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Master in: “Evaluation and Management of Occupational, Environmental and Pharmaceutical Risk”

Title: "Comparing Sexual and Reproductive Health Care of Afghan women on the move. Elliniko refugee camp versus official shelters in Athens"

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ABSTRACT

Title: "Comparing Sexual and Reproductive Health Care of Afghan women on the move, in Greece. Elliniko refugee camp versus official shelters in Athens"

The main purpose of this study was to identify the impact of living conditions, comparing two different types of accommodation, refugee camp and official shelters, to sexual reproductive health status of Afghan women, recently entered Greece after a long and unsafe for their life journey.

The final sample was 486 Afghan women entered in Greece from January 2016 till April 2017 either from Turkey crossing with boats the Aegean Sea to Greek islands or on foot from Turkey to Northern Greek borders.

From the analysis derives that women living in refugee camp are more likely to be diagnosed with Sexual Transmitted Infections comparing with women living in official shelters (apartments). Women living in apartments are more likely to be diagnosed as healthy (in terms of SRH) comparing to those living in refugee camps. Also women living in shelters are more likely to use a family planning method and more likely to have access in medical tests comparing with those living in a camp. Women living in a camp are more likely to visit sexual reproductive services for genital infections and menstrual disorders comparing to those living in shelters which are visiting SRH services due to pregnancy and family planning.

Housing conditions affects the quality of life and is an important indicator of the degree of integration for refugees. Provision of apartments seems to be a good practice for integration in the community. More research and systematic data collection are needed to form policies about integration.

Keywords: Women, sexual and reproductive health, Afghan, housing, refugees.

ABREVIATIONS

ANC: Ante Natal Care

CHW: Community Health Workers

CSO: Central Statistics Organisations

DCC: Day Care Center

MCH: Mother Child Healthcare

MOH: Ministry Of Migration

MSF: Medicines sans Frontiers

NIN: National Insurance Number

OCG: Operational Centre Geneva

PNC: Post Natal Care

SDGs: Sustainable Development Goals

SGBV: Sexual and Gender-Based Violence

SRH: Sexual and Reproductive Health

STIs: Sexual Transmitted Infections

TOP: Termination of Pregnancy

UNHCR: United Nations High Commissioner for Refugees

UTIs: Urinary Tract Infections

WASH: Water, Sanitation and Hygiene

WHO: World Health Organisation

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1.0 Research Overview

1.1 Introduction

The rationale for choosing this subject to study is because I noticed a gap in the current bibliography concerning a deeper understanding of the perspectives, knowledge and awareness of women on the move seeking for a better future due to war or other violent incidents in their home country. Through the provision of SRH services with regard to pregnancy, family planning, and sexual violence I would try to understand how social and environment factors affect health. Identification of which are the factors that affect or not women health when they are on the move and live in unstable and unsafe environment such as refugee camps or official shelters provided by humanitarian organizations.

My interest to study and analyse Afghan women population and not Syrian or African women on the move is related to the fact that the rates of maternity deaths and neonatal deaths in Afghanistan is on the top of the world list. According to several scientific papers and testimonies from humanitarian organizations, being a woman and more specific a pregnant woman in Afghanistan is the riskiest thing. Especially, for women living in rural areas access in health care services it seems impossible and this has a direct impact on their health. In 2002 UNICEF and CDC (UNICEF & Disease Control and Prevention, 2002) conducted a survey in four provinces at Afghanistan and more specific at Kabul, Laghman, Kandahar and Badakshan, in order to cover both rural and urban areas, from that survey identified an average of 1,600 maternal deaths per 100,000 live births. Additionally, it is estimated that approximately 515,000 women in Afghanistan die each year due to complications during pregnancy.

International organisations such as UNICEF and WHO realised that the majority of maternal and childbirth deaths could have been prevented, thus, WHO since 2003, implemented several education trainings to more than 2.700 midwives in Afghanistan in order public health care services to provide quality services to pregnant women and their newborns. A major contribution of those programs was focused in raise awareness and provision of safe family planning methods. (World Health Organization, n.d)

The government of Afghanistan which is in close collaboration with WHO, working together in order to improve key health issues in the whole country. From a recent report it seems that all the efforts made by WHO and the government have a positive impact in the maternal mortality as the ration was declined by 70.4% between 1990 and 2015 (from 1340 to 396 per 100 000 live births) and the mortality rate for children under 5 years old decreased by 49.7% (from 181 to 91 deaths per 1000 live births). (WHO, 2016). The major reasons for maternal mortality were postpartum haemorrhage, eclampsia and sepsis and

the reasons for mortality in children less than 5 years old were mainly, acute respiratory infections, prematurity and intrapartum related complications. From this report also derives an increase of the number of women receiving antenatal care in public structures as well as a trend of women requesting for contraceptives methods. (WHO, 2016)

Afghanistan is one of the countries with the highest rates related to gender inequalities; in a total of 152 countries Afghanistan is in 149th position. Despite the establishment of Ministry of women Affairs since 2002, only a small percentage of women have access to education and their participation in the labour market is still very low. What is of great importance is the fact that women in Afghanistan mainly, due to cultural barriers and social stereotypes doesn't have the right to move freely in their country and to decide about personal health issues, such as method of contraception and number of wanted pregnancies.

In 2012 the number of burden of disease attributable to ambient air pollution was up to 573.208 and pictures the impact of outdoor air pollution in Afghanistan. The main reasons were due to limited access to quality sanitation facilities and access to clean drinking water. One more factor that causes large number of indoor deaths is the usage of solid fuels for cooking and heating, resulting in 54.000 deaths per year. Traditional environmental risk factors are contributing to prevalence of both communicable diseases and non-communicable diseases. (WHO 2017).

On March 2017 Afghanian Ministry of Public Health (MoPH) presented a report which shows that more than 50 percent of pregnant women in Afghanistan do not have access to essential health services and more than 50 percent of the births take place without nursing facilities.

During the last 15 years international humanitarian organizations are struggling to improve access to health care services focusing to pregnant women and children, at the same time significant efforts are made to raise awareness about equity between females and males. Analysing the available data seems that there is an important improvement in access to health care services and in the quality of the provided services, but still Afghanistan remains one of the countries that women doesn't have descent health care services and also are not allowed to decide about their health.

Taking under consideration the situation in Afghanistan, in combination with the difficulties they faced during their journey to Greece and additionally the bad living conditions in Greece and the limited access at health care services, it seems to me very interesting to see the impact of all these factors and risks at women sexual and reproductive health.

1.2. Research Questions and Objectives

The main purpose of this study was to identify the impact of living conditions, comparing two different types of accommodation, Refugee camp and official apartments, to sexual

reproductive health status of Afghan women, recently entered Greece after a long and unsafe for their life journey.

The objectives of this study are to identify the medical and social needs of women on the move through the provision of sexual and reproductive services and to find out how living conditions, cultural differences and level of access in health care services are affecting their health status.

A deeper understanding of the living conditions in refugee camps and social factors that have an impact on health status of women on the move would help the development of applicable and successful policies to avoid risks and life-threatening illness. Also, to reinforce other medical studies related to refugee and migrant health background to eliminate stereotypes that refugees and migrants are risk for public health through transmitted diseases.

The study focused on the lived experience of the Afghan women refugees living in Greece either in camps or other type of official accommodation structures. Asylum seekers are people who have left their native country because of the risk related to war, extreme poverty, religious, political or other ethical issues. I chose the population of Afghan women on the move because they are coming from a country suffering for decades of war and turmoil and have led to millions of Afghan refugees seeking asylum in Europe. Women are extremely vulnerable at risks even when they are in a European country such as Greece and it is something that I would try to go in deeper analysis with this survey.

1.3. Added Value of this thesis

The main purpose of this study is to identify the impact of living conditions, comparing two different types of accommodation, Refugee camp and official apartments, to sexual reproductive health status of Afghan women, recently entered Greece after a long and unsafe for their life journey.

From the bibliographic review both at national and international level there are no such studies. This is most probably because the refugee/migrant crisis is still in progress in Europe. There are a lot scientific papers analysing the impact of living conditions in camps to people's on the move health, most of them in other continents except Europe. Most of them are focusing on the impact of mental health rather than to SRH needs. More recent studies and articles are describing as a specific determinant of health the situation of one person to be on the move and also the impact of huge flows of people moving to the host societies and environment.

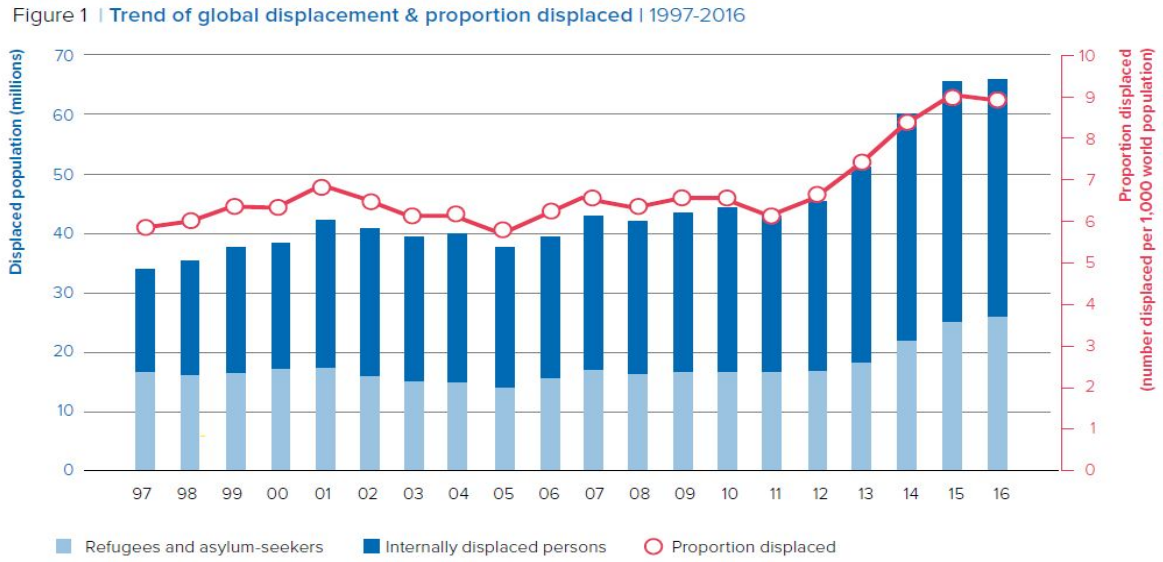
From my research I wasn't able to identify a paper that describes the living conditions in official shelters for people on the move (asylum seekers, refugees) and the impact in their health or if there is any relevance between health status and access to health care services.

This research is innovative because it seems that is a first step to identify how living conditions in temporary accommodations structures that tend to be permanent, are affecting sexual reproductive issues for a vulnerable group of women.

2. PEOPLE ON THE MOVE

Global trends displaced people

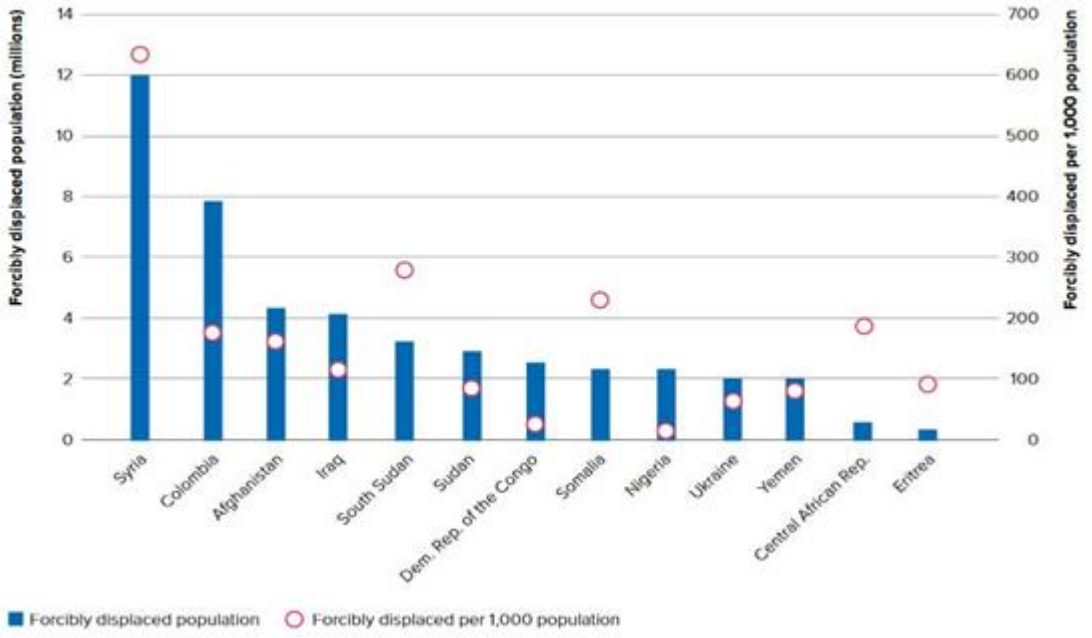
By the end of 2016, 65.6 million individuals were forcibly displaced worldwide as a result of persecution, conflict, violence, or human rights violations. That was an increase of 300,000 people over the previous year, and the world's forcibly displaced population remained at a record high.



Source: http://www.unhcr.org/5943e8a34.pdf Last visited 16/6/18

Looking at the forcibly displaced as a proportion of the national population, the Syrian Arab Republic (Syria) was the most affected. With 650 out of every 1,000 people forcibly displaced, Syria is the only country in which the experience of forced displacement now affects the majority of the population. The next most affected countries were South Sudan with 259 people forcibly displaced per 1,000 and Somalia with 238. Other countries where more than 1 in 10 people were forcibly displaced at end-2016 included Afghanistan, the Central African Republic, Colombia and Iraq. Figure 3.

Figure 3 | **Forcibly displaced population and proportion of population forcibly displaced** | end-2016



More than half (55%) of refugees of all countries came from Syria(5.5 million), Afghanistan (2.5 million), South Soudan (1.4 million).

Refugees from Afghanistan comprised the second largest group by country of origin, although their numbers decreased. At the end of 2016, there were 2.5 million Afghan refugees, compared with 2.7 million a year earlier. While this decline was mainly due to returns from Pakistan, that country nonetheless continued to host the largest Afghan refugee population (1.4 million). The Islamic Republic of Iran reported 951,100 Afghan refugees. In Germany, the number of Afghan refugees grew to 46,300 by the end of 2016, followed by Austria (20,200), Sweden (16,600), Italy (16,000), and Greece (11,400).

In 2015, Afghanistan was the country of origin with the most asylum-seekers, rising from 259,000 in 2015 to 369,000 in 2016 (an increase of 42%).

Greece saw more than a fourfold increase in new individual asylum claims, from 11,400 in 2015 to 49,800. More than half of these claims were from Syrians (26,600), compared to 3,300 in 2015. Similarly, asylum claims from Iraqis increased from 580 in 2015 to 4,800. Asylum claims also were received from Pakistanis (4,400), Afghans (4,300), Albanians (1,300), Iranians (1,100), and Bangladeshis (1,100). Figure 17.

Figure 17 | **Main countries of asylum for new asylum-seekers** | 2007-2016, (in thousands)

3.0 THE GREEK CONTEXT

Historically Greece has passed from several status related to migration. Greece was considered as a sending country of immigrants to other developed countries, as a host country for immigrants and refugees and also as a transit country for those looking either to escape war or looking for a better working and social environment.

The last 5 years Greek society is trying to handle and understand the phenomenon of both receiving big numbers of asylum seekers, mostly from countries facing war and conflicts, and at the same time, Greeks leaving their country in order to find better working conditions in other countries, due to the austerity measures of the government. It sounds a little bit weird the fact that in one hand Greeks are feeling unsecure in terms of working conditions and quality of life in Greece and on the other hand thousands of people are stranded in Greece as a safe country, waiting for long time asylum office decisions for their legal status that is mostly related to their integration to the Greek society and their access to health, education and workplace.

3.1 Greek History: Waves of Emigration

Greece is located at the crossroads between Asia, Africa, and Europe. Its position has played a key role in the global history related to commercial agreements. Greece is considered as the eastern border country of Europe and for those who want or are forced to move from one continent to another, is considered as an easily accessible gate to reach easily Europe, because of the extensive coastlines and the difficulty of the army to control the sea borders.

Greece was established as a state in the early 1830s. Looking to the Greek migration history we can notice three massive migration movements from Greece to other countries, the third is still ongoing.

The first wave of migration was spurred by the economic crisis of 1893 were Greece became a major source of labour immigrants. In the period 1890-1914, almost a sixth of the population of Greece immigrated to Egypt where they formed a large and socially heterogeneous community. Additionally, from the last decades of the 19th century to 1924, the USA received over 400,000 Greeks.

In the second wave of emigration, more than one million Greeks migrated, which mainly fell between 1950 and 1974. Most emigrated to Western Europe, the U.S., Canada, and Australia. Economic and political reasons often motivated their move, both connected with the consequences of 1946-1949 civil war and the 1967-1974 period of military dictatorship that followed. Official statistics show that in the period 1955-1973 Germany absorbed 603,300 Greek migrants, Australia 170,700, the U.S. 124,000, and Canada 80,200. The majority of these emigrants came from rural areas, and they supplied both the national and international labour markets.

Following the oil crisis of 1973 and the adoption of restrictive immigration policies by the European countries, these immigration flows were severely reduced and return migration increased. Other factors contributing to these changes including: integration difficulties in the receiving countries, the restoration of democracy in Greece in 1974 and the new economic prospects developed following the 1981 entry of the country into the European Economic Community. Between 1974 and 1985, almost half of the emigrants of the post-war period had returned to Greece.

According to statistics from the National Statistical Authority (ELSTAT, 2011) Greek people more vivid from 2007 started to migrate in other countries due to the economic crisis in Greece and the impact in the quality of life and the limited chances to access labour market. Due to lack of reliable statistics we cannot estimate the exact number of Greek people migrate the last ten years, taking under consideration the data from the General Secretariat for Greeks Abroad we can observe a rising in numbers of Greek people requesting allowance to work and live in other countries, in some cases the number doubled if compared to the number 5 years ago.

More than 5,000,000 citizens of Greek origin live outside the Greek borders, scattered in 140 countries of the world. We have a greater concentration of Greek-speaking population in the US (around 3,000,000), in Europe (1,000,000) - including the countries of the former Soviet Union-, in Australia (650,000 to 700,000), in Canada (about 350,000), Asia - Africa (about 100,000) and Central and South America (about 60,000).

Statistics from the Federation of Greek Communities in the Netherlands show an increase in migratory flows, as from 16,000 Greeks before 2010, this figure currently stands at 24,000.

The total number of Greeks living in Denmark on the first day of 2016, as recorded by the Danish Statistical Office, was 2.360 (when the same day of 2010 was 941). There is an increase in the number of Greeks, particularly those of the 25-29 age groups.

According to data from the British Ministry of Labor and Pensions, the number of Greeks who have acquired a National Insurance Number (NIN) has increased significantly in recent years. In 2008 2.931 Greek people took NIN and 12.022 in 2015.

In Qatar of 450 Greek people in 2008, they reached 1,000 in 2014 and continue to increase.

In United Arab Emirates in 2010, there was an increasing tendency for Greeks to move there for better career opportunities in 2010 were 1.500 Greeks, in 2011 they reached 1,850, in 2012 were 2,600 and in 2013 were 3,352. (K. Christodoulou, 2017)

3.2. Immigration waves

Many factors can explain the transformation of Greece into a receiving country the last thirty years. As mentioned before, the country's geographical location, as a crossroad of three continents and as the closest European country for those arriving from Middle East countries but also bordering with other Balkan countries such Albania, Bulgaria and Fyrom, played a significant and major role to attract people seeking for better life conditions.

The first flow of refugees in Greece was in 1923 with Lausanne treaty after the Minor Asia, where almost 1.500.000 Christian Orthodox residents in Minor Asia (Anatolia) region were forced to Greece as refugees, in the same time approximately 500.000 Muslims, residents at the East Thrace forced to return in Turkey.

The collapse of the Central and Eastern European regimes in 1989 transformed immigration to Greece into a massive and uncontrollable phenomenon. Neighbouring Albania, which was under communist dictatorship until 1991, was the source of most of the migrant population in Greece by the turn of the century. As a result, although Greece was at that time still one of the less-developed EU states, in the 1990s it received the highest percentage of immigrants in relation to its labour force.

According to the National Statistic Authority between 2005 and 2011, the number of people with a foreign citizenship officially settled in Greece were 201,122. Most of them came from Albania (64.087 or 31.9%), Bulgaria (26.321 or 13.1%), Romania (15.288 or 7.6%), Pakistan (15.086 or 7.5%) and Georgia (7,119 or 3.5%).

During 2010-2011, 45,803 people with a foreign nationality came to Greece. Most of them came from Albania (10,165 people or 22.2%), Bulgaria (7.379 or 16.1%), Romania (3.392 or 7.4%), Pakistan (2.944 or 6.4%) and Afghanistan (2.865 or 6.3%). (KATHIMERINI, 2014)

What we have to mention is the appearance of new Nationalities of migrants from Middle East countries such as Afghanistan. At this point we have to say that data are referred to those registered in Greece and not including the estimation of people living in Greece without official authorization to live in Greece.

Analysing the data of migration waves to Greece it is obvious that from 1990 till today, Greece has never stopped receiving people from other countries who were looking for better and safer living

conditions in Greece or they just passed from Greece in order to achieve reaching their final destination in another European country.

The latest and bigger migration flow started in 2012 and reached the biggest flow in 2015 where according to UNHCR more than 1.100.000 people passed from Greece trying to escape war and reach rich and developed European countries such as Germany and France. The vast majority were Syrian, Iraqi and Afghani people trying to survive from the war and conflicts. During 2016, 173.614 people entered Greece following the Aegean Sea route and during 2017, 29.595 number of people according to IOM. According to UNHCR till 13th of June 2018, 37,005 people arrived in Greece from the Aegean Sea (UNHCR 2017).

Reading the latest data from the asylum service in Greece we can see the incredibly big numbers of people asking for asylum in Greece (161.590). People from Afghanistan are among the first nationalities with Syrians, Pakistanis and Iraqis. As we can see from the data, 1/3 of the asylum seekers are women and most of them are of reproductive age between 18-34 years old. Almost all of them entered Greece following the refugee/migrant route from Turkey to the Greek islands through the Aegean Sea, putting their lives in several risks in order to reach a safe country and to be able to continue their journey to their final countries of destination.

Till 2014 refugee/migrant flows were very low, so those succeeded to arrive in a Greek island could continue their journey to mainland and then to the Northern, Greek-FYROM and Greek- Albanian borders and then reach mostly Germany or France. During 2015 the flows were incredibly high in numbers and many humanitarian actors started operations to Greek islands in order to rescue migrants/refugees and provide medical support to them. The government wasn't prepared to receive and protect that big numbers of people. The situation at the islands was horrible, with people trying to cover their basic needs of food, shelter and medical care in parks and with the support of solidarity actors and humanitarian organizations.

In 2015 there were in place only a few detention centers and almost no reception centers at the enter points of people, absolutely none organised accommodation structure either for asylum seekers or recognized refugees. There were poor screening and registry services for the newcomers at the islands and the asylum service was trapped in bureaucracy procedures of its establishment, without the capacity to serve all these requests.

Still the borders at the North of Greece was opened and without strict security measures, so people were arriving at Eidomeni region and then passed to FYROM and Skopia in order to continue their journey in other European countries.

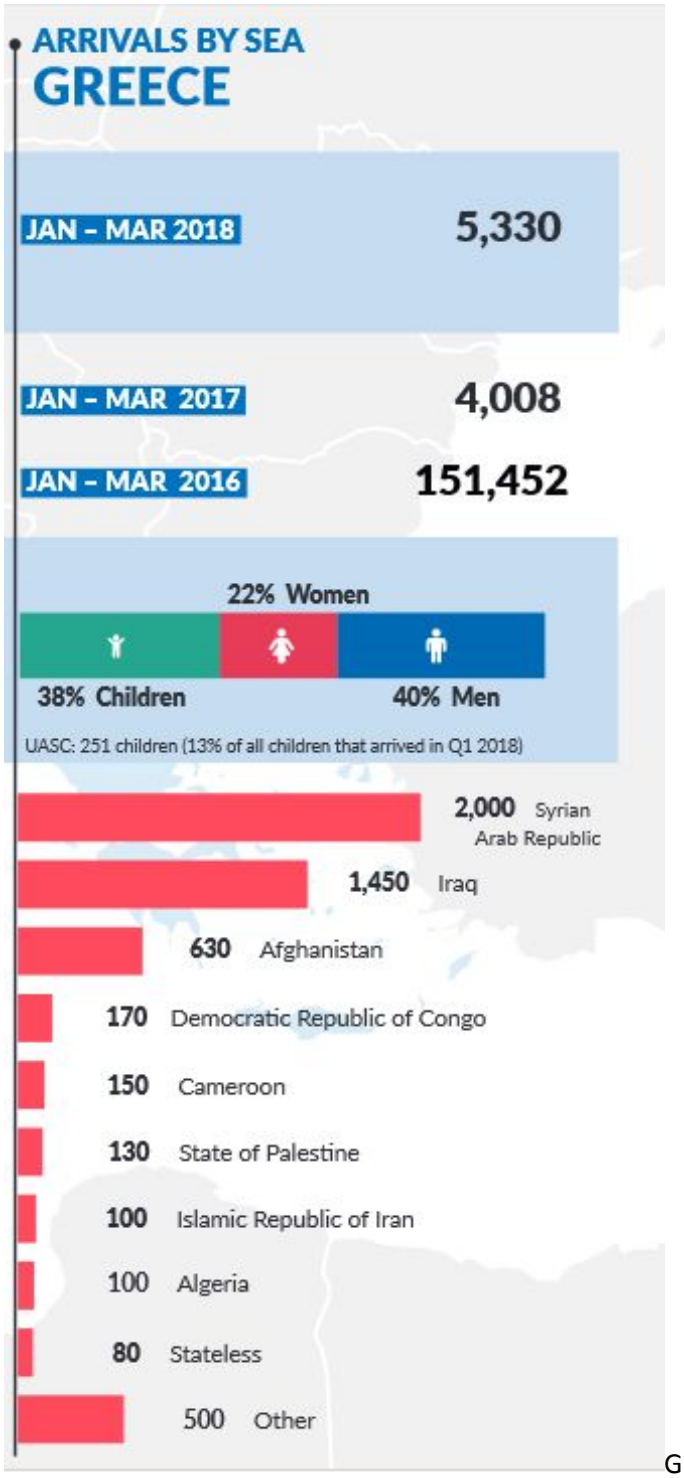
On March 2016 the borders were closed and a huge number of people stranded at Eidomeni area waiting a chance to continue their journey. The situation at Eidomeni was tragic and the living conditions horrible. People couldn't believe that they cannot continue their journey and they are stranded in Greece. It took almost one year for people to realise their new reality and the fact that the only way to stay in Greece is through the asylum system.

Asylum Applications - Countries of Origin									
	2013	2014	2015	2016	2017	May 2018	2018	Total	%
SYRIA	252	773	3490	26673	16385	1761	6962	54535	33,7%
PAKISTAN	610	1618	1822	4692	8923	648	2915	20580	12,7%
AFGHANISTAN	803	1709	1720	4364	7567	904	2804	18967	11,7%
IRAQ	107	174	661	4810	7923	748	4446	18121	11,2%
ALBANIA	419	569	1003	1420	2450	305	1359	7220	4,5%
BANGLADESH	230	633	738	1215	1383	124	581	4780	3,0%
IRAN	131	361	241	1096	1316	109	567	3712	2,3%
GEORGIA	342	350	386	687	1107	118	503	3375	2,1%
TURKEY	17	41	43	189	1827	231	738	2855	1,8%
PALESTINE	17	74	60	853	1310	124	375	2689	1,7%
OTHER COUNTRIES	1886	3129	3024	5055	8454	764	3208	24756	15,3%
Total	4814	9431	13188	51054	58645	5836	24458	161590	100,0%

Statistical Data of the Greek Asylum Service (from 7.6.2013 to 31.05.2018)

Asylum Applications												
	2013	Difference % (2013-2014)	2014	Difference % (2014-2015)	2015	Difference % (2015-2016)	2016	Difference % (2016-2017)	2017	Difference % (2017-2018)	2018	Total
Total	4814		9431		13188		51054		58645		24458	161590
Monthly average	688	14,3% ↑	786	39,8% ↑	1099	287,1% ↑	4255	14,9% ↑	4887	0,1% ↑	4892	2693

Asylum Applications - Gender and Age range																								
	2013			2014			2015			2016			2017			May 2018			2018			Total		
Age ranges	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-13	255	182	437	388	306	694	919	792	1711	7683	7103	14786	7614	6721	14335	734	640	1374	3174	2848	6022	20033	17952	37985
14-17	272	37	309	569	84	653	608	168	776	3534	1389	4923	4349	1093	5442	344	77	421	1480	405	1885	10812	3176	13988
18-34	2370	600	2970	5171	921	6092	6198	1466	7664	15282	6592	21874	21474	7164	28638	2300	816	3116	9229	3300	12529	59724	20043	79767
35-64	748	338	1086	1510	460	1970	2098	856	2954	5354	3796	9150	6572	3420	9992	575	329	904	2588	1347	3935	18870	10217	29087
65 and over	7	5	12	7	15	22	35	48	83	144	177	321	108	130	238	9	12	21	30	57	87	331	432	763
Total	3652	1162	4814	7645	1786	9431	9858	3330	13188	31997	19057	51054	40117	18528	58645	3962	1874	5836	16501	7957	24458	109770	51820	161590
Unaccompanied Minors (included in the above total)	177	12	189	385	35	420	332	51	383	1663	314	1977	2317	142	2459	178	7	185	759	53	812	5633	607	6240



Graph A

Source: https://data2.unhcr.org/en/documents/download/63572 Last visited 16/6/18

As we can see from the graph A, refugee flows only through the Aegean Sea are increasing during 2018 comparing to 2017. What we should mention is that the increasing flows from Evros region, in the Greek – Turkey borders, Evros is considered as an entry point of people but reception centers and asylum offices are not in place in that region. There are only police forces whose role is to check and arrest people who are entering the Greek territory without legal papers to enter the country. The first four months of 2018 police arrested 7.103 persons in the North of Greece, more specific

636 persons during January, 586 on February, 1.895 on March and 3.986 on April. During the same period last year (2017) less than 1.000 people have been arrested (T. Georiopoulou, KATHIMERINI, 2018)

Currently in Greece there are 58,100 refugees and migrants, 14,400 are stranded on the islands in mainly in hot spots and fewer in apartments and 43,700 in the mainland both in refugee camps and in apartments, official shelters provided by NGOs with funds from UNHCR, approximately 21.200 (UNHCR, 2018).

3.3. Migrant women in Greece

Traditionally, the participation of Greek women in the labour force has been something not very well accepted from the Greek society. Women were responsible to raise their children and mostly be occupied with the house holding. From 1971 till 1996, adult female participation in the paid labour force increased from 31.2% to 47.5%. Despite the fact that more and more Greek women were working, Greek cultural values regarding women's "duties" within the home has not changed as rapidly as female employment has. Greek women had to cope with responsibilities outside their home while their domestic tasks were remaining in the same volume. This created a demand for cheap working hands related to household and care work in Greece that is largely filled by female migrants.

Since the early 1990s a significant big number of immigrant women entered Greece coming from the Balkans and the former socialist countries of Eastern Europe, such as Albania, Bulgaria, Romania, Moldavia, Georgia, and Poland (76% Bulgarian immigrants, 70% Albanians, 76% Romanian, 85% Poles and 80% Filipino).

These women came to Greece in order to work mostly as domestic workers engaged in taking care of the elderly and children or as house cleaners in middle class Greeks. The vast majority was travelling to Greece with a touristic visa, without being registering to the migration unit, in order to claim official permission of work in the country. Most of them were providing their services without asking for social security and usually they preferred to stay in the house of the people they were taking care.

Taking under consideration the fact that these women travelled alone and far away from their families to a foreign country, the fact that the only occupation opportunities were to work as domestic carer’s in houses and very often under very hard conditions, without social security and without having official permission to stay and work. Immigrant women can be considered as a vulnerable population, in high risk of exploitation, without access to medical and other welfare services. We could describe them in one hand as invisible to the state but on the other hand as a key contributor in the economy but also in covering a huge gap by providing domestic care services. These women came in Greece with one major goal to gain money in order to support their families they left behind.

Although these migrant women offered vital services to Greek people, Greek society wasn’t ready to accept and recognise their work. This fact is closely linked with immigration stereotypes, gender inequalities and respect of human rights.

Greece has the highest female migration rate in Europe. Women from more developed countries tend to work in tourism and office work, while those from Asian, African, and former Soviet bloc countries are predominantly employed in household for domestic work, or as caregivers in medical centers. Filipino women are primarily employed as maids in families, while Albanian women are confined to domestic or cleaning roles.

It has been observed that migrant women from African countries are in high risk of sex exploitation or of being trafficked in Greece, according to Wikipedia over 20,000 migrant women are trafficked into Greece every year.

During the last 5 years Greece has received a high number of women as asylum seekers or refugees with different nationalities, cultural, educational and socio-economic background. These women have very limited opportunities to access the labour market due to several factors. What I would like to mention here, is the importance of having a normal and stable life. This has a direct effect to women individual mental health status but also for the rest of the family. We could say that in the current phase refugee and asylum seeker women are struggling to keep their role as householders and continue their daily tasks such as cooking and taking care of their children due to the bad living conditions in the host country.

It is a fact that the Greek legal system offers very little protection to domestic workers and in some cases may actually increase their insecurity and vulnerability. For those that are involved with survival sex there is no governmental strategy to protect and support them but also to protect public health.

3.4. Greek - social economic context

Although the European economic crisis started in 2008, its impact on the Greek population, in terms of increasing unemployment and reduced incomes, has mainly appeared after 2010 when a Memorandum of economic and financial policies was signed and a number of austerity measures were implemented, in order to avert Greece's default.

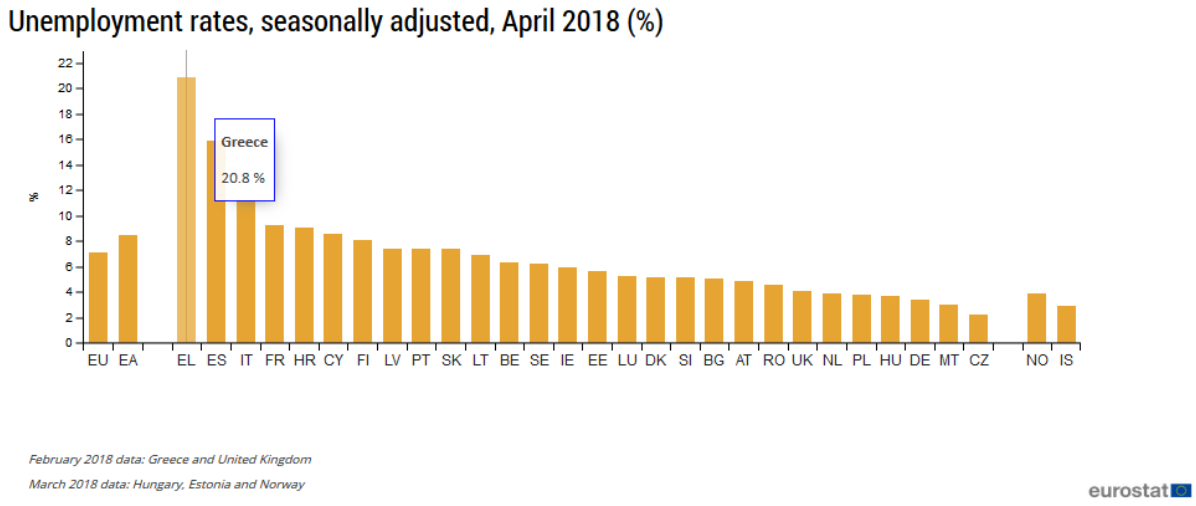
Historically the welfare state in Greece has been very weak, welfare benefits were provided focused more in a client model than based on a strategy according to social needs. The past decades it was the family was substituting the welfare state. Typically, if a young person lost his or her job or could not find a job, family was the one that provided support until their situation improved. Currently more and more people have become jobless and with pensions slashed as part of the austerity imposed on Greece from its creditors, Greeks are feeling the impact in their daily life where they cannot cover their basic needs to survive and keep their dignity.

Greece's public and non-profit mental health service providers have been forced to scale back operations, shut down, or reduce staff, while plans for development of child psychiatric services have been abandoned.

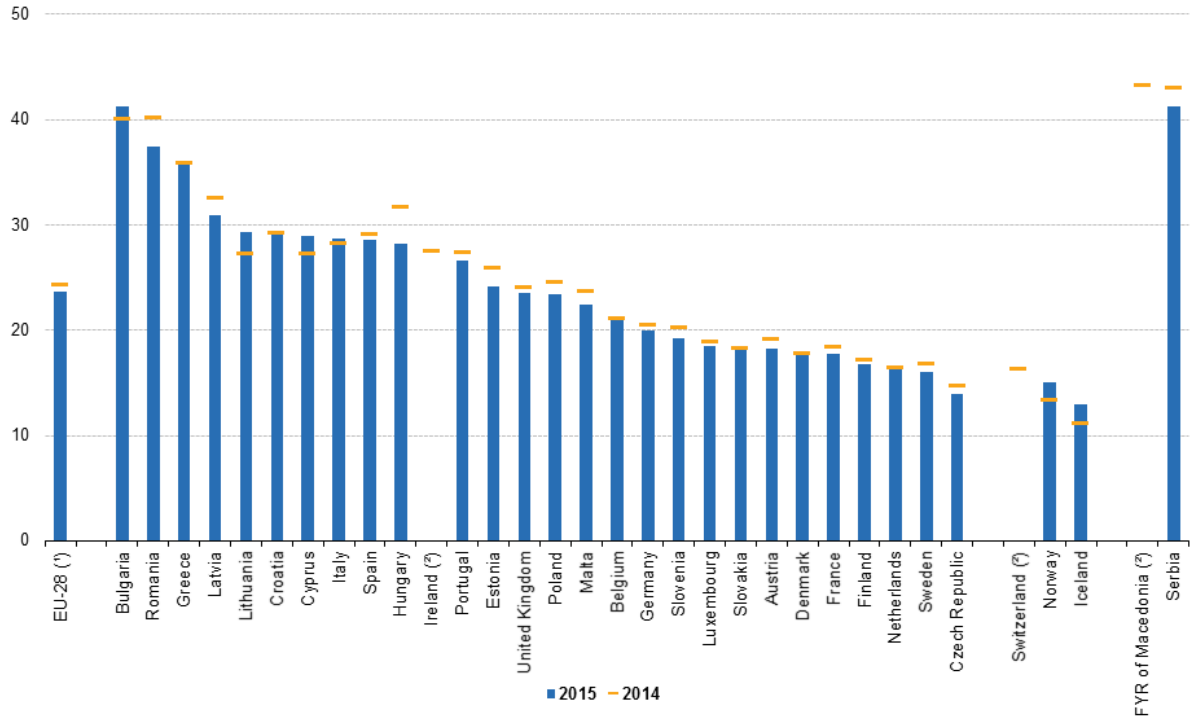
INE-GSEE's annual report on the Greek economy, using a series of alternative indicators - apart from conventional ones - to calculate "real unemployment", concludes that in the third quarter of 2017 the "real" total of the unemployed amounted to 1.355.620 people, a figure corresponding to a total

unemployment rate of 27.52%, or by 7 percentage points higher than the official rate of unemployment as recorded by EUROSTAT on February 2018, (20, 8%). Figure

Salaries in the private sector in 2017 have been set at extremely low levels. One out of two workers (50.2%) receives per month less than € 800 net, while the proportion of low-paid workers with net monthly earnings below €700 (37.4% in 2017 from 13.1% in 2009) has increased significantly. Up to 499 euros takes the 14.5%, between 500-699 euros the 22.9%. http://www.cnn.gr/oikonomia/story/122930/sto-27-5-i-pragmatiki-anergia-stin-ellada 16/6/18



The impact of this financial crisis in Greece has as results social exclusion and raise of social inequalities, with huge impact in social cohesion systems. It was expected to lead Greek people at great risk of poverty. According to EUROSTAT Greeks are among the top three EU countries at risk of poverty.



(1) 2015: estimate.
(2) 2015: not available

(EUROSTAT, 2016)

As a result of the limited occupational opportunities in Greece, "almost 450,000 Greeks left the country in the period between 2008-2016 depriving Greece of brain power while at the same time contributing to the aging of the population. The figures were presented on 2017, during the American-Hellenic Chamber of Commerce conference discussing the state of the labour market and emigration of Greeks to search for work abroad. According to the speakers, Greece is a country aging very rapidly, while the biggest problem it faces imminently is the "brain drain," the approximately 450,000 natives who left Greece during 2008-2016 to seek employment in other countries. The brain drain Greeks have yielded to the economies of these countries, particularly the United Kingdom and Germany, is 50 billion euros." (P. Chrysopoulos, 2017)

The overall unstable situation in Greece in combination with the huge migrant and refugees flows the last 5 years lead Greeks considering migrants and refugees as a great threat for their daily life and for the development and evolution of the Greek society. According to a research conducted by the University of Macedonia, half of Athenians declare that they are against immigrants.

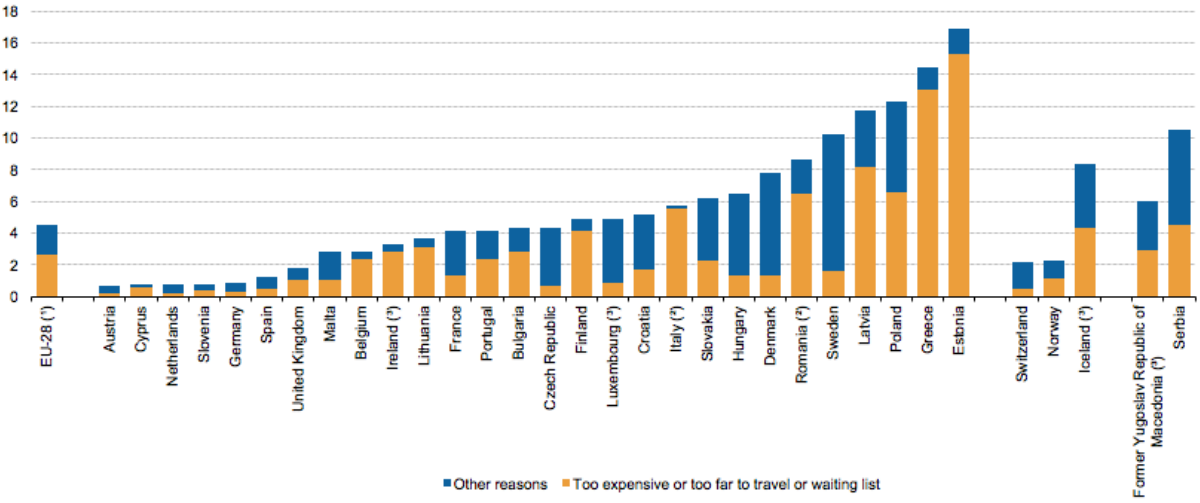
More specific, to the question, "what do you think is the impact of migrants on the country's economy?" (scale 0-10, with 0 negative and 10 positive) 59% of the residents in the 4th and 6th districts (including Kolonos area, Akadimia Platonos, Sepolia, Patissia and Kypseli, areas with high rates of migrants and refugees) and 53% of the residents of the rest Municipality of Athens districts, report that they think they are negative, while 33% in the 4th and 6th and 36% in the rest respond that they are neutral and 8% and 11% respectively feel they are positive.

At the question, whether immigrants are undermining or enriching the cultural life of the country, 61% of respondents in the center of Athens answer that they are undermining, 31% have a neutral position and 8% believe they are enriching it. Percentages for residents of the rest of Athens are 52%, 32% and 16% respectively (D. Galanis, TO VIMA, 2012).

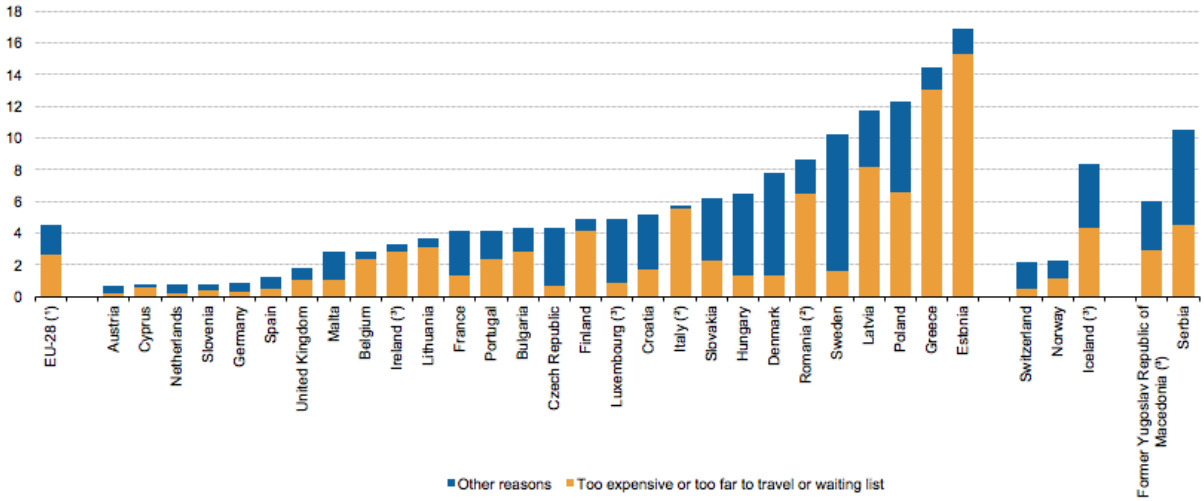
Albeit we have to mention that Greeks due to their huge national problems, responded to migrants and refugees entered Greece with great solidarity actions and provided support to them. It was very touching to see the most vulnerable and lower educated people, such elderly people and children to feel sympathy for this population and sharing the few basic necessities they had to cope with. It was impressive that Greeks opened their houses and hosted refugee families that were living out in the streets, due to their bad financial situation.

3.5 Impact on health care services and the health of local population

Since the global financial crisis began in 2008, Greece has been experiencing one of the most severe financial crises in its recent history. The crisis has had a direct effect on the Greek health system, which faced financial difficulties and structural problems long before the crisis hit. The implementation of public cuts resulted in a 25% reduction in health expenditures between 2008 and 2012. Unemployment increased from 7.8% in 2008 to 27.5% in 2013, making financing of the health system, which depends largely on social health insurance, even harder, and raising concerns regarding the reduction of health coverage among unemployment. Additionally, the reforms were focused at cost-cutting measures aimed at providing immediate effects and did not include any long-term considerations of the effect on equity of access and quality of care. Several studies but also EUROSTAT data reveal that the adverse economic environment caused a substantial increase in unmet health needs in Greece.



(1) Estimates.
(2) Provisional data.
(3) 2015.
Source: Eurostat (online data code: hlth_silc_08)



(1) Estimates.
(2) Provisional data.
(3) 2015.
Source: Eurostat (online data code: hlth_silc_08)

From my personal experience as a professional social worker for more than nine years in Greece, both in public services and international and local NGOs, I am in the position to express my point of view in the question how economic crisis affected local people. The global financial crisis started in 2008 and Greece was the first EU Country signed an MOU called Economic Adjustment Programme for Greece in May 2010. From 2010 till today the Greek governments are cutting benefits and reducing budgets for health care, education, social benefits at the same time taxes and unemployment increasing.

From 2010 till 2015 uninsured people couldn't have access to primary health care services and they had to pay everything related to medical care. Those with chronic diseases couldn't afford the cost of their medication and the cost for medical follow up. The result for them was not being able to have access to medical care and at their treatment with direct impact to their health status.

Vaccination for children wasn't for free for uninsured people. From August 2015 the government with a new law allowed uninsured people to have access to primary health care services and at their medication. This didn't mean that the access to health care was equal for all, but at least was a positive step. In one hand the government gave access to all, in public health care system on the other hand unemployment and Greece's obligation to reduce health care budget had as a result public health care services, especially hospitals, to operate understaffed, without adequate medical supplies, patients to wait months to do a medical test or to book an appointment with specialised doctors.

Many hospitals closed clinics because they don't have the staff or the equipment to treat more patients. Patients with cancer have to wait months to start chemotherapies. Greece's public and non-profit mental health service providers have been forced to scale back operations, shut down, or reduce staff, while plans for development of child psychiatric services have been abandoned. Funding for mental health services was decreased by 20% between 2010 and 2011 and 55% the following year, at the moment that the Greek society needed more than ever in the history access to mental health services. The cuts in social and health care services lead to the increase of suicides and

people to buy psychiatric medicines without being followed up by doctors. The largest proportion of Greeks is mentioning anxiety and insomnia disorders and they cannot cope with their daily duties.

	Mental health care			Prescribed medicines		
	15–44	45–64	65 and over	15–44	45–64	65 and over
EU-28	3.2	2.7	1.7	4.7	5.4	5.5
Bulgaria	1.2	2.9	3.3	5.7	9.5	14.0
Czech Republic	0.4	0.9	2.6	2.2	2.7	5.5
Denmark	19.6	10.8	2.4	4.5	3.9	5.1
Germany	6.1	2.9	1.4	5.1	3.1	2.7
Estonia	4.3	4.6	1.4	6.3	8.2	5.2
Ireland (1)	51.1	50.6	51.2	19.3	19.4	19.3
Greece	7.7	10.3	11.9	12.0	14.4	18.8
Spain	1.7	1.8	0.8	3.2	3.7	2.5
Croatia	1.0	1.7	2.8	3.5	5.7	8.3
Italy	3.7	4.3	2.7	6.4	8.0	7.2
Cyprus (2)	6.3	11.4	5.8	2.5	2.4	1.1
Latvia	7.0	7.0	4.2	12.7	19.6	21.3
Lithuania	8.3	2.8	3.5	2.7	4.3	4.5
Luxembourg	6.2	4.5	0.8	5.9	7.4	8.6
Hungary	1.0	2.1	1.1	4.5	8.7	4.5
Malta	3.0	1.8	1.0	1.9	3.3	6.4
Netherlands	3.3	1.9	0.0	2.5	1.9	0.8
Austria	7.6	6.4	4.1	1.8	3.1	1.7
Poland	3.3	5.0	4.3	5.3	11.4	14.5
Portugal	26.5	36.2	31.5	8.3	12.0	9.8
Romania	1.1	2.6	1.9	3.6	7.3	11.1
Slovenia	3.7	2.3	0.7	4.8	6.5	6.4
Slovakia	2.2	1.5	0.5	3.1	5.1	5.4
Finland (2)	11.1	6.5	2.8	8.2	11.0	14.0
Sweden	4.4	3.2	0.8	3.9	4.6	5.4
United Kingdom	0.9	0.9	0.1	1.8	1.3	0.2
Iceland	37.7	28.9	5.6	12.4	10.0	3.5
Norway	1.3	0.2	0.2	4.3	3.0	0.7
Turkey	6.4	6.8	3.8	12.0	11.2	9.2

(1) Unreliable data for mental health care for those aged 45 to 64 and those aged 65 and over.
(2) Unreliable data for mental health care for those aged 65 and over.
Note: Data not available for Belgium and France.
Source: Eurostat (online data code: hlth_ehis_un2e)

To conclude Greek society is struggling from 2008 till today with many and totally different crisis. Financially, approximately 25% are living under the poverty level, 37% are in danger to be at the poverty level, unemployment is still very high above 20%. Access to health care system is still not reachable for everyone and the system doesn't reassure equity to health and social services. Refugee flows are still high and approximately 65.000 are living in official refugee camps, apartments or other type of accommodation shelters. Their living conditions are not good and the most important is that they do not know what is going to happen in the future, for the moment they are stranded in Greece the vast majority want to travel to other European countries. Here in Greece they have to fight for access in basic human rights such as access to health care services, education, adequate and quality food and descent living conditions. The main nationalities are from Syria, Afghanistan, Pakistan, Iraq, Iran, Bangladesh and African countries.

International and local Humanitarian actors are offering primary health care not only to refugees and migrants, but also to the Greeks. The government is struggling to undertake their responsibility to cover these needs but it seems that it needs more time and efforts to succeed that.

4.0 The Situation in Afghanistan

4.1. Afghanistan Background Overview

Afghanistan is situated in the heart of Asia continent. It is a landlocked country, which is surrounded by Tajikistan, Uzbekistan, Turkmenistan, Iran, Pakistan and China. The full name is Islamic Republic of Afghanistan and governmental type is Presidential Islamic Republic, this particular form of government is adopted by some Muslim states; although such a state is, in theory, a theocracy, it remains a republic, but its laws are required to be compatible with the laws of Islam and a system of government where the executive branch exists separately from the legislature. http://www.who.int/countries/afg/en/ 16/6/18

Afghanistan

Map

This map is an approximation of actual country borders.

Statistics

Total population (2016)	**34,000**
Gross national income per capita (PPP international $, 2013)	**2**
Life expectancy at birth m/f (years, 2016)	**61/64**
Probability of dying under five (per 1 000 live births, 0)	not available
Probability of dying between 15 and 60 years m/f (per 1 000 population, 2016)	**272/216**
Total expenditure on health per capita (Intl $, 2014)	**167**
Total expenditure on health as % of GDP (2014)	**8.2**

Latest data available from the Global Health Observatory

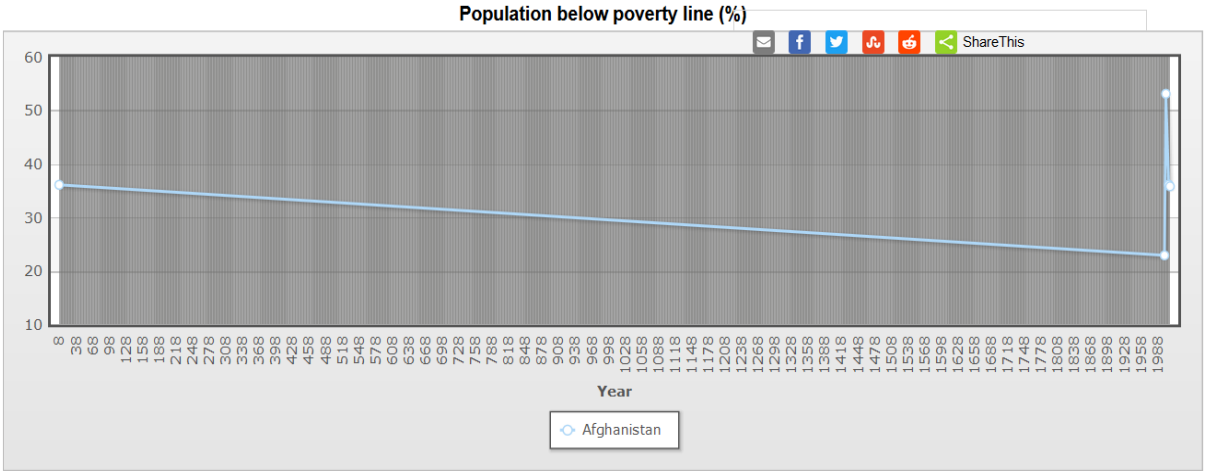
"Afghanistan is gradually recovering from decades of conflict. Before 2014, the economy had sustained nearly a decade of strong growth, largely because of international assistance. Since 2014, however, the economy has slowed, in large part because of the withdrawal of nearly 100,000 foreign troops that had artificially inflated the country's economic growth. Despite improvements in life expectancy, incomes, and literacy since 2001, Afghanistan is extremely poor, landlocked, and highly dependent on foreign aid. Much of the population continues to suffer from shortages of housing, clean water, electricity, medical care, and jobs. Corruption, insecurity, weak governance, lack of infrastructure, and the Afghan Government's difficulty in extending rule of law to all parts of the country pose challenges to future economic growth. Afghanistan's living standards are among the lowest in the world." (INDEXMUNDI, 2018).

For more than three decades of conflicts, it seems that Afghanistan, with the support of European Commission and other International Organizations progressively improves social and health determinants indicators such as access to clean water and quality food, improving living conditions, access to health care services and education. At the same time Afghanistan is not considered as a safe place, the security situation deteriorated during 2018. More specific during January, "the Taliban and the Islamic State in Iraq and the Levant (ISIL) launched a series of attacks on various civilian and government targets. On 4 January, an ISIL suicide bomber killed at least 15 and injured another 25 people in Kabul. On the night of 20 January, six Taliban fighters laid siege to the Intercontinental Hotel in Kabul, killing more than 40 people, including 14 foreign nationals, and injuring more than a dozen others. The siege ended the next day when government forces took

control of the hotel and killed the attackers. On 24 January, ISIL claimed responsibility for an attack on the international humanitarian organisation Save the Children in Jalalabad in which at least five people were killed. The deadliest attack this year occurred on 27 January when the Taliban activated a suicide car bomb in Kabul, killing more than 95 and injuring around 160 people." (SECURITY COUNCIL REPORT, 2018).

Today's Afghanistan is in a much better position on its human development than it was in 2001. According to European Commission,

- "Access to primary healthcare has increased from 9% of the population to more than 57%.
- More than 8 million students are enrolled in schools, with 39% of girls.
- New and rehabilitated highways and roads have cut travel times between the main regional centres by 75%.
- However, 39% of the population still lives in poverty.
- Only 26% of the population can read and write. Corruption continues to be a major problem, affecting the everyday life of Afghan citizens and undermining development." (European Commission, 2018)



Country	8	2002	2003	2008	2009	2011
Afghanistan	36	23	53	36	36	35.8

Maternal mortality ratio:
396 deaths/100,000 live births (2015 est.)**Infant mortality rate:**
total: 110.6 deaths/1,000 live births
male: 118 deaths/1,000 live births
female: 102.9 deaths/1,000 live births (2017 est.)**Life expectancy at birth:**
total population: 51.7 years
male: 50.3 years
female: 53.2 years (2017 est.)

Health expenditures:
8.2% of GDP (2014)

Physicians density:
0.3 physicians/1,000 population (2016)

Hospital bed density:
0.5 beds/1,000 population (2014)

Sanitation facility access:
improved:
urban: 45.1% of population
rural: 27% of population
total: 31.9% of population
unimproved:
urban: 54.9% of population
rural: 73% of population
total: 68.1% of population (2015 est.)

HIV/AIDS – adult prevalence rate:
<.1% (2016 est.)

HIV/AIDS – people living with HIV/AIDS:
7,500 (2016 est.)

HIV/AIDS – deaths:
<500 (2016 est.)

Major infectious diseases:
degree of risk: intermediate
– food or waterborne diseases: bacterial diarrhea, hepatitis A, and typhoid fever
– vectorborne disease: malaria (2016)

Obesity – adult prevalence rate:
5.5% (2016)

Children under the age of 5 years underweight:
25% (2013)

Source: CIA – The World Factbook – Afghanistan – accessed March 26, 2018

Less than fifteen years ago, in 2002, Afghanistan's maternal mortality ratio stood at 1,600 deaths for every 100,000 live births. Today, the pregnancy related mortality rate is 396.

Yet significant challenges remain. Maternal mortality in Afghanistan, though a fraction of its earlier levels, remains amongst the highest in the world. Skilled attendants, such as midwives, who can assist in a safe and hygienic childbirth and quickly identify and act on complications, are present at only 34 percent of deliveries, putting the lives of mothers and infants at risk. Maternal mortality and morbidity are further exacerbated by Afghanistan's high birth rate, early child bearing, and by pregnancies at close intervals. Women can expect to bear more than five children during their lifetimes, more than twice the global (UNFPA, 2018).

4.2 Sexual and Reproductive Health and Rights in Afghanistan

Afghan health status and health services were very poor. In 1960 the infant and child mortality rates were 215 and 360 per 1000 live births and the total fertility rate was 7.7. Health services were mostly provided by the government mainly in the urban areas, those that were living in rural areas didn't have access even to basic health care services. The government was struggling to implement vertical programs against tuberculosis, malaria and Leishmaniosis (RUTGERS, 2016).

Later after the war at 2002 and 2003 two studies focused on reproductive health care needs and gaps, the first concluded that, "of the hospitals, only 47% had female staff, and only 24% provided caesarean sections. Of the primary care centers, 48% provided antenatal care and deliveries, but only half of those were adequately equipped. Only 29% offered three or more methods of contraception. Female health professionals in the country constituted 90 out of 647 specialists, 605 out of 2203 general physicians, and a total of 467 midwives. Forty percent (40%) of health facilities had no female health worker." (WHO, 2009).

The second mortality study, done in four geographically contrasting districts in early 2002, estimated a national maternal mortality ratio of 1600-2200 per 100,000, one of the highest ratios in the world.

"A summary of reproductive health indicators at that time 2002-2003 would include for:

Maternal health
Maternal mortality ratio: 1600 per 100,000
Antenatal care by skilled worker: 16%
Skilled birth attendance: 14% (Urban 35%, rural 7%)
Family Planning
Total fertility rate 6.23 (Others quote 6.8)
Crude birth rate 48 per 1000
Heard of contraceptives 28%
Contraceptive prevalence rate 8.5%" (WHO, 2009)

Sexually transmitted diseases and HIV seem to be uncommon at this time. Gender based violence including rape, domestic violence, forced marriage is known that was high, but there are no available data due to the fact that is under-reported.

According to most recent data related to Afghanistan SRH issues are the following:

Mother's mean age at first birth is 19.9 years (2015 est.)

Maternal mortality ratio is 396 deaths/100,000 live births (2015 est.) Country comparison to the world is ranked at 28th in a total of 184 countries. Greece was at level 184 with 3 deaths/100,000 live births in 2015.

Infant mortality rate: total: 110.6 deaths/1,000 live births (2017 est.) Country comparison to the world is ranked as the **1st** in a total of 224 countries.

Total fertility rate is 5.12 children born/woman (2017 est.) Country comparison to the world is ranked as 10th in a total of 224 countries

Contraceptive prevalence rate: 22.5% (2015/16)

Comparing the data, it is obvious that the situation has been improved mostly due to the involvement and support from several international NGOs and other organizations that are present to the field but also supporting the government to implement new programs that promote women rights and raise awareness about gender equity (Central Intelligence Agency, 2018).

Still being a woman to Afghanistan is not a privilege and access to health care services and education is far from the standard services.

- ✓ Sexual violence remains a huge problem all over the country, women don't dare to report a rape incident because they are going to be stigmatised and most of them will be accused as it was their fault and will end imprisoned or murdered.

An inquiry by the Afghanistan Independent Human Rights Commission recorded 406 reported cases of honour killing and sexual assault between March 2011 and April 2013. Of these, 163 cases were identified as cases of sexual assault (including rape). 17% of sexual assault cases were committed by relatives, around 10% by neighbours, 4% by the victim's father, 2% by a brother and 1% by an uncle of the victim.

The government in 2009 vote a new law for the Elimination of Violence against Women that criminalises violence against women, including rape, battery, or beating. However, this law's definition of rape does not include spousal rape. The law imposes a prison sentence of 16 to 20 years for rape, and imprisonment of up to seven years the law is not widely accepted, and some people in the public and the religious communities consider the law un-Islamic. Many authorities lack the political will to implement the law and fail to enforce it fully.

One other aspect of sexual violence is minors forced marriages, Even though it is against the law, many brides continue to be younger than the legal marriage age of 16 (15 with the consent of a parent or guardian and a court). A survey by the Ministry of Public Health showed that 53 % of all women at the ages 25-49 had been married by the age of 18 and 21% by the age of 15. Forced marriages occur; according to the Afghan Independent Human Rights Commission, 60-80% of the marriages in Afghanistan are concluded without the consent or against the will of one of the spouses.

- ✓ Access in family planning methods and termination of pregnancy (TOP)

Afghani women are excluded from decision-making regarding many things, but also for issues related to their health and life such as decision to get pregnant and how many kids she would like to have. Women are not allowed to decide by their own which contraceptive method to use; their husband has to agree on that decision. Still rates of contraceptive use are low, especially among women with lower education level. In 2010, a study among married women aged 15-49 years found that only 22% used any method of family planning. The breakdown by method was as follows: injectable contraceptives (6.5%), oral contraceptive pills (5.3%); lactation amenorrhoea method (3.6%); male condoms (1.7%); the intrauterine contraceptive device (1.3%); traditional methods such as periodic abstinence and withdrawal (1.9%); and female sterilisation (1.4%). The total fertility rate

(average number of births per woman) was 4.8 in 2014. The adolescent (women aged 15-19 years) fertility rate was in 2004 was very high with 77/ 1,000 births.

According to Afghanistan's Criminal Code of 1976, abortion is considered as crime, with the only exception, if it is performed to save mothers life. However, it is known that many women choose to proceed in termination of pregnancies using unsafe methods with severe consequences to their health.

- ✓ Sexual orientation

Sexual acts among same sex persons are strictly prohibited in Afghanistan and are punishable with imprisonment or, under Islamic law, with penalty of death. Persons identifying as LGBT or are suspicious of having emotions for same sex persons, are likely to be expelled and persecuted by their family. LGBT people also face violence, sexual harassment, assault, rape, and arrest.

According to a recent report from Afghanistan Ministry of Health (March 2017) shows that more than 50% of pregnant women in Afghanistan do not have access to essential health services and more than 50% of the births take place without nursing facilities. Additionally, the rate of mortality among mothers is still on the rise. However, the mortality rate of children has dropped. The report states that from every 1.000 of children, 55 of them die before the age of five.

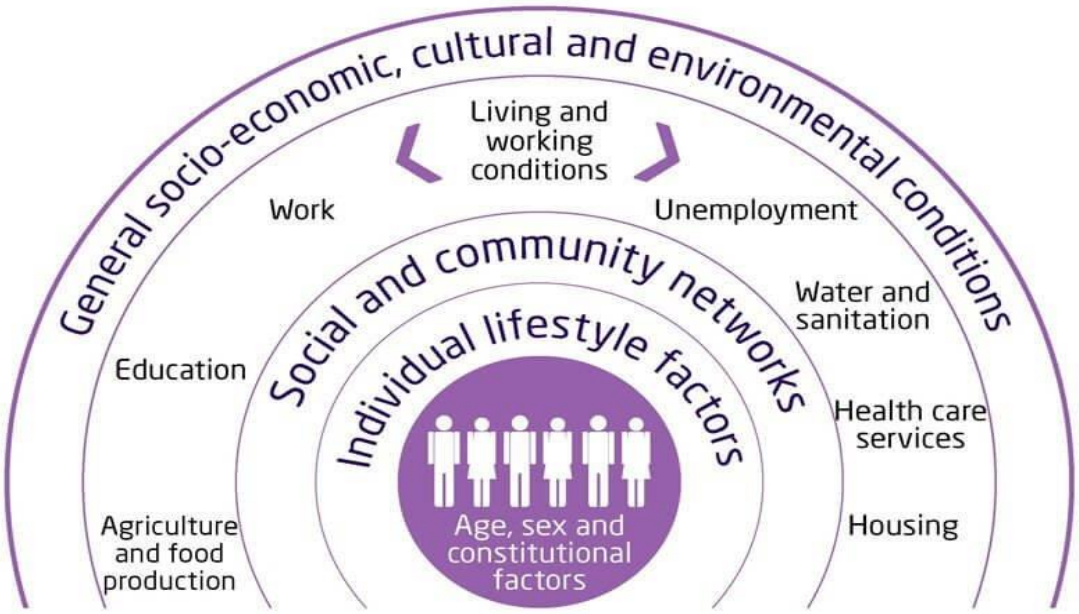
Meanwhile, the acting head of reproductive health at the ministry of public admits that the quality of health services in the country is very low and also the health distribution programs are unbalanced in the country. However, investments have been conducted on the health services, but the commitment of the health workers, quality of health is not satisfactory for us due to the lack of budget and resources. The minister of public health mentions that 40% of mothers are suffering from anaemia, 95% of mothers are lacking vitamin D while another 1% of mothers' lack of iodine, and these are among the items which we need to focus on before and after births.

The last year the Ministry of Public Health is also working on a five year plan for family planning and gaps between births in cooperation with the international organizations and donor countries (N.Ashrafi, TOLONEWS,2017).

5.0 Social, Health Determinants and Sustainable Development Goals

5.1 Social determinants of health for people on the move

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." The definition has not been amended since 1948. (WHO 1948). Being healthy is the wish of every person in the world. From the existence of human life there are countless surveys, discussions, opinions, papers, recipes etc trying to analyse and better understand the factors that contributing a person to be considered or not healthy. One of the latest and wide analysis for the factors affecting health status, is known as determinants of health.



Source: Dahlgren, G. and Whitehead, M. (1993)

To a large extent these factors are related to the environment we live, access to clean water and quality food, our relationships with friends, family our supportive networks, our involvement in the wider society, our living conditions and access to heating, our education opportunities, the level of access in medical and social services. All the above have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact.

It has been under research and discussion if migration, and further more people on the move that fled away from their countries of origin, constitute a separate condition that could be considered as one of the social determinants of health. It is a fact that people on the move experience different inequalities from the country of origin, during the transit countries but also in the host country for a long time after their arrival, which has an impact in their overall health status and social well-being. Health of people on the move goes beyond the traditional management of diseases and is linked with the social determinants of health and the unequal or limited access to the social determinants of health.

The target population in this paper is Afghan women forced to leave their country due to conflicts or bad living conditions. Their journey to reach Europe and more specifically Greece wasn't at all easy and safe they had to cope with severe environmental conditions, such us extremely low or high temperatures, they had to walk through very danger and risky for their life routes. Most of them either have lost their beloved ones forever or left them behind. Security was one of the biggest challenges because they had to trust smugglers to succeed arriving in Greece. Their stay in transit countries such as Turkey was described as a terrible situation without any access to health care and socio-legal services and in risk of sexual violence. Finally, when they reached Greece, they got disappointed first of all, from the first reception service at the islands where they had to live under

tragic living conditions in hot spots and camps. For those that continued their journey to other EU countries hopefully things are better. For those who didn't make it to leave Greece the situation is not good. Additionally, they have to cope with limited access to health care and socio-legal services due to the incapacity of the public services to adapt in these population needs. Asylum procedures, especially for nationalities such as Afghanis are extremely low and with low number of positive results. The offered from UNHCR and government accommodation shelters and camps are not designed to protect and provide a calm place of living. Usually they are overcrowded, without adequate common spaces and toilets. The food offered for a long time, especially in refugee camps, wasn't adapted to the cultural background of the hosted population. Access to education and language courses is limited. There are no protection systems in place to take care of vulnerable cases such as pregnant women, children, mental health patients. Access to work is extremely difficult because the unemployment rate is really high but also because there is no governmental integration plan for this population.

Policies at the local, state, and federal level affect individual and population health. European policies and also national policies have a great impact of people on the move. The EU-Turkey deal, the closure of the borders and policies excluding people from their right to have access in health care services, has a direct impact on their health. People living in uncertainty and they are don't have the resources to meet their daily needs and have a normal daily life are lead to face mental health issues. With limited access to medical services results in discontinuity of care and worsen their medical condition.

Discrimination and exposure to violence is a daily experience, especially for women. It is more difficult for refugee women to seek for support and join social and community networks in order to socialise and share their feelings and challenges.

Barriers to accessing health services include, lack of availability, cost, complex health care system and administration procedures, lack of insurance coverage, limited language services. All the above lead to unmet health needs, delays in receiving appropriate care, inability to get preventive services and hospitalizations that could have been prevented.

5.2. Sustainable Development Goals and refugee-migrant population on the move

In accordance to social determinants of health, on September 25th 2015, countries adopted a set of 17 Sustainable Development Goals (SDG) to end poverty, protect the planet and ensure prosperity for all as part of a new sustainable development agenda. Each goal has specific targets to be achieved over the next 15 years until 2030.

For the goals to be reached, everyone needs to participate according to their role such as governments, the private sector, civil society and individuals.

Reading and analysing the Sustainable Development Goals (SDGs) for 2030 there are not references or clear goals related to the millions of refugees, including their right to access health services. While SDG 3 on health is not presenting an explicit reference for the right of displaced people to health, the outcome document on the 2030 Agenda states that "to promote physical and mental health and well-being, and to extend life expectancy **for all**, we must achieve universal health coverage and access to quality health care. **No one must be left behind**". Transforming our World: The 2030 Agenda for Sustainable Development, Finalised text for adoption, August, 2015. (UN, 12/8/2015, page 7).

When it comes to access at health services, international human rights law is clear. States have the responsibility to provide assistance to displaced persons (no matter their legal status) in times of emergency and respect their right to health. According to their maximum of their resources ensuring refugees access to health services and the determinants of health such as provision of food, water and descent living conditions. Health is included in almost all of the other 16 Goals, not just in SDG 3. The progress on many of the Goals will affect health in general but also health of displaced people. Improving the health of all must be dependent not only in equal access but in equity.

Although we could analyse and link most of the goals and targets with displaced women I would like to pay attention in SDG number 3- Good health and wellbeing, which has specific targets linked with surveys target population needs such as:

3.1 *By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births*
3.1.1 Maternal mortality ratio
3.1.2 Proportion of births attended by skilled health personnel
3.2 *By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births*
3.2.1 Under-five mortality rate

3.2.2 Neonatal mortality rate
3.*4* *By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being*
3.7 *By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes*
3.7.1 *Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods*
3.7.2 *Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group*
3.8 *Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.*
3.8.1 *Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population).*
3.8.2 *Number of people covered by health insurance or a public health system per 1,000 population.*

Related targets are included in SDG number 5 – Gender Equality

5.2: *Eliminate all forms of violence against all women and girls in the public and private spheres*
5.6*: Universal access to sexual and reproductive health and rights*
(SDGS,UN,2018)

6.0 The role of humanitarian actors in refugee crisis in Greece

The contribution of International Humanitarian Actors globally in emergency situations is already known and has been analysed and criticised many times. Operations all over the world from International Organizations and local actors have been undoubtedly proved vital for millions of people in need. At the same time there is much criticism if this is their role or should be governments undertaking their responsibility to protect people. For sure is not black or white in every case. We all agree that governments should have the management and the resources to cope with emergency situations but in reality, this is not feasible. NGOs are proven more experienced in coping with emergencies, they have the knowhow, their staff is trained to intervene in such situations and they have the flexibility to act as soon as possible without losing precious time that maybe cost human lives.

In Greece, during the last 5 years many of International organizations and human oriented actors started operating in order to offer supportive and protection services to newcomer people. The global interest was focused to the Aegean islands such as Lesvos, Chios, Samos and Kos, which received the majority of people entering Greece. Those people reaching to the islands were extremely tired due to the dangerous journey they did, especially the last part, where they had to cross the Aegean Sea from Turkey in a boat, which was overcrowded, without any security measurements and with bad weather conditions. Also, the reception facilities at the islands where not adequate and there were lacking access to basic necessities such as food, water and safe accommodation. For people with medical needs the already established public system was

inadequate to take care of them, in most cases was inadequate to cover even the local population medical needs.

International Organizations intervene in order to cover these needs but also to witness the drama of these people, in their trial to survive from conflict and war zones.

The reception and living conditions to the islands is still very bad, people are protesting for the impact to their health. The majority of them are facing mental health problems and those with chronic diseases are not having proper medical follow up. Those facing severe medical conditions are transferred to local public hospitals and if they need more specialised care, they have to wait till the authorised services decide the lift of the geographical restriction, in order to be able to travel to the mainland legally.

In the mainland the majority of refugees live in refugee camps and around 20.000 in apartments that are supported by local NGOs. The living conditions in camps are not good, medical care services are not adequate to correspond to the needs. Access to social and legal services is very limited. Those that are considered lucky and they are placed in an apartment, testimony that apartments are overcrowded without enough space for all the residents. Usually there are problems in the cohabitation because they don't respect the rules that have been set.

Although many international organisations left the country due to lack in funding, still in the urban area of Athens there is a great presence of humanitarian actors providing psychosocial, medical, legal and other services for refugees/migrants/asylum seekers. The main issue is establishing an efficient referral pathway to public health care services. Several NGOs providing support by offering cultural mediation and interpretation services in public health structures.

NGOs main role in Greece is the provision of primary health care services in order to decongest public hospitals. Through the daily experience of front line practitioners trying to support access to health care for their beneficiaries, NGOs are advocating for bad practices and the raise awareness for the impact these policies and decisions have to the target population. Speaking out with testimonies and facts about the impact in health NGOs succeed to change and make the system more human and friendlier to all.

Without the support of International Humanitarian Organizations the situation would be a chaos, the Greek government wasn't prepared at all to face these huge refugee flows. Although Greece received an extremely amount of money from the European Commission proved unable to handle the situation because was lacking of experience and managerial mechanisms. Also, we have to admit that the European Commission was also proved unprepared and unable to handle refugee crisis and was limited to offer money and promises.

6.1 MSF operations in Greece

MSF is operated in the refugee crisis in Greece from 2014 till today, more specific to the entry points such islands and Evros, at the Aegean Sea with a rescue ship, to the mainland in several refugee camps, at exit points such as Eidomeni and Patras, to the urban area of Athens with two structures.

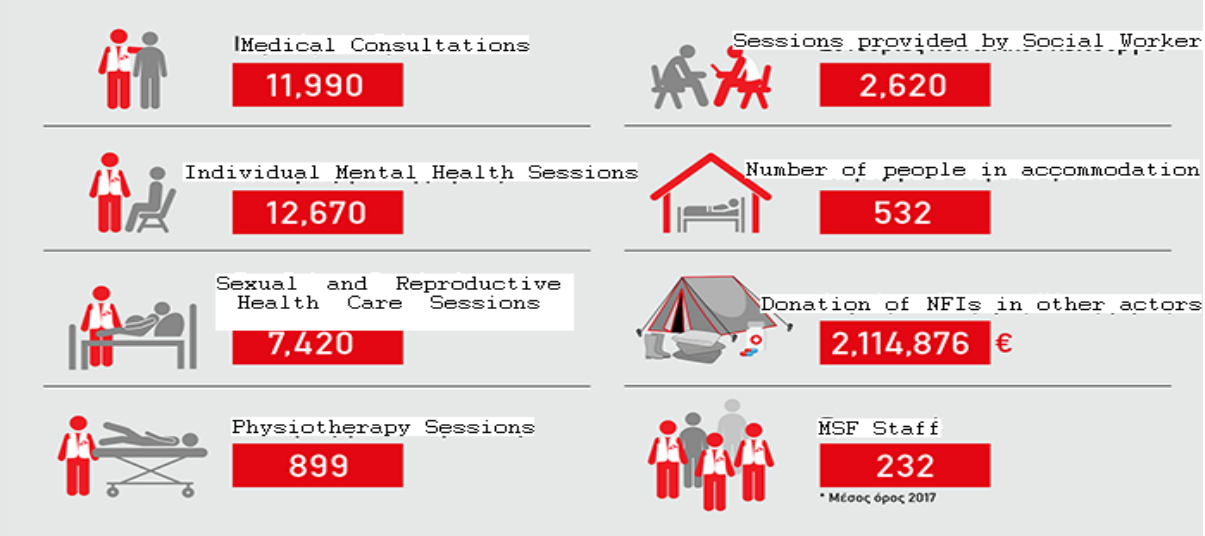
During 2016 MSF provided 54.200 outpatient consultations, 8.100 individual mental health consultations and 650 group mental health sessions.

In Athens during 2016 MSF operates three clinics in Athens to respond to the specific needs of migrants and asylum seekers living in formal and informal accommodation in the city. The Athens Urban Day Care Centre provides sexual and reproductive healthcare and mental health support and has an outreach unit that visits migrants where they live. A clinic in Victoria Square offers basic and mental healthcare on a walk-in basis. Between February and December, over 4,055 medical consultations were carried out there. In VOT (victims of torture) program, a team of psychologists, doctors, physiotherapists, social workers and cultural mediators works with local partners to offer interdisciplinary rehabilitation to victims of torture and other forms of ill treatment. After the implementation of the EU-Turkey agreement, the monthly average of new cases increased from 10 to almost 40.

MSF offered basic healthcare in Eleonas camp, Korinthos detention centre and Piraeus port. In Elliniko camp, which hosted up to 4,000 refugees in 2016, the team provided sexual and reproductive healthcare and mental health support (MSF, 2017).

MSF underlines that “hospitals are struggling to respond to the needs of both local people and migrants, mainly due to a lack of resources. As a result, people regularly face difficulties in accessing proper healthcare, especially specialised care. Whilst they theoretically have access to the treatment in hospital for specialised issues, in reality access is difficult due to a general lack of capacity, including a lack of financial and human resources.”

In 2017, Médecins Sans Frontières provided services in the urban area of Athens and in camps in the wider area of Attica, Central Greece, and in the islands such as Lesbos, Chios and Samos, as well as in Northern Greece.



During 2017, Médecins Sans Frontières through our presence to the field we were able to see the implications to health of the policies of deterring and restraining the European Union (EU) decided. Following the closure of the Balkan Road and the signing of the EU-Turkey agreement in March 2016, people remain locked in the Aegean islands and the mainland with direct impact to their health and wellbeing. In 2017, 60% of people arriving on the Greek islands were women and children (MSF, 2018).

7.0 RESEARCH METHODOLOGY

7.1. Purpose of study

Afghan women were among those who were forced to leave their country of origin due to war and conflicts, to escape from famine and extreme environmental conditions or to live with dignity in another safer place because they were expelled from their families, must be considered as vulnerable during their whole journey to their final destination and for a long time after their arrival.

A recent study in March 2016 by UNHCR related to Afghan people arriving in Aegean Sea Greek islands address some interesting points such as that "55% of Afghans interviewed were internally displaced in Afghanistan before starting the journey to Europe and 75% left Afghanistan due to conflicts and violence. 66% of those interviewed left Afghanistan in 2016, and for those moving directly from Afghanistan to Greece the duration of the journey was 37 days on average. The majority of those interviewed (68%) came directly from Afghanistan either through the route Pakistan/Iran/Turkey (37%) or the route Iran/Turkey (31%). 69% travelled with at least a close family member and 25% responded they were travelling alone. 16% of the interviewees said they stayed in another country (not Afghanistan) for 6 months or more before starting their journey to Greece and most mentioned lack of documents (35%) and fear of expulsion (23%) as main reasons for leaving that country. 52% of respondents directly witnessed or experienced protection incidents during the journey. In terms of other type of vulnerabilities, 20% of the interviewed were women, 4% of women were pregnant, 9% of women were lactating, 3% of the interviewed had a physical disability and 1% had a mental disability." (UNHCR, 2017).

Taking as granted that the majority of social determinants of health are changing and are not stable during the whole journey of people on the move we will try to measure how living conditions are affecting sexual reproductive health of Afghan women entered Greece during January 2016 till April 2017.

I started working with MSF on May 2016 in the Greek mission where the main activity was provision of medical care services with two mobile clinics at the Elliniko area refugee camp. The medical services were offered was focused on sexual and reproductive health care and mental health services. Elliniko camp was one of the worst camps because the government having no other choice to host people decided to open temporary the two older Olympic Stadiums of Hockey and Baseball for the people. These two stadiums had neither electricity nor water supplies and the toilets were damaged and out of order. The government considered Elliniko as an unofficial camp but at the same time Ministry of Migration undertook the management of the camp and army was providing food.
The majority of the residents at Elliniko camp were from Afghanistan and they had recently entered Greece and travelled to Athens in order to continue their journey to the Northern and reach other EU countries. For many of them Elliniko was a short stay till they manage to continue their journey,

for some other especially after the closure of the borders on March 2017 was proved to be their "home" for more than a year.

During SRH consultations women were disclosing very sensitive and dramatic stories, not only what happened during their journey but also from their daily life in the camp. In addition, with the horrible living conditions in the camp and the uncertainty for the future it was expected to have a direct impact on their health and this is one of the two groups of my research.

The second group consists of Afghan women that lived in refugee camps and after some time they were accepted to the accommodation scheme provided by local NGOs and they were living in better conditions in apartments in the urban area of Athens.

The scope of this research is to identify the impact of the living conditions to sexual and reproductive health of Afghan women in Greece, comparing those living in a camp, where the medical and other services are in the camp with those that recently moved in an apartment in the urban area, where the presence of available services are more many.

My interest to study and analyse Afghan women population and not Syrian or African women on the move is related to the fact that the rates of maternity deaths and neonatal deaths in Afghanistan is on the top of the world list. According to several scientific papers and testimonies from humanitarian organizations, being a woman, and more specific a pregnant woman in Afghanistan, is one of the most risky things. I choose the population of Afghan women on the move because they are coming from a country suffering for decades of war and turmoil and have led to millions of Afghan refugees seeking asylum in Europe. Women are extremely vulnerable at risks even when they are in a European country such as Greece and it is something that I would try to go in deeper analysis with this survey.

The objectives of this study are to identify the medical and social needs of women on the move through the provision of sexual and reproductive services and to find out how living conditions, cultural differences and level of access in health care services are affecting their health status.
A deeper understanding of the living conditions in refugee camps and social factors that impact on health status of women on the move would help the development of applicable and successful policies to avoid risks and life-threatening illness. Also, to reinforce other medical studies related to refugee and migrant health background to eliminate stereotypes that refugees and migrants are risk for public health through transmitted diseases.

7.2. Research Method and Data Collection

For the needs of this research I received the authorization to have access to the medical files that SRH mobile unit collected during their presence at Elliniko camp. Each medical form had a code number and not the name of the patient or other information that could reveal the identity of the person. The same procedure was followed for the patients that received SRH services in the Day Care Center in Athens.

The selection criteria were related to the date of the first visit to the mobile clinic and the DCC respectively, for the mobile clinic I collected medical files from January 2016 till April 2017 and for DCC patients from September 2016 till August 2017. Medical files were selected according to the Nationality of the patient only Afghan women were included in the research and according to place

of living. For the first group they had to be residents in one of the three structures at Elliniko broader refugee camp and for the second group they had to live in an apartment for least one month.

First group was focused on Afghan women living at Elliniko refugee camp during 2016-2017 and asked for medical support related to SRH services. According to MSF protocols SRH medical team had to keep for each patient visiting the mobile unit, standard medical history form and follow up form (English version). All medical data were collected during medical consultations from 3 midwifes and 1 gynaecologist with the presence of trained cultural mediators. All the patients were asked and agreed orally that MSF can use anonymously their medical data for medical or advocacy research and reports. More specifically the medical staff was asking for an oral consent and clarifies that giving or not their consent, will not have impact to the provided services by MSF.

Second group was focused on Afghan women living in official shelters in the urban area of Athens. We consider as an official shelter, apartments that were provided through NGOs funded from UNHCR accommodation program for asylum seekers and refugees in Greece. All of them came to MSF Day Care Center in Athens in order to be examined by SRH medical team during 2016-2017. All medical data were collected during medical consultations from 3 midwifes and 1 gynaecologist with the presence of trained cultural mediators. According to MSF protocols medical staffed used a standard medical form and follow up form (English version). All the patients were asked and agreed orally that MSF can use anonymously their medical data for medical or advocacy research and reports. More specifically the medical staff was asking for an oral consent and clarifies that giving or not their consent, will not have impact to the provided services from MSF.

For the cases under 18 years old, consent for using the data for medical research was given by their guardian.

Data collection: The medical files selected from the three unofficial refugee camps at Elliniko area, by the date of the first visit to MSF mobile unit for SRH services, from April 2016 till June 2017. The same method was followed for patients in the Day Care Center in Athens. The first step was to entry the data from the medical forms to electronic file. A unique code was given per patient without mentioning names, initials or other sensitive information that someone could identify the identity of the person.

Data quality checks were performed through a double check of 10% of the questionnaires. Also, field notes and related observations will be used for further description of the target population habits and behaviours. Data from excel file transferred to SPSS statistic program for analysis.

The indicators decided to be analysed for the purposes of this research are the following:

Nationality/ age group/ marital status/ enter point in Greece / period of entry/ sexual active /pregnancies/ deliveries/ alive/ dead/abortions/ regular period/ initial request/ diagnose/ family planning/ medical history.

The weakness of this study is related to the fact that the medical consultations took place with the support of cultural mediators in a foreign language. The different cultural and educational background among the medical staff and the patients may be affected the information given from the medical staff to the patient through the cultural mediator.
Moreover the fact that we use data from the standard MSF forms didn't allow us to add more indicators for deeper analysis of the living conditions and the impact in sexual reproductive health care issues.

7.3. Location of the Study

The medical consultations for the first group took place in the mobile clinic moving day by day at the three structures functioning as refugee camps in the broader area called Elliniko. More specific Elliniko 2 was the Arrival Building from the older National Airport, Elliniko 3 was Olympic Stadium of Baseball and Elliniko 2 was Olympic Stadium of Hockey. Elliniko region is a suburb of Athens, Greece. Since the 2011 local government reform, it is part of the municipality Elliniko-Argyroupoli, of which it is a municipal unit. Elliniko was known for the Ellinikon Olympic Complex for the summer 2004 Olympic Games, built on the grounds of the former Ellinikon International Airport. Lately was internationally known as one of the worst refugee camps and currently is sold to be transformed to Greek Riviera.

Photo 1 MSF archive Photo 2 http://www.msf.org/en/article/gallery-healthcare-refugees-elliniko-camp-athens-greece

The SRH consultations of the second group took place in MSF Day Care Center in Athens, in Exarheia region. The DCC is located down town in Athens city with easily accessible for people living in Athens urban area.

7.3.1 Day by day description of the living conditions in the three unofficial structures for refugees at Elliniko area.

Elliniko Refugee Camp is the place where the former Greek airport was located, at this area there are three Main buildings a) the Arrivals Building (Camp I) b) Olympic stadium HOCKEY (Camp II) and c) Olympic stadium BASEBALL (Camp III) , these three buildings were used us unofficial refugee camps from the authorities, from 28th of September 2015 till 2nd of June 2017. Although the three camps are mentioned us unofficial from the government, the Ministry of Migration had the management of the whole area.

During 2015 approximately 1.000.000 people passed through the Aegean Sea to the Greek islands and then to the mainland. Their passage was from the islands to Athens and then at the North Greece (Eidomeni) in order to continue their journey to other European countries. Greece government and authorities were not in a position to manage this situation. Both the government and municipality of Athens were not prepared at all to manage the large number of people arriving in the capital and cover their needs for shelter, food, safety, health care, assistance. During summer period it was easier for people to live in tents in squares and parks but when the weather started to

be rainy and cold the government decided to open Olympic stadiums to protect refugees from bad weather conditions. The government due to the bad weather conditions urgently opened TAE KWO DO Olympic stadium in order to host newcomer refugees but some weeks after there was organised a world wrestling event so they had to evacuate the stadium.

On **28th of September 2015** the government decided to move refugees in HOCKEY Stadium at Elliniko area. According to the representative of the Ministry of Migration (MOM) the capacity was 500-600 people, this was a temporary solution because the weather conditions were bad and simultaneously they were looking for other places not only in Athens but also at Thessaloniki.

The living conditions in HOCKEY camp were unacceptable, without electricity, without food services and all the toilets were out of order. The majority of people were families from Syria and Afghanistan. This time Greek – Serbian borders were open and the majority of the first residents in HOCKEY camp attempted and succeeded to continue their journey in other EU countries.

On **14th of December 2015** Deputy Minister of Migration Mr Giannis Mouzalas met the president of Central Union of Greek Municipalities (KEDE), Athens mayor and mayors from south Attica region and islands and announced them that the Greek government decided to use the former Greek Airforce facilities of Elliniko Airport into a hospitality center for refugees and migrants. The mayor of Elliniko-Argiroupoli Municipality was against that decision claiming that Greek people expect to see other projects in that area such as real estate etc. After several meetings Ministry of Migration, Mayors from municipalities of Elliniko, Alimos, Glyfada and the constructive company that the area belongs, agreed to use Elliniko area as temporary camp till end of March 2016 in order to host around 700 people.

During December and January the nationalities at HOCKEY were mostly single men from Morocco, Algeria, Somalia that they were not allowed to pass the Greek-Serbian borders, families either they crossed the borders or they transferred in Elaionas camp in Athens. Violent incidents were an everyday activity. Finally, police intervene and arrested 400 people that were making tensions they were transferred in a detention center in Korinthos city. At this moment the number of hosted people was approximately 200 in HOCKEY camp. Mr Mouzalas was assuring the mayors for one more time that until October Elliniko will be evacuated.

During the 2nd week of **February 2016** the government decided to open also the Arrivals Building at the former airport in order to host refugees because there were not available places for those that were coming from Greek islands such as Lesvos, Samos, Chios, Kos and Leros to the mainland. A lot of NGOs and volunteers were present and offering to people tea and water. The Arrivals building was totally damaged without even the basic standards to be habitable. People were sleeping in the floor only with blankets. The army was responsible for food distribution and there were many complaints from refugees about the quality of the food.

On **22th of February** the government transferred 1000 people at BASEBALL Stadium where UNHCR had placed 100 tents with ten people capacity per tent. According to the Mayor of Elliniko-Argiroupoli Municipality, BASEBALL camp does not have water supply. According to UNHCR data during February HOCKEY had 1000 people, Arrivals 1500 and Baseball 1000.

On **29th of March 2016** the government was obliged to respect the agreement with the construction companies and evacuate the area but still there were not identified new appropriate places to host those people. The situation in the three camps at Elliniko area was really bad and even worst in Arrivals building. At this moment the hosted population in the three camps were approximately 5000 people. Many NGOs and volunteers were providing mostly primary health care services but they could not cover the needs of people. At this moment tents, toilets and showers have been placed in Arrivals Camp till then people were going at the closest beach in order to have a shower. The army was still doing the food distribution.

On **11th of April 2016** the situation was still dramatic, more than 6000 of people were crowded trying to find free space at Elliniko area. Many of them placed their tents outside of the main buildings in Arrivals camp. People washing their clothes in the sea, they were preparing their tea with makeshift fire places and rubbish was stowed everywhere, kids were playing in this vast, unfriendly and full of places dangerous for accidents without any protection. Hygiene and protection issues were the biggest issues for the residents in the three camps and the wider area of the old airport.

On **19th of April 2016,** a young girl 17 years old from Afghanistan resident at Elliniko camp, passed away from unknown causes yet. She had been hospitalised at Laiko General Hospital but her parents sign a consensus paper to be discharged from the hospital, the girl went back to the camp where she was not feeling well and they transferred her again at the hospital where she died. This tragic incident was the reason that the government was convinced for the consequences these unacceptable living conditions will lead and they tried to decongest people at Elliniko area. Two hundred people from Arrival's Camp were transferred in Malakasa Camp. The Mayors of the municipalities close to Elliniko area denounce the horrible hygiene situation and that is a matter of public health.

The Greek –Serbian borders closed in May 2016 and people living in Elliniko Camps started realising they are stranded in Greece and the only way to have access in several services was to ask for asylum, otherwise their registration documents from police were valid only for 30 days, after that police could arrest them and keep them in a detention center.

The living conditions in the three camps were even worst due to tensions and violent incidents; toilets were broken offering no privacy in the showers. All tents were in the same room without fresh air. The population at Elliniko area was mixed, you could meet families, single women, single women with children, single men, drug users, people suffering from severe mental health issues. In combination with the bad living conditions, the instability and their background trauma, it wasn't a safe place especially for vulnerable cases such as women and children.

Criminality incidents were taking place almost at every day base. Police wasn't able to intervene because according to their safety protocols the number of police entering the camp should be proportionate to the number of residents and this was not possible.

To have a picture of the living conditions at Elliniko area we have to mention that every day there were 5 tonnes of rubbish. Due to lack of toilets and showers people were using the showers at the closest to the camps beach, every day they consumed twenty litre tonnes of water for having shower and wash their clothes.

During **June 2016** the Asylum Service started the pre-registration procedure in Elliniko three Camps for those who would like to request asylum in Greece or relocation or family reunification.

During July 2016, according to articles in the newspapers Greek authorities are planning to evacuate thousands of migrants From Elliniko area by the end of the month. Priority will be given to those that living in makeshift settlements (around 2500).

On **14th of July 2016,** a young Afghan men was killed in a brawl that broke out among several dozens of migrants. Police reinforcements were sent to the camp and two other migrants were also hospitalized with injuries.

During **August 2016** the approximate number of residents was 3500 people. Minister of Migration announced that it was not possible to evacuate Elliniko and this will happen in September or maximum in October.

Due to an article, journalists visited the basement in Arrivals Camp, where they found large amounts of standing water, probably from leakage in the sewage system. The smell was horrible and millions of mosquitos were flying. After that the regional department of South Attica removed stagnant water. KEELNO also visit the place and made some recommendations for protection measures to the government in order to protect public health and avoid epidemics.

On **21st of September**, the majority of the House of Parliament ratified the Convention on the former airport in Elliniko. The ratification of the Convention was one of the prerequisites for the disbursement of the tranche of 2.8 billion euros.

In September the estimated number of people at Elliniko area was 2500. According to their words the worst thing for them is boredom and uncertainty for the future. For months now, thousands of refugees have been stuck in Elliniko three Camps, which has been abandoned since 2001. Since the Greek border closed in May of this year, the people have been living in limbo. They don't know what's going to happen to them. They don't know when they can work again, or go to school again, or when they will have permanent shelter. Many of them said that they feel abandoned. Irish documentary makers The Reelists visited people living at Elliniko Airport area and ask them how they feel. It's a sharp insight into what it's actually like to live in such close proximity to thousands of other people, with minimal bathroom facilities and nothing for anyone to do all day.

October 2016

According to the official governmental data, 2,147 refugees and migrants are living at Elliniko Airport area.

Should they stay, should they move on, or should return - those stranded in the departure lounge of Greece's abandoned international airport ruminate on their options in a repetitive cycle. Many are anxiety-ridden, and some openly complain that the premises get tense, especially at night, and that the levels of friction among the residents have progressively increased. With refugees hailing from rival ethnic groups, the same communal tensions that have become pervasive in Afghanistan also erupt from time to time in this cramped holding. Most refugees at Elliniko, including those who have agreed to a "voluntary return" to Afghanistan, are already planning their onward journey. Nineteen-

year-old Suheil Rahimi, a Baloch from a village in southern Afghanistan, equates home with strife, blockades, tribal feuds and a Baloch nationalist insurgency that is as old as his country (Nallu.P. & Collins. D, 2016, Oct 3)

The majority of people living in the three Elliniko camps are from Afghanistan. It is unclear how long they will be in the camp given the government is only just starting to process asylum applications on the mainland. Afghan asylum seekers face a particularly precarious situation. Their country is now deemed "post-conflict". This means that they can be returned directly to Afghanistan (Inside the refugee camp of Elliniko, 2016, Oct 28)

November 2016

The potential closure of the camp is not only related to the fact that Afghanistan is now deemed post-conflict, but also to Greece's difficulties in sustaining the refugee population it accepted. The Greek government is straining to provide for the 57,000 refugees who indefinitely reside there. Because of this, the European Council is hoping that, with the assistance of the government of Afghanistan, will be able to provide "sustained political and financial support to Afghan peace," so that that Afghanistan will "remain on a firm path to political and economic stability, state-building and development."

But what does this discussion of closing the camp mean for the refugees currently residing in Elliniko? Some believe that this conference is just an excuse for the EU to "build a barricade against refugee flows." One individual who believes this to be the case is Electra Koutra, a Greek human rights lawyer who represents individuals in asylum cases. Koutra says that the EU is "exchanging money with returning people to unsafe places."

The closure of the refugee camp would likely cause a secondary displacement to take place. Not only have the Afghan refugees in Greece been displaced within their country, but now they would be displaced again from their asylum country. Elliniko is "one of the last remaining informal refugee settlements in Greece that is untouched by the government." The refugees in Elliniko do not get government assistance and "instead rely on aid workers and volunteers for their survival." (Sinistaj.D. 2016,Nov 15)

December 2016

Number of residents 2200

In the camps there is no heating system this has an impact at health condition of people especially for vulnerable groups such as newborns, pregnant women, children and people suffering from chronic diseases.

Eight-year-old Ali from Afghanistan, who uses a wheelchair and lives in the Elliniko camp in Athens, did not have access to an accessible toilet. "It is very difficult for us to take him to the toilets," said Ayesha, Ali's mother. "I cannot do it by myself and other women in the camp protest if my husband enters the female toilet to help me with Ali. So, we finally decided I would go to the men's toilet, with Ali and my husband helping. Then, men got angry and protested, 'Why is a woman inside a men's toilet?'" (Human Rights Watch. 2017, Jan 18).

February 2017

14.02.2017: Baseball stadium: 320, Hockey arena: 521, arrivals building: 695

Refugees blocked Mr Mouzalas (Minister of Migration) from entering Elliniko Camp. Migration Minister Yiannis Mouzalas was confronted on Monday by protesting migrants during his visit to the Elliniko Refugee Center, South of Athens. The migrants, protesting against the poor conditions at the reception center, blockaded the entrance of the site preventing the minister and police from entering the premises. According to the Movement "United Against Racism and Fascist Threat" (KEERFA), the conditions are unacceptable as mothers with infants and small children do not have basic necessities such as baby milk and diapers. Food from DRC organization is unacceptable and there is no available hot water or laundry machine. In addition, there are no interpreters, access to hospitals is very difficult and children need to be placed in schools Mr. Mouzalas was eventually allowed inside by migrants who were calling on the government to immediately satisfy the demands of refugees by improving the conditions in the Greek camp and to provide adequate housing.

"We understand the refugees' concerns, they are motivating us to do our best but the laws cannot be flouted," Migration Policy Minister Yiannis Mouzalas said in a press conference at Elliniko area. A group of camp residents had attempted to lock him out, chaining the gates to prevent him entering the camp, but were eventually persuaded to open the doors voluntarily, without police intervention. There followed a meeting between the minister and a delegation of camp residents. Mouzalas said the protestors, who were demanding better living conditions, had attempted to lock down the site and prevent supply trucks, doctors and school buses from entering the facility.

"They are not wrong to complain about the food but it's there: people are not hungry. It is hard to achieve a perfect balance," Mouzalas noted. He also pointed out that anyone who felt "oppressed" at the facility was free to leave. "Refugees can move freely, as can all Greeks," he noted. He admitted to delays in moving people out of Elliniko, which the government intended to abolish as a migrant reception centre but reported difficulties. Apart from the need to construct new reception facilities, he pointed out, there were also reactions from local communities when attempts were made to move migrants and refugees there. Strong criticism of Mouzalas' visit was voiced by the opposition Communist Party of Greece (KKE) and the Democratic Alliance parties, with the second demanding the minister's resignation.

According to Mr Mouzalas he doesn't know when Elliniko will be evacuated. But it is still a priority for the government.

March 2017-May 2017

During this period international organizations such as UNHCR, DRC and IOM in collaboration with the government were preparing those who had remain in the three camps to transfer them either in apartments for the most vulnerable cases or in another camp far away from Athens at Thiva city. Many of the residents decided to leave by their own because they didn't want to be transferred in a camp far away from Athens.

June 2017

Finally on 2nd of June 2017 Elliniko camp was evacuated and people were transferred in Thiva camp.

7.4. Ethical Issues and Limitations

This Study meets the Medicines Sans Frontiers ethics, reviewed by the Medical Coordinator and Deputy Head of Mission and approved the criteria for analysis of routinely collected program data.
Limitations related to the fact that in some medical files the handwritten wasn't legible to me so in order to avoid collecting or misinterpreted medical data I decided not to consider as valid these files. The medical files that weren't complete also were considered as invalid for the study.

8.0 Statistical Analysis Results – Discussion

8.1 Characteristics of Research population

The main purpose of this study is to identify the impact of living conditions, comparing two different types of accommodation, Refugee camp and official apartments, to sexual reproductive health status of Afghan women, recently entered Greece after a long and unsafe for their life journey.

As the main research question is what are the impacts of the type and the place of shelter at health of refugee women.

The objectives of this study are to identify the medical and social needs of women on the move through the provision of sexual and reproductive services and to find out how living conditions, cultural differences and level of access in health care services are affecting their health status.

A deeper understanding of the living conditions in refugee camps and social factors that impact on health status of women on the move would help the development of applicable and successful policies to avoid risks and life threatening illness.

The final sample was 486 Afghan women entered in Greece from January 2016 till April 2017 either from Turkey crossing with boats the Aegean Sea to Greek islands or on foot from Turkey to Northern Greek borders.

The selection criteria were related to the date of the first visit to the mobile clinic and the DCC respectively, for the mobile clinic I collected medical files from January 2016 till April 2017 and for DCC patients from September 2016 till August 2017. Medical files were selected according to the Nationality of the patient only Afghan women were included in the research and according to place of living. For the first group they had to be residents in one of the three structures at Elliniko broader refugee camp and for the second group they had to live in an apartment at least for one month.

Elliniko Refugee Camp is the place where the former Greek airport was located, at this area there are three Main buildings a) the Arrivals Building (Camp I) b) Olympic stadium HOCKEY (Camp II) and c) Olympic stadium BASEBALL (Camp III). Living conditions in camps are not good and especially in

unofficial camps such as Elliniko. People at Elliniko camp are living in abandoned Olympic Stadium without any privacy. They are using blankets as makeshifts walls to have some kind of privacy. Toilets are out of order and far from their place of living. During night women cannot use the toilet because they are afraid of sexual harassment or other types of violence. During medical consultations to SRH consultations, they usually ask for adult diapers because it was too risky to use the toilet during night. Some other discloses to our medical staff that they prefer to pie in bottles during night rather to go to the toilets. Hot water and washing machines aren't available so they cannot maintain acceptable personal hygiene.

The second category includes those women living in official apartments in the urban area of Athens city. According to what women described during medical sessions, living in an apartment is much better than in a camp but still they were facing difficulties. Many of the apartments are not in good condition and they lack of basic facilities such as heating and hot water. Some of the apartments are in the basement without natural lighting and with humidity, especially during winter time, and moldiness on the walls. Each apartment may accommodate more than one family and this can occur in tensions.

The final sample of the research is 486 Afghani women who arrived in Greece between 2016 and 2017. They came at the Greek island of the Aegean see (ie Lesvos, Chios, Samos, Kos, Leros) crossing the Eastern Sea borders with Turkey. The main reasons that these women left their countries of origin were to avoid conflicts, war and poor living conditions. Afghan Nationality (according to their declaration, without providing any official document of proof) and female sex were the main inclusive criteria of the research sample. All the participants were examined by MSF SRH medical teams in Greece and more specific from the mobile units at Elliniko unofficial camp and from the medical team working in the Day Care Center in the urban area of Athens. The place of residence was also one of the main criteria for the purposes of the research. About half of the final sample was living at the three structures of Elliniko unofficial refugee camp and the rest in official accommodation structures provided by NGOs in the urban area of Athens. As valid samples were considered those that there were living either in the camp or in an apartment for at least one month. From the survey were excluded victims of sexual violence and medical files with missing information. There was no age limit.

8.2. Statistical Analysis-Indicators

In Tables 1 to 10 the basic characteristics of the sample are presented.

- AGE of the participants

In terms of the age range in our sample, the biggest percentage belongs to reproductive health age groups, with 37,4% and 37% for age groups between 18-25 years old and 26-35, respectively. The average age is 28,1 years old.

Table 1: Participants Age groups

Table 1		N (%)
Age category	*12-17*	32 (6,6)
	18-25	182 (37,4)

	26-35	180 (37,0)
	36-45	73 (15,0)
	>45	19 (3,9)
Age (Mean(sd))		28,1 (8,86)

- Marital status

Concerning the marital status of our sample the initial categorization was in four categories such as married, widow, single and currently separated/divorced. For a better analysis we create two categories, those married and those not married. The vast majority of our sample are married (80%). (table 2)

Table 2: Marital Status of the participants

Table 2		N (%)
Marital status	*Married*	389 (80,0)
	Widow	16 (3,3)
	Single	53 (10,9)
	Divorced/Separated	28 (5,8)

- Enter point in Greece

The vast majority of our sample entered Greece by boat from Turkey coasts, crossing the Aegean and reaching a Greek island (89,1%). A very small percentage (4,5%) entered Greece using the land route from the Northern Greek – Turkey borders. What is impressive is the percentage of N/A category (6,4%) that describes the inability of women to respond to this question. The medical team was trying to ask more focused questions, such as "during the trip have you entered in a boat?", but even in such questions they weren't able to respond certainly. Some of them answered that their husband knows and they could ask them.

Table 3: Enter point in Greece

Table 3		N (%)
Enter point	*Island*	433 (89,1)
	North	22 (4,5)
	N/A	31 (6,4)

- Type of shelter

The type and the location of shelter is the main indicator for this research. Final categorization includes two categories: the first category includes women living in the unofficial refugee camp called Elliniko far from the urban area and the second includes women living in official structures, such as apartments in the urban are of Athens provided by UNHCR.55,1% of our sample were living

in the unofficial refugee camp Elliniko and 44,9% were living in official shelters (apartments).Table 4: Type of accommodation for the participants

Table 4		N (%)
Shelter	*Elliniko Refugee camp 1*	69 (14,2)
	Elliniko Refugee camp 2	102 (21,0)
	Elliniko Refugee camp 3	97 (20,0)
	Official Shelter	218 (44,9)
Final Shelter type	*Elliniko Refugee camp*	268 (55,1)
	Official Shelter	218 (4,9)

- Sexual Activity

As we can see on table 5 the vast majority of our sample are sexually active (78,6%). Whereas 11,5% declare no sexual active and 9,9% virgin.

Table 5: Sexual activity of the participants

Table 5		N (%)
Sexual active	*Yes*	382 (78,6)
	Virgin	48 (9,9)
	No	56 (11,5)

- Pregnancy related variables

For **pregnancies rates** of our sample four categories were created to better describe the results. The first category 0, describes those women that are sexual active and till the moment that the consultation took place they haven't ever got pregnant. Second category includes those women that got pregnant at least one time to 3 pregnancies. Third category includes women that got pregnant at least four times. Fourth category N/A describes women that till the medical consultation had no sexual activity so it wasn't possible to get pregnant. The biggest percentage (56,3%) of our sample belongs to the second category with pregnancy rate 1-3. Equally important is also the percentage (33,7%) of the women with four or more pregnancies. From the statistics derives that the average of pregnancies per women for our sample is approximately 3 pregnancies.(Table 6).

Concerning the **type of delivery**, four categories were created. First category includes women which deliver vaginally their babies and they consist the biggest percentage of the total sample of the research (58,2%), second category includes women which deliver their babies with caesarean-section (14%) third category includes women that delivered during different pregnancies with both types (vaginally and caesarean-section)and. Finally the fourth category N/A includes women without sexual activity till the moment of the medical consultation and women that have never got pregnant or those that may have got pregnant but they had a miscarriage during the first trimester of pregnancy or an abortion (Table 6)

The indicator number of **alive children** per women is analysed in four categories. Among the participating women, 11 (2,3%) had 0 alive children due to miscarriage, abortion, uterus death or postnatal death. In cases of more than one pregnancy it might be all the above mentioned reasons. The average number of alive children per women is 2,82 comparing it to the average of pregnancies per women 3,05, is lower this result is explained by the fact that some of the pregnancies maybe terminated or were uncomplete or a postnatal death happened. (Table 6)

For better analysis of the data we concluded in three categories for the indicator describing the **reason of uncomplete pregnancies** and cases of postnatal deaths (under 5 years old). The first category NO, includes women that at least one time in their life got pregnant and they haven't experienced miscarriage, abortion, uterus death and postnatal death (children under 5 years old) and constitute the biggest percentage of our sample (56,6%). The second category with 28,6% includes all women that have experienced one or more miscarriage/s and/or abortion/s and/or uterus death/s and/or postnatal death/s (children under 5 years old). Third category includes those women that haven't been pregnant yet.

Table 6: Pregnancy related variables

Table 6		N(%)
Pregnancies categorical	*0*	44 (10,0)
	1-3	249 (56,3)
	>=4	149 (33,7)
	N/A	44 (19,1)
Pregnancies (Mean (sd))		3,05 (2,19)
Type of Delivery	*Vaginal*	283 (58,2)
	C/S (caesarean-section)	68 (14,0)
	Both	34 (7,0)
	N/A	101 (20,8)
Number of Alive Children per woman	*0*	11 (2,3)
	1-3	275 (56,6)
	>=4	107 (22,0)
	N/A	93 (19,1)
Alive (Mean (sd))		2,82 (1,73)
Dead abortions grouped	*No*	246 (50,6)
	Yes (miscarriage/abortion/uterus death/postnatal death)	139 (28,6)
	N/A	101 (20,8)

- Women regular period

The vast majority of the women have regular period (60,9%). As regular or normal we could consider also those that are pregnant (9,1%) and those that are Breast feeding (6,2%). 20,2% of the sample don't have regular period.

Table 7: Categorization related to regular period

Table 7		N(%)
Regular period	*Yes*	296 (60,9)
	Not yet	3 (0,6)
	No	98 (20,2)
	Menopause	15 (3,1)
	Breast feeding	30 (6,2)
	Pregnant	44 (9,1)

- Initial Request to the SRH medical team

One of the main questions to the women by the medical staff was about the reason they visited the SRH team. It was difficult to categorize all 486 requests in a few categories in order to have better understanding. Moreover some of the women had expressed more than one request during their first visit. We created two different indicators REQUEST 1 and REQUEST 2, from the data collection of both indicators, derived 11 categories (Family planning, Family planning, Genital infection, Other, Family planning/genital infection, Genital infection/ other, Genital infection/ menstrual disorders, Other/ menstrual disorders, Follow-up pregnancy, Follow-up pregnancy/ family planning, Menstrual disorders, Menstrual disorders/ family planning). For better analysis we grouped some of the categories and we agreed on six final categories. More specifically 34,5% of the women came complaining for genital infections, 24,5% mentioned menstrual disorders, (14,7%) asked for family planning related issues, 9,1% asked for follow-up their pregnancy and 5,1% had more than one request (usually combination of genital infections, menstrual disorders and family planning). The rest 12,1% includes requests for other issues such as breast pain, back pain or irrelevant to the SRH team duties. (Table 8)

Table 8: Initial Request to the SRH team

Table 8		N(%)
Patients Request	*Family planning*	69 (14,7)
	Genital infection	162 (34,5)
	Other	57 (12,1)
	More than 1 request	24 (5,1)
	Follow-up pregnancy	43 (9,1)
	Menstrual disorders	115 (24,5)

- Diagnoses

The medical staff made several diagnoses for each woman. Sometimes the diagnoses were more than one medical issue for the same patient. The initial categorization constitutes from eight categories: Genital infection, Menstrual disorders, Normal, Other gynaecological issue, Pregnancy, STIs, Urinary tract infection. For better analysis we grouped them in five categories, considering pregnancy as normal situation. Additionally, UTI considered as genital infection and menstrual disorders were added to Other Gynaecological issues. Sexual transmitted infectious (STI) included also Human papillomavirus infection (HPV) and hepatitis B positive cases. From this final

categorization we have the following interesting results: 41,2% of the sample has been diagnosed as normal in terms of sexual reproductive health. 26,7% of the sample was diagnosed with genital infections (UTI, candida). The 18,9% of the sample was diagnosed with STIs, (Chlamydia, Gonorrhoea, Trichomonas, HPV). The rest 12,6% were diagnosed with other medical issues such as menstrual disorders and other obstetric issues (ovary cysts, polypus etc). (Table 9)

Table 9: Final diagnoses

Table 9		N(%)
Final diagnose grouped	*Other medical issue*	61 (12,6)
	Normal	200 (41,2)
	Infectious/STIs	92 (18,9)
	Genital infection/UTI	130 (26,7)
	Refused examination	3 (0,6)

- Family planning methods

The initial categories to analyse family planning methods were eight; one category for each method. (TOP according to WHO 2017 is considered as a family planning method, in one hand MSF gives access for women to safe TOP on the other hand medical teams don't promote it as a family planning method). Many women of the sample were requesting implants or injected contraception methods that are commonly used in their country of origin, but these two methods are not available in Greece. So they had to choose between condoms, pills, IUD and TOP. Surgical sterilization cases occured in their country of origin. As we can see the majority of the women prefer IUD method instead of other available methods in Greece. According to what women mentioned, IUD is more preferable because it lasts for five years and needs sporadic check-up. Condoms use (12,9%) seems that is not a favourable method among women because they had to convince their husbands to use them and culturally is not well approved. Using pills is a method that 25,2% women agreed to follow. Pill method needs consistency in the way of this treatment and women in the move are not able to follow such procedures. One other fact is that pills are not a widespread method in their country and many women came back to the SRH team because they lost the pills, they forgot to take it in a daily base or they weren't able to follow the instructions of the SRH team. Interesting is the percentage of women asked for TOP (6,8%) because of unwanted pregnancy. SRH team, when it was possible, facilitated their access to safe TOP. Finally, 1,4% came to ask support after having sex without protection, afraid of getting pregnant and emergency contraception was provided to them. In both cases the SRH team proposed the other available options of contraception, such as IUD, pills and condoms. For better analysis we grouped these eight categories into two categories, the first is YES for those women used a contraception method (30,2%) and the second NO, for those that they don't use contraception methods (69,8%). (Table 10)

Table 10: Family planning methods

Table 10		N(%)
Family planning	*Condoms*	19 (12,9)
	Emergency contraception	2 (1,4)
	Implant contraception	1 (0,7)

	Injected contraception	2 (1,4)
	IUD	60 (40,8)
	Pills	37 (25,2)
	Surgical sterilization	16 (10,9)
	TOP	10 (6,8)
Family planning grouped	*Yes*	147 (30,2)
	No	339 (69,8)

- Characteristics/Trends between the two groups, those living in the camps and those living in official shelters. (Table 11)

In Table 11 we can see that those living at Elliniko refugee camp are sexual active comparing to those living in shelters (p=0,033). Related to regularity in women period those living at Elliniko camp it seems that facing more issues with their period comparing to those living in shelters (p 0,004). Those that live at Elliniko are visit medical services complaining mostly for genital infectious (66,7%) and menstrual disorders (54,8%) comparing to those living in shelters who visit medical services asking for follow up pregnancy (60,5%) and family planning (50,7%) services (p <0,001). There are, also, significant differences in final diagnose between wome living in Elliniko camp and shelters (p <0,001). Those living at Elliniko refugee camp are mainly diagnosed with STIs/Infectious (79,3%), whereas only 20,7% of the women living at shelters are diagnosed with STIs/Infectious. Also more women living in shelters are considered as normal (58%) comparing with those living at Elliniko camp (42%). Those living at Elliniko camp seem to have better access in lab tests comparing to those live in shelters. Maybe the provision of lab tests is not available in the Elliniko camp in contrast with the available lab test services in the urban area where the shelters are.

There is not significant difference concerning age, number of deliveries per women, alive children per women between those living in Elliniko camps and shelters. The fact that the above mentioned indicators are not significant is important because it means that our sample in both types of living facilities has homogeneous without deviations in their basic profile indicators.

Table 11: Characteristics/Trends between the two groups, those living in the camps and those living in official shelters.

Table 11		**Elliniko**	**Shelter**	
		N(%)	**N(%)**	**P-value**
Marital status	*Married*	218 (56,0)	171 (44,0)	**<0,001**
	Not married	50 (51,5)	47 (48,5)	
Enter point	*Island*	245 (56,6)	188 (43,4)	**<0,001**
	North	2 (9,1)	20 (90,9)	
	N/A	21 (67,7)	10 (32,3)	
Sexual active	*Yes*	199 (52,1)	183 (47,9)	**0,033**
	Virgo	31 (64,6)	17 (35,4)	
	No	38 (67,9)	18 (32,1)	
Age category	*12-17*	22 (68,8)	10 (31,3)	0,389
	18-25	105 (57,7)	77 (42,3)	
	26-35	94 (52,2)	86 (47,8)	

	36-45	37 (50,7)	36 (49,3)	
	>45	10 (52,6)	9 (47,4)	
Deliveries	*Vaginal*	156 (55,1)	127 (44,9)	0,294
	C/S	31 (45,6)	37 (54,4)	
	Both	21 (61,8)	13 (38,2)	
	N/A	59 (59,0)	41 (41,0)	
Regular period final	*Yes*	148 (50,0)	148 (50,0)	**0,004**
	No	120 (63,2)	70 (36,8)	
Request final	*Family planning*	34 (49,3)	35 (50,7)	**<0,001**
	Genital infection	108 (66,7)	54 (33,3)	
	other	15 (26,3)	42 (73,7)	
	More than 1 request	24 (100,0)	0 (0,0)	
	Follow-up pregnancy	17 (39,5)	26 (60,5)	
	Menstrual disorders	63 (54,8)	52 (45,2)	
Pregnancies	*0*	26 (59,1)	18 (40,9)	0,737
	1-3	133 (53,4)	116 (46,6)	
	>=4	82 (55,0)	67 (45,0)	
	N/A	27 (61,4)	17 (38,6)	
Pregnancies (Mean				0,937
Alive categorical	*0*	7 (63,6)	4 (36,4)	0,630
	1-3	149 (54,2)	126 (45,8)	
	>=4	56 (52,3)	51 (47,7)	
	N/A	56 (60,2)	37 (39,8)	
Alive (Mean (sd))				0,965
Dead abortions	*No*	122 (49,8)	123 (50,2)	**0,031**
	Yes (miscarriage/abortion/death)	80 (57,6)	59 (42,4)	
	N/A	66 (64,7)	36 (35,3)	
Family planning	*Yes*	73 (49,7)	74 (50,3)	0,109
	No	195 (57,5)	144 (42,5)	
Final diagnose	*Other medical issue*	43 (70,5)	18 (29,5)	**<0,001**
	Normal	84 (42,0)	116 (58,0)	
	Infectious/STIs	73 (79,3)	19 (20,7)	
	Genital infection/UTI	65 (50,0)	65 (50,0)	
Tests final	*Lab tests*	109 (43,3)	143 (56,7)	**<0.001**
	Clinical examination	158 (67,8)	75 (32,2)	

- Sample characteristics by final diagnose of the sample (Table 12)

According to the analysis it seems that there are statistically significant differences in the final diagnosed between the two types of shelter. Residents at Elliniko camp are more diagnosed with Infectious/STIs (27,5%) comparing to those live in shelters (8,7%). Over half of those living at shelters (53,2%) are diagnosed as normal comparing to those at Elliniko camp (31,7%). Related to the marital status,t 43,7% of the married ones are diagnosed as normal (related to SRH issues) and 21,2% have Infectious/STIs, compared to singles (32,3% and 10,4%, respectively). At this point just its worth to mention that pregnancy is considered as normal situation that's why married women present bigger percentages. Concerning STIs maybe is more often among married women, because they are sexual active in contrast with those not married that are more likely to be not sexually active (virgin,

widows, divorced/separated). On the other hand, 39,6% of not married women were diagnosed with genital infections/UTI compared to married (23,8%). Maybe not married women are younger and they are not aware of hygiene tips or are older and they face more complex medical issues that have as side effects genital or UTI infections. Related to sexual activity, 23,3% of those with no sexual activity were diagnosed as normal whereas the corresponding percentages for to sexual active and virgin are 43,9% and 42,6%, respectively. Obviously, sexual active women have STIs/Infectious in much higher percentage than virgin. What is interesting is the percentage of those with declared no sexual activity (21,4%)that are diagnosed with STIs/Infectious comparing to those that are sexual active (20,8%). This maybe happens because those with no current sexual activity probably didn't know they had been infected from previous partners/husbands or they didn't disclose to the SRH team because of shame that they are currently sexually active. 36,2% of virgin, 24,5% of sexual active and 35,7% of those not sexual active were diagnosed with genital infections . Maybe this can be explained by the fact that virgin are too young and not aware about hygiene tips and methods. There is statistical significant difference among age groups by final diagnose. Only 29,3% of women >35 years old are diagnosed as normal. Additionally, 14,1% of women >35 years old and 27,5% of women aged 26-35 years old were diagnosed with STIs/Infectious. Younger and older women are diagnosed more frequently with genital infectious instead of those that are in middle age groups.

62,3% of women who came to SRH team with an initial request for family planning, 93% of those who came for follow-up pregnancy, 56,5% of those with menstrual disorders and 45,6% of those with other request, were diagnosed as normal comparing with those whose initial request was genital infections (9,4%) and more than one requests (16,7%). Those women came with initial request as genital infections and with more than one request are diagnosed with STIs/Infectious comparing to women requested something related to the other categories. Those came with initial request genital infectious are diagnosed with genital infectious/UTI (55,3%).

It seems that women with less pregnancies during their life are been diagnosed as normal comparing to those that had many pregnancies. Women which haven't get pregnant yet are diagnosed with genital infections/UTI (38,6%) comparing to those that have been pregnant at least one time in their life. Comparing the type of deliveries women delivered vaginally are diagnosed as normal (39%) instead of those that diagnosed with Other issues, STIs and Genital infections.

Family planning and entry point seems to be insignificant with the final diagnose. What we can notice is that women using a family planning method are diagnosed as normal (44,9%). Concerning the entry points, women entering Greece from the North are facing genital infection/UTI issues comparing those entered at the islands.

Table 12: Sample characteristics by final diagnose of the total sample

Table 12			
		Final diagnose grouped	**p-value**

		Other medical issue [N(%)]	Normal [N(%)]	Infectious/ STIs [N(%)]	Genital infection/ UTI [N(%)]	
Family planning	*Yes*	19 (12,9)	66 (44,9)	32 (21,8)	30 (20,4)	0,188
	No	42 (12,4)	134 (39,5)	60 (17,7)	100 (29,5)	
Type of shelter	*Elliniko*	43 (16,2)	84 (31,7)	73 (27,5)	65 (24,5)	**<0.001**
	Shelter	18 (8,3)	116 (53,2)	19 (8,7)	65 (29,8)	
Marital status	*Married*	44 (11,4)	169 (43,7)	82 (21,2)	92 (23,8)	**0,001**
	Not married	17 (17,7)	31 (32,3)	10 (10,4)	38 (39,6)	
Enter point	*Island*	54 (12,6)	176 (40,9)	82 (19,1)	118 (27,4)	0,855
	North	1 (4,5)	9 (40,9)	3 (13,6)	9 (40,9)	
	N/A	6 (19,4)	15 (48,4)	7 (22,6)	3 (9,7)	
Sexual active	*Yes*	41 (10,8)	167 (43,9)	79 (20,8)	93 (24,5)	**0,001**
	Virgin	9 (19,1)	20 (42,6)	1 (2,1)	17 (36,2)	
	No	11 (19,6)	13 (23,2)	12 (21,4)	20 (35,7)	
Age category	*12-17*	4 (12,5)	15 (46,9)	2 (6,3)	11 (34,4)	**<0,001**
	18-25	19 (10,5)	99 (54,7)	28 (15,5)	35 (19,3)	
	26-35	19 (10,7)	59 (33,1)	49 (27,5)	51 (28,7)	
	>35	19 (20,7)	27 (29,3)	13 (14,1)	33 (35,9)	
Age						**0,001**
Regular period	*Yes*	26 (8,8)	104 (35,4)	64 (21,8)	100 (34,0)	**<0,001**
	No	35 (18,5)	96 (50,8)	28 (14,8)	30 (15,9)	
Initial Request	*Family planning*	6 (8,7)	43 (62,3)	11 (15,9)	9 (13,0)	**<0,001**
	Genital infection	4 (2,5)	15 (9,4)	52 (32,7)	88 (55,3)	
	Other	12 (21,1)	26 (45,6)	4 (7,0)	15 (26,3)	
	More than 1	2 (8,3)	4 (16,7)	14 (58,3)	4 (16,7)	
	Follow-up pregnancy	0 (0,0)	40 (93,0)	2 (4,7)	1 (2,3)	
	Menstrual disorders	29 (25,2)	65 (56,5)	8 (7,0)	13 (11,3)	
Pregnancies	*0*	8 (18,6)	18 (41,9)	8 (18,6)	9 (20,9)	**0,011**
	1-2	16 (10,5)	72 (47,4)	24 (15,8)	40 (26,3)	
	>=3	29 (11,9)	91 (37,3)	60 (24,6)	64 (26,2)	
	N/A	8 (18,2)	19 (43,2)	0 (0,0)	17 (38,6)	
pregnancies						0,128
Alive	*0*	3 (27,3)	5 (45,5)	3 (27,3)	0 (0,0)	**0,007**
	1-3	24 (8,8)	116 (42,3)	62 (22,6)	72 (26,3)	
	>=4	18 (17,0)	36 (34,0)	20 (18,9)	32 (30,2)	
	N/A	16 (17,4)	43 (46,7)	7 (7,6)	26 (28,3)	
Alive						0,165
Miscarriage, abortions	*No*	25 (10,3)	101 (41,6)	52 (21,4)	65 (26,7)	**0,056**
	Yes	20 (14,4)	53 (38,1)	32 (23,0)	34 (24,5)	
	N/A	16 (15,8)	46 (45,5)	8 (7,9)	31 (30,7)	
Deliveries	*Vaginal*	35 (12,4)	110 (39,0)	64 (22,7)	73 (25,9)	**0,032**
	C/S	2 (3,0)	32 (47,8)	12 (17,9)	21 (31,3)	
	Both	6 (17,6)	11 (32,4)	7 (20,6)	10 (29,4)	

	N/A	18 (18,2)	46 (46,5)	9 (9,1)	26 (26,3)	

- Analysis comparing family planning status (table 13)

91,1% of women with no sexual activity and 97,9% of virgin and 63,1% of sexual active women don't use family planning methods. 0% of the women aged 12-17 years, 29,7% of those aged 18-25 years, 37,2% of those aged 26-35 years, 31,5% of those aged 36-45 years and 15,8% of those aged >45 years are using family planning methods. Is also statistically significant the relation between family planning and regular period. It seems that women in these categories pregnant, menopause and YES do not participate in family planning. What is also important is the percentage of women that are breastfeeding (43,3%) are using family planning method instead of (56,7%) that are not using.

Related to women's initial request it seems statistically significant , women with initial request family planning methods (88,4%) at the end they use one family planning method umber of Pregnancies seems to be significant as the percentage of NO is getting smaller as the number of pregnancies is bigger (p value <0.001).

Related to the type of deliveries it seems that only women that experienced both ways (55,9%) (p value <0.001) are participating in family planning methods comparing to those that experienced vaginally (36%) or caesarean-section (26,5%).

Table 13: Comparing those who use family planning methods and those who don't use in relevance with samples characteristics.

Table 13				
		Family planning grouped		**p-value**
		Yes [N(%)]	**No [N(%)]**	**<0,001**
Marital status	*Married*	135 (34,7)	254 (65,3)	
	Widow	2 (12,5)	14 (87,5)	
	Single	5 (9,4)	48 (90,6)	
	Divorced/ Separated	5 (17,9)	23 (82,1)	
Enter point	*Island*	129 (29,8)	304 (70,2)	0,790
	North	7 (31,8)	15 (68,2)	
	N/A	11 (35,5)	20 (64,5)	
Sexual active	*Yes*	141 (36,9)	241 (63,1)	**<0.001**
	Virgo	1 (2,1)	47 (97,9)	
	No	5 (8,9)	51 (91,1)	
Age category	*12-17*	0 (0,0)	32 (9,4)	**0,001**
	18-25	54 (29,7)	128 (70,3)	
	26-35	67 (37,2)	113 (62,8)	
	36-45	23 (31,5)	50 (68,5)	
	>45	3 (15,8)	16 (84,2)	
Age				**0,031**
Regular period	*Yes*	106 (35,8)	190 (64,2)	**<0,001**
	Not yet	0 (0,0)	3 (100,0)	
	No	26 (26,5)	72 (73,5)	
	Menopause	1 (6,7)	14 (93,3)	
	Breast feeding	13 (43,3)	17 (56,7)	

	Pregnant	1 (2,3)	43 (97,7)	
Initial Request	*Family planning*	61 (88,4)	8 (11,6)	**<0,001**
	Genital infection	37 (22,8)	125 (77,2)	
	other	13 (22,8)	44 (77,2)	
	More than 1 request	8 (33,3)	16 (66,7)	
	Follow-up pregnancy	0 (0,0)	43 (100,0)	
	Menstrual disorders	21 (18,3)	94 (81,7)	
Pregnancies categorical	*0*	4 (9,1)	40 (90,9)	**<0.001**
	1-3	81 (32,5)	168 (67,5)	
	>=4	61 (40,9)	88 (59,1)	
	N/A	1 (2,3)	43 (30,7)	
Pregnancies				**<0.001**
Alive categorical	*0*	3 (27,3)	8 (72,7)	**<0.001**
	1-3	90 (32,7)	185 (67,3)	
	>=4	48 (44,9)	59 (55,1)	
	N/A	6 (6,5)	87 (93,5)	
Alive				**0,009**
Dead abortions grouped	*NO*	89 (36,3)	156 (63,7)	**<0.001**
	Yes (miscarriage/abortion/death)	51 (36,7)	88 (63,3)	
	N/A	7 (6,9)	95 (93,1)	
Final diagnose grouped	*Other medical issue*	19 (31,1)	42 (68,9)	0,191
	Normal	66 (33,0)	134 (67,0)	
	Infectious/STIs	32 (34,8)	60 (65,2)	
	Genital infection/UTI	30 (23,1)	100 (76,9)	
	Refused examination	0 (0,0)	3 (100,0)	
Type of shelter	*Elliniko*	73 (27,2)	195 (72,8)	0,109
	Shelter	74 (33,9)	144 (66,1)	
Tests final	*Lab tests*	62 (24,6)	190 (75,4)	**0,004**
	Clinical examination	85 (36,5)	148 (63,5)	
Deliveries	*Vaginal*	102 (36,0)	181 (64,0)	**<0.001**
	C/S	18 (26,5)	50 (73,5)	
	Both	19 (55,9)	15 (44,1)	
	N/A	8 (8,0)	92 (92,0)	

- Binomial logistic regression was performed to ascertain the effects of marital status (divorced/separated, married, widow, single), sexual active (yes, virgo, no), age (continuous), regular period (yes, no), alive (N/A, 0, 1-3, >=4), type of shelter (shelter, elliniko), deliveries (vaginal, C/S, both, N/A) on the likelihood that Afghan women not participate in family planning (Table 14).

Women living in shelters are more likely to participate in family planning (p value ,034),(OR: 1,67, CI: 1,04-2,69) compared to women living at Elliniko camp. Deliveries significantly predicted the participation in family planning (p-value: 0,051), but only women who performed both deliveries (vaginal and C/S) (p value 0,034) were more likely to participate in family planning (OR: 2,63, CI: 1,15-6,02) compared to women who had a vaginal delivery.

Women that perform clinical examinations are more likely to participate in family planning (OR: 2,42, CI: 1,52-3,85) compared to women that perform lab tests. Maybe those women needed to do medical tests were facing more serious medical issues or according to their medical history had firstly to do lab tests in order to check which family planning method is the best for them.

The alive children born, significant predicted the participation in family planning (p-value: 0,002), but none of the subcategories statistically significant predicted the participation in family planning. Maybe there is a difference in those who didn't answer the question.

Marital status significantly predicted the participation in family planning (p-value: 0,054). Specifically, single women were much more likely to participate in family planning (p-value 0,007), (OR: 16,446, CI: 2,19 – 123,65), than divorced /separated women. This result is very important because it is connected with cultural issues, if a single woman will get pregnant without being married, she is at risk of being persecuted or even murdered, that's why single women tend to participate more in family planning methods.

As the age increases, the women participate significantly less in family planning (OR: 0,93, CI: 0,894 – 0,97).

Those who are not sexually active and virgin are less likely to participate in family planning (virgin: OR: 0,017, CI: 0,001-0,21, not sexually active: OR: 0,15 CI: 0,041- 0,55).

Finally, those who have regular period are more likely to participate in family-planning (OR: 1,73, CI: 1,08 – 2,78).

Table 14: Participation in family planning methods in relevance with type of shelter, type of test, type of delivery, number of alive children, marital status, sexual activity and regular period.

TABLE 14		
Variables	p-value	Odds ration (95% C.I.)
Type of shelter (Shelter)	**,034**	1,671 (1,040 – 2,686)
Type of Test (Clinical examination)	**,000**	2,420 (1,521 – 3,852)
Type of delivery (Vaginal)	**,051**	
C/S	,201	,658 (0,346 – 1,250)
Both	**,022**	2,631 (1,150-6,019)
N/A	,649	,495 (0,024 – 10,197)
Alive (N/A)	**,002**	
0	,399	2,425 (0,310 – 18,995)

1-3	,390	4,071 (0,166 – 99,734)
>=4	,114	13,818 (0,532 – 359,036)
Marital status (Divorced/Separated)	**,054**	
Married	,293	1,907 (0,572 – 6,358)
Window	,281	3,295 (0,378 – 28,726)
Single	**,007**	16,446 (2,188 – 123,648)
Age	**,001**	,932 (0,894 – 0,972)
Sexual activity (Yes)	**,001**	
Virgo	**,002**	,017 (0,001 – 0,213)
No	**,004**	,150 (0,041 – 0,552)
Regular period (Yes)	**,023**	1,730 (1,077 – 2,778)
Constant	,334	,174

- A logistic regression was performed to ascertain the effects of marital status (divorced/separated, married, widow, single), age (continuous), regular period (yes, no), type of shelter (shelter, elliniko), tests final (clinical examination, lab tests) on the likelihood Afghan women have related to final diagnose.

For better analysis of the model with independent indicator the final diagnose, we decided to group the categories into two categories with codification YES, NO more specifically NO=(normal, other medical issue) and Yes = (infectious/STIs, genital infection/UTI)), for the needs of the analysis we excluded the three samples which had refused examination.

Women living at Elliniko are 2,13 times more likely to have STIs or genital infection (OR: 2,13, CI: 1,41-3,22) compared to women living in Shelters. Women that performed lab tests were less likely to have STIs or genital infections (OR: 0,66, CI: 0,44-0,98) compared to women that performed clinical examination. Maybe this is because STIs and genital infectious can be identified from clinical examination and the doctor didn't apply lab tests in contrast with those women needed to do lab tests in order medical team to be able to give a diagnose. Women with regular period are 3,37 times more likely to have STIs or genital infections (OR: 3,37, CI: 2,23-5,10) . Maybe this is related also with the fact that the percentage of women with regular period identified mostly in shelters, so we could make a hypothesis that women living in shelters are at lower risk of STIs and genital infections. Married women were less likely to have STIs or genital infections (OR: 0,43, CI: 0,19 – 0,99). Maybe

the fact of being married (culturally is not allowed women to have out of marriage relations) and their priority is to look after their children are two of the reasons of this result. (Table 15)

Table 15: Checking the impact of the type of shelter, type of test, age, regular period and marital status to the final diagnose

Table 15			
Variables		**P value**	**Odds ratio (95% C.I.)**
	type of shelter (Elliniko)	**,000**	2,13 (1,41 – 3,22)
	Type of tests (lab tests)	**,038**	,66 (0,44 – 0,98)
	Age	,102	1,02 (0,99 – 1,05)
	regular period final (Yes)	**,000**	3,37 (2,23 – 5,10)
	Marital Status (Divorced/Separated)	,076	
	Marital Status (Married)	**,048**	,430 (0,19 – 0,99)
	Marital Status (Widow)	,755	1,25 (0,31 – 5,09)
	Marital Status (Single)	,062	,37 (0,13 – 1,05)
	Constant	,128	,396

8.3 Discussion

The main purpose of this study was to identify the impact of living conditions, comparing two different types of accommodation, Refugee camp and official apartments, to sexual reproductive health status of Afghan women, recently entered Greece after a long and unsafe for their life journey.

The final sample was 486 Afghan women which visited and examined by MSF SRH medical teams. The biggest percentage of our sample belongs to reproductive health age groups, with 37,4% and 37% for age groups between 18-25 years old and 26-35 respectively. The average age was 28,1 years old for both groups (those living in a camp and those living in official shelter). The vast majority of our sample were married (80%) and entered Greece by reaching one of the Greek islands crossing the Aegean Sea by boat from Turkey coasts (89,1%).

The type and the location of accommodation structure was the main variable for this research. So, we decided to analyse women living in the unofficial refugee camp called Elliniko and women living in official apartments in the urban area of Athens city. 55,1% of our sample were living in the unofficial refugee camp Elliniko and 44,9% were living in official shelters (apartments).

The majority of our sample were sexually active (78,6%). From the statistics derives that the average of pregnancies per women for our sample is approximately 3 pregnancies till her current life. Concerning the type of delivery women which delivered vaginally their babies have the biggest percentage of the total sample of the research (58,2%). The average of alive children per women is 2,82 comparing it to the average of pregnancies per women 3,05, is lower.

The biggest percentage of our sample hasn't experienced uncomplete pregnancy or postnatal deaths (under 5 years old) (56,6%). On the other hand (28,6%) of the sample experienced one or more miscarriage and/or abortion and/or uterus death and/or postnatal death (under 5 years old). The vast majority of the women have regular period (60,9%). As regular or normal we could consider also those that are pregnant (9,1%) and those that are Breast feeding (6,2%). 20,2% of the sample don't have regular period

The main reason women claiming during their first visit (34,5%) was related with genital infections, 24,5% mentioned menstrual disorders and (14,7%) asked for family planning related issues. The biggest part of the sample 41,2% was diagnosed as normal in terms of sexual reproductive health. 26,7% of the sample was diagnosed with genital infections (UTI, candida) and the 18,9% of the sample was diagnosed with STIs, (Chlamydia, Gonorrhoea, Trichomonas, HPV). The rest 12,6% were diagnosed with other medical issues such as menstrual disorders and other obstetric issues (ovary cysts, polypus etc).

Related to family planning methods, many women of the sample were requesting implants or injected contraception methods that are commonly used in their country of origin, but these two methods are not available in Greece. So, they had to choose between condoms, pills, IUD and TOP. Surgical sterilization cases happened in their country of origin. As we can see the majority of the women prefer IUD method instead of the other available methods in the Greek market. According to what women mentioned IUD is preferable because it lasts for five years and needs sporadic check-up. Condoms 12,9% it seems that is not a method that women prefer because they have to convince their husbands to use that method and culturally is not well approved. Using Pills is a method that 25,2% women agreed to follow, pill method needs consistency in the way of this treatment and women in the move are not able to follow such procedures. One other fact is that pills is not a widespread method in the country, many women came back to the SRH team because they lost the pills, they forgot to take it in a daily base or they weren't able to follow the instructions of the SRH team. Interesting is the percentage of women asked for TOP (6,8%) because of unwanted pregnancy, SRH team when it was possible facilitate their access to safe TOP. From the statistics derives that women used a contraception method (30,2%) are less comparing to those that they don't use contraception methods (69,8%).

From the analysis we see that women living at Elliniko refugee camp are having limited sexually activity comparing to those living in shelters (p 0,033). Related to regularity in women period those living at Elliniko camp it seems that facing more issues with their period comparing to those living in shelters (p 0,004). This maybe happens due to the instability of their life and due to the fact that their health is not in a good situation, after the long journey they followed and also the bad living conditions in their country of origin. Women living at Elliniko are more possible to visit medical services complaining for genital infectious (66,7%) and menstrual disorders (54,8%) comparing to those living in shelters who visit medical services asking for follow up pregnancy (60,5%) and family planning (50,7%) services (p <0,001). This maybe happens because genital infectious might be related with the terrible living conditions in the camp. Access to toilets and hot water was limited in the camp, women preferred to go to the close beach at Elliniko in order to have a shower and wash their clothes. Toilets were out of the camp in a remote area, women toilets were next to men toilets

without privacy. Women were afraid to use the toilets and this had as a result bad hygiene that might lead to genital infections and UTI.

According to the statistics it seems more likely for women living at Elliniko refugee camp to be diagnosed with STIs/Infectious (79,3%) comparing to those living at shelters (20,7%). It has been already mentioned in several papers that people on the move are forced to survival sex or are sexually exploited in order to gain money. The camp environment we could say it is ideally for those looking for having sex, usually without protection. We can make a hypothesis taking under consideration the cultural background that is not women who are having out of marriage sex, but men. Women are diagnosed with STIs first of all because the symptoms appear first in women and rarely to men. Sometimes men accusing their wives of transmission of illness at them and they refused to take also the necessary treatment, so the problem continues to exists.

Also what was derived from the data analysis it is more likely for women living in shelters to considered as normal (58%) comparing with those living at Elliniko camp (42%). This maybe happens because living conditions are better in apartments and they have access to toilet and clean water. Another reason we could take under consideration is that the apartments are located to the urban area, so women have access to several medical services.

Those living at Elliniko camp seem to be less likely to have access in lab tests comparing to those live in shelters. Maybe the provision of lab tests is not available in the Elliniko camp in contrast with the available lab test services in the urban area where the shelters are. Also people living at Elliniko didn't had as a priority their health but to find a way to continue their journey in other EU countries, thus women were visiting the doctor when they were thinking that have something really serious. On the other hand women living in apartments they had made the first step to establish a more permanent place of living so they had as priority now to check their health that's why they were in need for more lab tests. What was also significant and is connected with the fact that apartments are in the urban area and women might feel stability is the result that women living in shelters are more likely to participate in family planning (p value ,034),(OR: 1,67, CI: 1,04-2,69) compared to women living at Elliniko camp.

8.4 Findings

At this point, it is useful to summarize the main conclusions of this study related to the impact of living conditions, comparing two different types of accommodation, Refugee camp and official apartments, to sexual reproductive health status of Afghan women, recently entered Greece after a long and unsafe for their life journey.

- Women living in refugee camp are more likely to have problems with their period instead of those are living in apartments in the urban area.
- Women living in refugee camp are less likely to be sexual active in comparison with women living in apartments.
- Women living in refugee camps are more likely to visit SRH services for genital infections and menstrual disorders comparing to women living in apartments that

visiting SRH services in order to follow up their pregnancy and for family planning services

- Women living in refugee camp are more likely to be diagnosed with STIs/Infectious instead of those living in apartments.
- For women living in an apartment is more likely to be considered as normal (in terms of SRH) compared with women living in refugee camp.
- Women living in apartments have more possibilities to have access in lab tests comparing to those living in camp.
- Married women have more chances to be diagnosed as normal comparing with the not married.
- Married women seem to be more likely to be affected with STIs/Infectious and not married women seem to be more likely to have genital infections/UTI.
- Women with no sexual activity seem to have the same chances with sexual active women to have STIs/Infectious.
- Women as getting older have less possibilities to diagnosed as normal and they have more possibilities to be diagnosed with STIs. Genital infections seem to be more common in younger and older ages.
- Women with fewer pregnancies have more possibilities to be diagnosed as normal and less possibilities to be diagnosed with STIs/Infectious.
- Women that are virgin and those with no sexual activity are more possible not to use family planning methods instead of those are sexual active.
- Women from Afghanistan are not familiar to the available in Greek market contraception methods and culturally are not familiar to use contraceptive methods. What have been observed is that women which are breastfeeding tend to use family planning methods.
- Women who delivered both ways (vaginally and c/s) are more likely to participate in family planning methods comparing to those that experienced vaginally or c-section.
- Women living in shelters are more likely to participate in family planning compared to women living at Elliniko camp.
- Single women were much more likely to participate in family planning than married and divorced/separated women. This result is very important because it is connected with cultural issues, if a single woman will get pregnant without being married, she is at risk of being persecuted or even murdered, that's why single women tend to participate more in family planning methods.

- Women who are not sexually active and virgin are less likely to participate in family planning
- Women that performed lab tests were less likely to have STIs or genital infections compared to women that performed clinical examination.

8.5 Recommendations

From the results of this study we see the effect of living conditions in several health issues related to sexual and reproductive health of Afghan women on the move.

The bad living conditions in a camp and the location that usually is far from the urban area, with limited access to medical and other services, affects the health of women and more specifically the transmission of STIs/Infectious, the appearance of menstrual disorders, the limited access to lab tests and limited participation in family planning methods.

The recommendations are that host countries such as Greece should avoid placing and strand people in camps such was Elliniko because this decisions have direct impact to health of people. Staying in camps should be for a minimum stay till a more permanent solution to be found and camps should be organised accordingly to the needs of the residents.

Governments should provide safe and more permanent accommodation structures for people on the move, with access to medical and other social and legal services, in order to protect vulnerable people such as women and avoid harmful for the health incidents.

It is also important the current medical systems to adapt to the current needs of the target population and find options according to their needs. Family planning for women on the move is very important, the current available methods unfortunately seem that are not fit to the needs of the population. Women on the move seem to prefer injectable or implant contraception methods that are more safe and suitable for them. Both methods cannot be identified and it is not required further medical follow up in close time. According to testimonies of the women when they travel not with legal papers or legal routes are not allowed to carry with them pills and due to the difficulties of the journey it is difficult for them to remember taking the pill every day. On the other hand IUD it seems the most appropriate for the available ones but still women are not familiar with that method, they need to check it frequently and during the hard and difficult journey it is possible to have complications. Maybe government and National Pharmaceutical Organization should think the possibility of introducing in the Greek market injectable and implant methods of contraception.

I believe that living conditions and access to information and services accessible with equity are the main issues to protect health. People on the move and especially women are considered as extreme vulnerable. This new system of accommodation provided by UNHCR and local actors has to be further studied in terms of impact in health of people.

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