POLICY BRIEF

Sexual and Reproductive Health for Displaced Women in Greece: Closing the Access Gap

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Displaced women in Greece face persistent, avoidable barriers to sexual and reproductive health (SRH) care, including language and interpretation gaps, documentation requirements that gate access, financial cost, and service provision that collapses when short-term NGO funding ends. Drawing on published evidence and on frontline data from Women's Healthcare on the Move, a community-embedded outreach initiative in Athens, this brief identifies where the reception system fails displaced women and sets out six practical measures for health authorities, funders, and humanitarian actors. Our core argument is that SRH is basic healthcare, and access to it should not depend on a woman's paperwork, her language, or the funding cycle of the nearest NGO.

1. The Challenge

Forced displacement is at record levels worldwide, and women and girls carry a distinct and often invisible share of its health burden. In displacement, routine sexual and reproductive health needs, such as contraception, infertility, antenatal and postnatal care, cervical cancer screening, and care after gender-based violence, do not pause; they intensify, even as the systems meant to meet them break down.

Greece sits at the frontline of this challenge. Since 2015, roughly a million people have sought asylum in Europe via Greece, and successive border measures have left many women stranded in the country for years while their claims are decided. Some are now even being sent back to Greece after having established new lives in other EU countries, owing to individual EU countries' policy changes. Although refugees and asylum seekers hold a formal right to public healthcare, that right is routinely hollowed out in practice, and for women's reproductive health in particular, the gap between entitlement and access is wide.

2. Barriers to Care

The obstacles displaced women face are well documented and mutually reinforcing. A 2023 scoping review in PLOS ONE identified the main barriers to SRH access for migrant, displaced, and refugee women as limited knowledge of available services, cultural unacceptability of how services are offered, financial inaccessibility, and, repeatedly, language barriers between women and their providers, with limited to no access to properly trained, culturally-sensitive translators.

In the Greek context specifically, a 2026 study of refugee women in accommodation facilities found that access to preventive gynecological examinations, family planning, and prenatal and perinatal care was often limited or sporadic, and that most women were unfamiliar with preventive care before arriving in Greece, a knowledge gap

compounded by a lack of interpretation and clear health information. Formal barriers make this worse: reviews of SRH provision in Greece have documented that access can hinge on obtaining legal documents, and that survivors of sexual violence have faced requirements to report to police in order to receive post-rape medical care, a precondition that deters women from seeking care at all.

Underlying all of this is fragility of provision. Much SRH care for this population is delivered not by the public system but by NGOs and volunteer providers, and those programs stop when funding lapses or restrictions tighten, cutting off contraception, hygiene supplies, and health education overnight. Continuity of care suffers most: a woman started on an injectable or implantable contraceptive in one program may have nowhere to obtain her next dose, converting a preventable gap into an unintended pregnancy.

3. What We See on the Ground

Women's Healthcare on the Move (WHOM) was founded to address exactly this gap. Operating community-embedded outreach in Athens, WHOM delivers health education and connects refugee and migrant women to sexual and reproductive health services through partner organisations, and collects health-needs data to document what the system is missing. To date the initiative has reached more than 250 women from over a dozen countries of origin through regular community outreach sessions, working alongside a network of local and international partners.

Our field data mirror and sharpen the published evidence. The single greatest determinant of whether a woman receives appropriate care is not clinical complexity but language: without trusted interpretation, including for less-common and indigenous languages that mainstream services rarely accommodate, histories go untaken and consent is not truly informed. The second is continuity: women repeatedly present having begun contraception elsewhere with no pathway to sustain it. The third is trust, which community-embedded, women-centered care builds and which top-down, documentation-driven systems erode. These are not intractable clinical problems; they are solvable design and policy problems.

4. Policy Recommendations

1. **Guarantee funded interpretation.** Resource trained medical interpretation across all SRH services for displaced populations, explicitly including less-common and indigenous languages. Language access is not an add-on; it is the precondition for safe, consented care.
2. **Decouple care from documentation.** Remove legal-status and police-reporting preconditions for SRH and gender-based-violence care. Care after sexual violence, in particular, must never be contingent on a woman first filing a police report.
3. **Sustain multi-year funding for community outreach.** Fund community-embedded, NGO-delivered SRH outreach on multi-year rather than short-cycle terms, so that provision does not collapse mid-treatment. Continuity of funding is continuity of care.
4. **Standardize contraceptive continuity.** Integrate the full range of contraception, including continuity for long-acting reversible methods, into the reception system's standard of care, consistent with the Minimum Initial Service Package for reproductive health in crises.
5. **Invest in peer health-promotion workers.** Recruit and train health-promotion workers and interpreters from within refugee communities, extending reach, building trust, and improving cultural acceptability of services.
6. **Build routine, disaggregated data.** Establish systematic, disaggregated collection of displaced women's SRH needs and outcomes to guide resource allocation, replicating at scale the field-data model that frontline initiatives already use.

Conclusion

The barriers documented here are neither new nor mysterious, and none require scientific breakthrough to solve; they require political will, sustained funding, and service design that starts from displaced women's realities rather than from administrative convenience. Frontline initiatives can demonstrate what works, but they cannot substitute for a system that treats reproductive health as the basic healthcare it is. Closing this gap is achievable, and the measures above are where to begin.

Selected Sources

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