Health-related needs and barriers for forcibly displaced women: a systematic review

Jenny Jesuthasan
Charite Universitatsmedizin Berlin
Zara Witte
Charite Universitatsmedizin Berlin
Sabine Oertelt-Prigione (sabine.oertelt-prigione@radboudumc.nl)
Radboudumc https://orcid.org/0000-0003-3856-3864

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Abstract

Introduction Women represent a large proportion of the currently internationally displaced individuals. Due to gender roles, care duty, educational and economic imbalance their experiences and vulnerability during flight and relocation differ from that of men and children. The currently available information about their specific health-related needs and barriers to access is scarce and scattered. Methods We searched PubMed, Medline, EMBASE, Cochrane Library and Scopus to identify publications that explored the unique experiences of female refugees between 1 January 2008 and 30 June 2018. Publications needed to address the health needs of refugees, asylum seekers or displaced individuals, include at least 50% women in their study and employ a user-centered perspective, i.e. focus on the perspective of displaced individuals themselves and not health care providers. A framework of themes was identified and applied to all publications. Results We identified 1945 publications of which 13 could be included in the present review. Twelve of these publications employed qualitative and/or innovative methodology (e.g. ethnographies, index cards, photovoice). We identified five broad categories of health-related needs (immediate healthcare, communication, sultural/spiritual, social, economic), which are further detailed. Conclusions A concerted action providing information and culturally-sensitive care, while supporting language acquisition and economic empowerment is essential to improving the health status of female refugees. Transformative interventions need to address multiple axes of unequal access for female refugees to increase participation and overall health.

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refugees. Transformative interventions need to address multiple axes of unequal access for female refugees to increase participation and overall health.

Background

The most recent statistics from the United Nations High Commissioner for Refugees (UNHCR) estimate that currently about 69 million people live in a situation of displacement worldwide [1]. These people are classified as *asylum seekers* if they apply for refugee status in a country other than their one of origin, and *refugees* if they have been granted the status. In addition individuals can move within their country of origin as *internally displaced people* (IDPs) or move to other countries as *migrants*, i.e. without applying for asylum [2].

Conflict-related displacement has affected Africa and the Middle East for several decades, yet Europe, Northern America and Australia have limited the influx of refugees into their territories. In the years 2015/16 Europe has experienced the largest mass migrations since WWII and was dramatically unprepared to meeting the needs of these populations. Given the instability of the geopolitical situation in many regions of the world and the growing impact of climate change, flight and migration but also displacement within countries will likely increase [3]. Western nations will need to provide adequate supporting services, such as healthcare and social support, and ensure the fundamental right to health to facilitate long-term integration for the incoming.

Healthcare represents an essential need of the refugee population [4, 5]; in the acute post-arrival phase as well as in the long-term integration phase. Upon the assessment of needs and necessary interventions, subgroups are rarely taken into account. Women represent a particularly exposed group among refugees due to their gender roles, care duties and physical vulnerability. Many of the fleeing women have had limited access to education in their home countries, making them logistically, economically and physically dependent on their partners [6]. They frequently bare the sole responsibility of care for children and elderly limiting their mobility and social participation beyond their immediate family. Last, women are at higher risk for all forms of violence, domestic, physical and sexual, compared to male refugees [7-9].

While the Geneva Refugee Convention in 1951 did not specifically mention gender as a source of vulnerability, in more recent years the UNHCR identified the higher protection needs of women as a policy priority and explicitly mentioned gender as a relevant criterion in the asylum application process [10, 11]. Nevertheless, research into the specific needs of women and the development of tailored offers is lagging behind. This review will assemble the current knowledge about the health-related needs of female refugees to aid the development of future gender-sensitive programs and interventions. We will only focus on studies that address female refugees' health needs from their own perspective, not from the perspective of health care providers. Any methodology that serves this purpose will be taken into consideration and descriptive as well as interventional studies will be considered.

Methods

Research question and eligibility criteria

We designed the following review to highlight the specific health needs of female refugees, asylum seekers and displaced individuals.

Articles were included if a) they addressed health needs of female refugees, asylum seekers or displaced individuals, b) the included population was mostly female (i.e. more than 50% of the participants identified as women), c) described the experience from the perspective of the affected population and not of their health providers, d) were original publications

“Healthcare” was conceptualized as any intervention contributing to health and wellbeing and directed towards the reduction of disease/illness. Thus, next to medical interventions, preventative efforts, e.g. health promotion programmes and community-based interventions, were also included.

Search strategy

We developed the applied search strategy in consultation with a health librarian at our institution. We searched PubMed, Medline, EMBASE, Cochrane Library and Scopus using the terms and keywords ((refuge* OR asylum* OR newcomer* OR displaced*) AND (femal* OR woman OR women) AND health AND need) and identified all relevant publications published between January 1st, 2008 and June 30th, 2018 in English language. The initial search was conducted on February 27th, 2018, a follow up search on July 4th, 2018. In addition we searched the reference lists of the included articles for potential other relevant publications. Article titles and abstracts were reviewed by two researchers (ZW and SOP). If they disagreed on meeting of the inclusion criteria, agreement was reached by discussion and feedback from a third reviewer (JJ).

Data analysis

We collected, analyze and reported data according to the PRISMA (Preferred reporting items for systematic reviews) guidelines [12], however, the identified literature consists mostly of small qualitative studies, which limits the application of some of its criteria. Research about sensitive issues conducted with vulnerable populations under logistic constraints limits the opportunity to produce large, “high-quality” studies. Since our objective was collecting data from a user-centered perspective, the methodologies applied within the studies differ from the ones typically employed in well-controlled clinical settings. All identified articles are reported (Table 1). The included qualitative papers were read in detail by one reviewer (SOP) to define a model. This was compared to an independent classification by another reviewer (JJ) to ensure consistency of the identified themes. The derived themes were applied to all selected publications and data extracted. We collected information on settings, countries surveyed, sex distribution of the included population, origin of the researchers, size of the studied population, methodology and primary health-related issues identified. Bias was not specifically assessed given the nature of the included studies, yet the limitations derived by methodology will be addressed in the discussion.

Results

General results and methodological considerations

Work with displaced populations is characterized by a degree of complexity that exceeds many other forms of human-centered research. The population investigated is frequently on the move and living in precarious situations [3], which might shift their choices and priorities compared to a stable living situation. Organizing research with a highly mobile and vulnerable population under economic constraint is a logistic challenge as well as an ethical one [13, 14]. Language and culture might be very diverse in a single sample, mandating adaptation of research methodology and requiring a substantial degree of flexibility and empathy. Further, the investigation of the needs of specific subgroups, in our case women, is not a priority and this reflects on funding opportunities [15]. All of these factors can impact methodological choices, sample size, timing and incentives.

Our initial search identified 3191 articles. After screening, removal of duplicates and application of inclusion criteria 13 articles remained (figure 1) from 13 different research groups. Researcher originated primarily from Australia. The represented refugee populations were very diverse, including women from the Middle-East, Central and Eastern Africa and South-East Asia. Women represented between 60 and 100 % of the study population and participant numbers ranged from 6 to 1383 individuals. Twelve of the 13 included articles employed qualitative methodology, only one was a large quantitative survey. Most research was exploratory, and frequently based on techniques that would bridge cultural and linguistic barriers, such as ethnographies [16], the use of pictures and index cards [17] and photovoice [16]. The challenges of conducting a randomized controlled trial (RCT) with refugees has been reported elsewhere [13].

Our thematic analysis identified five health-related domains: direct healthcare needs and barriers, communication needs and barriers, cultural/spiritual needs and barriers, social/family needs and barriers, economical needs and barriers.

Direct healthcare needs and barriers

The fulfillment of healthcare needs hinges on access to services, which in most Western countries is associated with the availability of healthcare insurance. Insurance for asylum seekers and refugees is subject to different regulations in different countries, but frequently limited in its extension (). Furthermore, some countries extend insurance for families, placing women in a dependent position towards the head of household [18]. Access to services is limited by two factors: national rules for provision of services, i.e. certain services are covered according to the insurance plan accessible to refugees and others are for-payment only [16, 19], and understanding of the functioning of healthcare provision [17, 20-22]. This can be limited due to language barriers or to the difficulties associated with navigating an unknown system [20].

Next to the structural limitations in access, barriers also emerge when contact with healthcare providers is established. These might be due e.g. to request of a gender congruent service based on cultural or religious rules. Many of the issues addressed by women are related to the obstetric and gynecological domain and associated with culture-specific taboos [23]. Women frequently report that sexuality cannot be explicitly addressed, neither with family members nor with healthcare professionals [19]. Taboos around sexuality include themes ranging from menstruation to intercourse to contraception to sex work [23-25]. Female genital mutilation is also common and might represent a clinical challenge for inexperienced physicians.

Presence of these taboos associates with misinformation and unconscious risk behavior [23]. Misconceptions about menstruation, its function and management, safe intercourse and contraception are frequently reported. For example, girls confound menarche with injury or bleeding, young women are not informed about the relationship between intercourse and pregnancy [23, 25] and might not know that condoms cannot be used more than once [24]. Lack of knowledge limits female agency making women vulnerable for disease, but also abuse and violence (). Violence in general and specifically domestic violence are common in the female refugee population, yet often go underreported due to patriarchal concepts of consent [19, 23]. Women comply with culturally-set and socially-acceptable marital duties without questioning their acceptability and the opportunity to refuse to adhere to them.

Integration into the host societies frequently reduces these taboos and offers women the opportunity to obtain information and a degree of emancipation [23]. This emancipation, however, challenges formerly accepted gender roles and might be a source of conflict within the family.

Communication

Communication, specifically language barriers, is one of the most frequently mentioned hurdles for integration and successful meeting of healthcare needs [16, 19, 20, 22]. Women have been identified as frequently lagging behind in language acquisition due to several factors. These are, among others, no access to language courses, unavailability of courses close to their housing, unavailability of childcare during the courses and specific needs not being met, e.g. a desire for gender-homogenous groups.

Lack of language skills leads to reduced health literacy and long-term dependency on others for effective communication. Specifically, women will not be able to understand healthcare information in any form (oral, written or communicated through other media) in the language of their host country [19, 20]. This leads to a persistent dependency on translation and interpreter services. Interpreter services are not structurally provided in many contexts and even if translators are available, distrust in their abilities or intentions might be present [16, 20, 22]. Sometimes this is due to the translator being from a rival ethnic group in the home country or to simple distrust in the translation process. Women consequently recur to engaging family members and friends as translators [16, 20, 22] limiting the breadth of subjects that can be openly discussed with the healthcare provider. For example, if children take up the role of translators any discussion about reproduction, contraception or sexuality will not be addressed. If asked about their

preferences for health communication materials, pictorial designs and web-based information were favored [17].

Cultural/spiritual aspects

The main cultural differences described lie within the conceptualization of health and disease overall in different cultures. Many non-Western cultures conceive health in a holistic manner and refugees struggle with the pragmatic, disease-oriented approach in many countries of arrival [20, 22, 26, 27]. This specifically reflects in the perception that healthcare professionals in the host countries do not dedicate enough time to understand the illness presented [20].

Several themes might also constitute taboos in the country of origin and are, hence, never spontaneously addressed during consultation. These are specifically relevant to the areas of mental health, sexuality and HIV [22-24, 26, 27]. Sexual activity, sexually transmitted diseases including HIV and the performance of sex work all fall within this range. In addition cultural differences strongly influence ideas about family set-up, gendered roles and behaviors, affecting health-related factors such as e.g. the negotiation of consent [23].

Religion and spirituality also play an important role in the perception of health and, most importantly, in the degree of agency ascribed to the individual in the management of their health [23, 27]. Strong religious beliefs can lead to a degree of fatalism and assumption that sickness and health are God´s will and cannot be controlled by human action. Religious competence can, however, be productively employed to promote prevention in accordance with religious precepts [18].

Social networks/Family

Family separation represents one of the primary sources of distress for refugee women [19, 22, 27] and has been linked to a deterioration of mental health, ranging from sadness and grieving to depression [22, 28]. The presence of social networks, on the other hand, is perceived as a source of support [16]. The main consequence of family separations is an increase in vulnerability for the women affected, psychologically and physically. Women have less support to cope with the stress of the flight and resettlement and lack support for childrearing activities [22]. Severed from the sociocultural context of origin they suffer from fear, insecurity and question their ability to transmit cultural practices to their children [27]. This increases stress and reduces resilience. Physically, women without a male partner of family member are more vulnerable to all forms of violence, abuse and aggression in the context of displacement [28]. However, shifts in gender roles towards more male participation were also experienced due to the new environment [27]. Some female refugees perceived that single female providers might obtained more support than families [26].

Economic Aspects

Women are consistently reported as having less access to the job market in their host countries than men [22, 26, 28]. This is due to several factors, from gender role perceptions to lack of provision of adequate

courses. In the present context, we will not review this issue, but only refer to the health-related aspects. Lack of job-related social integration leads to less support from peers, less access to health relevant knowledge and less integration [21, 22]. Women remain dependent on social services or on a male provider, which places them at higher risk for abuse, e.g. domestic violence, and limits their ability to leave a violent context with their children [21]. If women are excluded from the job market, they might be driven into sex work, which significantly increases their health risks [24].

Discussion

Female refugees have unique health-related needs. Although all refugees display a similar range of necessities, the underlying priorities and vulnerabilities differ according to gender. Our present data offers a more nuanced description of these vulnerabilities, allowing us to define priorities for gender-sensitive action.

From a medical perspective the following areas will need to be prioritized through provision of adequate knowledge and specific services: reproductive health, mental health and infectious diseases. Most of the displaced women are of reproductive age [1], thus, adequate care represents an essential priority for this population [29]. However, the identified literature emphasizes how female and reproductive health topics are commonly associated with various degrees of taboo and stigma. This needs to be taken into account when designing targeted offers. Women will only engage in preventative measures, contraceptive and maternal care, if they are allowed to address cultural perceptions in a safe space. The identified literature highlights how a lack of knowledge of basic reproductive functions frequently impairs the ability to even recognize e.g. contraceptive and menstrual health needs [23, 25]. Since female health needs and health risks potentially increase in a situation of displacement, solutions that systematically combine information and service provision should be prioritized. As one of the cited studies demonstrated, the training of health operators within a refugee camp can represented an opportunity to provide knowledge, expose misconceptions and empower the women [24].

To bridge cultural and knowledge barriers, reliable and culturally-competent translational services are needed while concurrently ensuring maximum confidentiality. Bodily functions or complaints are not directly addressed in many cultures where illness is described through *idioms of distress* instead [30]. The interpreter needs to collect this hidden information and make it available to the health care provider in order to aid understanding and building of rapport. This is of particular importance for taboo themes, like sexuality, domestic violence or infectious diseases. Furthermore, absolute confidentiality needs to be guaranteed as stigma could compromise the safety of the client in her social circle.

Most importantly, the examined literature demonstrates how the specific vulnerability of women is rooted in interrelated forms of lack of access. Women lack access to education, which limits their access and ability to process health information. Their lack of access to education limits their opportunities in the workforce, which reduces their economic means, which in turn correlates with health itself and access to services. These inequalities are established in the societies of origin of many of the women, but the flight

and displacement process exacerbates their consequences in the form of poor physical, mental and reproductive health [31, 32]. Further, host countries generally provide services to refugees under the assumption that their permanence will be limited in time. Yet statistics demonstrate how currently refugees can be expected to remain in the host country for a decade or longer [33]. Services should be designed with this reality in mind.

The described lack of access is rooted in stereotypical gender roles, which restrict women´s opportunities, both within the country of origin and potentially in the host country. Addressing these gender roles and their consequences for health is imperative, yet, challenging these roles also represents a potential source of conflict. Depending on the gender norms in the host country, women might question their traditional roles and engage in a more emancipated lifestyle [34]. Some of their partners might encourage this transition and increasingly engage e.g. in care duty [27] themselves, but others might feel challenged in their self-worth and authority. This might lead to conflict within the partnership and in some cases, even trigger domestic violence [7, 35].

To our knowledge the current review is the first of its kind and several methodological challenges have to be pointed out. Research with refugees is complicated by potential linguistic, logistic, ethical and economic hurdles, which reflects on the size and methodology applied. Furthermore, many studies address the perspectives of healthcare providers or the logistics of healthcare access from a systemic perspective, but very few investigate the refugees' own priorities and needs. Most of the studies included had a limited sample size and an uneven geographical distribution. Samples were frequently convenience based and methodological choices had to be made to accommodate potential language and culture barriers. Thus, our results cannot be generalized to the same extent as large quantitative studies would have permitted. Nevertheless, the data gathered provides a richness and depth that qualitative studies would have missed.

Conclusions

The presented literature highlights how a concerted action providing information and culturally-sensitive care, while supporting language acquisition and economic empowerment is essential to improving the health status of female refugees. An increase in participation could furthermore empower them and decrease the costs of care during their permanence, as they would be more reliant on their own means rather than solely dependent on the host country. Transformative interventions should recognize these interrelations and concurrently address multiple axes of unequal access for female refugees to increase both participation and overall health.

Abbreviations

UNHCR – United Nations High Commissioner for Refugees

RCT – randomized controlled trial

Declarations

Ethics approval and consent to participate: not applicable

Consent for publication: not applicable

Availability of data and material: All data generated or analyzed during this study are included in this published article.

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Authors' contributions: SOP designed the study, JJ and ZW acquired data, JJ, ZW, SOP analyzed the data, SOP drafted the manuscript, JJ and ZW reviewed the manuscript for important intellectual content, SOP acquired funding. All authors have read and approved the manuscript.

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References

1. Affairs. UNOftCoH: „World Humanitarian Data and Trends 2016“. In.; 2017.

2. Refugees UNHCf: UNHCR Global Report 2005 - Glossary. In.; 2005.

3. Migration IOf: World Migration Report 2018. In. Edited by IOM. Geneva: International Organization for Migration; 2017.

4. Abubakar I, Zumla A: Universal health coverage for refugees and migrants in the twenty-first century. *BMC Med* 2018, 16(1):216.

5. The L: Healthy migration needs a long-term plan. *Lancet* 2016, 387(10016):312.

6. Shishehgar S, Gholizadeh L, DiGiacomo M, Green A, Davidson PM: Health and Socio-Cultural Experiences of Refugee Women: An Integrative Review. *J Immigr Minor Health* 2017, 19(4):959-973.

7. Okeke-Ihejirika P, Yohani S, Muster J, Ndem A, Chambers T, Pow V: A Scoping Review on Intimate Partner Violence in Canada's Immigrant Communities. *Trauma Violence Abuse* 2018:1524838018789156.

8. Jesuthasan J, Sonmez E, Abels I, Kurmeyer C, Gutermann J, Kimbel R, Kruger A, Niklewski G, Richter K, Stangier U *et al*: Near-death experiences, attacks by family members, and absence of health care in their

home countries affect the quality of life of refugee women in Germany: a multi-region, cross-sectional, gender-sensitive study. *BMC Med* 2018, 16(1):15.

9. Vu A, Adam A, Wirtz A, Pham K, Rubenstein L, Glass N, Beyrer C, Singh S: The Prevalence of Sexual Violence among Female Refugees in Complex Humanitarian Emergencies: a Systematic Review and Meta-analysis. *PLoS Curr* 2014, 6.

10. Refugees UNHCf: Conclusion on women and girls at risk: Excom Conclusions, 6 October 2006. In.; 2006.

11. Freedman J: Protecting Women Asylum Seekers and Refugees: From International Norms to National Protection? *Int Migr* 2010, 48(1):175-198.

12. Welch V, Petticrew M, Tugwell P, Moher D, O'Neill J, Waters E, White H, group PR-EB: PRISMA-Equity 2012 extension: reporting guidelines for systematic reviews with a focus on health equity. *PLoS Med* 2012, 9(10):e1001333.

13. Goodkind JR, Amer S, Christian C, Hess JM, Bybee D, Isakson BL, Baca B, Ndayisenga M, Greene RN, Shantzek C: Challenges and Innovations in a Community-Based Participatory Randomized Controlled Trial. *Health Educ Behav* 2017, 44(1):123-130.

14. Hugman R, Bartolomei L, Pittaway E: Human Agency and the Meaning of Informed Consent: Reflections on Research with Refugees. *J Refug Stud* 2011, 24(4):655-671.

15. Renzaho A, Polonsky M, Mellor D, Cyril S: Addressing migration-related social and health inequalities in Australia: call for research funding priorities to recognise the needs of migrant populations. *Aust Health Rev* 2016, 40(1):3-10.

16. McMorrow S, Saksena J: Voices and Views of Congolese Refugee Women: A Qualitative Exploration to Inform Health Promotion and Reduce Inequities. *Health Educ Behav* 2017, 44(5):769-780.

17. Lee SK, Sulaiman-Hill CM, Thompson SC: Providing health information for culturally and linguistically diverse women: priorities and preferences of new migrants and refugees. *Health Promot J Austr* 2013, 24(2):98-103.

18. Shirazi M, Shirazi A, Bloom J: Developing a culturally competent faith-based framework to promote breast cancer screening among Afghan immigrant women. *J Relig Health* 2015, 54(1):153-159.

19. Kim MS, Song IG, An AR, Kim KH, Sohn JH, Yang SW: Healthcare access challenges facing six African refugee mothers in South Korea: a qualitative multiple-case study. *Korean J Pediatr* 2017, 60(5):138-144.

20. Clark A, Gilbert A, Rao D, Kerr L: 'Excuse me, do any of you ladies speak English?' Perspectives of refugee women living in South Australia: barriers to accessing primary health care and achieving the Quality Use of Medicines. *Aust J Prim Health* 2014, 20(1):92-97.

21. Orach CG, Musoba N, Byamukama N, Mutambi R, Aporomon JF, Luyombo A, Rostedt A: Perceptions about human rights, sexual and reproductive health services by internally displaced persons in northern Uganda. *Afr Health Sci* 2009, 9 Suppl 2:S72-80.

22. Shrestha-Ranjit J, Patterson E, Manias E, Payne D, Koziol-McLain J: Effectiveness of Primary Health Care Services in Addressing Mental Health Needs of Minority Refugee Population in New Zealand. *Issues Ment Health Nurs* 2017, 38(4):290-300.

23. Ussher JM, Perz J, Metusela C, Hawkey AJ, Morrow M, Narchal R, Estoesta J: Negotiating Discourses of Shame, Secrecy, and Silence: Migrant and Refugee Women's Experiences of Sexual Embodiment. *Arch Sex Behav* 2017, 46(7):1901-1921.

24. Rosenberg JS, Bakomeza D: Let's talk about sex work in humanitarian settings: piloting a rights-based approach to working with refugee women selling sex in Kampala. *Reprod Health Matters* 2017, 25(51):95-102.

25. Schmitt ML, Clatworthy D, Ratnayake R, Klaesener-Metzner N, Roesch E, Wheeler E, Sommer M: Understanding the menstrual hygiene management challenges facing displaced girls and women: findings from qualitative assessments in Myanmar and Lebanon. *Confl Health* 2017, 11:19.

26. Pinehas LN, van Wyk NC, Leech R: Healthcare needs of displaced women: Osire refugee camp, Namibia. *Int Nurs Rev* 2016, 63(1):139-147.

27. Russo A, Lewis B, Joyce A, Crockett B, Luchters S: A qualitative exploration of the emotional wellbeing and support needs of new mothers from Afghanistan living in Melbourne, Australia. *BMC Pregnancy Childbirth* 2015, 15:197.

28. Lafta R, Aflouk NA, Dhiaa S, Lyles E, Burnham G: Needs of Internally Displaced Women and Children in Baghdad, Karbala, and Kirkuk, Iraq. *PLoS Curr* 2016, 8.

29. Curry DW, Rattan J, Huang S, Noznesky E: Delivering high-quality family planning services in crisis-affected settings II: results. *Glob Health Sci Pract* 2015, 3(1):25-33.

30. Hinton DE, Lewis-Fernandez R: Idioms of Distress Among Trauma Survivors: Subtypes and Clinical Utility. *Cult Med Psychiat* 2010, 34(2):209-218.

31. Bogic M, Njoku A, Priebe S: Long-term mental health of war-refugees: a systematic literature review. *Bmc Int Health Hum R* 2015, 15.

32. Fellmeth G, Fazel M, Plugge E: Migration and perinatal mental health in women from low- and middle-income countries: a systematic review and meta-analysis. *Bjog-Int J Obstet Gy* 2017, 124(5):742-752.

33. Devictor X, Do Q-T: How Many Years Have Refugees Been in Exile? *Pop Develop Rev* 2017, 43(2):355-369.

34. Ritchie HA: Gender and enterprise in fragile refugee settings: female empowerment amidst male emasculation-a challenge to local integration? *Disasters* 2018, 42 Suppl 1:S40-S60.

35. Assaf S, Chaban S: Domestic Violence Against Single, Never-Married Women in the Occupied Palestinian Territory. *Violence against Wom* 2013, 19(3):422-441.

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