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A Qualitative Metasynthesis of Published Research Exploring the Pregnancy and Resettlement Experience Among Refugee Women


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Abstract

The number of refugees and asylum seekers throughout the world continues to increase, leading to increasing challenges in meeting healthcare needs of these individuals. Women's antenatal health is of particular concern due to their vulnerability to sexual violence and the substantial proportion of refugees consisting of women and girls of or nearing reproductive age. The purpose of this qualitative metasynthesis was to integrate and interpret findings from previously published research reports in which authors explored aspects of pregnancy among resettled refugee women. Following a systematic search process, we used Dedoose qualitative data analysis software to manage the process of extracting and condensing data from primary sources. We developed themes including: comparing pregnancy care in resettlement with care at home; navigating unfamiliar language and cultural practices; making meaning through pregnancy and associated healthcare experiences. Our analysis revealed authors used thematic analysis regardless of research design, limiting the range of reported findings. Prior research focused on identifying challenges to pregnancy in resettlement; our findings expand this by considering how women navigate and make meaning from challenges. Service providers might encourage mentally healthy resettlement by guiding refugees to consider differences in an open-minded rather than judgmental attitude that respects old and new cultures.

Keywords

Refugee, Pregnancy, Qualitative Research, Metasynthesis, Meta-Themes

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A Qualitative Metasynthesis of Published Research Exploring the Pregnancy and Resettlement Experience Among Refugee Women

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The number of refugees and asylum seekers throughout the world continues to increase, leading to increasing challenges in meeting healthcare needs of these individuals. Women's antenatal health is of particular concern due to their vulnerability to sexual violence and the substantial proportion of refugees consisting of women and girls of or nearing reproductive age. The purpose of this qualitative metasynthesis was to integrate and interpret findings from previously published research reports in which authors explored aspects of pregnancy among resettled refugee women. Following a systematic search process, we used Dedoose qualitative data analysis software to manage the process of extracting and condensing data from primary sources. We developed themes including: comparing pregnancy care in resettlement with care at home; navigating unfamiliar language and cultural practices; making meaning through pregnancy and associated healthcare experiences. Our analysis revealed authors used thematic analysis regardless of research design, limiting the range of reported findings. Prior research focused on identifying challenges to pregnancy in resettlement; our findings expand this by considering how women navigate and make meaning from challenges. Service providers might encourage mentally healthy resettlement by guiding refugees to consider differences in an open-minded rather than judgmental attitude that respects old and new cultures. Keywords: Refugee, Pregnancy, Qualitative Research, Metasynthesis, Meta-Themes

According to the United Nations (UNHCR, 2018), the current number of refugees worldwide has reached an unprecedented level, where 25.4 million individuals have been forced to flee their homes due to war, persecution, or natural disaster. Refugees who have resettled for political or security reasons are at increased risk for negative health outcomes and challenges in accessing health care when compared to immigrants who resettle in other countries for economic, educational, or familial opportunities (Derose, Escarce, & Lurie, 2007). While most refugees remain in refugee camps prior to resettlement, around 1% are temporarily resettled in what are referred to as *third countries*, a location that is neither the individuals' homeland nor their eventual resettlement location (UNHCR, 2018). Schwarzer, Jerusalem, and Hahn (1994) asserted that the hardship and trauma experienced by refugees within their countries of origin, while fleeing, in third country refugee camps, and during resettlement, has been associated with long-term negative effects on health and well-being. Countering these long-term effects, that potentially influence mental as well as physical health outcomes, requires providers and agencies to employ multiple and thoughtful strategies for delivery of effective healthcare (Robertshaw, Dhese, & Jones, 2017). The large-scale displacement that is occurring globally offers a compelling opportunity to develop new

policies, programs, and approaches to refugee care in order to meet the needs of an increasingly diverse population.

The proportion of refugees and asylum seekers worldwide comprised of women and girls varies by home and resettlement countries but overall is estimated at 50% (UNHCR, n.d.). Most are of, or are approaching, childbearing age. Among applicants for resettlement to European Union countries, four out of five asylum seekers are under 35 years of age, with those between 18 and 34 comprising around half (Eurostat, 2018). The proportion of women or children refugees to the US from regions of Africa, Asia and Europe is 67% or higher (Zong & Batalova, 2017). Previous research has noted that female refugees are particularly vulnerable and as a result, face threats of physical and sexual violence throughout the refugee experience (Winn, Hetherington, & Tough, 2018). The United Nations Economic and Social Council (2014) estimated that roughly 20% of all female refugees or displaced persons had experienced sexual violence. In research that examined the delivery of primary health care to refugees, Tornabene (2017) acknowledged that for refugee women, health outcomes can be impacted by both culture and by their experiences of trauma as refugees.

Aspinell (2014) also identified antenatal care and infant mortality as areas of particular concern among refugees and asylum-seeking women, although the United Nations Economic and Social Council (2014) reported that as many as 60% of maternal deaths that take place in humanitarian settings are preventable. Therefore, researchers, healthcare workers, and aid workers would clearly benefit from additional insight regarding the unique challenges to women refugees' antenatal health. Because qualitative research is particularly well suited to investigate individual's perceptions and context specific details using methods that are simultaneously systematic, flexible, and interpretive, our data for this paper consists of findings from prior published qualitative research exploring pregnancy experiences among resettled refugee women.

Review of Literature

For female refugees, disparities in health outcomes have been observed when compared to the general population and to other immigrant groups (Allotey, 1999. Redwood-Campbell et al. (2008) examined health behaviors among resettled refugee women in Canada and reported that 94% of women aged 40 and older had never received a mammogram and that in the previous three years, only 34% had received screening for cervical cancer. When asked to provide a self-reported health assessment, 74% of refugee women from Chile, El Salvador, Nicaragua, and Guatemala resettled in Australia reported they did not feel they were healthy, and that their health was worse now than it had been when they arrived (Allotey, 1999).

Refugee women are also at increased risk for experiencing adverse maternal health outcomes, including preterm birth, low birthweight, stillbirth, and maternal mortality following resettlement (Malebranche, Nerenberg, Metcalfe, & Fabreau, 2017). Refugee women are also at increased risk for experiencing postpartum depression (PPD; Correa-Velez & Ryan, 2012; Gagnon, Merry, & Robinson, 2002). In the United States, it is estimated that 19% of women suffer from PPD at some point following their pregnancies, while the percentage may be as high as 42% for refugee women (Tobin, DiNapoli, & Wood-Gauthier, 2015). Among refugee women, the aggregation of stress beginning with experience of hardship in their countries of origin and exacerbated by resettlement stress, followed by potential feelings of isolation and loneliness in the host country, may place them at increased risk for developing PPD (Collins, Zimmerman, & Howard, 2011; Tobin et al., 2015).

In their study of providers who deliver pregnancy care to refugee women in Alberta, Canada, Winn et al. (2018) concluded healthcare providers who are unfamiliar with caring for refugees are often unprepared for the unique needs associated with refugee patients as a

vulnerable population group. According to Winn et al. (2018), because pregnancy care might be the first entry into the healthcare system for resettled refugees, it presents an opportunity to assess barriers and facilitators that impact refugee care, and potentially improve health-related quality of life.

In summary, prior researchers have identified increasing risk to refugee women during pregnancy for mental and physical health concerns. These concerns might result from stress experiences that begin prior to immigration and continue through the process of resettlement, that might involve an interim time spent in a third country. Resettled refugee women are less likely to obtain some preventative care services, although pregnancy might lead women to seek healthcare in their new homes.

Authors of much previous research exploring pregnancy in resettlement (e.g., Lephard & Haith-Cooper, 2016; Stapleton, Murphy, Correa-Velez, Steel, & Kildea, 2013) have used qualitative approaches in order to better understand the nuance of individual experience and, in turn, to identify ways to improve antenatal health. However, we identified no previously published synthesis of worldwide studies on immigrant maternal health, although identification of the universal elements of these women's pregnancy experiences across multiple contexts would provide beneficial insight. While Winn, Hetherington, and Tough (2017) conducted a systematic qualitative review of immigrant experiences with pregnancy care, these authors limited their sources to research conducted in the US and Canada and provided a concrete thematic synthesis. Our approach differs in our inclusion of research conducted throughout the world, which allows us to consider essential similarities across contexts, and our desire to interpret as well as to aggregate findings from prior research. This work provides a partial update of Gagnon, Merry, and Robinson's (2002) systematic review of reproductive health needs and concerns of refugee women; although we examined work published as recently as 2017, we did limit our sample to qualitative or mixed-methods research about pregnancy. Our work can also be considered complementary to Ivanova, Rai, and Kemigisha's (2018) recent systematic review of sexual and reproductive health knowledge, experiences, and access to resources of refugee, migrant, and displaced young women (age 10 – 24), as, unlike these authors who focused solely on participants from African nations, our work is not geographically restricted.

The purpose of this article is to identify, assess, synthesize, and reinterpret findings from qualitative research that examine the experiences of refugee women during their pregnancies following resettlement. Our expectation is that this report will supplement other studies and provide a useful resource to refugee service providers and other stakeholders to inform planning and refining of programs, policies, and interventions aimed at improving the pregnancy experiences and outcomes of this vulnerable group.

As authors of this work, our interests and experiences intersect in the broad areas of public health and qualitative research. The first author has conducted research about the pregnancy experiences of Bhutanese refugee women following resettlement in the U.S., in addition to research about the perceptions of the food environment of Bhutanese refugee mothers in their resettlement communities. In addition to this work, the first author is interested in maternal and child health within refugee populations in the U.S. and globally. The second author has methodological rather than direct subject matter expertise and is motivated to participate in qualitative meta-studies focused on various public health concerns.

Methods

Research Design

There are many approaches to qualitative meta-study (e.g., Noblit & Hare, 1988; Paterson, Thorne, Canam, & Jillings, 2001; Sandelowski & Barroso, 2007). To meet the goals of this study, that included aggregating prior research, and interpreted the findings sufficiently to provide direction to move the line of research forward, we combined meta-study processes described by Paterson et al. (2001) with elements described by Sandelowski and Barroso (2007) and incorporated some subtle variations. As with many meta-studies, we began with a search process, conducted quality assessment of sources, identified data of interest, and performed data analysis. Following, we describe these processes in detail.

Search process. To identify sources for this research synthesis, we used logical combinations of full or truncated search terms including: pregnancy, resettlement, refugee, qualitative research, maternal health, and health beliefs, to identify published research articles indexed within EBSCO databases Academic Search Complete, CINAHL, and PsychInfo, and other databases including PubMed and Google Scholar. We also consulted reference lists of identified sources.

We established eligibility criteria as: published qualitative or mixed methods research articles, or readily available commissioned reports, conducted primarily with resettled refugee/asylum seeking women, with a research purpose focused on exploring one or more aspects of the pregnancy experience. We further required that mixed methods research needed to include a qualitative data component, analyzed via qualitative methods. We excluded conference abstracts due to concerns over lack of detail, and we did not assertively search out unpublished literature or other non-peer reviewed sources such as dissertations although we established a process to follow up on any such sources, we might encounter in reference lists of identified sources. To otherwise be as inclusive as possible, we applied no publication date or location (resettlement or country of origin) limiters, although, because of the language-driven nature of qualitative research in combination with our own limited language skills, we only considered works that were published in or available in an English language version.

We conducted the initial search during December of 2015. At this time, we identified 60 sources that potentially met criteria. We reduced this sample to 35 sources by removing conference abstracts, obvious duplicates, and other non-research sources such as commentary articles, or reports from fixed response survey research that did not contain any results from qualitative inquiry. Of the 35 sources, 10 were duplicate citations and were removed. We added one source from reference list review. During preliminary analysis, we eliminated two additional sources due to lack of findings related to pregnancy, and one in which findings from interviews were presented quantitatively using descriptive statistics rather than a conventional qualitative analysis. This left an initial sample of 23 sources. From these 23 sources, we developed initial findings that were presented but not published (Kingsbury & Chatfield, 2017).

To further develop this work for publication, we updated the search October of 2017. At that time, through use of the same strategies and application of the same criteria, we identified 10 additional eligible sources, resulting in the current sample of 33 sources. All sources but one were converted from Adobe Acrobat into Microsoft Word and imported into Dedoose (2018) software. We manually typed the unconverted source, a document provided as a scanned image file, into Microsoft Word document for import.

Quality assessment. We used a modified version of the Critical Appraisal Skills Programme (CASP, 2018) to conduct quality assessment of each source. The modification

included adding a scoring protocol in which each of the 10 CASP items was assigned between 0 and 5 points. Each author reviewed each source independently and entered all item scores in a Microsoft Excel workbook. To assess consistency of scoring, we calculated a weighted Kappa coefficient, recommended by Viera and Garrett (2005) when greater differences between scores are more concerning than smaller differences. Our final weighted Kappa coefficient was .67, which reflects moderate agreement. We found no extreme disagreements (i.e., no instances in which one author assigned a “0” score and the other assigned a “5”), and through a process of further review of sources and scores determined that variations likely reflected our own preferences and priorities. Given this, we decided mean values were appropriate indicators of the central tendency of the quality scores. We calculated the mean of each subscore and added the 10 item means for each source to derive an overall quality score based on 50 possible points.

Data extraction and development of themes. Following the cautions described by Paterson et al. (2001) regarding researchers’ potential to find the things they most hope to find, we divided the sample in half, and traded halves multiple times for each subsequent stage of data extraction and analysis. This allowed us to constantly review and question each other’s decision processes.

Our goal for our first cycle of coding was to identify our data corpus. To this end, we used the coding function of Dedoose software (2018) to select and label excerpts from each source. We identified three types of data excerpts to select: themes, findings, and participant quotes.

We selected themes as data of interest, because through the quality review process, we identified that all source authors presented findings as themes, regardless of how they described their research design. Inspired by the description of “meta-data-analysis,” (p. 55), provided by Paterson et al. (2001) and aspiring to work toward “qualitative metasynthesis” (p. 199) as described by Sandelowski and Barroso (2007) we engaged in a process of developing interpreted meta-themes from the source themes.

We additionally decided to identify findings and quotes for two reasons. First, we wanted to capture any salient findings that were not incorporated in source authors’ thematic analysis. Second, we used findings and quotes, which reflect less transformed data, to assess the extent to which our themes were an accurate representation of the data. We used Sandelowski and Barroso’s (2007) description of a finding that specifies: “researchers’ interpretations of the interview, observation, and other data they collected or generated in their study” (p. 152). We identified participant quotes using punctuation and author cues provided in the text of the sources.

During first cycle coding, we concentrated on identifying the excerpts that comprised the three categories of data. To this end, we assigned codes that specified type and source (i.e., themeBeine). Type (i.e., finding, theme, quote) preceded source name to facilitate alphabetical sorting of codes by type as Dedoose (2018) has a built-in function to identify codes by source.

Our second cycle of coding consisted of “themeing” the themes, which we did by forming clusters of similar themes to condense and identify meta-trends in the data. We did not adopt a stringent definition of what comprised a similar theme, so we initially clustered themes based multiple types of similarities including conceptual, literal, process, and semantic. In comparing developed themes, we determined we had independently identified similar categories, so collaboratively condensed these further into five meta-themes we believed represented the sample as a whole while addressing our research purpose.

As suggested previously, to further assess the comprehensiveness of our developed theme structure, we considered the fit of each coded finding into one of the five themes. We created new clusters of the findings that did not fit in a theme and labeled the resulting categories. The resulting categories generally reflected concrete and context specific

information (i.e., how participants described the process of making an appointment with a health services provider in a certain locality), so did not address our purpose and were not developed further for this report. Lastly, we compared the identified quotes with our developed themes, and integrated representative excerpts from both authors' findings and participant quotes into the report of results.

Results

In this section, we begin by describing results of quality ratings, the general attributes of the sources, and summarize the contribution each source made to analysis. Following this, we describe each of the five themes in turn, and provide excerpts and additional interpretation.

Quality Ratings

We rated methodological quality for each report, using CASP (2018) as described previously. We assigned studies one of two quality ratings. Any study we assigned a total score, based on the total of subscore means, of less than 50% of all possible points (24 or below), was considered *fair to poor* quality. We categorized studies we scored at 25 or above as *good or better* quality. The most frequent low scoring items included: identifying researcher relationship with participants, for which item mean across the sample was 1.18 out of 5, with a standard deviation of 1.65; inclusion of information about ethical research processes including approval and protection of confidentiality of participants, for which item mean was 2.11, with a standard deviation of 1.62; provision of detail about data analysis, for which item mean was 2.58 with a standard deviation of 1.24.

We categorized 21 studies as good or better quality (Ahmed, Steward, Teng, Wahoush, & Gagnon, 2008; Akhavan & Edge, 2012; Briscoe & Lavender, 2009; Brown, Carroll, Fogarty, & Holt, 2010; Carolan & Cassar, 2007; Glavin & Sæteren, 2016; Harper Bulman & McCourt, 2002; Herrel et al., 2004; Higginbottom et al., 2013; Hill, Hunt, & Hyrkäs, 2012; Lephard & Haith-Cooper, 2016; Missal, Clark, & Kovaleva, 2016; Murray, Windsor, Parker, & Tewfik, 2010; O'Mahony, Truong Donnelly, Este, & Raffin-Bouchal, 2012; O'Mahony, Truong Donnelly, Raffin Bouchal & Este, 2013; Owens, Dandy, & Hancock, 2016; Riggs et al., 2012; Riggs et al., 2017; Russo, Lewis, Joyce, Crockett, & Luchters, 2015; Wojnar, 2015; Yelland et al., 2014). We categorized the remaining 12 as fair or poor (Ameresekere et al., 2011; Beine, Fullerton, Palinkas, & Anders, 1995; Carolan & Cassar, 2010; Iliadi, 2008; Kennedy & Murphy-Lawless, 2002; Kim et al., 2017; LaMancuso, Goldman, & Nothnagle, 2016; McLeish, 2005; Merry, Gagnon, Kalim, & Bouris, 2011; Robinson & Cort, 2014; Shafiei, Small, & McLachlan, 2012; Stapleton et al., 2013).

Our ratings were based entirely on our interpretation of the information included or lacking in the research reports, so these ratings of reports cannot be taken as proxies for quality of research. Journal length and structure requirements and preferences of editors and reviewers might impact the amount or depth of methodological information provided. In the specific instance of Kennedy and Murphy-Lawless (2002), reference in the source is made to a longer report that we were not able to easily obtain, that appears to contain more details on data processing and analysis.

Profile of Sources

To identify overlap, we further examined three sets of studies that had similar author lists so potentially contained similar participants or findings. O'Mahony and colleagues (2012; 2013) authored two published studies, each described as critical ethnography, and each

including as participants 30 immigrant women who had resettled in Canada. In one study (O'Mahony et al., 2012), the authors described conducting second interviews with a subset of the sample. Reported findings, expressed as themes, varied between the two reports. Due to these differences, we retained both in our sample.

In the other two instances of shared authors (i.e., Carolan & Cassar, 2007; 2010; Riggs et al., 2012; Riggs et al., 2017; Yelland et al., 2014) we identified substantial variation in number and type of participants and country of origin to indicate the reports reflected unique samples of participants, so we retained all in our sample.

Of 33 included research studies, 30 consisted entirely of qualitative data collection methods. Kennedy and Murphy-Lawless (2002), Shafiei et al. (2012), and Stapleton et al. (2013) described their reports as mixed methods studies.

Research design was described as qualitative or qualitative interview research in 20 of 33 studies. In some instances, a framework such as socioecological (Riggs et al., 2012) or feminist (Russo et al., 2015) was also described. In one instance the research was described as a qualitative focus group study analyzed via thematic content analysis (Hill et al., 2012). Other design alternatives included three studies described as phenomenological or phenomenologically-informed research (Lephard & Haith-Cooper, 2016; Murray et al., 2010; Wojnar, 2015), two participatory research designs (Riggs et al., 2017; Yelland et al., 2014), one case study (Briscoe & Lavender, 2009), three ethnographic designs (Higginbottom et al., 2013; O'Mahony et al., 2012; O'Mahony et al., 2013), one ethn nursing design (Missal et al., 2016), one thematic content analysis (Hill et al., 2012) and one study described as grounded theory (Robinson & Cort, 2014). As noted previously, all authors expressed findings as themes regardless of design

Authors of 13 studies (Ahmed et al., 2008; Akhavan & Edge, 2012; Briscoe & Lavender, 2009; Iliadi, 2008; Kennedy & Murphy-Lawless, 2002; Lephard & Haith-Cooper, 2016; McLeish, 2005; Merry et al., 2011; O'Mahony et al., 2012; O'Mahony et al., 2013; Owens et al., 2016; Riggs et al., 2012; Stapleton et al., 2013) included participants who represented multiple regions of the world. Authors of 11 studies included only participants from Somalia (Ameresekere et al., 2011; Beine et al., 1995; Brown et al., 2010; Glavin & Sæteren, 2016; Harper Bulman & McCourt, 2002; Herrel et al., 2004; Higginbottom et al., 2013; Hill et al., 2012; Missal et al., 2016; Robinson & Cort, 2014; Wojnar, 2015). Other authors included participants from Afghanistan (Russo et al., 2015; Shafiei et al., 2012; Yelland et al., 2014), Burma (LaMancuso, et al., 2016; Riggs et al., 2017), or multiple African nations (Carolan & Cassar, 2007; 2010; Kim et al., 2017; Murray et al., 2010),

Resettlement nations included Australia for 10 studies (Carolan & Cassar, 2007; 2010; Murray et al., 2010; Owens et al., 2016; Riggs et al. 2012; Riggs et al., 2017; Russo et al., 2015; Shafiei et al., 2012; Stapleton et al., 2013; Yelland et al., 2014), the United States for nine studies (Ameresekere et al., 2011; Beine et al., 1995; Brown et al., 2010; Herrel et al., 2004; Hill et al., 2012; LaMancuso, et al., 2016; Missal et al., 2016; Robinson & Cort, 2014; Wojnar, 2015), Canada for five studies (Ahmed et al., 2008; Higginbottom et al., 2013; Merry et al., 2011; O'Mahony, et al., 2012; O'Mahony, et al., 2013), the UK for four studies (Briscoe & Lavender, 2009; Harper Bulman & McCourt, 2002; Lephard & Haith-Cooper, 2016; McLeish, 2005), European Union nations for three studies (Akhavan & Edge, 2012; Iliadi, 2008; Kennedy & Murphy-Lawless, 2002), and one study each representing Norway (Glavin & Sæteren, 2016), and Korea (Kim et al., 2017).

Authors of five studies (Beine et al., 1995; Herrel et al., 2004; Higginbottom et al., 2013; Hill et al., 2012; Riggs et al., 2017) used data consisting of transcripts of focus group interviews; authors of five further studies (Brown et al., 2010; Harper Bulman & McCourt, 2002; Riggs et al., 2012; Russo et al., 2015; Yelland et al., 2014) used transcripts of individual and group interviews, and authors of two studies used other data types such as direct

observation or medical records (Briscoe & Lavender, 2009; Merry et al., 2011). The remaining 20 reports were based on data analysis of transcripts of individual interviews.

Five authors included mothers and healthcare or aid workers as participants (Carolan & Cassar, 2010; Harper Bulman & McCourt, 2002; Kennedy & Murphy-Lawless, 2002; Merry et al., 2011; Riggs et al., 2012); one study included mothers and their husbands as participants (Wojnar, 2015); authors of three studies included mothers, healthcare workers and others (LaMancuso et al., 2016; Stapleton et al., 2013; Yelland et al., 2014). Authors of the remaining 24 studies included only mothers as participants.

Authors of seven studies included mothers who were described as refugees (Ahmed et al., 2008; Akhavan & Edge, 2012; Briscoe & Lavender, 2009; Kennedy & Murphy-Lawless, 2002; Merry et al., 2011; O'Mahony, et al., 2012; O'Mahony et al., 2013); three studies focused on asylum seekers (Glavin & Sæteren, 2016; Lephard & Haith-Cooper, 2016; McLeish, 2005); the remaining 23 studies included a combination of refugees and asylum seekers.

Metasynthesis of Themes

We identified 266 themes and subthemes presented by authors in the source articles and coded 709 findings and 645 quotes. We titled the five themes we developed from the data: *comparing pregnancy care in resettlement with care at home; navigating unfamiliar language and cultural practices; acknowledging mental health concerns; considering new alternatives; making meaning through pregnancy and associated healthcare experiences.*

Comparing pregnancy care in resettlement with care at home. Participants within the source articles frequently described pregnancy practices in their new homes and compared and contrasted these with practices in their former homes. Referring specifically to family size, Wojnar (2015) described that research participants “focused their energy on identifying similarities between the host country and their own belief system to help them better interact with others at the community level and with the obstetric care teams during pregnancy and hospitalization for childbirth” (p. 362). Based on our analysis of these data, this statement could be applied to most aspects of pregnancy care among refugees.

Comparisons were made regarding attitudes toward pregnancy, general pre-natal care, medical tests, and birthing options. One Somali participant in Wojnar (2015) emphasized that pregnancy is not an illness but rather a natural state and described having a healthy baby despite not following medication advice, which the participant equated to illness treatment, offered by a midwife in the US. Another Somali participant described by Brown et al. (2010), indicated that she helped fellow Somali refugees continue to use traditional practices, including physical manipulation and use of hot beverages, after resettlement, but, according to the authors, “only without doctors or nurses in the delivery suite.” (p. 222). Participants in Beine (1995) were open-minded to pre-natal tests such as ultrasound but were not interested in, and sometimes distrustful of, results of fetal sex determination.

Several authors (e.g., Brown et al., 2010; Carolan & Cassar, 2010; Murray et al., 2010) explored perceptions of birthing options with participants. Some participants expressed preference for natural labor, which they frequently described as meaning no induction of labor and no use of cesarean section. The latter reflects one of the areas where participants expressed a clear preference for their home tradition that did not encourage cesarean section.

Navigating unfamiliar language and cultural practices. A common part of the experience of immigration for many individuals is the need to acquire or refine skills in a non-native language. Other needs include developing awareness of and comfort with the practices and expectations in a new culture. Research participants additionally perceived lack of

understanding on the part of care workers due to their unfamiliarity with the norms from immigrants' home cultures.

Iliadi (2008) and Riggs et al. (2012) provided examples where lack of language competence meant informational materials could not be accessed. Authors including Kim et al. (2017) and Merry et al. (2011) described how lack of awareness of how health systems work in other countries might limit access to care.

We also identified findings related to participants' regrets about their inability to express their own preferences for care. This occurred when participants were not comfortable admitting they lacked sufficient language fluency to understand care alternatives, as expressed in Riggs et al. (2012), and also when participants were not confident about their authority or aware of the process to question provider recommendations (Murray et al., 2010; Wojnar, 2015)

Participants felt cultural differences combined with refugee status contributed to misunderstandings and stereotypes. For example, Lephard and Haith-Cooper (2016) described that one participant feared her precarious status as an asylum seeker led providers to assume she wanted to terminate her pregnancy.

Acknowledging mental health concerns. Many participants across the included studies reported symptoms of poor mental health; some were attributed to their pregnancy experiences and others were more general. For refugee women, it was often reported that the causes of poor mental health were feelings of isolation and hopelessness, feeling overwhelmed, financial concerns, uncertainty and fear associated with resettlement and their refugee status, separation from family members, and feeling like an outsider. Causes of poor mental health specific to pregnancy included increased responsibilities due to infant care needs, separation from female family members during the pre-and post-natal period, limited access to childcare, fatigue and physical changes due to pregnancy, and specific identification of postpartum depression (PPD).

Across studies, women acknowledged cultural stigmas associated with poor mental health and described challenges they experienced with bridging the gap between the symptoms they were experiencing with cultural expectations to remain strong. Hill et al. (2012) quoted one Somali refugee participant: "We hide our feelings. Expressing them is a sign of weakness" (p. 77). In response, some women felt compelled to hide the symptoms they were experiencing from spouses, family, and healthcare providers due to stigma and fears they would not be viewed as strong enough to care for their child. Ahmed et al. (2008) found that fear of being found an "unfit mother" (p. 299) prevented some participants from seeking mental health counseling.

However, while there were concerns about stigma related to mental health, many women acknowledged the symptoms of poor mental health they were experiencing and were able to identify, in most cases, a cause. To address symptoms of poor mental health, women described seeking support from others, accessing mental health professionals, engaging with the broader community, engaging in spiritual practices, and for some women, seeking employment or enrolling in school. Ahmed et al. (2008) and O'Mahony et al. (2013) concluded that some participants were able to resolve their symptoms after finding assistance either professionally or individually.

Considering new alternatives. The participants in the sample sources had resettled to high-income countries and had primarily come from low-income countries. This meant that there were in some instances opportunities in pregnancy care that might not have been as readily available prior to resettlement. Carolan and Cassar (2010), Riggs et al. (2012) and

Shafiei et al. (2012) suggested participants came to value the greater emphasis on formal pre and postnatal care for mothers and children experienced in their new homes.

Participants also at times expressed willingness to consider practices that were not just less common but also less congruent with their previous culture. For instance, Brown et al. (2010) found participants expressed an open-minded approach even to cesarean sections when circumstances warranted the procedure. Wojnar (2015) conducted interviews with Somali women and their husbands and found that many men were interested in playing a more active role in the childbirth process after resettlement, despite coming from a culture in which childbirth was considered primarily the domain of women. Wojnar also described men as more receptive than their wives to the idea of reconstructive surgery for women who had undergone female genital mutilation.

Making meaning through pregnancy and associated healthcare experiences. For many refugee women, resettlement is more than simply fleeing their country of origin or relocating from a refugee camp. Resettlement also marks an important time for identity building, where women seek to make meaning out of their experiences and re-establish themselves. Pregnancy marks an important life event, and for refugee women experiencing a pregnancy following resettlement, it plays an important role in shaping their identity. While culturally, pregnancy was often viewed as “normal” and almost an expectation for women, to experience a pregnancy following resettlement required women to bridge cultural understandings of and practices associated with pregnancy with a new and often unfamiliar healthcare environment.

Ahmed et al. (2008), Carolan and Cassar (2008), and Russo et al. (2015) each described how pregnancy and motherhood provided women with the opportunity to make connections within their resettlement communities they may not have had access to otherwise. Women were provided with the opportunity to connect with others in similar situations – those navigating pregnancy and motherhood in a community far different than what they were familiar with, and often without the assistance of immediate family members whom they might otherwise rely on. During pregnancy, some women found the companionship of other pregnant women to be a comforting alternative to the support they normally receive from their sisters and mothers. One refugee from Afghanistan described this in the report by Russo et al. (2015): “I joined a group in my area and within a few months I felt like I was getting better...I realised [sic] that a lot of women in the group were having the same emotions like me and that I wasn’t alone” (p. 8).

Alternatively, some women found that there was no making up for the companionship and support provided by their close female relatives. Fortunately, while pregnancy was sometimes viewed as a lonely and isolating experience, motherhood was viewed as happy and fulfilling. McLeish (2005) provides one participant’s description: One “When I was pregnant I was unhappy, because I am all alone... I cried all the time. Now it’s different, because [my baby] is there. Before I was alone, but now we are a family. He is a whole family for me.” (p. 785).

For women who were rebuilding a sense of family in their resettlement communities, many reflected on the role their children played in shaping a new family dynamic. While pregnancy and motherhood played an important role in shaping identity, opportunities to interact with their broader community outside of the family was also viewed as a positive experience. Missal et al. (2016) described how pregnancy and motherhood were also motivating for many women, who felt compelled to further their education so that they might better serve their families and themselves. One Somali refugee woman stated: “I decided I needed to go back [to school] when I couldn’t help a neighbor’s child with second grade English. I became a better mother and wife” (Missal et al., 2016, p. 363).

Carolan and Cassar (2010) concluded that women were happy to resettle with their children in a safe place, where food was readily available, although many acknowledge a sense of loss of “family, friends and a culture where they were understood” (p. 194). For one participant interviewed by Russo et al. (2015), however, giving birth at least temporarily transcended other thoughts: “when I saw the face of my child, I think, all the world is mine” (p. 9).

Discussion

We conducted this qualitative metasynthesis to aggregate and interpret findings from prior qualitative research about pregnancy during resettlement among women refugees and asylees. In this section, we consider our findings in light of current knowledge, and describe the value and implications of these findings. We also provide our thoughts regarding other aspects of the source articles.

Previous research has acknowledged challenges faced by resettled refugee women during pregnancy, including increased risk for PPD, concerns about caesarean sections, the importance of cultural competence and sensitivity in healthcare settings, and the impact the loss of support from close female relatives has on pregnancy and childbirth experiences (Downs, Bernstein, & Marchese, 1997; Lazar, Johnson-Agbakwu, Davis, & Shipp, 2013; Stuchberry, Matthey, & Barnett, 1998; Tobin et al., 2015). These previous findings are reflected in the themes developed within this metasummary, however, the current research expands the discussion by considering how women navigate and make meaning out of these challenges. This provides directions for future research that might consider how refugee women develop a sense of personal agency following resettlement and what this means for their well-being in the future.

Perhaps one of the more pressing considerations that can be interpreted from these findings is the continued need to address refugee health needs in healthcare settings. While many health systems in the U.S. and beyond have implemented cultural and linguistic standards to guide the provision of healthcare to diverse populations, work remains to be done to ensure that healthcare providers are adequately trained to understand and address the needs of refugee patients and ensure their success in bridging the gap between cultural values, traditions, and expectations with access to what may be unfamiliar healthcare practices and settings. By interpreting the experiences of resettled refugee women during pregnancy, there is also an opportunity to better understand how identity is shaped following resettlement and during a significant life event. This would enable both clinical and community-based refugee service providers to develop practices and programming that meet the needs of refugee women with an emphasis on how the women identify themselves in their new communities.

Although our sample reflected a variety of qualitative approaches, authors universally presented findings as themes, and generally used coding as a data analysis method. For basic, generic or descriptive designs, including those described simply as qualitative or qualitative interview research, the decision to derive categories, based on frequency or other indications that trends run through the data, offers a simple way to reduce and organize data. Along with this, readers' confidence in findings is improved when authors both describe and provide sources for their data analysis. Our highest quality ratings for the data analysis subscore of research described as generally as qualitative interview research were given to the reports by Hill et al., (2012) who we scored at 4.5 out of 5 for thoroughly describing and supporting use of a content analytic analysis strategy, and Russo et al. (2015), who we scored 4.5 out of 5 for providing a detailed and supported description of an iterative coding and theme development process. We additionally awarded 4.5 for analysis to Murray et al. (2010) and O'Mahony et al. (2012) for reports that reflected phenomenology and critical ethnography approaches,

respectively, because authors provided ample data analysis detail in keeping with the CASP criteria.

What we did not find within our source reports were outcomes other than themes, such as the essence of participants' lived experience, that might be found in phenomenological work, or a theory to explain the process of interest, as might be found in a grounded theory study, or a detailed description of a culture, however this is defined, as might be found in an ethnography. The aspect of coherence between design, data processing/analysis and reported outcomes is difficult to capture within the 10 items on the CASP that mostly focuses on presence rather than quality of information. As authors continue to rely on coding-for-themes as the preferred form of analysis, regardless of qualitative approach, the range of research findings made available to help readers consider complex aspects of circumstances and behaviors potentially diminishes.

Limitations of this work include our potential to omit relevant and possibly contradictory findings from our research synthesis due to inability to identify via our search process. Because we aggregated and interpreted these findings, we do not assert that other authors might not draw different conclusions although we have some confidence that our systematic process, that included validating interpreted findings by rechecking against the data corpus as a whole, ensured that we had a trustworthy analysis process and developed credible findings. Additionally, our focus on a qualitative synthesis as opposed to a broader review, such as a combined meta-study and systematic review that integrates quantitative findings limited the presentation of our results. Future researchers exploring immigrant and refugee pregnancy might expand on our work by integrating quantitative research. Findings from a mixed study might contribute results that are triangulated and potentially more generalizable.

Economic, conflict, and natural disasters continue to impact immigration and refugee patterns throughout the world. Lack of cultural understanding and appreciation among those resettling and those in resettlement countries can exacerbate what is already a stressful and challenging circumstance for pregnant women and new mothers. Overall, our results suggest that simple assimilation is not an adequate adjustment strategy. Rather, considering differences, especially if this comparison is done with an open-minded rather than judgmental attitude, might present a mentally healthy way of approaching resettlement that respects both old and new cultures.

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