Barriers and facilitators to access mental health services among refugee women in high-income countries: a systematic review

Sarah C. DeSa

Thesis submitted to the University of Ottawa in partial fulfilment of the requirements for the Master of Science in Interdisciplinary Health Sciences

Interdisciplinary School of Health Sciences
University of Ottawa

ABSTRACT

Background

Based on the Global Trends report from the United Nations High Commissioner for Refugee, in high-income countries, there are 2.7 refugees per 1,000 national population, girls and women account for nearly 50 percent of this refugee population. In these high-income countries, compared with the general population refuge women have higher prevalence of mental illness. To our knowledge this is the first systematic review that addresses access to mental health services for refugee women in high-income countries. Thus, this review was conducted to examine the barriers to and facilitators of access to mental health services for refugee women in high-income countries for refugee resettlement.

Methods

MEDLINE, EMBASE, PsycINFO, and CINAHL databases were searched for research articles with qualitative component (including mixed-method or multi-method with qualitative component), in order to examine barriers and facilitators related to accessing mental health services. Relevant studies were collected on March 14, 2020 and were extracted and critically appraised by multiple authors. A narrative synthesis was conducted with the included studies to gather key synthesis evidence.

Results

Of the four databases searched, 1258 studies were identified with 12 meeting the inclusion criteria. The major barriers identified were language barriers, stigmatization, and the need for culturally sensitive practices to encourage accessing mental health care within a religious and cultural context. There were several studies that indicated how gender roles and biological factors played a role in challenges to accessing mental health services. The major facilitators identified were

service availability and awareness in resettlement countries, social support, and the resilience of refugee women to ease access of mental health services.

Conclusion

This review revealed socio-economic factors contributed to barriers and facilitators to accessing mental health among women refugees and asylum seekers. Addressing those social determinants of health can reduce barriers and enhance facilitators of access to mental health care for vulnerable populations like refugee women. Although there is a difference in health access policy among the top resettlement courtiers, the review found that there are no significant differences in accessing mental health for refugee and asylum seeker women among leading resettlement countries. The review findings suggest the need for further research on this topic given the potential significance of the findings on refugee and asylum seeker women mental health.

Keywords

Mental health service, refugee, asylum-seekers, women, resettlement countries, barriers, challenges, facilitators, enablers, access.

ACKNOWLEDGMENTS

I would like to express my deepest gratitude to my graduate supervisor Dr. Sanni Yaya, for his useful guidance, insightful comments, mentorship, and confidence in me to complete this thesis. The calm and focused professionalism he embodied, through the highs and lows of this project just reinforced the value he brings as a supervising professor.

I wish to express my special thanks to my Thesis Advisory Committee, Dr. James Gomes, and Dr. Raywat Deonandan for their precious assistance, scholarly knowledge, and enthusiasm. They provided thoughtful input and contributed exceptional insight and experience.

I want to mention my appreciation to my reviewer, Akalewold Gebremeskel and Olumuyiwa Omonaiye, for their dedication and energy to ensure this thesis was thorough and comprehensive. I valued their enthusiasm and commitment to making this a great learning experience.

I am the most grateful to my parents and family for the incredible support and flexibility through this entire spontaneous journey. All of my accomplishments are an ode to the sacrifice and hard work, love and care my parents have extended to me. My work and interest in improving migrant wellbeing were inspired by the long nights and multiple jobs my parents had to take in order to give me the dream life they aspired to have. I am forever grateful!

Lastly, I would like to express my heartfelt thanks to the people in my life who have believed in me and have given me the support and love that made this thesis possible.

LIST OF APPENDICES

SUPPLEMENTAL FILES

ABBREVIATIONS

CASP: Critical Appraisal Skills Programme

PRISMA-P: Preferred Reporting Items for Systematic Review and Meta-analysis Protocols

PROSPERO: International Prospective Register of Systematic Reviews

UNHRC: United Nation High Commissioner for Refugee

WHO: World Health Organization

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

Background

Globally, in 2019, there were almost 71 million people forcibly displaced [1]. The experience of forceful migration has been acknowledged as a complex and traumatic life event that can significantly affect mental health in a negative way [2,3]. Besides confronting the new changes in their environments, refugee populations are frequently overlooked when it comes to provision of health services, as well as access and delivery of mental health services [4]. According to the World Health Organization (WHO), "mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to contribute to his or her community" [4].

In relation to mental health promotion and mental health care plan for vulnerable populations such as refugees and migrants, the WHO in 2018 published a technical guidance report which provided a framework to addressing and promoting refugee's social integration and platforms for overcoming barriers to accessing mental health care, facilitating engagement and utilization of services [5,6].

About a third of people who have acquired refugee status live in high-income countries [7]. In the last several years, there has been a substantial increase in the number of refugees and asylum seekers seeking refuge and asylum status in major host and high-income resettlement countries. [8,9]. Worldwide, in 2019, about 64,000 refugees departed their home countries for resettlement in high-income countries [10]. With over 20,000 people arriving the United States in 2019, which is about 24 percent increase from 2018, makes the country the highest recipient of arrivals of new refugees. Other high-income countries like Canada and the United Kingdom received 9,031 and 5,774 arrivals, a 17 percent, and one percent increase from 2018, respectively. Other countries

that have been on top10 list of United Nations High Commissioner for Refugee (UNHCR) in terms of resettlement of refugees in the past decade include Sweden with 4,993 refugees arriving in 2019, Germany (4,622), France (4,544), Australia (3,464) [10]. With the increase of refugees in leading resettlement countries, it is crucial to understand the factors that influence access to the mental health care systems and the necessary interventions that can deal with the obstacles that refugees face in these resettlement countries [8,9].

In each of the resettlement countries, the contexts of health service availability, accessibility and refugee acceptance are different [8, 11]. The difference in cultural, political, economic, and social frameworks can play a considerable role in how a country prioritizes mental health service provision for refugee populations [11]. Additionally, in many of the host country the policies and entitlements relating to mental health care policies for refugee and asylum seekers are substantially different from the rest of the population [9,12]. In most resettlement countries there are systemic barriers that hinders refugees and asylum seekers from accessing mental health services. For example, the delivery of mental health care services in many of these high-income countries are often characterized by prolonged treatments which are not affordable because they are delivered by scarce and expensive mental health professionals [12]. Likewise, restrictive entry and integration policies have also been linked to poor migrant health outcomes in high-income countries [13]. Hence, it is important to understand how refugees are affected by migration policy in these high-income countries and its critical effect on access to mental health services.

By comparison to their male counter parts, evidence shows that there are risk factors that are specific to female refugees [14]. For instance, female Syrian refugees who arrived Canada with trauma resulting from gender based violence experienced in their country of origin who are now residing in a metropolitan city like Toronto, had many unmet health needs including mental health

due primarily to lack of access to health services and in particular mental health care services [15-17]. Moreover, several studies have documented the psychological risks related to female refugees and the protection needs and challenges involved in managing mental health disorders in this vulnerable group of refugees [8,18,19]. The presence of psychological risks, such as having survived torture or serious violence, being a woman or girl at risk of abuse and exploitation, or facing persecution because of gender or sexual orientation, among many other devastating scenarios plays its intrinsic role in meeting eligibility of resettling in top resettlement countries [10]. Simply put, there should be an expectation of adequate mental health service provided to refugee women, especially considering that the selection criteria for refugee women that resettle in high-income countries are partially based on the premise of trauma exposure [10].

To provide care and mental health services to refugee women, identifying and addressing barriers and facilitators that directly impact access, use and utilization of mental health services need to be understood [9,20-21]. Studies have identified social and structural constructs that exist as barriers to the ease and use of mental health services among vulnerable populations such as refugee women; these barriers include but not limited to the following scheduling or restrictive timing, linguistic barriers, low social status, discrimination and stigmatization [20-25].

Rationale for the Thesis

It is acknowledged that there is a need for mental health services to be accessible and acceptable within resettlement countries and should be consistent with the needs and difficulties of refugees. While there are numerous studies that have examined the barriers to accessing mental health services, there is a paucity of studies that have identified the facilitators and enablers of access to mental health care among refugee population, including the delivery of culturally sensitive

intervention [25], and the provision of gender concordant services [14,16,26].Although, there is large body of literature that have examined the barriers that influence mental health, there is an absence of systematic reviews that have specifically examined the evidence on barriers to and facilitators of access to mental health services for women refugees and asylum seekers in high-income countries [8,27]. In this context, the aim of this review is to examine existing barriers and facilitators to accessing mental health services for refugee women in leading high-income countries for refugee resettlement.

Research Question

What barriers and facilitators exist when accessing mental health services for refugee women in high-income countries.

Objective

The aim of this review is to examine existing barriers and facilitators to accessing mental health services for refugee women in leading high-income countries for refugee resettlement.

CHAPTER 2: LITERATURE REVIEW

Social Determinants of mental health among refugees

In exploring the literature, factors that affect mental health among refugees' social isolation, age, unemployment separation from family , and lack of information about available resources [28]. The stresses associated with resettlement put refugee populations at a higher risk, however women are even at greater risk to mental health concerns [29]. The responsibilities of childcare, stresses of isolation, and changes in family roles make women prone to additional stresses [29,30]. The literature on refugee mental health commonly categorized determinants of mental health among social, cultural, and structural determinants. The risk of developing psychological disorders increase among refugee populations when trying to cope with the effects of previous trauma, limited social support, financial instability, insecure immigration status[28-30]. Furthermore, refugee populations are disproportionately higher in receiving psychological disorders compared to migrants [31] and the general population in resettlement host countries [32-33]. The refugee experience is one that exposes refugees to multiple prolonged interpersonal traumatic events in the context of persecution when forcibly displaced to resettlement countries. This is a very different circumstance and experience faced by those that just migrate to different countries.

Cultural Determinants of mental health among refugees

Mental health stigma was an important and reoccurring determinant to mental health help seeking behavior. Negative attitudes about mental health had negative social consequences associated with having mental illness [34]. These negative social consequences included embarrassment for the family and affects potential marriage prospects [34]. Among cultural groups beliefs about mental health and mental illness varied depending on cultural background, ethnicity, and country of

origin. How individuals related mental health to themselves and their community played an important role in how refugees and migrants viewed themselves.

Physical Determinants of mental health among refugees

Factors such as insecure housing, difficulty locating relevant mental health services, appointment delays were all concerns that affected mental health service usage among refugee populations [35]. Additionally, issues surrounding lower levels of education that played a role in literacy and not being able to speak the dominant language or resettlement countries hindered refugees in accessing and using needed health services and mental health services[35]. Physical barriers like lack of transportation or cost of transportation limited access among some refugee populations [36]. These logistical determents hindered mental health care treatment usage and access.

Mental health services utilization for refugees

Many recent studies and systematic reviews investigate the utilization of mental health services among refugee populations [37]. The findings indicate a significant underutilization of mental health and psychosocial services within the refugee population [37]. This discrepancy led to the further investigation of barriers within low, middle- and high-income countries. Barriers varied specially when it came to understanding differences in engaging service provision and treatment seeking behaviour.

Gender Analysis

As mentioned above, gender plays an intricate role with mental health. Gender is a complex variable that change the dynamic nature of social and cultural systems. Studies show the effects of

social, cultural, and even policy affects refugee women differently and often neglect specific needs related to womanhood, compared to their male counterparts. Women and men are known to have different social and psychological needs [30,35]. Exposure to gender-based violence, intimate partner violence, abuse, sex- related torture, poverty, violence, and trauma are just a few example of risks that refugee women are affected by related to their mental health [38]. The role of gender can easily be accounted for when looking at vulnerability to violence and the challenges it poses to managing mental health [38]. Refugee women are more vulnerable to violence in part because it's integrated nature in race, class, and gender discrimination [38]. Additionally, there is a strong link between mental health and violence, especially among traumatic war-survivors [38]. Experiences of interpersonal trauma including rape torture being attacked or injured or witnessing the death of a loved one, can have a profound affect, despite reaching a safer resettlement country [38-39].

Influence of Policy

Policy plays a crucial role in addressing the deficiencies in society. Developing and updating policy frameworks can bring fundamental change in reducing the gap in knowledge and practice. The intersection of immigration policy and health policy addresses the many determinants that limits the quality of life among refugee populations. Both immigration and health policies vary among high-income countries, and accordingly reported barriers to mental health care correspond with deficiencies in the policy. For example, it has been estimated that in Germany, in 2015, only 5% of refugees in need of mental health care received treatment [12]. On the other hand, in 2016, the Mental Health Commissioner of Canada released information on the provincial needs to address and reduce disparities and improve access to mental health services in diverse communities

[4]. Similar reports sought to improve access and outcomes of mental health services for immigrants, refugees, and racialized ethno-cultural groups [6]. Canada's stance recognized the role of the federal government is not only about providing psychological well-being for refugees who have gone through traumatic events in violent settings, but also extends to reducing mental health problems related to unclear residential status, poor housing, poor access to jobs and education and limited social support [4]. These determinants directly affect refugees and quality of life in Canada as well as play an integral role on their mental health.

CHAPTER 3: METHODS

This review aimed to identify and collect all qualitative data that examined eligible studies in high-income countries for refugee resettlement.

Protocol Registration and Reporting

The present review has been registered within the PROSPERO database (registration number CRD42020180369). The published protocol for this systematic review [40] was written according to the Preferred Reporting Items for Systematic Review and Meta-analysis Protocols (PRISMA-P) guideline for reporting systematic reviews [41]. This review was conducted as per the Cochrane Collaboration Handbook of Systematic Reviews [42] and the findings were reported in accordance with the reporting guidance provided in the PRISMAs statement [41] and the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) statement [43]. (See Appendix V for details).

Inclusion Criteria

We have defined the following predefined eligibility criterion for this systematic review (see Appendix II for details): Eligible studies comprised of original research, peer-reviewed articles that had a qualitative component (i.e., qualitative, mixed-, or multi-method studies) written in English language .

The included studies involved refugee women (regardless of age) that could receive mental health services. Furthermore, studies conducted for both sexes were considered for inclusion, but only data for women were extracted. The eligible studies were conducted in leading high-income countries for refugee resettlement based on data from 2009-2019 in the UNHCR's Global

resettlement needs reports [10], and involved one or more type of usual standard mental health service for refugee women, including abuse support, addiction support, counselling, crisis support, psychiatric and psychological assessments and treatments, and support groups. The published protocol manuscript provides more details on the predefined eligibility criterion for this review [40].

Information Sources and Search Methods

The primary source of literature was a structured search of major electronic databases (from inception onwards): MEDLINE(Ovid), EMBASE, PsycINFO and CINAHL. The search strategies comprised of the following stages. First, a search of MEDLINE (Ovid) to identify relevant keywords contained in the title, abstract and subject descriptors. Second, we identified the synonyms and related terms for searches in EMBASE, PsycINFO, and CINAHL. In addition, we performed hand-searching of the reference lists of included studies, relevant reviews, or other relevant documents. The searches included a broad range of MeSH terms and keywords related to mental health services, accessibility, refugee, asylum seeker, women/female, and qualitative research. A final search was conducted on March 14, 2020, and a draft search strategy within multiple databases is provided in Appendix III. MeSH terms related to mental illness were not included, as this review focused on accessing mental health services and not necessarily the presence of mental illness. (See Appendix III for details).

Selection of studies

Citations were imported into the Zotero citation management software and uploaded in a zip file. The articles retrieved from searches within each database were uploaded into the Covidence article

management system and screened by two authors within the Covidence database for their relevance and eligibility to the review. Two reviewers (AG and SD) independently screened the titles and abstracts according to a pre-defined inclusion criteria checklist and exclude unrelated ones. Disagreements were resolved through discussion with SY and OO. This included title and abstract screening, followed by full-text screening against the eligibility criteria for studies deemed potentially eligible. Disagreements were settled through discussion. The PRISMA (Preferred Reporting Items for Systematic Review and Meta-Analyses) flowchart was used to document the selection process [41].

Data extraction and management

Following full-text screening, data was independently extracted from the retrieved eligible studies by two of the reviewers (ATG and SD). Disagreements were settled through discussion with SY and OO. The authors adapted a data collection document based on the needs of the review from a standardized data extraction form by the Cochrane Handbook [42]. The data that was extracted included all details specific to the review question, fulfilling the requirements for a narrative synthesis.

Assessment of risk of bias in included studies

A critical appraisal of included studies was conducted by two reviewers independently. All disagreements were resolved through discussion or consultation with the third and fourth reviewer as needed. Results from the appraisal were summarized narratively to highlight strengths and limitations within and across studies. The reviewers evaluated the studies using the appropriate Critical Appraisal Skills Programme (CASP) checklist [44]. The included studies were assigned

an overall score of 'high' (9-10), 'moderate' (7.5-9) or 'low' (less than 7.5) for overall quality. Studies were not excluded or weighted based on the quality of the reporting assessment, instead, the results of the appraisal were used to inform data interpretation and help confirm the validity of review findings and conclusions.

Therefore, seven studies were high quality (≥ 85%), five studies were moderate quality (75-85%), and none was of low quality (≤75%). The study that were within moderate quality ranges had some concerns with the lack of large enough sample size or need for randomization in sampling, as this impacted the ability to be generalizable to the broader refugee communities in each resettlement country.

Certainty of Evidence

The GRADE-CERQual ("Confidence in the Evidence from Reviews of Qualitative research") approach was applied to assess and summarize confidence in key findings [45]. This provided overall confidence in each of the key findings. Two reviewers independently assessed the certainty of evidence using the GRADE-CERQual approach [45]. Disagreements were resolved through discussion. Results were presented in GRADE-CERQual summary of qualitative findings tables [45].

Data synthesis

Evidence table of an overall description of the studies, data from each paper that provided details of study characteristics, context, participant immigration status, outcomes, and conclusion. A textual narrative synthesis was conducted, a method that was ideal for synthesizing evidence from a wide range of research questions and study designs with qualitative, mixed- or multi-method

approaches, as the emphasis is on an interpretive synthesis of the narrative findings of research. [46]. The data was described in a narrative synthesis, grouped by study type, participant characteristics, review objective and outcome (See Appendix VII for details). Accordingly, barriers and facilitators of mental health services for refugee women in high-income countries were identified and summarized.

CHAPTER 4: RESULTS

Search result

The reviewers identified 1258 records through database searches. After removing duplicates and conducting title and abstract screening and full text screening, there were 12 records that remained for inclusion within this systematic review. Details of the selection process and the reason for exclusion of excluded articles are provided on PRISMA Flowchart (see Appendix I for details).

Study Characteristics

Three studies were cross-sectional by design [47, 56, 58], eight studies used a qualitative approach [48,49-52,54-55,57], and one studies used mixed approach [53]. Accordingly, seven studies were conducted in North America, with five being conducted in Canada [48-50,52-53] and two being conducted in the USA [56-57]. Four studies were conducted in Australia [51,54-55,58], and one study was carried out in Europe (UK) [47]. (See Appendix IV for details).

Participant Characteristics

Participant were women either of refugee or asylum seeker status originating from Africa (Somalia, Nigeria, Gambia, Mali, Eritrea, Sudan, Sierra Leone, Congo, Liberia) Asia (Burma, Thailand, Pakistan, Vietnam, India, China, Bhutan) Middle East (Syria, Afghanistan, Iran, Iraq) and South America (Costa Rica, Colombia). Most participants sought general mental health services and three out of twelve sought mental health services related to antenatal care.

Finding 1: Barriers to accessing mental health services for refugee women in leading high-income countries for refugee resettlement

All of the studies (12/12) reported barriers to accessing mental health services among women refugees in top resettlement countries. There were three main barriers that were commonly mentioned in all the studies [47-58]. Those are language barrier, stigmatization, and lack of culturally appropriate resources.

Language

The challenges to accessing mental health services included the importance of linguistics and language barriers between participants and their health care provider [48,50-57]. Participants in these studies expressed the heavy reliance on interpreters, they specifically voiced concern for lack of funding of language services and lack of available interpreters in the health care system [55]. Studies showed that because of the limited grasp of English, participants expressed difficulty in understanding the health system, and medical terminology; these factors hindered appointment-scheduling and led to missed clinical appointments [50,52,55]. Similarly, studies have shown that language barriers also interfere with participants benefiting from available mental health counselling services and community-based health programs [50]. Participants spoke about using family members as interpreters in situations where there was a lack of available interpreters. However, conflicts of interest arose when family members often failed to translate exact messages or were sometimes the subjects of the issues being disclosed to mental health care providers. [50]. This conflict of interest and lack of confidentiality was an issue of utmost importance to participants and using lay interpreters that sometimes also had limited English literacy and communication skills [50].

Stigmatization

Another barrier to accessing mental health was the stigmatization experienced by refugee women seeking help for mental health care among family and their community [47, 51-54,56-58]. Mental health stigma was a theme most recognized among respondents across the various cultural groups of refugees. Apart from the stigma associated with having mental health issues, stigma was also apparent when trying to engage in help seeking behaviour. The notion of stigma extended to a varying degree of relationships of participants across the cultural groups and across studies. Participants most reported perceptions of stigma from within and outside their community [47, 51-54,56-58], but also included the fear of being stigmatized by their spouses. An example, are the words of women from Piwowarczyk, et al., 2014 study [57], which stated:

> "If you go, your husband or boyfriend will discourage you. You don't go to strangers to talk about something shameful" (Congolese woman, 18-25 years).
> ''Most would not go to a psychiatrist, don't want to talk to outsiders''
> (Somali woman, 18-25 years).
> "[husbands think] The same thing (as community responses to seeking help for mental health), that 'she's losing it'" (Somali woman, 25-36 years).

These types of similar narratives revealed that people may not necessarily be inclined to disclose to others about their suffering, which can result in negative consequences to their quality of life [57-58].

Lack of culturally appropriate resources

Another barrier to accessing mental health care included the need of culturally appropriate resources when accessing mental health services. The lack of trust in western medicine and the use of medication promoted by doctors in resettlement countries had some participants hesitant to adopt this form of treatment due to its cultural significance [50]. Additionally, concerns about confidentiality, privacy from the use of lay interpreters and concerns of accuracy from the use of health care workers proved to be big obstacles in accessing mental health services [54]. Through the inclusion of culturally sensitive care, perceptions and expressions of mental health needs can be relayed within an ethnic or cultural context to health care professionals [54]. Participants voiced concerns that health systems in resettlement countries, like Canada, are not sensitive to the unique cultural needs of immigrants and refugees thus resulting in further isolation within these populations [50]. Culturally sensitive care included the need for practices wrapped in religious and cultural contexts [47,50,54,57]. Spiritual practices were identified as a source of strength and hope, but also deterred women from accessing western biomedical treatment [50]. Participants explained misunderstandings related to treatments which adhered to a westernized medical model, failing to incorporate culture and belief system of the people [55]. Concepts like *Zar* possessions in Somalia, were a concept of spirit taking control over community members [47]. They believed *Zar* spiritual possessions could be explained by anger, unusual behaviour, nightmares, pains and even pregnancy. Participants struggled to hold traditional and religious beliefs with scientific and medical ones [47]. A refugee participant from Whittaker, et al., 2005 study [47] stated:

> Religious leaders . . . can do certain spiritual things to kind of release her from whatever's possessing her. . . . So, I'd just take her, I don't know, to a mosque or something. (Monique)

Gender roles

The role of gender and the associated consequential biological factors play a role on how refugee women access mental health service [48-54,57-58]. The variety of ways gender role affects mental health access, specifically the contribution to the family dynamic and the unique experience of being a woman and dealing with gender specific concerns such as post-partum depression [49,51,53]. For example, refugee women shouldered the responsibility of childcare and diminished the priority to take personal care of themselves such as accessing mental health care [48,52]. Furthermore, findings showed a gender hierarchy within relationships that portrayed male domination and control affecting women's health status and timely access to mental health services, increasing their social vulnerability in a dependent situation [48-50]. O'Mahony, et al., 2013 indicated that participants clearly identified that behaviour of their partner or spouse was a contributing factor to their post-partum depression. New immigrant and refugee mothers voiced that they found themselves in a powerless and generally dependent position that left them vulnerable to abuse [49].

Finding 2: Facilitators to accessing mental health services for refugee women in leading high-income countries for refugee resettlement

This review found that seven studies reported that there are facilitators to accessing mental health services among women refugees in top resettlement countries [47-48, 50-53,57]. Those are: service availability and awareness, social support, and resilience factors.

Service Availability /Awareness of mental health services

Service availability and awareness of mental health services also facilitated ease of access depending on the resettlement country and the national health and immigration policies that were set in place [47-48, 51-52]. Participants expressed their gratitude towards their hosting resettlement country for providing mental health services that they were eligible for. Equally importantly, participants mentioned strong health promotion of mental health resources to aid in accessing mental health services offered [47-48, 51-52]. The availability and awareness of services included the provision of mental health and mental illness prevention and treatment care at the primary health care level, but also refugee resettlement agencies that provided a network of caseworkers and mental health counselling services [48]. These types of programs that made mental health services available to refugees enabled ease in access in continued mental health care [47-48]. Donnelly et al., 2011 showed that participants talked about the awareness of mental health and well-being among refugee women is a positive change in the community. The study indicated the having written resources in their own language and making them available in public places like community centers.

Social Support

The importance of social support was identified as key facilitator among respondents in accessing mental health services [48, 50-51,53,57]. Support from spouses, family, and the community

provided varying degrees of support for easing mental health illnesses like stress, depression, and anxiety in everyday life [48, 50-51,53,57]. Social support also provided encouragement in help-seeking behavior for mental health services and improved self-efficacy and autonomy of participants. An example of a participant's experience of social support, related to a post-partum depression experience is taken from Ahmed et al., 2017 study [53] stating:

> Reem: "It should be like we can go and visit them, or the family can come and visit us. This way we would not feel like a bird in a cage or imprisoned…. This is the most important and critical issue here. This is what can cause depression."

> Joud: "You feel that you aren't alone, and you will feel that someone is standing beside you.…Like when you are going to give birth, you really need your mother, your aunt or somebody."

Additionally, participants identified that knowledge and awareness of mental illness by family members were important in continuing access to proper treatment and professional interventions, making mental health education imperative.

Resilience

There were some studies that identified the importance of autonomy of refugee women [48,50, 53-54]. The theme of resilience among refugee women was consistent across all studies but were explicitly outlined as a feature that exemplified the resilience strength and determination of the women [48,50]. The participants sought assistance and employed self-care strategies to deal with mental health problems within the context of limited resources [50]. The concept of resilience and

coping resonated among female participants that voiced their independence and high standard of self-efficacy that enabled help seeking behaviour and eased accessing mental health services [54]. Though refugee women recalled sad stories of trauma and sorrow, participants also showed strong and liberating values when it came to taking control of their lives and being determined to survive in a new resettlement country. Such admirable traits exhibited, were shown as empowering refugee women to access the mental health care they needed. Ahmed, et al., 2017 showed participants mention that partaking in exercises like walking and swimming helped their mental health [53]. Participants exemplified resilience by taking control of their life and engaging in activities that facilitate sound mental health care [53]. These mental health care services included support programs and gendered recreational group classes that helped refugee women form social connections and build social networks to make them feel supported [53].

CHAPTER 5: DISCUSSION

There is a large body of evidence that pertains to the barriers and facilitators which refugee women face when accessing mental health services in resettlement countries. This systematic review summarizes the evidence regarding mental health care barrier and facilitator study characteristics, context, and participant's sex and age, to address the experiences faced by refugee women when accessing mental health services in leading resettlement countries. The findings of this research may be applied to enhance existing mental health service access for refugee women in high-income countries.

The review revealed the prevalence of barriers to accessing mental health services, the most common being stigmatization of mental health and mental health seeking behaviour [47, 51-54,56,58]. Stigma is a theme that participants commonly discussed, and often related their understanding to how an individual and society views their mental health [53, 59-63]. Participants feared how mental health will be linked to their country of origin, families, and resettlement in immigrant communities [53]. When interviewed, refugee women mentioned the fear of disapproval of ethnic community members, family, and friends, as well as physical and emotional abuse from their partners as a consequence of seeking help or divulging mental health concerns [60-61]. Patterns of stigma and discrimination can be multi-fold, based on social identity [61]. Many studies support the notion that stigma and negative attitudes towards mental health and mental health services users play an influential role across refugee population and trauma survivors [62-65]. Shame is known to impede help-seeking combined with the embarrassment among sexual violence survivors [66].

The role of gender is an imperative component of this review, as almost all the included studies wrap the involvement of barriers and facilitators in accessing mental health as it pertains to the female refugee experience [47-53,57-58]. Women face barriers that are specific to biological factors because of their disposition to postpartum depression, a barrier that is non-existent for their male counterparts [51,54,60,67-69]. As such, the need for sufficient natal and antenatal mental health care is a concern that is worsened among refugee women predisposed to trauma conflict and violence [51,54,60,67-69].

Additionally, based on the findings, some participants suggested that a gendered hierarchy existed within some relationships, including a dependency on their husbands. Characteristics of social vulnerability were parallel to those that were described by refugee women participants [70-73]. These characteristics included not having other family in their resettlement country, not being financially independent, having an undocumented status and lack of education that perpetuated intimate partner violence [72].

Social support from the spouse, family or community offered to refugee women enabled access and promoted help seeking behaviour for mental health care [48,50-51,53,57]. While there are less studies that looked into facilitators of accessing mental health services, social support was a reoccurring theme voice by participants when discussing factors that contributed to accessing mental health care [48,50-51,53,57]. Similarly, several studies have shown the significance that social support provides to accessing mental health services among refugee populations [57]. Somali populations have supported their community members to provide social support through providing advice about treatment and coping behaviour, financial aid for seeking treatment, and religious guidance [64]. Friends and family were known as important gatekeepers to mental health service utilization and access, as they encourage women to seek professional treatment [73-74].

Implications

This review revealed socio-economic factors as potential contributing facilitators and barriers to access mental health among refugees and asylum seekers. Policymakers would benefit in addressing social determinants of health in order to remedy the concerns addressed by participants when accessing mental health services [75-76]. Increasing education and financial stability related to job and housing security can reduce added stresses of everyday life [75-76], but also can reduce social vulnerability of refugee women. Policy recommendations to address these kinds of social determinants of health can reduce

barriers and enhance facilitators of access for mental health care to vulnerable populations like refugee women.

Additional benefits of this review aim to reshape the view of refugee women from the associated stigmatization related to mental health to a narrative that showcases the resilience and strength of refugee women who are determined to access mental health services. Based on the body of evidence from this review, the undeniable relationship between the availability of social support and access to mental health services. This review can inform community outreach and public health programs to include and involve a greater focus on community engagement and social support or outreach to reduce isolation and stressors, but also to encourage community members in refugee populations and other social setting to address and promote mental health care.

Although there is a difference in health access policy among the top resettlement courtiers, the review found that there are no significant differences in accessing mental health for refugee and asylum seeker women among leading resettlement countries. The review findings suggest the need for further research on this topic given the potential significance of the findings on refugee and asylum seeker women mental health.

Limitations

This review gathers qualitative data to examine existing barriers and facilitators to accessing mental health services for refugee women in leading resettlement countries. There are several limitations of our systematic review methods. There is an exclusion of research published in languages other than English, which can result in the exclusion of valuable data. Additionally, some data may be unrepresented, underreported, or misreported due to sensitive and highly stigmatize nature of mental health issues among refugee populations. This may result in publication bias and methodological quality issues. Lastly, there were many studies in this review that made use of a cross-sectional research design. Factors

that are related to the length of time living in a resettlement country plays a role in the influence on awareness and utilization of mental health services, therefore the adoption of a longitudinal research design may be most appropriate for future research to assess the barriers and facilitators for accessing mental health services over time.

CONCLUSION

This systematic review examined the facilitators and barriers to access mental health services among refugee women. Evidence suggest that stigmatization of mental health from within the refugee population is a major barrier for women refugee mental health seeking behavior. One important facilitator of mental health services among women refugee is the strong health promotion of mental health resources in the countries of resettlement which aided access to mental health services. It will hope to inform community outreach and public health programs to include promote and encourage accessing mental health services among refugee women populations.

REFERENCES

1. United Nations High Commissioner for Refugees [UNHCR]. 2019. Figures at a Glance. Statistical Yearbook 2019. Retrieved from: https://www.unhcr.org/figures-at-a-glance.html

2. Silove D, Ventevogel P, & Rees S. The contemporary refugee crisis: an overview of mental health challenges. World psychiatry. 2017; 16(2), 130–139. doi:10.1002/wps.20438.

3. Robert AM, Gilkinson T. Mental health, and well-being of recent immigrants in Canada: Evidence from the Longitudinal Survey of Immigrants to Canada (LSIC). Research and Evaluation Branch, Citizenship, and Immigration Canada. 2012. Retrieved from : https://www.canada.ca/en/immigration-refugees-citizenship/corporate/reports-statistics/research/mental-health-well-being-recent-immigrants-canada-evidence-longitudinal-survey-immigrants-canada-lsic.html

4. Mental Health Commission of Canada. Changing directions, changing lives: The mental health strategy for Canada. Calgary, AB. 2016.

5. World Health Organization. Mental health promotion and mental health care in refugees and migrants. Copenhagen: WHO Regional Office for Europe (Technical guidance on refugee and migrant health. 2018.

6. McKenzie K, Hansson E, Tuck A, Lam J, & Jackson F. Improving mental health services for immigrant, refugee, ethno-cultural and racialized groups: Issues and options for service improvement. Calgary, AB: Mental Health Commission of Canada. 2009. Retrieved from:

http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Key_Documents/en/2010/Issues_Options_FINAL_English%2012Nov09.pdf

7. United Nations High Commissioner for Refugees [UNHCR]. Global Trends. Forced Displacement in 2016. 2017. Retrieved from: https://www.unhcr.org/statistics/unhcrstats/5943e8a34/global-trends-forced-displacement-2016.html

8. Priebe S, Giacco D, El-Nagib R. Public health aspects of mental health among migrants and refugees: a review of the evidence on mental health Care for Refugees, asylum seekers and irregular migrants in the WHO European region. Health Evidence Network Synthesis Report. 2016;27(ISBN-13):978–92. -890-5165-1, 2016.

9. Porter M, Haslam N. Pre-displacement and post-displacement factors associated with mental health of refugees and internally displaced persons: a meta-analysis. JAMA. 20015; 294(5):602-12.

10. United Nations High Commissioner for Refugees [UNHCR]. 2020. Projected Global Resettlement Needs 2021.Retreived from: https://www.unhcr.org/protection/resettlement/5ef34bfb7/projected-global-resettlement-needs-2021.html

11. Giacco D, Priebe S. Mental health care for adult refugees in high-income countries. Epidemiol Psychiatr Sci. 2018 Apr;27(2):109-116. doi: 10.1017/S2045796017000609. Epub 2017 Oct 25.

12. Sijbrandij M. Expanding the evidence: key priorities for research on mental health interventions for refugees in high-income countries. Epidemiology and Psychiatric Sciences. 2018; 27, 105–108. doi:10.1017/S2045796017000713

13. Norredam M, Mygind A, Krasnik A: Access to health care for asylum seekers in the European Union—a comparative study of country policies. Eur J Public Health 2006, 16: 286–290

14. Hollander AC, Bruce D, Burström B, Ekblad S. Gender-related mental health differences between refugees and non-refugee immigrants--a cross-sectional register-based study. BMC Public Health. 2011 Mar 24; 11:180. doi: 10.1186/1471-2458-11-180.

15. Ahmed A, Bowen A, Feng CX. Exploring maternal mental health in Syrian refugee women. BMC Pregnancy Childbirth. 2017 Jul 24;17(1):240. doi: 10.1186/s12884-017-1433-2.

16. Guruge S, Sidani S, Illesinghe V, Younes R, Bukhari H, Altenberg J, Rashid M, Fredericks S. Healthcare needs and health service utilization by Syrian refugee women in Toronto. Confl Health. 2018 Dec 3; 12:46. doi: 10.1186/s13031-018-0181-x.

17. Masterson A, Usta J, Gupta J, Ettinger AS. Assessment of reproductive health and violence against women among displaced Syrians in Lebanon. BMC Women's Health. 2014; 14:25. https://doi.org/10.1186/1472-6874-14-25.

18. United Nations High Commissioner for Refugees [UNHCR]. 2015. *Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians. A Review for Mental Health and*

Psychosocial Support Staff Working with Syrians Affected by Armed Conflict. Available from: http://www.unhcr.org/55f6b90f9.pdf

19. Jefee-Bahloul H, Barkil-Oteo A, Pless-Mulloli T, Fouad FM. Mental health in the Syrian crisis: beyond immediate relief. Lancet. 2015; 386:1531.

20. Hendrickx M, Woodward A, Fuhr DC, Sondorp E, Roberts B. The burden of mental disorders and access to mental health and psychosocial support services in Syria and among Syrian refugees in neighboring countries: a systematic review. J Public Health (Oxf). 2019 Nov 5. doi: 10.1093/pubmed/fdz097.

21. Van der Boor CF, White R. Barriers to Accessing and Negotiating Mental Health Services in Asylum Seeking and Refugee Populations: The Application of the Candidacy Framework. J Immigrant Minority Health. 2020; 22, 156–174 https://doi.org/10.1007/s10903-019-00929-y

22. Dickson K, Bangpan M. What are the barriers to, and facilitators of, implementing and receiving MHPSS programmes delivered to populations affected by humanitarian emergencies? A qualitative evidence synthesis. Glob Ment Health (Camb). 2018 Jun 1;5: e21. doi: 10.1017/gmh.2018.12.

23. Durbin A, Lin E, Moineddin R, Steele LS, Glazier RH. Use of mental health care for nonpsychotic conditions by immigrants in different admission classes and by refugees in Ontario, Canada. Open Med. 2014 Oct 28;8(4): e136-46. eCollection 2014.

24. Daya R. Changing the Face of Multicultural Counselling with Principles of Change. Canadian Journal of Counselling and Psychotherapy. 2007; 35(1). Retrieved from https://cjc-rcc.ucalgary.ca/article/view/58659

25. Kantor V, Knefel M, Lueger-Schuster B. Perceived barriers and facilitators of mental health service utilization in adult trauma survivors: A systematic review. Clin Psychol Rev. 2017 Mar; 52:52-68. doi: 10.1016/j.cpr.2016.12.001.

26. Colucci E, Minas H, Szwarc J, Guerra C, Paxton G. In or out? Barriers and facilitators to refugee-background young people accessing mental health services. Transcult Psychiatry. 2015 Dec;52(6):766-90. doi: 10.1177/1363461515571624. Epub 2015 Mar 2.

27. Martinez, O., Wu, E., Sandfort, T., Dodge, B., Carballo-Dieguez, A., Pinto, R., Rhodes, S. D., Moya, E., & Chavez-Baray, S. (2015). Evaluating the impact of immigration policies on health status among undocumented immigrants: a systematic review. *Journal of immigrant and minority health*, *17*(3), 947–970. https://doi.org/10.1007/s10903-013-9968-4

28. Misra, T., Connolly, A., & Majeed, A. (2006). Addressing mental health needs of asylum seekers and refugees in a London Borough: Epidemiological and user perspectives. *Primary Health Care Research & Development*, *7*, 241–248.

29. Palmer, D., & Ward, K. (2007). 'Lost': Listening to the voices and mental health needs of forced migrants in London. *Medicine, Conflict, and Survival, 23*(3), 198–212. https://doi.org/10.1080/13623690701417345.

30. Wong, E. C., Marshall, G. N., Schell, T. L., Elliott, M. N., Hambarsoomians, K., Chun, C. A.,& Berthold, S. M. (2006b). Barriers to mental health care utilization for U.S. Cambodian refugees. *Journal of Consulting and Clinical Psychology*, *74*(6), 1116–1120. https://doi.org/10.1037/0022-006X.74.6.1116.

31. Hollander, A. C., Dal, H., Lewis, G., Magnusson, C., Kirkbride, J. B., & Dalman, C. (2016). Refugee migration and risk of schizophrenia and other non-affective psychoses: Cohort study of 1.3 million people in Sweden. *BMJ (Online), 352*, 1–8. https://doi. org/10.1136/bmj.i1030.

32. Kessler, R. C., Petukhova, M., Sampson, N., Zaslavsky, A., & Wittchen, H. (2012). Twelvemonth and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research,21*(3), 169–184.

33. Silove, D., Ventevogel, P., & Rees, S. (2017). The contemporary refugee crisis: An overview of mental health challenges. *World Psychiatry, 16*(2), 130–139. https://doi.org/10.1002/wps.20438.

34. Jagdeo, A., Cox, B. J., Stein, M. B., Sareen, J., & Journals, P. P. (2009). Negative attitudes toward help seeking for mental illness in 2 population-based surveys from the United States and Canada. *The Canadian Journal of Psychiatry*, *54*(11), 757–766.

35. Alemi, Q., Weller, S. C., Montgomery, S., & James, S. (2016). Afghan refugee explanatory models of depression: Exploring core cultural beliefs and gender variations. *Medical Anthropology Quarterly*, *31*(2), 177–197. https://doi.org/10.1111/maq.12296

36. M'zah, S., Lopes Cardozo, B., & Evans, D. P. (2018). Mental health status and service assessment for adult Syrian refugees resettled in metropolitan Atlanta: A cross-sectional survey. *Journal of Immigrant and Minority Health, 0*(0), 0. https://doi.org/10.1007/s10903-018-0806-6.

37. Satinsky, E., Fuhr, D. C., Woodward, A., Sondorp, E., & Roberts, B. (2019). Mental health care utilisation and access among refugees and asylum seekers in Europe: A systematic review. *Health Policy*. https://doi.org/10.1016/j.healthpol.2019.02.007.

38. Sabri, B., Nnawulezi, N., Njie-Carr, V., Messing, J., Ward-Lasher, A., Alvarez, C., & Campbell, J. C. (2018). Multilevel risk and protective factors for intimate partner violence among african, asian, and latina immigrant and refugee women: Perceptions of effective safety planning interventions. *Race and Social Problems, 10*(4), 348-365. doi:http://dx.doi.org.proxy.bib.uottawa.ca/10.1007/s12552-018-9247-z

39. Nickerson, A., Bryant, R. A., Silove, D., & Steel, Z. (2011). A critical review of psychological treatments of posttraumatic stress disorder in refugees. *Clinical Psychology Review*, *31*(3), 399–417. https://doi.org/10.1016/j.cpr.2010.10.004.

40. DeSa, S., Gebremeskel AT., Yaya, S. (2020). Barriers and facilitators to access mental health services among refugee women in high-income countries: study protocol for a systematic review. *BMC Systematic Reviews*, 9:186 https://doi.org/10.1186/s13643-020-01446-y

41. PRISMA-P Group et al. - 2015 - Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 Statement. Available from: https://systematicreviewsjournal.biomedcentral.com/track/pdf/10.1186/2046-4053-4-1

42. Higgins JPT, Thomas J, Chandler J, Cumpston M, Li T, Page MJ, Welch VA (editors). Cochrane Handbook for Systematic Reviews of Interventions version 6.0 (updated July 2019). Cochrane, 2019. Available from www.training.cochrane.org/handbook.

43. Tong, A., Flemming, K., McInnes, E. *et al.* Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC Med Res Methodol* **12,** 181 (2012). https://doi.org/10.1186/1471-2288-12-181

44. Critical Appraisal Skills Programme. CASP Checklists - Critical Appraisal Skills Programme [Internet]. CASP Appraisal Checklists. CASP; 2018. Available from: https://casp-uk.net/casp-tools-checklists/.

45. Lewin, S., Booth, A., Glenton, C. *et al.* Applying GRADE-CERQual to qualitative evidence synthesis findings: introduction to the series. *Implementation Sci* **13,** 2 (2018). https://doi.org/10.1186/s13012-017-0688-3.

46. Popay J, Roberts H, Sowden A, Petticrew M, Arai L, Rodgers M, et al. Guidance on the conduct of narrative synthesis in systematic reviews: A product from the ESRC Methods

Programme, version 1 [Internet]. Lancaster: Institute of Health Research; 2006. Available from: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.178.3100&rep=rep1&type=pdf.

47. Whittaker, S., Hardy, G., Lewis, K., & Buchan, L. (2005). An Exploration of Psychological Well-being with Young Somali Refugee and Asylum-seeker Women. *Clinical Child Psychology and Psychiatry*, *10*(2), 177–196. https://doi.org/10.1177/1359104505051210

48. Clark N. (2018). Exploring community capacity: Karen refugee women's mental health. *International journal of human rights in healthcare*, *11*(4), 244–256. https://doi.org/10.1108/IJHRH-02-2018-0025

49. O'Mahony JM, Donnelly TT. How does gender influence immigrant and refugee women's postpartum depression help-seeking experiences? *J Psychiatr Ment Health Nurs*. 2013;20(8):714-725. doi:10.1111/jpm.12005

50. Donnelly TT, Hwang JJ, Este D, Ewashen C, Adair C, Clinton M. If I was going to kill myself, I wouldn't be calling you. I am asking for help: challenges influencing immigrant and refugee women's mental health. *Issues Ment Health Nurs*. 2011;32(5):279-290. doi:10.3109/01612840.2010.550383

51. Willey SM, Rebecca P Blackmore, Melanie E Gibson-Helm, Razia Ali, Leanne M Boyd, Jacqueline McBride, Jacqueline A Boyle. 2019. If you don't ask … you don't tell": Refugee women's perspectives on perinatal mental health screening, Women and Birth.

52. Tulli M, Salami B, Begashaw L, Meherali S, Yohani S, Hegadoren K. Immigrant Mothers' Perspectives of Barriers and Facilitators in Accessing Mental Health Care for Their Children [published online ahead of print, 2020 Feb 4]. *J Transcult Nurs*. 2020;1043659620902812.

53. Ahmed A, Bowen A, Feng CX. Maternal depression in Syrian refugee women recently moved to Canada: a preliminary study. *BMC Pregnancy Childbirth*. 2017;17(1):240. Published 2017 Jul 24. doi:10.1186/s12884-017-1433-2

54. Babatunde-Sowole, O.O., DiGiacomo, M., Power, T., Davidson, P.M. & Jackson, D. 2020. Resilience of African migrant women: Implications for mental health practice. Int J Mental Health Nurs, 29: 92-101. doi:10.1111/inm.12663

55. Smith, L.A., Reynish, T., Hoang, H., Mond, J., Hannah, C., McLeod, K., Auckland, S., & Slewa-Younan, S. 2019. The mental health of former refugees in regional Australia: A qualitative study. *Aust. J. Rural Health*. 27: 459– 462. https://doi-org.proxy.bib.uottawa.ca/10.1111/ajr.12583

56. Wong, E. C., Marshall, G. N., Schell, T. L., Elliott, M. N., Hambarsoomians, K., Chun, C.-A., & Berthold, S. M. (2006). Barriers to mental health care utilization for U.S. Cambodian refugees. *Journal of Consulting and Clinical Psychology, 74*(6), 1116–1120. https://doi.org/10.1037/0022-006X.74.6.1116

57. Piwowarczyk, Linda, MD, MPH, Bishop, Hillary, Yusuf, Abdirahman, Mudymba, Francine & Raj, Anita. (2014). Congolese and Somali Beliefs About Mental Health Services. Journal of Nervous & Mental Disease, 202, 209-216. https://doi.org/10.1097/NMD.0000000000000087

58. Drummond PD, Mizan A, Brocx K, Wright B. Barriers to accessing health care services for West African refugee women living in Western Australia. *Health Care Women Int*. 2011;32(3):206-224. doi:10.1080/07399332.2010.529216

59. Blitz, B. K., D'Angelo, A., Kofman, E., & Montagna, N. (2017). Health Challenges in Refugee Reception: Dateline Europe 2016. *International journal of environmental research and public health*, *14*(12), 1484. https://doi.org/10.3390/ijerph14121484

60. P.J. Shannon, E. Wieling, J. Simmelink-McCleary, E. Becher, Beyond Stigma: Barriers to Discussing Mental Health in Refugee Populations, J Loss Trauma 20 (3) (2015) 281–296, doi:http://dx.doi.org/10.1080/15325024.2014.934629.

61. Amri, S., F. Bemak, Mental Health Help-Seeking Behaviors of Muslim Immigrants in the United States: Overcoming Social Stigma and Cultural Mistrust, J Muslim Ment Health 7 (1) (2013) 43–63, doi:http://dx.doi.org/10.3998/jmmh.10381607.0007.104.

62. Ahmed A, Stewart DE, Teng L, Wahoush O, Gagnon AJ. Experiences of immigrant new mothers with symptoms of depression. Arch Women's Ment Health. 2008;11(4):295–303.

63. O'Mahony JM, Donnelly TT, Raffin Bouchal S, Este D. Barriers and facilitators of social supports for immigrant and refugee women coping with postpartum depression. Adv Nurs Sci. 2012;35(3): E42–56.

64. Markova, V., & Sandal, G. M. (2016). Lay Explanatory Models of Depression and Preferred Coping Strategies among Somali Refugees in Norway. A Mixed-Method Study. *Frontiers in psychology*, *7*, 1435. https://doi.org/10.3389/fpsyg.2016.01435

65. Jankovic, J., Vidakovic, I., Matanov, A., Schützwohl, M., Ljubotina, D., Lecic-Tosevski, D., & Priebe, S. (2011). Reasons for not receiving treatment in people with posttraumatic stress disorder following war. Journal of Nervous and Mental Disease, 199, 100–105. http://dx.doi.org/10.1097/NMD.0b013e3182083db5

66. Tiburcio Sainz, M., Natera Rey, G., & Berenzon Gorn, S. (2010). Mental health services utilization among Mexican female victims of intimate partner violence. Salud Mental, 33, 243–248.

67. Aberman, T. (2014), "Gendered perspectives on refugee determination in Canada", Refuge, Vol. 2 No. 30, pp. 57-65.

68. O'Mahony, J. M., & Donnelly T. (2007a). The influence of culture on immigrant women's mental health care experiences from the perspectives of health care providers. Issues in Mental Health Nursing, 28, 453–471.

69. O'Mahony, J. M., & Donnelly T. (2007b). Health care providers' perspective of the gender influences on immigrant women's mental health care experiences. Issues in Mental Health Nursing, 28, 1171–1188.

70. Marlowe, M. (2010), "Beyond the discourse of trauma: shifting the focus on Sudanese refugees", Journal of Refugee Studies, Vol. 23 No. 2, pp. 183-98.

71. Schweitzer, R., Brough, M., Vromans, L. and Asic-Kobe, M. (2011), "Mental health of newly arrived Burmese refugees in Australia: contributions of pre-migration and post-migration experience", Australia and New Zealand Journal of Psychiatry, Vol. 45 No. 4, pp. 299-307, doi: 10.3109/00048674.2010.543412.

72. Sabri, B., Nnawulezi, N., Njie-Carr, V.P.S. *et al.* Multilevel Risk and Protective Factors for Intimate Partner Violence Among African, Asian, and Latina Immigrant and Refugee Women: Perceptions of Effective Safety Planning Interventions. *Race Soc Probl* 10, 348–365 (2018). https://doi-org.proxy.bib.uottawa.ca/10.1007/s12552-018-9247-z

73. Bance, S., Links, P. S., Strike, C., Bender, A., Eynan, R., Bergmans, Y., & Antony, J. (2014). Help-seeking in transit workers exposed to acute psychological trauma: A qualitative analysis. Work (Reading, Mass.), 48, 3–10. http://dx.doi.org/10.3233/WOR-131650

74. Vogel, D. L., Wade, N. G., Wester, S. R., Larson, L., & Hackler, A. H. (2007). Seeking help from a mental health professional: The influence of one's social network. Journal of Clinical Psychology, 63, 233–245. http://dx.doi.org/10.1002/jclp.20345.

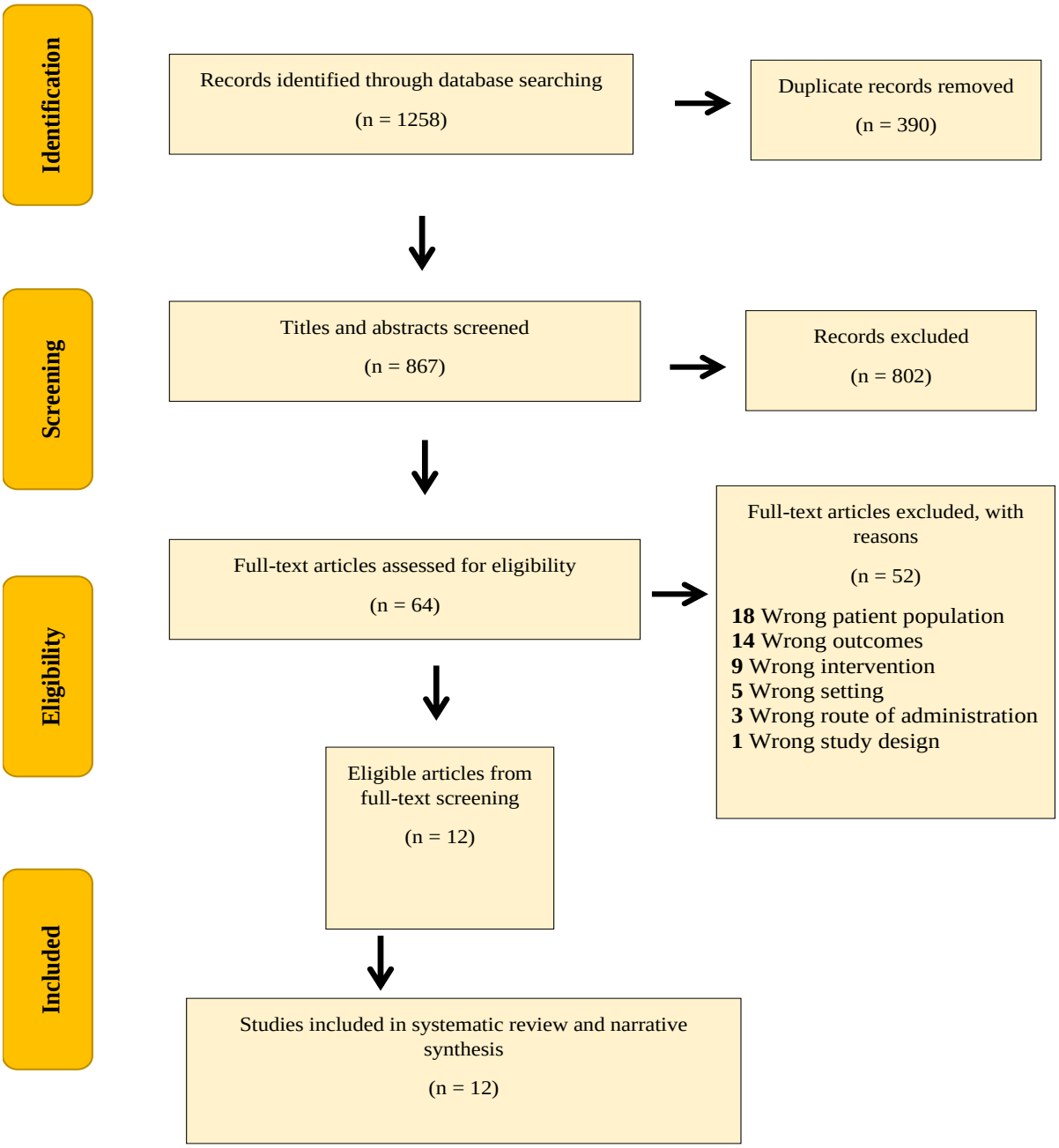
75. Adler, N. E., Glymour, M. M., & Fielding, J. (2016). Addressing social determinants of health and health inequalities. JAMA. Journal of the American Medical Association, 316(16), 1641-1642. https://doi.org/10.1001/jama.2016.14058.

76. Pickett, K. E., & Wilkinson, R. G. (2015). Income inequality and health: A causal review. Social Science & Medicine, 128, 316-326. https://doi.org/10.1016/j.socscimed.2014.12.031

APPENDICES

APPENDIX I: PRISMA Flow Diagram

Figure 1: PRISMA Flowchart



APPENDIX II: Study Selection Criteria

Table 1: Inclusion and Exclusion Criteria

	Inclusion Criteria	**Exclusion Criteria**
Participants	• Refugee women/females in leading resettlement countries. • Refugee women/girls at any age group that receive mental health services. • Refugee women data provided within gender comparative studies.	• Refugee men in resettlement countries that receive mental health services. • Men and women under non-refugee/Asylum seeker/ displaced migrant legal status.
Context	• Involves one or more type of usual standard mental health services for refugee women, including abuse support, addiction support, counselling, crisis support, psychiatric and psychological assessments and treatments, and support groups.	• Usage or need for non-mental health services for refugee women, including other health services unrelated to mental health treatment or prevention.
Comparison / Control Group	• No comparison group for this study.	
Outcome of Interest	• To present barriers or challenges, facilitators or enablers, related to accessing mental health services in leading resettlement countries.	

Setting	• Leading high-income countries based on data on data from 2009-2019 in the UNHCR's Global resettlement needs reports. • Included resettlement countries include: • North America: Canada and United States of America • Europe: Belgium, Denmark, Finland, France, Germany, Netherlands, Norway, Switzerland, Sweden and United Kingdom • Oceania: Australia and New Zealand	• Countries not included as a leading resettlement countries from the past 10 years.
Study Design	• Qualitative, mixed- or multi-methods studies. • Peer reviewed full-text research papers, published in English.	• Reviews, editorials and commentaries, discussions, theses or dissertations and other gray literature. • Articles published in any other languages other than English.

APPENDIX III: Search Strategy

Search Terms: Medline (OVID)

Set 1: Intervention

A) MeSH

Mental Health Services/ or Health Services Accessibility/ or Ethnopsychology/ or psychiatry/ or psychology/ or psychopharmacology/ or exp community mental health services/ or exp counseling/ or exp emergency services, psychiatric/ or exp psychiatric somatic therapies/ or exp psychological techniques/ or exp psychotherapy/

B) Keyword

Mental adj2 health adj2 (service* or Program*) or ethnopsych*

Set 2: Population

A) MeSH

Refugees/ or Asylum seekers/

B) Keyword

Refugee* or (asylum* adj2 seeker*) or (displac* adj2 person*) or (forced adj2 migrant*) or (undocumented or unauthorized or illegal)) adj2 (immigrant* or alien* or worker*)

Set 3: Search Alone

A) MeSH

Women/ or Female/

B) Keyword

Wom?n or girl* or female*

Set 4: Study Design

Qualitative Research/

Search Summary: Set 1 (A or B) and Set 2 (A or B) and Set 3 (A or B) and Set 4

APPENDIX IV: Study Characteristics

Table 2: Study Characteristics

Author	Year	Immigration Status	Study Design	Participant characteristics	High-Income Region	Study Country	Participant Country of Origin	Type of usual standard mental health services for refugee women
Whittaker, et al.	2005	Asylum-seeker; refugees	Cross-sectional	Female refugees born in north Somalia, entered UK as a child or adolescent living in England for over 1 Year	Europe	United Kingdom	Somalia	Doctors, counsellors, "shrinks", psychologists, bereavement groups, telephone help lines, homecare
Wong, et al.	2006	Refugees	Cross-sectional	Refugees from Cambodian origin between 35-75 years old	North America	USA	Cambodian	Mental health care services
Donnelly, et al.	2011	Refugees	Qualitative	refugee and migrant women living with mental illness	North America	Canada	China and Sudan	mental health care services
Drummond, et al.	2011	Refugees	Cross-Sectional	Refugee women aged between 20-67 years from Liberia or Sierra Leone who have lived in Australia for 6 months to 5 years.	Australia	Australia	Liberia, Sierra Leone	Health care services and mental health services
O'Mahony, et al.	2013	Refugees	Qualitative	Over 18 years old, non-European women with immigrant or refugee s status, living in Canada	North America	Canada	Costa Rica	post-partum depression mental health services
Piwowarczyk, et al.	2014	Refugees	Qualitative	Refugee women from Congolese or Somalian backgrounds, above the age of 18 years old.	North America	USA	Somalia and Congolese	Mental health services
Ahmed, et al.	2017	Refugees	Mixed-Methods	pregnant or within 1 year of giving birth, admitted to Canada as government or privately sponsored refugees, able to speak English and Arabic	North America	Canada	Saskatoon, Canada	natal and antenatal mental health care
Clark N.	2018	Refugees	Qualitative	Karen women receiving frontline health care services	North America	Canada	Karen speaking; Burmese and Thailand	mental health services
Smith, et al.	2019	Refugees	Qualitative	Adult and youth former refugee and essential service providers residing in Launceston	Australia	Launceston, Tasmania	Afghanistan, Bhutan, Burma, Sierra Leone, Sudan and Iran	mental health essential services
Willey, et al.	2019	Refugees	Qualitative	refugees that are in the last stages of pregnancy or post-natal pregnancy care, living in a suburb in Melbourne	Australia	Australia	Burmese and Dari-Afghan, Indian, Vietnamese refugee women	perinatal mental health screening
Babatunde Sowole, et al.	2020	Asylum-seeker; refugees	Qualitative	Women, fluent in English, over 18 years old	Australia	Australia	West Africa	mental health provision
Tulli, et al.	2020	Refugees	Qualitative	immigrant and refugee mothers living in Edmonton, Canada, and have children living in Canada.	North America	Canada	Sudan, Syria, Colombia	Pediatric and immigrant mental health care

Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	1
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	6
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	7
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	7
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	8
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	8,9
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	9
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	9
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	10
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	11
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	10
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	

Section/topic	#	Checklist item	Reported on page #
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	10
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	12
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	12
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	13
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	12
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	19
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	23
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	23
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	25

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

APPENDIX VI: CASP Checklist and Certainty of Evidence

Table 3: CASP Checklist

	Whittaker, et al.,2005	Wong, et al., 2006	Donnelly, et al., 2011	Drummond, et al., 2011	OMahony, et al., 2013	Piwowarczyk, et al., 2014	Ahmed, et al., 2017	Clark N., 2018	Smith, et al., 2019	Willey, et al., 2019	Babatunde Sowole, et al., 2020	Tulli, et al., 2020
Was there a clear statement of the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is a qualitative methodology appropriate?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Was the research design appropriate to address the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Was the recruitment strategy appropriate to the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Was the data collected in a way that addressed the research issue?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Has the relationship between researcher and participants been adequately considered?	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Have ethical issues been taken into consideration?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Was the data analysis sufficiently rigorous?	N	Y	Y	Y	Y	Y	Y	Y	N	Y	N	Y
Is there a clear statement of findings?	?	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
Is the research valuable?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Overall Score	8	9	9.5	9	9.5	8.5	9	8.5	8.5	9	8	9.5

Outcome	Evidence	Number of studies	Certainty in the Evidence
Barriers	Most studies found barriers had a significant influence on access to mental health services.	12	MODERATE ⊕⊕⊕O (due to minor concerns with methodological quality and limitations)
Facilitators	7 studies found facilitators that had an influence on access to mental health services.	7	LOW ⊕⊕OO (due to lack in rigour in data analysis, concerns of publication bias and minor concerns with methodological quality.)

APPENDIX VII: Narrative Synthesis

Whittaker et al., 2005 used a cross- sectional approach to investigate how young Somalian refugee and asylum-seekers perceive psychological well-being [47]. Using semi-structured personal and group interviews of female refugees born in north Somalia, Whittaker et al., focused on participants that entered the United Kingdom as children or adolescents and lived in England for at least 1 year [47]. They examined the access to doctors, counsellors, psychologists, bereavement groups, telephone help lines and homecare. The study identified facilitators to accessing mental health services among refugee women such as having mental health services available to refugee populations, as well as, resilience factors (like self-esteem and efficacy), religious and cultural social support [47]. Conversely, the study identified barriers of accessing mental health services such as confidentiality, trust in western treatments, fear of judgement and stigma [47].

Clark, 2018 uses their ethnographic research to examine Karen refugee women's experiences and the social structural factors which facilitated or challenged community capacity to support mental health during resettlement [48]. Using in-depth interviews and focus groups, this study assessed the access to standard mental health services in Canada among Karen speaking refugees originating from Thailand and Burma [48]. The study found that dependency on education and educated family facilitated access to health services [48]. Other facilitators included class position of Karen families as well as trust in interpreters, whereas barriers to accessing mental health services included lack of appropriate supports made them feel constraints [48]. Additionally, participants mentioned there was a lack of available interpreters; lack of funding for language services; lower health literacy and education available; the need for structural reform; and being unable to navigate health care resources [48].

O'Mahony et al, 2013 explored how cultural, social, political, historical, and economic factors intersect with race gender and class to influence the ways in which refugee women seek and access mental health services through a critical ethnography [49]. The study used purposive sampling to collect data through personal interviews of non-European immigrant or refugee women, that were 18 years old or old living in Canada with post-partum depression [49]. The findings of this study highlighted barriers of mental health access among refugee and immigrant women from Costa Rica. Barriers to mental health access included the importance of gender roles within the family dynamics and how a precarious immigration status can be related to mental health of immigrants and refugees through the consequence of no status [49]. Another barrier mentioned by participants were the dependency on others to translate and navigate the corrective routes to mental health care [49].

Donnelly et al., 2011 used a descriptive exploratory qualitative study to increase understanding of the mental health care experiences of immigrant and refugee women by inquiring about information regarding factors that either support or inhibit coping [50]. Using in-depth interviews, refugee women living with mental illness that were primarily of Chinese and Sudanese origin, living in Canada were shared their experiences of enablers to accessing mental health services [50]. Facilitators included informal support systems, self-care practices, education, knowledge and awareness of mental illness of family members, trust, rapport and faith in health care providers [50]. Conversely, participants also identified barriers accessing mental health services such as lack of awareness of mental health services available and lack of appropriate and culturally sensitive mental health services [50].

Willey et al., 2019 adopted a phenomenological study design to determine if a perinatal mental health screening program is feasible for refugee women [51]. The study included interview and focus groups to recruit refugee women that were in the last stages of pregnancy or post-natal care, living in a suburb in Melbourne, Australia [51]. Participants originated from Burma, Afghanistan, India, and Vietnam, and used perinatal mental health screening. Findings from this study expanded on facilitators of access mental health services such as family support and emotional well-being [51]. However, there were barriers also identified such as stigma, and language barriers between health professionals and participants [51].

Tulli et al., 2020 uses a qualitative descriptive design to explore immigrant and refugee mothers' perceptions of barriers and facilitators to accessing mental health for their children [52]. Semi-structured interviews were conducted with Sudanese, Syrian and Colombian immigrant and refugee mothers living in Edmonton, Canada who have children also living in Canada [52]. Participants were asked about their perception on the quality of mental health care and the adequacy of access to mental health care for their children [52]. This study found that there were enabling factor related to accessing mental health services such as availability of free services offered, high levels of education that contributed to ease in access, as well as, the variety of services and treatments offered [52]. The participants also identified challenges to accessing mental health care such as financial strain, feeling unheard during service intake, lack of information, racism and discrimination, stigma, and language barriers [52].

Ahmed et al., 2017 used a qualitative driven mixed method study to understand the experience of Syrian refugee women dealing with maternal depression in Canada [53]. The researched used a written questionnaire and focus groups of refugee women who were either pregnant or had given birth within

the year [53]. Eligible participants were required to be admitted to Canada through government or private sponsorship and be able to speak English or Arabic and were assessed for their natal and antenatal mental health care [53]. The study found that there were facilitators and barriers to accessing mental health services, including enablers such as strong social support including emotional support from the family [53]. Additionally, government support with the provision of mental health services, financial and social programs of support to minimize excessive stress [53]. Conversely, stigma of mental health, privacy and confidentiality concerns, and language difficulties were common barriers that were highlighted during discussions about accessing mental health [53].

Babatunde-Sowole et al., 2020 used a quality inquiry to explore and create awareness about west-African women's resilience prior to migration and post migration needs of support for trauma- informed care [54]. Using purposive snowball sampling, researchers conducted interviews with participants living in Sydney, Australia who originated from various parts of West Africa [54]. The study illustrated factors that enabled access to the provision of mental health care, such as resilience in adverse life situations within their host country [54]. On the other hand, participants also reiterated challenges in access mental health services like language barriers, distrust in host countries and western practices, experiences with xenophobia, and factors of job security related to immigration status that exacerbated stress and anxiety [54]. Stories of being unable to disclose mental health concerns related to physical and sexual violence epitomized some women's experiences [54].

Smith et al., 2019 used a phenomenological approach to their study in order to examine the resettlement experience of former refugees living in regional Australia, focusing on mental health and support services including barriers to access [55]. The study looked at the experience of former refugee youth and adults originating from Afghanistan, Bhutan, Burma, Sierra Leone, Sudan, and Iran that reside in Launceston, Tasmania [55]. Using semi-structured interviews and focus groups, researchers identified barriers to accessing mental health services such as language and the se of interpreters, the lack of culturally informed practices, and trauma informed care [55].

Wong et al., 2006 conducted a cross-sectional study to asses structural and cultural barriers to mental health care among refugees from Cambodia living in the USA [56]. The researchers conducted interviews and surveys with Cambodian women between 35-75 years old to find out how they can access and use mental health services [56]. The study identified barriers to accessing mental health such as stigma, lack of culturally sensitive care, language barriers, financial barriers, physical barriers like transportation to facilities [56].

Piwowarczyk et al., 2014 used a qualitative inquiry approach to examine both concepts of mental illness in addition to attitudes and beliefs about treatment as well as potential barriers to accessing mental health services [57]. Refugee women from Congolese or Somalian backgrounds, living in Boston, USA, above the age of 18 years old were convenience sampled for focus groups [57]. The outcomes of the study identified barriers to accessing mental health services such as the need for utilizing traditional methods of healing, lack of family support, stigma, financial strain, and a distrust or misunderstanding in western mental health services [57].

Drummond et al., 2011 used a cross- sectional study to identify barriers to accessing health care services among West African refugee women in Perth, Australia [58]. Researchers recruited refugee women between 20-67 years old from West Africa, who have lived in Australia between 6 months to 5 years [58]. Through interviews, refugee women from Liberia and Sierra Leone relayed experiences of barriers faced when accessing health services and mental health care, which included stigma, distrust in western medicine, distrust in medication, trying to cope alone, lack of awareness of services available, financial strain, and transportation as a physical barrier of access [58].

Systematic Reviews

PROTOCOL Open Access

Barriers and facilitators to access mental health services among refugee women in high-income countries: study protocol for a systematic review

Sarah DeSa[1], Akalewold T. Gebremeskel[2,3] and Sanni Yaya[3,4*]

Abstract

Background: According to the United Nation High Commissioner for Refugee Global Trends report in 2019, on average, there are 2.7 refugees per 1000 national population in high-income countries, where girls and women attributed to 48% of the refugee population. Evidence shows high prevalence of mental health disorder among women refugees in comparison to the general population. To our knowledge, no systematic reviews have addressed access to mental health services for refugee women. The aim of this study will be to examine existing barriers and facilitators to accessing mental health services for refugee women in leading high-income countries for refugee resettlement.

Methods: We designed and registered a study protocol for a systematic review. We will conduct a literature search (from inception onwards) in MEDLINE, EMBASE, PsycINFO, and CINAHL. Research articles having a qualitative component (i.e., qualitative, mixed, or multi-method) will be eligible. Study populations of interest will be refugee women at any age that can receive mental health services in leading high-income countries for refugee resettlement (e.g., 14 countries from North America, Europe, and Oceania). Eligibility will be restricted to studies published in English. The primary outcome will be all barriers and facilitators related to accessing mental health services. Two reviewers will independently screen all citations, full-text articles, and abstract data. Potential conflicts will be resolved through discussion. The study methodological quality (or bias) will be appraised using appropriate tools. Reporting will follow the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) statement. A narrative synthesis will be conducted, and summary of findings tables will be produced. As it will be a systematic review, without human participants' involvement, there will be no requirement for ethical approval.

Discussion: The systematic review will present key evidence on barriers and facilitators to access mental health services among refugee women in leading resettlement countries. The findings will be used to inform program developers, policymakers, and other stakeholders to enhance mental health services for refugee women. The final manuscript will be disseminated through a peer-reviewed journal and scientific conferences.

Systematic review registration: PROSPERO CRD42020180369.

* Correspondence: sanni.yaya@uOttawa.ca
[3]School of International Development and Global Studies, University of Ottawa, Ottawa, Ontario, Canada
[4]The George Institute for Global Health, Imperial College London, London, UK
Full list of author information is available at the end of the article

Background

According to the United Nation High Commissioner for Refugee (UNHCR) figures, as of May 2019, there were 70.8 million people forcibly displaced globally [1]. The experience of forcible migration has been documented as a complicated and stressful life event that can take a toll on mental health [2, 3]. In addition to facing changes in their surroundings, refugee populations are often neglected when it comes to adequacy of health services, including crucial gaps in access and delivery of mental health services [4]. According to the World Health Organization (WHO), mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to contribute to his or her community [4].

On the global front, in 2018, the WHO set in place a technical guidance report for mental health promotion and mental health care plan for refugees and migrants under their policy framework for 2020 [5]. This framework addressed ways to promote refugee's social integration, address and overcome barriers to accessing mental health care, facilitating engagement and utilization of services [5, 6].

Approximately one third of people who have obtained refugee status live in high-income countries [7]. The number of refugees and asylum seeker has been showing significant increase among major host and high-income resettlement countries [8, 9]. Global departures grew in 2019, with 63,726 refugees departing for resettlement [10]. The USA remains the country with the highest number of arrivals with 21,159 persons arriving in 2019, an almost 24% increase from 2018. Canada received 9031 arrivals, a 17% increase from 2018, followed by the UK with 5774 arrivals (just over a 1% increase from the previous year). Other countries that have been on the UNHCR's top 10 resettlement countries list in the past 10 years were Sweden with 4993 refugees arriving in 2019, Germany (4622), France (4544), Australia (3464), Norway (2351), Netherlands (1857), and Switzerland (990) [10]. With the increase of refugees in leading resettlement countries, it is important to comprehend the circumstances in accessing the mental health care systems and interventions to deal with those challenges [8, 9].

Refugee acceptance, health service availability, and accessibility contexts are different among resettlement countries [8, 11]. The variation in cultural, political, economic, and social frameworks can play a large role in how a country prioritizes mental health service allocation for refugee populations [11]. Mental health care policies and entitlements for refugee and asylum seekers also differ in each host country [9, 12]. Refugee mental health care services in most resettlement countries in high-income countries can consist of lengthy treatments, delivered by scarce and expensive mental health professionals [12]. There are system-wide obstacles hindering refugees and asylum seekers to accessing mental health services [12]. The health policy of majority of high-income and UNHCR refugee settlers ensures the access to health care. However, for refugees at country level, there are many associated obstacles to fully access health services including mental health services [12, 13]. Furthermore, there is evidence that shows restrictive entry and integration policies are linked to poor migrant health outcomes in high-income countries [13]. It is worthwhile to discuss how these countries of high refugee resettlement are affected by migration policy to assess its critical effect on access to mental health services. Studies have documented similar patterns and risk factors that are specific to female refugees compared to their male counter parts [14]. For example, the health needs of Syrian refugee women who have migrated to a resettlement country like Canada, although residing in a metropolis like Toronto, reported to have unmet health needs. These health needs included ineffective access to health services and mental health services linked to the disposition of gender-based violence and trauma [15–17]. Furthermore, studies have shown to a concern for psychological risks among refugees related to war, violence, and trauma protection needs among women and girl refugees, and challenges in managing mental health disorders [8, 18, 19]. Such psychological risk plays its intrinsic role in the eligibility of resettling in another country, including fitting a criteria such as having survived torture or serious violence, being a woman or girl at risk of abuse and exploitation, or facing persecution because of gender or sexual orientation, among many other devastating scenarios [10].

In general, identifying and addressing barriers and facilitators that directly impact needs, access, and use of mental health services can be worth exploring in order to provide better care and improved circumstances for vulnerable populations such as refugee women. When it comes to identifying barriers to mental health access and utilization, studies have illustrated the need for improving social and structural constructs to ease the use of mental health services among refugee population [9, 20, 21]. Barriers that have been identified to influence refugee mental health include understanding a new health system, structural barriers such scheduling or restrictive timing, linguistic barriers, attitudes, and perceived discrimination [20–22].

Another common problem faced within these resettlement countries is that neither refugees themselves nor their clinicians are fully aware of the exact entitlements of mental health services for refugees [12]. Additionally, systemic barriers, the social determinants of health like exposure to social exclusion, stigmatization, discrimination,

and low social status, also have a negative effect on accessing mental health services among refugees in major resettlement countries [23–25]. While there are many determinants that affect access to mental health services in high-income settings, there is a recognized need for services to be accessible, acceptable, and effective within resettlement countries, and should correspond with the needs and difficulties of refugees.

While there are lots of studies that examine the barriers to accessing mental health services, there are limited studies that identify facilitators to accessing mental health care among the refugee women population. Few studies have identified some facilitators in accessing mental health services among refugees, including provision of culturally sensitive intervention [25] and provision of gender concordant services [14, 16, 26].

Despite a growing body of literature, which examines barriers that influence mental health, there is a lack of systematic reviews that specifically examine the evidence on barriers and facilitators to access mental health services for women refugees and asylum seekers in high-income countries [8, 27]. In this context, the aim of this study will be to examine existing barriers and facilitators to accessing mental health services for refugee women in leading high-income countries for refugee resettlement.

Methods

Protocol registration and reporting

The present protocol has been registered within the PROSPERO database (registration number CRD42020180369) and is being reported in accordance with the reporting guidance provided in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Protocols (PRISMA-P) statement [28] (see checklist in Additional file 1). This review will be conducted following the Cochrane Collaboration Handbook of Systematic Reviews [29]. The proposed systematic review will be reported in accordance with the reporting guidance provided in the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) statement [28] and the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) statement [30].

Selection criteria

We have defined the following predefined eligibility criterion for the planned systematic review (see Additional file 2 for more details).

Study design

Eligible studies will be reports of original research, peer-reviewed articles having a qualitative component (i.e., qualitative, mixed, or multi-method studies).

Participants

We will include studies involving refugee women (regardless of age) that can receive mental health services. Studies conducted in both sexes will be considered for inclusion, but only data for women will be extracted.

Context

Eligible studies will involve one or more type of usual standard mental health service for refugee women, including abuse support, addiction support, counseling, crisis support, psychiatric and psychological assessments and treatments, and support groups.

Comparison or control group

There is no comparison group for this study.

Outcomes of interest

The primary outcome will be all barriers and facilitators related to accessing mental health services.

Setting

We will include studies conducted in leading high-income countries for refugee resettlement. Eligible countries will be selected based on data from 2009 to 2019 in the UNHCR's global resettlement needs reports [10]. According to this data source, the world's leading 14 resettlement countries for refugees within the last decade are as follows:

- North America: Canada and USA
- Europe: Belgium, Denmark, Finland, France, Germany, Netherlands, Norway,Switzerland, Sweden, and UK
- Oceania: Australia and New Zealand

Exclusion criteria

We will exclude reviews, editorials, commentaries, conference abstracts, dissertations, and other gray literature. Additionally, this review will exclude non-English articles, studies conducted only in men, and studies reporting data from countries outside of the UNHCR's leading resettlement countries from the past decade.

Information sources and search methods

The primary source of literature will be a structured search of major electronic databases (from inception onwards): MEDLINE (Ovid), EMBASE, PsycINFO, and CINAHL. The search strategies will comprise the following stages. First, a search of MEDLINE (Ovid) to identify relevant keywords contained in the title, abstract, and subject descriptors. Second, we will identify the synonyms and related terms for searches in EMBASE, PsycINFO, and CINAHL. In addition, we will perform hand-searching of the reference lists of included studies,

relevant reviews, or other relevant documents. Content experts and authors who are prolific in the field will be contacted. The search will include a broad range of MeSH terms and keywords related to mental health services, accessibility, refugee, asylum seeker, women/female, and qualitative research. A draft search strategy within multiple databases is provided in Additional file 3. MeSH terms related to mental illness were not included, as this review focuses on accessing mental health services and not necessarily the presence of mental illness.

Selection of studies

Citations will be imported into the Zotero citation management software and uploaded in a zip file. The articles retrieved from searches in each database will be uploaded into the Covidence article management system to be screened by two authors within the Covidence database for their relevance and eligibility to the review. This will include title and abstract screening, followed by full-text screening against the eligibility criteria for studies deemed potentially eligible. Disagreements will be settled through discussion. The PRISMA (Preferred Reporting Items for Systematic Review and Meta-Analyses) flowchart will be used to document the selection process [28].

Data extraction and management

Following full-text screening, data will be independently extracted from the retrieved eligible studies by two of the reviewers (ATG and SD). Disagreements will be settled through discussion with a third reviewer (SY). The authors will adapt a data collection form based on the needs of the review from a standardized data extraction form by the Cochrane Handbook [29]. The data extracted will include all details specific to the review question, fulfilling the requirements for a narrative synthesis. This includes the following information from each article: (i) authors and publication year, study setting, and study aim or hypothesis; (ii) sample characteristics, design and data collection methods, and outcome measures; and (iii) study findings. We will also contact primary study authors for key information when data are ambiguous or missing from the included studies.

Assessment of risk of bias in included studies

A critical appraisal of included studies will be conducted by two reviewers independently. All disagreements will be resolved through discussion or consultation with a third reviewer as needed. Results from the appraisal will be summarized narratively to highlight strengths and limitations within and across studies. Tables or figures will be used to present and/or graphically summarize results.

The reviewers will evaluate the studies using the appropriate Critical Appraisal Skills Programme (CASP) checklists [31]. Included studies will be assigned an overall score of "high" (9–10), "moderate" (7.5–9), or "low" (less than 7.5) overall quality. Studies will not be excluded or weighted based on the quality of the reporting assessment. The results of the appraisal will instead be used to inform data interpretation and help confirm the validity of review findings and conclusions.

Certainty of evidence

The GRADE-CERQual ("Confidence in the Evidence from Reviews of Qualitative research") approach will be applied to assess and summarize confidence in key findings [32]. This will provide overall confidence in each of the key findings. Two reviewers will independently assess certainty of the evidence using the GRADE-CERQual approach [32]. Disagreements will be resolved through discussion. Results will be presented in GRADE-CERQual summary of qualitative findings tables [32].

Data synthesis

Evidence tables of an overall description of the studies, including data from each paper that provided details of study characteristics, context, participant age and sex, outcomes, and conclusion. A narrative synthesis will be conducted, a method that is ideal for synthesizing evidence from a wide range of research questions and study designs with qualitative, mixed, or multi-method approaches, as the emphasis is on an interpretive synthesis of the narrative findings of research [33]. Synthesis of data will be described in a narrative synthesis, grouped by study type and participant characteristics and review objective and outcome. Accordingly, barriers and facilitators of mental health services for refugee women in high-income countries will aim to inform policy to improve access to mental health services for refugee women.

Discussion

Mental health care policies and entitlements differ in each country [8, 12], and across the leading resettlement, high-income countries, there is a variance in how the types of mental health services are available and accessed for refugee populations [8]. For example, it has been estimated that in Germany, in 2015, only 5% of refugees in need of mental health care received treatment [12]. On the other hand, in 2016, the Mental Health Commissioner of Canada released information on the provincial needs to address and reduce disparities and improve access to mental health services in diverse communities [4]. Similar reports sought to improve access and outcomes of mental health services for immigrants, refugees, and racialized ethno-cultural groups [3, 4].

This systematic review will summarize the evidence regarding mental health care barrier and facilitator study characteristics, context, and participant's sex and age, to

address the experiences faced by refugee women when accessing mental health services in leading resettlement countries. The findings of this research may be applied to enhance existing mental health service access for refugee women in leading resettlement countries.

This systematic review and its evidence synthesis will be published in a peer-reviewed journal and presented at different conferences and scientific meetings. This research aims to ultimately inform policymakers and stakeholders in mental health service promotion. Additionally, this review hopes to contribute to the campaign for effective delivery of ample mental health service resources for refugee women, such that follow the high standards set in high-income, leading resettlement countries. This review will provide insight on the extent to which health system, specifically mental health care, in resettlement countries enables or challenges refugee women to accessing those services.

This protocol outlines the methodological process of a systematic review that will gather qualitative data in order to examine existing barriers and facilitators to accessing mental health services for refugee women in leading resettlement countries. There are several limitations of our planned systematic review methods. There is an exclusion of research published in languages other than English, which can result in the exclusion of valuable data. Additionally, some data may be unrepresented, underreported, or misreported due to sensitive and highly stigmatize nature of mental health issues among refugee populations. This may result in publication bias and methodological quality issues.

Supplementary information

Supplementary information accompanies this paper at https://doi.org/10.1186/s13643-020-01446-y.

Additional file 1:. PRISMA Checklist.
Additional file 2:. Study selection criteria.
Additional file 3:. Search terms.

Abbreviations

CASP: Critical Appraisal Skills Programme; PRISMA-P: Preferred Reporting Items for Systematic Review and Meta-analysis Protocols; PROSPERO: International Prospective Register of Systematic Reviews; UNHRC: United Nation High Commissioner for Refugee; WHO: World Health Organization

Acknowledgements

Not applicable

Authors' contributions

SY led the design and coordination of the review. SD and ATG developed the search strategies in collaboration with a librarian. SD and ATG will conduct the screening of the articles, extract the data, appraise the quality of evidence, analyze the data, and write the report. SY had final responsibility to submit for publication. All authors were responsible for revising the protocol manuscript critically for important intellectual content. All authors read and approved this final protocol manuscript.

Funding

The authors declare no funding.

Ethics approval and consent to participate

Not applicable

Consent for publication

Not applicable

Competing interests

All authors declare that they have no competing interests

Author details

[1]Interdisciplinary School of Health Sciences, University of Ottawa, Ottawa, Ontario, Canada. [2]Faculty of Health Sciences, University of Ottawa, Ottawa, Ontario, Canada. [3]School of International Development and Global Studies, University of Ottawa, Ottawa, Ontario, Canada. [4]The George Institute for Global Health, Imperial College London, London, UK.

Received: 4 May 2020 Accepted: 5 August 2020
Published online: 16 August 2020

References

1. United Nations High Commissioner for Refugees [UNHCR]. 2019. Figures at a glance. Statistical Yearbook 2019. Retrieved from: https://www.unhcr.org/figures-at-a-glance.html.
2. Silove D, Ventevogel P, Rees S. The contemporary refugee crisis: an overview of mental health challenges. World psychiatry. 2017;16(2):130–9. https://doi.org/10.1002/wps.20438.
3. Robert AM, Gilkinson T. Mental health and well-being of recent immigrants in Canada: evidence from the Longitudinal Survey of Immigrants to Canada (LSIC). Research and Evaluation Branch, Citizenship and Immigration Canada. 2012. Retrieved from: https://www.canada.ca/en/immigration-refugees-citizenship/corporate/reports-statistics/research/mental-health-well-being-recent-immigrants-canada-evidence-longitudinal-survey-immigrants-canada-lsic.html.
4. Mental Health Commission of Canada. Changing directions, changing lives: the mental health strategy for Canada. Calgary, AB. 2016.
5. World Health Organization. Mental health promotion and mental health care in refugees and migrants. Copenhagen: WHO Regional Office for Europe (Technical guidance on refugee and migrant health. 2018.
6. McKenzie K, Hansson E, Tuck A, Lam J, & Jackson F. Improving mental health services for immigrant, refugee, ethno-cultural and racialized groups: issues and options for service improvement. Calgary, AB: Mental Health Commission of Canada. 2009. Retrieved from: http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Key_Documents/en/2010/Issues_Options_FINAL_English%2012Nov09.pdf.
7. United Nations High Commissioner for Refugees [UNHCR]. Global Trends. Forced Displacement in 2016. 2017. Retrieved from: https://www.unhcr.org/statistics/unhcrstats/5943e8a34/global-trends-forced-displacement-2016.html.
8. Priebe S, Giacco D, El-Nagib R. Public health aspects of mental health among migrants and refugees: a review of the evidence on mental health care for refugees, asylum seekers and irregular migrants in the WHO European region. Health Evidence Network Synthesis Report. 2016;27(ISBN-13):978–92. -890-5165-1, 2016.
9. Porter M, Haslam N. Pre-displacement and post-displacement factors associated with mental health of refugees and internally displaced persons: a meta-analysis. JAMA. 20015; 294(5):602-12.
10. United Nations High Commissioner for Refugees [UNHCR]. 2020. Projected Global Resettlement Needs 2021.Retrieved from: https://www.unhcr.org/protection/resettlement/5ef34bfb7/projected-global-resettlement-needs-2021.html.
11. Giacco D, Priebe S. Mental health care for adult refugees in high-income countries. Epidemiol Psychiatr Sci. 2018;27(2):109–16. https://doi.org/10.1017/S2045796017000609 Epub 2017 Oct 25.
12. Sijbrandij M. Expanding the evidence: key priorities for research on mental health interventions for refugees in high-income countries. Epidemiology and Psychiatric Sciences. 2018;27:105–8. https://doi.org/10.1017/S2045796017000713.

13. Norredam M, Mygind A, Krasnik A. Access to health care for asylum seekers in the European Union—a comparative study of country policies. Eur J Public Health. 2006;16:286–90.
14. Hollander AC, Bruce D, Burström B, Ekblad S. Gender-related mental health differences between refugees and non-refugee immigrants--a cross-sectional register-based study. BMC Public Health. 2011;11:180. https://doi.org/10.1186/1471-2458-11-180.
15. Ahmed A, Bowen A, Feng CX. Exploring maternal mental health in Syrian refugee women. BMC Pregnancy Childbirth. 2017 Jul 24;17(1):240. https://doi.org/10.1186/s12884-017-1433-2.
16. Guruge S, Sidani S, Illesinghe V, Younes R, Bukhari H, Altenberg J, Rashid M, Fredericks S. Healthcare needs and health service utilization by Syrian refugee women in Toronto. Confl Health. 2018;12:46. https://doi.org/10.1186/s13031-018-0181-x.
17. Masterson A, Usta J, Gupta J, Ettinger AS. Assessment of reproductive health and violence against women among displaced Syrians in Lebanon. BMC Women's Health. 2014;14:25. https://doi.org/10.1186/1472-6874-14-25.
18. United Nations High Commissioner for Refugees [UNHCR]. 2015. Culture, context and the mental health and psychosocial wellbeing of Syrians. A review for mental health and psychosocial support staff working with Syrians affected by armed conflict. Available from: http://www.unhcr.org/55f6b90f9.pdf.
19. Jefee-Bahloul H, Barkil-Oteo A, Pless-Mulloli T, Fouad FM. Mental health in the Syrian crisis: beyond immediate relief. Lancet. 2015;386:1531.
20. Hendrickx M, Woodward A, Fuhr DC, Sondorp E, Roberts B. The burden of mental disorders and access to mental health and psychosocial support services in Syria and among Syrian refugees in neighboring countries: a systematic review. J Public Health (Oxf). 2019. https://doi.org/10.1093/pubmed/fdz097.
21. Van der Boor CF, White R. Barriers to accessing and negotiating mental health services in asylum seeking and refugee populations: the application of the candidacy framework. J Immigrant Minority Health. 2020;22:156–74. https://doi.org/10.1007/s10903-019-00929-y.
22. Dickson K, Bangpan M. What are the barriers to, and facilitators of, implementing and receiving MHPSS programmes delivered to populations affected by humanitarian emergencies? A qualitative evidence synthesis. Glob Ment Health (Camb). 2018 1;5: e21. doi: https://doi.org/10.1017/gmh.2018.12.
23. Durbin A, Lin E, Moineddin R, Steele LS, Glazier RH. Use of mental health care for nonpsychotic conditions by immigrants in different admission classes and by refugees in Ontario. Canada. Open Med. 2014;8(4):e136–46 eCollection 2014.
24. Daya R. Changing the face of multicultural counselling with principles of change. Canadian Journal of Counselling and Psychotherapy. 2007; 35(1). Retrieved from https://cjc-rcc.ucalgary.ca/article/view/58659.
25. Kantor V, Knefel M, Lueger-Schuster B. Perceived barriers and facilitators of mental health service utilization in adult trauma survivors: a systematic review. Clin Psychol Rev. 2017;52:52–68. https://doi.org/10.1016/j.cpr.2016.12.001.
26. Colucci E, Minas H, Szwarc J, Guerra C, Paxton G. In or out? Barriers and facilitators to refugee-background young people accessing mental health services. Transcult Psychiatry. 2015;52(6):766–90. https://doi.org/10.1177/1363461515571624 Epub 2015 Mar 2.
27. Martinez O, Wu E, Sandfort T, Dodge B, Carballo-Dieguez A, Pinto R, Rhodes SD, Moya E, Chavez-Baray S. Evaluating the impact of immigration policies on health status among undocumented immigrants: a systematic review. J Immigr Minor Health. 2015;*17*(3):947–70. https://doi.org/10.1007/s10903-013-9968-4.
28. PRISMA-P Group et al. - 2015 - Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 Statement. Available from: https://systematicreviewsjournal.biomedcentral.com/track/pdf/10.1186/2046.4053.4.1.
29. Higgins JPT, Thomas J, Chandler J, Cumpston M, Li T, Page MJ, Welch VA (editors). Cochrane Handbook for Systematic Reviews of Interventions version 6.0 (updated July 2019). Cochrane, 2019. Available from www.training.cochrane.org/handbook.
30. Tong A, Flemming K, McInnes E, et al. Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. BMC Med Res Methodol. 2012;12:181. https://doi.org/10.1186/1471-2288-12-181.
31. Critical Appraisal Skills Programme. CASP Checklists - Critical Appraisal Skills Programme [Internet]. CASP Appraisal Checklists. CASP; 2018. Available from: https://casp-uk.net/casp-tools-checklists/.
32. Lewin S, Booth A, Glenton C, et al. Applying GRADE-CERQual to qualitative evidence synthesis findings: introduction to the series. Implementation Sci. 2018;13:2. https://doi.org/10.1186/s13012-017-0688-3.
33. Popay J, Roberts H, Sowden A, Petticrew M, Arai L, Rodgers M, et al. Guidance on the conduct of narrative synthesis in systematic reviews: a product from the ESRC Methods Programme, version 1 [Internet]. Institute of Health Research: Lancaster; 2006. Available from: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.178.3100&rep=rep1&type=pdf.

Publisher's Note