Gendering Resilience: Mental Health and Psychosocial Wellbeing of Women Refugees

Hülya Yüksel

2020 Laurea

Laurea University of Applied Sciences

Gendering Resilience: Mental Health and Psychosocial Wellbeing of Women Refugees

Hülya Yüksel
Global Development and
Management in Health Care
Master's Thesis
December, 2020

Laurea University of Applied Sciences **Abstract**

Degree Programme in Global Development and Management in Health Care

Master of Health Care

Hülya Yüksel

Gendering Resilience: Mental Health and Psychosocial Wellbeing of Women Refugees

Year 2020 Number of pages 90

This study explored the role of resilience in maintaining mental health and psychosocial wellbeing of women refugees and asylum seekers. It did so by conducting an integrative review of scientific publications between the years 2010-2020 relevant to resilience and resilience factors for women refugees. The review critically appraised, analyzed, and finally, synthesized findings related to the role of resilience, contributing factors, and obstacles to resilience. Based on these findings, it proposed interventions from a mental health care perspective to help build and enhance resilience. Finally, it highlighted gaps for further research.

After problem identification, the review process involved a database search where a total of 236 records were identified. This led to 142 potential references after removing the duplicates. Potential references were further screened for eligibility according to inclusion and exclusion criteria, first relying on the titles and the abstracts, and then on the full text. A total of 17 full-text, peer-reviewed scientific articles with various designs were included in the present study. The quality of the studies was assessed using the CASP tool for qualitative studies, PRISMA for systematic and integrative reviews, and STROBE for observational studies. A five-step approach was used to gather, evaluate, analyze, and present the findings of the integrative review.

As a result of the analysis, three interrelated roles of resilience were identified from a gender perspective: (1) survival, (2) positive adaptation, and (3) participation and empowerment. Contributing factors were (1) religion, (2) hope and positivity, (3) social connection, as well as (4) support and participation. Obstacles to resilience were identified to be (1) gendered vulnerabilities, (2) language barriers, (3) lack of or limited support, (4) family separation, as well as (5) discrimination and racism. The review concluded that an awareness of the role of resilience from a gender perspective would provide a useful starting point to developing holistic, strengths-based interventions which can help build and enhance women refugees' resilience. In addition to the provision of services with deepened insights, health professionals were also recommended to advocate for changes at the systemic level to ensure women refugees' full participation and empowerment.

Keywords: Keywords: Resilience, mental health and psychosocial wellbeing, gender, women refugees

Contents

1 Introduction

This project focuses on the role of resilience and resilience factors in maintaining mental health and psychosocial wellbeing of women refugees by conducting an integrative review of scientific publications between the years 2010-2020. The aim is to seek evidence and contribute to producing new knowledge related to the chosen topic, so that recommendations can be made to develop interventions in public and global health based on the analysis and the synthesis of available evidence, while identifying and pointing out the possible gaps that can be addressed in future research.

The research has mainly been driven by a focus on two factors: gender and resilience, because available knowledge about both seem to be dispersed among various study fields across time. Gender attracted much attention in development and migration studies during the 80s and 90s, because of the gender blind or gender-neutral formulation of international protective systems, which had failed to account for gender specific forms of persecution, violence, injustices and disadvantages (Fiddian-Quasmiyeh 2014, 396-397). The study of resilience meanwhile has been overshadowed by the trauma model and psychopathological aspects of trauma associated with being a refugee or asylum seeker (Ingleby 2005, 7), despite the acknowledgment that not all forcibly displaced persons develop mental disorders (Bhugra 2004). While research on resilience factors and resources seem to be few and far between, scholarly interest in trauma model is abundant and, at times riddled with conflicting claims (Summerfield 2003).

Furthermore, exclusive focus on trauma and vulnerabilities does only partial justice to the full picture, without giving adequate weight to the role of resilience. Approaching the matter from a trauma perspective has so far hindered the identification of resources and resilience factors in maintaining the mental health and wellbeing of refugees. Consequently, little is known about both resilience, and contributing factors and barriers to supporting and enhancing resilience in refugees in destination countries.

The plight of refugees and asylum seekers embarking on perilous journeys to flee from adverse conditions, armed conflicts, wars and persecution in their countries of origin for an unknown future elsewhere, has received much attention. The arrival of unprecedented numbers of people in search of safe havens in Europe in 2015 has been referred to as the Europe's biggest 'refugee crisis' since the World War II. The numbers worldwide are even more alarming. Of the forcibly displaced 65.3 million people worldwide in 2015, 21.3 million were refugees, 40.8 million were internally displaced persons (IDP) and the number of asylum seekers were 3.2 million. (UNCHR 2016.) The number rose to almost 71 million in 2018, some

13.6 million people becoming newly displaced during the course of the year. (UNHCR 2019; see Appendix 5). According to Eurostat, asylum applications in the EU in 2015 reached 1,256,600, more than twice the number of applications during the year before (Eurostat 2019). Women constituted almost half (46 %) of the total number of the displaced 79.5 million worldwide in 2019 (UNHCR 2020; see Appendix 5). The sheer number of arrivals in such a short time has become a rising global burden that caught destination countries unprepared, as well as an important global health issue that needs to be addressed.

This project approaches this global health issue by focusing on resilience, mental health and wellbeing of forcibly displaced women. Although research has shown that women have always been on the move as migrants, travelers, refugees and asylum seekers, the prevalent image of the refugee and asylum seeker has historically been that of men fleeing from wars, persecution, and human rights violations (Freedman 2008; Hajdukowski-Ahmed, Khanlou, Moussa 2008, 4; Hunt 2008). This enduring perception fails to account for women's experiences in the process of displacement, enroute, and during resettlement. As a result, gender specific dimensions of forced displacement concerning women refugees have received less attention or have been approached with a focus limited to gender-based violence, human trafficking, or domestic violence, catering to the perception of women refugees as oppressed and helpless victims (Freedman 2012, 45-59). Studies focusing on women as forced migrants have often looked at their experiences of persecution or other gender specific aspects and needs, such as pregnancy and reproductive health (Hunt 2008). Scholars and organizations focusing on the traumatic aspects of women refugees' experiences, as well as the effects of their cultural backgrounds and traditional roles, have paid little attention to resilience factors from a gender perspective.

This study argues that such a perspective is needed in order to reach an in-depth understanding of gender-specific issues and to address those issues through appropriate interventions and tools. The integrative literature review spanning the decade between 2010 and 2020 seeks to provide a much-needed examination of where the scholarly literature now stands on these issues. The next section lays the ground for the current project, by engaging and connecting with earlier research concerning women refugees' mental health and resilience.

2 Refugee mental health: resilience and gender

Mental health as defined by the World Health Organization (WHO) is "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO Fact sheet 2019). Mental health is influenced by individual attributes,

social circumstances, and the environment in which individuals live. Interacting dynamically, these determinants may protect or threaten a person's mental state (WHO Fact sheet 2019).

Different from mental illness, which is mainly defined in terms of symptoms, mental health is penchant upon autonomy and competence, subjective wellbeing, personal efficacy, and the actualization of one's potential. Mental health is defined mainly in terms of the successful functioning evidenced in productive activities, fulfilling relationships and resilience. Within this general context, it can be argued that specific circumstances of forcibly displaced persons, such as refugees and asylum seekers pose enormous challenges that can affect and limit the successful functioning of those individuals. (Derluyn, van Ee & Vindevogel 2019, 218.)

What follows in the remainder of this section is a discussion of studies, concepts and approaches, organized around these topics: 1) refugee mental health and approaches, 2) resilience, and 3) gender as a key dimension.

2.1 Refugee mental health and approaches

Studies focusing on the mental health of forcibly displaced populations (asylum seekers and refugees) suggest that the risk of developing mental disorders such as anxiety, depression, and post-traumatic stress disorder (PTSD) are higher for the displaced persons than for stable populations (Bhugra & Jones 2001; Craig 2010; Crumlish & O'Rourke 2010; Priebe, Giacco & El-Nagip 2016, 7; Rousseau 2019, vii). In addition, significant differences were found between different immigrant groups and individuals (Bhugra et al. 2011; Kirmayer et al. 2011). In a meta-analysis study, for example, refugees and asylum seekers were found to be the most vulnerable group with prevalence rates for depression more than twice as much, and the combined estimates for anxiety about two times higher than those of labor migrants (44% - 20%; 40% - 21%, respectively) (Lindert, von Ehrenstein, Priebe, Mielck & Brähler 2009).

Among the three broad conceptual frames of mental health in post-conflict settings - the trauma model, severe mental illness, and psychosocial model - the trauma model is the most dominant and has attracted much criticism. Silove claims that a singular focus on trauma may lead to an oversight of other pressing issues. As a result of the preoccupation with trauma and post-traumatic stress disorder (PTSD) in the trauma model, the plight of severely mentally ill has been neglected. (Silove 2005, 29,35.)

Ingleby (2005, 9) states that from about 1980 onwards there has been an explosive growth of the trauma approach, the concept of 'trauma' forming the basis of interventions and studies concerning mental health needs of refugees whether living in conflict zones or in the Western countries. The word 'trauma 'was used to describe both the disturbance and the situation

causing the disturbance, leading to the assumption that "if a situation was 'traumatic', those experiencing it would automatically be 'traumatized'" (Ingleby 2005, 9).

Similarly, Papadopoulos (2007) warns about the tendency among mental health professionals to approach the situation of or the state of being a refugee as though it was a psychological or psychopathological state, arguing that becoming and being a refugee are not of a psychological nature in and of themselves. Papadopoulos suggests two possible ways to address the relevance and benefit of mental health perspectives for refugees: the first relates to the way the psychological implications of experiences during the process of displacement and relocation affect the persons concerned. It considers situations of need such as safety, housing, and health care. The second is related to the way in which a person's 'psychological immune system' is damaged, which may differ highly, because of diverging ways of reacting to adverse external events. The usual theories of psychological trauma undermine this basic principle with the assumption that certain external adverse events are traumatic to all people who experience them. Rather than being regarded as 'traumatizing experiences' for some people, these events are referred to as 'traumatic events,' without distinction between the event itself and the experience and effect of it. (Papadopoulos 2007.)

As the popularity of the 'trauma' approach continued to increase in the 1990s, so did the doubts and criticisms concerning the relevance and universality of the diagnosis of PTSD. Some authors proposed a distinction between *normal* and *abnormal* ways of responding to extreme stress as a means of diminishing the pathological connotations of PTSD, designating the former as *post-traumatic stress reaction*. (Ingleby 2005, 10.) It was also reiterated that, since the prevalence of PTSD among refugees was highly variable, it is hard to predict whether someone will develop the condition solely on the basis of what they have experienced (Silove 1999, cited in Ingleby 2005, 10). The emphasis on PTSD was regarded by some authors as misplaced, because refugees with PTSD symptoms may not consider it as their most serious problem. Almost all the respondents in an epidemiological study of 824 asylum seekers in England, for example, mentioned schooling, work and family reunification as major concerns, while the authors who studied the same group reached the conclusion that half of the respondents had PTSD (Summerfield 2002, cited in Ingleby 2005, 10).

The trauma approach with the PTSD concept is likened to a funnel, reducing both causes and effects to a remarkably simplified form, leading to a kind of 'tunnel vision' among policy makers, researchers and mental health workers. Ingleby argues that a single life-threatening catastrophic event, or a sequence of such events cannot explain the causes of the psychological problems of refugees. Furthermore, uncertainty about the fate of one's family or obtaining asylum status is a situation, not an event. Thus, the concept of PTSD with its limited focus on only a part of stressful experiences and a small selection of their effects, singling out only three symptoms (re-experiencing, avoidance, arousal) fails to do justice to

the wide range of complaints encountered daily by those working with refugees. Moreover, from the system theory perspective, the PTSD diagnosis is inadequate, because it is concerned only with the individual patient, without considering possible disturbances of the social system. (Ingleby 2005, 11.)

Raising an important question on how such an inadequate concept came to occupy a dominant position in the mental health care for refugees, Ingleby (2005, 14, 21) points to the social consequences of PTSD diagnosis and the necessity of a biomedical category for certain rights. Ingleby (2005, 21) further asserts that a PTSD diagnosis is "the royal road to compensation for victims of many different sorts of violence, including refugees, and until a better system can be devised it would be wrong and until a better system can be devised it would surely be unjust to block off this road." In the cases of victims of violence, for example, the diagnosis of PTSD can make possible both social recognition and financial compensation for these persons, in addition to the relief brought by the treatment itself (Ingleby 2005, 7). Another example from France shows that a medical diagnosis for a refugee or undocumented migrant is important as a rare path to legitimacy (Fassin 2001, cited in Watters & Ingleby 2004). Thus, the diagnosis of mental health problems can have significant effects on critical decisions regarding the right to remain (Watters & Ingleby 2004).

In contrast to the top-down approach of the trauma model, the psychosocial model developed within the context of emergency and post-conflict settings by multilateral organizations and agencies offers programs that focus on disadvantaged groups with the aim of empowering them. The rationale that underlies this approach is that a reservoir of resiliency exists within each society, which, if mobilized and supported, enable members of the society to adapt effectively over time. When compared with the top-down model of trauma approach, psychosocial support employs a bottom-up approach involving members of affected groups and seeks to facilitate a process which leads to natural recovery. It has been noted that while the clinic-based trauma model replicates a culture of paternalism, the psychosocial model promotes autonomy. (Silove & Rees 2010, 268.) This model will be discussed in relation with resilience in the following section.

This section has discussed the ways in which an exclusive focus on trauma and vulnerability does partial justice to a fuller understanding of all relevant factors related to refugee mental health, while acknowledging the crucial importance of a medical diagnosis and the concrete difference it can make concerning rights and entitlements.

2.2 Case for resilience

As mentioned above, the risk of developing mental disorders such as anxiety, depression, post-traumatic stress disorder (PTSD) is higher for the displaced persons than for core populations (Bhugra & Jones 2001; Craig 2010; Crumlish & O'Rourke 2010). However, despite

the higher-than-average risk, many of the forcibly displaced persons do not develop mental disorders (Bhugra 2004; Drožđek & Silove 2019, 260), which is usually attributed to resilience.

In their review of research evidence of resilience in PTSD, Hoge, Austin and Pollack (2007) point to protective factors related to resilience, which help explain why not everyone experiencing adversity develop mental disorders. Similarly, the Inter-Agency Standing Committee (IASC) emphasizes that many people do not necessarily develop trauma related disorders or significant psychological problems (Guidelines on Mental Health and Psychosocial Support in Emergency Settings). "Many people show resilience, that is the ability to cope relatively well in situations of adversity. There are numerous interacting social, psychological and biological factors that influence whether people develop psychological problems or exhibit resilience in the face of adversity." (IASC 2007.)

The composite term mental health and psychosocial support (MHPSS), as described in the IASC guidelines, refers to "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder." The term in a way serves to unite complementary, yet different approaches by aid sector and health sector agencies in emergency and crisis settings. While health sector agencies tend to speak of mental health, agencies outside the health sector tend to speak of supporting psychosocial wellbeing. The compound term mental health and psychosocial support (MHPSS) thus incorporates both perspectives and emphasizes the need for diverse and complementary approaches for addressing diverse and complex health and support needs. (IASC 2007.)

In a similar manner, the IFRC World Disasters Report 2016 by the International Federation of Red Cross and Red Crescent Societies (IFRC) advocates the adoption of 'resilience thinking', maintaining that "investing in resilience saves lives and money" and calls for an approach that seeks to strengthen the resilience of at-risk and vulnerable communities at all points along the humanitarian continuum (IFRC 2016, 8-9). Thus, resilience deserves due consideration as an important element in promoting and maintaining mental health and wellbeing of refugees and asylum seekers.

According to the definition put forward by IFRC Psychosocial Framework of 2005–2007, *psychosocial support* is "a process of facilitating resilience within individuals, families and communities by respecting the independence, dignity and coping mechanisms of individuals and communities" (IFRC 2016). Psychosocial support, in this sense, foregrounds the importance of promoting social cohesion and increasing resilience in individuals and communities. The psychological dimension of the term 'psychosocial' involves emotional and thought processes, reactions and feelings of individuals, while the social dimension involves relationships, family and community networks, cultural practices and social values. From the

perspective of good practice, affected people and populations are regarded as capable people with resources, not as victims. (IFRC 2016.)

Resilience is a concept that originated from the developmental psychopathology in the 1970s and was widely studied in children and adolescents who developed well in the context of adversity. The concept is referred to as 'ordinary magic,' which overturned negative assumptions of the models focusing of deficits in the development of children growing up in adverse or disadvantaged conditions. When the operation of basic human adaptation systems is in good working order and protected, it was noted, the development is found to be robust, even in the face of extreme adversity. (Masten 2001.)

According to Catherine Panter-Brick, resilience can be described "as a process to harness resources to sustain well-being." Further elaborating on the word choice, she prefers "process", because of the implication that it is not an attribute. The phrase "to harness resources" requires the identification of the most relevant resources to people in different places. Finally, the expression "sustained wellbeing," encompasses more than just a narrow definition of health or absence of pathology. (in Southwick et al. 2014.)

For Ann Masten, resilience refers to "the capacity of a dynamic system [individual or community] to adapt successfully to disturbances that threaten the viability, the function, or the development of that system," for it facilitates collaborative work with people who are striving to build the capacity to adapt when confronted with disasters (in Southwick et al. 2014). Both approaches to resilience as a process and the capacity of a dynamic system allow for the recognition of resources and capabilities as well as risks and challenges at both individual and community levels across different contexts and situations.

According to Ungar (2012, 17), resilience, when exposed to significant adversity, is defined as: "The capacity of individuals to navigate their way to resources that sustain well-being; the capacity of individuals' physical and social ecologies to provide those resources; and the capacity of individuals, their families and communities to negotiate culturally meaningful ways for resources to be shared." This definition emphasizes the importance of taking into account the broad system encompassing the individuals, community and state as factors that can explain the capability to cope with exposure to adverse events. Further, it suggests that individual resilience depends on the resilience of other systems in which individuals are embedded. It can be assumed that, as the capacity of navigation will be different for refugees and asylum seekers in host societies than that of the citizens, support systems targeting these populations will be of utmost importance.

These approaches to resilience as a process and the capacity of a dynamic system and of social ecologies allow for the recognition of resources and capabilities as well as risks and challenges at both individual and community levels across different contexts and situations.

An apt metaphor for resilience therefore is ‘bouncing forward’ (Walsh 2002) to face an uncertain future. In this future, successful functioning, mental health and psychosocial wellbeing will depend, to a large degree, on the existence of the safety nets firstly to prevent a slip into the cracks of the society or in the systems of protection.

From the definitions of resilience discussed above, two crucial elements can be identified. The first is the *input* perspective of resilience, which, essentially, is exposure to risk and adversity. The exposure may vary in intensity, ranging from moderate to extreme. The second element is an outcome perspective that seeks to evaluate whether coping mechanisms lead to outcomes within or above the expected range. (Mohaupt 2008.) Further, an emphasis on the process aspect of the notion of resilience establishes that it is a dynamic concept, not a characteristic or trait of the individual. Following exposure to adversity, a process of interaction and adaptation takes place, requiring a dynamic assessment overtime from researchers. (Mohaupt 2008.)

This perspective is important in avoiding misunderstandings of the concept as a fixed personal characteristic, as Rutter explains: ‘[R]esilience cannot be seen as fixed attributes of the individual. If circumstances change, the risk alters’ (Rutter, 1990, cited in Mohaupt 2008). Some scholars also warn that, when resilience is mistakenly defined as a personal trait, it can lead to ‘blaming the victim,’ diverting attention from the responsibilities of the states (Luthar & Zelazo 2003, cited in Mohaupt 2008). In line with IFRC Psychosocial Framework of 2005-2007 discussed earlier, it is worth stressing that displaced persons, women refugees and asylum seekers are capable people with resources and agency to make positive changes in their lives. Therefore Spitzer (2007) view it as a responsibility to oppose dominant discourses that view refugee women as helpless victims without any agency or resources.

2.3 Gender as a key dimension

Before discussing the need for a gender perspective concerning mental health and forced displacement, it is important to first present relevant terms which are used to refer to uprooted persons and populations within the context of this study. These terms are refugee, asylum seeker, and forcibly displaced persons.

The term *refugee* is a legal term and refugees are defined and protected under international law. The 1951 Refugee Convention is a key legal document and defines a refugee as: “someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion” (UNHCR Webpage).

An *asylum seeker* is someone who applies for international protection and whose claim to protection is being processed for a final decision. Every recognized refugee is initially an

asylum seeker, but not every asylum seeker will eventually be recognized as a refugee. (IOM Glossary 2019). As is clear from the definitions, *refugee* is a legal term and a status with well-defined rights to international protection and obligations of the international community, while the term *asylum seeker* does not have such a legal status. These two terms are therefore not interchangeable. This distinction is not always made in the literature.

As an umbrella designation, this study also uses forcibly displaced persons or forcibly displaced to refer to both refugees and asylum seekers. Forcibly displaced persons, as defined in a report by the Office of the High Commissioner for Human Rights (OHCHR), are "those who are forced to move, within or across borders, due to armed conflict, persecution, terrorism, human rights violations and abuses, violence, the adverse effects of climate change, natural disasters, development projects or a combination of these factors" (OHCHR Webpage).

The recognition of the need for international protection for forcibly displaced people following the Second World War led the international community to establish international legal systems and instruments to protect adversely affected populations fleeing persecution, armed conflicts, wars, and disasters. The first step in this direction was the definition of fundamental human rights to be universally protected for the first time. The Universal Declaration of Human Rights by the United Nations recognized in Article 14 that "[e]veryone has the right to seek and to enjoy in other countries asylum from persecution" (UDHR 1948). This declaration was followed by the 1951 Convention and the 1967 Protocol relating to the status of refugees and the United Nations General Assembly Resolution 2198 (XXI), which constitute the basis of international refugee protection (UN 1951, 1967).

The fact that the 1951 Convention does not recognize persecution based on gender grounds as a claim for refugee status has been subject to criticism from various academic fields, as well as from organizations working on the ground (Valji 2001). Arguing that the 1951 Convention itself is both heteronormative and androcentric, critics from feminist and women's studies, as well as from development, refugee and forced migration studies have demanded that the definition of refugee should be rewritten to include gender as a basis of persecution. Furthermore, they called for redefining 'persecution' itself to recognize the political nature of female resistance, as well as violence against women in public and private spheres. (Indra 1987, cited in Fiddian-Qasmiyeh 2014, 398-399).

The gender blindness of the 1951 Refugee Convention was admitted only in 2002 by the UNHCR with the statement that "the refugee definition has been interpreted through a framework of male experiences, which has meant that many claims of women and of homosexuals, have gone unrecognized" (UNHCR 2002). As a result of this lack of recognition of gender specific forms of persecution, violence, injustices and disadvantages, the

international system of protection has not been able to provide protection and assistance needed by women refugees and asylum seekers (Fiddian-Quasmiyeh 2014, 396-397).

It has been argued that the interpretation of refugee law has evolved by examining male asylum applicants and their actions, illustrating and reinforcing established gender biases within states. It is men who have been considered the main agents of political resistance, and hence the rightful beneficiaries of protection from the persecution arising from it. Arising out of this is the awareness that the male paradigm within which the law has developed mirrors the factual circumstances of male applicants and as such does not address to the specific protection needs of women. (Crowley 1999, 2008, 309.)

Critics have long been drawn attention to the widespread nature of violence against women during armed conflicts that can be seen as forced labor, involuntary relocation, torture and executions, and policies limiting or denying access to health care, education and employment, among others. Rape and gender-based violence have been among routine strategies of war and conflicts. In addition, women are subjected to discrimination on the grounds of both race and gender. (Pittaway & Bartolomei 2001.) The manner in which forms of persecution based on gender affect mental health and wellbeing of the victimized is a crucial question to be raised, together with the ones that are related to the harm done or the risk of harm resulting from the 'gender blind' assumptions of protective systems.

Much criticism has also been raised against stereotypical representations of women refugees as "powerless victims of forces beyond their control." Situated notions of femaleness and maleness inform relations of power, prestige and privilege. Women refugees therefore cannot be categorized as a "comparatively invariant kind of 'multiple minority', victimized as 'women' in their source and host cultures and as 'refugees." (Indra 1999, 2008, iv, 2.)

Some studies claimed that gender and culture are important factors that affect experiences of displacement and migration. In addition to forms of persecution based on gender, it has also been noted that gender and culture influence how displaced persons experience and deal with resettlement stressors, which in turn affect mental health and psychosocial wellbeing. A comprehensive understanding of the complex mechanisms shaping displaced persons' life experiences requires focusing on women's experiences. (Young & Chan 2015, 30-31.) In addition to different experiences of displacement and response to stressors, changes in gender roles and gender role expectations will influence how women respond to migration stress and post-migration adjustment (Bhugra et al. 2011).

The concept gender received much attention in development studies, refugee and forced migration studies during the 80s and 90s, at a time when criticism of gender blind formulation of international protective systems was becoming more prevalent (Fiddian-Quasmiyeh 2014, 396-397). The concept has allowed for a wider perspective through which to view relations of

power and disadvantage within social relations. It has proved useful in drawing attention to gender specific forms of persecution, violence, and injustices within the trajectories of forced displacement as well as to the shortcomings of protective systems.

Conceptualizations of gender emphasize its relational characteristic. Gender as a core organizing principle of social relations embodied in gender roles and relations strongly rejects biological explanations for inequality and power hierarchies which privilege men and disadvantage women. Gender is not a fixed trait, constant overtime. It is constructed through cultural and social practices and ideas and displays of femininity and masculinity. (Goździak 2008, 187.) As such, it cannot be equated solely with women (Goździak 2008, 187; Indra 1999, 2008, 2). According to Indra (1999, 2008,2), gender is a key *relational* dimension of human thought and activity, which are "informed by cultural and individual notions of men and women, having consequences for their social or cultural positioning and the ways in which they experience and live their lives." The experience of forced migration will vary owing to different cultural and individual notions, however, how people respond to forced migration will always be gendered (Indra 1999, 2008, 2).

The voices of women refugees have remained unheard in prevailing discourses of immigration and asylum. As a result, the persecution and insecurities the women face are often ignored. Moreover, women have to conform to 'victimhood' representations in order to have their claims for security heard. (Freedman 2012.)

On the whole, up until the year 2010, the complex adversities refugee women faced have been dealt with in various academic disciplines and the gender-blind formulation of international protective systems received much criticism for failing to account for gender specific forms of persecution, violence, injustices and disadvantages (Fiddian-Quasmiyeh 2014, 396-397).

At the same time, the resilience perspective on mental health and wellbeing has been overshadowed by the trauma model and psychopathological aspects of trauma associated with being a refugee or asylum seeker, despite the acknowledgment that not all forcibly displaced persons develop mental disorders (Bhugra 2004). While research on resilience, resilience factors, and resources are scarce, even less attention have been paid to resilience factors from a gender perspective concerning the mental health and wellbeing of women refugees and asylum seekers.

This study argues that such a perspective is needed in order to reach an in-depth understanding of gender-specific issues and to address those issues through appropriate interventions and tools. The integrative literature review spanning the decade between 2010 and 2020 seeks to provide a much-needed examination of where the scholarly literature now stands on these issues.

3 Project Aims and Objectives

The aim of this study is to explore the role of resilience and resilience factors in maintaining mental health and psychosocial wellbeing of women refugees by conducting an integrative review of scientific publications between the years 2010-2020.

The objectives of the study are to:

- review the main arguments and findings of selected publications on the role of resilience. regarding mental health and psychosocial wellbeing of women refugees and asylum seekers

- make recommendations for developing interventions in public and global health to support and enhance resilience.

- identify and point out possible gaps in current research on resilience that can be addressed in future research.

The following questions will guide the objective of searching for evidence, appraisal, analysis, and synthesis:

1) What is the role of resilience in mental health and psychosocial wellbeing of women refugees?

2) What factors contribute to enhancing resilience in women refugees?

3) What are the obstacles to resilience for women refugees?

4) What interventions can be developed from a mental health care perspective to help build and enhance resilience?

5) What are the gaps, if any, that require further research?

4 Data and Methods

4.1 Integrative literature review as a research method

The amount of information available to all social and health care professionals is expanding as a result of the increasing demand for research evidence to inform evidence-based practice (EBP). Thus, literature reviews have become an essential tool making sense of the vast array of research now available (Aveyard 2014, 8,17). Among various types of literature reviews, the integrative review constitutes the broadest type of research review method. This methodological approach allows for evidence synthesis from studies employing diverse

methodologies simultaneously and offers the possibility to have a more comprehensive understanding of the phenomena under study. Data can also be combined from empirical as well as theoretical literature. (Whittemore & Knafl 2005.) To identify relevant evidence that answers a targeted question, a systematic approach and a detailed search strategy is used in integrative reviews. Gathered evidence from a range of studies is objectively appraised and summarized and conclusions are made about a subject area through systemic categorization and thematic analysis of included studies. As a sophisticated method, it requires insight and attention to detail. (Noble & Smith 2018.)

This study employs the five-stage approach described by Whittemore and Knafl (2005) for conducting integrative reviews. The five-stage approach, modified from Cooper (1998), is proposed to enhance rigor in integrative reviews and the stages involved are: 1) Problem identification; 2) Literature search; 3) Data evaluation; 4) Data analysis and 5) Presentation (Figure 1).

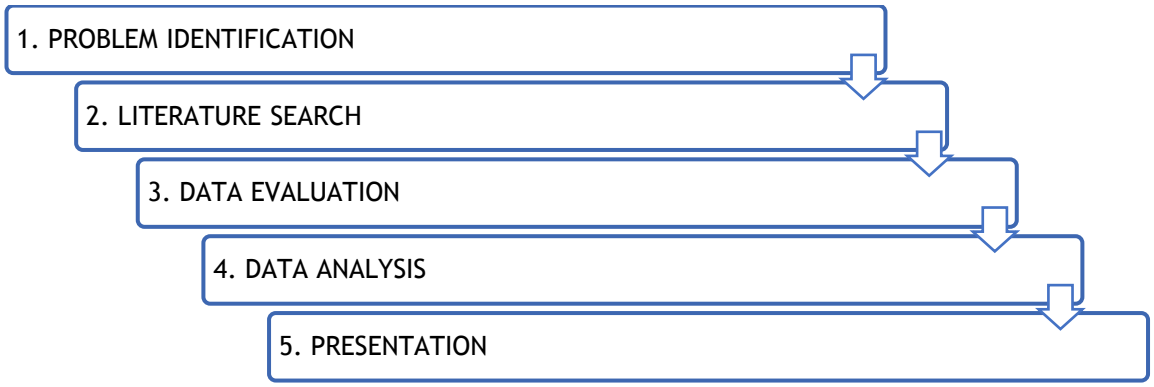

Figure 1: The five-stage approach for conducting integrative reviews adapted from Whittemore and Knafl (2005)

The integrative literature review method has the potential to enable multiple primary research methods to become a greater part of evidence-based practice initiatives. (Whittemore and Knafl 2005.)

4.2 Inclusion and exclusion criteria

As the study population is women asylum seekers and refugees, studies focusing on men, children, adolescents, or work-related immigration are to be excluded. Peer reviewed, full text, free access articles written in English are included. As there is no funding involved in this study, free access is essential (Table 1). Articles are searched from data bases using key / index terms with guidance from information specialist and studies including the search terms are selected.

Inclusion criteria	Exclusion criteria
Studies focusing on mental health of adult women / female asylum seekers and refugees (forcibly displaced women) Studies including search terms Peer-reviewed journal articles published between 2010-2020, English language All study designs: qualitative, quantitative, mixed methods, integrative literature review, systematic literature review Full-text and free-access articles (no funding to pay for access fees)	Studies focusing on male or children or adolescents Studies focusing on work related immigration Studies that do not include search terms Articles that are not peer reviewed Articles written in other languages Articles which are published before 2010 Editorials, textbooks, master theses, monographs it

Table 1: Inclusion and exclusion criteria

Time frame for the study is 2010-2020 in order to collect the most up to date evidence on the study topic.

4.3 Database search and review

Database selection was discussed and planned carefully in an online meeting with the information specialist of Laurea on 21 September 2020. Preceding this meeting, an online session with the lecturer of Information Management at Laurea took place concerning possible databases on 3 September 2020. Selected databases for data extraction were EBSCOhost combined search (combined with CINAHL with full text, APA PsycArticles), ProQuest, Web of Science, SAGE Premier and Google Scholar. Search was carried out in accordance with the guidance by the information specialist (Table 2).

Databases
CINAHL is an index of top nursing and allied health literature from Europe and America (Aveyard 2007, 81) (EBSCOhost combined search including CINAHL and PsycARTICLES)
PsycARTICLES database includes around 100 full text behavioral science journals from American Psychological Association (APA), APA Educational Publishing, Hogrefe Publishing and Canadian Psychological Association (Laurea LibGuides) (EBSCOhost combined search including CINAHL and PsycARTICLES)
ProQuest Central is large multidisciplinary database that includes more than 8000 full-text journals. Subject areas include business, health and medical sciences, social sciences, science and technology, among others (Laurea LibGuides)
SAGE Premier has more than 800 full text journals, including those from social sciences, economy, technology, health sciences, cultural studies and education, among others. (Laurea LibGuides)
Web of Science is a reference database that includes Science Citation Index (about 8500 publications), Social Science Citation Index (about 3000 publications) and Arts and Humanities Index (about 1700 publications (Laurea LibGuides)
Google Scholar, a web search engine for scientific information, provides a simple way to broadly search for scholarly literature, including peer-reviewed articles, abstracts, theses, books, technical reports from academic publishers, professional societies and other scholarly organizations.

Table 2: List of databases for literature search

Search terms were resilience OR resiliency OR resilient AND “mental health” OR “psychosocial wellbeing” AND gender OR women OR female AND refugees OR asylum seekers OR displaced. In addition to Boolean operators, truncation (*) was used for Web of Science Database as instructed in database guide (Table 3). In the initial phase of developing database search strategy, search for “gendering resilience” yielded zero result, for this reason “gender” is used as a search term together with “women OR female” (Table 3).

Search terms for databases (except Web of Science)	Search terms for Web of Science
(resilience OR resiliency OR resilient) AND ("mental health" OR "psychosocial wellbeing") AND (gender OR female OR women) AND (refugees OR asylum seekers OR displaced)	(resilien*) AND ("mental health" OR "psychosocial wellbeing") AND (gender OR wom* OR female*) AND (refugee OR "asylum seeker" OR displaced)

Table 3: Search terms

Selection of the literature for the review involved 4 interrelated steps (Figure 2). Step one is database search to identify citations. The databases used for search were CINAHL, APAPsycArticles (EBSCOhost combined search), ProQuest, Web of Science, SAGE Premier, as well as Google Scholar. The total number of citations identified was 236, which yielded 142 potential references after duplicates from databases were removed (n= 94) All references from Google search were found to be duplicates and removed, as well as 55 others found in more than one database or databases. CINAHL and APAPsycArticles duplicates were already removed automatically in the combined search.

Step two included screening titles and abstracts according to inclusion and exclusion criteria. The screening identified that 110 references did not meet the inclusion criteria and were removed. Many of the removed were related to adolescents, underage children, or male refugees or asylum seekers. The remaining 32 potential references were sent to own e-mail for further screening. Out of the remaining potential references, 6 were removed, because of lack of access to the full text.

Step three involved screening the full text of remaining articles for inclusion or exclusion. The number of full text articles as potential references were 26, all of which were saved to the research folder and evaluated according to inclusion and exclusion criteria. A total of nine articles, which did not meet the inclusion criteria was removed. Studies that do not include search terms or do not focus on mental health of adult women / female refugees and asylum seekers, those that are not peer reviewed, or the ones focusing on work-related immigration were excluded.

The last step involved the final in-depth review of the remaining articles by using relevant assessment tools. The total number of references for the review was 17. (Qualitative=13, integrative review 2, systematic review 1, observational study 1)

All selected articles for the review included search terms, were peer reviewed journal articles published in English language between 2010-2020 with qualitative, integrative and systematic literature review and observational study designs. Due to absence of funding, only free access full text articles were selected.

The diagram below (Figure 2) summarizes the four steps for data search adapted from PRISMA flow chart (Moher, Liberati, Tetzlaff, Altman, The PRISMA Group 2009).

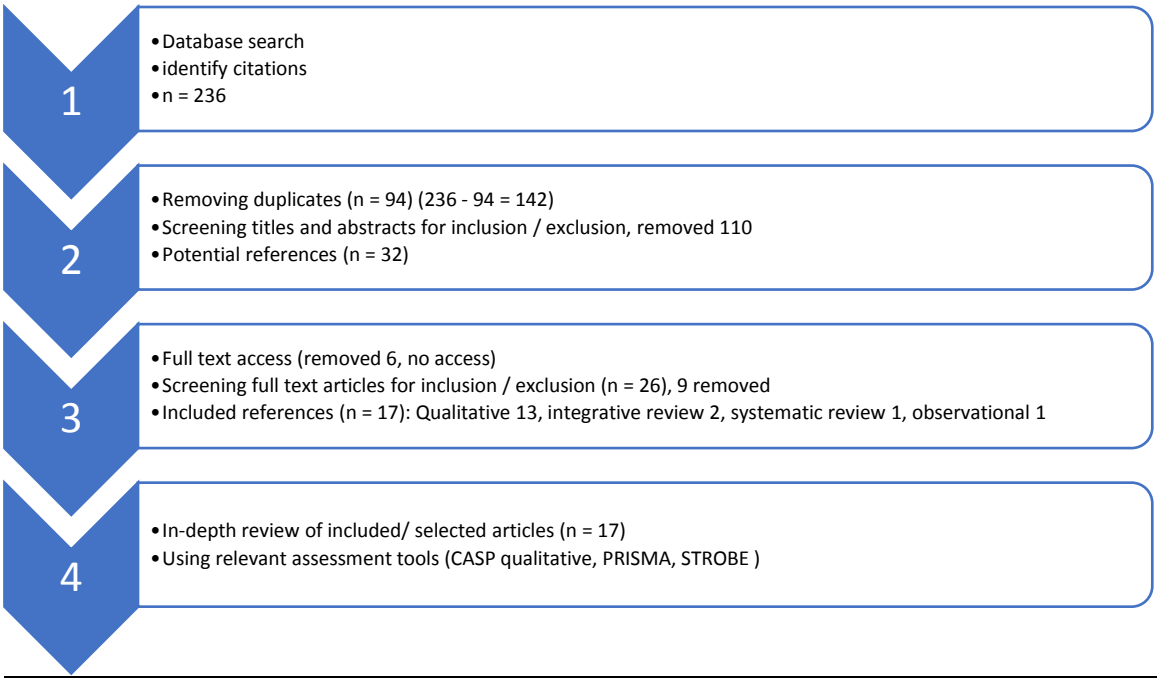

Figure 2: Four stages of data search adapted from The PRISMA Group (2009)

4.4 Quality assessment

All included papers were appraised for methodological quality by using specific assessment checklists of CASP, PRISMA and STROBE as relevant assessment tools (Appendix 2).

CASP (Critical Appraisal Skills Program) checklists include a set of critical appraisal tools which are designed to be used when reading research, including tools for Randomized Controlled Trials, Systematic Reviews, Cohort Studies, Case Control Studies, Economic Evaluations, Diagnostic Studies, Qualitative studies and Clinical Prediction Rule (CASP Checklists).

A total of 13 qualitative references were appraised using CASP qualitative checklist, which has ten evaluation criteria. Added to this is a scoring system, which used following scoring for each evaluation criteria: 'satisfies the criteria (++), partly satisfies (+), hardly, or not at all (-), does not apply (x), yielding a maximum score of 20 for evaluation.

PRISMA is an assessment tool for systematic reviews and meta-analyses with 27 items. Published in 2009, PRISMA Statement includes a checklist and a flow diagram (PRISMA Statement). Out of 27 evaluation items, 24 items were adapted as most relevant for the scope and purposes of this study (Prisma 2009 checklist). This tool was used for two integrative review and one systematic review articles. Same scoring system was used for each of 24 items, as in CASP. During the assessment, 6 of the selected items found to be 'not applicable,' thus scoring needed to be adjusted accordingly, yielding a maximum score of 36

(100%). This adjustment was suitable for both integrative and systematic review articles, for the majority of the included articles in the reviews were qualitative studies, assessment items for quantitative studies did not apply.

STROBE, developed in 2004, is used for observational studies in epidemiology and stands for STrengthening the Reporting of OBservational studies in Epidemiology (STROBE Statement). STROBE has 22 items to assess the quality of an observational study. The same scoring system was used for each of 22 items, as in CASP. The maximum score was 44 (100%).

4.5 Data Analysis

The objectives of the data analysis stage are a comprehensive and impartial interpretation of the primary sources, along with an insightful synthesis of the evidence. Analysis of data in integrative reviews includes organizing, labeling, categorizing and summarizing the data from primary sources into a cohesive and integrated conclusion on the research question. At first, extracted data are compared item by item for categorization and grouping of related data. These coded categories are subsequently compared to further the process of analysis and synthesis. This approach to data analysis is consistent with the application of varied information from various methodologies in the integrative review method, which comprises data reduction, presentation of data, comparison of data, drawing of conclusions and verification (Whittemore & Knafl 2005.) The figure below illustrates this process (Figure 3).

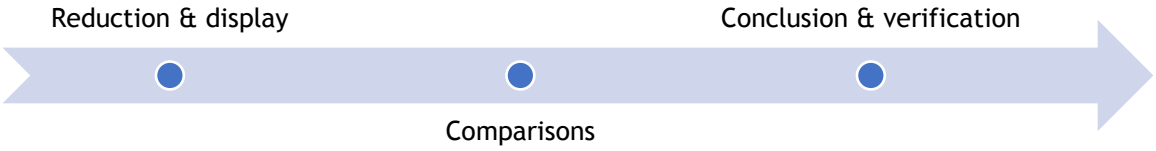

Figure 3: Analysis of data adapted from Whittemore and Knafl (2005)

5 Results

As discussed in Data and Methods section (4.3) the database search identified a total of 236 records. As a result of a four-step systematic screening process, 17 articles were included in the integrative review. The process of screening and selection is shown below using Prisma flow chart (Figure 4), followed by description of included studies (5.1), and presentation of the results (5.2).

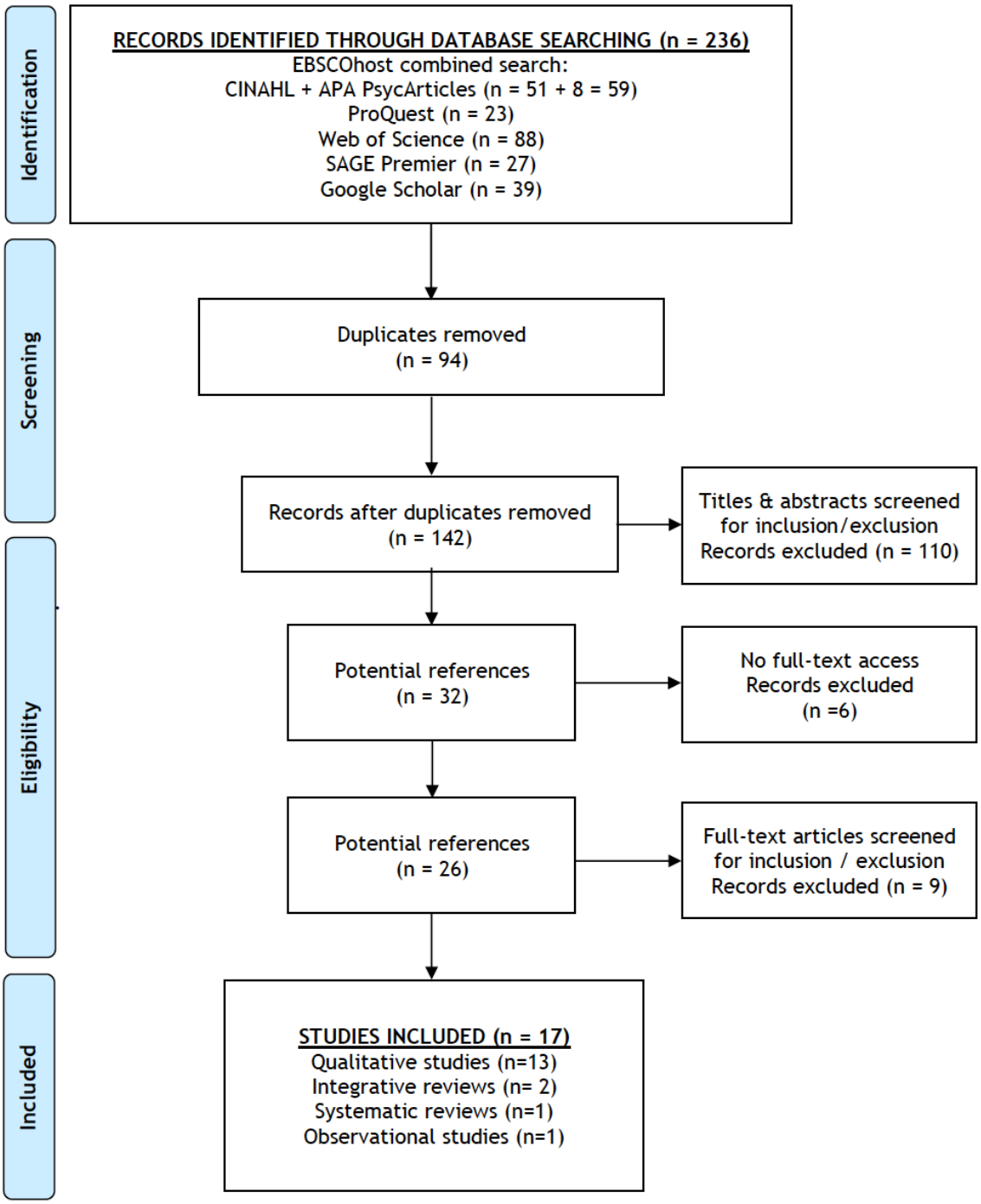

Figure 4: Data review process adapted from the PRISMA 2009 Flow Diagram (Moher et al. 2009).

5.1 Characteristics of included studies

All reviewed articles (n=17) are published between January 2010 – September 2020. Study characteristics of included articles and evidence tables are presented in Appendix 1.

Qualitative and observational study participants are a diverse population of refugee and displaced women originating from 16 countries. These are Eritrea (East Africa), Sudan, Palestine (internally displaced), Mexico, Central and South America, Middle East, West Africa, Bhutan, Arabic speaking women refugees, (country unspecified, article by Mangrio et al. 2019), Eastern Europe (countries unspecified), Zimbabwe, Somali, Congo, Burundi, Afghanistan.

Participants of studies included in review articles originate from African countries, Somalia, Sudan, East, Central, and North Africa (Babatunde et al. 2016), West Africa, Sudan, Iraq; Afghanistan, Somalia, Cambodia, Oromo (Ethiopia), Vietnam, Iran, Bosnia, Congo (Shishehgar et al. 2017), and Afghanistan, Rwanda, Angola, DRC, Sudan, Congo, Burma, Bhutan, Sub-Sahara Africa, SE-Asia, Iraq, Somalia, Sri Lanka, India, South America, Liberia, Ivory Coast, Mali, Ethiopia and Syria (Jesuthasan et al. 2019), with more than 30 countries.

Although two review articles focus on refugee women's health and socio-cultural experiences, and health-related needs and barriers, they discuss resilience factors and barriers with reference to their respective research questions. One of the review articles is concerned with the resilience of African migrants only. Resulting from differences in research questions and focus, search strategies and terms also differ, with only two overlapping articles included in the reviews: The article by Baird and Boyle (2012) with 10 participants is included in the review by Shishehgar et al. (2007), and the article by Lenette et al. (2013) with 4 participants is included in the review by Babatunde-Sowole (2016). The Jesuthasan (2019) review article does not specifically address resilience or mental health, but is deemed to be related, providing insights into the health-related needs of women refugees and the barriers they face. Addressing identified health related needs and barriers is likely to support and enhance resilience of women refugees.

Numbers of participants in review articles are as follow:
Babatunde-Sowole et al. 2016, N =112 (participant number range 4-62),
Jesuthasan et al. 2019, N= 2939 (participant number range 6-1216),
Shishehgar et al. 2017, N= 1770 (participant number range 5-486).

Qualitative and observational studies, N = 229 (range 1-60)
Total number of refugees, forcibly displaced women participants = 5050.

Countries of relocation are mostly western countries, with the exception of South Africa and the Palestinian territory, which provide a broader view into the conditions and resilience factors in non-western settings. Western countries include European countries (UK, Italy, Norway, Sweden), Australia, Canada and USA. As for countries of publication and primary authors, with the exception of South Africa (n=1), all articles are published in Western

countries. These are Australia (n=5), USA (n=4), Italy (n=2), Canada (n=1), Norway (n=1), Sweden (n=1), Germany (n=1), UK (n=1).

Of the 17 articles, 13 were qualitative studies with diverse designs and methodologies, including focus group, individual, semi-structured, in depth interviews, participant observation, content-focused hermeneutic analytic approach, strength-based story telling approach, ethnographic method, narrative case study, critical feminist approach, phenomenological approach, grounded theory, content analysis, thematic analysis. Observational study is a pilot study with cross-sectional design, using strength-based and resource-based theoretical approach; review articles follow a process of systematic evaluation, using PRISMA and CASP appraisal tools.

Quality assessment was carried out using three appraisal tools: CASP, PRISMA, and STROBE. CASP checklist was used with ten items for qualitative studies and with added scoring method, PRISMA checklist with adapted 24 items, and STROBE with 22 items. The majority of articles were found to be high-quality research. The high-quality paper score was 85 % and higher (n=16), and moderate quality score was 80% (n=1). The average score for all included studies was 92/100, indicating that the quality was high.

Women refugees of selected studies (qualitative and observational) were in three different settings:

1) Western countries, where some form of external and official support, albeit time limited, is provided with wide differences between countries,

2) Non-western contexts, without any form of formal support or service provision: South Africa (survival, unsafe and substandard housing, discrimination, red tape, hostility),

3) The Palestinian territory, a military conflict and war zone, where non-governmental organizations (NGOs) provide some services (survival, military conflict zone).

Although the study aimed at including both women refugees and asylum seekers, database search did not yield any records involving studies with women asylum seekers. Except for undocumented migrants in one study conducted in the USA (Goodman et al. 2017), qualitative studies with women participants in Western countries included women refugees only. Observational study included trafficked women residing in a shelter in Italy (Ginesini 2018). In addition, inconsistencies in terminology were identified; the term refugee is often used interchangeably with the term migrant, and the term migrant is used referring to both refugees, undocumented migrants, as well as voluntary migrants. Notwithstanding this inconsistency, selected studies provided multiple and diverse perspectives involving those with refugee women (documented, undocumented, internally displaced); one study with

service providers (Pulvirenti & Mason 2011) and one with trafficked women (Ginesini 2018). The participants in the three review articles considered only in calculating the number of total woman refuge/migrant participants.

5.2 Results of analysis

As discussed in section 2.2 on page 11, resilience is conceived both as a process and as a capacity of a broad system. As a process, resilience involves harnessing the most relevant resources to sustain wellbeing, beyond a narrow definition of health or absence of pathology, in the face of adversity (Catherine Panter-Brick in Southwick et al. 2014). Scholars have warned against conceptualizations of resilience as an innate or inner trait, because of the risk that it may lead to 'blaming the victim' (Mohaupt 2008). They have called instead for attention to broader systems within which processes of resilience take place and to the capacities of dynamic systems for successful adaptation to disturbances (Catherine Panter-Brick and Masten in Southwick et al. 2014), as well as to the capacity of physical and social ecologies to provide essential resources to help maintain wellbeing (Ungar 2012, 17).

Within the scope of this study in relation with forced displacement, resilience is understood as a dynamic, continual social process emerging from and embedded within everyday contexts of inter-relationality in social, cultural, linguistic, economic and political environments (Lenette et al. 20013) and as marked by always-gendered nature of the responses to forced migration (Indra 1999, 2008, 2).

Findings of the integrative review are presented below in relation to the guiding questions of the research, which concern the role of resilience, contributing factors, obstacles, interventions that can be developed from a mental health care perspective, as well as the gaps that require further research.

5.2.1 Role of resilience

The fact that many of the forcibly displaced persons do not develop mental disorders, despite the higher-than-average risk of doing so (Bhugra 2004; Drožđek & Silove 2019, 260), is usually attributed to resilience. Resilience is found to play a crucial role as a protective factor for mental health and psychosocial wellbeing across displacement and resettlement trajectories of emergency, transition and resettlement. Within the context of experiences of women refugees and asylum seekers, three interconnected aspects of resilience were identified. These interconnected aspects highlight the roles resilience play in supporting and maintaining mental health and psychosocial wellbeing of refugee women, and can be grouped as (1) *survival*, (2) *positive adaptation* (more-than-survival) and (3) *participation* leading to *empowerment*.

These three overarching roles of resilience have important implications in identifying the support needs of women refugees and developing interventions from a mental health care perspective to support mental health and psychosocial wellbeing (see, 5.2.4). These roles were identified in relation to the conditions and contexts within which experiences of women refugees were explored. This perspective was underscored by the trajectories of forced displacement involving emergency, transition (cultural, social, linguistic) and resettlement/integration. As a general frame to understand the overarching role of resilience from a gender perspective emerging from integrative review data, this study makes no definitive claims about the nature of categorizations, except that none was thought to be fixed. Depending on the interpretive frames and perspectives, different categorizations can be possible.

All three roles are of crucial importance for mental health and wellbeing and coping with challenges, as well as recognizing and embracing opportunities. Figure 5 below illustrates role of resilience in relation with displacement trajectories.

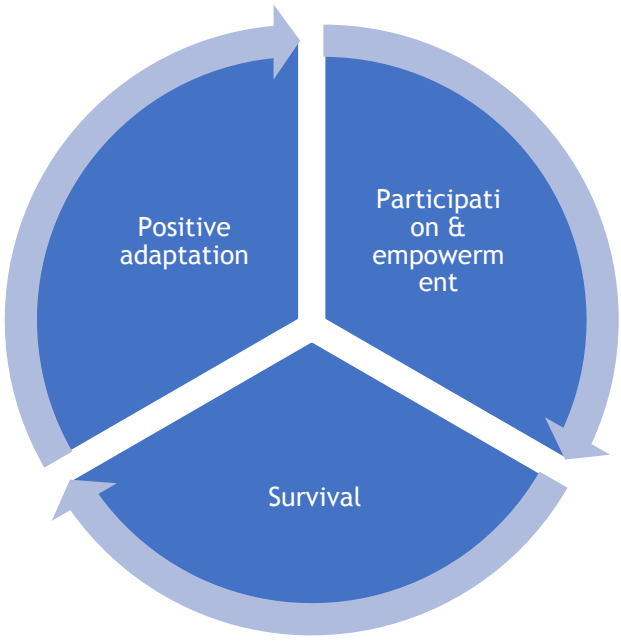

Figure 5: Role of resilience derived from the analysis of the selected articles

1) Resilience as survival

Resilience enabling *survival*, or resilience as basic survival involves all personal strengths and available resources to stay alive in the contexts of emergency, which can be of short or protracted duration, as in conflict zones or refugee camps. Analysis identified seven studies highlighting 'survival.' Three of them were in non-Western settings: two studies with participants in the Palestinian territories and one study with Congolese, Burundian and

Zimbabwean refugees in South Africa (Darychuk & Jackson 2015; Veronese et al. 2019; Smit & Rugunanan 2015).

These studies revealed that participants faced extreme conditions, involving risks to own lives and those of their families and children and extreme financial hardships. In the West Bank refugee camps, resilience played a vital role in strengthening the determination to exist as a community and remain connected to community and territory. This included the reproduction of stories, national identity, raising Palestinian children, while at the same time navigating traditional gender roles, and seeking ways to persist and create safe spaces to meet with other women to share their stories (Darychuk & Jackson 2015). For the second group of Palestinian women in Gaza Strip, the role of resilience was to build survival skills within armed conflict, as all women were confronted by a real risk of losing their lives and perceived their psychological and physical health as being precarious. They sought to maintain a sense of continuity and to live a 'normal' life in abnormal living conditions by actively mobilizing resources both within themselves, and in the surrounding social and political worlds (Veronese et al. 2019). Smit and Rugunanan (2015) found that, despite harsh living conditions and 'survival with impairment,' women refugees in the study showed distinct traces of a resilient approach to life. This inclination was evident in their tenacity to ensure the survival of their families by generating some form of income. In all three studies, women exhibited resolve to survive together with their families and children.

Some of the studies in Western countries explored women's experiences of both gender-based and forced displacement related vulnerabilities during the emergency phase. Babatunde-Sowole et al. (2020) applied a strength-based approach and focused on recounting women's experiences chronologically to identify and contextualize their aspirations, how they could keep hope alive, and continue to move forward. The stories with the first main theme "When the World Falls Apart," were replete with accounts of loss, trauma, family fragmentation exacerbated by gendered forms of physical and sexual violence, rape and abuse, experienced and/or witnessed. The second theme "Battered but Strong," involved experiences of living in refugee camps for long periods of time near conflict zones they fled. This protracted emergency period before their relocation to Australia was marked by isolation from, and rejection by the mainstream population, and their confrontation with dire living conditions. The role of resilience under these circumstances was evident in women's survival strategies, which involved communalism, religiosity, optimism, determination, resourcefulness, and social networking for support.

The study by Goodman et al. (2017) found many similarities between the two study groups, namely, the refugees and undocumented migrants in the USA. Women from both groups reported adverse experiences of a gendered nature such as rape, gang-rape, physical assault, captivity, on top of the ones related to other fears and threats of persecution. In the USA,

both groups faced intersecting and overlapping barriers within the matrix of domination and systemic oppression as refugees /undocumented migrants, and as women (Goodman et al. (2017). African refugees in the UK reported experiences of gender-based and political violence and being barred by strong patriarchal traditions to seek help when exposed to domestic violence while in their native countries. The role of resilience in both studies was survival through persistence involving both internal resources (such as faith, hope, positivity) and external supports. (Sherwood & Liebling-Kalifani 2012.)

Employing the Critical Feminist Perspective (CFP) and collective storytelling through individual narratives, Denzongpa and Nichols (2020) co-constructed the life story of a twice displaced Bhutanese woman. They made visible her gendered experiences, marked by marginalization throughout displacement, with severe health issues acquired throughout resettlement journey. The role of resilience in this case was survival through resistance and seeking educational and employment opportunities. (Denzongpa & Nichols 2020.)

2) Resilience as positive adaptation (more-than-survival) marked by a phase of transition from the state of emergency to resettlement with basic conditions of relative safety. This positive adaptation encompasses a process of rebuilding and transformation within a new social, cultural, linguistic, economic and political environment, filled with unfamiliar situations to contend with (Lenette et al. 20013)

In the transition phase between forced displacement and resettlement, the role of resilience was to assist and enable positive adaptation. The importance of receiving support from families, peers and community, as well as resettlement support and opportunities from host countries in the transition phase was highlighted by the participants of the studies included (Abraham et al. 2018; Babatunde-Sowole et al. 2016; Baird & Boyle 2012; Goodman et al. 2017; Welsh & Brodsky 2010; Sherwood & Liebling-Kalifani 2012). Babatunde-Sowole et al. (2016) suggested that for successful settlement and positive adaptation of African women migrants, receiving some kind of support was of crucial importance. Resilience was shown to have an important role in the welfare and healthy settlement of African migrants and their families into a new culture, and the resulting benefits to the new communities. (Babatunde-Sowole et al. 2016). In addition to receiving support, giving financial support to family members and others in need in the countries of origin was also underlined (Welsh & Brodsky 2010; Baird & Boyle 2012). When supported in rebuilding their lives, women reported feeling more resilient.

Pulvirenti and Mason (2011) identified external supports as crucial in assisting women move on and establish meaningful lives. External supports were thought to increase women's participation in the host society, improving both self-reliance and overall health as a result. (Jesuthasan et al. 2019). Both Mangrio et al. (2019) and Sherwood and Libeling-Kalifani (2012)

suggested that opportunities of education and work also enhanced resilience and encouraged women to feel that they had a 'choice' and 'control'' over their lives. (Mangrio et al. 2019; Sherwood & Liebling-Kalifani 2012.)

Employment both enabled refugee women to boost their health status and to increase their social networks. Moreover, ability to support oneself provided a sense of pride and empowerment leading to hope, optimism mental health and wellbeing. (Shishehgar et al. 2017.) Goodman et al. (2017) suggested that the provision of timely assistance in meeting immediate economic and resource needs, accessing child-care resources, language classes, and job opportunities helped to facilitate women's resilience.

3) The role of resilience as participation and empowerment reveals the necessity of an ongoing navigation through shifting challenges and opportunities and finding productive paths through a maze of ups and downs (Lenette et al. 20013; Denzongpa & Nichols 2020; Pulvirenti & Mason 2011). According to Jesuthasan et al. (2019), resilience plays a role in cultivating women's agency leading to empowerment, increasing participation and self-reliance.

In co-creating the life story of twice displaced Bhutanese women as the leader of local women's group in the US, Denzongpa and Nichols (2020) discussed resilience as playing an important role in transforming experiences into lessons and providing opportunities for other women in the community. It enabled the main protagonist to achieve a degree of normalcy through educational and employment pursuits, advocating for women's rights, and practicing self-efficacy. As a refugee back in Nepal, she was denied a formal education. However, through after-school sessions offered by nonprofit organizations, she was able to continue her education, and actively participate in training workshops on health care at refugee camp clinics. In the USA she attended English as second language (ESL) and citizenship classes and rose to a formal leadership position in a local women's group, where she had begun as a volunteer. She demonstrated resilience in her response to the traumatic experiences she faced in terms of her gender, culture, displacement, and resettlement. As president of the local women's group in the US, the participant worked to protect the integrity of the community by advocating for health and safety. She used her leadership as a tool to challenge patriarchal gender norms and create new opportunities for women to prosper in the US. (Denzongpa & Nichols (2020.)

Goodman et al. (2017) suggested that resilience can help build a common platform for communities of resistance to question and reject oppressive narratives, cultivate empowerment, and produce advocacy actions. Similarly, service provider participants in the study by Pulvirenti and Mason (2011), maintained that the continual process of resilience needs to be built and rebuilt collectively, and not just assumed. Collective resilience connects the individual with the family, the community, broader social networks, and

government policies and instruments. It also includes the resources mentioned explicitly by the study participants: individual skills, social networks, internal community support, external social resources, social capital, infrastructure and activities, and citizenship. (Pulvirenti & Mason 2011.)

In the ethnographic study of four refugee single mothers, Lenette et al. (2013) found that, despite the upheaval caused by their circumstances and their multiple responsibilities, the women in the study navigated daily life challenges and opportunities with resilient outcomes, which was evident in successful functioning. The authors claimed that day-to-day pathways through which resilience outcomes are achieved deserve more attention, because of their important implications for mental health practice frameworks for refugees (Lenette et al. 2013).

Enactments and accomplishments of social processes of resilience in the milieu of everyday attested both to the dynamic nature of resilience as an ongoing process and to ordinary environments. It was achieved by the study participants interacting within a complex cluster of gendered roles, judgements and expectations highlighting both vulnerabilities and strengths (Lenette et al. 2013). Thus, refugee women need to be conceived as more than victims, and as more than survivors (Pulvirenti & Mason 2011). In addition, an understanding of the role of resilience as a form of agency can assist in invalidating dominant discourses and portrayals of refugee woman as merely 'helpless victims' without any resources and capacity to make meaningful changes in their lives (Pulvirenti & Mason 2011; Spitzer 2007).

5.2.2 Contributing factors

An analysis of the review data identified four inter-related categories: (1) religion (faith, and spirituality); (2) hope and positivity; (3) family and social connection; and (4) support and participation. Discussions of these factors can broadly be described as revolving around internal (faith, hope) and external (connection, supports) factors. Internal and external factors contributing to resilience do not operate in isolation, but are inextricably interlinked (Lenette et al. 20013; Babatunde-Sowole et al. 2016)

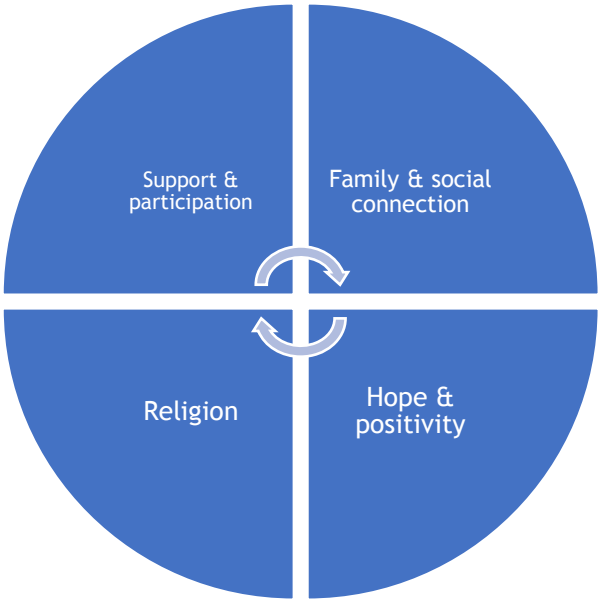

Figure 6: Contributing factors to resilience derived from analysis of selected articles

1) Religion

In most of the studies, faith, both in religious and spiritual terms, is considered a contributing factor to resilience in women refugees. In the observational study by Ginesini (2018) faith was identified as having a double role in the lives of refugee women, as both a resource and a form of strength. Faith as a resource involved support gained from prayers, church attendance, community, and from friends and family. Faith as a strength meanwhile involved a positive attitude, having hopes and goals, and perceptions of growth and resilience (Ginesini 2018).

The role of religion and faith in helping to make sense of what was happening was a major factor for resilience (Sherwood & Liebling-Kalifani 2012). Babutunde-Sowole et al. (2016) identify spirituality and faith as vital sources of resilience and strength, and religiosity as a resilience strategy in overcoming adversity in refugee camps (Babatunde-Sowole et al. 2020). Similarly, prayer, meditation, attending religious services, and overall spirituality were important coping mechanisms and bases of resilience for Eritrean women refugees in Norway (Abraham et al. 2018).

Baird and Boyle (2012) emphasized the importance of belief in a 'higher' purpose and strong religious convictions in helping to transcend difficulties (Baird & Boyle 2012). Religion was found to be a significant source of hope and appeared to play a key role in the ability of women to cope with their challenging life experiences (Smit & Rugunanan 2015). For Muslim refugee women in the West Bank, religious affiliation played an important role in their

resilience, orienting their daily lives and helping to frame their situation as part of a larger struggle beyond their individual experiences (Darychuk & Jackson 2015). Indeed, Shishehgar et al. (2017) found that spiritual fulfilment, both religious and non-religious, was among various resilience strategies employed by refugee women. For Afghan refugee women, religion, as much as participation in religious activities, was an important coping mechanism, because it afforded them a sense of control and hope through prayer (Welsh & Brodsky 2010). As the evidence showed, religion was a crucial source for resilience, from which women refugees drew both strength and resources to cope with the challenges and adversities they faced (Veronese et al. 2019).

2) Hope and positivity

Positivity, having a forward-looking perspective, and harboring hope for the future were among the contributing factors to resilience. These were linked to a sense of coherence (SoC) and the transformation of stressful events into comprehensible, manageable and meaningful issues. Refugee women were apt to accept their psychological symptoms of stress or distress as 'normal'. This, combined with a strong belief that their current mental state would improve in parallel with improving life conditions, provided them with a strong sense of coherence. The perception of the disruption and difficulty as a temporary stage towards a new and improved stability was most often envisioned as an expected move from the migrant reception center to a permanent home to begin a new life. (Abraham et al. 2018.) Babatunde-Sowole et al. (2016) found positivity and achieving positive outcomes as reflecting personal values and skills to maintain equilibrium. Most common among the many cognitive strategies were mental reconstruction of migration stress in relation to current achievements, and ac-acceptance of difficult situations with an aspirational focus.

Similarly, refugee women from the Dinka tribe of South Sudan who had been resettled in the USA, identified their hopes for the future as a contributing factor to their resilience. It marked an affirmation of their purpose in a new country and simultaneously strengthened the link to their past (Baird & Boyle 2012). In the same manner, for African women refugees in the UK, having hopes for their future helped increase their resilience and inner strength. It involved thinking of a positive future and taking positive action (Sherwood & Liebling-Kalifani 2012).

In the integrative review by Shishehgar et al. (2017), hope and optimism were found to be arising from the ability to support oneself, which in turn enabled a sense of pride and empowerment. Linked to their hope for the future, women refugees in South Africa stated their love and concern for children as an important element for their emotional wellbeing, and a source of hope and joy (Smit & Rugunanan 2015). Maintaining hope was of vital importance for Afghan women refugees as a form of perception-focused coping, regardless of

changing circumstances. It involved shifting the focus away from present difficulties toward the fu-ture, as in the Afghan proverb in the study title: “After every darkness is light.” Their positivity included expressing gratitude, having a sense of gratitude for their own lives, as well as for those of family members amidst immense hardship and loss (Welsh & Brodsky 2010.)

3) Family and social connection

Alongside with religion, hope and positivity, connection to family and community were emphasized as contributing factors to resilience. These connections, however, underscored an array of gendered roles and expectations, with both challenges that placed additional hardships on women, as much as opportunities to increase their autonomy and independence. As evidenced in the study by Baird and Boyle (2012), Dinka women had to find ways to reconcile conflicting expectations by patriarchal traditions of Dinka culture, while at the same time embracing new roles and opportunities defined by their new context. This involved becoming employees and providers for their families, being equal partners in marriage, learning to adapt to the customs of their new country, such as working outside their homes, earning independently, and managing their own money. Resettlement experiences involved a situational transition, a state of liminality, which women defined as being ‘caught in-between.’ (Baird & Boyle 2012.)

Darychuk and Jackson (2015) placed focus on community resilience through accounts of Palestinian refugee women in West Bank. They had to navigate the impacts of gender on the process of building community resilience. The main perceived role for women was reproduction, an obvious result of their identification principally with their gender over and above other aspects of their situation. Reproduction, however, took on several other connotations outside of giving birth to and raising ‘Palestinian’ children. It also entailed the reproduction of social traditions and stories of the collective, and the reproduction of national identity. Excelling in maternal capabilities was a source of pride for many refugee women, and vital to community function and reproduction. As traditional and cultural norms restricted the participation and socialization of women in the public sphere, women utilized women’s clinics in the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) centers as a safe space to socialize and network with other women to share stories and hardships. (Darychuk & Jackson 2015.) Similarly, maternal agency and motherhood were important for Palestinian women in the study by Veronese et al. (2019), which identified protective factors contributing to resilience. Family ties, both immediate and extended, friendships, and community protection were identified as psychosocial resources. Differing from the Palestinian women in the Darychuk and Jackson (2015) study, participants of this study were professional women. As teachers employed in a school operated by a non-governmental organization (NGO), they had more active roles. They could

actively mobilize resources, both within themselves as well as in their external worlds to maintain a sense of continuity both for themselves and their families, while striving to live a 'normal' life in abnormal living conditions (Veronese et al. 2019).

The importance of connection and maintaining or having a sense of fellowship with other refugees is an effective means of developing a proxy family (Abraham et al. 2018). Interdependence and bonding between refugees from various African countries helped reduce feelings of isolation. Using communication technologies to remain connected to the families and communities left behind was also instrumental in maintaining a sense of connection (Babatunde-Sowole et al. 2016), as was communalism and social networking for support (Babatunde-Sowole et al. 2020). As the leader of women's group in the local non-governmental organization (NGO), the participant in the Denzongpa and Nichols (2020) study worked to protect the integrity of her community by advocating for health and safety, and used her leadership position as a tool to challenge patriarchal gender norms and create new opportunities for women to prosper in the USA.

Connection to family was found to be essential both for mental wellbeing and effective integration (Mangrio et al. 2019) and a united family as a contributing factor enhancing family wellbeing (Shishehgar et al. 2017). For Afghan women, connection to family and community also involved helping family members, particularly female members, in their country of origin. This was cited as a culturally distinct coping strategy, even after settling in the USA (Welsh & Brodsky 2010).

Family, community, and wider social environments of connection and interactions of women occurred within a complex cluster of gendered roles, judgements, and expectations, highlighting both the vulnerabilities and strengths of women. Gender is of crucial importance, because of clearly gendered nature of wider social environments within which refugee women were vulnerable to being 'othered' on multiple levels. (Lenette et al. 20013.) As suggested by Indra (2008, 2) as a key relational dimension, gender has consequences for social or cultural positioning of women and the ways in which they experience and live their lives. Lenette et al. (20013) found that social sources of resilience and stress are not entirely discrete. Community, for example, can be a source of support and a source of stress at the same time, because of the highly gendered ways of experiencing both support and stress within the community.

4) Support and participation

Support and participation overlap with each other in terms of their overall contribution to resilience. All selected studies unanimously emphasised support as crucial factor. Resettlement and adaptation to a new life requires support from families, peers, communities, as well as from social and health care services and governments of receiving

countries. Provision, as well as the range of and access to services may differ among countries with direct consequences on the health and wellbeing of refugee women.

In order to cope with challenges of displacement and resettlement, it is essential for women refugees and asylum seekers to have access to a combination of individual, family, and social support networks and resources. Goodman et al. (2017) suggest that the provision of assistance in meeting immediate economic and resource needs, such as access to childcare re-sources, language classes, and job opportunities help facilitate refugee women's resilience. Similarly, in addition to coordinated action to provide information and culturally sensitive care, provision of support in language learning and economic empowerment were found to be essential. These supports were thought to be contributing to the increased participation of women and their self-reliance. Such interconnections need to be recognized across trans-formative initiatives and multiple axes of differential access for female refugees should be addressed simultaneously in order to improve both women's participation in the host society and their overall health. (Jesuthasan et al. 2019.)

Opportunities such as education and work, beneficial for the integration and well-being of refugee women (Mangrio et al. 2019), contributed to enhancing women's resilience, encouraging them to feel that they have 'choice' and 'control'' over their lives (Sherwood & Liebling-Kalifani 2012). Social support helped maintain an equilibrium for refugee women despite their uncertain status and ongoing distress. Employment enabled refugee women to boost their health status and to increase their social networks. Moreover, the ability to support oneself provided a sense of pride and empowerment leading to hope, optimism, mental health and wellbeing. Additional supporting sources, families, and communities contribute to wellbeing and integration into a new society. Extended family and close friends were found to be important sources of support. (Shishehgar et al. 2017.)

As we have seen, participation and support were found to be different in the two studies with Palestinian refugee and displaced women (Darychuk & Jackson 2015; Veronese et al. 2019) and stood in contrast with the studies carried out in Western contexts. Participation in public life was restricted by traditional cultural norms for women refugees in the Darychuk and Jackson (2015) study. Engaging in economic activities considered a taboo, reducing the women to their reproductive functions only. Yet, working outside the home was necessitated for a growing number of women due to dire economic conditions and uncertainty about the job prospects of their husbands. Lack of money and household income insecurity led women to take part in sewing projects, cleaning or handicraft lessons in women's centers of the camp. These participatory activities went against traditional gender norms.

The second study with displaced Palestinian women, identified them as active participants not only in working life (all participants were teachers) but also in social and political life,

alongside the other responsibilities of their gendered roles (Veronese et al. 2019). In the studies undertaken in Western countries, conflicts arising from different expectations between traditional norms of countries of origin and the new roles in the host countries attested to further intersecting disadvantages and challenges for women refugees (Baird & Boyle 2012; Denzongpa & Nichols 2020; Sherwood & Liebling-Kalifani 2012).

Service provider participants in the Pulviretti and Mason (2011) study maintained that the resilience of refugee women was a process which can be built through support, both from within immediate refugee communities, and from the larger host community, by 'opening doors' and 'being there' in the form of collective responsibility sharing. External support was found to be a necessary element in the transformations indicating resilience, which assisted women to move beyond their pasts, establish meaningful lives for themselves, and build social capital. Refugee women need to be perceived as more than victims and as more than survivors. What makes refugee women resilient is their capacity to transform their lives with the provision of adequate support. Material support related to employment and housing, was suggested as providing the necessary material conditions for a new start and produce a foundation for personal transformation.

Lenette et al. (2013) located participation contributing to resilience in the daily activities, by conceiving resilience as a dynamic social process emerging from everyday practices situated in person-environment interactions. The ordinary nature of resilience in normal routines evidenced in juggling multiple responsibilities in a new social, cultural, linguistic, economic, and political environment with numerous unfamiliar situations to withstand. Women refugees faced shifting challenges and opportunities over time, making the act of resilience an ongoing process of shifting, changing, learning, building and moving past their difficult experiences. 'Everydayness' was in itself an achievement and a potential aspect of resilience. Resilience outcomes achieved through day-to-day pathways have important implications for refugee mental health practice frameworks. (Lenette et al 2013.)

Pulviretti and Mason (2011) drew attention to the risks of naming women refugees as resilient. This nomination could shift the responsibility away from governments and onto the refugees themselves, leading to the reduction of support services and abandonment of women refugees with the assumption that they are able to fend for themselves. Another risk involved in describing resilience as an innate characteristic to refugee women can lead to the generation of a binary between resilient and non-resilient women. This then enables the tendency to 'blame the victim' for not having the raw ingredients to transform her life. (Pulviretti & Mason 2011.) Rather than simply being a certain kind of person with a particular set of resilient 'traits', and more than overcoming past experiences, resilience appears to be about finding productive paths through a maze of ups and downs (Lenette et al 2013).

5.2.3 Obstacles to resilience

All of the reviewed articles demonstrated that women refugees had to contend with the vulnerability of being 'othered' and marginalized on multiple levels. The participants in the Abraham et al. (2018) study highlighted dangerous environments for women, such as the traumas of endless military service, punishment, and gender-based violence in emergency phase and post-migration stressors heightened by endless waiting in refugee centers in the host country. Babatunde-Sowole et al. (2020) identified similar experiences of vulnerability. Ginesini (2018) drew attention to vulnerabilities of a group of trafficked women who were sexually exploited and oppressed, while Shishehgar et al. (2017) identified a significant concern among women about the exploitation of young girls and their involvement in sex work. Darychuk and Jackson (2015) discussed the effects of gender discrimination that limited women's participation and presence in public life, although they participated and supported community resilience. The experience of resettlement in a country with different cultural and gender norms than those of the country of origin of led to additional challenges for women refugees, described as 'caught-in-between,' as well as new opportunities (Baird & Boyle 2012; Welsh & Brodsky 2010; Denzongpa & Nichols 2020). The figure below shows obstacles to resilience as a vicious circle (Figure 7).

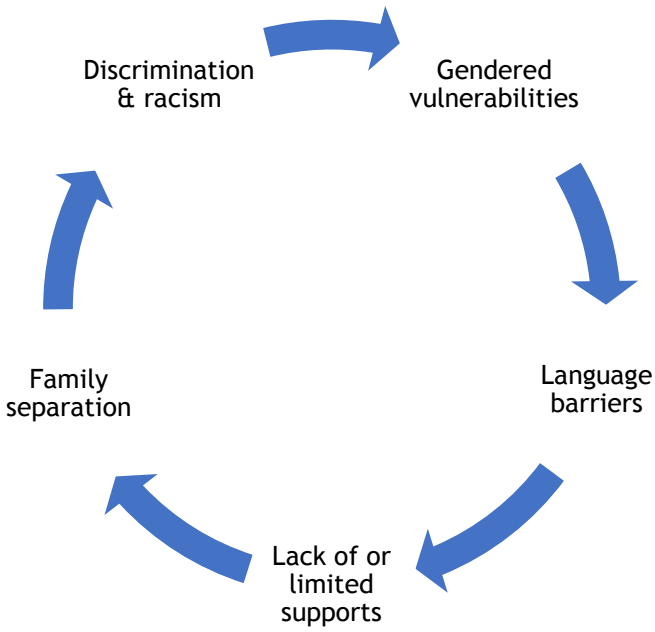

Figure 7: Obstacles to resilience derived from the analysis of selected studies

Language barriers encountered in the host countries caused communication difficulties in expressing the needs of refugee women, and negatively affected their social and economic participation and their overall mental health (Abraham et al. 2018; Goodman et al. 2017; Jesuthasan et al. 2019), increased the risk of loneliness, low self-esteem, and depression (Shishehgar et al. 2017).

Limited support and material resources or their complete absence were identified as obstacles to mental health and wellbeing (Denzongpa & Nichols 2020). Similarly, limited or no resettlement supports and services, created economic insecurity and posed a challenge to meeting basic needs. This pushed basic needs to the forefront of women's priorities and diverted focus from their mental health struggles (Goodman et al. 2017). In addition, difficulty in finding a secure job and affordable housing was a stress factor, hindering resettlement and establishing social networks (Shishehgar et al. 2017). Lack of job-related social integration of women refugees made general integration difficult, with less support from peers and reduced access to relevant health knowledge. Increased dependency on social services or on a male provider also increased the risk of abuse and domestic violence, further limiting women's ability to leave violent contexts. (Jesuthasan et al. 2019.)

Family separation and lack of social connections were identified as structural and situational stressors that could lead to psychological symptomatology (Goodman et al. 2017). Family separation as a primary source of distress was linked to the deterioration of mental health, which increased vulnerability for women. The lack of social networks, coupled with the separation from their sociocultural context of origin, increased feelings of insecurity, fear, and stress, reducing resilience. Women without a male partner or family member were more vulnerable to all forms of abuse, violence, and aggression. (Jesuthasan et al. 2019.) In addition to family separation as a key source of stress, uncertainty about the family members left behind was a contributing factor to the experience of depression and other mental disorders (Shishehgar et al. 2017). Similarly, being separated from loved ones and family was found to cause distress, suffering and a sense of loneliness (Mangrio et al. 2019).

Finally, obstacles erected by discrimination, hostility and racism were found to negatively affect refugee women's mental health. African women in refugee camps experienced isolation from the mainstream population of their country of refuge, as well as rejection and being perceived as 'troublemakers' (Babatunde-Sowole et al. 2020). According to Goodman et al. (2017), systemic forces such as immigration policies affected women negatively. Discrimination (a form of trauma) and aggression in the context of majority culture were highlighted as contributing to the production and maintenance of anti-immigrant sentiments and policies. Similarly, Smit and Rugunanan (2015) referred to xenophobic sentiments and outright hostility in any social, economic and political milieu as a potent source of fear, distress, frustration, and disillusionment. Baird and Boyle (2012) suggested that an unintended consequence of presenting refugees as traumatized and maladjusted from a biomedical perspective was the risk of further marginalization and continued oppression of women refugees in the host countries.

5.2.4 Recommendations to develop interventions

The evidence from existing research suggests that mental health and wellbeing interventions should be designed on the basis of holistic models that go beyond a narrow focus on psychopathology. Such holistic approaches imply strengths-based, multifocal and culture-centered interventions that should take into account the gendered experiences of women and recognize their strengths, capabilities, and resilience processes. Health professionals are uniquely positioned to provide assistance within health care, offer guidance towards social and material supports that are available, as well as advocating for the recognition of their rights. The suggestions that arose from the literature review are presented below.

Abraham et al. (2018) suggest a dynamic and multidimensional understanding of the mental health of refugees. Rather than perceiving them as 'passive victims' with mental health problems, such an understanding pays attention to the resilience and coping mechanisms of the refugees, while being attentive to their experiences and expressed needs. In a similar manner, the study by Veronese et al. (2019) opposes gender stereotypes confining women to a narrowly constructed role of the vulnerable victim. The study suggests that mental health intervention programs need to be geared towards fostering women's resilience and mobilizing the ecological resources that can protect them at the individual, relational, and cultural levels. Intervention programs with an exclusive focus on psychiatric symptoms, the authors warn, increase the risk of induced effects. For their part, Darychuk and Jackson (2015), propose to go beyond dichotomous explanations, calling for an understanding of the complex intersections of religion, culture, and gender, which create a specific form of resilient adaptation.

Advocating a holistic approach, Babatunde-Sowole et al. (2020) point out that an understanding of migrants' lives and values could be beneficial to the provision of trauma-informed care and support needed in the resettlement countries. Excellent health outcomes can be achieved by situating care within identified or communal strengths (Babatunde-Sowole et al. 2020). Similarly, the findings of the study by Sherwood and Liebling-Kalifani (2012) point to a more holistic model of understanding African women's experiences. Implications for responding to refugees' mental health needs involve the need to recognize and build on women's resilience to help them access their rights to health, provision of services such as education and employment, and justice. According to the authors, the provision of health services can support women's further empowerment. (Sherwood & Liebling-Kalifani 2012.)

The study by Baird and Boyle (2012), guided by the middle-range theory of transitions by Meleis et al. (2000, cited in Baird & Boyle 2012), encourages nurses to think differently (out-of-the-box) about culturally competent interventions for promoting health and wellbeing of women. Nurses can promote and maximize the inner resources of refugees to foster healthy

transitions. Women refugees' healthy transitions will in turn ensure and enhance their mental health and wellbeing. Applying a critical feminist perspective (CFP) to understand women refugees' experiences, Denzongpa and Nichols (2020) identify that women refugees are greatly disadvantaged and more likely to experience situational and structural stressors. This is due to the place of women refugees in the society with particular gender norms, their difficulty in accessing resources, and the language barriers they face. For social work practice, the study foregrounds the need for interventions that support women as leaders, empower them in their communities, and facilitate refugee communities' access to organizational resources (Denzongpa & Nichols 2020).

Ginesini (2018) suggests a culturally relevant and responsive approach to the needs of refugee women, an approach that can be used to establish more specific and efficient advocacy programs for trafficked refugee women. Programs that enhance resilience and mindfulness through a strengths-based perspective were shown to be promising in social work with refugee women. The need for a positive psychology approach was demonstrated in the context of work with sexually exploited and trafficked refugee women.

Goodman et al. (2017) advice that counselors should offer culture-centered mental health services to immigrant women. Culture-centered models of healing offer a promising form of counselling to those facing forms of trauma and discrimination related to their cultural, racial or religious identities. A multifocal approach is of critical importance to understand and address ecosystemic factors that influence the vulnerability of women to trauma and ongoing stressors, as well as their ability to access internal and external mechanisms to foster resilience. Counselors can encourage the development of communities of resistance in which women can come together in order to question/reject oppressive narratives, cultivate empowerment, and produce advocacy actions. Increasing community members' connections will improve information and resource sharing, creating social support and solidarity on a wider scale for future advocacy work. Advocacy work is also important for systemic changes to policies, laws and practices that affect women negatively. Such advocacy can include addressing discrimination and aggressions of the majority culture that produces and maintains anti-immigrant sentiments and policies. (Goodman et al. 2017.)

Diverse and culturally grounded coping processes of Afghan women highlight the importance of preventive efforts and programs that are tailored to individual needs and cultural context and that account for multiple pathways to resilience and individual differences in coping strategies (Welsh & Brodsky 2010). Moreover, interventions that aim to strengthen human relationships within a nurtured environment can help achieve and enhance resilience (Babatunde-Sowole et al. 2016).

Jesuthasan et al. (2019) emphasise the need for coordinated action to provide information and culturally sensitive care, while supporting language learning and economic empowerment of women refugees. According to the authors, increasing women's participation contributes to their empowerment, self-reliance, and overall health. For Lenette et al. (2013), day-to-day pathways through which resilience outcomes are achieved deserve more attention. This is because daily processes of resilience have important implications for the design of mental health practice frameworks for refugees. The authors also point out that there is a need to pay attention to women's vulnerabilities and strengths in a complex cluster of gendered roles within which women interact. An understanding of a highly gendered array of vulnerabilities faced by refugee women may provide insights into gendered accounts of resilience that have so far been scant in discourses on resilience. A resilience 'lens' is beneficial to comprehending women's experiences, for such a lens provides a strength-based starting point that allows for the de-medicalization of the 'needy victim' status frequently attached to the refugee label. (Lenette et al. 20013.)

The study by Pulvirenti and Mason (2011) emphasise the crucial importance of external supports to the processes of resilience and transformation of refugee women's lives. Material support related to employment and housing can provide the material conditions for a new start and produce a foundation for personal transformation. The continual process of resilience needs to be built and rebuilt collectively, not just assumed. Collective resilience connects individual with the family, the community, broader social networks, and government policy. It includes resources such as individual skills, social networks, internal community support, external social resources, social capital, as well as citizenship. (Pulvirenti & Mason 2011.)

Shishehgar et al. (2017) advocate for effective strategies to minimize the adverse impact of conditions surrounding resettlement on the health and wellbeing of women refugees. According to the authors, targeted policies and services are needed to support communities in empowering refugee women. The provision of health information and services can enable refugee women to identify and seek professional help in a timely manner. Mental health support groups that are culturally and linguistically appropriate can provide a space for refugee women to share their experiences and burdens, and to receive mutual support from others who share similar experiences and challenges.

In conclusion, interventions from a mental health care perspective need to pay attention to gender dimension relative to the role of resilience, to factors contributing to resilience, as well as to obstacles to building and enhancing resilience. Health professionals in their various roles as practitioners, researchers, educators, and administrators need to be aware of the contributing factors to resilience as well as the barriers to resilience. They need to be attentive to the important role of resilience as they devise and implement interventions in

support of women refugees' mental health and wellbeing. Furthermore, recognizing the strengths and capabilities of women refugees, keeping one's own biases and prejudices in check, and respecting the dignity and human rights of women enable health professionals both to provide the needed care and to guide them towards available systems of social and material support. Health professionals can usefully advocate for basic human rights of forcibly displaced populations and for provision of external support to promote health and wellbeing of displaced persons. Promoting and ensuring healthy transitions for displaced women will enhance their resilience and help them to become empowered and well-functioning full members of the new country, which in turn will benefit the society as a whole.

5.2.5 Gaps identified for further research

As discussed earlier on pages 7-9, mainstream approaches to refugee mental health have been dominated by models of trauma and post-traumatic stress disorder (PTSD) (Silove 2005, 29, 35; Papadopoulos 2007; Ingleby 2005, 7, 10-11), which do partial justice to understanding the whole range of issues related to forced displacement and mental health. It is well recognized that, despite extreme adversity and stressors, not all forcibly displaced persons develop mental health disorders (Bhugra 2004; Drozdek & Silove 2019, 260). This outcome is usually attributed to resilience. The studies included in this integrative review research focused on resilience and forced displacement from a gender perspective. This section examines the gaps identified by the studies reviewed.

The gap Darychuk and Jackson (2015) identified concerns the scarcity of research on the gendered experiences of community resilience in situations of displacement. In particular, the authors call for reflection on the complex intersections of religion, culture, and gender. Ginesini (2018) suggests that the underlying causes of migration and victimisation need to be addressed in order to stop sex trafficking. The power relations between women and men as well as the disparities that result from these power dynamics need to be addressed. Policymakers should strengthen and respect the political, economic and social rights of women, in order to implement effective policies against human trafficking and sexual abuse of women, as well as against any form of violence against women.

The study by Goodman et al. (2017) found that some women seemed to gather internal resources when confronted with barriers to external supports, which suggests that there is a need to explore the relationship between these two facets of resilience processes. The authors also highlight the need for advocacy work pressing for changes at the systemic level to policies, laws and practices that affect women negatively. Such advocacy can include addressing discrimination and aggressions of majority culture producing and maintaining anti-immigrant sentiments and policies. (Goodman et al. 2017.) Similarly, Abraham et al. (2018) identified the need to consider broader social policy contexts for further research.

The gap in the scholarly research identified by Shishehgar et al. (2017) concern the exploration of new challenges that refugee women encounter during resettlement, and the ways in which they can overcome those barriers. Pointing out that women refugees constitute an understudied refugee population, the authors call for an exploration of the extra burdens women have to shoulder in the migration processes. Indicating the need to include cultural transition as a distinct type of transition, Baird and Boyle (2012) calls for further research to investigate cultural transition in other displaced and relocated populations.

Lenette et al. (2013) maintain that discourses on resilience fail to pay attention to the highly gendered array of vulnerabilities faced by refugee women. A focus on such vulnerabilities could provide insights into gendered accounts of resilience. Pulvirenti and Mason (2011) advocate for further research on collective resilience that emphasizes the importance of wider institutional, structural or social influences. The authors warn that an individual approach to resilience focusing on internal or individual attributes can lead to the unhelpful assumption that some individuals do not have what it takes to 'bounce back' from negative life circumstances. An overemphasis on the individual, identified as problematic in the trauma model from the systems theory perspective in 2.1, seems to be equally problematic when it comes to studying resilience, as Pulvirenti and Mason (2011) point out.

The studies included in the review with refugee women from diverse settings provide deeper insights into the gendered experiences of women refugees that can usefully be adopted in the design and provision of mental health and psychosocial support services to support and enhance resilience. Some works also emphasize the need for advocacy, which further highlights the importance of considering the broader social policy contexts within which resilience can be achieved. There is still need for further research to explore gendered responses to forced migration (Indra 2008, 2) from multiple perspectives. Further studies on gender and forced migration can include participants from all genders beyond the male-female binary. Studies can also involve participants from social and health care professionals to fully explore gendered experiences of forced migration and their implications for resilience, mental health, and wellbeing. The review provided here was devoted only to exploring resilience, mental health and wellbeing of women refugees, highlighting the challenges and vulnerabilities of refugees of female gender encounter in the trajectories of forced displacement. There is certainly much more to be studied regarding gendered experiences of other groups related to forced displacement.

As the included studies approach resilience from the level of provision of health care and social services, there appears to be yet another gap that requires addressing. Further research can usefully adopt an upstream approach to explore socio-economic, political, and environmental determinants of health for forcibly displaced migrants. It can also address health inequities and disparities faced by these disadvantaged populations from perspectives

of human rights and social justice (Ingleby 2019). The need to go upstream is in line with the United Nations Sustainable Development Goals (UNSGDs) for Agenda 2030, which stresses the importance of "reaching out to those that are furthest behind first" to implement Sustainable Development Goals (SDGs) with three principles of universal values, which are: 1) Human rights-based approach, 2) Leave no one behind, 3) Gender equality and women's empowerment (UNSDGs 2020).

6 Discussion

This study sought evidence from selected studies to draw attention to the role resilience play in maintaining mental health and psychosocial wellbeing, as well as gender specific vulnerabilities and challenges women refugees face. Contributing factors and obstacles were also identified together with the recommendations for interventions that can be developed from a mental health care perspective. Moreover, the study pointed to the gaps that further research can address.

This study included seventeen scholarly articles with a variety of research designs. Most works were qualitative studies, which provided in-depth and rich accounts of refugee women's experiences of forced displacement. The analysis of the studies suggested that resilience played a role in three interrelated dimensions: (1) survival, (2) positive adaptation, as well as (3) participation and empowerment. The evidence gathered from selected studies suggests that building and enhancing resilience is of vital importance not only for mental health and psychosocial wellbeing of women refugees themselves but also for the societies. Fostering resilience promises multiple gains to the societies and countries thanks to the successful integration of women refugees. This is because resilience seems to play an important role in helping refugee women adapt and integrate to the host country.

Four factors were identified as contributing to resilience: (1) religion (faith, spirituality); (2) hope and positivity; (3) family and social connection; and (4) support and participation. Obstacles to resilience were (1) gendered vulnerabilities; (2) language barriers; (3) lack or limited support and material resources; (4) family separation; and (5) discrimination, hostility, and racism.

Suggestions for interventions from a mental health care perspective stressed the need for holistic, strengths-based, and culturally competent interventions. Health professionals need to be aware of gendered vulnerabilities refugee women have in their trajectories of forced displacement, recognize their strengths and capabilities, control their own biases and prejudices, and respect the dignity and human rights of women refugees. In addition to providing the needed care, health professionals can usefully advocate for basic human rights

of forcibly displaced populations as well as for the provision of external support to promote the health and wellbeing of displaced persons.

Gaps identified for further research included exploring and addressing dynamics of power relationships between women and men, exploring challenges refugee women encounter during settlement, and gendered accounts of resilience. Moreover, scholars highlighted the need for further research to explore the always gendered responses to forced migration (Indra 2008, 2) from multiple perspectives. Indeed, there appears to be a need for an upstream approach to explore the socio-economic, political, and environmental determinants of health for forcibly displaced migrants and to address health inequities and disparities from perspectives of human rights and social justice (Ingleby 2019).

Finally, this integrative literature review resonates with and will be beneficial to the author's current work as a project researcher at the Finnish Institute for Health and Welfare (THL) Manifold More Project. The project aims to advance professional career paths of highly educated immigrant background women and promote diversity in working life (THL, Manifold More). Advancing immigrant and refugee women's professional careers will enable their participation as full members of the society and empowerment, enhancing and supporting at the same time their resilience, as was suggested by the analysis of selected literature.

6.1 Strengths and Limitations

This study draws from a variety of study designs, focusing on the most recent decade to gather most up-to-date evidence to explore the scholarly literature on the role of resilience in maintaining mental health and psychosocial wellbeing in forcibly displaced women refugees from a gender perspective. The integrative literature review spanning the decade between 2010 and 2020 provided a much-needed examination of where the scholarly literature currently stands on these issues. The total number of participants of reviewed literature was 5050, suggesting that gathered evidence was strong enough to draw conclusions and make recommendations. In addition, the studies were conducted in different countries and geographical locations, which provided a global perspective.

The main limitation was the fact that the study was conducted by one author. A review with more than one author or investigator could have been more beneficial in bringing all relevant points to the fore. To reduce risk of bias, two investigators could independently apply eligibility criteria for selection of review articles in the literature search stage, as well as evaluate and appraise the quality of articles in the evaluation stage. Comparison and discussion of independently carried out evaluations would lead to joint decisions regarding differences. (Smyth & Jones 2012, 191.) Although the author of the study took extreme care to follow strategies to enhance the rigor, kept a detailed record of reading and gathering evidence, and referred to articles many times, some of the relevant details might be

overlooked or missed. A second author independently reviewing all articles and discussing and comparing findings of both authors could have minimize risk of bias and increase accuracy of conclusions of the study. (Whittemore & Knafl 2005.) Another potential limitation could be that it was not possible to include articles that required payment for access, because there was no funding for the study (Aveyard 2014, 96).

6.2 Ethical considerations

This study was a review that relied on existing data from published scientific articles. Therefore, no ethical approval was needed for original data collection. However, like all scholarly research, this study entails the ethical responsibility and integrity of the researcher. Following ALLEA and TENK guidelines for research integrity, this study explained all the processes of the research in a transparent, open, honest, and accurate manner (ALLEA 2017; TENK 2012). Moreover, due diligence was exercised to respect the work and achievements of other researchers by citing consulted sources appropriately and giving the credit and weight their publications warranted (TENK, RCR guidelines 2012). Research misconduct refers to unethical practices such as fabrication, falsification, or plagiarism, which go against the rules of good scientific practice (Bornmann 2013). Throughout all the stages of this study, the utmost care was taken to avoid such research misconduct. Therefore, the ethical responsibility for research integrity and good scientific practice was strictly followed. There was also no conflict of interest involved in the study.

As already mentioned in Strengths and Limitations section above, the sole author of this study was well aware of the possible risk of bias in conducting an integrative review alone, thus, extreme care was taken to reduce this risk by adhering to strategies to enhance rigor and accuracy. A detailed note taking and organization of main findings in an evidence table together with study characteristics were found to be useful in conducting the analysis and appraising the methodological quality of the selected publications. Some relevant points, however, may have been missed or overlooked. Different authors could have chosen to carry out the analysis in a different way. Yet, the important point is that the choices the sole author of this study made and the strategies followed were presented in a transparent manner.

7 Conclusion

This study explored the role of resilience and resilience factors in maintaining mental health and psychosocial wellbeing of women refugees by conducting an integrative review of scientific publications between the years 2010-2020. A total of 17 full-text, peer-reviewed scientific articles with various designs were included in the integrative review. The findings

of the study suggest that it is essential to pay attention to the role of resilience, contributing factors and obstacles to resilience from a gender perspective. Through such an awareness, health professionals can develop holistic, strengths-based, and culturally sensitive interventions which can help build and enhance women refugees' resilience. In addition to providing mental health and psychosocial support services, health professionals can advocate for changes at the systemic level to support women refugees' full participation and empowerment.

References

Printed

Aveyard, H. 2014. Doing a Literature Review in Health and Social Care. 3rd edition. Berkshire: Open University Pres.

Craig, T. 2010. Mental distress and psychological interventions in refugee populations. In Bhugra, D., Craig, T.& Bhui, K. (eds.) Mental health of refugees and asylum seekers. New York: Oxford University Press, 9-21.

Crowley, H. 1999 (reprint 2008). Women and refugee status: beyond the public/private dichotomy in UK Asylum Policy. In Indra, D. (ed.) Engendering Forced Migration: Theory and Practice. New York: Berghahn Books, 308-333.

Derluyn, I., van Ee, E.& Vindevogel, S. 2019. Psychosocial Wellbeing of 'Vulnerable' Refugee Groups in (Post-) Conflict Contexts: An Intriguing Juxtaposition of Vulnerability and Resilience. In Wenzel, T.& Drožđek, B. (eds.) An Uncertain Safety: Integrative Health Care for the 21st Century Refugees. Cham, Switzerland: Springer International Publishing, 213-231.

Drožđek, B.& Silove, D. 2019. Psychotherapy and Psychosocial Support in Host Countries: State-of-the-Art and Emerging Paradigms. In Wenzel, T.& Drožđek, B. (eds.) An Uncertain Safety: Integrative Health Care for the 21st Century Refugees. Cham, Switzerland: Springer International Publishing, 257- 281.

Fiddian-Quasmiyeh, E. 2014. Gender and forced migration. In Fiddian-Quasmiyeh, E., Loescher, G., Long, K.& Sigona, N. (eds.) The Oxford handbook of refugee and forced migration studies. Oxford: Oxford University Press, 395-408.

Freedman, J. 2012. Taking gender seriously in asylum and refugee policies. In Khory, K. (ed.) Global Migration: Challenges in the Twenty-First Century. New York: Palgrave Macmillan, 45-64.

Goździak, E. 2008. Pray God and Keep Walking. In Hajdukowski-Ahmed, M., Khanlou, N.& Moussa, H. (eds.) Not Born a Refugee Woman: Contesting Identities, Rethinking Practices. New York: Berghahn Books, 180-195.

Hajdukowski-Ahmed, M., Khanlou, N.& Moussa, H. 2008. Introduction. In Hajdukowski-Ahmed, M., Khanlou, N.& Moussa, H. (eds.) Not Born a Refugee Woman: Contesting Identities, Rethinking Practices. New York: Berghahn Books, 1-24.

Indra, D., 1999 (reprint 2008). Not a "Room of One's Own": Engendering Forced Migration Knowledge and Practice. In Indra, D. (ed.) Engendering Forced Migration: Theory and Practice New York: Berghahn Books, 1-22.

Ingleby, D. 2005. Editor's Introduction. In Ingleby, D. (ed.) Forced Migration and Mental Health: Rethinking the Care of Refugees and Displaced Persons. New York: Springer, 1–27.

Rousseau, C. 2019. Foreword: Continuity and Shifts in Contemporary Refugee History. In Wenzel, T.& Drožđek, B. (eds.) An Uncertain Safety: Integrative Health Care for the 21st Century Refugees. Cham, Switzerland: Springer International Publishing, v-ix.

Silove, D. 2005. From trauma to survival and adaptation: Towards a framework for guiding mental health initiatives in post-conflict societies. In Ingleby, D. (ed.) Forced Migration and Mental Health: Rethinking the Care of Refugees and Displaced Persons. New York: Springer, 29-51.

Silove, D.& Rees, S. 2010. Paternalism or autonomy? Ethics, ideology, and science in refugee mental health interventions. In Bhugra, D., Craig, T.& Bhui, K. (eds.) Mental Health of Refugees and Asylum Seekers. Oxford: Oxford University Pres, 263-274.

Smyth, R. L.& Jones, L. V. 2012. Using evidence from systematic reviews. In Craig, J.V.& Smyth, R.L. (eds.) The Evidence-Based Practice Manual for Nurses. 3rd edition. [Edinburg]: Churchill Livingstone Elsevier, 187-213.

Ungar, M. 2012. Social ecologies and their contribution to resilience. In Ungar, M. (ed.) The Social Ecology of Resilience: A Handbook of Theory and Practice. New York: Springer, 13-31.

Whittemore, R. & Knafl, K. 2005. The integrative review: updated methodology. Journal of Advanced Nursing, 52 (5), 546-553.

Young, M. Y., & Chan, K. J. (2015). The psychological experience of refugees: A gender and cultural analysis. In S. Safdar & N. Kosakowska- Berezecka (eds.), Psychology of gender through the lens of culture: Theories and applications. New York: Springer International Publishing, 17-36.

Electronic

Abraham, R., Lien, L.& Hanssen, I. 2018. Coping, resilience and posttraumatic growth among Eritrean female refugees living in Norwegian asylum reception centers: A qualitative study. International Journal of Social Psychiatry, 64 (4) 359-366. Accessed 23.9.2020. https://journals-sagepub-com.nelli.laurea.fi/doi/pdf/10.1177/0020764018765237

All European Academies (ALLEA). 2017. The European Code of Conduct for Research Integrity Revised Edition. Accessed 4.12.2020. https://www.allea.org/wp-content/uploads/2017/05/ALLEA-European-Code-of-Conduct-for-Research-Integrity-2017.pdf

Babatunde-Sowole, O., Power, T., Jackson, D., Davidson, P.& DiGiocomo, M. 2016. Resilience of African migrants: An integrative review. Health care for women international,37 (9) 946–963. Accessed 23.9.2020. http://web.a.ebscohost.com.nelli.laurea.fi/ehost/pdfviewer/pdfviewer?vid=1&sid=e4313ed8-9b4a-4d27-9667-5e589731a23b%40sessionmgr4007

Babatunde-Sowole, O., O., DiGiacomo, M., Power, T., Davidson, P., M.& Jackson, D. 2020. Resilience of African migrant women: Implications for mental health practice. International Journal of Mental Health Nursing, 29, 92–101. Accessed 24.9.2020. https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/inm.12663

Baird, M.B.& Boyle, J. S. 2012. Well-Being in Dinka Refugee Women of Southern Sudan. Journal of Transcultural Nursing, 23 (1), 14-21. Accessed 27.9.2020. https://journals-sagepub-com.nelli.laurea.fi/doi/pdf/10.1177/1043659611423833

Bhugra, D.& Jones, P. 2001. Migration and mental illness. Advances in Psychiatric Treatment, 7, 216-223. Accessed 3.3.2020. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.519.496&rep=rep1&type=pdf

Bhugra, D. 2004. Migration and Mental Health: Review article. Acta psychiatrica scandinavica, 109, 243–258. Accessed 3.3.2020. https://www.ncbi.nlm.nih.gov/pubmed/15008797

Bhugra, D., Gupta, S., Bhui, K., Craig, T., Dogra, N., Ingleby, J.D., Kirkbride, J., Moussaoui, D., Nazroo, J., Qureshi, A., Stompe, T.& Tribe, R. 2011. WPA guidance on mental health and mental health care in immigrants. World Psychiatry, 10 (1),2-10. Accessed 23.4.2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3048516/

Bornmann, L. 2013. Research Misconduct—Definitions, Manifestations and Extent. Publications 1 (3), 87-98. Accessed 4.12.2020. https://www.mdpi.com/2304-6775/1/3/87/htm

CASP Checklists. 2018. Accessed 10.4.2020. https://casp-uk.net/casp-tools-checklists/

Darychuk, A.& Jackson, S. 2015. Understanding Community Resilience Through the Accounts of Women Living in West Bank Refugee Camps. Affilia: Journal of Women and Social Work, 30 (4), 447-460. Accessed 24.9.2020. https://journals-sagepub-com.nelli.laurea.fi/doi/pdf/10.1177/0886109915572845

Denzongpa, K.& Nichols, T. 2020. We Can't Step Back: Women Specially … A Narrative Case Study on Resilience, Independence, and Leadership of a Bhutanese Refugee Woman. Affilia: Journal of Women and Social Work, 35 (1), 129-145. Accessed 24.9.2020. https://journals-sagepub-com.nelli.laurea.fi/doi/pdf/10.1177/0886109919871266

Eurostat. 2019. Asylum seekers in the EU in 2018. Accessed 7.11.2019. https://ec.europa.eu/eurostat/en/web/products-eurostat-news/-/EDN-20190620-1

Freedman, J. 2008. Women's Right to Asylum: Protecting the Rights of Female Asylum Seekers in Europe? Human Rights Review, 9,413–433. Accessed 31.8.2020. https://www-proquest-com.nelli.laurea.fi/docview/194788540?accountid=12003

Ginesini, G. 2018. Forced Migration: Trauma, Faith, and Resilience. Social Work and Christianity, 45 (4), 98-121. Accessed 23.9.2020. https://search-proquest-com.nelli.laurea.fi/docview/2135987496

Goodman, R.D., Vesely, C. K., Letiecq, B.& Cleaveland, C.L. 2017. Trauma and Resilience Among Refugee and Undocumented Immigrant Women. Journal of Counseling and Development, 95 (3), 309-321. Accessed 25.9.2020. http://web.a.ebscohost.com.nelli.laurea.fi/ehost/pdfviewer/pdfviewer?vid=1&sid=89e5e7e4-c777-4b11-8b55-5ee2f1a8c352%40sessionmgr4007

Hoge, E.A., Austin, E.D.& Pollack, M.H. 2007. Resilience: research evidence and conceptual considerations for posttraumatic stress disorder. Depression and Anxiety 24 (2), 139-152. Accessed 3.9.2020. http://corstone.org/wp-content/uploads/2015/05/Review-Resilience-Research-Evidence-and-Conceptual.pdf

Hunt, L. 2008. Women Asylum Seekers and Refugees: Opportunities, Constraints and the Role of Agency. Social Policy & Society, 7 (3), 281-292. Accessed 27.4.2020. http://usir.salford.ac.uk/id/eprint/9264/1/Lisa_Hunt.pdf

IFRC World Disasters Report. 2016. Resilience: saving lives today, investing for tomorrow. Accessed 10.11.2019. https://www.ifrc.org/Global/Documents/Secretariat/201610/WDR%202016-FINAL_web.pdf

Ingleby, D. 2019. Moving upstream: Changing policy scripts on migrant and ethnic minority health. Health Policy, 123 (9), 809-817. Accessed 22.9.2020. https://www.sciencedirect.com/science/article/pii/S0168851019301617

Inter-Agency Standing Committee (IASC). 2007. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC. Accessed 10.11.2019. https://www.unicef.org/protection/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

International Organization for Migration (IOM). 2019. Glossary on Migration. Accessed 24.3.2020. https://www.iom.int/glossary-migration-2019

Jesuthasan, J., Witte, Z.& Oertelt-Prigione, S. 2019. Health-Related Needs and Barriers for Forcibly Displaced Women: A Systematic Review. Gender and the Genome, 3, 1-8. Accessed 25.9.2020. https://journals-sagepub-com.nelli.laurea.fi/doi/pdf/10.1177/2470289719895283

Kirmayer, L.J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A.G., Guzder, J., Hassan, G., Rousseau, C.& Pottie, K. 2011. Common mental health problems in immigrant and refugees: general approach in primary care. CMAJ, 6,959-967. Accessed 27.4.2020. https://www.cmaj.ca/content/183/12/E959

Laurea LibGuides. Accessed 21.9.2020. https://libguides.laurea.fi/bit/journals

Lenette, C., Brough, M.& Cox, L. 2013. Everyday resilience: Narratives of single refugee women with children. Qualitative Social Work, 12 (5), 637-653. Accessed 23.9.2020. https://journals-sagepub-com.nelli.laurea.fi/doi/full/10.1177/1473325012449684

Lindert, J., von Ehrenstein, O. S., Priebe, S., Mielck, A.& Brähler, E. 2009. Depression and anxiety in labor migrants and refugees – a systematic review and meta-analysis. Social Science & Medicine, 69, 246-257. Accessed 31.5.2020. https://www.sciencedirect.com/science/article/abs/pii/S0277953609002627?via%3Dihub

Mangrio, E., Zdravkovic, S.& Carlson, E. 2019. Refugee women's experience of the resettlement process: a qualitative study. BMC Women's Health, 19 (1), 1-6. Accessed 24.9.2020. https://www-proquest-com.nelli.laurea.fi/docview/2328246228?accountid=12003

Masten, A. 2001. Ordinary magic: Resilience processes in development. American Psychologist, 56 (3), 227-238. Accessed 7.9.2020. http://web.a.ebscohost.com.nelli.laurea.fi/ehost/pdfviewer/pdfviewer?vid=1&sid=f9fe52ab-0410-4d25-b4a3-bbdd55f8988a%40sdc-v-sessmgr03

Mohaupt, S. 2008. Review Article: Resilience and Social Exclusion. Social Policy and Society, 8 (1), 63–71. Accessed 13.3.2020. https://search-proquest-com.nelli.laurea.fi/docview/221263812/fulltextPDF/F867DC6B8B4F4EC9PQ/1?accountid=12003

Moher, D., Liberati, A., Tetzlaff, J.& Altman, D.G., The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Medicine 6,7. Accessed 20.4.2020. https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1000097

Noble, H.& Smith, J. 2018. Reviewing the literature: choosing a review design. Evidence Based Nursing, 21 (2), 39-41. Accessed 11.4.2020. https://ebn.bmj.com/content/ebnurs/21/2/39.full.pdf

Papadopoulos, R.K. 2007. Refugees, trauma and Adversity-Activated Development. European Journal of Psychotherapy and Counselling, 9 (3) 301–312. Accessed 27.4.2020. https://reliefweb.int/sites/reliefweb.int/files/resources/RKP%20Refugees%20Trauma%20and%20AAD%202007.pdf

Pittaway, E.& Bartolomei, L. 2001. Refugees, race, and gender: The multiple discrimination against refugee women. Refugee: Canada's Journal on Refugees, 19 (6), 21-32. Accessed 2.9.2020. https://refuge.journals.yorku.ca/index.php/refuge/article/view/21236/19907

Priebe, S., Giacco, D.& El-Nagib, R. 2016. Public health aspects of mental health among migrants and refugees: a review of the evidence on mental health care for refugees, asylum seekers and irregular migrants in the WHO European Region. Health Evidence Network (HEN) Synthesis Report 47. Copenhagen: WHO Regional Office for Europe. Accessed 31.5.2020.

https://www.euro.who.int/__data/assets/pdf_file/0003/317622/HEN-synthesis-report-47.pdf?ua=1

PRISMA Statement. Accessed 10.4.2020. http://prisma-statement.org/PRISMAStatement/PRISMAStatement

Pulvirenti, M. & Mason, G. 2011. Resilience and Survival: Refugee Women and Violence. Current Issues in Criminal Justice, 23 (1), 37-52. Accessed 23.9.2020. https://www-tandfonline-com.nelli.laurea.fi/doi/abs/10.1080/10345329.2011.12035908

Sherwood, K. & Liebling-Kalifani, H. 2012. A Grounded Theory Investigation into the Experiences of African Women Refugees: Effects on Resilience and Identity and Implications for Service Provision. Journal of International Women's Studies, 13 (1), 86-108. Accessed 23.9.2020. https://vc.bridgew.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1058&context=jiws

Shishehgar, S., Gholizadeh, L., DiGiacomo, M. Green, A.& Davidson, P. M. 2017. Health and Socio-Cultural Experiences of Refugee Women: An Integrative Review. Journal of Immigrant Minority Health, 19, 959–973. Accessed 23.9.2020. https://search-proquest-com.nelli.laurea.fi/docview/1826661907

Smit, R. & Rugunanan, P. 2015. Transnational forced migration and negotiating emotional well-being: the case of women refugees in South Africa. Social Dynamics- A Journal of African Studies, 41 (1), 184-203. Accessed 25.9.2020. https://doi.org/10.1080/02533952.2015.1029749

Southwick, S.M., Bonanno, G.A., Masten, A.S., Panter-Brick, C.& Yehuda, R. 2014. Resilience definitions, theory, and challenges: interdisciplinary perspectives. European Journal Of Psychotraumatology, 5: 25338. Accessed 9.11.2019. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4185134/pdf/EJPT-5-25338.pdf

Spitzer, D.L. 2007. Immigrant and Refugee Women: Recreating meaning in Transnational Context. Anthropology in Action, 14 (1 & 2), 52-62. Accessed 17.9.2020. https://www.berghahnjournals.com/view/journals/aia/14/1-2/aia14010206.xml

STROBE Statement. Accessed 10.4.2020. https://strobe-statement.org/index.php?id=strobe-home

Summerfield, D. 2003. Mental health of refugees. British Journal of Psychiatry, 183 (5), 459-460. Accessed 31.8.2020. https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/mental-health-of-refugees/41C1A0020F9C7F3FEC6CC98399A6C26A/core-reader#

TENK RCR Guidelines 2012. (Responsible conduct of research and procedures for handling allegations of misconduct in Finland) Accessed 17.3.2020. https://www.tenk.fi/sites/tenk.fi/files/HTK_ohje_2012.pdf?_ga=2.5932275.1167760908.1605186781-2072259054.1605186781

Terveyden ja hyvinvoinnin laitos (THL). Manifold More Project - Leverage to the professional careers of immigrant background women. Accessed 13.12.2020. https://thl.fi/en/web/thlfi-en/research-and-expertwork/projects-and-programmes/manifold-more

The Office of the High Commissioner for Human Rights (OHCHR). The human rights to water and sanitation of forcibly displaced persons in need of humanitarian assistance. Accessed 7.9.2020. https://www.ohchr.org/EN/Issues/WaterAndSanitation/SRWater/Pages/ForciblyDisplacedPersons.aspx

The Universal Declaration of Human Rights. 1948. Accessed 8.11.2019. https://www.un.org/en/universal-declaration-human-rights/

The United Nations. 1951, 1967. Convention and protocol relating to the status of refugees. Accessed 8.11.2019. https://www.unhcr.org/protection/basic/3b66c2aa10/convention-protocol-relating-status-refugees.html

UN Sustainable Development Goals Agenda 2030. 2020. Accessed 11.11.2020. https://unsdg.un.org/2030-agenda/universal-values

UNHCR. 2020. Global Trends: Forced Displacement in 2019. Accessed 15.9.2020. https://www.unhcr.org/5ee200e37.pdf

UNHCR. 2019. Global Trends: Forced Displacement in 2018. Accessed 9.11.2019. https://www.unhcr.org/5d08d7ee7.pdf

UNHCR. 2016. Global Trends: Forced Displacement in 2015. Accessed 9.11.2019. https://www.unhcr.org/576408cd7

UNHCR. 2002. Guidelines on international protection: Gender-related persecution within the context of Article 1A(2) of the 1951 Convention and/or its 1967 Protocol relating to the Status of Refugees. Accessed 27.4.2020. https://www.unhcr.org/3d58ddef4.pdf

UNHCR Webpage. What is a refuge? Accessed 10.3.2020. https://www.unhcr.org/what-is-a-refugee.html

Valji, N. 2001. Women and the 1951 refugee convention: Fifty years of seeking visibility. Refuge: Canada's Journal on Refugees, 19 (5), 25-35. Accessed 8.9.2020. https://refuge.journals.yorku.ca/index.php/refuge/article/view/21227

Veronese, G., Cavazzoni, F., Russo, S.& Sousa, C. 2019. Risk and Protective Factors Among Palestinian Women Living in a Context of Prolonged Armed Conflict and Political Oppression. Journal of Interpersonal Violence, 1-29. Accessed 25.9.2020. https://journals.sagepub.com/doi/pdf/10.1177/0886260519865960

Walsh, F. (2002). Bouncing forward: Resilience in the aftermath of September 11. Family Process, 41, 34-36. Accessed 18.4.2020. http://web.b.ebscohost.com.nelli.laurea.fi/ehost/pdfviewer/pdfviewer?vid=1&sid=286028a7-2a59-4649-832d-75b6e0c8a548%40pdc-v-sessmgr06

Welsh, E.A.& Brodsky, A.E. 2010. After Every Darkness Is Light: Resilient Afghan Women Coping with Violence and Immigration. Asian American Journal of Psychology, 1 (3), 163-174. Accessed 25.9.2020. http://web.a.ebscohost.com.nelli.laurea.fi/ehost/detail/detail?vid=0&sid=c59f36cc-ff4d-4b6e-8ada-f01acb22873d%40sdc-v-sessmgr01&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#AN=2010-21070-001&db=pdh

Watters, C. & Ingleby, D. 2004. Locations of care: Meeting the mental health and social care needs of refugees in Europe. International Journal of Law and Psychiatry, 27, 549–570. Accessed 31.8.2020. https://www-sciencedirect-com.nelli.laurea.fi/science/article/pii/S0160252704001219?via%3Dihub

WHO. 2019. Mental health: Fact sheet. Accessed 10.11.2019. http://www.euro.who.int/__data/assets/pdf_file/0004/404851/MNH_FactSheet_ENG.pdf?ua=1

Figures

Tables

Appendices

Appendix 1: Study characteristics and evidence table

Reference & country	Purpose & aim of study	Design & study sample	Data & methods	Results	Quality score
Abraham et al. 2018. Norway Coping, resilience and posttraumatic growth among Eritrean female refugees living in Norwegian asylum reception centres	To identify sources of resilience, coping and posttraumatic growth in female Eritrean refugees living in Norwegian asylum reception centres	Qualitative study Two focus groups & 10 individual in-depth interviews 18 female Eritrean refugees aged 18-60 participated, all had refugee status & were living in reception centers (8 reception centers in southern & central Norway)	Data gathered from two focus groups and 10 individual in-depth interviews A content-focused hermeneutic analytic approach was used. Interviewees were encouraged to talk about mental health problems /trauma experiences & coping skills, psychosocial and existential meaning resources Language used: Tigrinya, first author conducted the interviews & translated them into English	Description of challenges: Trauma of pre-flight: endless military service in Eritrea, dangerous environment for women, punishments, violence and rapes During flight: stressful occurrences, risk of harassment, being shot or drowned Current living conditions: communication difficulties and the 'endless' waiting for transfer to a municipality; asylum center crowded, stressful Resilience factors: Positivity and hope for future helped to cope with challenges Focusing on future, hope and dreams for future Religion, prayer, meditation, attending church services - spiritual, religious resources important for coping and resilience Social support from peers and staff (fellow Eritrean refugees as a proxy family) Interpersonal relations and acceptance of psychological symptoms as a normal reaction to what they experienced and belief that their mental state will improve when moved to a permanent home to begin a new life Sense of coherence (SOC): perception of the world and inevitable stressful events as comprehensible, manageable and meaningful – strongly associated with perceived mental health A dynamic and multidimensional understanding of	18/20 (90 %)

				mental health is needed Conclusions: Attention needs to be paid to resilience and coping of refugees, (their experiences and expressed needs) rather than perceiving them as 'passive victims' with mental health problems. Consider broader social policy contexts.	
Babatunde-Sowole et al. 2016. Australia, UK, USA Resilience of African migrants: An integrative review	To identify factors influencing, & strategies for developing resilience in African migrant women aged 18 & over (the term migrants include refugees and voluntary migrants)	Integrative literature review, 15 articles included (qualitative n = 14; peer-reviewed journal articles n = 9; grey literature n = 6) Sample sizes of studies ranged from 4 to 62 African people; documented number of women 112. Women: population of interest - due to paucity of literature, some studies including men were also included	Integrative literature review using systematic evaluation approach & PRISMA framework Databases: Ebsco, Scopus,CINAHL, Medline, PsychInfo, Multicultural Australia and Immigration Studies Quality appraisal: review for design, sample, setting, data collection method & analysis, clarity of writing, generalizability & reflexivity Key factors (internal & external) in achieving resilience identified, discussed & represented diagrammatically	Methodological challenge: lack of clear definition of resilience - used interchangeably with coping, adaptation and "helps" Strategies for resilience: **1. Internal factors (microsystem):** thoughts, behaviors, personal values, skills to maintain equilibrium and achieve positive outcomes; cognitive strategies: mental reconstruction of migration stress in relation to current achievement, acceptance of difficult situations with an aspirational focus; spirituality and faith: vital sources of resilience & strength for women **2. External factors (meso-, exo-, & macro-systems levels); communalism:** interdependence, being African as a communal bond, receiving support to adapt to new life, support from families, friends and community; remaining connected to home countries; associating with other migrant women, establishing connections and new relationships to reduce feelings of isolation; use of communication technology; support from government, financial settlement assistance Empowerment as a key outcome of resilience (role of resilience), internal and external factors interwoven together - not operating in isolation Empowerment of both individual and community by establishing associations to resist marginalization and	33/36 (92 %)

			using an ecological framework (micro-, meso-, exo-, & macro-levels)	to encourage integration; empowered community providing opportunities to its members to use their skills, and resources to collectively meet community needs. Empowerment: Achieving & enhancing resilience of refugees by strengthening of human relationships within a nurtured environment Conclusions: the review emphasizes the importance of resilience to welfare and healthy settlement of migrants into a new culture as well as the benefits to the new communities	
Babatunde-Sowole et al. 2020. Australia, USA Resilience of African migrant women: Implications for mental health practice	To facilitate increased awareness about West African women's pre-migration resilience by exploring how these experiences reflect women's resilience and strengths in order to support trauma-informed care provided by mental health practitioners	Qualitative study 22 participants: West African women living in Sydney, Australia for more than a year, aged 18 years and over Semi-structured interviews Participant recruitment from migration resource centers, African community groups & associations via posters, flyers. Snowball sampling also used	A strength-based storytelling approach to explore pre-migration experiences, describe unnamed protective processes, and add power to women's voices Data consisting women's stories collected in face-to-face interviews and audio-taped. Thematic analysis used to analyze the data.	Women's life stories told chronologically, relevant to strength-based approach, helped identify and contextualize their aspirations, how they could keep hope alive, and continue to move forward Two main themes emerged from women's stories: 1."When the World Falls Apart" with two subthemes: *Enjoying a peaceful home* and *Then horror came knocking* The women talking about their peaceful lives in countries of origin prior to adversity - providing context to later experiences and aspirations. Sudden disruption of peaceful lives forced many women to flee from their countries, leading to chaos, displacement, family fragmentation. Life from a normal and happy existence to a dark and painful one. Weeks spent walking through difficult and dangerous terrain. Sudden break of war culminating into displacement and loss of family members. Stories of physical and sexual violence, rape. 2. "Battered but Strong" with two subthemes: *Precarious living* and *Resilience from adversity* Women's experiences of living in refugee camps for	20/20 (100 %)

				long periods of time before migration to Australia. Women experienced isolation from mainstream population of refuge country as difficult. Rejection and perception of refugees as 'troublemakers.' Life in refugee camps was hard, mostly lived in tents without basic amenities. Many camps close to conflict areas they fled. Experiences typified by fear, horror, uncertainty. Resilience strategies in overcoming adversities in refugee camps: ingenuity, resourcefulness, small entrepreneurship activities, social networking for support, communalism, religiosity, optimism, determination, self-reliance. Examples: fetching and selling water, children's education through homeschooling Conclusion: A holistic approach with an understanding of migrants' lives and values could be beneficial to provide needed support, and trauma-informed care in migrants' new countries. Excellent health outcomes can be achieved by situating care within identified or communal strength. Also, important to note that, while some migrants experiencing trauma may have mental health problems, many will not.	
Baird & Boyle. 2012. USA Well-Being in Dinka Refugee Women of Southern Sudan.	To explore health and wellbeing of Sudanese refugee women resettled with their children to the US in connection with resettlement experiences	Qualitative study Interpretive ethnography, interviews & observation, a purposive sample of 10 refugee women from Dinka tribe of southern Sudan	Ethnographic method of in-depth individual interviews (a total of 21) and participant observation with extensive field notes. Before data collection, 3 years	Three themes emerged from data analysis: **1) liminality** - living between two cultures, **2) self-support** - standing on own feet **3) hope for the future.** **Liminality:** Conceptualization of resettlement experiences as being in-between or liminal state with associated challenges of living between Dinka & American cultures – 'caught in-between' **Self-support:** Resettlement providing new opportunities to stand on own two feet, pride, sense	18/20 (90 %)

		A total of 21 interviews	were spent participating in community events & developing relationships. Two women from Dinka tribe hired as interpreters. Data collected in multiple settings over a year. The Sudanese Community Church as a site for participant observation	of accomplishment. Learning new skills, different roles. Financial support to family members in Sudan. Independence and equality in marital relationships. New roles: employee, family provider, equal partner in marriage / the head of the household, incorporating aspects of being an 'American woman'. **Hopes for the future:** affirmation of their purpose for being in a new country and strengthening the link to their past. Hopes for preservation of tribal lineages and cultural traditions providing a 'higher' purpose, which helped to transcend the difficulties. Belief in a 'higher' purpose linked to strong religious convictions. Vital to positive adjustment: staying connected to Dinka community and to their homeland. Hope for own future linked to their hope of future of family and community and country of Sudan. Resettlement as an opportunity to secure the success and survival of entire Dinka tribe. The process toward wellbeing described by three themes: liminality, self-support, and hope for the future. No direct translation of wellbeing in Dinka language, most close word *mietpieu*, meaning 'peace in heart,' referring also to 'happiness, a good environment, and harmony' – wellbeing of women tied to that of their community. Conclusions: Refugee women presented as strong, resilient and capable of being responsible for their own health and wellbeing. Three major themes of study guides nurses to think differently (out-of-the box) about culturally competent interventions for promoting health and wellbeing of women. Nurses can promote and maximize the innate resources of refugees to foster healthy transitions.	

Darychuk & Jackson. 2015. Canada Understanding Community Resilience Through the Accounts of Women Living in West Bank Refugee Camps.	To explore how Palestinian women understand their contributions to the resilience of refugee communities in West Bank Refugee Camps	Qualitative study 31 participants, between the ages 22-48, selected from women in the UNRWA health center waiting room - married 25, single 6 Convenience sampling method, recruitment and most of the translations by psychosocial counsellor of the clinic UNRWA: The United Nations Relief and Works Agency for Palestine Refugees in the Near East	Semi-structured interviews with 31 women in UNRWA health centers of nine camps in West Bank Data. Constant comparative method to search for instances that represent categories Interviews conducted with the assistance of translators. 20 interviews recorded. Written notes from English verbal translation for those not recorded. Informal discussions with the psychosocial counsellors about the general state of women's participation in camp society also included in the study.	Aspects of community resilience: 1**. Reproducing social traditions:** social construct *sumud* signifying determination to exist & remain connected to physical territory - belonging to the Palestinian nation. Community events giving women a sense of meaning & access to social support. Reproducing stories & placing importance on the collective as the most prominent ways for women to contribute to community resilience & reproduce national identity **2. Religious affiliation:** religion plays an important role in the resilience of West Bank communities, 98% Muslim. Women discussed how their religion oriented daily life & helped them deal with hardships & material poverty. Religion help understand their situation as part of a larger struggle/ environment within which the exist. **3. Raising 'Palestinian' children:** major components of women's contribution consisted raising children & instilling in them Palestinian values. Maternal capabilities bringing pride & positively reinforcing that being a good mother vital to community functioning & reproducing itself **4. Working outside the home:** a growing number of women working outside the house, traditionally a taboo, became a necessity due to depressed economic situation & uncertainty about job prospects of their husbands. Sewing projects, cleaning or handicraft lessons in women's centers of the camp. Lack of money & household income insecurity as source of pressure on traditional gender norms. **5. Meeting spaces:** lack of meeting spaces in camps, originally built as short-term housing, led to utilizing UNRWA centers as meeting places for socializing.	18/20 (90 %)

				Cultural norms restricting women's movement in public places without a male relative not applicable when women seek medical care in UNRWA centers. These centers provide access to community networking, mental health education and a safe space for socialization. Women seek out more time at health centers to meet with other women and share stories and hardships. Repurposing of public space for health-promotion purposes illustrates gendered differences women experience when trying to work & socialize. Female refugees find ways to navigate the impacts of gender on community resilience. Barriers to resilience: **Difficulties for community participation**: family obligations, customs. **Gender discrimination**: Patriarchal society intersecting with cultural religious norms to limit women's participation and presence in public life. Cultural norms as barriers preventing equal participation of women in public activities and decision making, although they participate and support resilience within their communities. Need to go beyond dichotomous explanations of 'turning inward' and 'looking outward' coping paths for refugee women – inwards turn toward traditional values; outwards looking to and adopting Western norms and ways of life, for it fails to reflect the complex intersections of religion, culture, and gender, which create a specific form of resilient adaptation. Need for more research on the gendered experiences of community resilience in situations of	

				displacement.	
Denzongpa & Nichols. 2020. USA We Can't Step Back: Women Specially … A Narrative Case Study on Resilience, Independence, and Leadership of a Bhutanese Refugee Woman.	To examine the lived experience of a twice-displaced Bhutanese refugee woman holding a leadership position post-settlement in order to better understand the role of resilience in resettlement experiences through a critical feminist perspective (CFP).	Qualitative study, 1 participant An intrinsic narrative case study design was used, emerging from a larger ethnographic study which employed community-based participatory research (CBPR) methodology.	Data collection through extensive observational field notes and multiple formal and informal interviews. Co-construction of the story with the participant through an iterative process of developing, verifying, and refining to increase accuracy - a thick, rich description of the refugee woman's life experiences.	The trajectory of women's ability to succeed or even exercise basic human rights is constantly diverted by traditional gender roles as well as migration factors. Intersecting disadvantages of being a woman and a refugee prevents the participant from pursuing higher education and limits employment options in the refugee camp setting. Social identities such as culture, citizenship status, age and economic status determine the access to services, and women are often disadvantaged when systemic factors such as migration adversely affect these identities. When health issues and health-care barriers are introduced into gender and migration issues, refugee women become the most vulnerable and severely disadvantaged within the social context. Participant's struggles to overcome challenges, disrupting gender norms, striving for education and employment provide rich description of what refugee women experience. Resilience is shown to have mitigating effects when faced with multiple stressors and challenges. Resilience plays a role in turning experiences into lessons and opportunities for other women in the community, being able to achieve a degree of normalcy through educational and employment pursuits, advocating for women's rights and practicing self-efficacy. Reflected throughout participant's life story, resilience can be seen in her responses to traumatic experiences she faced around issues of gender, culture, displacement, and	19/20 (95 %)

				resettlement. Pursuing continual growth through learning and not giving up led the participant to a leadership position in the community. In both formal and informal situations, the independence she displayed in disrupting gender norms and her resilience in overcoming gender barriers were constantly observed. As president of the local women's group, the participant worked to protect the integrity of the community by advocating for health and safety. Leadership as a tool to challenge patriarchal gender norms and create new opportunities for women to prosper in the US. Applying critical feminist perspective (CFP) to understand women refugees' experiences, study identifies that, due to their social positioning concerning gender norms, lack of resources and language barriers, women are greatly disadvantaged and more likely to experience situational and structural stressors. For social work practice, the study foregrounds the need for interventions that support women as leaders and empower them in their communities, as well as connect refugee communities with organizational resources.	
Ginesini. 2018. Italy Forced Migration: Trauma, Faith, and Resilience.	To investigate the impact of socioemotional resources (including faith) and protective factors on	Observational pilot study, cross-sectional design Sample (n = 18) eighteen trafficked women, ages 20 to 42	A combined strength-based and resource-based theoretical approach to explore refugee women's ability to	- Faith (spirituality, religion) in refugee women's life has double role as both resource and strength. Faith as a resource involves support gained from prayers, church attendance, community, friends and family. As a strength, faith involves a positive attitude, having hopes and goals, perceptions of growth and resilience	39/44 (89 %)

	resilience among female victims of multiple traumas including trafficking, sexual exploitation and torture.	(mean = 33, standard deviation = 6.22), forced to migrate to Italy from Central and Western Africa and Eastern Europe. Structured questionnaires used in the interviews. Participants were from a community shelter for political refugees, asylum seekers and beneficiaries of international protection.	successfully and flexibly cope with multiple traumas. A structured paper-and-pencil questionnaire, "Relational Resources and Resilience," during face-to-face interviews with a clinical psychologist. Six measures used: **1. The Social and Emotional Resources Inventory** (SERI, Mohr, 2007), a 10-factor measure combining protective factors from individual, familial & community areas. **2. Resilience Scale** (RS-14, Wagnild & Young, 1993), identifying degree of individual resilience. **3. The Perceived Ability to Cope with Trauma scale**	Testing the six hypotheses of the pilot study: **H1**: "Individual, familial and community resources builds resilience in refugee women" – not confirmed by the results, no direct relation between resources and resilience; but faith as protective factor for coping flexibility. **H2**: "Protective factors influence the impact of life events, both positive and negative" – confirmed by the results. Coping flexibility predicting overall impact of life events and mindfulness predicting scores of positive life events. **H3**: "Protective factors are predictive of resilience levels in refugee women" – partially confirmed by the results. Only positive affect among three protective factors (mindfulness, positive and negative affect and coping flexibility) was found to predict resilience level. **H4**: "Resilience and impact of life events influence each other reciprocally" – A reciprocal influence between resilience and the impact of life events is confirmed for negative life events only. **H5**: "Resilience predicts well-being and autonomy" – not confirmed by the results. **H6**: "Stress level and the impact of life events are strongly correlated" – confirmed by the results. - Socioemotional resources were found to have an important role in predicting the ability to cope flexibly with trauma and move forward. Faith predicted significantly a more positive assessment of life events and coping flexibility. Significant differences in the mean values of positive and negative life events were also explained by positive affect and contributed statistically significantly to	

			(PACT, Bonanno et al. 2011), measuring coping flexibility. **4. The Positive & Negative Affect Scale** (PANAS, Watson et al. 1988) to measure positive & negative affect. **5. The Mindful Attention Awareness Scale** (MAAS, Brown et al 2003, MacKillop et.al 2007)), measuring mindfulness. **6. The Life Events Survey** (LES, Sarason et al. 1978), measuring life changes. SPSS 24.1. for statistical analysis: descriptive statistics, correlations, and multiple regression analysis.	the prediction of resilience scores. - Benefits of and need for positive psychology approach was demonstrated in working with sexually exploited and trafficked refugee women. Important pre-migration resources were evidenced at individual, family and community level, rather than pathologies and deficits. Participants used resources, especially faith, as protective factors against abuse. The results confirmed positive affect as significant protective factor and building block for coping flexibility and resilience. - Programs to enhance resilience and mindfulness were shown to be promising to apply the strengths perspective in social work with refugee women. In order to facilitate social justice, social workers need to acknowledge the resources of persons in vulnerable situations that helped resist exploitation and oppression. **Conclusions**: Underlying causes of migration and victimization need to be addressed to stop sex trafficking. Policymakers should address the dynamics of power relations between women and men together with resulting disparities, and strengthen and respect the political, economic and social rights of women, in order to implement effective policies against human trafficking and sexual abuse of women, as well as any form of violence against women. The findings suggest a culturally relevant and responsive approach to the needs of refugee women that can be used to establish more specific and efficient advocacy programs for trafficked refugee women.	
Goodman et al. 2017. USA	To explore how refugee and	Qualitative study	Individual in depth interviews, method	Four themes and several sub-themes have emerged: **1. Three salient types of trauma**: socio-political-	20/20 (100 %)

Trauma and Resilience Among Refugee and Undocumented Immigrant Women.	undocumented immigrant women experience stress and trauma and the ways in which they develop resilience to cope with them.	Phenomenological approach Purposive sampling to ensure participation of certain information-rich women (n = 19) (10 undocumented from Mexico, Central or South America, 9 refugees from Middle East & Africa), mean age = 35,6 Recruitment from social service delivery sites & NGOs in Washington, DC. Research conducted by four women researchers (White European American backgrounds, and full-time faculty members)	of structured discovery, focus on specific topics, but allowing flexibility for other areas of focus to emerge. Specific strategies used to increase credibility, dependability, transferability and confirmability. Spending lengthy time in the field (6 months), collecting thick descriptions of experiences, consulting with multiple sources to verify meanings & triangulating data sources & methods	based, status-based and post-migration traumas **2. Experiences of structural and situational stressors with two emergent subthemes**: family separation and employment, economic, and situational stress. **3. Psychological symptomatology**: post-traumatic stress symptoms, depression, suicidality. **4. Processes of coping and resilience:** the ways in which women persist in difficult environments using both internal (belief about a better future) & external (social supports, community resources) processes of coping. Despite significant traumatic and stressful experiences, women refugees developed ways to persist. Intersecting and overlapping barriers: the matrix of domination and systemic oppression both groups of women situated in restricts their ability to cope as individuals and within their communities. Time-limited access to resettlement supports and services creating financial difficulties; economic insecurity and encountered challenges in meeting basic needs due to high living costs combined with limited or no income or government assistance; limited job prospects because of status and language barriers; even when job search assistance available other barriers such as lack of childcare or bus fare. Despite mental health issues, refugee women focused mainly on securing employment and navigating social welfare, health, educational, and childcare systems on behalf of their families. Often	

				exposed to poor treatment and discrimination because of social status, race/ethnicity, language skills, worsening stressors and poor mental health, while also deterring from seeking help. Ecosystemic and layered nature of resilience processes: the combination of individual, family, and social support and resources women were able to obtain as essential for coping and resilience building. When confronted with barriers to external supports, some women seemed to gather internal resources, suggesting the need to explore the relationship between these two facets of resilience processes. Implications: Multifocal approach in the work of counselors of critical importance. Counselors need to understand and address ecosystemic factors that influence the vulnerability of women to trauma, forms of exposure to trauma and ongoing stressors and their ability to access internal and external mechanisms to promote resilience. The experiences of women clearly demonstrate the manifestation of systemic forces such as immigration policies and government resources on women's lives. Advocacy for changes to policies, laws and practices on the systemic level that affect women negatively. Such advocacy can include addressing discrimination and aggressions of majority culture producing and maintaining anti-immigrant sentiments and policies. Providing assistance in meeting immediate economic and resource needs, accessing child-care resources, language classes, job opportunities to help facilitate women's resilience.	

				Increasing community members' connections will improve information and resource sharing, as well as create social support and solidarity on a wider scale for future advocacy work. Counselors can encourage the development of communities of resistance in which women can come together in order to question and reject oppressive narratives, cultivate empowerment, and produce advocacy actions. Counselors should offer culture-centered mental health services to immigrant women. Since discrimination can be a form of trauma, culture-centered models of healing offer clients, particularly those facing trauma and stress related to their cultural, racial or religious identities, a promising form of counseling.	
Jesuthasan et al. 2019. Germany, Netherlands Health-Related Needs and Barriers for Forcibly Displaced Women: A systematic review	To explore the specific needs of the female refugee population employing a user-centered perspective to aid development of gender sensitive programs and interventions.	Systematic review: 13 articles were included in the review (n = 13) Twelve of the included articles used qualitative methodology, only 1 was a large-N, quantitative survey. Included studies address health needs of female refugees from	Data collected, analyzed, and reported according to the Preferred Reporting Items for Systematic Reviews (PRISMA) guidelines. The identified literature involved mostly small qualitative studies, limiting the application of some of its criteria.	Thematic analysis identified 5 health-related needs and barriers: **1. Direct healthcare related**: structural limitations to access; a) national rules for provision of services, b) difficulties related with navigating an unknown system & how health care provision functions, and language barriers. **2.Communication related**: Lack of language skills as a major barrier to integration and meeting health care needs. Language barrier leads to reduced health literacy and long-term dependency on family members or interpreter services for communication. **3. Cultural/spiritual related**: Differences in conceptualizations of health and disease (holistic conception of health vs. disease-oriented approaches) constituting barriers. Mental health, sexuality, HIV might be taboos and go unaddressed in	33/36 (92 %)

		their own perspective. Total number of women participants (refugee, displaced) in the included studies were around three thousand (N = 2940), ranging from 6 to 1383 individuals per study. Diverse populations from the Middle East, Central, South East Asia and Eastern Africa Databases: PubMed, Medline; EMBASE, Cochrane Library, Scopus	The opportunity to produce large, "high-quality" studies limited due to logistic constrains of research with vulnerable populations. The collection of data from a user centered perspective, with methodologies applied differing from the ones used in well-controlled clinical settings. In addition to economic & logistic constrains, ethical challenges of research with highly mobile and vulnerable population.	consultations. **4. Social/family related**: Family separation as one primary source of distress linked to the deterioration of mental health and increased vulnerability for women. Lack of social networks coupled with separation from sociocultural context of origin increases feelings of insecurity, fear and stress, an d reduces resilience. Women without a male partner / family member more vulnerable to all forms of abuse, violence and aggression. **5. Economical needs and barriers**: Women's access to job markets reported to be less than that of men. Lack of job-related social integration of women refugees make integration difficult leading to less support from peers and reduced access to relevant health knowledge. Increased dependency on social services or on a male provider also increase the risk of abuse and domestic violence, further limiting women's ability to leave violent contexts. Unique health-related needs of female refugees require gender-sensitive action. From a medical point of view, reproductive health, mental health and infectious diseases will need to be prioritized through the provision of adequate knowledge and specific services. Solutions consistently integrating knowledge and service provision need to be prioritized as female health needs and health risks likely to increase in displacement. Training health operators within refugee settings can be an opportunity to provide information, identify misconceptions, and empower women. **Conclusions**: In order to improve health status of female refugees, it is essential to take coordinated	

				action to provide information and culturally sensitive care, supporting at the same time language learning and economic empowerment of women refugees. Furthermore, increasing women's participation also contributes to their empowerment and self-reliance. Such interconnections need to be recognized across transformative initiatives and multiple axes of differential access for female refugees should be addressed simultaneously in order to improve both their participation in the host society and overall health.	
Lenette et al. 2013. Australia Everyday resilience: Narratives of single refugee women with children.	To explore the concept of resilience critically based on an ethnographic study among single refugee women	Qualitative study An ethnographic study with in-depth interviews. Participants: 4 single refugee women with children in Brisbane, Australia. (2 widows with 5 children, 2 divorced, one with 7 children + 3 dependents, the other with 1 child + 2 dependents) (n = 4), aged from late-thirties to mid-fifties.	A combination of participant observation, in-depth interviews, and visual ethnography to explore the women's experiences. Visual ethnography phase involved reflexive photography and digital storytelling, enabling women to explore issues in ways that respect their capacity to articulate themes, because knowledge is grounded in experiences	Resilience needs to be recognized as a social process emerging from daily life's mundane practices and situated in person-environment interactions. Three interconnected aspects of resilience situated in everydayness: 1**. The ordinary nature of resilience in normal routines:** juggling multiple responsibilities in a new social, cultural, linguistic, economic and political environment with numerous unfamiliar situations to contend with. **2. The dynamic process underlying the achievement of resilience each and every day**: an ongoing and ever-changing dynamic process, women refugees facing shifting challenges and opportunities over time. **3. The social complexities of stress and resilience:** women's notions of resilience indicate that social sources of resilience and stress are not entirely discrete (community as a source of support and as a source of stress) – women experience both support and stress within the community in highly gendered ways. Rather than simply being a certain kind of	19/20 (95 %)

		Purposive sampling combined with the 'snow-ball' technique	Ongoing & iterative data collection & in-depth analysis An intersectional approach was used to analyze women's narratives	person with a certain set of resilient 'traits', resilience appears to be about finding productive paths through a maze of ups and downs. Two different angles deserve further attention: **1. The everyday nature of the concept:** Resilience embedded in daily routines challenges the focus of much of the resilience discourse on 'extraordinary' traits. More than overcoming past experiences, resilience involves a dynamic process of shifting, changing, learning, building, and moving on. Everyday life-worlds not 'stadiums' to observe resilience in action – 'everydayness' itself an achievement and a potential aspect of resilience **2. The person-environment dimension of resilience:** Gendered structures shaping women's realities as single refugee women with children reflected their pathways to resilience. The person-environment dimension recognizes the irreducible relation between worlds typically depicted as distinct, as 'inner' or 'outer' social worlds in which lives are embedded. Inherently social, involving both person's inner resources and external resources; internal and external interwoven - they do not operate in isolation Despite the upheaval caused by refugee circumstances and juggling multiple responsibilities, refugee women in the study navigated through daily life challenges and opportunities with resilient outcomes. Day-to-day pathways through which resilience outcomes are achieved deserve more attention, because of important implications of this for mental health practice frameworks for refugees.	

				Enactments and accomplishments of social processes of resilience in the milieu of everyday attest both to the dynamic nature of resilience as an ongoing process and to ordinary environments it is achieved – interactions of women within a complex cluster of gendered roles, judgements and expectations highlight both vulnerabilities and strengths. Gender is of crucial importance because of he clearly gendered nature of wider social environments, within which refugee women, also single mothers in this study, are vulnerable to being 'othered' on multiple levels. A highly-gendered array of vulnerabilities faced by refugee women may provide insights into gendered accounts of resilience, which is missing in discourses on resilience. A resilience 'lens' is beneficial in comprehending women's experiences, for it provides a strength-based starting point with the opportunity to de-medicalize the 'needy victim' status frequently attached to the refugee label.	
Mangrio et al. 2019. Sweden Refugee women's experience of the resettlement process: a qualitative study	To explore the perception of refugee women in Sweden concerning their situation during active participation in the resettlement process in the country.	Qualitative study with 11 participants (n = 11); recently arrived refugee women with residence permits. Convenience sampling	Interview study The material was analysed with content analysis Adherence to the COREQ (COnsolidated criteria for REporting Qualitative research) guidelines to	Three categories identified with associated sub-categories: **1. Suffering from being separated from loved ones;** sub-categories: Reactions to being split as a family and a sense of loneliness. **2. To live with pressure to achieve the best possible life;** sub-categories: desire to achieve something, setting new goals, the importance of learning the language and to be able to combine different aspects of life. **3. Balancing health and illness; perceived as challenge;** subcategories: to regain physical health and to stay mentally fit.	16/20 (80 %)

			promote complete and transparent reporting, improve the rigor, comprehensiveness and credibility of the interview study	As mental well-being is essential for an effective integration, the impact of family reunification for newly arrived refugees is important to consider. The importance of finding opportunities for and fast entrance into employment in the host countries; beneficial for the integration and well-being of refugee women after migration.	
Pulvirenti & Mason 2011. Australia Resilience and Survival: Refugee Women and Violence.	To examine the resilience concept within the context of refugee women's experiences of violence.	Qualitative study Semi-structured interviews with 18 service providers who work with refugee women in Victoria and South Australia. Snowball sampling across two different states to have a sufficient range of services and a cross-section of agencies	Semi-structured interviews with specific questions supplemented with probing questions during the interview. Thematic analysis of interview data by each researcher followed by a second, joint analysis to confirm themes and their significance to research aims, as well as to literature	Three key themes: **1. Women refugees are resilient:** a) Resilience as a matter of survival; women survived dangerous journeys out of countries of origin and refugee camps; b) Extraordinary ability of refugee women to cope with violence, who experienced and witnessed trauma, violent conflict, loss of family members, poverty and extreme conditions - the danger in linking 'tolerance' to violence to resilience. c) Resilience as a process, related to women's capacity to transform their lives despite experiences of violence. A process of learning, a pathway both leading and linked to personal growth. **2. Risks associated with naming women refugees as resilient:** Usage of the term 'resilience' in relation to refugee populations, refugee women especially, caused some concerns, because of potential or witnessed shifting of responsibility away from government and on to the refugees themselves. It can serve as a justification for the assumption that refugee women can fend for themselves and thus are not in need of government support, justifying reduction of resources for support services.	20/20 (100 %)

				3. Refugee women's resilience as built through support, not innate: Participants understood resilience of refugee women as something that could be built with support, by 'opening doors' and 'being there.' A necessary element in the transformations indicating resilience is external support, which assist women to move on and establish meaningful lives. Important caveats: **1. Resilience:** a useful concept, if seen as a process that receives external support, not as an individual trait. **2. Resilience should not be used to justify abandoning of state and social responsibility** which results in reduction of resources and services. Refugee women can be conceived as more than victims and beyond that, as more than survivors. What makes refugee women resilient is the capacity to transform their lives with adequate supports. The continual process of resilience needs to be built and rebuilt collectively, not just assumed. Collective resilience connects individual with the family, the community, broader social networks, government policy and includes the resources mentioned by study participants: individual skills, social networks, internal community support, external social resources, social capital, infrastructure and activities, and citizenship. Conclusion: Resilience of refugee women is not an innate characteristic, but a process that can be built through support, both from within immediate refugee communities and from larger host	

				community. In addition to building social capital, material support related to employment and housing provides material conditions for a new start and produce a foundation for personal transformation.	
Sherwood & Liebling-Kalifani. 2012. UK A Grounded Theory Investigation into the Experiences of African Women Refugees: Effects on Resilience and Identity and Implications for Service Provision	To explore experiences of African women refugees in UK, and to develop a greater understanding of the roles of resilience, coping and, identity.	Qualitative study explorative, grounded theory approach Purposeful sampling Semi-structured interviews with six participants (n = 6) aged between 24-46 years: 5 women from Zimbabwe and one from Somalia attending a refugee center in West Midlands, UK.	Interview data was analyzed using procedures of grounded theory using a software package (Atlas Ti). Open Coding in initial stage to develop descriptive themes (33 lower order categories), followed by Axial Coding to reduce initial categories to an explanatory framework of 'higher order' categories. Selective Coding formalized the relationships into theoretical frameworks. Lower order categories of interview data produced seven higher order categories, which	Effects of African women's experiences on resilience and identity. Seven categories identified: **1. Cultural/Societal influences:** Gendered roles in patriarchal society with strong cultural traditions prevented women from seeking help when subjected to domestic or sexual violence – inner struggle for wanting to seek help yet fearing rejection by families or communities. **2. Experiences:** Witnessing and/or experiencing sexual and political violence **3. Psychological effects after exposure to violence in Africa:** trauma, anger, blame, sense of hopelessness. **4. UK experiences:** Fear of being sent back to countries of origin, uncertainties about the future, not being able to work during the processing of asylum applications, feeling secure in the UK. **5. Resilience:** Coping strategies that helped increase inner strength and resilience include positive thinking, thinking of a positive future, positive action by problem solving. A major factor for resilience was religion and faith, which helped to make sense of what was happening. Participants described feeling empowered through experiences and having hopes for future. **6. Access to Rights and Support:** When felt supported in rebuilding their lives, women reported feeling more resilient and stronger. An important aspect of becoming empowered and more resilient	19/20 (95 %)

			provided an explanatory framework for emerging data.	was accessing to equal rights and justice. Opportunities such as education and work have also enhanced resilience and encouraged women to feel that they have 'choice' and 'control'' over their lives. **7. Identity:** Women cherished their identity as a 'mother' and 'provider,' which helped them to be strong and resilient for their children's sake. Analysis of the interview data found that resilience, access to rights and support and identity were interrelated and directly affected by cultural and societal influences, war experiences, and the psychological effects of them. Striving to reconstruct new identities, women also strengthen their resilience and ability to take action. Implications for service needs: women need assistance to have access to opportunities such as education and employment. Implications for clinical practice: The findings contribute to a more holistic model of understanding African women's experiences. Implications for responding to refugees' mental health needs involve the need to recognize and build on women's resilience to help them access their rights to health, service provision and justice. By utilizing a rights approach, provision of health services can support women's further empowerment.	
Shishehgar et al. 2017. Australia, USA Health and	To investigate the impact of refugee women's resettlement and socio-cultural	Integrative review Peer-reviewed & grey literature published between	8 databases: Medline, CINAHL, ProQuest, Academic Search Complete, Scopus,	Due to lack of social support, poverty, violence, adverse health conditions, and discrimination, the risk of mental health problems, such as depression and anxiety are greater for refugee women. In the immigration process, women have extra burdens as	36/36 (100 %)

Socio-Cultural Experiences of Refugee Women: An Integrative Review	experiences on their health and to explore factors promoting resilience in refugee women.	2005 - 2014 with focus on adult refugee women were included in the review 20 articles (n = 20) included in the review: Qualitative (n = 12) Quantitative (n = 6) Mixed methods (n = 2)	Informit, PsycINFO, Google Scholar, also searching reference lists of included articles for relevant articles. Quality of articles assessed using the Critical Appraisal Skills Program (CASP) and PRISMA assessment tools. As an organizing framework: Resource-Based Model (RBM) - the post-migration phase for analysis and presentation of results	wives and mothers to support adjustment of family members to a new way of living and shoulder the role of protecting and sustaining family values, culture, and beliefs. Women refugees constitute an understudied refugee population. Four main categories identified influencing health of refugee women: **1. Cultural factors:** Lack of proficiency in the dominant language of the host country constitutes a barrier to sharing experiences and burdens, and increases the risk of loneliness, low self-esteem, and depression. Unfamiliar lifestyle and contact with a different culture causing stressful experience of culture shock. **2. Social and material factors:** A key factor in the mental health and wellbeing of refugees is finding a stable job. Employment helps refugee women to boost their health status and to increase their social networks. However, lack of language proficiency can be a barrier to finding employment. Difficulty in finding affordable housing is a stress factor hindering resettlement. Loss of social support from family or husbands may cause sadness, hopelessness and poverty. **3. Personal factors:** A key source of stress is family separation and uncertainty about the family members left behind, a contributing factor to the experience of depression and other mental disorders. A united family in contrast is a factor enhancing family wellbeing. Another significant concern is the exploitation of young girls and involvement in sex work. **4. Resilience factors:** Among various resilience strategies refugee women employ are spiritual	

				fulfilment (religious, non-religious) and social support that help maintain equilibrium despite uncertain status and ongoing distress. Ability to support oneself accord a sense of pride and empowerment leading to hope, optimism and wellbeing. Additional supporting sources (families and communities) contribute to wellbeing and integration into a new society. Extended family and close friends – important sources of support. The findings indicate that conditions surrounding resettlement may have an adverse impact on the health and wellbeing of women refugees and asylum seekers; adopting effective strategies on the other hand helps to minimize these impacts. To support communities in empowering refugee women targeted policies and services are needed. Provision of health information and services can enable refugee women to identify and seek professional help in a timely manner. Mental health support groups that are culturally and linguistically appropriate can provide a space for refugee women to share their experiences and burdens, and to receive mutual support from others who share similar experiences and challenges. Need for further studies to explore new challenges refugee women face during resettlement and the ways to overcome barriers.	
Smit & Rugunanan. 2015. South Africa	To explore perceived emotional well-being of a group of	Qualitative study Purposive sampling	In-depth interviews for the three focus groups	Participants' intrapersonal ambivalence: Two major themes identified: 1**. Emotional distress** due to experience of a) fear for safety and challenging financial	17/20 (85 %)

Transnational forced migration and negotiating emotional well-being: the case of women refugees in South Africa	Congolese, Burundian and Zimbabwean female refugees living in Johannesburg and Pretoria.	Comparative qualitative study done in South Africa among Congolese, Burundian and Zimbabwean refugees. (n = 60), aged mid-twenties to late forties: 1. Three focus groups, 10 participants in each, Congolese & Burundian women refugees 2. Further 4 Burundian & 6 Congolese refugees – individual interviews 3. 20 Zimbabwean refugee women - individual interviews	Individual interviews with the further 4 Burundian, 6 Congolese and 20 Zimbabwean refugee women Glaser and Strauss's constant comparative method as well as Giorgi's four-step phenomenological praxis used in analyzing the data and identifying core themes. Findings sample-specific, not generalizable.	circumstances, b) frustration about obtaining refugee status, employment, housing, c) disillusionment because of unmet expectations, d) sadness for being away from their countries and family members. Emotional wellbeing Negative emotions: fear and distress; frustration, disillusionment, feeling depressed, sadness from family separation, unmet transnational family obligations. Negative emotions evoked by current surroundings, social, economic & political milieu with xenophobic sentiments and outright hostility **2. Hope for the future, resilience and religious convictions and love for their children** Positive aspects: Resilience: distinct traces of a resilient approach to life, despite hardships and 'survival with impairment.' Resilient inclination evident in women's tenacity to ensure survival of their families by generating some form of income through work or by asking others for financial and material help. Significance of religion as a source of hope: religion appeared to play a key role in women's ability to cope with their challenging life experiences Another source of hope and an important element for emotional wellbeing is love and concern for their children, hope and joy revolving around children. In contrast to the Congolese & Burundian refugees, the Zimbabwean women's fluency in English aided the process of securing some form of employment.	

Veronese et al. 2019. Italy, Palestinian Territory, USA Risk and Protective Factors Among Palestinian Women Living in a Context of Prolonged Armed Conflict and Political Oppression	To investigate the consequences of war and political violence for women's mental health and psychosocial functioning in the aftermath of the recent war in Gaza in 2014.	Qualitative study In-depth individual interviews (n = 21) 21 internally displaced participants selected following an ethnographic procedure and a purposive snowball sampling method All women were teachers (aged from 20-47) working at a private school run by an NGO, Jabalia, Gaza Strip	In-depth individual interviews, recorded, transcribed, translated from Arabic into English Questions designed to draw out the risks and protective factors characterizing the women's lives – examination of risk and resilience using social ecological perspective Data analysis done following the principles of grounded theory and thematic content analysis to extract main themes Resilience operationalized as women's agency and survival strategies	5 themes related to risks and protective factors for women's overall functioning identified: **1. Human Security:** protective factors: feeling safe, psychophysical health, house moving; risk factors: feeling unsafe, lack of psychophysical health, house destruction, displacement **2. Family Ties:** protective factors: protection provided by both nuclear and extended family; risk factors: threats and risks for the family **3. Psychosocial Resources:** friendships, community protection as protective factors; separation from friends, lack of protection as risk factors **4. Individual Resources:** work, education, spirituality, activism and civic engagement, humor, and play as protective factors; disruptions in protective factors, loss of hope and strength as risk factors **5. Motherhood:** protection of children and maternal agency as protective and lack of these as risk factors. During the war, all women faced the risk of losing their lives on one or more occasions and perceived their psychological and physical health as being precarious. Forced to be on the move constantly to protect themselves and their families from the attacks. Yet, they actively mobilized resources both within themselves and social and political worlds to maintain a sense of continuity and strived to live a 'normal' life in abnormal living conditions. Conclusions: Findings add credence to frameworks challenging gender stereotypes that confine women	18/20 (90 %)

				to narrowly constructed role as vulnerable victims without any agency. Moreover, findings advance evidence-based knowledge on women's capabilities of facing extreme traumatic realities as socially and politically situated subjects drawing on their environments to actively cope with hardships, combat traumas, and strengthen their own self-efficacy as they build functioning and survival skills within armed conflict. Highlighting social environment as a source of resilience, results suggest that mental health intervention programs need to be oriented at fostering women's resilience and mobilizing the ecological resources that can protect them at the individual, relational, and cultural levels. Intervention programs with an exclusive focus on psychiatric symptoms increase the risk of induced effects.	
Welsh & Brodsky. 2010. USA After Every Darkness Is Light: Resilient Afghan Women Coping with Violence and Immigration	To explore the experiences and strategies of eight Afghan women to support the mental health of themselves and others.	Qualitative study Individual, semi-structured interviews with eight participants. Purposeful and snowball sampling with the aid of key informants.	Interviews about experiences prior to, during and after immigration, focused on coping responses both within Afghanistan and throughout immigration. Thematic analysis Used the Afghan War Experiences Scale (AWES) & the 23-item Afgan symptom Cheklist	Difficulties in Afghanistan and in Afghan refugee camps: The loss of family, friends, and community members, the need to flee, as well as the loss of roles, economic opportunities, and normal life Already oppressive cultural practices, such as restriction to basic resources & infrastructures- employment, education, health care, got exacerbated by war, political unrest and poverty. Coping Strategies: **1. Problem-focused active coping in response to threat and in security within Afghanistan:** leaving the country as a coping mechanism, as well as source of new stressors. **2. Helping others:** family members, Afghan girls & women - as a distinct coping strategy, even after	19/20 (95 %)

			(ASCL) to measure mental health symptoms.	settling in the US **3. Social support:** emotional social support from family members and perception of a sense of community within refugee camps and with Afghans in general. **4. Maintaining hope:** as a form of perception-focused coping, regardless of changing circumstances. **5. Focus on future:** shifting focus away from present difficulties and toward the future, toward future light, as in the Afghan proverb in the title: "after every darkness is light." **6. Expressing gratitude:** a sense of gratitude for own lives, as well as for those of family members amid immense hardship & loss. **7. Determination:** despite many challenges, an an attitude of determination helps throughout immigration process. **8. Religion:** involvement in religious activities and a faith in God helped coping with difficult experiences. A sense of controllability and hope through praying. **9. Meaning-making coping:** making causal attributions and searching for meaning in adversity. Conclusion: The identified coping processes represent diverse and culturally grounded methods of facing hardship, suggesting that they may have played some role in the positive outcome of being resilient. The multiple pathways to resilience and individual differences in coping strategies suggest that preventive efforts and programs will need to be tailored to individual need and cultural context.	

Appendix 2: Quality assessment table for qualitative studies adapted from CASP (Qualitative)

REFERENCE	1	2	3	4	5	6	7	8	9	10	SCORE
Abraham et al. 2018	++	++	++	++	++	-	++	++	++	++	18/20 (90 %)
Babatunde-Sowole et al. 2020	++	++	++	++	++	++	++	++	++	++	20/20 (100 %)
Baird & Boyle 2012	++	++	++	++	++	-	++	++	++	++	18/20 (90 %)
Darychuk & Jackson 2015	++	++	+	++	++	+	++	++	++	++	18/20 (90 %)
Denzongpa & Nichols 2020	++	++	++	++	++	+	++	++	++	++	19/20 (95 %)
Goodman et al. 2017	++	++	++	++	++	++	++	++	++	++	20/20 (100 %)
Lenette 2013	++	++	++	++	++	+	++	++	++	++	19/20 (95 %)
Mangrio et al. 2019	++	++	++	++	+	-	++	++	++	+	16/20 (80 %)
Pulvirenti 2011	++	++	++	++	++	++	++	++	++	++	20/20 (100 %)
Sherwood et al. 2012	++	++	++	++	++	+	++	++	++	++	19/20 (95 %)
Smith & Rugunanan 2015	++	++	++	+	++	-	++	++	++	++	17/20 (85 %)
Veronese et al. 2019	++	++	++	++	++	-	++	++	++	++	18/20 (90 %)
Welsh & Brodsky 2010	++	++	++	+	++	++	++	++	++	++	19/20 (95 %)

Scoring: satisfies assessment criterion ++ partly satisfies + hardly - does not apply x

Assessment criteria adapted from CASP (Qualitative)

1.There was a clear statement of the aims of the research.
2. A qualitative methodology is appropriate.
3. The research design was appropriate to address the aims of research.
4. The recruitment strategy was appropriate to the aims of the research.
5. The data collected in a way that addressed the research issue.
6. The relationship between the researcher and participants has been adequately considered.
7. Ethical issues have been taken into consideration.
8. The data analysis was sufficiently rigorous.
9. There is a clear statement of findings.
10. There is a discussion on the value of the research (contribution, transferability, new areas of research)

Appendix 3: Quality assessment table for systematic (SR) and integrative reviews (IR) adapted from 27-item PRISMA 2009 Checklist

Reference	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	score
Babatunde-Sowole et al. 2016 (IR)	++	++	++	++	++	++	++	++	x	x	x	++	x	+	++	++	x	++	++	x	++	++	++	-	33/36 (92 %)
Jesuthasan et al. 2019 (SR)	++	++	++	++	++	++	++	++	x	x	x	++	x	++	++	++	x	+	++	x	++	++	++	++	33/36 (92 %)
Shishegar et al. 2017 (IR)	++	++	++	++	++	++	++	++	x	x	x	++	x	++	++	++	x	++	++	x	++	++	++	++	36/36 100 %

Scoring: satisfies assessment criterion ++ partly satisfies + hardly - does not apply x

Assessment criteria adapted from PRISMA 2009 checklist

1. The title identifies the study as systematic / integrative review.
2. The abstract provides an explanation of the study background.
3. The introduction states the objectives.
4. Criteria for eligibility is presented.
5. Information sources are described.
6. Full electronic search strategy for at least one database is presented.
7. The process for selecting studies is stated.
8. The method of data extraction from reports is described.
9. All variables for data search are listed and defined.
10. Methods utilized for assessing risk of bias of individual studies are described.
11. Principal summary measures are stated.
12. The methods used for handling data and combining results of studies are described.
13. Any assessment of risk of bias which may affect the cumulative evidence across studies is specified.
14. Methods of additional analyses are described.
15. Study selection is explained with numbers of studies screened and eligibility assessments.
16. Characteristics of each selected study are presented.
17. Risk of bias within each study is presented.

18. Results of individual studies are included
19. Synthesis of study results is presented
20. Risk of bias is presented across studies
21. Summary of main findings are included
22. Study and outcome level limitations are discussed
23. Within the context of other evidence, a general interpretation of the results is provided
24. Source of funding is reported

Appendix 4: Assessment of observational study applied from STROBE checklist

Author(s)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	Score
Ginesini 2018	+	++	++	++	++	++	++	++	+	++	++	++	++	++	++	++	+	++	++	++	++	-	39/44 (89%)

Scoring: satisfies assessment criterion ++ partly satisfies + hardly - does not apply x satisfies assessment criterion ++

Assessment criteria applied from STROBE checklist:

1. Study title indicate the design and abstract provide a summary
2. Background of the study is explained
3. Objectives are stated including any prespecified hypotheses
4. Study design is presented with key elements
5. Study settings are described with locations, recruitment and data collection
6. Participants eligibility criteria and selection methods are presented
7. Variables are clearly defined
8. Data sources/measurement are described for each variable of interest
9. Efforts to address bias are described
10. Study size is explained
11. Study explained quantitative variables and how they were handled
12. All statistical methods are described
13. Number of the participants is reported
14. Descriptive data is presented with characteristics of participants
15. Outcome data of the study is reported
16. Main results are reported with estimates and their precision
17. Other analyses done in the study are reported
18. Key results are summarized with reference to objectives of the study
19. Limitations of the study are discussed
20. Overall interpretation of results is presented
21. Generalizability of the study results is discussed

Appendix 5: Forced displacement at a glance

Facts and Figures: In search of 'safe haven'

Refugees	**25.9 million**
Internally displaced persons (IDP)	41.3 million
Asylum seekers	**3.5 million**
Total number of forcibly displaced persons worldwide	70.8 million

Table 1. Forced Displacement Worldwide in 2018 (Adapted from UNHCR 2019)

Demographic characteristics by UNCHR region in 2018

EU	Africa	America	Middle East & North Africa	Asia & Pacific
44 %	52 %	45 %	49 %	48 %

Table 2. Percentage of women refugees & asylum seekers by region in 2018. Adapted from UNHCR 2019

Gender and age structure of internationally displaced persons in 2019

As distribution of internationally displaced according to gender and age shows in the following table, women constituted almost half (46 %) of this population worldwide in 2019. The total number of forcibly displaced in 2019 was 79,5 million.

Age	Male	Female
60+	2 %	2 %
18 - 59	32 %	26 %
12 - 17	6 %	5 %
5 - 11	8 %	8 %
0 - 4	6 %	5 %

Table 3. Gender and age structure of the internationally displaced persons in 2018. Adapted from UNHCR 2020