Health and socio-cultural experiences of refugee women: An integrative review

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All authors participated in the design of the study. PMD, LG, AG, and MD provided critical feedback on drafts. All authors read and approved the final manuscript.

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ABSTRACT

Background: Approximately half of the global refugee population are women, yet they remain largely understudied from the perspective of gender. The aim of this review was to investigate the impact of refugee women's resettlement and socio-cultural experiences on their health. This review also explored factors promoting resilience in refugee women.

Methods: Eight databases were searched for peer-reviewed manuscripts published from 2005 to 2014. Grey literature was also reviewed. Data were extracted for population, data collection methods, data analysis, and findings. The Resource-Based Model was used as an overarching framework for data synthesis.

Results: Following the screening of titles and abstracts, 20 studies met the study inclusion criteria. Cultural factors, social and material factors, personal factors, and resilience factors were identified as main themes influencing the health of refugee women.

Conclusion: Promotion of factors that enable resettlement is important in promoting the health and wellbeing of refugee women.

Keywords: health, integrative review, refugee women, socio-cultural

What do we know?

- Refugee women are at greater risk of mental health problems, such as depression and anxiety, due to lack of social support, violence, poverty, adverse health conditions, and

discrimination.

- As wives and/or mothers, women bear extra burdens in the process of immigration in order to support family members adjust to a new way of living and often undertake the role of protecting and upholding family values, culture, and beliefs.
- Refugee children and the elderly have been at the center of attention in health research; however, women remain an understudied refugee population.

What does this paper add?

- This review outlines specific issues facing refugee women. These issues can impact on their health and integration into host societies.
- Refugee women develop resilience strategies that help them mitigate adverse experiences associated with migration.
- The review incorporates a conceptual framework based on the Resource-Based Model and argues that the addition of resilience factors can lend a better explanation to immigrant population experiences.

Recommendations:

- Targeted policies and services are needed to support the capacity of communities empowering refugee women with social and cultural supports.
- Providing health information and services such as counselling can enable refugee women to appropriately identify and seek professional help in a timely manner.
- Culturally and linguistically appropriate mental health support groups can provide a platform for refugee women to share their experiences and burdens and attain social support from individuals who share common experiences and challenges.
- Further qualitative studies are needed to explore new challenges that refugee women confront during resettlement and the ways to overcome barriers.

INTRODUCTION

In recent decades, the number of asylum seekers and refugees has risen dramatically worldwide because of war, political conflict, and oppression (1). While an 'asylum seeker' is a person who has applied for refugee status under the 1951 Geneva Convention, a 'refugee' is a person whose application has been accepted (2). The global number of refugees under the United Nation High Commissioner for Refugees' mandate (UNHCR) is estimated to be 11.1 million. Currently, the United States (USA), France, Uganda, Sweden, and Australia receive a large number of asylum seekers (3). Recent conflict in the Middle East, particularly Syria, has created an outpouring of refugees, many of whom are women and children (4).

Refugees and asylum seekers have diverse experiences and reasons for leaving their home countries. While some people choose to migrate voluntarily, millions are forced to leave their countries of origin and resettle in other countries due to factors including war, famine, poverty, political unrest, fear of persecution, economic instability and natural disasters (5, 6). Refugees and asylum seekers frequently leave their countries in haste without any preparation and with a hope to be able to return to their country of origin. Many have had "no time to say goodbyes" (7, 8).

Globally, about half of the refugee population consists of women (9); yet, they often remain underrepresented in research and receive inadequate attention and support as a result of socio-cultural disadvantages and language barriers (10). Over the last decade, a developing body of literature on refugee and immigrant women and their health needs has predominantly revolved around their reproductive and antenatal health (11, 12). In general, studies have either not separated refugees from immigrants in their report or addressed the health experiences of refugees as a whole without gender differentiation. While refugee children and

the elderly have drawn some attention, the health and socio-cultural experiences of refugee women are often overlooked.

Evidence suggests that refugees, and in particular women, are vulnerable to mental health issues (13-15). They are reportedly at greater risk of post-traumatic stress disorder (PTSD), depression, and anxiety related to lack of social support, poverty, poor health conditions, and discrimination (16, 17). As wives and/or mothers, women bear extra burdens in the process of immigration in order to support family members to adjust to a new way of living and often undertake the role of protecting and upholding family values, culture, and beliefs (18).

Resettlement is particularly challenging for women due to their lower socioeconomic status (19). For example, compared to men, language barriers more often impede women's access to education, employment opportunities, health care services and factors that can facilitate adjustment and adaptation (20, 21). O'Mahony (2013) calls for further research to explore the experiences of refugee women in pre-migration and post-migration stages in order to help identify their unique health concerns and social support needs (22). The authors of this review set out to analyze the relevant literature from the past decade to help understand refugee women's resettlement and socio-cultural experiences and the impact of these experiences on their health and overall wellbeing.

METHODS

Eligibility criteria

Peer-reviewed and grey literature published between 2005 and 2014 were included to reflect the contemporary contextual conditions for refugees and asylum seekers in host countries. Articles needed to focus on adult refugee women who left their country seeking asylum in other countries. Both quantitative and qualitative studies were included to help capture the various aspects of refugee women experiences. Articles were excluded if they did not focus on adult refugee women.

Search strategy

A systematic search strategy was developed in consultation with a health librarian. Databases and search engines used were Medline, CINAHL, ProQuest, Academic Search Complete, Scopus, Informit, PsycINFO, Google Scholar, and Google. Search terms and keywords were 'refugee*', 'asylum seeker*', 'humanitarian', 'women', 'female', 'cultur*', 'social', and 'health'. Reference lists of included articles were also searched for relevant articles. Article titles and abstracts were reviewed by the first author who applied inclusion and exclusion criteria. If unclear, the full text of the articles was also reviewed. This integrative review followed the Preferred Reporting Items for Systematic Review (PRISMA) guideline to ensure a systematic search. The PRISMA guideline is an established appraisal tool enabling researchers to perform practical and transparent literature searches and report on systematic reviews (23).

Methodological assessment and data analysis

Quality of the relevant articles was assessed using the Critical Appraisal Skills Program (CASP) and the PRISMA tool. However, due to the lack of adequate high-quality studies addressing the aims of this review, low-quality studies were not excluded from the review. The first author reviewed the studies for research population, setting, method of data collection and analysis, and findings. Table 1 illustrates the key findings of included articles. Extracted data were independently reviewed by all authors to increase the rigor of the review, and dissensions were resolved through conversations among the authors.

The post-migration phase of the Resource-Based Model (RBM), which is a combination of Berry, Hobfoll, and Lazarus and Folkman's theories, was used as an organizing framework for this review and provided the structure for analysis and presentation of results (24). While there are some similarities between the RBM and social determinants of health framework (25), the RBM focuses specifically on migrants' adaptation process and their psychological

wellbeing. The RBM reflects the various resources immigrants use to meet their needs, goals and demands. The assumption is that when needs, goals and demands are met suitably by accessible resources, individuals are satisfied with their psychological health (26).

The findings of the included qualitative papers were read several times by the first author to derive direct analysis without a model or priori expectation. The primary findings were discussed by all authors to assure the trustworthiness of the derived themes and findings. Derived themes were then grouped under the main categories of RBM to provide an overview of refugee women's experiences and health issues.

RESULTS

The literature search yielded 899 articles. Following the application of the study's inclusion and exclusion criteria and removal of duplicates, 25 articles remained for further review. Five articles were subsequently excluded because of the amalgamation of immigrants and refugees, and men and women in the reporting of results. The search process and article selection are depicted in Figure 1. Of the included 20 articles (Table 1), the majority of the studies were qualitative (n=12), followed by quantitative (n=6) and mixed methods (n=2).

Overall, four main categories were identified. These included: (1) cultural factors, (2) social and material factors, (3) personal factors and (4) resilience factors. The findings of this review are explained in greater detail in the following sections.

Cultural Factors:

Lack of proficiency in the dominant language of the host country reduces refugee women's chance of sharing experiences and burdens, increasing the risk of low self-esteem, loneliness, and depression (27, 28). Refugee women, consequently, can become socially isolated, a factor that can negatively affect their acculturation and resettlement process (29). In their exploratory study, Casimiro et al. (2007) assessed the impact of language proficiency on the process and length of resettlement time among refugee women in Australia. They

found that the ability to communicate with others was a significant factor in securing a job, accessing education services and promoting personal autonomy. Although interpreter services are frequently available, their uptake and utilization are variable. Refugee women may not be willing to share their personal experiences with interpreters due to a fear of misinterpretation, exposure, long waiting times, and perceived impatience of interpreters (29).

Culture shock is a multidimensional stressful experience resulting from experiencing an unfamiliar lifestyle or contact with a different culture in a new environment (30, 31). This is commonly experienced by refugee women and described as "dropping from the moon to the earth" (32). In a study by McBrien (2011), refugee mothers were concerned about their ability to survive in the USA because of a lack of cultural intelligence. They were concerned about the extent of changes in their children's behavior and underlying cultural values. Refugee women were particularly apprehensive about their daughters being bullied at school or developing disrespectful habits (33).

Social and Material Factors:

Having a secure job is a critical factor in mental health and wellbeing of refugees (22, 27, 29, 32, 34-37). Being employed enables refugee women to enhance their health status, as well as increasing their social networks (27). Nevertheless, employment is strongly linked to language competency. The ability to communicate efficiently is considered a critical factor in recruitment (27, 28).

Furthermore, refugee women face many challenges in securing safe and affordable housing. Difficulty in obtaining housing is a post-migration stressor that hinders resettlement. Difficulties include the perception of realtors that refugee renters may not be able to pay the rent or that multiple children may damage properties (22, 28, 36, 38, 39). Not having convenient and secure accommodation is a stressful resettlement experience that should not

be neglected by health providers who aim to improve the health and wellbeing of refugee women (36).

Loss of social support from either family or husbands leaving refugee women may result in sadness, hopelessness, and poverty. These feelings may be aggravated by being abandoned by their husbands who seek to profit from more advantaged women in the host country (40).

Personal factors:

Family separation is another problem that confronts refugees. Many refugee women describe leaving behind family members in an unsettled situation as a “traumatic experience” (13, 22, 28, 32, 41, 42). Uncertainty about the condition of family members who have been left behind is a key source of distress amongst refugee women (43). This is seen as a major contributing factor to the experience of depression and other mental disorders (13, 21, 41, 42, 44). In contrast, a united family is a factor that enhances and maintains relationships and family wellbeing (43).

Exploitation of young girls is another significant concern for refugee women. Many women in refugee camps report worrying about their daughters being involved in sex work. In a study of a refugee camp in Africa, mothers explained that although they could not afford it, their young daughters requested luxuries such as clothes and shoes to be accepted in the new society and “look smart”, a need that may lead them to be involved in sex work. Alternatively, some women want to support their young daughters by undertaking extra work or being engaged in sex work themselves (35).

Collectively, these factors increase the risk of mental health problems among refugee women, making adjustment to new host countries particularly difficult for this group (13). Some women may also lose their hope for a bright future. A study in the Congo found that

refugee women attempted to improve circumstances only for their children and had no hope of a better future for themselves (35). These adverse feelings can result in social isolation making some refugee women vulnerable to decision-making biases and the loss of successful social integration (40). In contrast, Bosnian refugee women were optimistic and believed in a bright future for their children and themselves (32).

Resilience factors:

The review of the literature suggests that refugee women employ various strategies to cope with their new way of life. Spiritual fulfilment and social support are commonly used resilience strategies that help asylum seeker and refugee women maintain equilibrium in spite of their uncertain status and ongoing distress (32). Spirituality is defined as either non-religious spirituality which can contribute to coping with new situations and accompanying shocking experiences (32) such as loss of parental authority (42), loss of professional status (29), and family disconnection (32), or belief in a higher power which leads to a "sense of meaning", "purpose in life", and "wellbeing" (27). "Standing on our legs" is a conceptualization used by some refugee women, giving them a sense of pride and empowerment, and leading to optimism, hope, and a sense of wellbeing (27).

Family and ethnic communities are additional supporting resources contributing to the wellbeing of refugee women and their integration into a new society. Ethnic communities support refugees by linking them to community and health services, which can ease the acculturation process for new arrivals (27). These communities provide an opportunity for women to share their experiences and cultural values with their counterparts, alleviating the burden of distress (45). Communities also provide support in the form of information and empower refugee women to deal more effectively with their existing concerns (27). The

social supports provided by ethnic communities are recognized as a critical predictor of refugees' mental health (13, 32, 45).

In addition, re-establishing kinship and ensuring family unity helps to mitigate adverse effects of immigration (43). As such, refugee women who lack family resources may experience more vulnerability to mental health problems (41). Apart from immediate family members, extended family and close friends have also been cited as important sources of support (41). Making self-sacrifices for family has been reported as a resilience factor by some refugee women which can help strengthen their self-confidence, position in the family, and identity over the period of transition to a new life (32).

DISCUSSION

This integrative review highlights individual and socio-cultural difficulties that refugee women may encounter in the process of resettlement and the impact of these experiences on their health and wellbeing. The results of this review suggest that the circumstances surrounding resettlement may adversely affect the health of those who seek asylum and/or refuge, while adopting effective strategies helps mitigate these impacts.

In spite of refugee women's tendency to be integrated into new societies, an inability to communicate in the language of the host country may affect their successful integration (27, 28), as language competency is an important factor facilitating the resettlement process for this population group (29, 46). This finding is also supported by a study that found that integration is easier for those who arrive at a younger age, possibly because language acquisition is considerably easier (47). However, some studies have found that language barriers are not a critical constraint in the integration process of refugees (29, 48), and that prejudice and family breakdown are more significant barriers hindering the integration of refugee women (29, 48). This inconsistency may relate to differences in study designs and

needs further research. Language deficiency may also negatively affect refugee women's health by hindering them from accessing health care services including preventive screening such as mammography and cervical screening programs (48), although some believe that lack of information and "shyness" are more influential barriers (49). There is a need for further research to identify barriers to health service access and use in particular population groups (50, 51).

Supporting refugee women to obtain affordable and good quality accommodation is another critical factor that can facilitate their successful resettlement and accelerate the integration process (52, 53). Lack of a secure job (52) and stigma towards refugees (22) have been identified as the major obstacles to attaining safe and convenient housing. However, this seems to vary from place to place even within the same host country (52). For example, if refugees are able to find a secure job in Montreal, they can also afford a convenient property, while the story is different in Vancouver and Toronto due to the high cost of accommodation, shortage of social housing, and racial discrimination. These findings, however, cannot be generalized due to small sample size and existent bias related to recruitment among a specific immigrant organization (52).

Separation from family as a personal resource exposes refugees to the risk of depression. While refugees' self-esteem, sense of mastery, and integration usually improve in host countries (54-56), the risk of depression seems to increase with the length of time away from close relatives (13). The role of the intact family as a significant supporting resource in successful integration is important and has been considered in the RBM (24). However, discrepancy between refugees' and Westerners' concepts of family makes it difficult for refugees to apply for family reunification. Refugees who are mostly from Eastern cultures, define family as people who are living together including extended family, not just parents, children and siblings. Once a great support resource, separation from immediate and/or

extended family adds to the burden of stress increasing the risk of mental disorders such as depression in this population (57). Understanding different cultural meanings of “family” and making changes towards reunification policies should be important considerations for policy makers and care providers when developing evidence based and tailored supportive programs to help improve the health and wellbeing of refugees.

Providing health information and services such as counselling and educative workshops can enable refugee women to appropriately identify and seek professional help in a timely manner (58, 59). Moreover, culturally and linguistically appropriate mental health discussion groups provide a platform for refugee women to share their experiences and burdens and attain social support from individuals who share common experiences and challenges (60).

While much of the literature on refugees has focused on adverse effects such as vulnerability and challenges, immigration can also bring about some positive changes for refugee women such as freedom, equity, and greater opportunities for education and work (56). The negative experiences associated with immigration can be considered loss of resources that can induce further loss. For example, losing social status due to language deficiency begets further loss in refugees. This is referred to as “resource loss spiral” which can adversely impact on the mental health of refugees (26, 61).

Findings of this review lend support to the RBM. Resilience facilitators were also identified as important factors affecting the resettlement process and the health of refugees. These factors also need to be understood to provide a more comprehensive picture of immigrants’ strengths and challenges (Figure 2).

Resilience is a dynamic and multidimensional factor (62) which empowers refugee women to cope with a new situation through adapting as well as recovering from traumatic or

stressful conditions (63). While resource loss is a threat to mental health of this population group (64), understanding facilitators of resilience can help develop appropriate programs to prevent further health decline and improve overall health and wellbeing of refugees (65). Resilience is an overlooked area of refugee research, including the RBM (66-68), but it is increasingly gaining attention (56, 69-71).

There are many studies that emphasize the significant role of resilience factors (spirituality and social support) on health and wellbeing (39, 65, 69, 70, 72), however, further research is needed to help resolve some existing controversial issues (73). For example, while overall women seem to be more resilient than men, the rate of depression and anxiety is also higher amongst women (63). Moreover, while many studies consider resilience as a protective factor that enables women to maintain or promote their health status (13, 27, 32, 45), hardly any research has focused on understanding how resilience mitigates the adverse resettlement experiences of refugee women (71).

CONCLUSION

The findings of this review suggest that cultural, social and material, and personal resources of refugee women are lost during the different phases of immigration (23). Yet, helping refugee women to appropriately identify and apply culturally appropriate resilience facilitators can improve the health and experiences of this vulnerable population group. It is recommended that resilience factors be incorporated into the RBM to help depict a more complete picture of immigrants' challenges and resilience strategies. In addition, understanding refugee women's values, perspectives, and expectations and using this knowledge to inform immigration policy can help improve care and outcomes for refugee populations.

COMPETING INTERESTS

The author(s) declare that they have no competing interests.

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Figure 1: PRISMA flow chart presenting the selection of studies

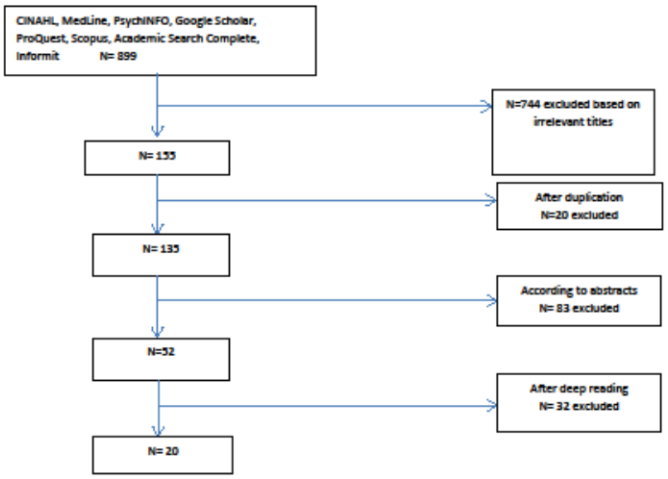

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Figure 2: Incorporated Conceptual Framework Based on the Resource-Based Model

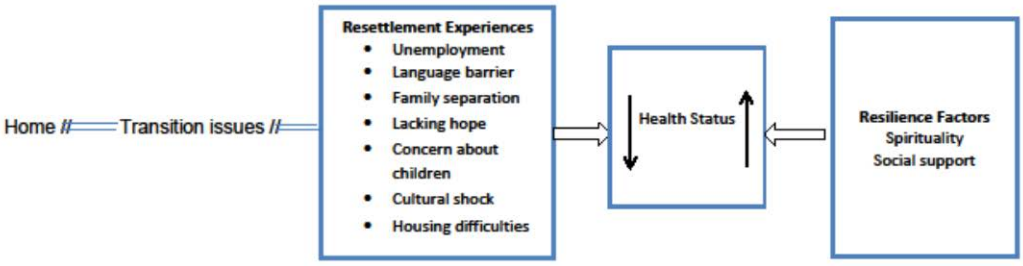

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Table I: Summary of selected articles by first author, country, and aim of study, sampling method, instruments, main results, and type of study

Author (year)	Country	Aim of study	Sampling Method	Instruments	Main results	Type of study
Drummond et al (2011)	Australia	To determine whether highly stigmatized health problems create particular barriers for health care utilization in resettled refugees, and to ascertain whether age, level of education, or duration of resettlement might influence help-seeking pathways or barriers to health care.	51 west African refugee women and 100 Australian women were recruited by invitation from the social network of eight west African survey administrators (African women). Undergraduate psychology students each recruited 12-15 female adults (Australian women).	Demographic questionnaire The questionnaire was part of a large survey initiated by a group of women from the West African community in Perth who were concerned about HIV and other disease spreading within their community.	Barriers to access health care services: (West African refugee women) Interpersonal barriers (feeling too embarrassed or ashamed, afraid of others thinking, afraid of being judged, fear of losing their job or being hospitalized, pessimism, a sense of personal control).Increasing years of residence in Australia contributed to increase the thinking about no money, no time, the distance to health care services. Australian women: older less-educated women were more likely than younger more-educated women to approach a medical practitioner to manage stress. Feeling ashamed or embarrassed, fear of other's thinking, fear of losing their job.	Quantitative
Hashimoto and Rose (2011)	Australia	to explore Sudanese refugee women's perceptions of the program and ongoing resettlement needs for future service development.	12 adult women were recruited from an 8-week program at the Mamre Homestead	Group interview Interview questions were based around the exploring issues in resettlement to determine participant needs, including respite, language needs, employment and access	Key stressors raised include: Acculturation, housing difficulties, developing language skills, lack of employment opportunities and family separation.	Qualitative
Casimiro et al (2007)	Australia	To explore resettlement issues of Muslim refugee women during their first five years of arrival	80 Muslim refugee women (35 Iraqi, 34 Sudanese and 11 Afghan) were recruited by purposive sampling	Semi-structured interviews Focus group with 30 participants Questions were based on the participants experiences over resettlements years and their needs	The main issues: English language competency (poor language was seen as a significant barrier to employment, feeling isolation, loneliness and depression) Economic and job security(lack of recognition of overseas qualifications, lack of financial resources to upgrade qualifications, discrimination, poor understanding of job network and lack of understanding of religious beliefs and practices) Gender and spousal influence Security and fear (media, racism and discrimination)	Qualitative
Schweitzer et al (2006)	Australia	To explore the impact of pre-migration trauma, post-migration living difficulties and social support on the current mental health of resettled Sudanese refugees	63 (21 female, 42 male) were recruited by Snowball sampling by bilingual community workers	Demographic and social characteristics The Harvard Trauma Questionnaire Hopkins Symptom Checklist Post-migration Living Difficulties	Social support leads to well-being mentally. Support from ethnic community is the most important form of support. Pre-migration trauma, family status and gender influence mental health outcomes.	Quantitative

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