALITY AND SEXUALLY TRANSMITTED DISEASES OF SYRIAN WOMEN AND MEN IMMIGRATED TO HATAY-ANTAKYA: A QUALITATIVE STUDY

Kadriye Şahin[1], Pınar Döner Güner[2]

[1]Hatay Mustafa Kemal University, Department of Anthropology, Hatay, Turkey

[2]Hatay Mustafa Kemal University Department of Family Medicine, Hatay

Correspondence:

Kadriye Şahin (e-mail: sahinkadriye@gmail.com)

Submitted: 29.07.2021 // Accepted: 23.12.2021

Ankara Yıldırım Beyazıt University Faculty of Medicine

Department of Family Medicine

ANKARA MEDICAL JOURNAL

Abstract

Objectives: The aim of this study is to comparatively present the knowledge and experiences about sexuality and the sexually transmitted infections in both the men and women migrating from Syria to the nearest province, Hatay-Antakya in Turkey, due to the ongoing internal conflicts in Syria.

Materials and Methods: The study consists of in-depth interviews with 12 female and 12 male participants who had to migrate from Syria. In the research, using the qualitative method, the findings were interpreted using the descriptive analysis technique.

Results: In consequence of the study, women and men were determined to have different knowledge levels on sexuality before marriage, especially women to have experienced it at first night after marriage and men to be more familiar with sexuality. To have a speech on sexuality and sex life before marriage is taboo, and it's keeping the "honor" under control for women. As they have not received sufficient education, they do not have enough information about sexually transmitted diseases (STD).

Conclusion: As a result, girls having been forced to get married at an early age have sexual experiences prematurely; their inadequate knowledge and experience about sexuality, belief and cultural truths cause certain traumatic processes. The education provided to men and women on sexuality and awareness about STD should be raised.

Keywords: Sexual health, sexually transmitted diseases, Syrian immigrants, primary health care, culture and disease, qualitative research.

Introduction

Having begun as a peaceful social movement in March 2011, the Syrian uprising turned into a war as a result of domestic clashes and exterior interventions.[1] According to United Nations Refugee Agency, the clashes in Syria have caused 6.2 million refugees to migrate to neighboring countries since 2011.[2,3] Turkey, located just by the Syrian border, has become nearly the most refugee receiving country.[4] While the number of Syrian immigrants under temporary protection status is 3,653,19 in Turkey; it is 437,095 in Hatay.[5] The immigrants' strong perception of human security in the country to immigrate increases the migration rate to that country.[6] Because of the security perception created by unending chaos, the migration still keeps going.

Even if migration has affected the neighboring countries, most Syrian immigrants have affected the world globally. Sexually Transmitted Diseases (STD) are one of these effects, and since these illnesses are carried through immigration, this issue is a global health problem.[7] Moreover, insufficient education about sexuality is also effective in STD contagion. Refugees have higher risks of getting STDs because of the factors related to displacement as a result of war and conflicts, including poor socio-economic situation and insecurity.[8] While socio-economic reasons lead people to migrate, they also obstruct these people from reaching the health system. Sexuality may constitute the most confidential side of the individuals, especially in traditional and patriarchal societies. Therefore, they may remain incapable of sexual knowledge and experiences, and some have limited or incorrect knowledge about STDs while others have no information. Hatay is one of the places where Syrians densely live in Turkey. Knowledge levels and attitudes about sexual knowledge and experiences and STDs of Syrian women and Syrian men who immigrated to Hatay-Antakya were discussed in this study with a qualitative approach.

Materials and Methods

A qualitative research method was used in this study. The qualitative study presents daily life practices and moods of the individuals, especially in migration-themed studies. In this way, accurate representations of human life can be introduced.[9] The discussed case in the qualitative study has a representation power whether it is singular or biographical, and the extent of sample discussed in a qualitative study is not supposed to be as in the quantitative study, because the significance of qualitative study results is their covering the empirical varieties and differences more than the extent of the sample.[10] The aim of the interview technique in qualitative studies is to determine the implications, silences, stresses and mimics of the interviewed person more than the determination of cold facts, and thus the findings are determined more effectively and thoroughly.[11] Semi-structured questions, snowball sampling and narrative techniques were used in the study. Narratives provide potential ways for revealing the comprehension of health and illness processes, how the subjective human experiences are shared and how the behavior is organized.[12] Medical anthropology and family medicine

specialists researched this topic together. Medical anthropology studies focus on the relationship between culture and health with qualitative studies. Health perceptions and practices are mostly affected by beliefs and traditions. Family Medicine discipline deals with biopsychosocial and cultural values with a holistic approach. Therefore, the togetherness of these disciplines and qualitative research techniques were preferred for this research. In this study, a total of 24 people, 12 women and 12 men, were interviewed. The age range of the women was 18-55 and 23-55 for men. The education levels of the participants are heterogenic, covering all steps (Table-1). One of the interview places is Immigrant Primary Health Center in Hatay-Antakya. 6 women and six men, 12 people in total, were interviewed in this center. They were interviewed in a special room for convenience in the company with an interpreter. The second interview place includes home or public areas. Interviewing with men was more difficult than with women. Some part of men put forwarded some reasons such as: not missing doctor row, going back to work as soon as it finishes or not making their wives wait. While women were more in comfort than men, some were tried to be interviewed with their kids in their lap. Participants from Hama, Homs, Idlib, Latakia and Aleppo were interviewed through 2 Syrian interpreters, one female and one male. Before starting the study, the participants were informed about the study and a pilot study was conducted with them. Privacy was tried to be provided by interviewing female participants with a female interpreter and men with a male. Voluntary Participant Form (VPF) was used in the research. VPF in Arabic and Turkish were used in the study, which was conducted in September and October 2019.

Table 1. General information for participants

Number	Sex	Age	Level of education	Marital status	City migrated from Syria	Year immigrated from Syria
P1	Female	35	High school	Widow	Idlib	2017
P2	Female	54	Secondary school	Widow	Humus	2015
P3	Female	31	Secondary school	Married	Idlib	2015
P4	Female	25	Diploma	Single	Latakia	2011
P5	Female	28	Diploma	Married	Idlib	2016
P6	Female	22	High school	Married	Latakia	2012
P7	Female	51	Secondary school	Married	Aleppo	2014
P8	Female	55	Elementary school	Married	Hama	2013
P9	Female	26	Secondary school	Married	Aleppo	2011
P10	Female	39	High school	Married	Latakia	2011
P11	Female	54	Secondary school	Widow	Humus	2015
P12	Female	43	Secondary school	Married	Idlib	2015
P13	Male	37	Diploma	Married	Hama	2013
P14	Male	50	Diploma	Married	Idlib	2018
P15	Male	55	College	Married	Idlib	2011
P16	Male	39	Diploma	Married	Hama	2016
P17	Male	33	College	Married	Latakia	2012
P18	Male	27	Diploma	Married	Latakia	2012
P19	Male	31	Diploma	Married	Latakia	2017
P20	Male	34	Diploma	Married	Latakia	2013
P21	Male	23	High school	Single	Latakia	2012
P22	Male	38	High school	Married	Hama	2017
P23	Male	31	Elementary school	Married	Aleppo	2013
P24	Male	28	Academic	Married	Aleppo	2015

Results

Sexuality as a taboo area: "shame" and "confidential"

The participants indicated sexuality as shame, it is not appropriate to talk about it clearly, and it should be a secret issue. Although high school and college students remarked that they learned from course books at school or from the internet, sexuality is not a freely spoken issue by women and men. Moreover, they remarked that their teachers did not cover this and similar issues in detail, and they wanted to skip another subject. The way to learn about first sexual experience differentiates between women and men. Most of the interviewed women got married at a young age, and they experienced the first experience without completing their developments. The sexual experience starting with marriage focuses on the child during the marriage. In addition, the sensations of women and men about the sexual experience throughout the marriage are different. *My husband told me that it is something nice, he is nice to me. Child strengthens the bond of love between spouses. It did not*

*affect our sexual life (*Participant, 15, P15). *We used to talk about sex more before having our children, but child necessarily affects. Now we talk about it less* (P10). In fact, the participant expresses that she/he experiences sexuality less. *You experience something more when you have no kids, but when you have kids, you fall into trouble. It doesn't come to your mind to talk about sexuality much* (P14). Sexuality is generally waved aside after having children (Table 2).

Table 2. Interview Quotes and Themes

Themes	**Interview Quotes**	
	Syrian Women	**Syrian Man**
Sexuality	Shame, Secret	Shame, Secret
First sexual experience knowledge	I learned at the night that I got married I learned from my husband. I learned from my fiancée. My mother never talks about it. It is a shame. I learned from a sibling or a friend. I learned from the ones who got married before me. I learned from school. My brother's wife expressed My paternal aunt expressed My mother-in-law expressed My maternal aunt expressed I learned from the internet	I learned with my wife when I married No one taught. It is not spoken with relatives, shame. Experienced friends expressed. It is not spoken with a brother or father. I learned from the internet I learned from school.
Perception of sexual life in marriage	We do not talk about sexuality. Children strengthen the bond of love. Children do not affect sexual life	We used to talk about it when we didn't have children Children affect the sexual life We used to talk about more at first. Child does not affect it, it is already standard. We had sexuality when we have no kids.
STD knowledge	I don't know STD I heard about STD but I do not know exactly. I heard about AIDS in Syria I heard about cervical cancer in Turkey.	AIDS Gonorrhea Penis's catching infection Developing a verruca on sexual organ I heard about cervical cancer in Turkey.

Sexual Knowledge and Experiences in Syrian Women

Sexuality, forming a taboo area, even sexual knowledge acquisition, is directly related to kinship relationships, especially in women. The participants generally express that they sometimes or never talk about sexuality besides not experiencing sexuality or, aunt or mother-in-law from family elders inform them about what will happen the night before the wedding when they get married. *I learned about it on my wedding day. My mother*

told me. However, it is a shame to talk about this with other people in our culture (P10). There are also women who learned from friends or siblings apart from the family elders. It also points out that they can share knowledge about sexuality with people they feel close to rather than elders. *I learned about it from my sisters and friends. They got married before me. They were experienced. The elders wouldn't talk with us about it. They would tell it on the wedding day before marriage. We did not have knowledge before it. The girls generally would be informed by their mothers or mother-in-law on the wedding day* (P2). Some of the participants indicated that they had no information about sexuality when they got married, and they couldn't have sexual relations in the first months of the marriage and learned about it in time. *I did not know about it; they did not even tell me about it when I got married; we did nothing in the first seven months, we slept just like siblings, something started to happen by learning something from someone as time went by* (P4). Knowledge about hymen together with first sexual experienced could be learned by women after they get married. As it is understood from the participant's statement below, the husband of the woman is seen to inspect whether she is a virgin or not, which is regarded as an "honor" symbol. *No one said anything. I found myself in bed after getting married. I bled when I was married for two months. I went to the doctor. It was my hymen's blood. Nevertheless, my husband had a try with me and then he had sex with me* (P8). Women's not having S turns their first sexual experiences into a fearful situation. *I did not have any education on it; even I was scared on the day I got married, I did not know what to do; nothing happened between us in the first six months, then he told me about it* (P2). *My mother told me about it. She told me just before the wedding, but I was scared a lot; there is no one who is not afraid of sexuality, everyone is frightened* (P6). *They told me about it when I wore my wedding costume. I did not know at all. I was deeply embarrassed, terrified. I did not know anything at all till I got married. Mostly paternal or maternal aunt expresses the sexual relation* (P9). *They explained too little. However, I got frightened. My husband behaved so nicely, he told me not to be afraid, and nothing will happen, but I was still frightened* (P5). Information about sexuality is obtained from the internet among youngsters. *No, I did not have any education, but I had searched on the net wonderingly* (P6).

Sexual Knowledge and Experiences in Syrian Men

Education on sexual knowledge hadn't been provided in men as in women. Mostly, they remarked to have learned about sexual knowledge and experiences and experienced sexuality when they got married. *We hadn't talked about these issues at all before getting married; we learned with my wife when we got married. We talked with friends after marriage. Indeed we got the education, too* (P15). *No one taught it; such issues are not spoken with relatives; you learn when you get married, you experience* (P13). Sexual knowledge is sometimes shared with friends by talking without getting married. Apart from that, mass media and wide-spreading internet networks led Syrian men to have more information about sexuality. *Some issues are expressed by experienced friends. It wasn't expressed at school, but they already learn most of them from the internet. This issue is not talked about with a relative, brother or father because it is a shame. It is talked about with friends* (P16). Although he

learns sexuality by reading, there also exist some people who say sexuality already inheres in humans, and it consists of a set of impulses appearing automatically when it is experienced. *I learned by reading. Sexuality already exists in human natality. It shows up when it finds a backcloth; we haven't talked about this issue with the others* (P14). The pulse in men is to learn sexuality by living instead of talking about sexuality with others. *I got married to my wife at the age of 16. She was 16. She fell pregnant after two months. I taught her* (P15).

STD Knowledge in Women and Men

Lack of sexual knowledge and experiences in women and men also caused them to have deficient knowledge of STDs. STD knowledge of women is much more limited compared to men. Yet already the most heard illness by two groups is AIDS. *I have no knowledge of sexually transmitted diseases. I am single now* (P4). *I just heard about AIDS disease; it is transmitted blood-borne or with sexuality* (P11). A Syrian woman summarizes the current situation with limited precautions taken: *My cousin was a health care worker; he used to tell about these diseases. For instance, he would say not to use others' razors; blood is contaminated. Male kids would be taught at mosques; we were informed not to go to women we do not know. For this reason, this disease would not be seen much in Syria* (P1). Syrian woman indicated as: *Yes, I heard about STD. It results from polygamy (*P3). Man can get married to four women in Syria. There also exist perceptions that this situation increases STD. *I was informed at high school in Syria. It occurs when men go to prostitutes. It occurs at women you do not know without taking precautions, not using preservatives. The ones having AIDS do not tell anyone. People look differently at patients with AIDS. They do not draw near to* (P10). The reality that AIDS disease in the expressions of the participants is especially hidden indicates that this disease is more common than we think. STD knowledge of men is a little bit more than women. *I have heard about AIDS and gonorrhea. I know they are transmitted sexually or blood-borne* (P13). Although they do not know the whole names of some diseases, they can describe their symptoms*. Yes, I heard about it. I also heard of AIDS disease. There is an illness like erupting acne around the organ. I do not know its name now, but it is also a venereal illness* (P10). There are also illnesses whose names are forgotten. *There may occur AIDS or maturation on the penis. I forgot the names of the illnesses* (P15). In addition, one said there is a relation between STD and religious beliefs. Based upon this belief, there also exists a notion that STDs won't be common in Islamic countries. *"I heard about venereal diseases. For instance, I heard about AIDS, acne erupts at the sexual organ, but actually, there aren't many venereal diseases in Islamic countries. The sexual act is not free insomuch in Islamic countries. It is a sin religiously. Everyone's peer is definite, there is no reason to get the disease, but we used to hear about it."* (P14). In conclusion, while women say they heard about AIDS in Syria, they do not know about STDs. They heard about STDs but did not know at all; men sort the diseases as AIDS, gonorrhea, penis's catching an infection, developing a verruca on a sexual organ.

Discussion

Culturally, the Middle East is a conservative society where sexuality or sexual violence issues are social taboos or personal matters.[13,14] Cultural and religious beliefs about sexuality may prevent refugees from openly discussing issues related to sexual health, such as sex before marriage or birth control.[14,15,16] In Arabic countries and Iran (except for some exceptions in Iran, Algeria, Djibouti, Sudan and Tunisia), the sexual and reproductive health of youngsters proceed to be discussed because of the taboos and religious sanctions against sexual relations before or outside marriage.[17] Talking about sexuality and STDs for Syrians is one of the sensitive subjects.[18] Women learn about sexuality by experiencing it with their husbands. It is expressed by first-degree relatives from school or the internet. Men learn about sexuality when they get married, from friends, school or the internet. While first-degree relatives give women little information, this is out of the question for men. Since sexuality is already seen as taboo, talking about sexuality with a relative reveals layered privacy. Since sexuality is approved as it can be experienced after marriage and it is not appropriate to talk about sex before marriage, the perception that sex is an issue to be ashamed of is understood to be common in our study. Whole participants being Muslim, emphasize that it is forbidden to have sexual relations outside marriage by their belief. Early marriage or traditions and beliefs specific to their country may result in deficiency of education on social gender roles, sexual knowledge, common public policies and STD. Besides, the migration factor is a reason in itself. Refugees' being separated from their regular sexual partners their problems in achieving health and social services increase their risk to catch STDs. [19] In addition to this, refugees' limited knowledge on STIs or their concealing/neglecting the disease is a risk threat both for the places they came from or they settled in. Most of the refugees in Malta did not use preservatives during sexual relations, their education/knowledge was detected to be low, and most of the research participants hadn't had AIDS tests in advance.[20] Hepatitis B-C and HIV/AIDS were seen to be more in refugees in New Zealand.[21] Male refugee laborers in Tanzania carry a higher risk of catching STIs relative to women.[22] While women, gonorrhea, infection on sexual organ or verruca know only HIV/AIDS are sorted as STD by men. STIs symptoms were detected in %50,2 of Syrian women in Şanlıurfa.[23] As to the findings obtained in the study, a preservative is not a commonly preferred preservation method. One of the reasons that Syrian men are not using preservatives for protection is their thought that "a human-made" thing is an obstacle for given fertility. Moreover, since women and men get married at early ages not have sufficient education on sexuality and STDs, they are at risk of STDs. Having deficient sexual and reproductive health knowledge, Syrian refugee mothers in Jordan perceived STD treatment as "not effective". They have a fear of embarrassment and breach of confidentiality.[24] Both female and male participants mostly know about HIV/AIDS. Knowledge on contamination of HIV/AIDS in the Middle East and North Africa is limited. [25] 5000 HIV/AIDS infection is estimated to be in Iran in 2016.[26] There is a relation between the spreading of the HIV/AIDS virus and poverty. Inadequate economic conditions, treatment, not having necessary medicines cause AIDS to spread.[27] WHO reported annual HIV infections to decrease in some regions while they increase

in the East Mediterranean region. Estimated infection number has the highest rate of increase by rising from 29.000 infections in 2010 to 36.000 in 2017.[28] The effect of Syrian immigrants should not be neglected in the aforesaid region between the years 2010-2017. The rate of HPV in Syrian patients was similar to women in our country, and the most common are other types of high-risk HPV.[29] Finally, some of both female and male participants indicated to have learned about cervical cancer after coming to Turkey.

The findings obtained in this study indicate the sexual knowledge and experiences and STD knowledge of Syrian immigrants to be insufficient. With the Syrian immigrants turned into a problem of the global world, insufficient information has spread to the whole world. When the massive extent of migration is considered, this situation may be reviewed to be a threat risk for public health. Training activities need to be conducted against this threat risk. In patriarchal tradition, knowledge on sexuality and sexually transmitted diseases that are related to this is gained in line with social norms' expectations. Thusly, the content of the training should be formed on eliminating common misconceptions about sexually transmitted diseases and social gender inequality.

Ethical Considerations: Ethical approval of this study was given by Hatay Mustafa Kemal University Social Sciences Ethics Committee with the decision dated 07.03.2019 and numbered 07.

Conflict of Interest: The authors declare no conflict of interest.

References

1. Salloukh BF. The Arab Uprisings and the Geopolitics of the Middle East. The International Spectator. 2013;48(2):32-46. (doi:10.1080/03932729.2013.787830).
2. UNHCR. Syria regional refugee response [Internet]. https://data2.unhcr.org/en/situations/syria (Accessed:13.07.2019).
3. UNHCR. Internally displaced people [Internet]. https://www.unhcr.org/sy/internally-displaced-people (Accessed: 15.11.2021).
4. Syrians in Turkey. Special report [Internet]. https://www.ombudsman.gov.tr/syrians/special_report.pdf, (Accessed:18.05.2020).
5. Temporary Protection. [Internet]. https://en.goc.gov.tr/temporary-protection27 (Accessed:15.11 2021.
6. Ibrahim S, Philip LM. Sources of Irregularity and Managing Migration: The Case of Turkey. Border Crossing. Transnational Press London. 2014;4(1-2):1-16.
7. Maatouk I, Cristaudo A, Morrone A. Sexually Transmitted Infections and Migration. In: Morrone A, Hay R, Naafs B, ed. Skin Disorders in Migrants. Cham: Springer International Publishing; 2020:129-37.
8. De Schrijver L, Vander Beken T, Krahé B, Keygnaert I. Prevalence of Sexual Violence in Migrants, Applicants for International Protection, and Refugees in Europe: A Critical Interpretive Synthesis of the Evidence. Int J Environ Res Public Health 2018;15(9).1979:1-17 (doi: 10.3390/ijerph15091979).
9. Morawska E. Qualitative Migration Research: Viable Goals, Open-Ended Questions, and Multidimensional Answers. In: Zapata-Barrero R, Yalaz E, ed. Qualitative Research in European Migration Studies. Cham: Springer International Publishing; 2018:113-131.
10. Barglowski K. Where, What and Whom to Study? Principles, Guidelines and Empirical Examples of Case Selection and Sampling in Migration Research. In: Zapata-Barrero R, Yalaz E, ed. Qualitative Research in European Migration Studies. Cham: Springer International Publishing; 2018:151-168.
11. Fedyuk O, Zentai V. The Interview in Migration Studies: A Step towards a Dialogue and Knowledge Co-production? In: Zapata-Barrero R, Yalaz E, ed. Qualitative Research in European Migration Studies. Cham: Springer International Publishing; 2018:171-188.
12. Costa GMC, Gualda DMR. Antropologia, etnografia e narrativa: caminhos que se cruzam na compreensão do processo saúde-doença [Anthropology, ethnography, and narrative: intersecting paths in understanding the processes of health and sickness]. Hist Cienc Saude Manguinhos. 2010;17(4):925-937 (doi:10.1590/s0104-59702010000400005).
13. Ahmad M, Dardas L. Jordan: Aspiration for a culturally sensitive nursing model. In: Fitzpatrick JJ, Whall AL, ed. Conceptual models of nursing: Global perspectives. Vol 133805751. Fifth ed. Upper Saddle, NJ: Pearson; 2016.

14. Metusela C, Ussher J, Perz J, Hawkey A, Morrow M, Narchal R, et al. "In My Culture, We Don't Know Anything About That": Sexual and Reproductive Health of Migrant and Refugee Women. Int J Behav Med 2017;24(6):836-845 (doi:10.1007/s12529-017-9662-3).
15. Botfield JR, Zwi AB, Rutherford A, Newman CE. Learning about sex and relationships among migrant and refugee young people in Sydney, Australia: 'I never got the talk about the birds and the bees'. Sex Educ-Sex Soc Lea 2018;18(6):705-720 (doi:10.1080/14681811.2018.1464905).
16. Kingori C, Ice GH, Hassan Q, Elmi A, Perko E. 'If I went to my mom with that information, I'm dead': sexual health knowledge barriers among immigrant and refugee Somali young adults in Ohio. Ethnic Health 2018;23(3):339-352 (doi:10.1080/13557858.2016.1263285).
17. DeJong J, Jawad R, Mortagy I, Shepard B. The Sexual and Reproductive Health of Young People in the Arab Countries and Iran. Reprod Health Matter 2005;13(25):49-59 (doi:10.1016/S0968-8080(05)25181-9).
18. 18.RefugeesfromSyria.[Internet]. https://www.teslontario.org/uploads/news/RefugeesfromSyriabackgrounderCulturalOrientationReso.pdf (Accessed:15.11.2020).
19. Liu ZY, Li J, Hong Y and Yao L. Reproductive health service utilization and social determinants among married female rural-to-urban migrants in two metropolises, China. J Huazhong Univ Sci Technolog Med Sci 2016;36(6):904-909 (doi:10.1007/s11596-016-1682-8).
20. Padovese V, Farrugia A, Almabrok Ali Ghath S, Rossoni I. Sexually transmitted infections' epidemiology and knowledge, attitude and practice survey in a set of migrants attending the sexual health clinic in Malta. J Eur Acad Dermatol Venereol 2021;35(2):509-516 (doi:10.1111/jdv.16949).
21. Nybo M, Friis-Hansen L, Felding P,Milman N. Higher prevalence of anemia among pregnant immigrant women compared to pregnant ethnic Danish women. Ann Hematol. 2007;86(9):647-651 (doi:10.1007/s00277-007-0305-7).
22. Norris AH, Loewenberg Weisband Y, Wiles M, Ickovics JR. Prevalence of sexually transmitted infections among Tanzanian migrants: a cross-sectional study. Int J STD AIDS 2017;28(10):991-1000 (doi:10.1177/0956462416685486).
23. Şimşek Z, Yentur Doni N, Gül Hilali N, Yildirimkaya G. A community-based survey on Syrian refugee women's health and its predictors in Şanliurfa, Turkey. Women Health 2018;58(6):617-31 (doi:10.1080/03630242.2017.1321609).
24. Al-Maharma D, Safadi R, Ahmad M, Halasa S, Nabolsi M, Dohrn J. Knowledge, Attitudes And Practices Of Syrian Refugee Mothers Towards Sexually Transmitted Infections. Int J Womens Health 2019;11:607-15 (doi.org/10.2147/IJWH.S221605).
25. Mumtaz GR, Hilmi N, Majed EZ, Abu-Raddad LJ. Characterising HIV/AIDS knowledge and attitudes in the Middle East and North Africa: Systematic review and data synthesis. Glob Public Health September 2020;15(2):275-98 (doi:10.1080/17441692.2019.1668452).

26. Abedinia N, Rasoolinajad M, Noorbala A, Badie BM. I am HIV-positive, but I am a human being: qualitative study on experiences of stigma in health care centres in the Islamic Republic of Iran. E Mediterr Health J 2019;25(10):669-76 (doi.org/10.26719/emhj.19.012).
27. Can AR. Is HIV/AIDS a disease of poverty? Eurasian J Anth 2018;9(2):57-65.
28. World AIDS Day 2018. http://www.emro.who.int/world-aids-campaigns/wad2018/index.html. (Accessed: 01.05.2020).
29. Alan M. Oruç MA, Yılmaz N. Aytaç H. Sancı M, Alan Y. Evaluation Of Hpv Incıdence and Cervıcal Smear Results in Syrian Refugees. Ankara Med J 2020;(1):1-10 (doi: 10.5505/amj.2020.52296).