Understanding Refugee Women's Contraceptive Health Needs:

A Scoping Review

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Abstract

Background: Canada has accepted over 40,000 refugees in the past five years. Approximately half of these are women of reproductive age. Following forced displacement, refugee women face several health inequities that affect their use of health services. Refugee women underutilize contraceptive care and have unmet contraceptive needs, and yet many engage in unprotected sexual activity with no desire to conceive. With the humanitarian crisis causing record-breaking shifts in migration, it is imperative that nurses understand the needs of refugee women related to their contraception. Objective and methods: To systematically identify the global literature on refugee women's use of contraception within the reproductive age group. A scoping review study design using Arksey and O'Malley's methodology was used. The systematic search of PubMed, Embase, CINAHL,Global Health, Nursing and Allied Health, Scopus, PsychInfo, and Gender Watch databases was designed with a health sciences librarian. All standard synthesis procedures were followed. The Integrated Framework for Health (IFH) guided data synthesis and I followed the PRISMA-ScR guideline in the conduct and reporting of the study. Results: Social characteristics, risk and protective factors, psychosocial resources, and health status factors that influence refugee women's use of contraception, as well as key knowledge gaps. Conclusion: While each refugee will experience their forced displacement differently, there are patterns relevant to their contraception use that can inform clinical practice, policy, education, and future research.

Keywords: refugee, women, contraception, sexual and reproductive health

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Conflicts of Interest

There are no conflicts of interest to declare.

Table of Contents

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Access to sexual and reproductive health services (SRH) was part of the Millennium Development Goals (MDGs) and is included in the universal Sustainable Development Goals (SDGs) for low and high-income countries to ensure safe and equitable healthcare for all (Lince-Deroche et al., 2016). SRH encompass the use of contraception, otherwise known as birth control or family planning (World Health Organization (WHO), 2018). Women use various methods of contraception to prevent health-threatening or unintended pregnancies (WHO, 2018), and every woman has the right to equal access to accurate information and health services that provide contraception (WHO, 2018). Contraception reduces rates of unsafe abortions and associated mortality and allows women and families to decide when - and if - they wish to have children (WHO, 2018). Various methods of non-permanent contraception exist, which include oral contraceptive pills (OCPs), condoms, intrauterine devices, and subdermal implants, among others (WHO, 2018). According to the WHO (2018), access and utilization of contraception empower women by protecting their fundamental human rights through the promotion of informed decision-making regarding childbearing status.

In response to global needs, Canada has accepted over 40,000 refugees in recent years. Contrary to voluntary migration with the goal of achieving greater social or employment opportunities, life-threatening circumstances force refugees (also referred to as asylum-seekers) to flee their host country to a safer place (Aptekman et al., 2014; Ahmed, Bowen, & Feng, 2017). The forced displacement during humanitarian crisis' that refugees experience can adversely impact their health in various ways (Ivanova, Rai, & Kemigisha, 2018). The social determinants of health of refugees can be negatively affected because of relocation, and they may encounter notable challenges when trying to navigate political and medical systems, which are often

fragmented (Robertson & Hoffman, 2014). Not only do refugees experience a loss of home, community, and culture, they are often disadvantaged with poor housing conditions, financial burden, and limited opportunities for employment and education (Robertson & Hoffman, 2014). Nearly half of the world's refugee population are women, and in 2016 alone, over half of the refugees accepted into Canada were women (Khanlou et al., 2017). Additionally, the global rate of forcibly displaced women is rising (Cherri et al., 2017). Many refugee women confront gender-based violence and sexual abuse while having limited access to appropriate health services (Ivanova et al., 2018).

Much of the global female refugee population is within the reproductive age group (Shishehgar et al., 2017). This is defined as any person with functional female reproductive organs aged fifteen to forty-nine years, or women who can conceive (Aptekman et al., 2014; WHO, 2017). Previous research has found that refugee women within this age group are more vulnerable, and this vulnerability is attributed, in part, to their underutilization of SRH services, and, specifically, the use of contraception (Aptekman et al., 2014; Silverberg et al., 2018). This population is documented as having unmet contraceptive needs, which is associated with negative health consequences (Aptekman et al., 2014; Silverberg et al., 2018).

Inequalities in access to contraception exist for refugee women when compared to their non-refugee counterparts, and research findings indicate that refugee women are prescribed contraception less than native-born women (Hawkey, Ussher, & Perz, 2018). Inequalities to such services and information may be a result of the challenging circumstances associated with forced displacement (Hawkey et al., 2018). Factors that impact refugee women's access to contraceptive services post-resettlement might also be related to cultural influences or misconceptions of contraception and associated side effects, religious beliefs forbidding

utilization, patriarchal roles related to decision-making, limited educational opportunities in host countries, financial stress, and poor access to contraceptive care prior to relocation (Rogers & Earnest, 2014). Ultimately, refugee women have been found to be less knowledgeable about the various contraceptive methods available following resettlement and are less likely to use contraception while sexually active - even when they are trying to avoid pregnancy (Hawkey et al., 2018).

Barriers affecting refugee healthcare are multi-factorial and extend beyond the individual factors of the woman who is a refugee (Niles et al., 2016). Healthcare providers' (HCPs) experiences of providing contraceptive health services and health teaching to refugee women in the reproductive age group are described as challenging (Mengesha et al., 2018). Difficulties communicating with this population because of cultural differences, language barriers, religious identities, and issues with cultural competency have caused a reciprocal discomfort in both parties involved (Mengesha et al., 2018). Specifically, women who are refugees report feeling uncomfortable discussing contraception with HCPs, and some HCPs voice unease initiating contraception discussions during their therapeutic interactions (Mengesha et al., 2018). Moreover, HCPs express challenges, such as limited resources and a lack of funding, to sufficiently care for this population who has diverse linguistic and cultural needs (Niles et al., 2016).

While the existing body of evidence highlights the pertinence and implications of refugee health generally, much of the previously published research on reproductive-aged refugee women explores antenatal and post-partum health experiences (Shishehgar et al., 2017; Silverberg et al., 2018). For example, Ivanova et al. (2018) published a systematic review of sexual and reproductive health knowledge, experiences, and access to services among young

refugee women in Africa, and yet the complexities explicitly tied to contraception use for this population are less studied (Hawkey et al., 2018). Furthermore, women who are refugees and immigrants are often grouped together in research samples (Ahmed et al., 2017). This has the potential to obscure the differences in experiences between women refugees who live forced displacement and immigrant women who migrate to another country by choice (Ahmed et al., 2017). Finally, when studies target women refugees, investigators tend to focus on a particular minority group (e.g. Rogers & Earnest, 2014; Verran et al., 2015). Although the information obtained through previously published studies is potentially transferable to other populations, there is no systematic comparison of results across studies to identify patterns and variability within these experiences (Metusela et al., 2017).

Research Objectives and Significance

The purpose of this study is to explore the social characteristics, risk and protective factors, psychosocial resources, and health status factors that influence refugee women's use of contraception based on existing literature. The specific objectives of the study were to systematically identify the global qualitative literature on refugee women's use of contraception within the reproductive age group. Identifying the breadth and depth of current qualitative evidence on contraception for women who are refugees will enhance understanding of their self-identified needs, as well as the factors that influence their contraceptive use.

Thesis Outline

This first chapter of the thesis provided an overview of the current state of published literature about contraception for refugee women. I identified the significance and objectives of the research, which were to explore the experiences expressed by refugee women, a vulnerable population largely understudied in relation to family planning. Chapter two is a literature review

on the topic of interest, which focuses on the various factors that affect refugee health, as well as women's sexual and reproductive health and rights. The third chapter details the methodological considerations and the procedures followed during the conduct of the scoping review. Following this, chapter four presents the findings of the qualitative synthesis that are presented in both narrative and tabular formats. Finally, the fifth chapter is the discussion in which the findings are considered within the extent literature and implications for practice, policy, education, and future research are described.

Literature Review

In this chapter, I provide a review of the literature about the health of refugee women, the sexual and reproductive health of women within the reproductive age, what is known regarding the provision of contraception, and the complex implications a refugee status has on a person and/or community's physical and psychological health and well-being.

Refugee Women and Health

Since the year 2000, the global percentage of migration has doubled, and the complexity of global migration is increasing. It is important to accurately attribute a migration status to a person or population because the different ways in which migration is experienced impact one's social determinants of health and their health status (Douglas et al., 2019). Someone who has claimed refugee status (government assisted refugee or privately sponsored refugee), or who is in the process of claiming refugee status (asylum-seeker or refugee claimant), is very different from an immigrant, a migrant, or person who is internally displaced. While an immigrant is someone who was granted permission to permanently live in another country of choice for personal, social, or economical purposes, a migrant refers to an individual who moves frequently within their country's borders, or to other countries for social and economic advancements (Douglas et al., 2019). Conversely, persons who are internally displaced (IDP) are often conflated with refugees because they have both been forced to flee their homes to avoid the effects of humanitarian disasters such as war, conflict, and violence (Douglas et al., 2019; United Nations High Commissioner for Refugees (UNHCR), 2018). However, IDP's do not cross their country's borders, nor receive the status of a refugee, and remain under the protection of their own country's government, not protected by international laws (UNHCR, 2018).

Based on worldwide circumstances, changes in migration, and the presence of humanitarian conflicts, there are over seventy-four million persons of concern globally (UNHCR, 2018). Included within these persons of concern are more than: 1) twenty million refugees, 2) three million asylum-seekers, 3) forty-one million IDPs, 4) four million returned refugees and IDPs, 5) two million stateless persons, and 6) three million individuals who do not qualify to be within the aforementioned groups but benefit from the protection of the UNHCR (UNHCR, 2018). Additionally, data from the UNHCR indicates that refugees account for approximately 30% of persons of concern, with the majority of these refugees seeking asylum in countries such as Turkey, Pakistan, Uganda, Sudan, and Germany. In 2018 alone, the UNHCR submitted over eighty-thousand refugee claims, with twenty-five countries accepting more than ninety-thousand refugees for resettlement (UNHCR, 2018).

Refugee Status

The United Nations High Commissioner for Refugees (UNHCR) is a globally recognized organization based in Switzerland, with offices in countries all over the world (UNHCR, 2009). The UNHCR was founded by Western states in December of 1950, following the Second World War, when many refugees were fleeing Europe and moving West (Loescher, 2017). The UNHCR's objective and mandate is to provide international protection to refugees, and alongside allied governing states, establish sustainable solutions to maintain the safety and well-being of refugee populations following resettlement (UNHCR, 1999; 2009). For many years, the UNHCR has assisted millions of refugees; they define a refugee as an individual who is forced to flee their home country due to a well-founded fear of persecution for reasons such as race, religion, nationality, membership of a particular social group, or political opinion (UNHCR, 2009). Refugees are similar to other immigrants in that they are multiethnic, linguistically and

religiously diverse, and have varying cultural traditions and lifestyles (Gagnon & Tuck, 2004). However, due to life-threatening circumstances (such as armed conflict, rape, or violence) and fear of persecution, refugees are forced to leave their homeland for survival; they are unable to seek protection from their country of origin's governing body and cannot return to their native country (UNHCR, 2009). The UNHCR (2011) reports that refugee claimants have a "well-founded fear" of persecution based on the context of the country of origin and defines the fear of persecution as "indiscriminate threats to life, physical integrity, or freedom resulting from generalized violence or events seriously disturbing public order" (UNHCR, 2011, p. 81). The 1951 Convention relating to the Status of Refugees and its 1967 Protocol were pivotal in establishing international laws and policies protecting refugees, determining criteria for international assistance, and outlining basic refugee rights - including their right to not be forced to return to their native country where their life or freedom is at risk (UNHCR, 2009). Although governments who host refugees maintain a large responsibility for protecting them on their territory, governments work alongside the UNHCR, non-governmental organizations (NGOs), and other partners to safeguard rights and provide legal and physical protection (UNHCR, 2009).

The terms "refugee claimants" and "asylum-seekers" are sometimes used interchangeably in the literature. However, an asylum-seeker is an individual who is claiming to be a refugee but is undergoing refugee status determination. In other words, an asylum-seeker has yet to have a refugee status approval from either the country in which they are seeking safety, or from the UNHCR (UNHCR, 2009). Every person applying for refugee status, regardless of the country, must undergo a process to verify that they meet the predetermined criteria, although "not every asylum-seeker will ultimately be recognized as a refugee, but every refugee in such countries is initially an asylum-seeker" (UNHCR, 2011, p. 407).

Resettlement and migration of refugees does not occur randomly, as geographical proximity and countries bordering the ones inflicted with civil wars and humanitarian crises play an important role in migration and migration pathways for refugees (Cavusolgu et al., 2019). A recent ecological study revealed that typical migration patterns for refugees include initially seeking safety in neighbouring countries, where escaping immediate life-threatening circumstances is possible (Cavusolgu et al., 2019). The authors also reported that refugees may only attempt to resettle in middle- and high-income countries such as Canada, the United States, and Germany, after their safety is secured (Cavusolgu et al., 2019). Culture, religion, and other commonalities between the neighbouring countries and a refugee's home country also influence resettlement location (Cavusolgu et al., 2019).

Interestingly, two thirds of the world's refugee population come from five countries: 1) Syrian Arab Republic (6.7 million), 2) Afghanistan (2.7 million), 3) South Sudan (2.3 million), 4) Myanmar (1.1 million), and 5) Somalia (0.9 million) (UNHCR, 2018). The countries from which most refugees originate have not changed much in recent years (Cavusolgu et al., 2019). The Syrian Arab Republic has consistently been the primary country producing refugees because of the ongoing civil war which began in 2011; while the neighbouring country of Turkey continues to be among the top countries worldwide hosting refugees (Cavusolgu et al., 2019).

In Canada, refugees are identified through the United Nations Refugee Agency as part of the UNHCR, and no individual can make a claim directly to the country. Those who have received a refugee status approval are either sponsored privately or supported by the government. Government-assisted refugees are helped through a variety of services and programs to ease the resettlement process and establishment of their life in a new country. Settlement programs assist new refugees with English and French language skills, finding a new home and building

communities, accessing childcare services, and finding resources for people with disabilities or requiring counselling (Government of Canada, 2019). A private sponsor must provide financial and emotional support for the designated period of sponsorship, or until the refugee can support themselves (Government of Canada, 2019).

Refugee Status and Health

Given the context of forced migration, many refugees are exposed to traumatic events and hardships, such as physical and sexual violence, psychological distress, and separation from and loss of families and communities (Robertson et al., 2006). Refugees might be forced to reside in refugee camps with unfavorable living conditions for a prolonged or undetermined period, while others remain in refugee camps prior to receiving refugee status approval from a developed country (Yalim et al., 2019). Refugees are at an increased risk for a variety of health problems and health disparities because of limited access to adequate health services and poor living conditions in refugee camps, or because of the challenges faced prior to relocation (Yalim et al., 2019). Even after relocation to a country of safety, one systematic review of the literature found that refugees experience significant stress levels due simply to being a refugee (Nakeyar & Frewen, 2016). Refugees face social marginalization, limited societal resources, and experience barriers to access to healthcare services, which predispose them to a variety of psychological conditions including insomnia, anxiety, depression, and post-traumatic stress disorder (Yalim et al., 2019). However, every person who is forcibly displaced will be exposed to unique experiences and challenges affecting their health status, which are influenced by their resettlement process (Nakeyar & Frewen, 2016).

Once in the host country, refugees have unmet health needs because of barriers to healthcare services, which leads to poorer health status in comparison to other immigrants or

non-refugee counterparts (Yalim et al., 2019). Physical and structural barriers influence a refugee's desire and motivation to seek healthcare services, even when healthcare costs are not an issue, such as in a context like Canada with universal healthcare (Yalim et al., 2019). These barriers include the cost and availability of transportation, language barriers, lack of professional translators, cultural differences and cultural insensitivity, poor health literacy, health insurance coverage limitations, lack of awareness of available services, or mistrust of healthcare providers (HCPs) (Yalim et al., 2019).

Refugee Women and Health

There are over 22.5 million refugees worldwide - not including those who are undocumented (UNHCR, 2018; Ganle et al., 2019; Yalim et al., 2019). Approximately half of the current refugee population are women and girls (UNHCR, 2019), which is notable, given that in 2002, only twenty percent of the world's forcibly displaced population were women within the reproductive age-group (Hynes et al., 2002). Refugee women are oftentimes considered to be the most vulnerable amongst migrants because of the way they experience migration (Gagnon & Tuck, 2004).

Although generally understudied as a population, refugee women have documented personal and sociocultural challenges and difficulties associated with the various phases of forced displacement. Refugee women are at a higher risk of experiencing poverty and discrimination, poor health conditions, and mental health issues including anxiety, depression, and post-traumatic stress disorder in comparison to their male counterparts (Shishehgar et al., 2017). For many women and girls, the effects of war and migration can enhance "discrimination already present at different levels of society" (Byrskog et al., 2014, p.2). Although men will experience challenges during resettlement, one recent systematic review investigating the socio-

cultural implications of forced displacement on refugee women's health identified that refugee women will experience an additional stress related to their roles as mothers and wives. Many women assume a greater responsibility to protect and support family members while adjusting to life in a new country, all while preserving family values and cultural beliefs, which may be an additional burden to carry throughout the resettlement process (Shishehgar et al., 2017).

The challenges associated with the resettlement process are heightened for refugee women who are of lower socio-economic status. This is illustrated by the fact that refugee women will experience greater barriers in comparison to refugee men when seeking educational opportunities, employment opportunities, health services, and adaptation services because of language barriers (Shishehgar et al., 2017). Moreover, women may experience a decreased ability to participate in activities aimed at assisting refugees through the resettlement process. Considerations for women refugees related to these activities are as follows:

1. Due to other responsibilities, such as a new pregnancy after arrival or pre-existing childcare demands, they are less likely to be eligible for employment, which is known to be beneficial to refugees' mental well-being and promotes financial stability for families, improves health outcomes, and encourages engagement within different social networks (Shishehgar et al., 2017).
2. Personal factors predispose refugee women to isolating circumstances that negatively affect their ability to accomplish personal autonomy, and place them at a greater risk of depression, lower self-esteem, and anxiety. Social isolation might occur because of language barriers or a lack of proficiency in the host country's language, culture shock, loss of family members, or separation of the family unit (Gagnon & Tuck, 2004).

3. Although there are opportunities to utilize professional and cultural translators once resettled in a host country, many obstacles exist to the uptake of these services, including long wait times, exposure, and fear of being misinterpreted and judged (Shishehgar et al., 2017).
4. Refugee women describe traumatic experiences of leaving some of their family members behind during relocation because of humanitarian crisis. Loss or separation from family members, and the associated uncertainty of their wellbeing, causes overwhelming sadness and significant distress, which further enhances risk for mental disorders in refugee women (Shishehgar et al., 2017).
5. Exposure to violence and sexual exploitation during the time spent in refugee camps is commonplace and some refugee women report engaging in sex work to provide basic necessities, such as clothing and food for their families, or to keep their daughters safe (Shishehgar et al., 2017). Furthermore, pre-migratory experiences of torture, rape, sexual abuse, harassment, or forced sexual favors in exchange for basic necessities such as food, also influence post-traumatic stress disorders in refugee women and affect their ability to seek health services when needed (Gagnon & Tuck, 2004). Such traumatic experiences severely affect refugee women's overall health status, and systematic reviews of the literature have identified refugee women as being more at risk that the general population for developing psychological conditions (Kirmayer et al., 2011).
6. Finally, many refugee women originate from countries where women are disadvantaged, with limited access to educational opportunities about their sexual and reproductive health (Raben & van den Muijsenbergh, 2018).

The Sexual and Reproductive Health of Women

Achieving individual and population health involves the assurance of accessible and equitable healthcare regardless of socioeconomic status, gender, geographical location, and annual income. However, disparities in access to appropriate healthcare services for various vulnerable populations persist globally, including in Canada, where barriers to accessible healthcare can negatively influence one's capacity to seek preventative and curable health services (Socias et al., 2016). As an attempt to reduce health inequalities, the Social Determinants of Health (SDH) were created, explaining that a person's place in society is governed by several elements (Government of Canada, 2019). These elements consist of social, personal, economic, and environmental factors that not only influence health, but predict and determine health outcomes on an individual and population level. The eleven social determinants of health are as follows: 1) Income and social status, 2) employment and working conditions, 3) education and literacy, 4) childhood experiences, 5) physical environments, 6) social supports and coping skills, 7) healthy behaviors, 8) access to health services, 9) biology and genetic endowment, 10) gender and 11) culture (Government of Canada, 2019). These social determinants of health can guide, measure, and predict health opportunities. By identifying the extent of health inequalities and discrepancies of health opportunities across various vulnerable populations in different locations, strategies can be created to bridge gaps where health inequities exist (Government of Canada, 2006).

Role of Gender

Historically, the role of gender has been an imperative social determinant of health, which interacts with other determinants of health in complex ways. For example, men, women, and persons who are trans not only view health differently and have different beliefs related to

health, they are also exposed to factors that have a strong influence on their health status in different ways (Heise et al., 2019). These differences experienced by persons different genders are often based on restrictive gender norms, accounting for health inequalities that still exist in the present day (Baheiraei et al., 2015; Heise et al., 2019). While sex and gender are terms frequently used interchangeably in the literature, they do differ. A person's sex refers to the biological differences in relation to chromosomes, hormones, reproductive organs, and external genitalia (Heise et al., 2019). Gender, by comparison, is typically considered to be the acceptable roles and responsibilities, as well as the distribution of power and resources, that are socially and culturally created and associated with being or identifying as a man or as a woman or otherwise (Heise et al., 2019). Women and girls historically have had unequal rights compared to men as a result of socially constructed views that prioritize male gender and masculinity (Heise et al., 2019). For various social, cultural, and political reasons, women have been confronted with a) gender inequality where they suffer from unequal treatment and suboptimal access to resources, b) gender inequity, classified as an unjust distribution of responsibilities based on being a woman, and c) gender discrimination, where they have been excluded from their full human rights because of socially fabricated gender constructions (Heise, 2019; WHO, 2001). In the 1990's, two global conferences were held to attract world-wide health leaders with the main objective to reorient health systems to be gender-sensitive in acknowledging and enforcing women's rights, including their right to make their own health decisions regarding their bodies, their sexuality, and their reproductive health (WHO, 2001).

As much as there has been substantial global developments following the aforementioned conferences, and in recent years pertaining to positive health outcomes for women and girls, there is still room for improvement. In Canada, we have adopted the Feminist International

Assistance Policy, which focuses on empowering women and girls and enhancing their sexual and reproductive health and rights. Many women globally still have limited control over their own bodies and are denied rights to making their own decisions regarding their sexual and reproductive health (Trudeau, 2018). Women remain disadvantaged because of their unequal access to education, increased risk for sexual violence, and experiences with gender-based discrimination.

The concept of sexual and reproductive health (SRH) for women in the reproductive age-group (fifteen to forty-nine years, or the ability to conceive) extends beyond health policies, or a focus solely on maternal-child care (Erdman & Cook, 2006; Pizzarossa & Perehudoff, 2017). SRH corresponds to the health and well-being of women and their health outcomes pertaining to their bodies, sexuality, and reproductive organs over their complete life-course (Sen & Govender, 2015). Therefore, SRH comprises protecting women and girls against forms of violence (which includes the prevention of harmful female genital mutilation), advocating for adolescent reproductive health, and ensuring that global states included in the United Nations (UN) implement their legal duties to ensure that women are not denied access to healthcare that includes sexuality education, safe abortions, contraception and family planning, breast and cervical cancer screening, and sexually transmitted infection screening and treatment (WHO, 2014).

The Committee on Economic, Social and Cultural Rights (CESCR), as well as the Committee on the Elimination of Discrimination against of Women (CEDAW) have declared that accessible SRH care services to all women is a fundamental human right (Office of the United Nations High Commissioner for Human Rights (OHCHR), n.d.). This declaration affirms that all state members must reinforce women's rights to universally accessible and acceptable

SRH care, and are "legally obligated to respect, protect, and ensure women's rights to the highest attainable standard of health throughout their lives" (Erdman & Cook, 2006, p.991). Therefore, women's right to adequate SRH services is directly related to their right to overall health, their right to life, and their right to dignity (Perehudoff et al., 2018). This means that all women should have the right to SRH services and facilities that: a) provide quality care in adequate numbers to meet their needs, b) is physically and economically attainable, and c) that is provided without judgement and discrimination (OHCHR, n.d.).

The right to safe and accessible SRH services that provide medical abortions is not a worldwide norm and women may need to leave their families and communities to travel long distances to reach a location with access to safe abortions, birthing services, or contraceptive care (Erdman & Cook, 2006). For low-income women in many countries, access to medically safe abortions and reproductive health services remains unattainable. In some cultures, women are at a higher risk of contracting sexually transmitted infections including HIV/AIDS and experiencing forced female genital mutilation or sterilization (Erdman & Cook, 2006). Women continue to endure high rates of mortality and morbidity related specifically to their SRH (Kane et al., 2016) and discrepancies in access to health services specifically directed to women's health occur because of deep-rooted societal norms influenced by patriarchy (OHCHR, n.d.).

Contraception and Health

Family planning, also called reproductive planning, refers to women's reproductive control over their childbearing status. Every woman within the reproductive age group with the ability to conceive has a fundamental right to freely and voluntarily make an informed decision concerning the amount and spacing of children they desire (United Nations, 2019). Family planning, conception, and the decision to use contraception or not, are all components of

women's basic SRH rights (Ferrerira et al., 2017). Contraception, also referred to as birth control, and accessible family planning services are components of primary healthcare and play a key role in ensuring women's reproductive health (Alan Dikmen et al., 2018). Contraception can have "positive effects on regulation of women's fertility" (Alan Dikmen et al., 2019, p.46), whereby methods are used to prevent unintended pregnancy, contributing to healthy sexual practices that consider an individual's life circumstances (Aptekman et al., 2014; Ferrerira et al., 2018).

Unmet Contraceptive Needs. In 2017, it was estimated that over two-hundred million women globally had an unmet need for family planning, putting women and their families at risk of unintended pregnancies (Pizzarossa & Perehudoff, 2017). Women are documented as having unmet contraceptive needs if they are not currently using any method of contraception but are sexually active with no desire to conceive. An unintended pregnancy does not insinuate that the pregnancy is undesired but refers to the mistiming of conception (Metcalfe et al., 2016). However, many unintended pregnancies are, in fact, undesired and it is estimated that over thirty percent of pregnancies are unintended, and half of these pregnancies end in abortions (Singh et al., 2010). Unsafe abortion procedures account for approximately 40,000 maternal deaths annually (Pizzarossa & Perehudoff, 2017). Thus, identifying women who have unmet contraceptive needs, and monitoring these needs pertaining to pregnancy preference and modern methods of contraception is essential to uphold SRH rights, maintain policies, and create adequate programming for populations at risk of unmet contraceptive needs (Moreau et al., 2019). Finally, the use of contraception has been shown to be advantageous for women at different stages of their reproductive life not only by preventing unintended pregnancies, but also by empowering women through the advancement of equal human rights, reducing rates of

maternal morbidity and mortality, and promoting educational and economic opportunities for women and girls who may otherwise be forced into early child marriages and pregnancies (WHO, 2018).

Accessing Contraception. Although the male condom and hormonal contraceptive pills are the most cited methods of contraception used, a variety of methods with varying costs, side effects, and efficacies are available to women depending on the distribution of health-related resources in a given geographical location (Metcalfe et al., 2016). Multiple temporary methods of contraception exist, including long-acting reversible contraceptives (LARCs), hormonal contraceptives, and single-use contraceptives (Di Meglio et al., 2018). LARCs are administered to patients at a single point in time and act continuously for years before requiring the administration of a new device (Di Meglio et al., 2018). LARCs include copper and hormonal intrauterine devices, as well as subdermal implants that release progesterone. Another classification of contraceptives are hormonal contraceptives, which differ from LARCs in that they require administration more frequently. Examples of hormonal contraceptives include a) daily administration of combined hormones, or progesterone-only hormones in a pill format, b) weekly administrations of the transdermal patch, c) monthly insertions of the vaginal ring, or d) quarterly injections of depot medroxyprogesterone acetate. Other non-permanent methods of contraception include barrier methods that are used at a single point in time to inhibit conception and include male and female condoms, the diaphragm, cap, sponges, spermicides, and the emergency contraceptive pill. Ovulation and fertility awareness and the withdrawal method (also known as “the natural method”) are also commonly used by women and families to prevent pregnancy (Di Meglio et al., 2018). Permanent methods of contraception (female sterilization) are documented as the most commonly used contraception in low-income countries (Kohls et al.,

2017). However, one Canadian study documented that the rates of female sterilization are decreasing, and most commonly used by Canadian women between the ages of thirty-five to forty-four (Black et al., 2009). The same study identified that condoms and oral contraceptives are used most frequently by younger women (Black et al., 2009). Different methods of contraception exist, and the methods chosen may differ based on experience and life-stage (Black et al., 2009). Contraception is generally accessible to women through multiple healthcare access points, such as out-patient clinics and walk-in clinics, family doctors or nurse practitioners, school or satellite clinics, or contraceptive specific programs such as Planned Parenthood (Journal of Obstetrics and Gynaecology Canada (JOGC), 2015). However, inequalities in contraceptive care access persist worldwide, including in Canada. Barriers to accessing appropriate services may be related to cost, geographical location and isolation, limited resources or limited clinic staff and hours of operation, language issues, immigration status, partner or peer pressures, or a lack of knowledge of health system functioning. Furthermore, healthcare providers may play a role in reducing women's access to contraceptive care by denying patients adequate counselling regarding the availability of methods, imposing their personal beliefs, or lacking the appropriate training required to assist women in choosing the most suitable method of contraception delivery (JOGC, 2015).

The use of contraception can be directly influenced by one's awareness and experiences, such as previous educational opportunities addressing the anatomy and physiology of reproductive organs, different birth control methods, and the availability of sexual and reproductive health clinics (Ussher et al., 2017). Women seeking contraception to temporarily inhibit conception are greatly influenced by socioeconomic factors and the social determinants of health including the "the social settings in which they are born, grow, and live" (Bose &

Heymann, 2019, p.1). The decisions pertaining to when to start using contraception, which method is most appropriate, or where to seek accurate information can be complex. In Canada, healthcare providers are expected to engage in discussions pertaining to sexuality, sexual health, and contraception with their pre-adolescent patients and with youth prior to their engagement in sexual activities (Di Meglio et al., 2018). In a situation where formal education is lacking and there is cultural reluctance to discuss contraception, women interested in postponing pregnancy might rely on information garnered through other sources (Newbold & Willinsky, 2009; Westhoff & Lopez, 2008). Social influences, such as friends and social media, are shown to have a profound impact on how a woman perceives contraception and what they believe to be true regarding its use (Hawkey et al., 2018). With this, comes the risk of circulating misconceptions, myths, and inaccurate information, which may result in improper or inappropriate use of contraception or beliefs that using any form of contraception can cause harm (Hawkey et al., 2018; Metusela et al., 2017; Oda et al., 2017; Rogers & Earnest, 2014). Misconceptions about contraceptives include the notions that they cause tumors or cancers, result in giving birth to babies with abnormalities, or cause infertility and delayed pregnancies (Potasse & Yaya, 2021). These ideas illicit fears and influence the use of traditional family planning methods (such as herbs) over modern contraceptives (Potasse & Yaya, 2021).

The decision-making process associated with contraception can be related to an individual's personality or their cultural and religious beliefs about sexuality, conception, and pregnancy. Religion guides many individual's actions, where they may only use certain contraceptives with the approval from religious leaders (Gele et al., 2020). Within certain faiths, it is believed that God decides childbearing status and becoming a mother is synonymous to womanhood, thus, having children is necessary to fulfill a happy, prosperous life (Hawkey et al.,

2018). Intercourse preceding marriage or for reasons other than conception may be forbidden, while some fear being condemned by others discovering they are using any form of contraception (Hawkey et al., 2018). As part of some cultures, open dialogue regarding sexual practices is taboo or forbidden and may jeopardize familial status; conversations about contraception between parents, their children, or other members of the same community are often disregarded (Hawkey et al., 2018). The reluctance to discuss SRH within their community might impact one's desire for professional advice.

The decision to start using a contraceptive method might also be related to an individual's health status, their spouse's preference of methods, their knowledge of reproductive health and hormones, their knowledge of available methods, and their perception of sexuality (Gabalci & Terzioglu, 2010). The chosen contraceptive methods itself has the capacity to impact a person's sexual health in both positive and negative ways (Gabalci & Terzioglu, 2010). It is imperative that evidence-based and accurate information be provided to all persons seeking contraceptive health services.

Contraception and Refugee Women Within Reproductive Age-Group

It is a fundamental human right to have accessible and appropriate resources for contraceptive health services. However, the challenging circumstances associated with forced displacement result in refugee women accessing contraceptive services less frequently than non-refugee populations. Many women in refugee situations have poorer SRH outcomes, are at high risk of unintended pregnancies and abortions, and are known to have significant knowledge gaps about the use and availability of modern contraception (Dunn et al., 2011; Ganle et al., 2019).

The nuanced complexities associated with both the use of contraception and the stress of experiencing forced migration have an interrelated influence on one's contraceptive-related

health-seeking behaviors. Refugee women, by virtue of their status, have limited opportunities to seek preventative or primary healthcare services in their native countries, including restricted access to adequate SRH services and sub-optimal family planning guidance. Refugee women are said to have unmet contraceptive needs for many reasons, including patriarchal, cultural and religious perceptions forbidding the use, limited educational opportunities, social influences, and fears of infertility (Dunn et al., 2011).

A refugee woman's country of origin can affect their exposure to certain diseases and healthcare experiences, while their cultural upbringing and values may directly affect their view on health and illness (Kirmayer et al., 2011). Although refugee women flee from many countries, their SRH is consistently documented as being at risk. Pre-displacement and post-displacement factors contribute to a refugee women's SRH status. Cultural and religious norms in their country of origin, access to health services throughout growth and development, a woman's disadvantaged position in their community or country, and exposure to war, violence, and conflict can make refugee women more vulnerable and at risk of poorer SRH.

One retrospective descriptive study analyzing patient records in the Netherlands identified that contraception was discussed significantly less with refugee women who originated from countries in Sub-Saharan Africa compared to refugee women who originated from other countries (Raben & van den Muijensenbergh, 2018). Although the most common form of contraceptives used by both refugee women and native Dutch women were oral contraceptives, this study illustrated that general practitioners prescribed contraceptives less frequently to refugees in comparison to female migrants and the native population (Raben & van den Muijensenbergh, 2018). For many refugee women, the use of contraception, especially prior to marriage, is forbidden because childbearing is viewed as an honor and a blessing (Ussher et al.,

2017). Additionally, women report requiring the permission of their husbands to seek medical services for contraception: “if you make the medicine to stop babies and the man says no…he may separate with the wife” (Ussher et al., 2017, p. 1913).

Although refugee women are a heterogeneous population with diverse ethnic backgrounds and different health needs, patterns within their experiences are reported in the extent literature. For many refugees from various countries, sexual and reproductive health discussions are seen as taboo, stigmatizing, or forbidden altogether (Raben & van den Muijensenbergh, 2018). A noteworthy qualitative study conducted in Australia and Canada explored the sexual constructions and sexual health needs of female refugees that originated from various countries around the world. In this study, the participants reported shame, silence, and secrecy related to sexual health conversations, which had profound implications on their sexual health knowledge (Ussher et al., 2017). The shame the participants associated with SRH began when they reached menarche and experienced their first menstruation, which is commonly associated with transitioning from child to woman. The participants explained how in some cultures, menstruation means that the woman (or child) is ready for marriage: “they tell you now you grow up. After period now you can get married” (Ussher et al., 2017, p. 1908). The feelings of embarrassment and shame about their sexuality stemmed from a belief that their menstruation was something very private, “something dirty and something to feel bad about” (Ussher et al., 2017, p. 1908). This study shed light on the secrecy associated with menstruation and it associated this custom with a knowledge deficit regarding pregnancy, sexuality, and fertility. While some of the participants reported receiving informal education regarding their sexual development, information was often inaccurate or passed down from generations where mothers

warned their daughters to “be careful, don’t mix with a lot of the boys, just mix with the girls” (Ussher et al., 2017, p. 1909).

For many participants (women from different backgrounds) included in Ussher et al’s (2017) study, premarital sexual intercourse and simply engaging in sexual dialogue was completely forbidden, and only women with negligible education or moral values would partake in these conversations (Ussher et al., 2017). For many participants, if it became known that they engaged in premarital sex, they were isolated, classified as unmarriageable, or at risk of violence (Ussher et al., 2017). For these reasons, participants explained how they resorted to the internet or partook in secret discussions with close friends to avoid being shamed by their family or other members of their cultural community (Ussher et al., 2017).

The results of the study conducted by Ussher and colleagues (2017) identified that many refugee women demonstrate resilience and voice a yearning to have access to SRH knowledge. One participant from Somalia declared that “the acceptability of sex education in Australia and Canada contributed to this open communication, allowing women to let go of this sense of shame” (Ussher et al., 2017, p. 1910). As demonstrated by Ussher et al.’s findings, perspectives and values about SRH might change upon relocation to a new host country where cultural and religious norms differ, though I could find no other studies exploring this phenomenon. Clearly, more research is needed to provide a comprehensive understanding of this topic.

Theoretical Framework

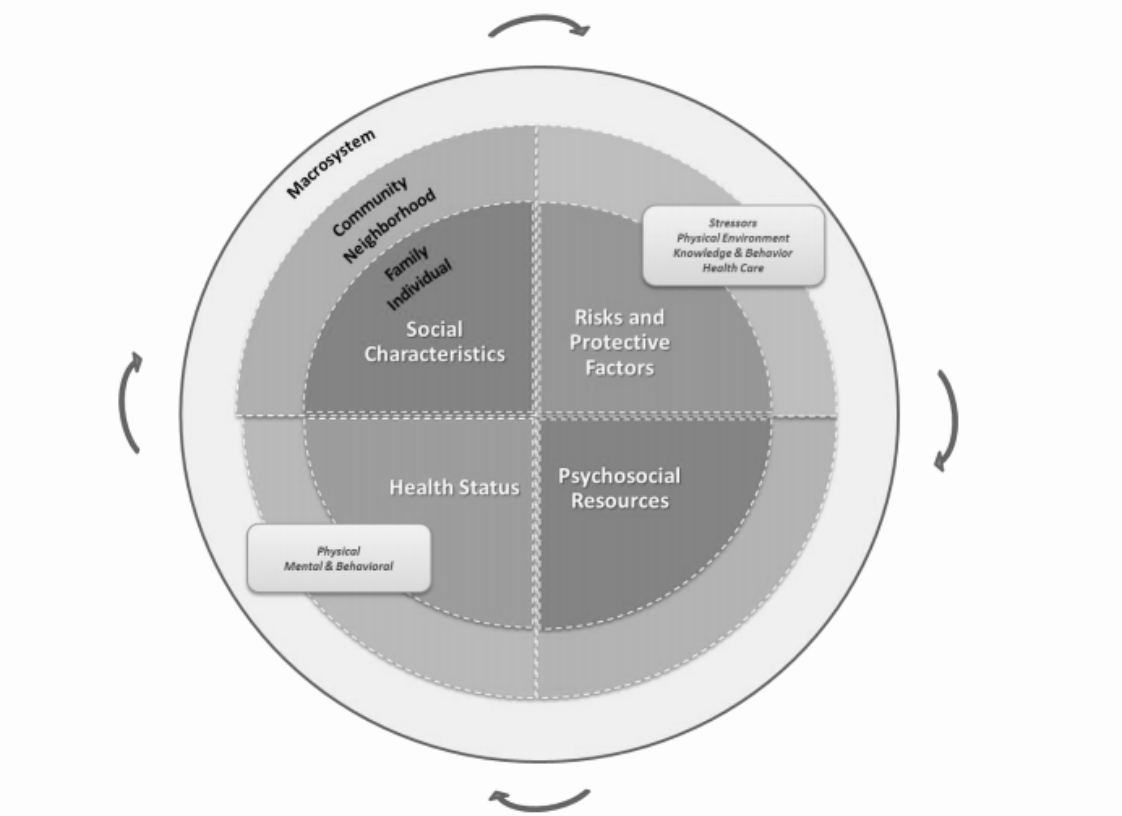
Health disparities exist between various social groups. Social determinants of health consist of characteristics that contribute to the health of an individual or community based on the distribution of societal resources (Copeland & Wexler, 2017). Certain populations, such as

refugees and refugee women, experience lower health status compared to other groups who have more positive health outcomes. Disparities in health and health-related outcomes can be hazardous, leading to further disadvantage for already marginalized and vulnerable populations (Copeland & Wexler, 2017). These disparities amongst populations are complex and influenced by different social, structural, economic, and cultural factors (Copeland & Wexler, 2017).

The Integrated Framework for Health (IFH) was developed by Lunn (2014) as an organizational guide to summarizing empirical research that conceptualizes the "interrelated process that produce health status in a particular population" (p.5). The creation of IFH was based on existing theories of health and health-related outcomes. Specifically, the IFH framework is underpinned by psychosocial theories, social production of health theories, and ecological theories. This framework was developed to be responsive to new theories and/or empirical evidence, as well as a mechanism to help identify areas of needed research. The IFH was created to acknowledge the complexity of health and the health status of different groups of people, while avoiding propositions that linear relationships between characteristics lead to certain health outcomes. The IFH is intended to be flexible, where multiple components can overlap, and focused on social phenomena that are complex. Therefore, the original author acknowledges that elements in the framework can have reciprocal relationships or influence an individual at one point in time, or throughout one's life course (Lunn, 2014).

Figure 1

The Integrated Framework for Health (Lunn, 2014)



Note. This figure illustrates the four main components of the IFH and the surrounding influences such as the macrosystem, community, neighborhood, family, and individual.

There are four main components to the IFH, which include: a) social characteristics, b) protective and risk factors, c) psychosocial resources and d) health status. Each component spans multiple levels including the macrosystem, communities, neighbourhoods, families, and individuals. This means that the components of the framework are not only viewed on an individual level but also understood from broader perspectives, including the community and macrosystem. The macrosystem is defined as "the structural context in which various relationships manifest" (Lunn, 2014, p.6). Economic, social, cultural, political, and legal systems are examples of what can be included in the macrosystem. The macrosystem accounts for the

system and settings that an individual has been exposed to that affect their development and circumstances (Lunn, 2014). Lunn (2014) provides examples of macrosystem influences, such as distribution of power, governance, legislation, discrimination, economic, social, cultural and political contexts, world peace and conflict, and healthcare systems. The neighbourhood and community are the immediate environment that one is encircled by. This can be the physical neighborhood and its resources, as well as the workplace or other settings frequented by the individual. Community level constructs and environment will have both direct and indirect implications on health outcomes (Lunn, 2014).

The first component of the IFH is social characteristics. Within the IFH, social characteristics include an individual's age, race, ethnicity, sexual orientation, family structure, socioeconomic position, and migration and integration. These factors are complex, and have the capacity to affect one's views about, and relationship with, health (Lunn, 2014). Categorizations of race and socioeconomic status have largely been socially and historically founded, which can disadvantage certain groups, especially refugees who have fled their native countries with minimal possessions and uncertainty regarding their economic position (Lunn, 2014).

The second component corresponds to the risk and protective factors of an individual or population. These include a) stressors (major life events, trauma, migration, discrimination), b) physical environment (housing and environment quality such as exposure to pathogens, public transportation), c) knowledge and behavior (diet and physical activity, alcohol consumption or smoking), and/or d) healthcare (access and use, unmet needs, cultural competence of HCPs, availability and location of HCPs). Depending on the circumstance, these factors may be advantageous or disadvantageous to one's health on an individual or community level. Although individual responses to stress differ, stressors (including chronic stressors), such as psychological

distress, are pertinent for refugees who often suffer traumatic events and challenging circumstances throughout their forced migration process (Lunn, 2014). Separation from family members, and other mental health problems (post-traumatic stress, depression, etc.) can have a severe impact on one's overall health status (Lunn, 2014).

The third component includes the psychosocial resources (personal and social resources) of an individual, or a particular population, that enable them to cope with their health status and avoid negative outcomes (Lunn, 2014). These psychological variables comprise sense of control, self-esteem, identity, coping, optimism, purpose in life, and more. Additionally, culture, and the amount and quality of social support an individual has, may act as a psychological resource that can positively influence one's health behaviors (Lunn, 2014).

The fourth component of the IFH is health status. Health status can be a major component on its own, or an outcome of the previous elements/variables described in other components. Health status refers to an individual's physical health (aging, mortality, morbidity), as well as their mental and behavioral health (distress) and the institutions and availability of associated health services (Lunn, 2014). With refugee populations, such as refugee women within the reproductive age group, it must be acknowledged that the understanding of illness, disease, and health can vary drastically across cultural groups (Lunn, 2014).

The elements previously described are interrelated, each influencing the individual, family, community, or macrosystem at various points in time or simultaneously. This framework was developed to examine and identify the complex factors that contribute to health status, health disparities, and social determinants of health for refugees resettled in the United States. Therefore, the IFH is a suitable structure that will be used to understand nuanced complexities

associated with the health and well-being of refugee women in the reproductive age-group and their use of contraception.

Methodology

In this chapter, I explain my epistemological standpoint as a researcher and how this relates to the chosen methodology. The systematic research process and procedures used to carry-out the study are also described in detail.

Philosophical Paradigm

There are four competing philosophical stances typically used within nursing science that guide research: the positivist, post-positivist, constructivist, and critical paradigms (Guba & Lincoln, 1994). Each tradition is built upon distinct assumptions about the nature of the world, how it came to be, and how researchers and participants fit within it (Guba & Lincoln, 1994). With the purpose of exploring the factors (social characteristics, risk and protective factors, psychosocial resources, and health status) that influence contraception use for refugee women, the constructivist worldview is appropriate because the women who describe these factors are speaking to their experiences that may be similar to, or different from, the experiences of others.

Constructivism is a historically and socially constructed philosophy commonly utilized in qualitative research, with ideas developed by several philosophers including Crotty (1998), Neuman (2000), Schwandt (2007) and Guba & Lincoln (1985-2000) (Creswell, 2009, p.8). Mills et al. (2006) explain that the constructivist research paradigm "denies the existence of an objective reality" (p.2), resulting in a relativist ontological stance. In this paradigm, the epistemology is transactional and subjective, while "knowledge is highly contextualised" (Hall et al., 2013, p.18) by factors such as culture and politics; knowledge is constructed (or made) rather than acquired by humans. These constructions are then analyzed and interpreted in research through inductive approached (i.e. deductively testing pre-existing theories and validating data are not compatible with constructivist research) (Appleton & King, 1997).

As per Allen (1994), the constructivist's approach is collaborative because the researcher "invites conversation about meaning, so that values, ethics and context clearly are relevant topics" (p.43). This paradigm is useful when exploring real-world nursing issues and the concepts underpinning them, which are encountered in practice (Appleton & King, 1997). Constructivist assumptions are compatible with nursing values and align well with my personal views that thoughts and experiences are influenced by an ever-changing environment; the world around us. Viewing the proposed phenomenon from the constructivist lens will enable an open-minded, richer understanding of the current context and the factors that affect refugee's accessibility to equitable contraceptive health services from their perspectives.

Synthesis Research

Knowledge and research synthesis methodologies by philosophers date back to the 12th century (Tricco et al., 2016). An early example of this type of research was published in 1904 within the health discipline, where data from 11 studies were gathered to examine the effectiveness of the typhoid vaccine (Chalmers et al., 2002; Tricco et al., 2016). Although evidence of research synthesis methods dates back centuries, the frequency of use and usefulness of these approaches significantly increased within the past 30 or so years. Beginning in the 1980's, the conduct and publication of research increased substantially, leaving policy makers and healthcare practitioners overwhelmed with the volume of data available to inform their decisions (Chalmers et al., 2002, p.26). Subsequently, in 1995, The Cochrane Database of Systematic Reviews was established, which consolidated access to research syntheses and had a profound impact on international policies in healthcare, as well as for the general public who wish to make informed decisions based on a collection of evidence (Chalmers et al., 2002). Researchers support the positive effect of utilizing knowledge garnered from evidence synthesis

in the development of health policies, practices and protocols in schools, hospitals, prisons, courts, clinics, welfare programs, and other public institutions (Chalmers et al., 2002).

Various forms of research synthesis exist, and there are strengths and challenges to each, and oftentimes, alternate terms are used to reference identical methodological approaches, such as “meta-ethnography” and “meta-interpretation” (Tricco et al., 2016, p.20). Regardless of the type of knowledge synthesis used, the ultimate objective is to organize information from a variety of studies in a systematic manner on a specified subject. Furthermore, many of the procedural steps overlap in design and across different professional disciplines such as nursing, philosophy, social sciences and others (Chalmers et al., 2002). Specifics steps differentiate the different types of synthesis studies, some examples of which include reviews of interventions with meta-analysis, realist reviews, mixed-method syntheses, or qualitative systematic reviews (Perrier et al., 2016). Synthesizing qualitative research requires careful consideration from the authors to ensure that an accurate representation of the findings, based on a particular context and from unique participants. Therefore, synthesizing qualitative research may be complex and adherence to rigour criteria is important to ensure that original data are accurately represented (Thomas & Harden, 2008).

Scoping reviews are a form of knowledge synthesis used to describe fundamental concepts associated with a research idea, where working definitions and theoretical boundaries, including key concepts, are clarified (Joanna Briggs Institute (JBI), 2015). Although scoping reviews follow a similar approach to traditional systematic reviews, they do differ. Historically, health synthesis research has used traditional methods following the rigorous systematic review guidelines outlined by Cochrane (Straus et al., 2016). However, contrary to systematic reviews that focus on answering a narrowed and precise question, scoping reviews are advantageous as

they explore emerging evidence (JBI, 2015). With this, scoping reviews can clarify areas in research where gaps persist. In addition to evaluating the necessity of a future systematic review, scoping reviews provide knowledge users with a comprehensive understanding of the existing evidence in terms of extent, range, and nature (Tricco et al., 2018). Scoping reviews are often the most appropriate methodological form of synthesis research when the chosen topic is complex and information on the subject can be found across various professional disciplines (Tricco et al., 2016).

Similar to JBI, Colquhoun and colleagues (2014) described scoping reviews as a method of knowledge synthesis, which can provide knowledge users with an overview of relevant evidence when large quantities exist (Colquhoun et al., 2014). Of note, scoping reviews have been used in health research to answer questions pertaining to women's health, to implement change within healthcare organizations, and to address research gaps (Colquhoun et al., 2014).

While the scoping review methodology was most appropriate for my study, some researchers and authors critique the approach for being less meticulous than traditional systematic reviews. Apprehensions about this study design exist because guiding methodological documents tend to omit a mandatory quality appraisal of included studies (Peterson et al., 2016). However, scoping reviews allow for flexibility to include studies using different methodologies or from diverse professional disciplines (Peterson et al., 2016), and quality appraisal is frequently done despite it not being mandatory – such was the approach employed here.

Study Design

Arksey and O'Malley (2005) were among the first to produce a six-stage, methodological framework that guides researchers conducting scoping reviews. The framework has been used in various scoping review studies and involves the following steps: identifying the research

question, searching for relevant studies, selecting relevant studies through post-hoc inclusion and exclusion criteria, charting the data, collating, summarizing and reporting the results, and an optional aspect of consulting with stakeholders to inform or validate study findings (Colquhoun et al., 2014). The six steps of the framework by Arksey and O'Malley (2005), along with the scoping review recommendations by Levac et al. (2010) formed the methodological foundations of this study. Additionally, the preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) and the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) statement were used for the conduct and reporting of the study (Tricco et al., 2018).

Identifying evidence from qualitative research is an appropriate methodology because it allows for an understanding of how a specific phenomenon is experienced by those involved, including refugee women (Noyes et al., 2013). Presenting and synthesizing evidence from qualitative studies can play a vital role in ensuring that relevant and reliable evidence is used to inform policies, practices, and healthcare decisions (Noyes et al., 2013).

Stage One: Identifying the Research Question

The first step in the scoping review process is to identify the research question. The question must be broad in nature to reach the breadth of evidence corresponding to the topic of interest (Arksey & O'Malley, 2005). Levac and colleagues (2010) suggest that the research question be explicitly stated and linked to the purpose of the study, clearly articulating the "scope of inquiry" (p. 3). For this study, the research question was "Which social characteristics, risk and protective factors, psychosocial resources, and health status factors influence refugee women's knowledge and use of contraception?"

Eligibility Criteria. The eligibility criteria were defined according to the Population, Concept, and Context tool (PCC framework) created by JBI (2015). The PCC framework is useful to inform the search strategy and ensure that data identified are relevant to the study's objectives. Final eligibility criteria were agreed upon by the thesis committee. Verifying the understanding of the inclusion and exclusion criteria by all parties reinforces reliability of screening process (described below).

Population. The population of interest was any individual who identifies as a woman with functional female organs and the ability to conceive. Participants were any women capable of conceiving or any women between the ages 15 and 49 years old.

Concept. The concept of interest was contraception, otherwise described in the literature as birth control. Contraception is defined in this study as any non-permanent method to avoid pregnancy and assist women with family planning. Family planning is another central concept in this study, which differs from contraception. Family planning is a concept used to describe the services, policies, knowledge, and practices that can assist individuals in freely choosing whether, when, or how many children they wish to have (Starbird et al., 2016). The use of contraceptives goes under the umbrella of family planning. Therefore, studies also focusing on family planning were targeted.

Permanent methods to avoid conception, such as female sterilization, were excluded. Additionally, any literature focusing on male sterilization, such as a vasectomy, were excluded as the main objective was to consolidate the subjective lived experiences of refugee women pertaining to their views and experiences with contraception.

Context. The concept of interest was explored within a refugee context. A refugee, or asylum-seeker was defined as any individual who has been forcibly displaced from one country

as a result of life-threatening circumstances and relocated to another country seeking safety. For the purpose of this study, we did not include internally displaced persons (IDPs) or stateless people in the inclusion criteria. This is because they differ in their experiences from refugee and asylum-seekers. Many IDPs remain under the protection of their own government. Additionally, if studies included the experiences of immigrants and migrants, we ensured that refugee or asylum-seekers experiences could be clearly differentiated. The focus was on a refugee context because the experiences associated with a "refugee" status differ greatly from someone who is an immigrant (Ludwig, 2016). Many who have been granted a refugee status in a new country will be allotted certain benefits such as protection, medical assistance, and access to government programs (Ludwig, 2016). Table one illustrates the eligibility criteria for this study.

Table 1

Eligibility Criteria

Criteria	Included	Excluded
Population	Women within the reproductive age group defined by WHO (15-49) Women with the ability to conceive	Anyone without the ability to conceive
Concept	Non-permanent methods of Contraception Birth control Family planning methods	Male sterilization Female sterilization Permanent methods of contraception
Context	Refugee Asylum-seeker	Immigrant or migrant context Internally displaced persons (IDPs) or stateless people context

		Any other context outside of being a refugee/asylum-seeker
Language	English French	Any other language
Date Range	2009- Present	Any publications prior to 2009
Type of Publication and Study Design	Full-text articles Qualitative studies Mixed-method studies	Quantitative Abstracts Conference proceedings Grey literature

Search Limits. Strategic parameters for the inclusion and exclusion of articles were necessary to ensure an appropriately sensitive and specific literature search. Only full-text studies were included, with grey literature, letters, abstracts, and conference proceedings excluded. Mixed-methods studies were included only when the authors provided examples, including direct quotations, of subjective experiences explicitly from refugee women related to the concept of contraception or family planning. The search was limited to studies published in English and French from 2009 to February 19th, 2020 - the day the search was conducted. Since 1980, Canada has accepted over one million refugees. However, the number of refugees continues to increase as global conflicts persist. In 2019, Canada ranked the world leader in refugee resettlement (UNHCR, n.d.). Therefore, by including articles published within the last 10 years, I captured this change in national context. A 10-year timeframe is also typical in synthesis studies.

Stage Two: Searching for relevant studies

The second step of the scoping review involved the creation of a search capable of identifying relevant studies to answer the proposed research question.

Information Sources. Seven electronic databases were identified and chosen with assistance from an experienced, library scientist at the University of Ottawa. These databases were chosen based on the nursing focus of this research, and the broad collection of biomedical and life science literature that each database contains. Table 2 presents the databases used to conduct the search, which were CINAHL, Embase, Gender Watch, Global Health, Medline, Nursing and Allied Health, and PsycInfo.

Table 2

Selected Databases and Information

Database	Information
CINAHL Cumulative Index of Nursing and Allied Health Literature www.ebscohost.com	Provides indexing for nursing and allied health professionals literature. Largest nursing database.
GENDERWATCH www.proquest.com	Database that focuses on gender, family, ethnic, and societal studies (including women's studies, LGBT, and the evolution of gender roles) from 1970 to present day.

GLOBAL HEALTH www.cabi.org	Database that covers all aspects of public health knowledge and practice, including internationally and within the community from biomedical and life sciences disciplines.
EMBASE Excerpta Medica database www.embase.com	Database that includes pharmacological and biomedical literature from 1947 to present day.
MEDLINE www.ovid.com	U.S National Library of Medicine (NLM), which contains journals of literature from life science fields with a focus on biomedicine from 1946 to present day. This database is distinctive as it indexes journals according to Medical Subject Headings (MeSH terms).
NURSING&ALLIED HEALTH www.proquest.com	Database that provides nursing and allied health information, including alternative and complementary medicine. Designed to meet the needs of healthcare students, instructors, and researchers.

PSYCINFO www.ebsco.com	The largest database containing literature that focuses on behavioral sciences and mental health. Includes publications from fifty countries, with literature coverage dating back to the 17th and 18th centuries.

Search. The literature search occurred in the above-mentioned electronic databases on February 19th, 2020. An additional hand-search of the reference lists of all included studies was performed. Reference lists of studies were screened by hand to identify any studies that may have been omitted using the keywords selected for the search. The search was designed and executed in collaboration with a library scientist. Keywords and Medical Subject Headings (MeSH) terms were chosen based on review of relevant literature on the topic. Keywords used in all databases were: contraception, birth control, family planning, refugees, and asylum-seekers. Figure 2 illustrates an example of the search strategy used in one of the chosen databases.

Figure 2

Example of Search Strategy Used on PsycInfo

PsychInfo: February 19 saved from final search strategy

1. refugees/ or asylum seeking/ or political asylum/
2. asylum seeking/ or political asylum/ or refugees/
3. 1 or 2
4. ((asylum adj2 seek*) or refuge*).ti.ab
5. 3 or 4
6. exp birth control/
7. exp family planning/
8. reproductive health/ or birth control/ or family planning/ or fertility/ or infertility/ or "sexual intercourse (human)"/ or sexual reproduction/
9. (contracept* or (birth adj2 control) or (family adj2 planning)).ti.ab
10. ((reproductive adj2 health) or (birth adj2 control) or (family adj2 planning) or fertility or infertility or (sexual adj2 intercourse) or (sexual adj2 reproduction)).ti.ab
11. or/6-10
12. 5 and 11

The final search strategy was identical and replicated in the seven electronic databases on the same day. Once the search was finalized by the primary author, the saved searches were sent to the library scientist to be validated and assessed for error. The search strategies are provided in order to ensure the study's transparency and replicability, and a Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) diagram is used to portray the search results (see Appendix A).

Stage Three: Selecting relevant studies

The third scoping review step was the selection of studies for inclusion in the review. This was an iterative process that required careful consideration and adjustments to ensure the

chosen literature was appropriate for answering the proposed research question (Levac et al., 2010).

Selection of Sources of Evidence. After identifying the studies through the systematic search of each database, the citations were uploaded to Covidence, an online citation management software used to sort, organize, and screen citations. After removal of duplicate citations, those remaining were screened for eligibility against eligibility criteria that were approved by the thesis committee. Screening was done independently by verifying the citations for relevancy through a two-step process. First, the titles and abstracts were read for congruence with the eligibility criteria. Studies that met the criteria and the studies for which there was insufficient information to assess congruence were retained. Next, the full texts of all retained articles were assessed against the eligibility criteria. At this point, only studies overtly meeting all criteria were retained. Final consensus on the included citations occurred through a meeting with the thesis supervisor. If there was insufficient, or unclear data presented in the studies to make a final decision regarding selection, I emailed the primary authors of these studies for clarification.

In all, seventeen authors were sent an email asking for clarification of their study participants or any additional data or supplemental files that could have been useful to determine the study's eligibly. Copies of the emails were kept for transparency. In the end, six authors replied with responses that resulted in the inclusion of two articles. The studies in which no response was received from the authors were filed separately. These studies were not included in the final study selection because I was unable to confirm their eligibility. Of note, there were studies that were not electronically accessible, that we would typically request from the library. Due to extenuating circumstances related to the COVID-19 pandemic, these studies could not be

requested or borrowed internationally between libraries. Details of the screening process and the rationale for study exclusions are presented in the PRISMA 2009 flow diagram (Appendix A).

Stage Four: Charting the data

Data Items. Data items included study characteristics, participant characteristics, and findings of the included studies. Given the emergent nature of scoping reviews, there were changes and additions to the data items that were extracted as the scoping review process ensued. Any changes or additions that were made were discussed with and agreed upon in consultation with my thesis supervisor and thesis committee. Study characteristics included the authors, year of publication, country of origin, study design, study population and number of participants, and the research questions or the objectives of the study as suggested by the authors (JBI, 2015) (Appendix B). Participants' characteristics included age, country of origin, religion, place of resettlement, marital status, and number of children (Appendix C). Extracted findings included each theme/sub-theme (or category/sub-category) name, the author-provided definition or explanation, and all the supporting quotes and exemplars from the study participants, related to the social characteristics, risk and protective factors, psychosocial resources, and health status of refugee women seeking contraceptive care as defined by the Integrated Framework for Health (IFH) (Appendix D).

Data Extraction. I, alongside my thesis supervisor, created a data extraction template in Microsoft Word to record data. This template was pilot tested on two of the selected studies by my supervisor and myself (individually). We then compared our extraction and made adjustments to the template as necessary.

The process of data extraction begun with reading and re-reading the included studies to ensure that I had a fulsome understanding of the work. Subsequently, I used the finalized

template to guide data extraction. This process was not linear. As I extracted the data, I consulted with my research team to ensure congruency. Extracted data were organized into summary tables.

Critical Appraisal. Critical appraisal of the included studies is an important component of synthesis research, which is done using tools or checklists designed for this purpose (Majid & Vanstone, 2018). Although Arksey and O'Malley's (2005) framework does not include a quality appraisal of the selected literature, others have recommended quality appraisal as an essential component that can determine whether research findings are meaningful and practical manner (Daudt et al., 2013, p. 5). Appraising health research, including qualitative studies, is pertinent for readers and professionals to make inferences regarding the study's results and how they may be credible, transferable and applicable to clinical practice, education, research, and health policies (Hanson et al., 2019). By critically assessing a study's strengths and weaknesses in a structural manner, readers can identify if the most appropriate methodological approach was undertaken in regard to the research question, and whether the researcher's role in the study may have caused bias in the interpretation of the main research findings (Young & Solomon, 2009). Appropriately appraising a study using an adequate process or tool can ensure the trustworthiness of the research is identified without underrating or overrating the study's quality (Majid & Vanstone, 2018). Ultimately, according to some authors, without assessing study quality, scoping reviews are not an appropriate study design to produce recommendations or changes for policy or health practices (Pham et al., 2014).

Therefore, I opted to appraise the quality of the included studies using the JBI critical appraisal tool for qualitative research. This assessment tool (see appendix E) was used to determine the quality of the evidence in terms of bias in study design, content, analysis, and

includes the assessment of congruency between the researchers' philosophical perspectives, their research questions, and their choices for methodology, data collection, interpretation, and representation of study findings (JBI, 2020). The JBI qualitative critical appraisal tool was chosen for its clarity and precision of the questions to be addressed (Majid & Vanstone, 2018).

Stage 5: Summarizing and reporting the results

Arksey and O'Malley (2005) describe the fifth stage of the scoping review process as "collating, summarizing, and reporting the results" (p. 27), where an overview of the research findings is clearly presented.

Summary of Evidence. Descriptive tables and narrative summaries were used to report the characteristics of the included studies. The synthesis of the extracted data occurred through qualitative content analysis, as suggested by Levac and colleagues (2010). Conventional content analysis occurred in an inductive manner; whereby, the extracted findings were examined to identify discernable themes and patterns within them (Hsieh & Shannon, 2005; Polit & Beck, 2017). The preliminary coding was based on the Integrated Framework for Health (IFH) by Lunn (2014), which enabled the extraction of information and groupings of themes that specifically addressed social characteristics, risk and protective factors, psychosocial resources, and health status factors.

The extracted data were re-read several times and I highlighted words that captured the central meanings and concepts described by the IFH (Lunn, 2014). Information relevant to the phenomenon of interest, that did not fit within the preliminary coding structure, was kept aside and coded as "other" initially. The extracted data were then re-read several times by myself and my supervisor to identify codes pertaining to the key features of the data, including the category marked as other. As new ideas emerged, new codes were formed (Hsieh & Shannon, 2005). The

codes were sorted into meaningful categories, and the relationships between these categories were well described (Hsieh & Shannon, 2005). Verbatim quotations from the original articles were used to support the findings, ensuring that the data was depicted and interpreted in a manner that relates to the study's objectives, and future clinical and research implications (Daudt et al., 2010). This process was not linear, and for that reason, I kept a record of analytic decisions and routine discussions that took place with my thesis supervisor and the thesis committee.

Stage 6: Stakeholder Consultation

Although Arksey and O'Malley agree that there are benefits to consulting stakeholders in the final stage of the scoping review process, their framework continues to identify this component as optional (Daudt et al., 2013; Levac et al., 2010). For the purpose of this study, I consulted with one stakeholder throughout the entirety of the study. This stakeholder is a trained healthcare provider (HCP) in Ottawa with over five years of experience in providing contraceptive care to resettled refugee women. This stakeholder was also a member of the thesis committee and acted as an advisor to assist in the direction of the scoping review processes. Unfortunately, the initial idea of including additional stakeholders (locally trained HCPs in Ottawa) to participate in an open conversation about this study's findings did not occur. The purpose of this conversation was to discuss their experiences, expertise, and their perspectives on the significance of the findings identified in this study in relation to the local and current context of contraceptive care. It was my goal to include stakeholder consultation as their expertise, knowledge, and experiences could have provided insight and guidance for recommendations in practice, research gaps, avenues for education, and priority areas for policy. However, due to scheduling conflicts and safety protocols associated with the ongoing COVID-19 pandemic, this was not feasible.

Ethical Considerations

This study did not require approval from the University of Ottawa Research Ethics Board (REB).

Rigour

To enhance the rigour of this study, I followed the following the ENTREQ statement (see Appendix F) within the introduction, methods, and methodology section (otherwise known as Domains 1 and 2), I verified that the methodological approach to this research was selected based on the research question proposed, the intended audience and synthesis, the context, as well as the philosophical position chosen (Tong et al., 2012).

For the third domain of the ENTREQ statement, I ensured there was no lack of transparency regarding the type of databases used to search for evidence, and provided a rationale for choosing the selected databases, while also providing a detailed description of the search process employed (see Appendix H). This included providing the pre-planned sensitive search strategy (with the search terms related to the population, context, and health issue) used and including the PRISMA flow-chart depicting the different stages of searching, screening, and selecting articles based on the inclusion and exclusion criteria (Tong et al., 2012). There is also a table clearly representing the inclusion and exclusion criteria, alongside a narrative explanation as to why certain studies were not included, and the rationale for including others. Furthermore, to enable readers to make inferences related to the transferability of the findings for their professional settings, a full description of the selected studies was provided (Tong et al., 2012).

As per the fourth domain of the ENTREQ statement, a quality appraisal of the selected studies was completed using the JBI qualitative appraisal tool to score the quality of the included studies. By assessing and reporting the quality of the articles selected in the study, the target

audience is better able to determine the credibility, dependability, transferability, and confirmability of the presented evidence within the studies and if they adequately contribute and respond to the proposed research question in a valid and reliable manner (Tong et al., 2012).

Finally, the synthesis of the findings (Domain 5), was clearly documented for readers. This included a description of the coding and data analysis procedures, how many reviewers were involved in the process, and a representation of the significant findings with direct quotations and interpretations from the studies. The objective was not to solely provide a summary of the findings, but to generate "rich, compelling, and new insights" (Tong et al., 2012, p.7). An adequate synthesis of findings is important for enhancing rigor because a reader must be confident that data were managed in a systematic manner (Tong et al., 2012).

Results

In this fourth chapter, I provide the scoping review findings. First, I detail the final search results and provide a descriptive summary of the selected studies, quality appraisal, and the participant characteristics. Following this, I explain the results of the data synthesis through the main themes and sub-themes associated with Lunn's (2014) Integrated Framework of Health (IFH). Verbatim quotes from the original studies are used to illustrate the patterns within the experiences of refugee women, as well as the factors that affect their knowledge and use of contraception.

Search Results

The search strategy executed in seven databases generated a total of 1,270 records (i.e. citations). The first level of screening removed 529 records that were duplicates. The remaining 741 articles were screened using the studies' titles and abstracts. During this step, 648 records were removed. Records were excluded if: 1) their title and/or abstract did not contain relevant information regarding this review's objectives and topic (contraception, family planning, refugee women, asylum-seekers); 2) if the study design was not qualitative in nature; and 3) if the study was in a language other than English or French. 93 records were retained after title and abstract screening, and three additional studies were identified by hand-searching their references. These 96 records were subjected to second-level screening for eligibility based on the chosen inclusion criteria. After full-text screening, 68 studies were excluded for the following reasons: 1) full texts were unobtainable (i.e. not accessible on academic platform); 2) full text articles did not exist (i.e. conference abstracts and letters/commentaries); 3) in a language other than English or French; 4) inappropriate study design (i.e. quantitative study design, or no qualitative data from refugee women or no qualitative data related to contraception or family planning); and 5) study

population did not meet this study's population criteria (i.e. did not clearly identify if study participants were refugees, immigrants, or migrants). A total of 28 studies were included for the scoping review (See Appendix A-PRISMA flow diagram).

Critical Appraisal

The critical appraisal score ranged from zero to ten. All research teams chose appropriate qualitative study designs and collected data in a manner that was congruent with the research question/objectives and aligned with qualitative methodology. For the studies that consisted of mixed designs, the chosen methods for the qualitative data collection were appropriate. All but three studies lost one point for not clearly reporting the philosophical or theoretical foundations upon which the study was based. Additionally, 11 studies did not clearly report on the influence of the researchers throughout the research process, to the degree to which the researchers interacted with the study participants, or if critical reflection about how their role or pre-existing views might influence the results. This component is relevant in qualitative research as the researcher's influence has the potential to interfere with the analysis and interpretation of the results through bias of subjective perspectives, and/or misrepresenting the true meaning of the participants' voices. Engaging in critical appraisal of the selected studies was important to understand the current state of science and for making and recommendations for future research (see Appendix E for detailed critical appraisal results).

Study Characteristics

The 28 studies included in this review were conducted in 14 different countries. Six studies were conducted in the United States, four in Africa (Ethiopia, Kenya, Nigeria, Uganda), three in Europe (Belgium, Sweden, the United Kingdom), three in the Middle East (Israel, Jordan, Lebanon), two in Asia (Thailand and Myanmar, Nepal), and four in Australia. The

sample size ranged from nine to 185 participants. All but five studies were descriptive or exploratory qualitative studies, with five being mixed-methods study designs. The cited methods of qualitative data collection included individual in-person semi-structured or in-depth interviews and focus-group discussions (FGDs). For every study, the author made the research objectives clear to the readers and thematic analysis strategies were used in the data analysis process. Of the retained studies, 10 clearly articulated a theoretical framework or conceptual model that guided their research (see Appendix B for complete study characteristics).

Each study included in this review described their participants' socio-demographic information differently. In all studies, authors reported the number of women they included and their age range, as well as their country of birth or country of origin prior to relocating as a refugee. Authors inconsistently reported on their participants marital status, the number of children they had, their religion or ethnicity, their level of education, their occupation, or the number of years since their relocation to a new country.

Overall, 1,411 women were included in the studies, with two women identified as trans women. Their ages spanned from 13 to 80 years, with most women being between the ages of 18 and 49 years. The country of relocation was often the same the country in which the study took place. Six out of the total 28 studies included refugee women who relocated to the United States, four studies included those who resettled in Australia, three studies included women who resettled to Thailand, and the remaining studies included women who fled their country and resettled to either Belgium, Sweden, the United Kingdom, Lebanon, Ethiopia, Israel, Jordan, Nepal, Kenya, Uganda, or Nigeria. In 14 of the included studies, the authors did not explicitly state how many years their participants were relocated to their new country as a refugee. When this information was reported, nine studies included participants who were resettled in a new

country for less than ten years and five studies included refugees who were resettled in a new country for over one decade. Marital status was reported in 18 of studies, with 14 including married women and five including women who were single or never married. 12 studies included women who had at least one child, while two studies included women who were never pregnant, and the remaining 14 studies did not explicitly report on the number of children the participants had, or if they had any. Out of the included studies, 17 did not report the religion or ethnicity of their participants. Of the demographic information included in each study, refugee women who followed Islam, Christianity (and denominations of Christianity), and Buddhism were included. The educational backgrounds of the women in their study samples were included in 18 studies. In 13 studies, participants reported a minimum of primary school education, with participants in eight of those studies having a diploma or education higher than secondary school. Five studies reported that participants did not have any formal education, while the remaining studies did not report on education. Only three studies included in this review described the occupations held by their study participants. These occupations included informal labor jobs, farming, healthcare workers, home caregivers, teachers, and business/shop workers (see Appendix C for complete participant characteristics).

Contraceptive Characteristics

Various methods of contraception and family planning strategies were described throughout the included studies. Family planning was a common umbrella term used to describe both the use of contraception and the decisions one makes about birth spacing. West et al. (2017) reported one perspective of family planning by describing “all participants associate the term family planning with modern contraceptive methods” (p. 97), while participants in Zhang et al.

(2020) study described that "family planning has a western approach. It's not something in the Muslim society that is talked about or considered" (p.69).

Twelve studies specifically focused on the exploration of contraception and family planning in refugee women, and the remaining studies explored diverse areas of women's reproductive health patterns and behaviors, subsequently identifying contraception as a theme in their findings. Included in the selected studies was research that focused on a specific method of contraception, such as long-acting reversible contraceptives and emergency contraceptive pills. In three studies, authors described contraception in general terms such as "birth control", "general contraceptives", or "family planning".

Across the selected studies, condoms (n= 15 studies) and contraceptive pills (n= 16 studies) were the most frequently cited reversible methods of contraceptives that refugee women had knowledge about or utilized. Some of the included studies did not reference these methods at all. For example, two studies reported that natural contraceptive methods were commonly used compared to hormonal-based methods. These natural methods included exclusive breastfeeding, the rhythm method or calendar method, the withdrawal method, or abstinence (Ivanova et al., 2019 & Kaczkowski & Swartout, 2019). In three studies (Cherri et al., (2017), Kaczkowski et al., (2019), & Kabakian-Khasholian et al., (2017), abstinence and natural methods of contraception were reported as preferable birth control options for many of the refugee women included. Other methods of contraception identified in the selected studies included the use of injections, such as medroxyprogesterone acetate, otherwise known as Depo-Provera (n=11 studies) and implants (n= 3 studies). This scoping review did not focus on permanent contraceptive methods such as female sterilization, however, Salisbury et al. (2016) study reported that half of their study

population had knowledge of female sterilization and believed it to be an acceptable form of contraception.

Refugee Women and Contraception – Integrated Framework for Health

The knowledge and experiences with contraception and related health services shared by refugee women are described using Lunn's (2014) Integrated Framework of Health (IFH), which articulates four relevant categories of characteristics: a) social characteristics, b) risk and protective factors, c) psychosocial resources, and d) health status (See table 3).

IFH Category One: Social Characteristics

As per the IFH (Lunn, 2014), social characteristics include both the individual and family and the neighbourhood and community, as well as their combined effect(s) on health behaviors. These elements can determine an adult refugee's health status and include the economic and political context one lives in (discrimination, age, gender, race, sexual orientation, socioeconomic status, migration and integration, and family structure). Participants included in this scoping review came from a variety of countries that differ in many of these elements. However, similarities were noted regarding the role that family, as well as the forced migration process, had on their contraceptive health-seeking behaviors. To help articulate this social characteristic category, there are two sub-categories a) family structure and b) migration and integration.

Family Structure. For many of the included participants, family was considered a central construct for how reproductive decision-making occurred. Furthermore, their utilization of contraceptive health services was predominantly influenced by family members' opinions that childbearing is a blessing and an expectation, especially once married: "[Contraception] not okay ... if you use a lot maybe you cannot get baby, nobody marry you" (Dean et al., 2016, p.26). Lack

of exposure to contraception was also common, as participants reported contraception being an unacceptable topic of discussion in their households: “Our families don’t talk about this kind of stuff. They [parents] don’t mention it ... you aren’t allowed to” (Dean et al., 2016, p.24), and: “[Parents] holding very fast ... they don’t want their children to ... know about sex ... about this Australian culture” (Dean et al., 2016, p. 23).

Reported in several of the studies, was the notion that the husbands’ desires and beliefs shaped their family’s reproductive behaviors: “If the woman does not want to use a (contraceptive method) that messes with her hormones, (she suggests the condom to her husband). The final decision is taken by the husband. He either uses a condom or he does not” (Cherri et al., 2017, p.8). When discussing their husbands’ role in the use of birth control, participants reported that although there were inconsistencies in their husbands’ beliefs, they still established if contraceptive uptake would be appropriate for their family: “Some men, they don’t like it, but some men, they say go ahead, take it” (Agbemenu et al., 2017, p.3358).

Fear of deviating from their husbands’ stance was also spoken about: “When I gave birth to my last baby, I wanted to have the ring, and he said you aren’t allowed, you can’t do that. Once, I didn’t tell him that I was taking the birth control. I did it, I bought some birth control [at the local UNRWA health clinic], and he found it, the pills, and he was going to beat me for it ... he doesn’t want me to do it” (Pell, 2017, p.148). Despite this, participants in two studies reported opposing sentiments to their husbands’ viewpoints about whether they should - or could - use contraception. In one study, authors highlight how participants spoke openly about encouraging women to make autonomous contraceptive decisions if they would benefit their family: “She should say, ‘husband it’s good for us this, it’s better for [our family]” (Agbemenu et al., 2017, p.3359). In this same study, some participants discussed their secret use contraception: “You

keep your secret inside your heart and then you don't tell your husband" (Agbemenu et al., 2017, p.3358). Perspectives about birth control from other family members also had an important impact on refugee women's sexual health behaviors:

> In China, my parents were strict and I was sheltered and unknowledgeable regarding sexual matters. After coming to the UK and having a sexual relationship with my boyfriend, my understanding ... about intercourse was very limited, so immediately after intercourse, I would go for a pee and thought that would prevent pregnancy. (Verran et al., 2015, p.124)

Also considered part of family structure within the IFH is the socioeconomic position of the family unit, which sometimes plays an important role in the timing and decision to bear children. Based on the included studies, it appears that the use of contraception is often directly associated with its accessibility and affordability: "Even if you have the money, they won't give you a break [from work] to get your treatment. If you say you are sick and don't go to work today, then you will get fired the next day. And we can't afford to get fired" (Gebreyesus et al., 2017, p.262). Refugee women seem to have knowledge regarding different options (including emergency contraceptive pills (ECPs)) but not the means to afford them: "I have heard about it [EC] and I know someone who has used it, but it is expensive" (Nara et al., 2020, p.114) and: ''[ECPs are] not very expensive, but for some people, they cannot afford it" (Nara et al., 2020, p.114).

Migration and Integration. Migration and integration refer to the changes and the level of adaptation one lives because of one's refugee status. Regarding this, participants of the included studies commonly reported that they experienced new challenges following forced relocation and described how the changes to their lives impacted their contraceptive knowledge and health-seeking behaviors. Many difficulties arising from forced migration were expressed, such as: "In

Somalia, our mothers didn't know much or they didn't depend on contraceptives. Here, there are challenges that cause changes" (Zhang et al., 2020, p.70). Differences in exposure to contraception and sexual healthcare in one's host country in comparison to the country of relocation was common:

> [In Afghanistan] the [religious] scholars were saying [contraception] is made of Satan (evil) ... They were preaching about these things, saying that if you are using condoms it means you are doing something against God. That sort of rumour was back there ... [But when people] come to Australia, they realise that whatever they were thinking, it was all wrong. (Russo et al., 2019, p.8)

For some participants, sexual intercourse was a means of survival to make money, especially when forced relocation meant residing in a refugee camp with minimal resources for a prolonged period. This experience is best illustrated in the study by Okanlawon et al. (2010):

> Some refugee girls in this camp are unaccompanied minors who came alone to Nigeria without their parents or families and so, they are on their own. Many of them and other refugee girls sleep with older men, who are indigenes of the host community and refugee men, for money, food and other material things. Girls like this and other refugee girls who are prostitutes seriously need contraceptives to prevent pregnancies and diseases. (p.21)

For some refugee women who were forcibly relocated to refugee camps, the use of contraceptives was important to avoid unintended pregnancies because sex was used for survival:

> Many girls in this camp sleep with men in order to survive. We are here in Nigeria with nothing and nobody to help us and we have to survive. I already have a child (a son) who is 2 years old and I don't want to have another child again now so I use pills and it works

> for me. It hasn't let me down. I also use condom too when I'm with new partners. (Okanlawon et al., 2010, p.23)

Other participants reported a period of adaptation to a new culture and view on sexual health, which caused them discomfort when utilizing contraception or attempting to access family planning services: "People feel shy when they are not married, and then they don't want to talk about birth control" (Dhar et al., 2017, p.792), and many attributed this to their cultural upbringing: "[Parents] holding very fast ... they don't want their children to ... know about sex ... about this Australian culture" (Dean et al., 2017, p. 23), and "Our families don't talk about this kind of stuff. They [parents] don't mention it ... you aren't allowed to" (Dean et al., 2017, p.24). Per the studies, some women reported recognizing differences in exposure to contraceptives and family planning between their host country and their country of relocation:

> They came out from Afghanistan, they went to Iran, Pakistan – more civilised countries than Afghanistan – and many other countries like Australia, Europe. When [Afghan people] went and they look at the world, they realise that they were living in a very, very backwards way. So, after that all the people were using contraception; they become more modern. (Russo et al., 2019, p.8)

IFH Category Two: Risk and Protective Factors

According to the IFH (Lunn, 2014), the physical environment, knowledge and behaviors, and the healthcare system can directly act as barriers or facilitators to achieving health, depending on the context. Based on this synthesis, there are several factors that act as barriers and facilitators, which might influence a refugee woman's contraceptive health-seeking behaviors. Some situations enhance women's access to equal reproductive healthcare, while others can hinder it. In this section, I describe both the risk and protective factors, expressed by

the participants, that played a role in their contraceptive behaviors. These included: Knowledge and Behaviors and Healthcare System.

Knowledge and Behaviors. For the participants in the included studies, their knowledge about contraception influenced their behaviors and perceived need for family planning services. Accessibility to accurate knowledge was reported as both a barrier and a facilitator to contraceptive health services, depending on the individual, family, community, and macrosystem at play (healthcare system, healthcare providers, environment, distribution of resources).

First, some refugee women appeared to be aware of contraceptives: "The only thing I know is about using condoms. When I talk about safety, it means that to use condoms while having sex so that you will not get pregnant" (Dhar et al., 2017, p.792). Some participants were able to describe different methods "It is like this, before having sex with a man you take one of the yellow [pills], and after having sex with a man and you are in the period of ovulation, you take one red and one yellow" (Nara et al., 2020, p.115), as well as their desires and contraceptive needs: "If they [doctors] talk more [about FP] I would benefit from them but they don't talk, so I don't ask" (West et al., 2017, p.98). Although some participants reported having knowledge of contraceptives, other barriers to utilization were present: "When thinking about IUD process 'I'm going to be naked, someone's going to be looking at me or going to be doing something on me. . .I start not to feel comfortable" (Agbemenu et al., 2017, p.3360).

Conversely, some participants lacked knowledge about contraception, despite being sexually active:

> I did not know that, first, sex can result in pregnancy, but my husband knew; but he said he really loves me and that's why we did not use any contraception. I did not want to have children at that time, but I got pregnant. (Benner et al., 2010, p.6)

Unproven methods of contraception were used to prevent pregnancies when access to sound information was limited: “We did not know if [the other medications] were effective. Sometimes we would use Quinine; you swallow it and it works. But [I would also use] paracetamol” (Nara et al., 2020, p.114). Also, natural methods were relied upon for preventing unplanned pregnancies: “You can use two types of family planning. A mother does not become pregnant unless the baby is weaned. If the mother gets her period while breastfeeding, then she can use an injection or family planning tablets” (Royer et al., 2019, p.400).

Participants described how being exposed, in their home country, to information about contraception and birth control enhanced their desire to use family planning methods: “Back in Eritrea, for example, it’s something that is constantly there because there is a lot of condom ads encouraging young people to use condoms because the HIV is spreading.” (McMichael & Gifford, 2010, p.268). Upon resettlement, some participants were confused by the different contraceptive options now available to them. This uncertainty was described as such:

> The most important [problem] is that people don’t know about the contraceptive methods and where to get them...”, as well as a confusion about how to access them “I don’t know if there are any kinds of [FP] services here and where ... no one told me .... nobody cares. (West et al., 2017, p.98)

Thus, participants in the studies had varying levels of knowledge of contraception and family planning methods. There were differences in knowledge acquired from one’s home country and new exposures to birth control in a host country that influenced contraceptive health-seeking behaviors.

Healthcare System. A common experience for the participants in the included studies was how their access to contraception and other family planning services was tied to the healthcare norms and systems in place within the country of relocation:

> The doctor explains to us about issues with contraception failing and we don't entirely understand so it makes us worry ... I still would rather trust my friends' advice on the best method of contraception. If none of my friends can give me an ideal answer, it worries me ... I have received leaflets from doctors but they do not describe adverse reactions. Also, the long- term effects have not been explained to me so I get worried. (Verran et al., 2015, p.124)

For many, navigating the system was complicated, and being a refugee made it more difficult: "The most important [problem] is that people don't know about the contraceptive methods and where to get them..." "I don't know if there are any kinds of [FP] services here and where ... no one told me .... nobody cares" [Participant 9] (West et al., 2017, p.98).

Access and use of contraceptives also appeared to largely depend on location of availability (i.e. different methods are available in different places). Refugee women reported having to travel long distances to obtain sufficient access to trained HCPs who could provide them with safe options: "I know a woman ... she comes from 'Eilat' [a five-hour bus ride from Tel Aviv] to get treated here [Tel Aviv] ... and 'Eilat' is the furthest from this town" (Gebreysus et al., 2020, p.260). Needing to travel to receive care was particularly important for women who were living in refugee camps. A lack of transportation that was accessible and affordable was considered a barrier to accessing facilities when needed:

> It is not easy for us to get contraceptives in this camp. When we need it, we go to hospitals in the neighboring communities like Victory hospital, Oru Awa maternity center

> and so on. The nearest clinic where we get contraceptives is about 30 minutes' walk from the camp so we trek there. The other ones are far away so, we go by car. (Okanlawon et al., 2010, p.24)

These women reported that changes in the refugee camp's delivery of health services caused significant stress because contraceptives that were once offered at no cost, were no longer available:

> Before, contraceptives like pills, IUD, injectables, etc., were free in this camp, but since the camp clinic was closed in 2007, we now go to hospitals in the surrounding community to receive the service. It's no longer free. Some of us like to use it, but we can't get it in the camp. That's the problem. (Okanlawon et al., 2010, p.23)

Having limited finances was a significant barrier to obtaining the desired birth control method. For example: "In Burma it is really rare that [women] use the IUD, and also it is expensive; they don't provide it in hospitals. So, if you want to use the IUD, you have to search for a clinic that provides it" (Gedeon et al., 2015, p.4). As a refugee woman, this contributed to unmet contraceptive needs: 'They are not here. Please give us those ones so that we can use [them]. We don't have them; those ones are good" (Nara et al., 2020, p.114).

A recurrent topic discussed by participants in the included studies was language barriers and cultural differences with HCPs: "There is nobody to translate for you in your own language and, instead of translating for you or giving you the proper drugs, they give you the wrong ones" (Gebreysus et al., 2020,p.265), and: "They seem to only give medications and condoms to the married couples. If some of them are still in school, they wouldn't be given anything to prevent pregnancy" (Asnong et al., 2018, p.8). The need for professional translators was common: "The doctor needs to book an interpreter. But if the interpreter is there, it is hard to say things, sexual

health things. I do not feel comfortable in front of an interpreter, so it's much better to use a phone interpreter" (Royer et al., 2019, p.11). Even with access to professional translation services, some women expressed discomfort communicating with HCPs about contraception because it was viewed as a sensitive topic: "I feel shy for getting a condom, we feel a bit uncomfortable to get condoms from the health-workers working in our villages" (Asnong et al., 2018, p.8).

IFH Category Three: Psychosocial Resources

The psychosocial resources of a person and family that are included in the IFH are identity, psychosocial affect and functioning, culture and acculturation, and interpersonal relationships. As reported in the included studies, participants most often described their culture and religion as having an impact on contraceptive health-seeking behaviors.

Culture and Religion. Traditional values of their culture played a predominant role in their lives: "As always, our life is covered by not only tradition, most of the thing we do is [driven by] religion" (Agbemenu et al., 2017, p.3359) and family planning decisions: "I think the family planning has a western approach. It's not something in the Muslim society that is talked about or considered" (Zhang et al., 2020, p.69). Some participants described how they were not allowed to choose how many children to have: "When you are still young, you are not allowed, in my tradition, to say, 'I will not have another baby.' That is forbidden. Don't say that, because you are still married, you have your husband. Anything can happen, whether it is intentional or not intentional. Anything can happen" (Agbemenu et al., 2017, p.3359). Instead, becoming pregnant and bearing children was left to fate because of the values espoused by their religion. For some refugee women, this meant that contraception use was forbidden: "My religion doesn't allow me to control the birth" (Davidson et al., 2017, p.1703). Depending on the country of

origin and the religion practiced by the refugee woman, modern contraception was seen negatively: “In Islam you are not allowed to decide how many kids you have. It’s not allowed. You can’t say, ‘I want three kids and that’s all.’ You can have periods of time between them, but you can’t say, ‘I only want this amount of children” (Pell, 2017, p.146) and: “It’s permissible to take a break from having children, but one isn’t allowed to say, “I will never take what God gives me and I will never want any more children” (Pell, 2017, p.147). For other women, religion determined the contraceptive options that were acceptable: “Islamic Religion permits a mother to breastfeed her baby for two continuous years. You can use breastfeeding as family planning.” (Royer et al., 2019, p.400), with natural methods of delaying subsequent pregnancy commonly permitted: “Islam encourages you to have spacing for at least 2 years, to breast feed for 2 years for the baby’s brain development, for many reasons, also for the mother’s health” (Zhang et al., 2020, p.68) and “The one method that religion talked about was that friends of the prophet back in the day used to practice the pull-out method” (Zhang et al.,2020, p.68).

Sometimes, the values and beliefs of others influenced refugee women’s decision-making and health behaviours. Some had fears of being associated with sex-work and felt embarrassment, discouraging access and utilization of contraception:

> I like using condom during sex, but I didn’t use it the last time I had sex because I didn’t want to buy it in the camp. I don’t want anyone to think I’m a prostitute. I remember the last time I went to buy condom and pills in a chemist in the camp; I was embarrassed by some women. They asked me what a young girl like me wanted to do with condom and pills. I was so ashamed that I had to lie that someone sent me. So, I prefer buying it outside the camp, a little bit far away, where no one knows me. (Okanlawon et al., 2010, p.23)

IFH Category 4: Health Status

As described in the IFH, the health status category refers to both the physical and emotional health status of an individual. This category was illustrated in the narratives of the refugee women as they discussed the effects of contraception on their physical and mental health.

Physical Health. The refugee women in the included studies frequently reported on the side effects associated with the use of different birth control methods. Some described personal experiences and complications, while others described their worries and fears: "There's a lot stigma so it's like, 'Oh my God the pill, what is it going to do to me? Is it going to make me lose my hair? Does it have hormones? Is it going to make me crazy? The shot, oh my God it's going to make me gain like 50 lb?' (Zhang et al., 2020, p.70). A common fear was the physical side effects associated with taking a new medication. Although the reported side effects of contraception varied, the concerns about the effects on physical health were significant: "I can't risk my life by using contraceptives, they are dangerous. I know a woman in this camp who died due to adverse effects of contraceptives. I know another woman who told me the story of how contraceptives affected her and made her menstrual cycle irregular. Nurses are wicked. They don't tell people about the side effects. They just tell us to use it" (Okanlawon et al., 2010, p.22). Participants also spoke to concerns about the effects of contraceptive use on future childbearing abilities: "Umm... I have heard that taking contraception pills can sometimes lead to uterus contraction, and a girl can no longer conceive a baby after that." (Asnong et al., 2018, p.8) and: "They said it [the OCP] might cause me not to have children anymore" (West et al., 2017, p.97).

Some participants described advantages to their physical health resulting from the use of contraception, which encouraged their continued use:

> "To me, family planning is good. Currently, I use the injection. I don't have any bleeding problem. I can use them up to six or seven. As soon as I stop using them, and then I get pregnant. I don't have any problem with family planning. I don't bleed a lot. My, my menstruation is coming normal". (Agbemenu et al., 2017, p.3360)

For these participants, being informed about the additional benefits of contraception, such as protection from sexually transmitted diseases, encouraged use: "That person might have a disease or sickness in his body and then he doesn't want to let you know and he wants to infect you. You don't know. So, you have to protect yourself by using condom, stuff like that." (McMichael & Gifford, 2010, p.270).

Integrated Discussion

In this chapter, I provide a summary of my study, I relate my findings to the Integrated Framework of Health (Lunn, 2014), and discuss the use of this theory for research on the topic. I also discuss the barriers to accessible contraceptive services for refugee women, as well as gender implications for the topic. I provide implications for nursing practice, policy, education, and future research. Finally, I acknowledge and describe the strengths and limitations of my study and offer conclusions.

Summary

The purpose of this knowledge synthesis study was to systematically identify the global literature on refugee women's use of contraception within the reproductive age group. Arksey and O'Malley's (2005) six-stage methodological framework was used to guide the scoping review procedures. I extracted and synthesized subjective data from refugee women within the reproductive age-group (not from healthcare providers (HCPs) or other parties) to identify their lived experiences. Twenty-eight studies from fifteen countries were retained for inclusion. The findings highlight the following influencing factors: social characteristics, risk and protective factors, psychosocial resources, and health status. The IFH framework was useful in categorizing the qualitative findings based on micro (individual) and macro (community, system) level influences, because the main categories shed light on the various barriers and facilitators reported by participants that influenced their knowledge and uptake of contraception and associated healthcare.

The Integrated Framework of Health Theory

The Integrated framework of health (IFH) was created by Lunn (2014) as a structural framework to examine and identify the complex factors that contribute to the health status, health

disparities, and social determinants of health of refugees resettled in the United States. This framework posits that factors within the individual (family, gender, age, race) and macrosystem (economic, social, cultural, political, legal) levels are interrelated and can have an effect on health singularly, simultaneously, and throughout one's lifespan.

The IFH allows for the categorization of factors that extend beyond the social determinants of health, recognizing broader elements such as community and the macrosystem as key elements affecting refugee's health. The main categories of the theory are social characteristics, risk and protective factors, psychosocial resources, and health status. The elements (sub-categories) included in each main category are interrelated and can have an impact in other main categories.

Using the IFH as a theoretical grounding for this study allowed me to organize the findings from the included studies into meaningful categories that illustrated the overlapping factors influencing refugee women's health. In using this theory to guide preliminary synthesis, I was able to recognize the multifactorial elements that affect health following forced migration, while acknowledging diversified experiences. When reflecting on the findings of the synthesis and how they relate to the IFH (Lunn, 2014), we see how both individual and macrosystem elements influence refugee women throughout the forced migration process, as well as after resettlement.

The IFH and Findings

The following section speaks to the findings within this scoping review as they relate to the IFH. Refugee women included in the reviewed studies reported on the *social characteristics* that affected their knowledge and uptake of contraceptive methods. Family planning and birth spacing behaviors were primarily influenced by family and the role of the family structure, rather

than influenced by HCP recommendations. Family beliefs and values, especially those held by the participant's husbands, were an important contributing factor as to whether contraceptive usage was deemed acceptable. The migration and integration processes associated with being a refugee meant that exposure to appropriate knowledge and access to contraception varied from host countries to countries of relocation. Refugee women reported on their sexual health and contraceptive behaviors, describing risk and protective factors that influenced their actions. Some voiced confidence in their knowledge on the topic to guide and protect against unwanted pregnancies or sexually transmitted infections (STIs). Other women described barriers to contraceptive uptake, including financial restrictions, lack of accessibility to health services, and negative experiences with HCPs such as cultural insensitivity and discrimination.

The *psychosocial resources* category within the IFH helped to shed light on the findings that explored a woman's identity and how it affects her health status and health-seeking behaviors. For many women, their cultural traditions and religious identities played a significant role in their family planning decision-making. They often relied on their faith when discussing childbearing, pregnancies, and family planning options.

From a *health status* perspective, using the IFH, we see how women sometimes associate contraception with negative outcomes that might alter their physical health. Side-effects and adverse effects were frequently feared; however, some participants reported no prior use of contraception and, thus, their fears were based on stories from others. When participants reported on physical health advantages to utilizing contraception, these were often motivating forces to continue seeking contraceptive health services.

Perhaps the most useful aspect of the IFH for this study was its explanation of the various, interconnected aspects of a refugee's life that can influence their health-seeking

behaviours. Interestingly, through this synthesis of study findings, it was clear that some aspects are more widely discussed, and that the overlapping nature of these influences is important. For example, although refugee women spoke about their experiences from different contexts and point of views – some women were in refugee camps, while others were resettled for years – the factors influencing their health-seeking behaviors appear to be somewhat similar. Through the data analysis process, I began to question whether by using the IFH as a classification tool, I was missing some of the nuance of the participants' experiences. Ultimately, as I became more familiar with the topic through my Master's program, I recognized the limitations of this framework as a tool to organize the data, rather than a perspective to interpret and understand the experiences of these marginalized women who represent many sub-populations. While utilizing the IFH, I realized the complexity of overlapping factors that affect one's family planning decision-making process. The participants within this review all spoke to their individual experiences, and while similarities existed, it was obvious that new information cannot simply be placed in one category. Analysis of the participants unique experiences was difficult, and it was important to avoid making gross generalizations that undermined their realities.

The IFH and Intersectionality

Lunn's (2014) framework is useful when analyzing refugee health, especially women's health surrounding a sensitive topic. The author acknowledges the various contexts of the macrosystem (economic, political, social, cultural, distribution of power) that affect all components/categories described in the framework. Further, Lunn (2014) recognizes that the complexities of refugee health will continue to change over one's lifespan. The IFH aims to clarify the nuanced factors contributing to health disparities in this marginalized population to relieve health inequity.

Although the IFH (Lunn, 2014) enabled categorization of the qualitative findings into meaningful ideas, the complexity of the topic led to overlapping and interrelated factors that varied across all the included studies or populations. Furthermore, the various factors embedded within the macrosystem were not the only influences on refugee women's health at any given time. Based on the findings of my scoping review, which integrates data from all retrievable studies on the topic, the factors associated with forced migration are complex and continuously evolving, such that country of origin or culture only superficially inform us about a person's preferences and healthcare needs. For example, women described their identities within a refugee *and* family context, while elaborating on barriers and oppressions that kept them from learning about sexual and reproductive health. Although some barriers were structural (such as lack of available clinics or limited transportation), others were based on patriarchal family traditions and beliefs (Cherri et al., 2017; Davidson et al., 2017; Gebreysus et al., 2020).

To augment the theoretical framework (i.e. the IFH) for this study, I explored the theory of intersectionality to further understand the participants' experiences. Intersectionality is a critical framework that was initially created to examine the effects of racism on health inequalities, originating from the American Black feminist movement (Rai et al., 2020). The theory posits that "multiple social categories (e.g., race, ethnicity, gender, sexual orientation, socioeconomic status) intersect at the micro level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro, social-structural level (e.g., racism, sexism, heterosexism)" (Bowleg, 2012, p.1). Intersectionality is used to comprehend marginalized populations, conceptualizing the effects of privilege and social oppressions on health and identities, while "acknowledges how such intersectional dynamics between different social inequalities and identities are contextual and may change over time and be different in

different cultural and geographical settings" (Rai et al., 2020). Thus, intersectionality is useful to understand the experiences of refugee women (i.e. a marginalized population) who face oppressions. This theoretical perspective is relevant to my topic because the participants occupy many identities, such as gender minority, racial minority, or a person of limited social status; each of these can influence their health and well-being (Cole, 2009). Throughout the included studies, for example, participants described how simply being labeled a 'refugee' can affect the availability of resources and contraceptive healthcare; they also explained how gender has a strong influence on family planning decision-making authority.

Intersectionality is often used in nursing research to examine issues of social justice, understanding "the degree of equal opportunity made available to individuals by the social, political, and economic structures within which they live" (Van Herk et al., 2011, p.29). For example, Cramer & Plummer (2009) used the conceptual framework of intersectionality to explore help-seeking and help-receiving behaviors of people of color with disabilities. In this study, the framework allowed for an analysis of women's decision-making behaviors based on "political, historical, economic, cultural, and social contexts" (Cramer & Plummer; 2009, p. 176) with the aim to encourage HCPs to better understand the women's lived experiences in order to provide improved services. Research about refugee women and contraceptive knowledge and health-seeking behaviors is well-positioned to use an intersectional approach because the theory acknowledges the complexities of the intersections between race, gender, class, and socioeconomic status on the influence of contraceptive health-seeking behaviour.

Gender Considerations

Gender and its influence on the topic of interest were important considerations for my study. When examining the findings from the included studies, we see that gender plays a large

role in how HCPs approach contraception, as well as its effect on how refugee women view their place within their family structure pertaining to contraceptive decision-making. For most participants, gender was discussed predominantly through experiences of gender norms and the participants' cultural upbringings, which were rooted in patriarchal influence. For many women in the included studies, it was their spouses – reported by them as 'their husbands' – who made the final decisions about which family planning method was appropriate. For some participants, simply having a conversation about contraception was not allowed by their husbands and cultural norms. Some participants reported not feeling comfortable approaching the topic of sexual health or contraception with male/men HCPs, and they felt embarrassed or shameful being seen asking for condoms.

As evidenced by the findings of this scoping review, gender, oftentimes, shapes health outcomes or contributes to unequal access to health services. Some study participants also spoke about the intersections of their changing identities, feelings of marginalization based on their gender, and their refugee status. Intersectionality, as mentioned above, has been used in research to understand women's health, men's health, gender and health inequities as "varied and fluid configurations of social locations and interacting social processes" (Hankivsky, 2012, p.1712). Although priorities are shifting to ensure better representation of gender diversity in research (Hankivsky, 2012), most gender and sex research is focused on binary populations. Oftentimes, this means comparing health differences between men and women (or males and females) without considering other genders (Hankivsky, 2012). Furthermore, gender is commonly examined in isolation, without considering its relationship to sex and sexuality. Instead, gender should be examined with the overlapping biological and social processes that influence social inequity and systematic oppressions (Hankivsky, 2012). This scoping review explicitly

highlights this gap because, of the 28 studies included, only one had participants who identified as transgender women. Keygnaert et al., (2014) included two transgender women in their research, which aimed to explore how refugees, asylum seekers, and migrants define sexual health and seek sexual health information.

It is no longer sufficient to only consider gender and sexual orientation binaries when conducting research on topics that attempt to understand the relationship between gender, sex, and accessibility to sexual healthcare services (especially contraception) and associated health outcomes. Addressing the topics of women's health, contraception, and access to care must consider all those who define themselves as women, but also persons who have female sex organs but who do not identify their gender as 'woman'. Non-binary populations, for example, who are at an elevated risk for poor mental and physical health (Scheim & Travers, 2017), are likely to have unmet contraceptive and sexual health needs, and research shows that healthcare providers are less comfortable providing care to nonbinary patients; they may exhibit this through misgendering or microinvalidations (Renner et al., 2021). For persons who are trans, research indicates that they face fear of discrimination and stigma from HCPs, and, as a result, they are ill-equipped to know how and where to seek appropriate medical attention (Scheim & Travers, 2017). For refugees who live within cultures that do not accept or recognize their nonbinary or transgender identity, it is likely that they experience increased barriers to gender-affirming sexual healthcare and contraceptive counselling, despite participating in sexual practices that may lead to unintended pregnancy (Gomez et al., 2020).

Refugee Women and Contraception: Challenging "Unmet Needs"

There are similarities in the results of this study when compared to previously published studies on refugee overall health. This review, however, highlights aspects of refugee women's

sexual health, which are otherwise buried within experiences of health and healthcare generally. Women in this study reported on cultural, linguistic, and structural influences that affected access to healthcare services. While some participants reported on positive experiences engaging in reproductive healthcare services, many women described different levels of barriers to family planning services. This is problematic because research shows that refugee women have a high need for care (Mangrio & Sjögren Forss; 2017). While the included participants consistently described barriers inhibiting them from seeking contraceptive health services, the specific difficulties varied based on culture, geographical location, finances, and medical systems.

Cultural Differences

Culture was often described as a strong influence on the uptake of contraceptive health services. Many refugee women in this study resettled in countries that approach family planning differently than in their host country. Within this scoping review, 6 studies (Dean et al., (2017); Gebreyesus et al., 2017; Pavlish et al., 2010; Royer et al., 2019; Russo et al., 2019; Verran et al., 2015) specifically reference the difficulties associated with adapting to a new culture following resettlement and the impact it can have on family planning decision-making. For many women, culture and religion were mentioned simultaneously. Participants often described their religion and faith as their guide regarding whether to have big families or not use contraception. For some participants, specific methods such as coitus interruptus and breastfeeding were the only acceptable options to delay childbearing. For others, they believed God decided how many children their family would have, and it would be considered taboo to not bear children (Agbemenu et al., 2017; Zhang et al., 2020). Family structure and spousal influence were also frequently reported as influencing factors to choosing a method of contraception or using it at all. This review demonstrates that family structures deeply rooted in cultural and traditional practices

have a strong influence over a women's desire to seek family planning services. It did not matter what contraception method was being referenced, the influence from a spouse or family member was the primary driver in decision-making.

Although this review is not representative of all countries, studies conducted with refugee women from countries in Africa (Agbemenu et al., 2017; Davidson et al., 2016; Dean et al., 2017; Ivanova et al., 2019), Syria (Cherri et al., 2017; Kabakian-Khasholian et al., 2017; West et al., 2017), and China (Verran et al., 2015) described their families and spouses as both direct and indirect influences over their decision-making. As a direct influence, participants explained that husbands make the final decision, husbands disagree with certain contraceptive methods, and husbands can prohibit the use of contraception if they want more children. Spouses were seen as indirect influences on family planning decision-making when participants reported avoiding contraception due to fear of their husband (Ivanova et al., 2019). Although the influence of the spouse was prominent in the included studies, authors West et al. (2017) highlighted how participants might secretly seek health services without their husbands' consent. 'Sneaking' healthcare services is shown to be dangerous, though, as the study by Pell (2017) reported this experience: "Once, I didn't tell him that I was taking the birth control. I did it, I bought some birth control [at the local UNRWA health clinic], and he found it, the pills, and he was going to beat me for it ... he doesn't want me to do it." (Pell, 2017, p.148).

Cultural taboos were voiced by participants from a variety of countries as impeding their access to sexual and reproductive health information. These cultural clashes between generations (grandparents to grandchildren, parents to their children) and differences in approaches to sexual health in comparison to one's home country and the host country, were frequently reported as barriers to seeking safe family planning services, and for many women, gaps in knowledge about

their reproductive system and contraception were present. When the refugee's culture conflicts with the typical cultural beliefs held by the healthcare providers of the host country with whom they are interacting, participants reported feelings of ambivalence, fear, and embarrassment. Published research has also demonstrated that perceived stigma and discrimination can adversely affect one's health management (Terui, 2017).

This review emphasizes the importance of healthcare professionals avoiding cultural stereotypes or bias when providing sexual healthcare to refugees; religious and cultural identities should be acknowledged and respected, but not used to make assumptions about the person. Providing culturally sensitive nursing care means the "understanding of cultural diversity is essential to the provision of effective and safe care" (Burchill & Pevalin, 2014, p.152). As seen in the results chapter, cultural traditions had a strong influence on family planning decisions, emphasizing the importance of HCPs' roles in assessing cultural beliefs, values, and attitudes because they can greatly affect their views on health and illness (Burchill & Pevalin, 2014). Culturally competent approaches to healthcare can vary, but usually coincide with the following attributes: cultural awareness, cultural knowledge, and cultural skills (San Lau & Rodgers, 2021). The literature points to limitations of culturally competent healthcare among refugee populations as a result of uncertainty and "lack of clear definitions and operational guidance" (San Lau & Rodgers, 2021, p.124). Beyond assessing a client's cultural beliefs and traditions that may influence their health and health-related behaviors, culturally sensitive nursing care means being able to practice reflexivity by being aware of one's own cultural beliefs and background and how it may affect their approach to care (Burchill & Pevalin, 2014). According to Repo and colleagues (2017), the process of becoming culturally competent is "commonly recognized as a healthcare professional's lifelong and dynamic developmental process aimed at effective

healthcare with diverse patients" (p. 99). Thus, recommendations for future research include the exploration of HCPs cultural competence within refugee health settings and examining methods to enhance and evaluate the cultural competence models currently used in education and practice.

Linguistic Barriers

Participants in several studies (Dean et al., 2017; Gebreyesus et al., 2017; Russo et al., 2019; Verran et al., 2015) described language barriers as an obstruction to their ability to gain knowledge about contraceptive methods and safe family planning services. Linguistic barriers in healthcare settings have been associated with health disparities and negative health outcomes affecting patient-provider relationships, adherence to treatments, and patient satisfaction (Terui, 2017). Linguistic barriers can minimize the effect of health promotion initiatives specifically targeted towards migrant populations (Terui, 2017). When linguistic minority populations are unable to clearly communicate with practitioners, navigating a new healthcare system is challenging, and poorly communicating signs or symptoms can delay diagnosis of a disease (Egli-Gany et al., 2021). Effective communication has been identified as crucial element to establishing a trusting patient-practitioner relationship, especially when considering persons with diverse cultural and linguistic backgrounds (Patel et al., 2021). When a language difference is present between HCPs and client in a healthcare setting, the use of a trained, professional interpreter is recommended to reduce miscommunication between patients and HCPs (Puthoopparambil et al., 2021). Interestingly, the results of one included study showed that even when a trained professional interpreter was available, participants felt uncomfortable discussing sensitive topics such as sexual health and contraception in person if they did not have an established professional relationship (Russo et al., 2019).

Findings from a literature review exploring refugee and asylum seekers' communication experiences in primary care (Patel et al., 2021) identified how patients often prefer same-sex interpreters for translation purposes. In this literature review (Patel et al., 2021), the authors sought to explore previous literature that linked the use of informal translators with poor quality translation and issues with maintaining confidentiality. Additionally, a study conducted in Austria found that a lack of available interpreters or trained healthcare providers affected early health service utilization, subsequently increasing the chance of further follow-up costs in tertiary settings (Kohlenberger et al., 2019).

Throughout my research, I observed that linguistic and cultural barriers and facilitators were often discussed in conjunction with one another when exploring factors that influence refugee health. One scoping review exploring cultural competence in refugee settings (San Lau & Rodgers, 2021) found that actively incorporating language and culture into their health services enhanced cultural competence. This suggestion fits with my findings in that having culturally appropriate verbal, written, and visual resources accessible to refugee women regarding family planning would be beneficial to ascertain client understanding of available family planning services.

Structural Barriers

The participants in the included studies who described their personal experiences and knowledge of family planning were from countries around the globe. Some participants spent time in refugee camps in low-income countries neighbouring their home nations, while others were resettled in high-income countries far from their roots. This is pertinent because their experiences accessing family planning health services may be varied based on their geographical location and the availability and distribution of sexual health resources.

The structural barriers identified throughout the studies created significant challenges for the participants who were interested in seeking sexual health services. They described a lack of available transportation, employment restrictions and financial burdens, limited availability of trained HCPs, and lacking options for contraceptive methods. When accessing primary healthcare is difficult, there are greater risks for health complications and negative effects on health outcomes, which strain the health system (Turin et al., 2020). Ensuring that refugee women can undergo health screening and be directed to appropriate sexual health services during the early resettlement phase might decrease the potential of unmet contraceptive needs. Transportation, or a lack thereof, is shown to be associated with decreased healthcare access, with vulnerable or marginalized populations having greater transportation barriers that negatively affect their health because of missed appointments and/or delayed care and treatment (Syed et al., 2013).

In low- and middle-income countries with limited resources, the use of mobile devices has gained popularity with tailored health tools to communicate and deliver health information (Dev et al., 2019). Overcoming transportation barriers is crucial to ensuring equal access to contraceptive healthcare. Interventions such as the interactive mobile application with a decision aid (iMACC) are useful for this purpose. Though the iMACC was created to assist postpartum patients with contraceptive decision making when living in both rural and urban areas in Kenya (Dev et al., 2019), the principles are transferable – remote access to care. Of course, given the limited financial resources available to many refugee women, investment by organizations would likely be necessary.

Using mobile clinics and community outreach programs to bring healthcare to those who cannot easily access it is not a new concept. In Canada, there are over 200,000 persons who

experience homelessness and have difficulty accessing health services for reasons similar to those reported by refugee participants in my study, including: discrimination, lack of uncertainty surrounding health costs, and competing needs, among others (D'Souza & Mirza, 2021). In Canada, mobile clinics are often used to bring health services to those who cannot reach them, some examples include cancer screening, drug testing, and needle exchanges (D'Souza & Mirza, 2021). Researchers are recommending that mobile clinic programs be used for diverse health needs because they can promote health and prevent complications and illnesses among any 'hard to reach' population (D'Souza & Mirza, 2021). Similar outreach programs and mobile clinics would be effective to reduce inequities in contraceptive healthcare for refugee women residing in refugee camps or settings far from health institutions. This is an area that would benefit from future research to ensure that sustainable and fair access to care is considered in healthcare delivery and policies (Atuoye et al., 2015).

Based on this study, there appears to be a need for education to increase sexual health awareness for refugee women, as certain experiences with unplanned pregnancies were due to a lack of understanding about sexual intercourse. Previous research has shown the contraceptive knowledge gap within this population, and the nuanced factors that contribute to the ongoing disparities in accessing adequate sexual health education. Aptekman et al., (2014), for example, conducted a retrospective chart review to quantify refugee womens' unmet contraceptive needs in Canada. Utilizing the WHO's definition to identify the degree of unmet need, their results identified that refugee women had increased unmet needs and a lower prevalence of contraceptive use compared to Canadian-born women (Aptekman et al., 2014). Additionally, a recent German study (2020) found female refugee and asylum-seekers to have high unmet needs for contraception because most participants were sexually active and had no intention or desire to

become pregnant, with only 53% of participants utilizing any form of contraception (Inci et al., 2020). Although the findings of these studies highlight the presence of a knowledge gap regarding contraception for this population, there is a paucity of research on the root causes of this persistent gap, as well as how to rectify it.

In preparing this discussion chapter, I located one study reporting a decreased use of contraception among young adolescents in low and middle-income countries as a result of stigma surrounding nonmarital sex (Li et al., 2020), and another study identifying an access gap to contraceptives related to differing state-specific financial coverage for refugees and asylum seekers (Inci et al., 2020). However, based on the results of this synthesis review, many reasons contribute to the lack of knowledge surrounding sexual activity, pregnancy, and family planning (cultural taboo, religion, barriers to sexual health services, educational opportunities). It is important for HCPs to avoid assumptions regarding refugee women's previous knowledge of contraception, and to assess their exposure to comprehensive sexual health education. Research in countries such as Botswana, Nigeria, and South Africa have linked enhancing sexual health education in schools with minimize gaps in care and challenges associated with unmet contraception needs and unplanned pregnancies (Zulu et al., 2019). However, other research conducted in the African context (Zambia) highlights the discordance between programs aimed at improving sexuality education for adolescents in schools, and the disapproval of such by persons who are deeply rooted in cultural and religious traditions where they are viewed as unacceptable (Zulu et al., 2019). Understanding refugee women's specific health needs and acknowledging any barriers they face when accessing knowledge (and care) is needed to improve their overall health, as well as their integration into the new country of resettlement (Kohlenberger et al., 2019).

Nursing Implications

Below I present implications for nursing practice, policy, education, and research.

Implications for Practice

Conducting a synthesis study based on a complex topic with many influencing factors was challenging. I did not limit the inclusion criteria based on the refugee women's ethnic and religious backgrounds. This was done purposely to identify as many barriers and facilitators as possible affecting this population's contraceptive needs. However, synthesizing this information into results that can inform future guidelines and produce concrete practice recommendations to assist HCPs was not a simple or linear process – rather it was quite iterative. Although some patterns within the experiences were evident, applying universal contraception practices for all refugee women is not possible nor appropriate. Instead, gender, religion, socioeconomic status, family structures, and cultural considerations must be taken into account when speaking about contraception and providing sexual healthcare.

Periodic counselling on sexual health and investigation into the need for contraception is an identified recommendation to prevent unintended pregnancies for all women within the reproductive age group (Dunn et al., 2011). This is especially important for refugee women, who are shown to be at the highest risk for unplanned pregnancy within three months of resettlement (Dunn et al., 2011). However, as the results of this review have exemplified, there are many confounding barriers that can influence the interactions between HCPs and refugee women. Many refugee women experience competing priorities following resettlement, including finding employment and housing (Rogers et al., 2020), or learning a new language or enrolling in educational programs- affecting access to sexual and reproductive health services. Oftentimes primary care practitioners are among the first to meet newly resettled refugees, and if sexual and

reproductive health is not viewed as priority at that time, having accessible written information on preventative sexual health and family planning in their language might enhance their health literacy and knowledge, and allow them to learn at their own pace (Davidson et al., 2022).

The Canadian Medical Association Journal (CMAJ) created 'Evidence-based clinical guidelines for immigrants and refugees' (Pottie et al., 2011) focusing on preventative healthcare and improving health outcomes for this specific population. These guidelines include assessing for infectious diseases, mental health and trauma, chronic and communicable diseases, and maternal and sexual health (Pottie et al., 2011). Although these guidelines are not specific to family planning and contraceptive care, they address the importance of utilizing algorithms and checklists to ensure preventative care details are not missed and promote early screening for unmet contraceptive needs following resettlement (Pottie et al., 2011).

Upon consultation with a nurse practitioner, (who is also acting as a committee member), barriers to contraceptive care described in this review are also apparent in current practice. With such a large influx of refugees recently, health clinics in Ottawa who specialize in newcomer health care are facing challenges with over capacity. This has caused a delay for newcomers to receive their initial appointments following arrival to Canada, when contraceptive needs are often assessed. This emphasizes the need to increase the number of healthcare practitioners with this population to ensure their health needs are being met following resettlement.

Implications for Policy

Confusion regarding migrant status exists for refugees, and oftentimes, these people are aggregated with other populations, including asylum-seekers, migrants, and immigrants, especially in research. Professionals report confusion when providing care to refugees because of their limited knowledge about what health services a refugee is entitled to (Mangrio & Sjögren

Forss; 2017). In recent years, there have been several changes in healthcare coverage for refugees in Canada due to changes in funding decisions from the federal government. Refugees resettled in Canada fell under the Interim Federal Health Program (IFHP) until they were able to apply for provincial healthcare coverage (Winn et al., 2018). Between 2012-2016, changes occurred in coverage under the IFHP, causing uncertainty about health coverage and costs amongst HCPs caring for refugees (Winn et al., 2018). To reduce negative health experiences and enhance HCPs delivery of care to these vulnerable populations, policies and refugee rights to care need to be explicit and known to both service users and providers. With the growing number of refugees globally (Esses et al., 2017), increased funding aimed at preventative sexual and reproductive health (SRH) services for refugee populations is crucial. Healthcare providers can play an important role in advocating for refugee health services at an institutional level to gain more funding (Ho et al., 2019). Previous research supports a multidisciplinary approach to achieving inclusive refugee health services and creating policies (Ho et al., 2019). Stakeholders, policymakers, healthcare providers (HCPs), and researchers should work together to develop appropriate plans responding to refugees' health needs (Ho et al., 2019). Additionally, collaboration between community agencies and programs with primary care practitioners are encouraged to enhance health resource availability (D'Souza & Mirza, 2021). With the ongoing influx of refugees into Canada (Winn et al., 2018), policy-level initiatives addressing refugee sexual health are pertinent as universal and public access to SRH services has been recognized by the World Health Organization (WHO) (Davidson et al., 2022).

Implications for Education

Some participants in the included studies voiced feeling uncomfortable or stigmatized in the presence of practitioners. Others reported feeling embarrassed, shy, or ashamed approaching

the topic or responding to questions about contraception based on their cultural traditions. Finally, some participants were fearful of being judged/discriminated or felt discomfort in the presence of practitioners who were not women. Although the focus of this review was on participant experiences, these findings suggest that HCPs could also benefit from initiatives aimed at improving their cultural competence. A systematic review about accessing preventative SRH for refugee women identified the benefits of enhancing cultural competency in HCPs to reduce discrimination and improve quality of care (Davidson et al., 2022).

Cultural competency training for all HCPs in Canada has been recommended by The Truth and Reconciliation Commission of Canada (TRC) (Kurtz et al., 2018). The responsibility of embedding cultural competency and associated skills-based training into health field programs (nursing, medicine, social work, occupational and physical therapy, anthropology, pharmacy, education) has been left to the discretion of educational institutions (Kurtz et al., 2018). Research has shown an improvement in HCP's service, knowledge, and attitudes when educational initiatives included information about individual cultures and worldviews rather than general concepts (Kurtz et al., 2018). The Canadian Nurses Association (CNA) promotes cultural competence in nursing because it is an entry-to-practice level competency for registered nurses. CNA stipulated "the responsibility of supporting cultural competence is shared among individual nurses, employers, educators, professional associations, regulatory bodies, unions, accreditation organizations, government and the public" (CNA, 2010, p.2). Various methods of incorporating cultural competence training are identified across institutions in Canada, but these are, unfortunately, inconsistent (Guerra & Kurtz, 2017). Some schools have embedded a framework across their curricula, while others have implemented training programs for educators or yearly cultural workshops (Guerra & Kurtz, 2017). While the literature largely describes cultural safety

and cultural competence initiatives towards bridging gaps in healthcare between Indigenous and non-indigenous Canadians (Guerra & Kurtz, 2017), the ultimate goal is to improve the provision of healthcare in a culturally respectable manner. Educational opportunities to enhance cultural awareness and cultural safety for students and HCPs should be made readily available to improve refugee health. The literature has recommendations such as ensuring skills training are developed specifically for HCPs while also offering diverse modules of training such as web-based programs and distance education resources (Matlin et al., 2018).

Implications for Research

Based on this study, greater integration of intersectional approaches to examining and understanding gender, sex, and health and their influences on family planning would be beneficial. Research assessing how social and political oppressions affect refugee women's health is pertinent. Many challenges exist when attempting to engage refugee women in research initiatives, but their participation is necessary to improve the current state of healthcare practices. Advancing refugee women's health research should be a priority, as it has advantages for both the participants (improved healthcare) and the host countries (decreased healthcare costs long-term, refugees engage in economic growth) (Al-Hamad et al., 2022).

While conducting the literature search, other studies included different participant groups when exploring contraception knowledge and uptake. For example, in some studies adolescent boys, or single and married men were interviewed to gather their perspectives on family planning health services. Although this study focused on refugee women within the reproductive age-group, the results shed light on the importance of building on refugee health research by including viewpoints from other genders/gender minorities and age-groups (adolescents, men, spouses, LGBTQ2S+), as well as the factors that influence their family planning decision-

making. Scarce research exists addressing gender minorities with refugee status. Although undocumented migrants were not included in this synthesis, they are also an important group to consider because they face significant health challenges and decrease access to sexual health resources (Kerani & Kwakwa, 2018).

A narrow focus on refugee women and contraception was surprisingly rare in the existing body of literature, as such it is difficult to make concrete conclusions about the topic. Language barriers might prevent refugee women from participating in research, which could explain why a significant portion of the literature retrieved through the search was from physician perspectives. Researchers interested in this area should prioritize both the voices of the women living this reality, as well as the various other HCPs who also support them in their integration process (not just doctors).

Academia plays an important role in advancing research in refugee health. As new knowledge is communicated, researchers can share responsibility with other HCPs, policymakers, funders, and the public to promote and advocate for refugee health (Matlin et al., 2018). Research focusing on improving the provision of refugee health in other health disciplines, such as social work or education, would be necessary with the continuous influx of refugees globally. New knowledge can assist in the production of evidence-informed policies and funding opportunities (Matlin et al., 2018; Al-Hamad et al., 2022).

Limitations of Thesis

There are several limitations to consider when using the findings of this review.

First, although I defined refugee and asylum seeker status prior to initiating the systematic search, it was challenging to ensure that each study met our inclusion criteria. As previously explained, I attempted to contact authors for clarification, but not everyone

responded. The omission of studies where authors did not respond might limit the applicability of my findings, if new ideas were articulated in those studies, and therefore not embedded in this scoping review. However, with the range of migrant statuses and how each migrant status can affect one's health and experiences differently, I did not want to conflate ideas by not being sure that all participants were in fact refugee women.

A second limitation is the length of time it took to complete this review, as well as reality that only one reviewer (me) completed some steps typically requiring two people. Specifically, I did not involve a second person to undergo the study search, study selection, and data extraction, although my thesis supervisor provided oversight to these steps. If I were to pursue publication of this study, I would update my search and re-run it, while asking a second reviewer to independently review the above steps.

Third, this study was originally designed to include a consultation with stakeholders to compare the review findings to the local Ottawa context. Due to the COVID-19 pandemic, I was unable to complete the original plan.

Fourth, it is important to recognize that this study's inclusion criteria were restricted to research published in English and French. It is possible that I missed pertinent knowledge from research conducted in other languages. Additionally, the omission of grey literature might have contributed to this.

Conclusion

This scoping review mapped existing qualitative research about refugee women's' knowledge and access to contraceptive heath care services. Twenty-eight studies were retained from fifteen countries around the world. The categories embedded within The Integrated Framework of Health (IFH) were utilized to understand the social characteristics, risk and protection factors, psychosocial factors and health status indicators that influence family planning within this population. Participants voiced concrete examples of how they viewed family planning, and what services they lack, which contribute to unmet contraceptive needs. Refugee women experienced forced migration is various ways and are at an increased risk for decrease sexual health outcomes given the challenges they face, such as gender discrimination, limited resources, and language barriers. Research from other refugee populations (women's partners, adolescents, non-binary) and health professionals viewed through the lens of intersectionality would be valuable to inform future practice and policy.

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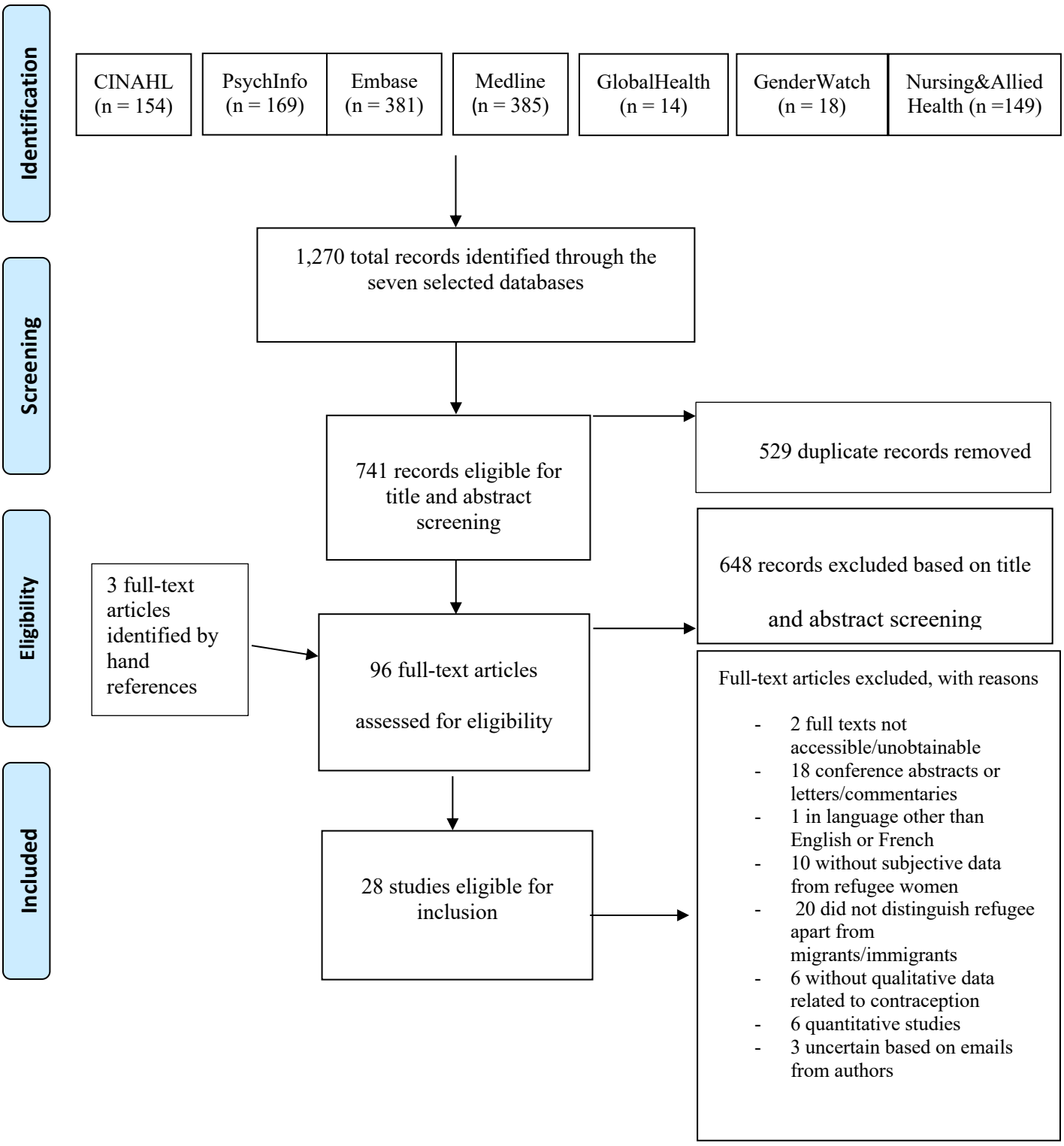
Appendix A

PRISMA 2009 Flow Diagram



Appendix B

Study Characteristics

ID#	Author	Year	Country	N	Study Design	Qualitative Data Collection	Data Analysis	Theoretical/ conceptual Framework	Research Question/ Objective
1	Agbemenu et al.	2018	USA	30	Qualitative descriptive	Focus groups	Qualitative content analysis	NR	To elicit Somali Bantu women's perspective on factors that influence reproductive health decisions through the directed exploration their experiences.
2	Asnong et al.	2018	Thailand-Myanmar Border	20	Qualitative	Interviews Focus groups	Inductive thematic analysis	NR	To better understand the knowledge of adolescent pregnancy, and sexual and reproductive health of the community and family along the Thailand-Myanmar border.

3	Benner et al.	2010	Thailand	19 (397)	Mixed methods	Interviews	Analysis by framework approach as reported by authors	NR	To assess young Burmese refugee's reproductive health information, knowledge, attitudes, beliefs, resources, and their quality of life in long-term refugee camps in Thailand.
4	Cherri et al.	2017	Lebanon	108	Qualitative	Focus groups	Inductive thematic analysis	NR	To assess and understand the sexual and reproductive health needs of Syrian refugee women, including marriage perceptions and behaviors.
5	Davidson et al.	2016	Ethiopia	117	Qualitative	Interviews Focus groups	Thematic analysis	NR	To explore the family planning beliefs and practices of Ethiopia's Somalian and Eritrean refugee women.
6	Dean et al.	2017	Australia	11	Qualitative-exploratory, descriptive	Interviews Focus groups	Thematic analysis	Integrated Behavioral Model (IBM) by Fishbein	To explore the sexual health knowledge, attitudes, and beliefs of young Sudanese refugees living in Queensland.
7	Dhar et al.	2017	USA	14	Qualitative-Exploratory	Interviews	Inductive thematic analysis-using constant	NR	To examine the attitudes and beliefs towards sexual and reproductive health of young,

							comparison method		unmarried, Bhutanese refugees.
8	Gebreyesus et al.	2017	Israel	44	Qualitative	Interviews Focus groups	Thematic analysis	McLeroy's Social Ecological Model	To understand the structural barriers associated with contraception for Eritrean asylum-seekers.
9	Gedeon et al.	2015	Thailand	31	Qualitative	Interviews	Thematic analysis	NR	To understand the perceptions and experiences that Burmese women have with an IUD in order to improve contraceptive services along the Thailand-Burma border.
10	Gee et al.	2019	Kenya	207	Qualitative	Interviews Focus groups	Thematic analysis	NR	To understand the lived experiences of refugees surrounding their beliefs and practices with reproductive, maternal, and newborn health.
11	Ivanova et al.	2019	Uganda	23	Mixed methods	Interviews	Descriptive statistics Thematic content analysis	NR	To explore the sexual and reproductive health knowledge, experiences, and access to health services of adolescent refugee girls living in Uganda.
12	Kabakian-Khasholian et al.	2017	Lebanon	84	Qualitative – Exploratory	Interviews Focus groups	Thematic analysis	NR	To understand the fertility behaviors and the associated provision of health care services of

									refugees in conflict settings.
13	Kaczkowski & Swartout	2019	USA	12	Qualitative	Interviews Focus groups	Thematic analysis	NR	What do young refugees know about sexual health (STIs, contraception, sexual health facilities available in their community)? Are there differences between young refugee men and women in terms of their knowledge? How do young refugees access sexual health information? Do young refugee men and women use different sources of information? What are the barriers to young refugees seeking sexual health services and information? Do young refugee men and women experience different barriers for accessing services and information?
14	Keygnaert et al.	2014	Belgium and the Netherlands	135	Qualitative methods as part of a community-	Interviews	Framework Analysis Technique	1.Human rights perspective adapted by WHO	To explore how refugees, asylum-seekers, and undocumented migrants define sexual health, and

					based participatory research project			2.Socio-ecological perspective on health and violence 3.Desirable Prevention	how they seek associated services, and identify the risk and protective factors applicable to this population.
15	McMichael & Gifford	2010	Australia	75	Qualitative	Interviews Focus groups	Thematic content analysis	NR	To explore how resettled youth access, view, and interpret sexual health information, with a focus on risk and protection and how social contexts influence understanding and attitudes.
16	Nara et al.	2020	Uganda	21	Multi-methods assessment - Qualitative	Interviews Focus groups	Thematic content analysis	NR	To explore the sexual and reproductive health experiences, needs, and opinions of Congolese refugees.
17	Okanlawon et al.	2010	Nigeria	116	Mixed methods, Descriptive qualitative	Interviews	Thematic analysis	NR	To understand the family planning needs, knowledge, attitudes, practices, and the barriers that exist to accessing contraceptive care for refugee youth.
18	Pavlish et al.	2010	USA	57	Qualitative	Interviews Focus groups	Inductive thematic analysis	Socio-ecological framework	To explore the health concerns for Somali immigrant women and girls and understand the health experiences of

									Somali women as they manage their health.
19	Pell	2017	Israel	12	Qualitative	Interviews	Thematic analysis	1.Conception influenced by anthropological theory 2. R.W. Connell's theory of gender regimes	To examine the reproductive desires and outcomes of Palestinian women and understand the influencing factors that are contributing to the decline in fertility rate.
20	Royer et al.	2019	USA	66	Qualitative part of a mixed methods ethnographic study	Focus groups	Modified grounded theory analysis	Reproductive Justice Framework	To assess the needs, attitudes, beliefs, and practices towards family planning in Somalian and Congolese women resettled in the U.S.
21	Russo et al.	2019	Australia	57	Qualitative	Interviews Focus groups	Thematic analysis	Socioecological Model of Health – applying the cultural studies notion of "trans-culturalism"	To explore the experiences associated with family planning of Afghan refugee men and women resettled in Australia.
22	Salisbury et al.	2016	Thailand	120	Mixed methods-Qualitative aspect	Interviews Focus groups	Thematic analysis	NR	To identify the family planning knowledge, attitudes, and practices of refugee and migrant women alongside the Thailand-Myanmar border.

23	Svensson et al.	2017	Sweden	9	Qualitative	Interviews	Thematic content analysis	Nutbeam's conceptualisation of health literacy	To explore the experiences that resettled refugees have with exposure to health education regarding sexual and reproductive health and the contributing factors to sexual and reproductive health rights and literacy.
24	Tanabe et al.	2015	Kenya Nepal Uganda	287	Qualitative-participatory methods	Interviews	Content analysis	NR	To explore the knowledge of the reproductive system, barriers to accessing SRH care, perceptions of caregivers, and impact of stigma of refugees with disabilities in three locations.
25	Ussher et al.	2012	Australia	42	Qualitative	Focus groups	Thematic analysis	NR	To examine the lived experiences and constructions of sexual and reproductive health, and associated health services in two distinct groups- Assyrian and Karen women resettled in Australia.
26	Verran et al.	2015	UK	10	Qualitative	Interviews	Thematic analysis	NR	To explore Chinese asylum-seekers knowledge and experiences with family planning after resettling in the UK.

27	West et al.	2017	Jordan	16	Qualitative	Interviews	Thematic Framework Analysis	NR	To explore factors that influenced the facilitation or limitation of accessing family planning services in a refugee camp.
28	Zhang et al.	2019	U.S.	53	Qualitative	Focus groups	Grounded theory: Constant Comparison Approach	NR	To explore Somali women's knowledge, attitudes, and experiences with birth spacing and contraception after resettling in the U.S.

Appendix C

Participant Characteristics

Study ID	Number and Age Of Women	Country of Origin (COO)	Current location & Years	Marital Status	Number of Children	Religion/ Ethnicity	Education	Occupation
1 **Agbemenu et al., 2017**	Total women in the study: 30 18-35: 12 36-55: 14 55+: 3	Somalia or Kenya (Kakuma and Daadab)	USA Less than 10 years: 6 More than 10 years: 23 Missing years of relocation: 1	Married: 16 Single: 10 Divorced, separated, or widowed: 4	0-2: 4 3-5: 16 6-8: 9 9+: 1	Muslim: 30	Primary school or less: 12 High school (did not graduate): 6 High school graduate: 2 College or University or Trade: 1 None: 6	Farming: 17 Healthcare: 1 Education: 1 Business: 1 None/Other: 8
2 **Asnong et al., 2018**	Total women in the study: 26 Interviewed : 20 FGDs : 6 non-pregnant adolescents	Myanmar (Burnma)	Thailand	Married: 20	NR	NR	1-4 years in school: 11 5-10 years in school: 6 11+ years in school: 1	Farming: 13 Household: 2 Shop: 2 Home caregiver: 1 None: 2

	13 yo : 1 14 yo: 1 15 yo: 6 16 yo: 7 17 yo: 5						None: 2	
3 **Benner et al., 2010**	Total women in the study: 182 Total women surveyed: 15-19: 122 20-24: 60 Women interviewed: 12 Of the interviewed women age range was 15-24 yo Data presented here is from survey with all women	NR	Thailand	Total women surveyed: Single: 127 Married: 55 Of the interviewed women: Married: 4 Unmarried: 8	Total women surveyed: NR Of the interviewed women: NR explicitly	Total women surveyed: Buddist: 29 Baptist: 124 Roman Catholic: 18 Islam: 2 Seventh Day: 7 None: 0 Of the interviewed women: NR explicitly	Total women surveyed: Currently in primary school: 26 Currently in secondary school: 74 Finished/stopped primary school: 24 Finished stopped secondary school: 48 Of the interviewed women: 4 left school as soon	Total women surveyed: NR Of the interviewed women: NR explicitly

							as they were married	
4 **Cherri et al., 2017**	Total women in the study: 108 15-18: 11 19-24: 24 25-35: 52 36-49: 21	Syria	Lebanon	Single: 9 Married: 99	0-2: 61 3-4: 23 >5: 24	NR	Primary school or less: 44 Secondary or Preparatory school: 51 College or University or Trade: 5 None: 8	NR
5 **Davidson et al., 2016**	Total women in the study: 77 between the ages of 18-44 y Total women interviewed: 10	Eritrea Somalia	Ethiopia Residing within Ethiopian refugee camp > 6 months	Married: 77	Mean number of children for Eritreans: 2.9 Mean number of children forSomalians: 4.6	Christian Islam	NR	NR
6	Total women in the study: 6 aged 19-24	Sudan	Australia	Stated majority single	Women with	Christian: 6	Stated majority studying a	NR

Dean et al., 2017			# of years residing in Australia between 4-8	No numbers reported	children (no #): 3		vocation or at a university Specifics NR	
7 **Dhar et al., 2017**	Total women in the study: 14 aged 16-20 yo	Born in refugee camps in Nepal	USA	Never married	Never pregnant	NR	NR	NR
8 **Gebreysus et al., 2020**	Total women in the study: 26 between the ages of 18-49 years old In-depth interviews: 6 women between the ages of 21-30 yo FGDs: 20 women Socio-demographic was not collected for them.	Eritrea	Israel # of years residing in Israel between 1-6	Married: 4 Single: 1 Divorced: 1	No children: 2 1 child: 3 3 children: 1	NR	Completed middle school: 2 Completed high school: 4	6 women worked in informal sectors

	Women in the FGDs were not the same as the ones in the interview							
9 **Gedeon et al., 2015**	Total women in the study: 31, age ranging from 21-55 yo. 21 out of 31 were refugees, the other migrants.	Burma	Thailand	Married: 31 Single: 0 Divorced: 0	At least 1 child: 30	NR	NR explicitly, Just stated various educational backgrounds	NR explicitly, just reported various "histories in the labor force"
10 **Gee et al., 2019**	Total women in the study: 57, not including the grandmothers. FGDs were done with "mothers, fathers, grandmothers, and birth attendants. In-depth	Somalia	Kenya	NR	NR	NR	NR	NR

	interviews were done with key informants.							
11 **Ivanova et al., 2019**	Total women in the study: 260 girls aged 13-19 yo who responded to the questionnaire 23 of which did a qualitative interview	DR Congo Burundi Rwanda Ethiopia Somalia Uganda (refugee born in Uganda) South Sudan Tanzania Eritrea	Uganda In Uganda for: Less than one year:11 1-5 years: 135 >5 years: 96 Since birth: 16 Unsure: 2	NR	NR	Protestant: 167 Catholic: 45 Jehovah's witness: 32 Orthodox: 8 Muslim: 6 Traditional: 2	Currently in school: Yes: 165 No: 95 Completed Primary: 185 (71%) Completed Secondary: 67 (26%)	NR
12 **Kabakian-Khasholian et al., 2017**	Total women in the study: 84 between the ages of 18 to 45 Interviews only done with HCP	Syria	Lebanon	Married: 84 (all)	# of children per woman in each FGD 18-25: 0-8 1 pregnant 26-35: 1-8 1 pregnant	NR	18-25: Elementary:5 Secondary: 9 University: 8 Other: 2 26-35: Elementary: 5 Secondary: 8 University: 6 Other or N/A: 10	NR

					36-45: 1-13 0 pregnant		36-45: Elementary: 6 Secondary: 7 University: 0 Other or N/A: 14	
13 **Kaczkowski & Swartout, 2019**	Total women in the study: 12 women between the ages of 18-24 yo 18-19: 6 20-21: 6 22-24: 0	Burma/ Myanmar: 5 Central African Republic: 2 DR Congo: 3 Somalia :2	USA Residing in the USA for 1-2 years: 7 3-4 years:5	Married: 0	Children: 0 (none had children)	NR	After resettlement: High School (In progress): 6 High School (Completed): 4 College (In progress): 2	NR
14 **Keygnaert et al., 2014**	Total women in the study: 135 women (including 2 transsexuals from Belgium)	Afghanistan Common Wealth of Independent States (CIS) Iraq (including Kurds) Iran (including Kurds) Slovakia & Czech	Belgium Netherlands	*not distinguished between men and women	NR	Christian Islam	Education levels vary from none to university level *not distinguished between men and women	*not distinguished between men and women

		Republic (Roma) Somali						
15 **McMichael & Gifford, 2010**	Total women in the study: 75 between the ages of 16-25 Women included in in-depth interviews: 8	Iraq Afghanistan Sudan Liberia Ethiopia Burma	Australia Residing in Australia between 1-5 years	NR	NR	NR	Reported participants "both attending and not attending school"	NR
16 **Nara et al., 2020**	Total women in the study: 36 women in FGDs aged 15-48 yo 21 in-depth interviews (IDIs) with women aged 15-49 yo	Democratic Republic of Congo (DRC)	Uganda	FGD: Married:16 Single: 20 IDIs: Single: 4 Married: 9 Widowed: 8	NR	NR	Nursery school to 8th grade: 3 Some high school, no diploma: 7 High school graduate:5 Some university credit, no degree:1 Trade/technical/ vocational training:2 Bachelor's degree:2. Post-graduate degree:1	NR

17 **Okanlawon et al., 2010**	Total women in the study: 116 aged 10-24 yo 10-14: 11 15-19: 76 20-24: 29	Liberia Sierra Leone DRC Other African countries	Nigeria Residing in the Nigerian refugee camp between 1-20 years	Single: 107 Married: 9	NR	Christian: 102 Islam:14	No formal education: 6 Primary: 7 Secondary: 91 Post-secondary:12	NR
18 **Pavlish et al., 2010**	Total women in the study: 57 women between the ages of 18-80 yo	Somalia	USA Residing in the USA between 1 week to 20 years	NR (data from this study is detailed in another study that is not included in this synthesis as per the information emailed to us by the author)	NR	NR	NR	NR
19 **Pell, 2017**	Total women in the study: 14 women between the ages of 18-84 yo. 12/14 women were documented as being within	West Bank Palestine	Israel	Married: 12 Unmarried: 2	No children: 2 1-3 children: 3 4-6 children:5	NR	NR	NR

	childbearing age. 2 participants were over the age of 80				>6 children: 3 Pregnant: 1			
20 **Royer et al., 2019**	Total women in the study: 66 between the ages of 18-68 yo Somalian women: 41 Congolese women: 25	Somalia DRC	USA	NR explicitly	NR explicitly	NR explicitly	NR explicitly	NR explicitly
21 **Russo et al., 2019**	Total women in the study: 18 between the ages of 23-43 years 10= women in interviews 18 = FGDs	Afghanistan	Australia, living there between 4 months to fourteen years	All married (part of the inclusion criteria)	Between zero and six children, women had a mean of 2.75 children	Hazara ethnicity Pashtu Tajik Sadath Afghan	22% of women reported completing any schooling beyond primary school	NR explicitly
22	Total women in the study:			All demographic data only	NR explicitly	NR explicitly	NR explicitly	NR explicitly

Salisbury et al., 2016	120 in the FGDs	Thailand-Myanmar border	Thailand-Myanmar border	reported for the information collected through cross-sectional survey				
23 **Svensson et al., 2017**	Total women in the study: 9 between the ages of 24-38	Syria Jordan Iraq Afghanistan Somalia	Sweden, resettled between 4 and 18 months	Married: 6 Not married: 3	NR explicitly	Christian (2) Muslim (7)	Basic Education (greater or equal to 9 years):4 Medium Education (greater or equal to 12 years):2 High education (greater or equal to 15 years): 3	NR explicitly
24 **Tanabe et al., 2015**	Total women in the study: 185 between the ages of 20-49 years	Somalia, South Sudan, Ethiopia, Democratic Republic of Congo (DRC), Sudan, and Burundi Bhutan Rwanda, Ethiopia, Eritrea	Kenya Nepal Uganda	NR explicitly	NR explicitly	NR explicitly	NR explicitly	NR explicitly

25 **Ussher et al., 2012**	Total women in the study: 42 between the ages of 18-78 years	Iraq (Assyrians) Burma-Thailand border	Australia, resettled between 3.5-7.5 years	Single: 14 Married: 24 Engaged: 1 Widowed: 3 Other: 1	Participants had an average of two children	Christian Buddhist	Participants had an average of 10 years of schooling	NR explicitly
26 **Verran et al., 2015**	Total women in the study: 10 between the ages of 26-41 years, average age being 34.2 years	China	UK, average years of resettlement being 8.4 years	NR explicitly	All participants had two or more children	NR explicitly	NR explicitly	NR explicitly
27 **West et al., 2017**	Total women in the study: 16 women between the ages of 18-43 years	Syria	Jordan	All participants were married and living with their husbands, except for one woman whose husband	Six women had one child; four women had more than three children	NR explicitly	All participants completed a minimum of elementary school	NR explicitly

				returned to Syria				
28 **Zhang et al., 2020**	Total women in the study: 53 women, average age of the women was 35, with only two women were under the age of 20, and 19 women thirty-five years or older	Somalia	U.S, average years of resettlement being fifteen years	Married: 36 Unmarried: 17	No children: 17 1-2 children: 13 3-5 children: 16 More than 5 children: 7	Muslim	Less than high school education: 9 Some high school education: 17 More than high school education: 24	NR explicitly

Appendix D

Categories/Themes and Sub-categories/Sub-themes From the Qualitative Studies

Study ID	Category(sub)/ Themes (sub)	Description	Representative Quotes
1 **Agbemenu et al., 2017**	1. My children are my wealth: Factors in reproductive decision making		"Some men, they don't like it, but some men, they say go ahead, take it" (p.3358) "That's a problem. But when you see that, you are a grown woman. You don't have to listen what he say, do whatever good for you" (p.3358)
	a) Family Influence	The women describe family influences to affect their decision to use family planning methods and decide spacing and number of children they will conceive. Some stated their husbands were not supportive of contraception, while others looked towards a collaborative approach to family planning decision-making as a couple	"But some of them, they don't wanna wait that long. They just like you [act as if you are] wasting their time if you wait any longer" (p.3358) "You keep your secret inside your heart and then you don't tell your husband" (p.3358) "If you have help for you, if he's helping you, it's good, have baby. But no help at home, you cannot have more baby—I'm so sorry" (p.3358) "When two people make [the decision] together, there will be a solution" (p. 3359)

b) Culture/Religion	Culture and religion were frequently mentioned simultaneously by many women. Cultural traditions and what are considered to be taboo, as well as their religious standpoint, have a large impact on family planning and whether they choose to use birth control or not.	"She should say, 'husband it's good for us this, it's better for [our family]" (p.3359) "All of us, we still want to have more" (p. 3359) It's hard on our heart each time you see your child is growing you say you need to give birth to another one. For me right now I want to give birth so bad, but they are not coming. All my children are like old, only one who is a little bit younger, but I want more" (p. 3359) "When you are still young, you are not allowed, in my tradition, to say, 'I will not have another baby.' That is forbidden. Don't say that, because you are still married, you have your husband. Anything can happen, whether it is intentional or not intentional. Anything can happen" (p.3359) "I cannot say that I don't want to give birth; that's like a taboo, people from my culture" (p.3359) "As always, our life is covered by not only tradition, most of the thing we do is [driven by] religion" (p.3359) "You give birth until we believe in God until God say that maybe [the children] is enough for her" (p.3359)

		"If you pray, then Allah will give your time [spacing between children]" (p.3359)
c) Experience with family planning methods	Women described experiences with different methods of family planning to affect their decision to use contraception or not. Many women had knowledge regarding different methods, while some women experienced side effects, and others viewed contraception in terms of child spacing. These experiences had an impact on contraception use and advice they would give to other women	"It's when you take your baby, they shave the hair. And then after that, when I come back from there, I start my menstruation will come. And when it comes, I'm ready to give—to get another baby. That will be after two years. Another woman also explained this that tradition of spacing, I have to breastfeed and sit for like two years without having any problem. After two years there is a traditional thing, they call Mighazi (p.3359) "[it was an] agreement between husband and wife so that we can raise the baby. And then when the baby is two years, and then we go ahead and have another one. But when we got here, we followed the doctor's advice. They said after you have a baby, you have to use family planning. Otherwise, you will get pregnant sooner "(p.3359) "Back home we didn't use to use this family planning, What we used to do is when we have a baby, when we are crying like to get close to each other like enjoyment [sexual intercourse], it doesn't pour you know it goes outside [with- drawal] until the baby sometimes 2 years old or sometimes 3 years old. We have our special, we have a special towel we use for that and the husbands know, and that's how we use to raise our children so

	that they don't get closer to each other [birth spacing]" (p.3359) "The benefit in the family planning is, first, you don't get pregnant. And the second time, you have a lot of time to spend with, with your husband and other family. If you don't space your children all the time, the children will be clinging on you. You know, when a child is young, they need more attention. So, all those are the benefits of family planning" (p. 3360) "I will never use the family planning, because I already know what works with my body or positive, this idea of family planning is not good for our bodies" (p.3360) "I use six injections. So now I decide to stop, because I always have heavy menstruation. It is heavy, and it doesn't stop for a while" (p.3360) "To me, family planning is good. Currently, I use the injection. I don't have any bleeding problem. I can use them up to six or seven. As soon as I stop using them, and then I get pregnant. I don't have any problem with family planning. I don't bleed a lot. My, my menstruation is coming normal" (p.3360) "People are different. You know, there are those who are using the injection, and they

			don't have problem with that one. And there are those who are using injection, they get problem, spotting, bleeding heavy, different stuff" (p.3360) When thinking about IUD process "I'm going to be naked, someone's going to be looking at me or going to be doing something on me. . .I start not to feel comfortable" (p.3360) "I heard from somebody saying that sometimes it gets lost in your body" (p.3360) "I go with the calendar or withdrawal; my husband will do it outside" (p.3360) "I used the pills, but this pill didn't help, and at the end I got pregnant" (p.3360)
2 **Asnong et al., 2018**	Getting Pregnant a) Too young b) Marriage c) Planned or unplanned pregnancy? d) Contraception e) School dropout	A + B) The authors describe the various factors that both refugee and migrant adolescents stated have an influence on their views of getting pregnant. All adolescents in this study stated they were too young to get pregnant and said an age closer to 20 would have been better. Premarital sex is very sensitive, and many end up marrying because they got pregnant.	"Some end up getting pregnant because they indulge themselves in the wrong track in their lives" (p.6) "I didn't plan for this, my pregnancy, but it just happened. And my husband told me that we would not get pregnant until we were financially doing well. If we have the baby now, both for us and for the baby, we'll be in trouble. My mother has to live with her husband and if she wants to help me or give

	C) Only two migrant girls in the study used contraception before getting pregnant. The rest of the pregnancies were unplanned, and no contraception was being used, or was not being used properly (irregularly). Some Muslim women use religion as an explanation for the unplanned pregnancy.	me money, she needs to get permission from my stepfather. When I feel sad, I have to make myself feel better, because I cannot talk to my mother anymore." (p.6) "It is just the way it is because God gives blessings to them for their pregnancies." (p.7)
	D) Contraception is still taboo for many in the setting where this study takes place, as well as SRH as a whole. There is a quote the authors included from a staff member who describes that many adolescents feel embarrassed talking about family planning, and their families feel that speaking about SRH can corrupt young minds. SRH teaching in camps is limited to menstruation, puberty, and pregnancy. Young girls will seek information about contraception from friends, family members, or neighbours. Seldom mentioned seeking information from a reliable HCP. Other adolescents who have heard about contraception, have misconceptions about it, or did not take it properly. While some staff refuse to provide the contraception that is available at an antenatal clinic (condoms, pills, injectable hormones) to girls who are unmarried. Other adolescent girls still hesitate because of the stigma surrounding being sexually active before marriage.	"In school I only learned about menstruation and the boys laughed about this when the girls were explained" (p.7) "We don't feel comfortable to talk about this with our mothers: without getting married, talking and discussing with our mothers about this is a bit … our mothers may think that their daughters are pregnant ... we will end up being scolded." (p.8) "Umm... I have heard that taking contraception pills can sometimes lead to uterus contraction, and a girl can no longer conceive a baby after that." (p.8)

			"They seem to only give medications and condoms to the married couples. If some of them are still in school, they wouldn't be given anything to prevent pregnancy." (p.8) "I feel shy for getting a condom, we feel a bit uncomfortable to get condoms from the health-workers working in our villages." (p.8)
3 **Benner et al., 2010**	1. Knowledge of reproductive health issues	Many women and girls in the study stated they were informed about their bodies from their mothers. Many reported not knowing that pregnancy could happen after their first-time having sex.	"I got pregnant when I was 14 years because I did not know when I had my first sexual relationship that it could result in pregnancy; that is why I got pregnant." (p.6)
	2. Quality of life	The author uses this theme to identify how the quality of life in a refugee camp is extremely limited for young adults. Financial constraints, lack of opportunity for education, and premarital sex can lead to young and early marriages, which can then hinder further opportunities for education. Many adolescents, both male and female, lacked knowledge that sex can lead to pregnancy.	"I did not know that first sex can result in pregnancy, but my husband knew; but he said he really loves me and that's why we did not use any contraception. I did not want to have children at that time, but I got pregnant." (p.6)

4 **Cherri et al., 2017**	1. Pregnancy behaviors and perceptions	Many newly married couple did not use contraception after getting married, nor did they want to wait to have children, or else the families would think that "something is wrong with his wife and would encourage the husband to re-marry. Many believed that using contraception could cause infertility, or that delaying pregnancy should not be decided on by the woman. For some women, they would only discuss the use of contraception after already having a few children.	"(Gtting pregnant) directly is better. (If her pregnancy) got delayed by two months (after marriage), she is a bit late. A woman cannot take any contraceptive or family planning method when she first gets married. She does not have the will to delay pregnancy. She (also) cannot agree (with her husband) to wait for four months or one year before getting pregnant; no (she cannot)." (p.7)
	2. Family planning behavior and perceptions	The various methods of contraception being used by Lebanese women in this study were: contraceptive pills, injectable hormones every three months, the IUD, withdrawal method, rhythm method, and breastfeeding. The most common methods of contraception being used were the pills and the IUD. Many used breastfeeding, the withdrawal method, and the rhythm method because they believed it to be the least harmful ways for family planning. Most women stated that they were using the contraceptive method that was best suited for them.	"If the woman does not want to use a (contraceptive method) that messes with her

		Barriers to contraception included husband's disapproval of use, the lack of availability of a preferred method, or the lack of knowledge that a certain method was available at an affordable cost for refugees. All the women in the study stated that religion was not a barrier to use, but that the side effects of contraception on their bodies is a barrier. Women reported excessive bleeding, back pain, depression, irregular menstruation, anger, or anxiety as a side effect. Some women were not aware of what condoms were. The author describes the knowledge these women had in regard to accessibility. Many women sought contraception from private doctors, the pharmacy, or a primary healthcare clinic. For some women, family played a large role in contraceptive behavior, where if their husband did not agree, they could not use contraception.	hormones, (she suggests the condom to her husband). The final decision is taken by the husband. He either uses a condom or he does not." (p.8)
5 **Davidson et al., 2016**	1.Attitudes towards family Size a) Ideal family size b) Birth spacing	Family size was largely guided by cultural, religious, and social norms. For many, birth spacing was acceptable and valued.	''Our Somali community wishes in having birth with many children. Our culture and our religion both are encouraging in having birth of more children.'' (p. 1701)

		‘‘Our religion says 2 years is the best, to have healthier mother and child.’’ (p.1702)
2. The effect of IRC education on family planning beliefs	The IRC (International Rescue Committee) held several campaigns, and many in this study were aware of contraception as a result of this. Different contraceptive methods including pills, condoms, copper IUD, and a subdermal contraceptive implant were made available to refugee women for free, and this initiative helped reduce misconceptions surrounding contraception. In this study, the population was open to receiving more accurate knowledge and education surrounding family planning.	‘‘I myself did not know it until the IRC social worker came and teach us. After that I knew it and went to the center.’’ (p.1702) ‘‘I have two children the first one exceeds one year than the other, now there is a development because we use pills or injection. Thanks for IRC.’’ (p.1702)
3. Participants’ general and LARC- specific contraceptive attitudes and practices a) General attitudes towards contraception	For many, their general attitudes towards contraception was to use for birth spacing, not to limit or choose family size. Many women therefore saw contraception as beneficial. Somali women were less open to modern contraceptive methods than the interviewed Eritrean women in this study. Religious views regarding the use of contraception vary. However, breastfeeding as a method to use for birth spacing was widely acceptable.	‘Family planning is spacing children from three to 4 years differ- ence. We can say this is family planning.’’ (p.1703) “Now we have... this family planning... we would like to have family planning at this time. So people in this camp need/want to have children with plan. Everything is told to

		us, so we know it. This is the present situation of the camp. "(p.1703)
		''They like it. All women took injection or pills. No one hate it.'' (p.1703)
	Many had concerns about the side effects of implants such as irregular bleeding, headaches, or weight-gain. In comparison to Eritrean women, Somali women in this study expressed more barriers (religion and cultural) to using an implant as a method of contraception.	'You can use birth control, but you had better use natural methods not artificial methods.'' (p.1703)
		''Religion leaders (sheikhs) say it is good to have a time interval between two children... they preach us to use the oral contraceptive pills and injection.'' (p.1703)
b) Contraceptive implant		'My religion doesn't allow me to control the birth.'' (p.1703)
	Many were not aware of the IUD, and once it was explained, they felt that many within their community would not adopt this method, keeping long-term effects on their bodies in mind. Many believed it could cause infertility, and contraceptive methods with shorter usage or that were not long-term were more acceptable in both the cultural and religious context.	'I hear that it [implant] is the best while they were telling us; I mean it is preferable.'' (p. 1703)
		"I meet other who have different idea than me; they say to me, ''What do you need implant? If you die while implant is with you then you will be in the hell.'' However, my husband and I agreed to use this method." (p.1703)
c) IUD		"My husband told to me leave implant because our religion does not allow it, then if

	I disagree with him our family will destroy" (p.1703) "We heard this method, from the health staff, but, it is not effective and we do not know why, we are in confusion, people who took it became pregnant." (p.1703) "We heard it but it is impossible to us because it is a long term. "(p.1704) "I do not know the time of intrauterine device takes, so I may die before having any child. "(p.1704) "This is very difficult contraception method to use, besides waiting 10 years; people cannot accept waiting in 3 years, particularly in the Somali com- munity. I do not belief that refugee women in this camp will accept this kind of birth control ever. "(p.1704) "This device goes inside a women uterus, sometimes it can bring cancer disease, it can bring other side effect such like removal of the uterus because of different problems from inserting it inside the uterus at the beginning and this object stay there for at least 10 years' time. No one will use this instrument except a failure person." (p.1704)

			"As you would expect, this method of birth control creates me hopelessness, Allah gives us donations, this method takes a very long time, I feel a very big misery. "(p.1704)
6 **Dean et al., 2017**	1. Young people have more freedom	The opportunity to now be in another country has helped many gain more knowledge and access to SRH information.	"The main problem is ... they started having sex ... young and they don't use protection. They don't have knowledge about the sexual diseases. They need to get educated about that." (p.23)
	2. Attitude to talking about sex is more open	Many of the participants in this study mentioned that sexual health was still a sensitive topic and not discussed traditionally. However, in the resettlement country is was much more of a norm. For many older generation resettled refugees, talking about sex caused fear that it would lead the young into having more sex. While everyone in the study acknowledged that traditional taboos related to sex prevented them from receiving new education.	"[Parents] holding very fast ... they don't want their children to ... know about sex ... about this Australian culture." (p. 23) "Our families don't talk about this kind of stuff. They [parents] don't mention it ... you aren't allowed to. "(p.24)
		Many people are still scared to use contraception, or methods such as condoms for various reasons. Some stated that contraception can cause infertility, a lack of	

	3. Attitudes and beliefs towards relationships and sexual behavior are different	sexual pleasure, promiscuity, and were culturally unacceptable. Others, especially the younger resettled in Australia, stated that a motivator to use condoms was the cultural shame that would be boasted upon them if they got pregnant at young age and prior to marriage. This was also noted to be a reason for inconsistent contraceptive use.	"[Contraception] not okay ... if you use a lot maybe you cannot get baby, nobody marry you." (p.26) "If I got pregnant ... I'm going to give shame to my family ... really bad, that's going to influence my Mum and Dad in the community." (p.26)
7 **Dhar et al., 2017**	No themes/categories formally identified. Results and discussion narrative with embedded quotes and quotes in a table	Cultural norms influenced the participant's perspective and attitudes towards SRH. Premarital sex is stigmatized, and many only seek SRH information when they are married. Knowledge on SRH depended on where participant's attended school. Most knew what the male condom was and where they could obtain them. However, many had misconceptions that SRH services would only be available to those who were married and could not have access to services if they were adolescent or believed it would be required to obtain parental consent.	"People feel shy when they are not married, and then they don't want to talk about birth control." (p.792) "The only thing I know is about using condoms,.when I talk about safety, it means that to use condoms while having sex so that you will not get pregnant" (p.792)

8 **Gebreysus et al., 2020**	Barriers to contraceptive care seeking: 1) Distance to health facilities 2) Limited healthcare resources at access point 3) Fragmentation of the healthcare system	Many women have to use public transportation and travel for hours to seek contraceptive health services that are situated in Central Tel Aviv. All participants stated there was only two clinics where affordable contraception could be accessed. The clinics offering contraception suffer from a lack of resources, including health care professionals, shortage of products, and limited hours of being open to clients. Budget constraints can cause a long wait time for women to receive contraception. Many clinics do not offer all contraceptive services and require many women to seek referrals for private gynecologists and have to wait longer. The author describes the complexity of the healthcare system, stating the fragmented system of how care is delivered makes it more difficult for women to obtain services even when they exist. Many asylum seekers cannot afford private clinics where services are offered, and low wage employments alongside exclusions from public health insurances make purchasing some contraceptives difficult. For many, they worry about paying for basic necessities, and do not concentrate their spending on healthcare services of any kind,	"I know a woman ... she comes from 'Eilat' [a five-hour bus ride from Tel Aviv] to get treated here [Tel Aviv] ... and 'Eilat' is the furthest from this town." (p.260) "We don't know what is going on outside of our towns … we don't know if there is a better doctor in other areas because they are too far away." (p.261) "There are many people there [at the health facilities] and there is a long queue and it might be time for you to get to work and since you can't go back and forth you stop coming for your checkup." (p.262)

	let alone contraception. There are both direct, and indirect costs associated with seeking care.	
4) Cost of contraceptive services	Many professionals in private sectors will try to offer their services for a reduced rate to asylum seekers, but many participants stated they received incorrect information from private sectors, or the doctors didn't respond to any of their questions.	"Even if you have the money, they won't give you a break [from work] to get your treatment. If you say you are sick and don't go to work today, then you will get fired the next day. And we can't afford to get fired." (p.262)
	Many participants feel discriminated against for being Eritrean when attempting to seek healthcare services. Even when discrimination isn't always present, and there are some positive experiences, one participant describes a "fear" of it happening when seeking health services.	
5) Low standard of care in facilities providing contraceptive services	Language barriers make it difficult for many asylum seekers to express their specific health needs, and it is difficult to advocate for themselves. Many noted there are a lack of translation services available. Some women are scared that health- care professionals will use informal sources of translation, such as other Eritrean women waiting in the waiting room, and that their personal information such as seeking contraceptives, would get	"He only cares about his time and money and he injects six women at the same time without even changing gloves … He uses a medication that is meant to be used for one person and divides it for two. He claims that he provides pregnancy tests but he doesn't even check … It has happened to me. I was three weeks late and I went there and he gave
6) Discrimination		

		leaked into their community where it may not be socially acceptable.	me an injection … After two months I started to experience morning sickness … I went after a month to get injected [again] and he examined me and he confirmed that I was pregnant and I asked: "how is this possible?" because he was supposed to check if I was pregnant before injecting me … I know this lady who without even knowing that she was four months pregnant went ahead and got injected." (p.263)
	7) Social and linguistic communication barriers		"[W]herever we go, … they [Israelis] don't listen to us … . They call us 'kushi' [pejorative term for dark-skinned person] … and their impression is that we are worthless … They let us into this country. Why didn't they kill us if it was like this? That would have been better … I am so done I cannot speak anymore." (p. 263) "you get scared [that] this discrimination will happen. So instead of going to the hospital you choose to do everything yourself and get better at home … "(p.264) "There is nobody to translate for you in your own language and, instead of translating for you or giving you the proper drugs, they give you the wrong ones." (p.265)
9			

Gedeon et al., 2015	1) Women's experiences with the IUD are overwhelmingly positive	Many women voiced positive benefits to using the IUD such as long-lasting, effective, and easy. Many also described that becoming pregnant after removing it was important. Many preferred the IUD over other hormonal contraceptives such as the pill or injections because of the multiple side effects they experienced such as dizziness, weight gain, and irregular bleeding. Out if the 31 women being interviewed, only two of them removed their IUD early for bad odor, and abdominal pain. However, they weren't sure if the IUD was the cause or not.	"If we use the pill, we will have a lot of side effects. If we use depo [Depo-Provera], it makes us fat. And we don't want to be fat...Before using the IUD I had to worry all the time about whether or not I would get pregnant or when my menstruation would come...for the IUD you don't need to remember every day. So it is really good. " (p.3) "When you take out the IUD, you have a chance to get pregnant [again]." (p.3)
	2) Financial considerations and access to health facilities shape use	The women being interviewed are in a setting where poverty and unemployment rates are high, so a major theme was considering the financial responsibilities associated with unintended pregnancy. It was also advantageous for many to use the IUD so they did not have to displace themselves or leave work for regular doctor visits for contraception. Women stated a primary source of contraceptive information was from within their social circles.	"If we use the IUD, menstruation comes every month so we don't have many side effects. But if we use other things, we have side effects...we get very fat or [have] muscle tension. [For us] the IUD is good and not bad." (p.3) "I think the IUD is good. We don't need to take it, like the depo, every 3 months. And even when we are putting the IUD in, there is no frustration. We don't need to worry about anything. If we are using depo, we have to go back every 3 months, and also when we are getting depo, it is painful to get every time." (p.4)

3) Experiences of friends and family impact use	Knowledge and access to services that provide the IUD in Burma was very rare, many women learned about it only after relocating into Thailand. Many agreed that more information should be shared, and unmarried women should also be targeted because access to reproductive health services for unmarried women is decreased. Some women suggested that advertisement for different contraceptive methods could help or holding group information sessions would be beneficial to combating myths and rumors about the IUD.	"I [heard] some people say that if you use the IUD it can cause cancer in our uterus and I was scared to use it...But my sister, she explained that she used the IUD and that she was feeling good with no side effects, that's why I started using it and now I feel good!" (p.4)
4) Use of the IUD along the border is rare		"I didn't know anything about this [the IUD]. But because my friends suggested to me that this is good, I went [to the clinic] and got it inserted." (p.4)
5) More education and awareness about the IUD is needed		"In Burma it is really rare that [women] use the IUD, and also it is expensive; they don't provide it in hospitals. So if you want to use the IUD, you have to search for a clinic that provides it." (p.4) "It would be better if we were able to enter the community and offer education about...reproductive health and also about contraception and explain the types of contraception...like the IUD; how it works, the negatives and positives...stuff like that." (p.5)

10 **Gee et al., 2019**	Preconception: a) Family dynamics and social status	The author describes how the participants discussed early marriage having a strong association with early pregnancy and childbearing. In their culture, as soon as you hit puberty and start menstruating, you can marry or get pregnant. Culturally, large families are favorable. Bearing more children means having more honor and social class.	
	b) Fears of contraception	Some view the use of contraception as "interfering with the work of God". Many do not feel comfortable discussing family planning openly, and if they need to seek contraceptive services, they will go to someone who is not Somali (outside their culture or religion). Mothers in the group report fears of side effects of using contraception.	"One might end up being barren if injected or used drugs for birth control. You might be cursed and won't get children in the future." (p.4)
	c) Advantages of birth spacing	Many mothers and fathers in the groups did not like modern contraception, but viewed birth spacing to have many advantages and stated that breastfeeding was an acceptable way to delay a pregnancy.	
11 **Ivanova et al.,**	a) Sexual and reproductive health knowledge among girls	Abstinence and condom use were most frequently mentioned by the young girls being interviewed in this study. Only a few participants had knowledge of two or more	"The methods of preventing pregnancy are like this: when you are still a student, you must abstain from sex. Then when you are a

2019		contraceptives that exist. Misconceptions about the use and effects of family planning are also present.	woman and you want to have sex without producing, you can use pills, injections and self-control." (p.5)
	b) Sources of information and access to SRH services	The primary source of SRH information of all kinds was reported to be from schools and/or teachers. The second most common source for these girls to obtain SRH knowledge was from guardians or parents. Many voiced they were closest to their mothers but were hesitant to speak about SRH matters due to fear or shame. Many girls reported not knowing where to seek SRH care or contraceptive services and did not know where any clinics were located. Some girls who knew where to seek resources were hesitant due to fear and lack of privacy that their needs would be spoken about to others.	"... I cannot use family planning methods because they are not good. They can affect life." (p.5) "... .some of them [teachers] are tough. Some of them [teachers] when you tell them some problems of yours they also go to speak with fellow teachers." (p.6)
		Many participants did not use any form of contraceptive during their first experience with intercourse. Some girls reported the lack of contraceptive use being attributed to fear from the man, or because the man wanted them to become pregnant.	"... I feared him and I didn't use any contraceptives to stop pregnancy because of the fear." (p.7)

	c) Sexual experiences including pregnancies and forced intercourse		
12 **Kabakian-Khasholian et al., 2017**	a) Women's desired family size	Women express their desire to have a large family associated with: God's will", and many mention the importance of having a boy as well. Some felt that it was encouraged to get pregnant after displacement because of the financial and medical aid they would receive, and they felt as though they should replace the children that were lost in the war. Others felt as though getting pregnant would be difficult with the conflicts occurring in the country.	
	b) Decision-making about fertility during displacement	Polygamy is popular in the culture being interviewed, and many women feared their husbands finding someone else if they did not conceive a male child or want to conceive when their husbands wanted to. Husbands play the leading role in decision-making when it comes to fertility and family planning. Some women use contraception without the approval or knowledge of their husbands.	"If I disagree with him he will marry another woman, he will say I want children." (p.86) "I could not negotiate this issue with him before, if the man wants a child you cannot prevent him, but now I have good reasons to convince him and to say no." (p.86)

	c) Perceptions about contraceptive needs and provision	Women have expressed the need to have access to more contraceptives, some wanted to limit their family size as a result of the difficult living conditions associated with forced displacement, while others were scared to use contraception if they have not reached their desired family size in fear of infertility associated with contraceptives. Many women in the FGDs preferred "natural" family planning methods over the use of modern contraceptives.	"Women used pills after having ten children, but we have only one or two and want to use the pill now." (p.86)
13 **Kaczkowski & Swartout, 2019**	1) Contraception	Many identified abstinence as the best way to prevent pregnancy or unintended pregnancies. Others identified condoms as the most common use of contraception. Some women mentioned other types of modern contraceptives but viewed them negatively	"You can have sex with a condom but it's not 100 perfect. It cannot protect you 100% ... It breaks all the time. It's not a good idea to have sex with a condom" (p.375)

		with thought that they are ineffective or have too many negative side effects.	"You know for guys when you tell them no sex, they keep telling you to do it. Boys always want sex from you, but you have to decide for yourself and you have to protect yourself" (p.375)
	2) Sources of information	Many stated that their mothers or parents were their sources of sexual health information. Some sought information from schools or healthcare professionals as well but did not feel that they learned much from those sources.	"Those drugs are capturing you, they will affect your body. You will become fat for no reason. But it's not fat healthy, it's fat of a disease. You see yourself just ... everywhere become big. When you touch your body like this? It will be like a banana. A yellow and brown banana." (p.375)
	3) Perceived barriers to resources	Reasons for not seeking sexual health resources or services, such as contraception were cited to be the lack of money, lack of insurance, or transportation issues. When asked about methods to improve services for SRH, many women stated they would prefer to have individual meetings with HCP where they felt the environment was more caring, non-judgemental, and discreet. Many women also stated parental involvement would help them understand more about SRH.	
14 **Keygnaert et al., 2014**	1) Definition of sexual health	The author does not provide a description for this theme but categorizes the different definitions of sexual health that the interviewed participants gave. Some women mentioned that "becoming a woman" was associated with family planning.	"A safe and satisfying sex life": "Being completely comfortable with having sex (no pain, tension, coercion)", "using

			contraception", "enjoying sex" or "having sex on a regular basis." (p.5)
	2) Internal sexual health locus of control	Many respondents associated safe sex with good sexual health, where many felt that the most important thing was having accurate access to information and resources. Many mentioned different sources for seeking SRH information, regardless of their educational background. Some cited receiving information from medical professionals and educational institutions, others from their immediate environment such as family and friends, and others from the media or the internet.	"Family planning and fertility" was mainly defined as "being able to bare children", "being fertile" and "having healthy children". (p.6) "Using a condom", "using contraception in general" and "considering the health status of the sex partner before having sex" (p.8)
15 **McMichael & Gifford, 2010**	1) Talking about STIs and HIV	Many young people had inaccurate information or were not adequately ware of STIs and their transmission, while some knew about the transmission and the importance of condoms due to the spreading of HIV in Africa.	"Back in Eritrea, for example, it's something that is constantly there because there is a lot of condom ads encouraging young people to use condoms because the HIV is spreading." (p.268)
	2) Contraception as protection	Almost all the participants acknowledged protection is required to prevent unintended [pregnancies. The knowledge of the participants varied from general knowledge to those who used contraception. Condoms	

		were the most common method used. Other methods mentioned for contraception use included: the rhythm method, pills, injections, "the rod", gels, diaphragms, and the morning-after pill. Some women stated that the male should take responsibility for the use of the condom. Contraception was largely viewed by women to prevent pregnancies due to the stigma and how becoming pregnant could be viewed "harshly". Knowledge of the various types of contraception were predominant around the participants who were already sexually active or experienced an unplanned pregnancy.	"That person might have a disease or sickness in his body and then he doesn't want to let you know and he wants to infect you. You don't know. So you have to protect yourself by using condom, stuff like that. "(p.270) "Why would you have condoms in your bag if you're a girl? The people would be laughing at you. He should have it." (p.270) "After that I was scared of things like pregnancy and HIV. After that I started to use condoms. I always use condoms. I had an HIV check and it came back fine, and I felt really good. After that I always use condoms to make sure that I never get anything. "(p.270)
16	1) The availability of emergency	The author describes the various findings from the women who participated in the	

Nara et al., 2020	contraception (EC) is inconsistent in the Nakivale Refugee Settlement The out-of-pocket costs for ECPs is prohibitive for urban refugees	FGDs. Some women stated when they needed emergency contraception, they were able to receive it, while others voiced that it was unavailable in the settlement when they needed it.	'They are not here. Please give us those ones so that we can use [them]. We don't have them, those ones are good." (p.114) "I have heard about it [EC] and I know someone who has used it, but it is expensive." (p.114) ''[ECPs are] not very expensive, but for some people, they cannot afford it." (p.114)
	2) Women use other medications in place of EC for post-coital pregnancy prevention	Many EC are available at many service points throughout the refugee settlement; however, they are expensive especially for many of the women who have no income. Many women have used other medications in an attempt to prevent pregnancy after intercourse. Women reported using these medications because they are familiar to them and have less side effects than progesterone only EC pills.	"We did not know if [the other medications] were effective. Sometimes we would use Quinine; you swallow it and it works. But [I would also use] paracetamol." (p.114) ''When you take contraception every day, I find that well. . .there are consequences and because I want to have children one day, [I] can take the medication instead. It is [the] medication for malaria." (p.114)
	3) Refugees' accurate knowledge of contraception is limited	Knowledge regarding contraception is limited, where many refugees are not aware of various types of contraception that exist. Many women report inaccurate drug regimens with insufficient contraceptive counselling opportunities. Many women did	'It is like this, before having sex with a man you take one of the yellow [pills], and after having sex with a man and you are in the

		not feel as though they have been receiving proper and enough information, so they made custom regimens of oral contraceptives.	period of ovulation, you take one red and one yellow." (p.115) "I wanted to say about family planning. Here they do not take care of us and they don't give us information about it. We fear to give birth because we fear dying. So women are struggling by themselves. . .because they don't know what to take. "(p.115)
17 **Okanlawon et al., 2010**	1) 1) Risky sexual behaviors and unintended pregnancies	Many reported not intending to become pregnant while engaging in sex but were aware of the risks.	''I didn't know it would happen. I wasn't ready to have a child at that time. I still regret not using contraceptives then because the baby I gave birth to is suffering in the camp.'' (p.20)
	2) Need for contraceptives and barriers to its use	Many interviewed stated that their refugee status and being displaced made them more vulnerable and at an increased need for contraception. During interviews, many stated they did not use contraceptives because they believed they would be harmful to their reproductive system, and feared side effects.	"Some refugee girls in this camp are unaccompanied minors who came alone to Nigeria without their parents or families and so, they are on their own. Many of them and other refugee girls sleep with older men, who are indigenes of the host community and refugee men, for money, food and other material things. Girls like this and other refugee girls who are prostitutes seriously need contraceptives to prevent pregnancies and diseases." (p.21)

		"I can't risk my life by using contraceptives, they are dangerous. I know a woman in this camp who died due to adverse effects of contraceptives. I know another woman who told me the story of how contraceptives affected her and made her menstrual cycle irregular. Nurses are wicked. They don't tell people about the side effects. They just tell us to use it.' (p.22)
3) Perceptions, beliefs and contraceptive use	Interviews revealed that the perceptions and beliefs of modern contraceptives plays a role in the non-use and create a barrier to using. One young woman consistently uses contraception and explains her rationale in a representative quote.	"The only type of contraceptive I like is condom because I have heard so many negative things about the other contraceptive methods and so I'm afraid of them. But unfortunately, my boyfriend doesn't like condom at all. He objects anytime I mention it. He says he won't enjoy sex if he uses condom. He prefers to do it naturally so that's why he doesn't use it and if I should force him to use it, he may leave me and go for another girl and I don't want to lose him because he really helps me by giving me money." (p.22)
4) Condom use	Many felt that the use of condoms was safer than pills, emergency contraception, the IUD, injections, and implants. However, in FGDS and during the interviews, many women reported not using a condom during their last sex for different reasons, some reported feeling uncomfortable asking to use a contraceptive, while others stated their partner did not permit it. Some said family planning methods are only used for women and couples who are married.	
	Many interviewed in the refugee camp felt it was a challenge to have access to different contraceptive options. Many mentioned that they know where they could get condoms, but	"Many girls in this camp sleep with men in order to survive. We are here in Nigeria with nothing and nobody to help us and we have to survive. I already have a child (a son) who is 2 years old and I don't want to have another child again now so I use pills and it works for

		they cost money. The author reports that the location of the camp is a barrier to accessing contraceptives in relation to the distance of the community to the health facility.	me. It hasn't let me down. I also use condom too when I'm with new partners." (p.23) "I like using condom during sex but I didn't use it the last time I had sex because I didn't want to buy it in the camp. I don't want anyone to think I'm a prostitute. I remember the last time I went to buy condom and pills in a chemist in the camp; I was embarrassed by some women. They asked me what a young girl like me wanted to do with condom and pills. I was so ashamed that I had to lie that someone sent me. So, I prefer buying it outside the camp, a little bit far away, where no one knows me." (p.23)
	5) Access to contraceptives		"Before, contraceptives like pills, IUD, injectables, etc., were free in this camp, but since the camp clinic was closed in 2007, we now go to hospitals in the surrounding community to receive the service. It's no longer free. Some of us like to use it, but we

			can't get it in the camp. That's the problem." (p.23) "It is not easy for us to get contraceptives in this camp. When we need it, we go to hospitals in the neighboring communities like Victory hospital, Oru Awa maternity center and so on. The nearest clinic where we get contraceptives is about 30 minutes' walk from the camp so we trek there. The other ones are far away so, we go by car." (p.24)
18 **Pavlish et al., 2010**	1) Reproductive health	Reproductive health and corresponding issues are largely kept silent and not openly communicated. Silent suffering is very common for many reasons. Sex is still a taboo subject with many Somalians, and a key informant stated that abortion rates are high because contraception is not being used but many young women want the pregnancy to be terminated even if it is prohibited in their culture or religion.	"Right now there's a cultural clash between the older generation and the younger generation […] young Somali girls are sexually active, and they don't know how to protect themselves. This is a taboo subject in our culture. Our mothers will not sit down with us and say, 'Okay, don't have sex, but if you are, do this and this.' [Instead] they will say, 'Don't have sex' and there is nothing beyond that. The reality is, as much as our parents would love the idea that kids are doing the things they are supposed to, a lot of girls are having abortions. I don't know about cases of HIV. But that means if girls are not getting education from their mothers or the

			family, then we should have outside sources available. Culture and religion are not allowing us to talk about this. We can't talk about prevention especially with our own parents." (p.358)
19 **Pell, 2017**	1) Socio-economic context	The author describes the relationship between the economy and reproductive decision-making. One woman started birth control due to economic factors, having more children to be too challenging.	
	2) Religious values	Religion plays a large role in reproduction for many. For many Muslim women, planning a specific family size is prohibited. However, many women being interviewed were using birth control, and did not see it as a problem with their religion.	"In Islam you are not allowed to decide how many kids you have. It's not allowed. You can't say, 'I want three kids and that's all.' You can have periods of time between them, but you can't say, 'I only want this amount of children." (p.146) "It's permissible to take a break from having children, but one isn't allowed to say, "I will never take what God gives me and I will never want any more children" (p.147)
	3) Marital relationship	Many interviewed women discussed their fertility and family size in accordance to their husband's desire for a larger family. For many, the husband decides the number of children.	"I have no say in the matter of how many children we have. It's my husband who decides, but after the fourth child I wanted sometime between the children. I went to the UNRWA clinic and got birth control pills. I brought them home and told my husband I

			wanted time. He said okay but after five months told me to stop using the birth control. It's just not up to me; it's up to my husband."(p.148) "When I gave birth to my last baby, I wanted to have the ring, and he said you aren't allowed, you can't do that. Once, I didn't tell him that I was taking the birth control. I did it, I bought some birth control [at the local UNRWA health clinic], and he found it, the pills, and he was going to beat me for it ... he doesn't want me to do it." (p.148)
20 **Royer et al., 2019**	Domain 1: Family planning Themes (only the ones relating to the issue) a) Fertility management Sub-themes: Delay of first birth Birth spacing Birth limiting Method acceptability	Many Somali and Congolese women interviewed stated that fertility and family planning was related and left for God. Opinions varied between women regarding whether or not the use of contraception and which methods were acceptable. Some stated that contraception could be used to space out the births of their children but not to limit the births of children, while others accepted to use contraception for both reasons. Many women stated that the first birth should not be delayed, and a large reason for not delaying first birth was family influence and cultural	

Partner/family influence	expectations to become pregnant after marriage. For many being interviewed, the health of the woman/mother was an indication to space of births of children, which is acceptable in many of their religions including Islam. Congolese women being interviewed stated that contraception and family planning methods could be used to space births, but many did not actually use any. For many Somali women, limiting the number of children you have is not acceptable, and many women notice a cultural difference between their beliefs and those of many women in the United States. During the interviews, many Congolese women stated that limiting births is acceptable, and attributed decisions to limit birth based on post-settlement and the limited resources available to them as a refugee. Congolese women acknowledged that in their culture it is common to have many babies, but after resettlement it may be less possible. For many Somali women, acceptable family planning methods are those that align with Islamic teachings/beliefs. These methods include breastfeeding, oral contraceptives, and injections (to compliment breastfeeding). Many women were aware of injections as contraceptives as a result of being in a refugee camp. No Somali women mentioned	"To get many children without family planning is not good for [maternal] health and it is not good for the health of the child either." (p.399) "Islamic religion allows spacing children for good growth and that is in fact good for mother's health. You get another child when your child has already grown up and is walking." (p.399) "Islamic Religion permits a mother to breastfeed her baby for two continuous years. You can use breastfeeding as family planning." (p.400)

	withdrawal, calendar method, condoms, or implants, and only one woman identified the IUD, but they all stated they would seek medical attention from a doctor if they needed any method. Congolese women were aware of many methods that can be used to prevent pregnancy, citing the calendar method. Many Congolese women addressed openness to a variety of contraceptive methods but were unable to articulate their rationale for having a preference over one method in comparison to another one, and most stated they did not know where to go to get contraceptives. Somali women did not discuss family planning with their partners, while Congolese women identified the importance of doing so. However, the husbands were usually the ones to have the final decision regarding family planning	"You can use two types of family planning. A mother does not become pregnant unless the baby is weaned. If the mother gets her period while breastfeeding, then she can use an injection or family planning tablets." (p.400) "There are also these modern small things which I have never known . . . young ladies use inserting [into] their bodies." (p.400) "[we] learn in school how to cal- culate. You know, the dates to not get pregnant." (p.400) "Congolese [men] do not like condoms." (p.400) "I really like the vaccine, and want it now." (p.400) [referencing contraceptive injections]
	Somali women largely believe that pregnancy is a gift from God, and did not acknowledge the concept of unintended pregnancy, whereas Congolese women did.	"If you ask him he won't agree, he may not want it . . . [get contraception] by yourself and he may tell you to go back to your parents." (p.400)

	b) Considerations surrounding unintended pregnancy Sub-themes: adoption Abortion		
21 **Russo et al., 2019**	1) Pregnancy prevention and termination: beliefs	Many women in this study were open to the idea of contraception, associating the use and knowledge of contraception with being "open-minded, modern, and educated". Many	"They came out from Afghanistan, they went to Iran, Pakistan – more civilised countries than Afghanistan – and many other countries

		were accepting of contraception by trying to separate it from the traditional Islamic beliefs that it is forbidden to use contraception.	like Australia, Europe. When [Afghan people] went and they look at the world, they realise that they were living in a very, very backwards way. So, after that all the people were using contraception; they become more modern." (p.8)
	2) Experience using contraception	Many women did not have great knowledge or exposure to contraception prior to resettling in Australia, but many voiced the g=fact that after arrival, they sought information or hormonal contraceptives from a physician. Many voiced disadvantageous side effects and preferred to use a condom instead. Condoms were seen as being effective and accessible to both men and women. However, some women voiced that negotiating condom use with their husbands was more difficult, and if the husband did not like it, resulted in the withdrawal method to avoid pregnancy.	"[In Afghanistan] the [religious] scholars were saying [contraception] is made of Satan (evil) ... They were preaching about these things, saying that if you are using condoms it means you are doing something against God. That sort of rumour was back there ... [But when people] come to Australia, they realise that whatever they were thinking, it was all wrong." (p.8)
			"I used the pill and I was always impatient; I would give answers so quickly. Now I put the capsule (Implanon) in my arm ... I'm feeling good, but my period is less and I'm gaining weight." (p.8)
		Religion formed the foundation of whether communication regarding family planning would be open or closed between couples, but many voiced shared decision-making as ideal when it comes to family planning.	"When I came to Melbourne, I used Implanon. But it had side effects on me; I had a lot of bleeding issues. And then my husband said, 'No, take [it] out, condom is much better' (p.9)
		Some women reported feelings of shame and embarrassment bringing up family planning due to "traditional cultural systems that	"I like condoms. Women usually like things which have no side effects on them ... Men do

	3) Partner communication and decision-making	reinforced patriarchy" (p.9). Many women expressed feeling responsible to prevent unintended pregnancies. Some women felt it was acceptable to use contraception without the permission or knowledge of their husbands if he wanted more children but did not consider her state or well-being. Throughout this study it was notable that most believed general physicians should be the primary contact for assistance and services regarding family planning. It would be preferential for most to seek medical attention from a HCP of the same sex but not mandatory. Barriers to seeking services included the use of interpreters for adequate communication, while some voiced feeling uncomfortable expressing sexual health with an interpreter present. For many, it took multiple visits before being able to speak about their sexual health needs due to feelings of shame. Overall participants reported a willingness to learn more about family planning and reported using HCPs and the internet as a way to learn about their bodies, and the variety of contraceptive methods that are available.	not like condoms, and they use withdrawal method ... We start fighting, and men usually asks us to go and use pill, and put capsule in our arm, and women say 'This has side effects, this is not good' ... We ask them to use condoms, but usually men do not agree with us." (p.9) "When my husband is talking about all these things, I'm feeling shy and I am saying 'Don't say all these things to me! I don't like to say these things!' I'm awkward; I am not comfortable. In our religion, husband and wife should be very close, they should not have any secrets between each other ... But I don't know, I can't discuss anything." (p.9) "Always the man is more demanding. And they usually do not use condom and they say, 'Whatever happens, if you get pregnant, it's not my problem, it's not my responsibility. If you do not want to get pregnant, contraception is your responsibility, your problem!'"(p.10)

	"If men want [a baby], and women do not want, she can [use contraception] without him knowing, if she is clever ... Women are always dominated by men, and women do not have to do everything he says!" (p.10)
4) Health seeking: opportunities and barriers	
	"The doctor needs to book an interpreter. But if the interpreter is there, it is hard to say things, sexual health things. I do not feel comfortable in front of an interpreter, so it's much better to use a phone interpreter." (p.11)
	"I can't say (points to condom). I can only say 'plastic, plastic'. And I am not confident to say body parts, like this, what this is (points to breast). I can't say. I feel shy, with my husband, with doctor, everyone." (p.11)
	"I had infections when I had Mirena [IUD] ... I didn't tell the doctor that I have infection in my, ah, there (points to vagina). I told her that

			I had sore legs, and I'm feeling very uncomfortable ... Very bad sore legs and I think I have an infection." (p.12)
22 **Salisbury et al., 2016**	1) The intrauterine device (IUD): health and beliefs	Reported rationales for using an IUD consisted of the fact that they are long-lasting, easy to be placed/used, and have less side effects that other hormonal contraceptives. Religious concerns were less prominent while discussing the IUD in comparison to permanent methods of contraception such as female sterilization.	
	2) Lack of knowledge and fear/misconceptions		"...because I am old I will not get pregnant." (p.7) "I am very afraid that after a steri I cannot lift heavy things. I carry 25 kg of rice two to three times a month, also charcoal". (p.8)
	3) Role of the husband		"My husband does not agree for steri but after counseling we agree for IUD" (p.8)
23	1) Opening the door to new understandings	For many, accessing sexual health information was perceived as easier in the	

Svensson et al., 2017	of sexual and reproductive health and rights a) Access to previously unavailable sexual and reproductive health and rights information b) Sexual and reproductive health and rights information colored by own norms and traditions c) Questioning the approach to delivering information	new country of resettlement than in their country of origin, regardless of the obstacles and challenges associated with learning and navigating a new healthcare system. Feelings of shame and cultural taboos are still present and strongly associated with sexual health. This stopped many from seeking sexual healthcare in their country of origin. Knowledge of sexual health varied, and there were evident knowledge gaps regarding sexual health which lead to strong misconceptions. Participants suggested that a "gender-sensitive approach" would be useful when communicating sensitive topics such as sexual health. Many participants acknowledged the importance of sexual and reproductive health, and the importance to adapt to new cultural norms.	"... that it is not safe ... it is not one hundred percent ... there is always a risk that the women will get pregnant even if you use a condom ... they say that at all condoms have a hole in it so it will leak ..." (p.758) "One time he [the communicator] brought condoms and it was free ... but no one took any because it was embarrassing. If I had a man I would have taken many, I had never seen what one looks like before." (p.758) "It was through the discussions, because it was a man who instructed this ... but we never participated in the discussions because it was a sensitive topic, but you got a lot of information ... especially when they draw on the board, and when they showed pictures

	2) Planting the seed for engagement in sexual and reproductive health and rights issues		through the computer and things like that ... then we received a lot of information, but we could not communicate with the others, because it was very sensitive and we were very shy." (p.760)
24 **Tanabe et al., 2015**	1) Awareness of SRH concepts	The degree of knowledge varied across participants and was dependent on whether they were isolated in their homes or educational exposure. Knowledge was especially lacking for refugees with disabilities. Family planning methods that were mentioned by participants included condoms, pills, and injectables. No participant heard of emergency contraception, even though it was made available in the refugee camps. Misconceptions and fears were present as some believed that condoms would get stuck in a woman's body, cause disease, or cause infertility. Various responses were given in regard to the autonomy a female refugee with a disability has when making decisions for family	''The parents will take her to hospital and tell the clinicians to give her any family planning method to avoid her becoming pregnant again, with or without her consent.'' (p.420)

	2) Ability of refugees with disabilities to exercise SRH rights	planning. Many voiced restrictive abilities to decide.	
25 **Ussher et al., 2012**	1) Prohibition of Reproductive and Sexual Health Services for Unmarried Women: Cervical Screening, Contraception, and Abortion	Contraception use and knowledge is seen as taboo for many participants in this study, even learning about contraception from schools is not acceptable in their culture. Many older women in the study believed their daughters should not know about contraception because they won't use it until they are married, while the younger girls in the study reported having knowledge that they could receive contraception from a doctor if they wanted to. Many Assyrian and Karen women voiced learning about contraception prior to resettling in Australia, with many learning about it in refugee camps. The women who used contraception reported using the IUD or condoms. Women stated they did not have enough information about other methods	''against our belief''. (p.476) ''because they don't use it until they marry'' (p.476) "I: She saying like she said when they came, her daughter 17 or 18, years, like age, the high school and they told them to use the condom, their teacher told them and they, the girls don't know this is against our belief, against our religious but they say to them er it's good to, to use it, like to know F1: And so what do you think about that? P8: It's wrong" (p.476) "didn't like it'', or can ''control himself'' (p.480) [in reference to not using contraception because] "P4: Ah pills, some people they think that if you take for a long time if you think about kids again then you won't have them very quickly, so is that mean- I'm not sure if it's

	2) All Women Want Children: Valuing Fertility and Negating Post-Natal Depression	besides barrier methods. Many also held misconceptions about the oral contraceptive pill, questioning its safety to use and associating its use with infertility. When asked where they would access contraception most women replied with the doctor.	true or not. [Cross talk] keep using pills they tell you won't have children P8: Yeah that's what my doctor says P4: So that's why I never use anything P8: It's not good to use it for a long time. There's 50 percent chance to have kids again" (p.480)
26 **Verran et al., 2015**	1) Family planning knowledge: level of knowledge on arrival in the UK	There was little knowledge surrounding sexual health prior to arrival in the UK, and only one study participant had used contraception before, and she was a HCP. Those who used contraception in China were limited to long-term contraceptives and only knew about the IUD. Primary care settings and post-natal services were primary points mentioned to access contraceptive services, but many voiced knowing about multiple places to find services once arriving in the UK. Some experienced challenges getting appointments or navigating a new health system. Cultural differences and language barriers caused problems for the participants, and many were worried about the side effects they could experience with contraception.	"In China, my parents were strict and I was sheltered and unknowledgeable regarding sexual matters. After coming to the UK and having a sexual relationship with my boyfriend, my understanding ... about inter-course was very limited, so immediately after inter- course, I would go for a pee and thought that would prevent pregnancy." [P8] (p.124) "The doctor explains to us about issues with contraception failing and we don't entirely understand so it makes us worry ... I still would rather trust my friends' advice on the best method of contraception. If none of my friends can give me an ideal answer, it worries me ... I have received leaflets from doctors but they do not describe adverse reactions. Also, the long- term effects have

			not been explained to me so I get worried." [P3] (p.124)
	2) Influences on family planning decisions: influences on decisions about family size	The most common methods used for contraception were the IUD, condoms, and the implant. The IUD was used more for those who decided they did not want to have more children anymore. Friends and family also affected how they viewed hormonal contraceptives. Many felt that hormonal contraceptives were not natural and were concerned about the effects it would have on their menstrual cycle.	"For people like us, who have a language barrier and are attending a GP to get contraception fitted, the most that I am able to understand is probably the effectiveness of the contraceptive and how safe it is, but I would like to know more about the side effects of the implant and the implications of its stopping menstruation.... I'd like to be provided, not only with information on its efficacy, but also its side effects and the most recent research findings on the contraception." [P9] (p.124) "With regards to the coil, because everyone uses it and says that it is very tolerable, so I have also used it." [P8] (p.125) "My concern is not that contraception prevents me from having children, but that it is an unnatural method ... because it reduces the volume of menstruation from normal which makes it unnatural." [P7] (p.125)
27			
West et al., 2017	1) Awareness of FP (family planning)	Many participants in this study associated family planning with modern contraceptives	

methods and services	and believed that FP was important to maintain maternal and child health. Some voiced concerns about side effects. Knowledge and awareness of contraception in the camps did affect their ability to go and seek services from HCPs. Prior to refugee camps, many sough information from social networks such as female family and friends who based their opinions on personal experiences.	"I used condoms ... and I know that some women use pills and coils [IUDs], and injections." [Participant 14] (p.97) "We believe that after the first child it's preferable ... not to have [unspecified] contraception methods because we think ... maybe we won't be able to have more children ... Some women have been sterile after they used contraception." [Participant 7] (p.97) "They said it [the OCP] might cause me not to have children anymore." [Participant 6] (p.97) "The most important [problem] is that people don't know about the contraceptive methods and where to get them..." "I don't know if there are any kinds of [FP] services here and where ... no one told me .... nobody cares." [Participant 9] (p.98)
2) Utilisation and acceptability of FP services	Many used breastfeeding exclusively as a method, and most of the women reported not using family planning services while in the camp. Most women who were using contraception were older and already had children, the most common reported contraceptive methods they sought to use were the IUD and condoms.	"When women gather they talk about these things [FP] so I know about those things from neighbours and family... my sister told me about condoms and we started to buy condoms afterwards." [Participant 13] (p.98) "If they [doctors] talk more [about FP] I would benefit from them but they don't talk, so I don't ask." [Participant 1] (p.98)

		"The most important thing for them [doctors] to do is ... counselling and advising when they [women] go to the hospitals and clinics here." [Participant 11] (p.98)
	Many women stated that the use of family planning was accepted in their culture and would like to use it. Some women stated that their husbands were accepting of FP services, while others stated their husbands and family did not approve of FP.	
		"I know that my period will not come until he [the baby] is 8 or 9 months ... and then I will start using condoms." [Participant 13] (p.98)
3) Cultural acceptability of FP services		"I think it would be better if I had planned births actually, because I want to have better health for myself and to take good care of my children." [Participant 6] (p.98)
	Experiences with practitioners play an important role in accessing FP services. Many women stated that for services to improve, HCPs need to carry out examinations and consultations in a respectful manner.	"He [husband] told me not to put [the IUD in], he wants more children ... but I am going to do it without his permission. I am going alone to put it [in] ..." [Participant 1] (p.99)
		"Men need to hear about this [FP] even more than the women, because they control ... this whole children thing." [Participant 1] (p.99)
		"People don't like to talk about this [FP] because it's in their heads that they should have a lot of babies, so it's not ... a common subject in Syria." [Participant 1] (p.99)
4) Quality of services		

			"[If] I needed any kind of [FP] counselling ... I prefer not to go ... they're not respectful to me." [Participant 9] (p.99)
28 **Zhang et al., 2020**	1) Family Planning Practices are Rooted in Cultural, Religious, and Social Identities	Social, cultural, and religious beliefs were all factors that affected the participant's beliefs on family size and the use of contraception. Participant's stated that in Islam, birth spacing with natural methods such as exclusive breastfeeding or the withdrawal method are acceptable. For many Somali women, they valued the advice and opinions of their family and friends, which shaped their views on contraception. Although some women used modern contraception, they believed their fertility control was left up to God, and they had little power over the number of children they would have or birth timing.	"Islam encourages you to have spacing for at least 2 years, to breast feed for 2 years for the baby's brain development, for many reasons, also for the mother's health". (p.68) "The one method that religion talked about was that friends of the prophet back in the day used to practice the pull-out method." (p.68) "Preventing pregnancy, so some people think that's haram [i.e. sin], like making sure you don't get pregnant." (p.68) "The doctor asked me after I give birth if I was ready for IUD. I said I'll think about it and then I talked to a few sisters that have been here longer than me, they told me not to take the IUD. They said it won't be good for your health. They advised me to go the

	2) Allah has Ultimate Control Over Individuals' Fertility and Pregnancy Timing		natural method... I never went back to the doctor." (p.68)
		For many, resettling to the US changed their views on family planning and family sizes. Many expressed wanting to learn more about modern contraceptives.	"I took the pills first because I wanted to space them apart but it didn't work...and I still got pregnant...I also think it's all up to God." (p.69)
	3) Facilitators and Barriers to Modern Contraceptive Uptake Among Somali Women are Influenced by Their Experiences After Immigration to the U.S	Worries regarding side effects of modern contraceptives and misconceptions about the different methods were present and caused barriers to usage. Fear of infertility was common.	"I think the family planning has a western approach. It's not something in the Muslim society that is talked about or considered." (p.69)
			"In Somalia, our mothers didn't know much or they didn't depend on contraceptives. Here, there are challenges that cause changes." (p.70)
			"There's a lot stigma so it's like, 'Oh my God the pill, what is it going to do to me? Is it going to make me lose my hair? Does it have hormones? Is it going to make me crazy? The shot, oh my God it's going to make me gain like 50 lb?'" (p.70)
			"I remember a girl...who used the shot; then her period stopped. How can that happen?

	They said there was something added to the needle, to the injection. We don't know what it is. I'm really concerned about that." (p.70) "Many people who are religious...have this belief that if you use...contraceptives, that you will never have kids anymore." (p.70) "Yes, there's a lot of talk about birth control...Now we're seeing a lot of miscarriages and people are saying stay away from the perpetual pill, stay away from the IUD." (p.70)

Appendix E

Critical Appraisal Checklist (JBI Critical Appraisal for Qualitative Research Questions, 2017)

1. Is there congruity between the stated philosophical perspective and the research methodology?
2. Is there congruity between the research methodology and the research question or objectives?
3. Is there congruity between the research methodology and the methods used to collect data?
4. Is there congruity between the research methodology and the representation and analysis of data?
5. Is there congruity between the research methodology and the interpretation of results?
6. Is there a statement locating the researcher culturally or theoretically?
7. Is the influence of the researcher on the research, and vice- versa, addressed?
8. Are participants, and their voices, adequately represented?
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

Study ID	Year & Primary Author	JBI Critical Appraisal Checklist Questions	Total Score out of 10 (/10)
1	Agbemenu et al., 2017	Q1: Unclear, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: No, Q7: Yes, Q8: Yes, Q9: No, Q10: Yes	7/10
2	Asnong et al., 2018	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: No, Q7: Yes, Q8: Yes, Q9: Yes, Q10: Yes	8/10
3	Benner et al., 2010	Q1: No, Q2: Yes, Q3: Yes, Q4: No, Q5: Yes Q6: No, Q7: Unclear, Q8: Yes, Q9: Yes, Q10: Yes	6/10
4	Cherri et al., 2017	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: Unclear, Q7: Yes, Q8: Yes, Q9: Yes, Q10: Yes	8/10
5	Davidson et al., 2017	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: Unclear, Q7: Yes, Q8: Yes, Q9: Yes, Q10: Yes	8/10
6	Dean et al., 2017	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: Yes, Q7: Yes, Q8: Yes, Q9: Yes, Q10: Yes	9/10
7	Dhar et al., 2017	Q1: No, Q2: Yes, Q3: Yes, Q4: Unclear, Q5: Unclear Q6: No, Q7: No, Q8: Yes, Q9: Yes, Q10: Yes	5/10
8	Gebreysus, 2020	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: Yes, Q7: Yes, Q8: Yes, Q9: Yes, Q10: Yes	9/10
9	Gedeon et al., 2015	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: No, Q7: Yes, Q8: Yes, Q9: Yes, Q10: Yes	8/10
10	Gee et al., 2019	Q1: Yes, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: Unclear, Q7: Yes, Q8: Yes, Q9: Yes, Q10: Yes	9/10
11	Ivanova et al., 2019	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: No, Q7: Unclear, Q8: Yes, Q9: Yes, Q10: Yes	7/10

12	Kabakian-Khasholian et al., 2017	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: No, Q7: Yes, Q8: Yes, Q9: Yes, Q10: Yes	8/10
13	Kaczkowski & Swartout, 2019	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: Yes, Q7: Yes, Q8: Yes, Q9: Yes, Q10: Yes	9/10
14	Keygnaert et al., 2014	Q1: Yes, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: Yes, Q7: Yes, Q8: Yes, Q9: Yes, Q10: Yes	10/10
15	McMichael & Gifford, 2010	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: Yes, Q7: Yes, Q8: Yes, Q9: Yes, Q10: Yes	9/10
16	Nara et al., 2020	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: No, Q7: Yes, Q8: Yes, Q9: Yes, Q10: Yes	8/10
17	Okanlawon et al., 2010	Q1: No, Q2: Yes, Q3: Yes, Q4: No, Q5: Yes Q6: No, Q7: No, Q8: Yes, Q9: No, Q10: Yes	5/10
18	Pavlish et al., 2010	Q1: Yes, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: Yes, Q7: No, Q8: Yes, Q9: Yes, Q10: Yes	9/10
19	Pell, 2017	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: Yes, Q7: No, Q8: Yes, Q9: Yes, Q10: Yes	8/10
20	Royer et al., 2019	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: Yes, Q7: Yes, Q8: Yes, Q9: Yes, Q10: Yes	9/10
21	Russo et al., 2019	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: Yes, Q7: No, Q8: Yes, Q9: Yes, Q10: Yes	8/10
22	Salisbury et al., 2016	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: No, Q7: No, Q8: Yes, Q9: Yes, Q10: Yes	7/10
23	Svensson et al., 2017	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: Yes, Q7: Yes, Q8: Yes, Q9: Yes, Q10: Yes	9/10

24	Tanabe et al., 2015	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Unclear Q6: No, Q7: Unclear, Q8: Yes, Q9: Yes, Q10: Yes	5/10
25	Ussher et al., 2012	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: No, Q7: Unclear, Q8: Yes, Q9: Yes, Q10: Yes	7/10
26	Verran et al., 2015	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: No, Q7: Yes, Q8: Yes, Q9: Yes, Q10: Yes	8/10
27	West et al., 2017	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: No, Q7: Unclear, Q8: Yes, Q9: Yes, Q10: Yes	7/10
28	Zhang et al., 2020	Q1: No, Q2: Yes, Q3: Yes, Q4: Yes, Q5: Yes Q6: Yes, Q7: Yes, Q8: Yes, Q9: Yes, Q10: Yes	9/10

Note. Every study included in this scoping review was appraised using the checklist. Each question was answered with a response of either “yes”, “no”, or “unclear”. If the question was answered with the response “unclear”, then a point was not given. Each question was worth one point, for a total score out of ten. Regardless of the total score, all studies were retained for this synthesis to ensure no relevant data was omitted.

Appendix F

Enhancing Transparency in Reporting the Synthesis of

Qualitative Research by Tong et al., (2012)

(ENTREQ 21-Item List for Rigor)

Item	Guide and description	Reported on page #
1. Aim	State the research question the synthesis addresses.	4
2. Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology (e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis).	27 32 33
3. Approach to searching	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until theoretical saturation is achieved).	38 42
4. Inclusion criteria	Specify the inclusion/exclusion criteria (e.g. in terms of population, language, year limits, type of publication, study type).	38
5. Data Sources	Describe the information sources used (e.g. electronic databases (MEDLINE, EMBASE, CINAHL, psychINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar), hand searching, reference lists) and when the searches were conducted; provide the rationale for using the data sources.	45
6. Electronic Search strategy	Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research and search limits).	226
7. Study screening methods	Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies)	46
8. Study characteristics	Present the characteristics of the included studies (e.g. year of publication, country, population, number of participants, data collection, methodology, analysis,	47

	research questions).	
9. Study selection results	Identify the number of studies screened and provide reasons for study exclusion (e.g. for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications t the research question and/or contribution to theory development).	48
10. Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings).	48
11. Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope [25]; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting).	49
12. Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.	49
13. Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.	215
14. Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (e.g. all text under the headings "results /conclusions" were extracted electronically and entered into a computer software).	48
15. Software	State the computer software used, if any.	46
16. Number of reviewers	Identify who was involved in coding and analysis.	97
17. Coding	Describe the process for coding of data (e.g. line by line coding to search for concepts).	53
18. Study comparison	Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary).	95

19. Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive.	52
20. Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations or the author's interpretation	165
21. Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct).	88

Appendix G

Table Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	i
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	ii
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	4
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	4
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	37
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	39-40
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional	43

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
		sources), as well as the date the most recent search was executed.	
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	44
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	46
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	47
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	47
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	49
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	52
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	56
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	56-59
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	49 & 215

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	128-214
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	55-59
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	72-88
Limitations	20	Discuss the limitations of the scoping review process.	96
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	99
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	N/A

Note. JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.

* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.

† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).

‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.

§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and

acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).

Appendix H

Search Strategy Used (MeSH Terms Used in Title and Abstract)

Concept 1	Concept 2
refugee	contracept*
refuge*	contraception
asylum seek*	birth contro/l
	family planning/
	reproductive plan/*
	sexual reproductive health

Example of Search Strategies Used in Ovid Platform in Title and Abstract Search

Number	Search Terms
1	exp asylum seeker
2	exp refugee/
3	1 or 2
4	((asylum adj2 seek*) or refuge*).ti.ab
5	3 or 4
6	exp contraception/
7	birth control/ or contraception/ or family planning/ or induced abortion/
8	reproductive health/
9	exp family planning/
10	(contracept* or (birth adj2 control) or (family adj2 planning).ti.ab
11	or/6-10
12	5 and 11

Appendix I

Ethics Exemption

Per the information in your email, an REB approval is not required for your project. As it is stated in the TCPS 2:

Article 2.1

In some cases, research may involve interaction with individuals who are not themselves the focus of the research, in order to obtain information. For example, one may collect information from authorized personnel to release information or data in the ordinary course of their employment about organizations, policies, procedures, professional practices or statistical reports. Such individuals are not considered participants for the purposes of this Policy. This is distinct from situations where individuals are considered participants because they are themselves the focus of the research. For example, individuals who are asked for their personal opinions about organizations, or who are observed in their work setting for the purposes of research, are considered participants.