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Refugee women's experiences in accessing maternal healthcare: qualitative exploration from Krisan and Ampain refugee camps in Western Region, Ghana

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Abstract

Background Refugee populations in Ghana faced significant challenges in accessing maternal healthcare services, including antenatal care, skilled birth attendance, and postnatal care, due to socio-economic, cultural, and health system factors. Limited research has explored the specific barriers encountered by refugee mothers in Ghana. This study explored the experiences of refugee mothers in accessing maternal healthcare services in Krisan and Ampain Refugee Camps in the Western Region, Ghana.

Methods Anchored by Bronfenbrenner's Ecological Systems Theory, Giorgi's descriptive phenomenological design was employed to collect data from refugee mothers aged 15–49. Data was gathered through in-depth interviews using a structured interview guide. Purpose, snowball, and maximum variability sampling techniques were applied to recruit participants who could provide relevant insights. In total, 29 interviews were conducted, and the data, including field notes and interview transcripts, were thematically analyzed to identify key patterns and themes.

Results Major themes that emerged were language barriers, financial constraints, discrimination, inadequate social support, transportation difficulties, long waiting times at health facilities, and negative attitudes from healthcare providers. Social support networks and good interpersonal relationships with healthcare staff were however reported as enablers to maternal healthcare access.

Conclusion Maternal healthcare for refugee mothers was found to require targeting their unique circumstances and healthcare needs. Integrating policies such as the United Nations High Commissioner for Refugees (UNHCR) Health Strategy and Sphere Standards into national health systems could improve access to equitable maternal care for refugees. Policymakers, including Ghana's Ministry of Health and UNHCR, should collaborate with healthcare providers and non-governmental organizations (NGOs) to implement policies that ensure equitable access and person-centred care for refugee.

Keywords Refugees, Maternal healthcare, Experiences camps, UNHCR, Sustainable development goal (SDGs)

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Background of the study

Nearly 80 million people worldwide are displaced within their own country or across national borders [1]. The term “Refugees” are persons who have left their country of origin due to fear of persecution, conflict, violence, or human rights violations (UNHCR, 2019). Approximately half of the global refugee population are females, and a significant number of them are of childbearing age [1, 2]. Currently, there is no available data on the number of pregnant women of forced migration globally [3]. International studies indicate that refugee women face unique health challenges that go beyond pregnancy, including the effects of rapid acculturation, social marginalization, and limited access to healthcare services [4, 5]. These challenges often result in higher rates of psychological issues such as depression and anxiety, which can compound the risk of maternal and child health complications [6–9]. The intersectionality of refugee status, gender, ethnicity, and socio-economic factors further exacerbates these challenges, leading to some keen disparities in health outcomes when compared to both native populations and other migrant groups [10].

The Sustainable Development Goal 3 aims to improve health and well-being for all, regardless of background, by 2030 [11]. Similarly, the Global Strategy for Women’s, Children’s, and Adolescent’s Health affirms that all individuals, including refugee populations, should have access to the highest attainable standard of health [11]. However, many refugee women seeking healthcare experience multiple health conditions, often going undetected, untreated, or unrecognized, which is compounded by limited resources and healthcare access [12, 13]. Refugee mothers face numerous challenges to accessing maternal healthcare services within refugee camps [14]. A significant barrier is the lack of culturally sensitive and gender-responsive healthcare services, leading to mistrust and reluctance to seek care [15]. Additionally, language barriers and limited availability of interpreters hinder effective communication between healthcare providers and refugee mothers. Resource constraints, including inadequate infrastructure, limited medical supplies, and understaffed facilities, contribute to suboptimal healthcare service delivery [16]. Furthermore, socio-economic factors such as poverty, lack of transportation, and competing priorities deter refugee mothers from prioritizing maternal healthcare [17]. Meanwhile, studies have shown that refugee and migrant women, including those seeking asylum, are more vulnerable with higher rates of maternal and newborn morbidity and mortality compared to host populations [2, 18]. An estimated 40% of refugees are affected by post-traumatic stress, depression, and anxiety disorders, with women seeking asylum during pregnancy and postpartum being at greatest risk [19]. Additionally, refugee women have a higher risk of

adverse perinatal outcomes, including pre-term delivery, low birth weight, and congenital malformations [20, 21].

Despite global efforts to improve maternal health outcomes and reduce disparities, refugee mothers continue to encounter challenging barriers that impede their access to quality maternal healthcare services [22]. Additionally, existing literature has primarily focused on quantitative assessments of maternal health outcomes among refugee populations, often overlooking the nuanced experiences, perspectives, and narratives of the individuals directly affected [14, 23, 24].

In Ghana, refugee populations are mainly hosted in settlements such as the Krisan Refugee Camp in the Western Region and the Ampain Refugee Camp in the Ellembele District. These camps host refugees from countries including Côte d’Ivoire, Liberia, Togo, and Sudan, many of whom are women of reproductive age [1]. Refugees in Ghana are entitled to access health services through the national healthcare system, particularly via the National Health Insurance Scheme (NHIS). However, systemic gaps limit their ability to fully benefit. Rural siting of camps, long travel distances to district hospitals, and shortages of skilled healthcare professionals within camp clinics often hinder timely maternal care. Moreover, structural challenges within Ghana’s healthcare delivery system such as inadequate logistics, limited cultural sensitivity training for providers, and persistent underfunding of primary health care exacerbate the vulnerabilities of refugee mothers. Understanding these challenges within the Ghanaian context is crucial, as it highlights how global maternal health concerns intersect with localized health system constraints, shaping the lived experiences of refugee mothers in accessing maternal healthcare.

This qualitative study aims to fill this gap by providing a platform for refugee mothers to voice their lived experiences and shed light on the intricacies of their healthcare-seeking behaviours, decision-making processes, and interactions with healthcare systems. By uncovering these findings, the study seeks to inform the development of contextually relevant, culturally sensitive interventions and policies aimed at improving maternal healthcare access, utilization, and outcomes for refugee populations. Ultimately, the findings from this study have the potential to contribute significantly to the global discourse on maternal health equity and inspire targeted strategies to address the unique needs and challenges faced by refugee mothers in accessing essential healthcare services.

Conceptual and theoretical perspective anchoring the study

Refugee maternal healthcare refers to the specialized health services provided to women forcibly displaced due to conflict, persecution, or environmental disasters.

These services encompass pregnancy, childbirth, and postnatal care, with an emphasis on improving access, equity, and outcomes for refugee mothers [1]. For the purpose of this study, refugee mothers are defined as women living in Ghana's refugee camps, particularly Krisan and Ampain, who are pregnant or have recently given birth. Understanding their experiences requires considering the social, economic, and systemic factors that hinder their ability to access timely and appropriate maternal healthcare.

To fully understand these experiences, the study is anchored by Bronfenbrenner's Ecological Systems Theory (EST) [25], which provides a comprehensive framework for analyzing how multiple levels of environment interact to influence health-seeking behaviors. EST consists of five interrelated components. The microsystem represents the immediate environment in which individuals directly interact with family, peers, or healthcare providers. The mesosystem captures the linkages and interconnections between these microsystems, such as how relationships between families and healthcare services affect maternal care. The exosystem refers to settings that do not directly involve the individual but still exert influence, including health policies, humanitarian programs, and institutional decisions. The macrosystem embodies the wider societal, cultural, and policy context, such as national refugee policies, cultural beliefs, and public attitudes toward maternal healthcare. Finally, the chronosystem adds the dimension of time, emphasizing how life-course events (e.g., migration experiences) and historical shifts in policies shape access to maternal healthcare over time. This framework has been widely applied in studies on vulnerable populations, including teenage mothers, to analyze how different levels of the environment influence their health-seeking behaviors [26, 27]. In the context of refugee maternal healthcare, EST is particularly relevant as it helps to examine the various barriers and facilitators that impact access to healthcare services in Krisan and Ampain Refugee Camps. For example, at the microsystem level, challenges such as language barriers, cultural misunderstandings, and healthcare providers' attitudes significantly affect maternal healthcare access. The mesosystem highlights the interactions between healthcare facilities, refugee community leaders, and NGOs providing maternal health support. The exosystem encompasses broader influences like resource allocation, international humanitarian assistance, and health sector financing that indirectly shape service delivery. At the macrosystem level, national health policies, cultural norms, and societal attitudes toward refugees structure the overall healthcare environment. Finally, the chronosystem accounts for long-term changes, such as evolving refugee policies, health system reforms, and shifts in Ghana's

healthcare priorities, all of which influence refugee mothers' access to care.

While valuable, EST has limitations. It may risk portraying system boundaries as overly rigid, neglecting issues of power and inequality, or spreading analysis too thin by focusing equally on all system levels. The chronosystem is also often underused despite its importance in capturing temporal dynamics. In this study, these concerns were addressed by treating systems as interconnected, explicitly integrating questions of power and inequality, prioritizing analysis at the micro-, meso-, and exosystem levels, and enriching the chronosystem by drawing on women's migration histories, policy changes, and life-course perspectives. Overall, Bronfenbrenner's Ecological Systems Theory provided the analytical foundation for examining how different layers of social and institutional context influenced refugee women's access to maternal healthcare. The theory guided the framing of interview questions, the organization of thematic coding, and the interpretation of findings linking personal experiences of refugee mothers such as provider attitudes and language barriers with structural determinants like health policies, humanitarian interventions, and societal perceptions of refugees. Through this lens, the study demonstrated how interactions between personal, community, and systemic environments collectively shape the lived maternal healthcare experiences of refugee women in Krisan and Ampain Camps.

Methods

Study design

This study adopted Giorgi's descriptive phenomenological design to explore the experiences of refugee women in accessing maternal healthcare. The phenomenological approach is defined as a systematic description of participants' lived experiences from their first-person perspective, free from preconceived assumptions or external interpretations. This makes it directly aligned with the study's aim of capturing experiences as they are lived, while ensuring that the researcher brackets personal biases to maintain objectivity [28]. Unlike interpretative phenomenological analysis (IPA), which focuses on subjective meaning-making by both participants and the researcher [29], Giorgi's approach ensures rigor and objectivity through bracketing, thereby minimizing bias and enhancing credibility. The phenomenological method also enabled the collection of rich, in-depth narratives that revealed the complex perceptions, challenges, and interactions of refugee women with the healthcare system. Furthermore, given the relatively small population of refugee women in the study area, this approach facilitated close engagement with participants, ensuring nuanced experiences were represented. Thus, the use of Giorgi's descriptive phenomenological design is justified

on the grounds that it provides philosophical and analytical tools to uncover the essence of refugee women's maternal healthcare encounters, maintains trustworthiness through systematic bracketing, and allows for deep exploration of behaviours, perceptions, and narratives in their lived realities. However, a key limitation of this approach is that findings are context-specific and may not be generalizable beyond the study population. In addition, the reliance on participants' ability to articulate their experiences may have constrained the depth of insight in cases where language barriers or cultural differences limited expression [28, 29].

Study setting

The study was conducted in the Krisan and Ampain Refugee Camps in the Western Region of Ghana. These camps are managed by the Ghana Refugee Board in collaboration with the United Nations High Commissioner for Refugees (UNHCR), and provide refugees with shelter, primary healthcare, and basic amenities. The camps host a population of approximately 5,000 refugees from diverse backgrounds. The majority of the refugees come from Côte d'Ivoire, Togo, Liberia, and Sudan, with smaller groups from countries such as Burkina Faso, Sierra Leone, and the Democratic Republic of Congo. These refugees have fled their home countries due to political instability, armed conflicts, and human rights violations, seeking safety and humanitarian assistance in Ghana. Women of reproductive age (15–49 years) account for about 25% of the total refugee population. Out of the estimated 1,250 women of reproductive age in both camps, 578 were mothers, with 361 (46.2%) residing in Krisan Camp and 217 (17.4%) in Ampain Camp. Accommodation is provided in shared housing units, but these are frequently overcrowded and lack privacy [30]. Refugees receive food assistance from humanitarian agencies, though supplies are not always sufficient or culturally appropriate.

Healthcare facilities in the camps include health centers and Community-based Health Planning and Services (CHPS) compounds, staffed by medical personnel providing maternal healthcare, immunizations, and treatment for common illnesses. These facilities are primarily government-run with support from Non-Governmental Organization (NGOs) and international organizations such as UNHCR. Additionally, there are auxiliary healthcare services, including maternity homes, pharmacies, and over-the-counter medicine seller shops, which supplement healthcare access for refugee mothers.

Study participants and sampling procedure

The study participants comprised women who had previously utilized maternal healthcare services in the camps within the last five years, those who had recently given

birth and were seeking postnatal care (PNC) services, as well as those who were pregnant and seeking antenatal care (ANC) services at the time of the study. To capture diverse experiences, the study also extended to women in the camp communities who, despite being eligible, were unable to attend either ANC or PNC services; these women were interviewed after providing informed consent. This eligibility framework ensured representation across the full continuum of maternal healthcare from pregnancy through childbirth and postnatal care thereby enriching the perspectives on challenges and successes encountered in accessing and utilizing services.

Recruitment and sampling were carried out in close collaboration with healthcare providers, community organizations, and camp administrators. Outreach activities in PNC clinics and other healthcare facilities within the camps were used to inform eligible women about the study and invite them to participate. Informed consent was obtained from each participant, with emphasis on confidentiality and voluntary participation. To capture diverse experiences, a combination of purposive, snowball, and maximum variability sampling techniques was employed, ensuring inclusion of women from different nationalities, age groups, and lengths of stay in the camps. By focusing on women who had previously given birth and utilized maternal healthcare services within the camps, the study generated insights into the complex dynamics of maternal healthcare access and utilization in the refugee context. The sample size was not predetermined but guided by the principle of data saturation. Data collection and preliminary analysis were conducted simultaneously, with interviews transcribed and coded on an ongoing basis. Saturation was assessed by examining whether new interviews were contributing fresh perspectives, themes, or sub-themes. As interviews progressed, recurring patterns and consistent narratives began to dominate the data. Points of saturation were identified when successive interviews no longer yielded novel insights into key analytical themes such as barriers to accessing ANC/PNC, the influence of cultural norms, experiences with healthcare providers, and strategies for navigating maternal health challenges [31].

In practical terms, after approximately 25 interviews, the research team observed that responses had become repetitive, with no new categories emerging. A further four interviews were conducted to confirm saturation and ensure robustness across demographic groups. Ultimately, saturation was reached with 29 participants (14 from Krisan and 15 from Ampain). The diversity in age, education level, marital status, occupation, and length of stay in the camps further reinforced that saturation had been adequately achieved, ensuring that the thematic domains were well-explored across different demographic backgrounds.

Reflexivity

Given the phenomenological orientation of this study, reflexivity was essential to ensure confirmability and transparency. The researchers acknowledged that their professional and personal backgrounds, particularly in maternal and child health, could influence how participants' narratives were interpreted. To minimize bias, *bracketing* was applied, whereby pre-existing assumptions and experiences about refugee healthcare access were consciously set aside during data collection and analysis [28]. The primary researcher maintained a reflexive journal throughout the process, documenting reflections, emotional responses, and potential influences, while regular debriefing sessions with co-researchers helped critically examine interpretations and challenge subjective assumptions. These measures enhanced the credibility and rigor of the study by ensuring that interpretations remained grounded in participants' lived experiences rather than researchers' preconceptions.

Data collection

In-depth face-to-face interviews were conducted with the study participants. The interviews were held in convenient and private locations within the refugee camp, including designated community meeting spaces and participants' homes, depending on where the mothers felt most comfortable. Privacy and confidentiality were prioritized in selecting these locations to ensure open and honest conversations. Before each interview, ethical protocols were strictly observed. Written or verbal informed consent was obtained from every participant after explaining the purpose of the study, procedures involved, and their right to withdraw at any stage without consequences. Participants were assured of confidentiality and anonymity, with codes used instead of names during transcription. Permission was also sought for audio recording. Each interview began with background questions covering age, place of residence, educational background, profession, marital status, number of children, country of origin, duration of stay in the camp, and number of children delivered while living in the camp. The interviews lasted approximately 50 min to 1 h.

An interview guide (see Supplementary file 1: In-Depth Interview Guide for Refugee Women) was developed to facilitate the discussion. The content of the guide was informed by a comprehensive literature review on refugees' experiences and challenges in accessing maternal healthcare, as well as the study's aim [32–34]. The guide contained standardized open-ended questions, which ensured that all participants were asked the same core questions in the same manner, while still allowing flexibility to explore emerging issues in greater depth. This approach enhanced comparability while capturing diverse perspectives.

Given the multilingual nature of the camp, language considerations were addressed carefully. The principal investigator conducted interviews in English, while the research assistants engaged in this study were graduates in public health and the social sciences with prior experience in qualitative data collection. Prior to the data collection, the research assistance trained to facilitate the interviews in French, Arabic, and Twi. For non-English interviews, immediate translation was done by the assistants during the session, and the audio recordings were later transcribed and verified against field notes to ensure accuracy and consistency of meaning. This process minimized potential translation bias and maintained the integrity of participants' responses. Field notes were taken alongside the recordings to capture non-verbal cues, contextual observations, and reflections during the interviews.

Data processing and analysis

Data were analyzed using thematic analysis, following a systematic process to ensure consistency. All the recorded interviews were transcribed verbatim to capture the full depth of participants' responses [35, 36]. Non-English language interviews were first transcribed in the original language and translated into English by an independent translator. Back-to-back translation was done on selected transcripts to check the quality of translation. The researchers then read the transcribed data multiple times to familiarize themselves with the content, after which key sections were highlighted, and initial codes were assigned. These codes were systematically grouped into categories based on similarities and patterns observed in the responses. The actual thematic analysis process followed Braun and Clarke's [37] six-phase framework, the process involved familiarization with the data, generating initial codes, searching for themes, reviewing and refining themes, defining and naming themes, and finally producing the report in line with research objectives. Themes and sub-themes were continuously refined through an iterative approach to ensure accurate reflection of the data, and the finalized themes were reviewed and validated by the research supervisor. Both transcripts and field notes were comprehensively analyzed using this approach, ensuring a robust and trustworthy interpretation of the findings.

Trustworthiness

Several measures were implemented in line with the recommendations by Lincoln and Guba [38] to ensure the trustworthiness of the data. First, and as noted above, all interviews were audio-recorded and then transcribed verbatim to capture participants' responses accurately. Following transcription, selected participants reviewed the transcripts to confirm the accuracy of the information

they provided, with only minor edits made by a few participants. To enhance transferability, we provided a rich and thorough description of the research process and setting, allowing for potential replication in similar contexts. Dependability was ensured through a detailed documentation of the research methodology, including data collection and analysis procedures, to ensure consistency and reliability. Additionally, an audit trail was maintained to track all research decisions, supporting transparency in the analytical process. Confirmability was achieved through reflexivity, where the researchers critically examined their potential biases and maintained neutrality in interpreting the data. Regular peer debriefing and discussions with colleagues helped validate the findings and strengthen the objectivity of the study.

Ethical considerations

This study was conducted in accordance with the ethical principles of the Declaration of Helsinki. Ethical approval was obtained from the University of Port Harcourt,

Nigeria (ID NO: UPH/CEREMAD/REC/MM97/013) and the Ghana Health Service Ethics Review Committee (ID NO: GHS-ERC 022/04/24). Administrative approvals were also secured from the Ghana Refugees Board, Western Regional Health Directorate, and Ellembele District Health Directorate. Facility leaders at the two refugee camps consented to the study. All participants gave informed consent after the study's objectives, risks, benefits, confidentiality, and voluntary nature were explained to them.

Results

Characteristics of participants

Table 1 shows data on essential characteristics of 29 refugee mothers who participated in the study. Participants were aged between 27 and 45 years, with an average age of 35.3 years. Regarding education, 48.3% had completed secondary school, and 17.2% had no formal education. The majority of participants were from Côte d'Ivoire (44.8%). In terms of marital status, 55.2% were married,

Table 1 Characteristics of participants

Participants # ID	Age	Level of Education	Country of Origin	Number of children	Marital Status	Name of camp	Length of stay in the Camp
P1	33	Tertiary	Liberia	2	Married	Krisan	30 years
P2	40	Secondary	Ivory Coast (Côte d'Ivoire)	5	Separated	Ampain	13 years
P3	36	Secondary	Liberia	5	Married	Krisan	22 years
P4	30	Secondary	Ivory Coast (Côte d'Ivoire)	2	Separated	Ampain	13 years
P5	34	Tertiary	Ivory Coast (Côte d'Ivoire)	2	married	Krisan	10 years
P6	37	Secondary	Logo	2	Married	Krisan	11 years
P7	41	Basic	Ivory Coast (Côte d'Ivoire)	6	Married	Ampain	13 years
P8	33	Basic	Central African Republic	3	Married	Krisson	10 years
P9	42	Basic	Ivory Coast (Côte d'Ivoire)	5	Married	Ampain	13 years
P10	31	Basic	Côte d'Ivoire (Ivory Coast)	1	Single	Krisan	11 years
P11	33	Basic	Côte d'Ivoire (Ivory Coast)	4	Separated	Ampain	11 years
P12	41	Secondary	Central African Republic	2	Single	Krisan	11 years
P13	43	Secondary	Liberia	2	Married	Krisan	30 years
P14	40	Secondary	Ivory Coast (Côte d'Ivoire)	5	Married	Ampain	13 years
P15	30	No Education	Ivory Coast (Côte d'Ivoire)	2	Married	Ampain	13 years
P16	33	No Education	Ivory Coast (Côte d'Ivoire)	4	Married	Ampain	13 years
P17	42	Secondary	Ivory Coast (Côte d'Ivoire)	5	Separated	Ampain	13 years
P18	36	Secondary	Liberian	1	Married	Krisan	2 months
P19	45	Secondary	Ivory Coast (Côte d'Ivoire)	6	Married	Ampain	13 years
P20	33	No Education	Central African Republic	1	Single	Krisan	10 years
P21	29	No Education	Liberian	2	Single	Krisan	-
P22	34	Tertiary	Ivory Coast (Côte d'Ivoire)	2	Single	Ampain	13 years
P23	36	Secondary	Ivory Coast (Côte d'Ivoire)	2	Married	Ampain	13 years
P24	27	Secondary	Ivory Coast (Côte d'Ivoire)	1	Single	Ampain	13 years
P25	33	Secondary	Ivory Coast (Côte d'Ivoire)	1	Single	Ampain	13 years
P26	35	Secondary	Mali	2	Single	Krisan	13 years
P27	37	Secondary	Togo	2	Married	Krisan	24 years
P28	36	High school	Liberia	2	Widow	Krisan	34 years
P29	30	No education	Togo	1	Single	Krisan	13 years

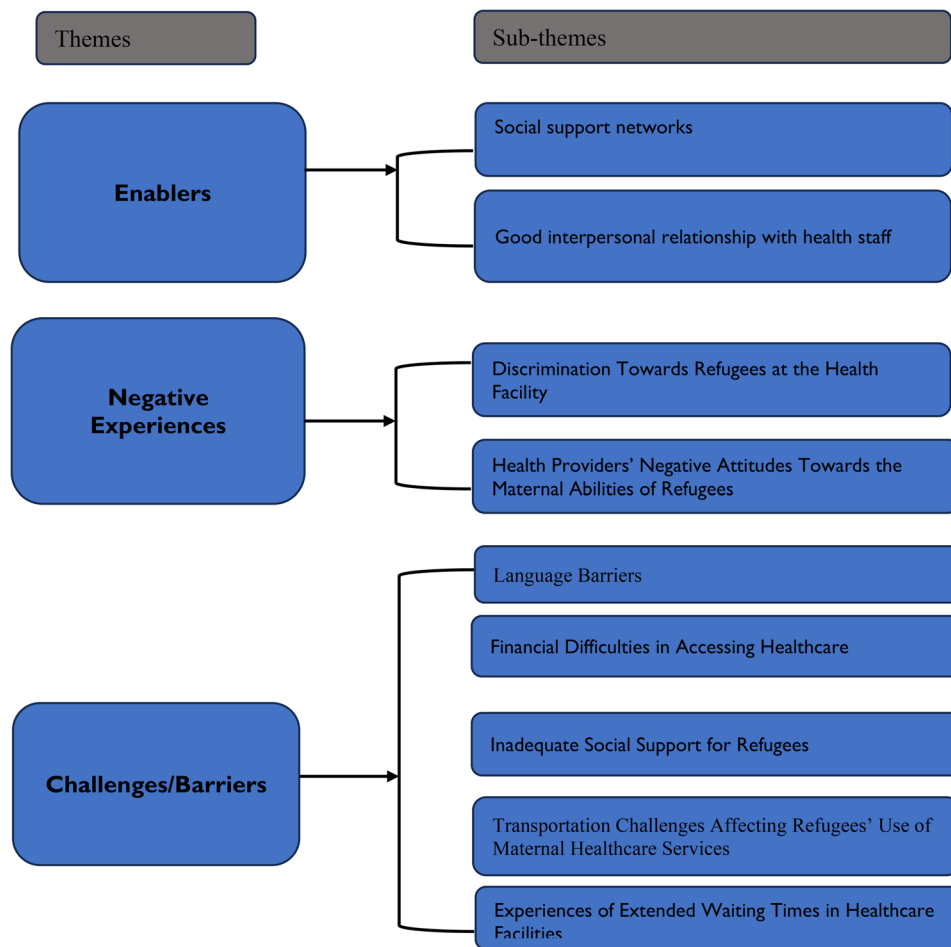


Fig. 1 Identified themes and sub-themes from the study

and 20.7% were single. Most participants had multiple children, with 48.3% having between 2 and 4 children. The length of stay in the camps varied from less than one year to 13 years, with the majority (37.9%) having lived there for 13 years. These findings highlight the diverse backgrounds, economic activities, and social experiences of refugee mothers in the camps.

Summary of emerging themes

Figure 1 summarizes the main themes and sub-themes that generated from the data. The findings revealed enablers as well as negative experiences and challenges/barriers. Refugee mothers identified key enablers such as strong social support networks and compassionate healthcare providers who delivered culturally sensitive care. At the same time, they reported negative experiences including discrimination and poor treatment, alongside broader challenges such as language difficulties, financial constraints, inadequate social support, transportation problems, long waiting times, and negative provider attitudes. The sections that follow present an in-depth discussion of these themes and sub-themes.

Theme 1: enablers

Access to social support networks

Social support networks play a crucial role in the health and well-being of pregnant refugee women. In displacement settings, where access to formal healthcare is often limited, these networks help reduce isolation, increase access to resources, and provide emotional and practical support during pregnancy and childbirth. Refugee women rely on these informal networks for guidance on prenatal care, childcare, and navigating healthcare facilities, making them an essential part of their maternal health experience. One participant described the impact of peer support within the refugee camp:

When I first arrived, I felt completely alone, but the other women in the camp helped me settle in. We share our experiences and support one another through pregnancy. It makes a big difference knowing I'm not going through this alone. (Participant ID 15. Ampain Camp)

Beyond women's groups, broader community support structures also influence maternal healthcare access. Community members often step in to assist with transportation, childcare, and emergency situations, which are critical in environments where formal support systems are weak. A participant explained:

In our community, everyone comes together when there's a problem. If a pregnant woman needs help getting to a clinic, or there's an emergency, it's not just the women men help too. We make sure no one is left without support. (Participant ID 2, Ampain Camp)

However, the availability and strength of these support networks varied by location. Ampain Camp had stronger communal bonds that facilitated information sharing and assistance for pregnant women seeking maternal healthcare. In contrast, Krison faced weaker social cohesion, language barriers, and fragmented community structures, making support less reliable. These differences influenced access to maternal healthcare.

Good interpersonal relationships with health staff

For many refugees, a positive relationship with healthcare providers can make a significant difference in their healthcare experiences. Health providers who are respectful, empathetic, and culturally sensitive can build trust and ensure that refugees feel supported throughout their care. One participant shared:

After I gave birth, I was really struggling to pay for the medicine and the lab tests. I had no money, and I was feeling so helpless. But the nurses here, they noticed my situation and quietly contributed to help cover the costs. It was such a relief, and I felt deeply moved by their kindness. They didn't just care for my health; they cared about me as a person. Without them, I don't know what I would have done. (Participant ID 2, 11. Ampain Camp)

For one woman, the doctor's thoughtful approach made a lasting impact:

What I really appreciated was that the doctor didn't rush me during my appointment. She made sure I understood everything and answered all my questions. It felt like she really cared about my health and didn't treat me like just another patient. (Participants ID 6. Krison Camp)

The emotional support provided by healthcare workers was equally important and a participant had this to share:

I was feeling really overwhelmed after giving birth, and the nurse came to check on me regularly. She was always kind and reassuring, and it really made me feel like someone cared about how I was coping emotionally as well as physically. (Participants ID 28, 29. Krison Camp)

Theme 2: negatives experience and challenges

Discrimination towards refugees at the health facilities

Discrimination within healthcare settings poses a serious threat to equitable care for refugees. Many refugees encountered prejudice from healthcare providers, which reportedly led to substandard care and exacerbated their health conditions. This discrimination not only affected the quality of care but also had psychological effects, contributing to emotional distress.

"During my pregnancy, when I went to the Eikwe hospital for routine check-ups and lab tests, I noticed that native patients consistently jumped the queue with the support of the nurses. While refugees like me waited, it felt like natives were always called in first. At the lab, it was even worse; only native patients' names were called. This made seeking maternal healthcare stressful and disheartening." (Participant ID 8, Krison Camp)

Discrimination also manifested in xenophobic remarks, which reinforced feelings of alienation. One woman recounted:

"One day, a nurse stood up and began shouting at me, accusing foreigners of using the hospital without paying taxes and having babies. I was terrified and didn't know how to respond, so I quietly left and decided never to return to that clinic." (Participant ID 15).

Another participant narrated how she was neglected during childbirth:

"The day I went to give birth was the worst of my life. When I urgently called for help, nobody came. A nurse finally approached me and dismissively said, 'You kwerekwere, you always scream. Just keep quiet, you still have a long way to go.' I felt abandoned and dehumanized." (Participant ID 5, Ampain Camp)

These experiences reflect how systemic and interpersonal discrimination undermined trust in healthcare and made maternal health services more difficult to access.

Health providers' negative attitudes towards refugees

Negative attitudes and misconceptions held by health-care providers towards refugees significantly impact the quality of maternal healthcare refugees receive. Prejudiced attitudes can result in inadequate and inappropriate care, as providers may not take the health concerns of refugees seriously or provide the necessary support. One participant shared their distress after an encounter with a nurse following surgery, where financial demands were made before further care could be provided:

"One major challenge is the unfriendly relationship between nurses and we the refugees seeking maternity care. After a surgery, a nurse threatened me about payment before giving any further treatment. Patients are often shouted at or treated harshly, which frightens and stresses us, making our condition worse." (Participant ID 1, Krisan Camp).

Others described how financial barriers were compounded by providers' insensitivity, even in emergencies:

"When I was in labor, the hospital (Healthcare providers) refused to proceed with my delivery because I didn't have enough money to cover the cost. I was in excruciating pain, and they told me to leave until I could pay. The humiliation was unbearable. It was like my life and my baby's didn't matter." (Participant ID 3, Krisan Camp).

Theme 3: challenges / barriers

Language barriers

Language barriers are a significant challenge for refugees accessing maternal healthcare services. Many refugees face difficulty in communicating with healthcare providers, which hampers their ability to express their health concerns and obtain the requisite care. Many of the participants expressed their frustration in trying to comprehend medical instructions and sometimes missed the treatment regimen. This often resulted in frequenting the health facility over the same issue. A participant had this to share

Many of the doctors and nurses only spoke the local language, which I don't understand well. I tried using hand gestures and simple words, but it was frustrating. Sometimes, I would leave the clinic feeling like I didn't get the care or information I needed. (Participants ID 6, Krisan camp)

Some participants noted how they had to resort to translators to understand the medical instruction:

I used to bring someone to help with translation, but even that was difficult because the translator was also a refugee with limited English skills. Despite this, the nurses continued speaking in Twi.[the host local language], and I didn't understand a word (Participants ID 24, Ampain camp).

Another participant indicated that in a more severe case, the lack of effective communication delayed urgent care:

Hmmm I almost forgot this one, during my labour period when I needed a blood transfusion, the nurses tried seeking my consent to transfuse me. Although they spoke English, I did not understand them. They then tried using Twi and sign language, that too didn't help. They brought other refugees there, none could speak Arabic. I was on the brink of losing my life because they were unwilling to proceed with the care. This situation lasted nearly 30 min until my mother returned and translated for me so I could understand. (Participant ID 29, Krison Camp).

Financial difficulties in accessing healthcare

Financial difficulties presented a significant challenge for refugees seeking maternal healthcare. While maternal healthcare services are generally free, hidden costs such as transportation, medication, diagnostic tests, and procedural fees pose significant barriers. Many refugees struggle to cover these expenses, forcing them to choose between healthcare and other essential needs. One participant shared this experience:

Even though some services are free, we still face significant expenses like transportation, medication, and special tests. My husband is still looking for work, so we often had to skip appointments or delay tests due to lack of money. I had to choose between basic needs like food and rent and healthcare, which made me worry about my baby's health. (Participant ID 4, Ampain Camp).

Another participant highlighted the difficulties of traveling to the clinic, especially when financial constraints forced her to go alone, navigating unsafe areas. Although the camp has a healthcare facility, it lacks certain specialized services, requiring refugees to seek care outside the camp. In such cases, they often have no choice but to travel to St. Martin's Hospital in Ekwei, the only hospital in the district, which serves as a referral center for more complex medical cases.

Traveling to the clinic meant passing through unsafe areas. I often had to go alone because my husband needed to work to feed us. This was especially dif-

difficult during the later stages of my pregnancy when I had mobility issues (Participant ID 25. Ampain Camp).

The costs of maternity care also pose a serious concern for refugee mothers, who often struggle to afford the essentials:

The costs for maternity care are going up, and many refugees cannot afford what's needed. Breast milk becomes a problem when there is no food. We urgently need more help for the mothers here (Participant ID 15. Ampain Camp).

Participants also spoke about how financial limitations delayed their treatments and made healthcare less of a priority:

I had to delay my treatment because we could not afford the medication and transport cost. I remember one time I was so worried about my baby's health that I had to ask neighbors for [monetary] help just to get to the clinic. It felt like we were always struggling to make ends meet, and healthcare was often the last priority (Participants ID 14. Ampain Camp).

Some refugees felt disregarded by clinic staff due to their inability to pay for services, deepening their sense of helplessness. While antenatal and postnatal care are generally free under NHIS, refugees often face hidden costs for medication, lab tests, and uncovered procedures. Additionally, administrative barriers, lack of awareness, or financial constraints prevent some from registering, leaving them struggling to access essential maternal care. This financial insecurity sometimes led to distressing encounters with healthcare workers, as one participant shared:

The clinic staff often don't understand how hard it is for us. They see us as just another patient who can't pay. When I needed help urgently, I was told to wait until I could pay for everything. My baby and I suffered because we had no choice but to wait. Only for the nurse tell me, we the refugees are always complaining. If you don't like it, go back to your country.' I felt so small and helpless. (Participants ID 7, Ampain Camp)

Inadequate social support for refugees

Lack of social support networks was also reported. Without adequate support, refugees face increased challenges in navigating the healthcare system and advocating their health needs. This lack of support led to isolation, further

compounding the difficulties they face in maintaining their health and well-being. One participant shared her feeling of fear and loneliness after discovering her pregnancy, emphasizing the lack of family support:

When I found out I was pregnant, I was happy but also scared. Back home, I had family to support me, but here, I'm alone. My husband works long hours, and I don't have friends or family nearby. I struggle with the language and get confused by forms and instructions at the clinic. The doctors and nurses are always in a hurry, and I feel like just another number. I go to bed every night worried that I'm not doing things right for my baby and feel lost without anyone to turn to for advice. (Participant ID 26. Krison Camp)

Another participant likened the experience of living in the camp to being lost in a jungle, with everyone focused on their own survival and little opportunity for emotional or practical support:

Life in the camp feels like being lost in a jungle. Everyone is focused on survival. Even when you're pregnant and need help, there's no time to ask for it. People are preoccupied with their own struggles, and while occasional help might come, you can't rely on it. Going through pregnancy alone here makes you feel invisible. (Participant ID 1. Krison Camp)

The challenges of single motherhood were starkly highlighted by one participant who spoke about the difficulty of raising children without support, particularly after a traumatic childbirth experience. She explained:

As a single mother of three, I'm completely on my own. The father left because he couldn't handle the responsibilities. Support is almost non-existent here. I nearly lost my life during childbirth with my last child, surrounded only by young children who couldn't help. In that moment, I realized how truly alone I am in navigating the challenges of pregnancy and childbirth, with no support system to help me access care when I need it the most. (Participant ID 20. Krison Camp)

Transportation challenges

Transportation challenges served as a critical barrier for refugees in accessing maternal healthcare services. These challenges were twofold: lack of reliable transportation options and high costs. Refugees residing far from healthcare facilities often faced delays or missed appointments due to limited transport access. While some camps had on-site clinics, these were often inadequate, requiring

referrals to district hospitals for specialized care. The cost of transportation further exacerbated financial strain, making it difficult for refugees to seek essential maternal healthcare services. One participant described the difficulty in reaching healthcare, emphasizing the need for improved transportation:

The main challenge we face is the lack of transportation. UNICEF took away the ambulance, and we urgently need it returned. Having an ambulance in the community would enable us to transport sick individuals quickly to Eikwe. Without it, many are afraid to seek care at night and prefer to deliver at home. Community Health Nurses (CHNs) are available at the Ampain health centre even at 11 p.m., but without proper transportation, their efforts are limited. We urgently need help to bring back the ambulance. (Participant ID 2, Krison Camp)

Another participant shared their experience about transportation costs that often prevented them from seeking care:

The clinic for my prenatal care is far from the camp, and the only transportation available is an expensive motorcycle taxi. Each visit requires careful budgeting, and sometimes I must skip appointments due to lack of funds. I constantly worry about missing critical care for my babies because of these transportation issues. (Participant ID 2, Ampain Camp)

Transportation challenges became even more critical during labour for some refugees, as one participant described:

During one rainy season, I was in labor and needed to get to the nearest health facility. The only transport was an old truck that struggled through muddy paths. It was overcrowded, and I had to sit on the floor. The journey was long and painful, and by the time we arrived, I was exhausted and scared. All I wanted was a safe place to give birth. (Participant ID 9, Ampain Camp)

One particularly distressing account involved delays in reaching medical care during pregnancy complications:

During my pregnancy, I faced severe complications that needed immediate medical care. The camp's only ambulance was frequently unavailable, and the nearest clinic was hours away on foot. When we eventually found a vehicle, the delay had already caused significant stress. I felt helpless and terrified for my baby's life due to the lack of timely transport-

tation. My baby was born severely asphyxiated. I was only lucky the nurses resuscitated the baby back to life. (Participant ID 11, Ampain Camp)

Extended waiting times at health facilities

Extended waiting times at health facilities discouraged refugees from seeking the care they need. Prolonged delays were particularly challenging for those with urgent health needs, young children, or work obligations that made spending an entire day at the clinic difficult. Overcrowding in public health facilities further exacerbated the issue, leading to reduced quality of care. Unlike local patients who may have multiple healthcare facilities to choose from, refugees are often limited to designated camp clinics or selected public hospitals, which are frequently overcrowded. While some refugees may access care through the National Health Insurance Scheme (NHIS), coverage is limited, and not all services are included. As a result, long queues are inevitable, and some refugees perceive that local patients are prioritized over them, further compounding their frustration and discouraging timely healthcare use. One participant highlighted this challenge:

"Every antenatal appointment was a long ordeal. I would spend hours waiting at a crowded clinic with limited staff, often from early morning until late afternoon. The prolonged waits were exhausting and stressful, making me worry about my baby's health." (Participant ID 17, Ampain Camp)

For many refugees, the lack of social support during these long waits made the experience even more difficult. Unlike local women who may have family members or friends accompanying them, refugee women often endured these hours alone, without assistance in managing their children or seeking clarification from healthcare workers. A participant described:

"Postnatal care was similarly challenging, with waits extending over four hours just to see a nurse. This was particularly tough as I was recovering from childbirth and caring for a newborn. Additionally, frequent visits to the lab for tests involved unpredictable and lengthy waiting times, which were frustrating and tiring." (Participant ID 12, Krison Camp)

Many refugees faced difficult trade-offs between seeking healthcare and meeting daily survival needs. Long waiting times, coupled with financial hardships, forced some to forgo essential maternal healthcare services. For those engaged in precarious work, missing an entire day at the clinic meant losing wages needed for food, rent, or other necessities. The struggle to balance healthcare with

economic survival often led to missed appointments and delayed care. One participant shared:

“The clinic is far from our camp, and I cannot afford to miss work every time I have an appointment. If I spend an entire day at the hospital, I lose money for food. Sometimes, I skip appointments because I cannot afford the long waits.” (Participant ID 10, Krisan Camp).

Discussion

The utilization of maternal healthcare services among refugee women remains a critical global health challenge, particularly in resource-limited settings like refugee camps in Ghana. By applying Bronfenbrenner's Ecological Systems Theory, these experiences can be understood across multiple interacting levels: individual, interpersonal, community, and institutional, providing a nuanced understanding of maternal healthcare access among refugee women. This study is among the first in Ghana to explore the maternal healthcare experiences of refugee women. The study revealed varied experience in seeking healthcare namely, enablers such as social support networks (interpersonal/community level) and good interpersonal relationships with healthcare staff (institutional level), which fostered trust and encouraged service utilization. Conversely, negative experiences such as discrimination at health facilities and negative provider attitudes toward refugees' maternal healthcare rights and abilities, coupled with challenges like language barriers, financial difficulties (individual level), inadequate social support (interpersonal level), transportation challenges, and extended waiting times at facilities (community/institutional level), discouraged timely and adequate care. By analyzing these contrasting experiences through an ecological lens, this study provides a structured understanding of the multiple levels of influence on maternal healthcare access among refugee women, integrating findings with existing literature to offer a comprehensive perspective on their healthcare realities.

Social support networks were generated as one of the most influential enablers of maternal healthcare access. Communal solidarity among refugees reduced feelings of isolation, enhanced emotional and practical support, and facilitated access to resources. Interpreted through Bronfenbrenner's Ecological Systems Theory, these networks operated across multiple levels: at the microsystem level, direct peer interactions offered reassurance and guidance during pregnancy; at the mesosystem level, they strengthened coordination with family and other supports, thereby improving care-seeking behaviour; at the exosystem level, camp management structures and organized support groups shaped the availability and functioning of these networks; and at the macrosystem level,

broader cultural norms and policies on refugee integration influenced opportunities for social cohesion. This aligns with studies such as Pangas et al. [17], which demonstrated that strong social networks in resource-limited settings enhance maternal healthcare access and alleviate stress. Stewart, et al. [39], similarly found that peer networks in refugee camps play a crucial role in overcoming barriers to antenatal care. These variations likely stem from differences in cultural dynamics and camp management. The findings from this study highlight the need to foster strong communal networks in refugee settings to sustain their positive impacts on maternal healthcare outcomes.

The study also revealed that good interpersonal relationships with healthcare providers significantly improved refugee women's healthcare experiences. Through the lens of Bronfenbrenner's Ecological Systems Theory, such supportive interactions operate at the microsystem level, directly influencing the women's engagement with care, while also shaping the mesosystem, as positive interactions enhance trust and communication between families and healthcare providers. Respect, empathy, and cultural sensitivity fostered trust and ensured that refugees felt supported, with tangible benefits such as financial assistance and emotional care. This finding resonates with Ngarmbatedjimal et al. [40] who emphasized that respectful maternity care enhances health outcomes and patient satisfaction for vulnerable groups.

The study also revealed that discrimination in healthcare settings is a significant barrier to refugees' access to maternal care, with many feelings marginalized due to cultural insensitivity, systemic biases, and discriminatory practices. These findings are consistent with Bronfenbrenner's concept of the exosystem, where broader institutional policies and practices beyond the immediate control of the individual impact maternal healthcare experiences. Mehta et al. [41] found that African refugee women in Boston felt excluded because healthcare providers failed to address their cultural needs, while Lin et al. [42] reported that migrant women with HIV in China delayed seeking services due to stigma and fear of legal repercussions. Ahrne et al. [43] also noted how Somali-born women in Sweden felt their cultural values were disregarded. These studies confirm the negative impact of discrimination on refugee women's healthcare access. However, some research, such as Berkel et al. [44], suggests that discrimination can be mitigated through cultural mediators and tailored services, reducing feelings of exclusion. Additionally, Bartlett et al. [45] found that refugee women perceived providers as supportive when efforts were made to understand their cultural backgrounds. These contrasting findings highlight that while discrimination is common, its impact can be reduced

with proper training and policies, such as integrating cultural competence and allowing flexibility within Standard Operating Procedures (SOPs) to meet the diverse needs of refugees. While these challenges are particularly significant for refugees, they are not unique to them. Studies in Ghana have reported mistreatment of Ghanaian women during childbirth, including verbal abuse, neglect, and denial of care due to financial constraints [46–48]. This suggests that the negative attitudes and discrimination observed in refugee maternal care may be an extension of broader systemic issues within Ghana's healthcare system. However, the refugee situation potentially exacerbates these experiences due to additional factors such as language barriers, legal uncertainties, and the perception that refugees are outsiders competing for limited healthcare resources. Thus, while discrimination in healthcare is not exclusive to refugees, their status makes them more vulnerable, reinforcing the need for targeted interventions to improve healthcare experiences for both refugees and host populations.

The negative attitudes of healthcare providers toward refugee women and their maternal healthcare rights are another critical barrier identified in this study. From the perspective of Bronfenbrenner's Ecological Systems Theory, these negative interactions reflect microsystem influences, as they occur in the immediate environment of refugee women and directly affect their experiences of care. Healthcare providers' prejudices or misconceptions regarding refugees' rights, cultural practices, or adherence to medical advice shape the day-to-day experiences of these women, demonstrating how microsystem interactions can either support or hinder access to services. Studies such as, Billett et al. [49] and Peprah et al. [50] similarly highlight how discrimination and conflicts between cultural expectations and healthcare systems affect continuity of care, illustrating the interaction between the refugee's microsystem (direct experiences with providers) and the mesosystem, where relationships between the women and the healthcare system are mediated by institutional norms and cultural understandings. Degni et al. [51] also reported unfriendly attitudes and poor communication in Finland, reinforcing the role of provider behaviors as proximal determinants of care experiences. These microsystem barriers are, in turn, influenced by exosystem and macrosystem factors, including healthcare policies, organizational culture, and broader societal attitudes toward refugees, which shape provider behaviors indirectly. Addressing these negative attitudes therefore requires interventions not only at the microsystem level such as cultural competency training but also at the exosystem and macrosystem levels, through policy reforms and institutional support, to foster empathy, respect, and protection of maternal

healthcare rights for refugee women, as suggested by Robertshaw et al. [52].

Language came out as one of the key barriers hindering the full utilization of maternal healthcare among refugee women in camps across Ghana. Several studies confirm this finding, emphasizing its role in miscommunication, delayed care, and inadequate treatment. For instance, Ojeleke, Groot and Pavlova [53] highlighted language barriers as a primary impediment to care delivery in complex emergencies, while DeSa, Gebremeskel, Omonaiye and Yaya [54] linked these barriers to stigmatization and reduced healthcare utilization among refugee mothers. However, some studies challenge this view, suggesting that language barriers are not always the primary obstacle. Kavukcu & Altıntaş [55], argued that while language can pose challenges, other structural issues such as limited healthcare infrastructure and socio-economic disparities often play a more significant role in restricting access to maternal care. Similarly, a study by Amponsah et al. [56], in Ghanaian refugee camps revealed that many women prioritized financial constraints and long travel distances over language as their main barriers to healthcare. Importantly, these studies did not rank the challenges but highlighted them as interrelated and context dependent. This suggests that while language barriers are critical, they must be understood within a broader web of interconnected obstacles. Addressing these issues effectively requires not only language solutions such as interpreters and cultural competency training, but also broader systemic changes, including improving healthcare accessibility and reducing socio-economic inequities, to fully meet the needs of refugee women seeking maternal healthcare.

Financial difficulties in accessing healthcare are another pervasive barrier impacting maternal healthcare access for refugee women. This finding resonates with the perspective of Bronfenbrenner's Ecological Systems Theory which posits that, these financial constraints affect multiple levels of influence: at the microsystem level, they limit women's immediate ability to seek maternal care; at the mesosystem level, they affect interactions between women, families, and healthcare providers; and at the exosystem and macrosystem levels, they reflect broader economic policies, social support structures, and societal attitudes toward refugees. The Biopsychosocial Model by Gatchel, Ray, Kishino and Brindle [57], provides a holistic view of how financial stress, coupled with psychological and social factors, influences healthcare-seeking behaviour among refugees. Financial barriers prevent many refugee women from accessing essential maternal care, often leading to delayed care and increased health risks [32, 58]. However, some studies challenge the extent of financial barriers, noting that in some refugee settings with international support, subsidized healthcare

services alleviate economic constraints to some degree [59, 60]. This discrepancy aids the importance of context-specific interventions.

Transportation has emerged as a key barrier to health-care access for refugee populations, particularly in rural and underserved areas. Vu et al. [61] emphasized the importance of transportation in facilitating access to sexual and reproductive health services for refugee women. Refugees often reside in remote areas or camps with poor transportation infrastructure, making it difficult for them to travel to healthcare facilities for antenatal and postnatal care. The need for transport among refugees stems from the remote locations of camps and the distance to healthcare facilities. Given Ghana's already weak public transport and ambulatory systems, access is even more challenging for refugees who lack financial resources. Mahimbo et al. [62] also highlighted limited access to transportation as a significant factor impeding refugees' ability to receive immunization services in Australia. Similarly, Lusambili et al. [63] found that fear, economic challenges, and lack of migrant-inclusive health policies contributed to transportation difficulties that hindered refugees' access to maternal healthcare during the COVID-19 pandemic. The lack of reliable and affordable transportation options contributes to delays in seeking care, missed appointments, and, in some cases, home deliveries without skilled birth attendants. While UN agencies and camp managers provide some support, it remains inconsistent. Strengthening transport infrastructure and integrating emergency transport services into camp management could help bridge this gap, ultimately improving healthcare access for refugee populations.

The findings revealed that extended waiting times at health facilities, often due to overcrowding and long queues, significantly delayed access to maternal healthcare, particularly antenatal and emergency obstetric services. Robertson [64] in Sweden highlighted that women from refugee backgrounds often experienced long waiting times and felt tense and disembodied due to the hardships of migration and healthcare system constraints. Long waiting times are particularly challenging for refugee women, as they may be unfamiliar with the healthcare system and often face additional barriers, such as language difficulties and lack of family support, as noted by Riggs et al. [15] also note that unfamiliarity with health systems, coupled with language barriers and lack of family support, amplifies the burden of waiting. From the perspective of the Three Delays Model, prolonged waiting reflects the second delay receiving timely and adequate care at a health facility while also compounding the first delay, as women may postpone seeking care if they anticipate long queues and frustration.

Within Bronfenbrenner's Ecological Systems Theory, these delays can be explained across levels: at the micro-system, prolonged waiting and strained interactions with staff create stress and discourage timely care-seeking; at the mesosystem, delays disrupt coordination with family and social support; the exosystem reflects institutional barriers such as understaffing and inadequate infrastructure; and the macrosystem highlights how national refugee and health policies shape access and prioritization. Addressing these multi-level barriers through improved staffing, better service organization, and refugee-sensitive health policies could reduce waiting times and mitigate both systemic and personal delays in maternal care for refugee women.

Strengths and limitations of the study

A major strength of this study is its ability to capture in-depth narratives of mothers in Krisan and Ampain Refugee Camps, offering unique insights into maternal healthcare within refugee settings that are often under-explored. The use of interpreters, while necessary to overcome language barriers, may have introduced minor translation inconsistencies despite efforts to ensure accuracy. Another limitation was the use of a structured interview guide, which provided consistency across participants but may have constrained deeper exploration of issues outside the predetermined questions. Additionally, resource limitations restricted the inclusion of other key stakeholders, such as healthcare providers and policymakers, which could have provided complementary perspectives. Nonetheless, the achievement of data saturation with 29 participants shows the robustness of the findings, emphasizing that the strength of the study lies in the richness and depth of the narratives rather than numerical size.

Implications for policy and practice

Addressing the challenges identified in this study requires targeted policy interventions and improvements in healthcare practices. The Ministry of Health (MoH) and the Ghana Refugee Board (GRB), in collaboration with the United Nations High Commissioner for Refugees (UNHCR), should prioritize multilingual healthcare services and the recruitment of trained translators to facilitate effective communication between refugee mothers and healthcare providers. Additionally, existing financial assistance programs such as the Livelihood Empowerment Against Poverty (LEAP) initiative or UNHCR's cash assistance programs should be evaluated and expanded to fill gaps in maternal healthcare coverage, ensuring that refugee mothers have access to subsidized or free services. To combat discrimination and promote inclusivity,

the Ghana Health Service (GHS), in partnership with organizations like Médecins Sans Frontières (MSF), should implement comprehensive cultural competence training for healthcare providers, focusing on reducing bias and addressing the specific needs of refugee populations. Furthermore, existing policies like the National Health Insurance Scheme (NHIS) should be reviewed to ensure that refugees are fully integrated into the system, particularly in relation to maternal healthcare coverage. To enhance the effectiveness of these strategies, the Network of Practice (NOP) framework, which encourages collaboration and knowledge sharing among stakeholders, should be leveraged to improve coordination between healthcare providers, refugee organizations, and policymakers. Finally, addressing operational challenges such as long wait times requires systemic changes like task-shifting and improved referral systems, which can be implemented by the GHS at refugee camps like Krisan and Ampain. By optimizing current policies and integrating the NOP framework, stakeholders can improve the accessibility, quality, and equity of maternal healthcare for refugee populations, leading to better maternal health outcomes.

Conclusion

This study highlights the multifaceted challenges and experiences of refugee mothers in accessing maternal healthcare services within refugee camps in Ghana. The findings showed that refugee women experienced both positive (enablers) and negative experiences in their pursuit of maternity care. Negative experiences included discrimination at health facilities and negative attitudes from healthcare providers regarding refugees' maternal healthcare rights and abilities. Additionally, key challenges such as language barriers, financial difficulties, inadequate social support, transportation challenges, and long waiting times further restricted timely and equitable maternal healthcare access. Despite these barriers, some refugee women reported some enablers, including social support networks and good interpersonal relationships with healthcare staff, which fostered trust and encouraged service utilization. Taken together, the study reveals that these challenges and experiences not only affect the physical health of refugee mothers but also contribute to psychological distress and exacerbate existing inequalities in healthcare access. Addressing these barriers and leveraging positive factors are essential steps toward ensuring more inclusive and equitable maternal healthcare services in refugee settings. Therefore, future interventions must focus on improving healthcare accessibility through overcoming language and financial barriers, promoting cultural sensitivity among healthcare providers, and strengthening social support networks to enhance maternal health outcomes for refugee women.

Supplementary Information

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Supplementary Material 1.

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Authors' contributions

Contributors Conceptualization: LB conceptualized the study under the supervision of DSO and JKG. LB prepared the original draft, while DSO and JKG reviewed and edited the manuscript. The study was self-funded, with project administration and supervision provided by DSO and JKG. DSO served as the guarantor of the study.

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Data availability

Data are available upon reasonable request. All data relevant to the study are included in the article. Further data in the form of deidentified participant data such as interview transcripts are stored in a secure server within the University of Port Harcourt, Nigeria School of Public Health and are available on reasonable request by emailing the corresponding author.

Declarations

Competing interests

The authors declare no competing interests.

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