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Women Refugee's Perceptions, Experiences and Coping Mechanisms in Situations of Sexual and Gender-Based Violence (SGBV): A Metasynthesis

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Abstract

Women represent almost half of the 20 million refugees worldwide, and although they play a key role in their communities, their voices and needs are often missing from research and policies directed to this population. A qualitative systematic review, or metasynthesis, was conducted to examine the experiences, perceptions, coping mechanisms, and psychological discourses of women refugees in situations of sexual and gender-based violence (SGBV) that occur during the travel, interception, and destination migratory stages. A systematic search was conducted on five multidisciplinary databases and was complemented with a manual search, resulting on a total of 511 articles which were screened for eligibility. Only qualitative, peer-reviewed, and English-written research articles were selected, and they were required to (1) focus on women refugees above 15 years of age and (2) report on their experiences, perceptions, psychological discourses, and/or coping with SGBV during their migration across countries (international migration). Ultimately, a total of 14 qualitative research articles were selected for the review. Using the thematic synthesis approach as a guideline, the results were summarized in the following themes: experiences of SGBV, perception of SGBV, perception of the risk factors creating and perpetuating their vulnerability, coping with SGBV, barriers to help-seeking, and psychological consequences. Despite the broad search, only information about some types of SGBV experiences from Asian and African refugee communities was found. Nonetheless, the available qualitative information on this topic is effectively integrated, knowledge gaps are identified, and future research, interventions, and policies using an integrated and culturally sensitive framework are suggested.

Keywords

refugee, women, sexual and gender-based violence (SGBV), experiences, qualitative systematic review

An increasing number of people worldwide have been forcibly displaced from their home due to armed conflict, destruction following natural disasters, infectious diseases, economic crisis, and widespread hunger, creating one of the biggest humanitarian crises of our present time: the refugee crisis. There are more than 20 million refugees and 4 million asylum-seekers worldwide (United Nations High Commissioner for Refugees (UNCHR), 2021). The UNCHR defines refugees on the 1951 Refugee Convention as:

> Anyone who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable, or owing to such fear, is unwilling to return to it. (UNCHR, 1951, p. 14)

This definition later expands to include women whose claims for refugee status are based upon a well-founded fear of gender-related persecution (UNCHR, 1988). In contrast to refugees, asylum-seekers are individuals who flee their home country and are awaiting a decision on their request for international protection (De Schrijver et al., 2018). For convenience, the term women refugees will be used in this paper to refer to both populations. Despite the progress made in assisting the refugee population, many issues remain unresolved, particularly for the female population. Regardless of accounting for more than half of the population, they are particularly vulnerable to problems or challenges in societies that remain strongly patriarchal (Holt, 2013; UNCHR, 2021). During a humanitarian crisis, a series of risk factors increase the vulnerability of refugees. These include breakdown of social, family and government protective structures, loss of

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police protection and/or of the legal recourse or justice, loss of basic and/or economic resources, and low awareness of rights (Wirtz et al., 2013). These, in combination with the social acceptance of gender-based violence (GBV) in many refugee cultures, and preexisting gender and/or ethnic inequalities, heighten the risk of exposure of women refugees to sexual and gender-based violence (SGBV) (Lafrenière et al., 2019).

The UNCHR defines GBV as "violence that is directed against a person based on gender or sex. It includes acts that inflict physical, mental, or sexual harm or suffering, or threats of such acts, coercing, and other deprivations of liberty" (2003, p. 10). Specifically, sexual violence (SV) is a form of GBV that includes exploitation and abuse and any sexual act or attempt to obtain a sexual act, without the voluntary consent of the victim, that results, or is likely to result, in physical, psychological, and emotional harm (Araujo et al., 2019; UNCHR, 2003). Due to the prevalence of SV as a key aspect of GBV within the refugee population, the combined term SGBV is commonly used within the discourse about refugees (Simon-Butler & McSherry, 2019). Accordingly, rates of SGBV tend to increase during complex humanitarian emergencies (Araujo et al., 2019; Keygnaert et al., 2012; Stark & Ager, 2011). Particularly, the prevalence of SV among female refugees across 14 countries affected by complex humanitarian emergencies is of 21.4%, suggesting that approximately one in five female refugees experience SV (Vu et al., 2014). A scoping review on GBV coordination in emergencies from 1990 to 2020 shows it is a problem that remains due to a series of factors including lack of appropriately trained staff, low resources, and limited engagement of affected populations (Raftery et al., 2022). The conditions of irregularity, instability, and insecurity combined with the fact that their needs, voices, and priorities are often missing from policies designed to protect them make women refugees particularly vulnerable to SGBV during the whole migration process (Gebreyesus et al, 2019; United Nations (UN) Women, n.d.).

Research in this area is quite recent. The use of quantitative methodologies has been crucial to determine the prevalence of SGBV among women refugees and its association with mental health sequelae like depression and post-traumatic stress disorder (PTSD) (Araujo et al., 2019; Bhui et al., 2003; Rizkalla et al., 2020; Stark & Ager, 2011; Tilbury & Rapley, 2004; Vu et al., 2014). However, prevalence studies tell us very little about women refugees, accordingly the use of the term "hidden crisis" to refer to the problem of SGBV in the female refugee population. Women refugees are often pathologized through quantitative studies, ignoring their personal experience, their social circumstances, and the systems of oppression that affect them (Yohani & Okeke-Ihejirika, 2018). The use of mental health diagnoses is frequent, reducing their complex experiences to one label and diverting the attention from the multifaceted aspects of their problems (Berman et al., 2009). As Clark (2018) proposes, mental health is a construct that has different cultural meanings among cultural groups, and diagnosing these women based on their premigration trauma overshadows their day-to-day experiences and their own constructions of health and well-being. Their life is largely influenced by a particular sociopolitical and cultural environment that is generally unfamiliar to the Western researcher, thus understanding their stories requires hearing them and obtaining a more culturally sensitive account of their experience (Tillbury & Rapley, 2004). That being so, it is indispensable that qualitative research, which focuses on exploring individual experience and human meaning-making, is now used to investigate and understand the experiences of SGBV lived by women refugees (Major & Savin-Baden, 2010).

To our knowledge, the present synthesis is the first intent to integrate all the available qualitative information. A multicultural feminist standpoint is adopted in the present metasynthesis. From this perspective, knowledge is built from the lens of intersectionality, acknowledging that an individual's world view is influenced by multiple aspects of their identity including race, ethnicity, language, gender, sexual orientation, age, disability, class status, education, religion, spiritual orientation, and other cultural dimensions (American Psychological Association [APA], n.d.b; Hurtado, 2010). The female perspective is emphasized, giving voice to these women, and trying to understand the subjective experiences of their lives, considering the implications of pertaining to certain social groups (Hurtado, 2010).

The aim of this synthesis is to explore how women refugees perceive, experience and cope with SGBV during three migration stages: travel, period between place of origin and destination; interception, situations of interim residence; and destination, arriving to the intended location (Zimmerman et al., 2011). Perception refers to the way these women understand SGBV and the risk factors creating and perpetuating their vulnerability toward it. Their experience of SGBV encompasses the way they lived through or came across this violent event (e.g., location, perpetrators, etc.). Coping with SGBV refers to the behaviors or actions that they took in dealing with the stressful or threatening situation, including help-seeking behaviors and barriers to help-seeking (APA, n.d.a). Furthermore, their psychological discourses in SGBV situations are thought to determine SGBV mental health sequelae as described by them. Our intent is to acknowledge the stories of women refugees, paving the way for future research, interventions, and policies that may advance their well-being in accordance with their desires and needs (Donnelly et al., 2011; Gough et al., 2013).

Method

Design

The present qualitative systematic review or metasynthesis was based on the norms developed by Soilemezi and

Linceviciute (2018) for qualitative evidence synthesis. Thomas and Harden's (2008) synthesis approach was used to analyze the selected articles. This method of synthesis is appropriate for synthesizing research reporting on people's experiences and is commonly used to analyze data in primary qualitative research (MacGregor et al., 2020; Thomas & Harden, 2008). The results of the present review were reported according to both the PRISMA statement (Preferred Reporting Items for Systematic Reviews and Metasynthesis) and the ENTREQ checklist (Enhancing Transparency in Reporting the Synthesis of Qualitative Research) (Page et al., 2021; Tong et al., 2012). The PRISMA and ENTREQ checklist are available on Supplemental Appendices A and B, respectively.

Search Strategy

A systematic search of published literature was completed during April 2021 in the following five academic databases: PsycINFO, PubMed, Embase, Scopus, and CINAHL. The previous combination of databases was selected to ensure obtaining all the relevant information published on the topic on different disciplinary areas (e.g., psychology, health, and sociology). To identify articles, we used search terms including "sexual and gender-based violence," "rape," "intimate partner violence," "domestic violence," "physical violence," "psychological violence," "forced marriage," "forced prostitution," "refugee women," or "asylum-seeking women." The full search term strategy is available on Supplemental Appendix C. Only qualitative articles were selected, and due to the language-driven nature of qualitative research, only English-articles were included. Due to the recency of the topic, the search was not limited to any specific time frame.

Selection Criteria and Screening

In addition to considering empirical, English-written qualitative articles, the selected literature had to comply with the following criteria: (a) articles required to focus on the experience, perception, psychological consequences of SGBV, and/or coping with SGBV during migration (journey, interception, and arrival phases) across countries (international migration), among refugee adult women; (b) the women studied must be above 15 years of age, in accordance with the start of the reproductive age in women as defined by the World Health Organization (WHO, 2006). These operative criteria allowed the research to focus on a rather uniform population that have a higher probability of having lived through similar stressful experiences.

The screening process was completed in the following way. An initial systematic search in the selected databases generated a total of 243 articles after eliminating duplicates. Two researchers screened the titles and abstracts of each one, indexing to the bibliographic manager RefWorks a total of 64 articles that met the defined criteria. The latter were subjected to a full screening process, they were completely read and assessed for eligibility, and a total of 51 records were excluded because they did not meet the criteria. This resulted in the selection of 13 articles. By consulting the reference list of the identified sources, one more article was selected. In total, 14 articles were selected and included in the metasynthesis. This process is depicted in the PRISMA flow diagram shown below in Figure 1.

Quality Assessment

There is no formal guidance on how to choose a good appraisal instrument for conducting good qualitative research (Soilemezi & Linceviciute, 2018). For this review, the Critical Appraisal Skills Programme (CASP, 2020) tool, due to its popularity among novice researchers, and the Joanna Brigs Institute (JBI, 2019) Critical Appraisal Checklist for Qualitative Research, due to its high coherence (Soilemezi & Linceviciute, 2018), were considered as possible quality appraisal tools. However, in the end, considering the purpose of this review is to examine the experience of these women as described by them, it was not deemed relevant or appropriate to determine the inclusion of articles containing authentic and useful accounts of these women's experiences based on their quality. Nonetheless, to reduce possible biases and assure minimal quality, only studies published in peer-reviewed journals were included.

Data Extraction and Analyses

The data extraction was completed by noting in an Excel spreadsheet the key characteristics of the included studies: authors, year of publication, study setting, sample size, sample characteristics (e.g., age, nationality), stage of migration in which the experiences reported in the study occurred (e.g., travel, interception, destination), aim of the study, and method. Next, all the information reported in the results section of each of the articles was analyzed using the thematic synthesis approach proposed by Thomas and Harden (2008) as a guideline. Firstly, a line-by-line coding was completed, almost every sentence of the results section of each of the included studies was assigned a meaningful label or code, most of them were assigned more than one code. Secondly, the codes were grouped into categories based on similarities and differences between them, these categories led to the generation of descriptive themes. Thirdly, by placing the descriptive themes previously created in the context of the research question, that is, trying to use these themes to directly answer the research question, new interpretations and explanations were provided, leading to the generation of analytical themes supported with *verbatim* quotes (Thomas & Harden, 2008). All this process was completed by one researcher and verified by a second one after the finalization of each stage.

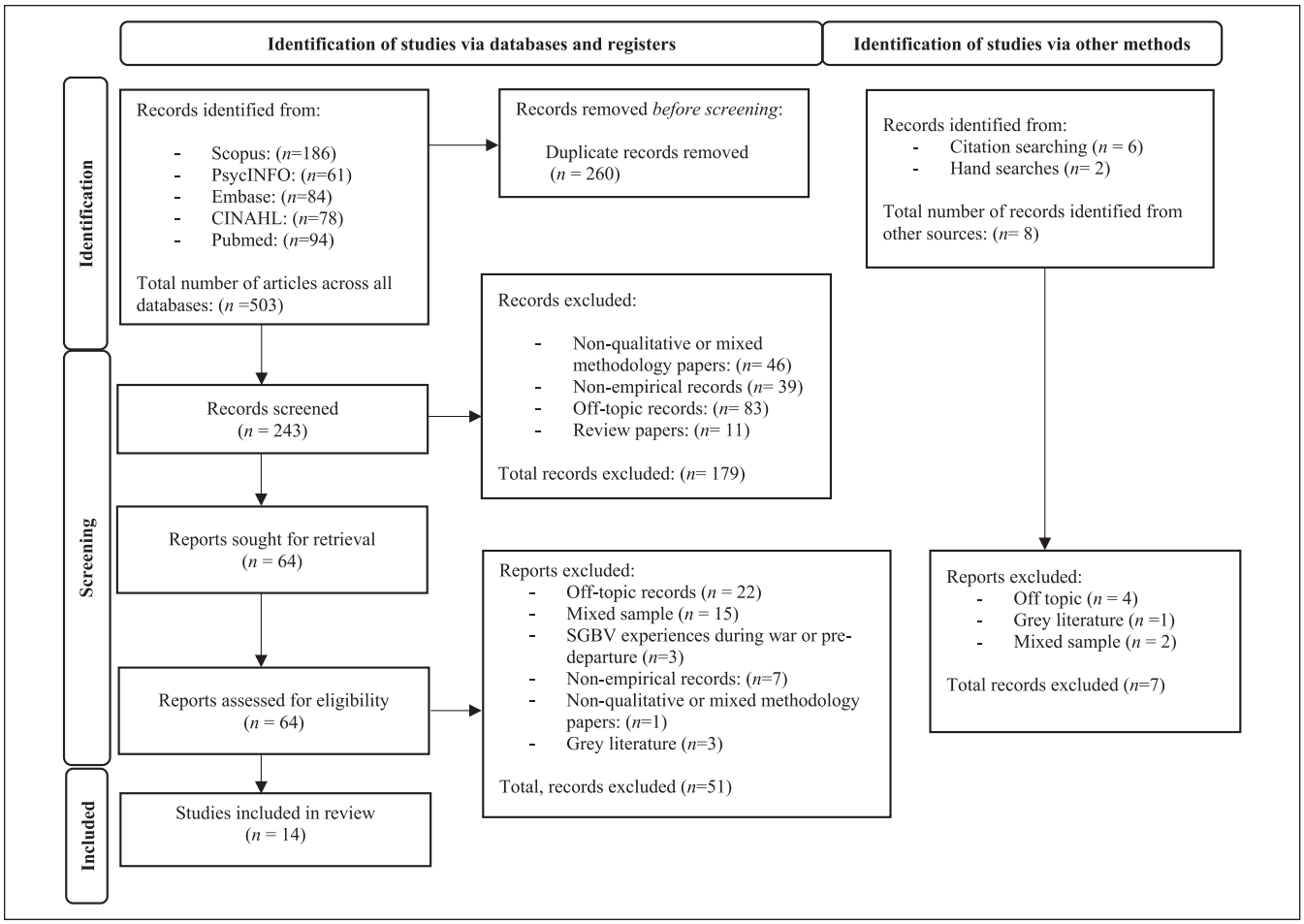

Figure 1. PRISMA 2020 flow diagram of study selection process.

Results

General Characteristics of the Included Studies

For a summary of the article selection process, see Figure 1. In total, 14 articles were included in this review. All studies included refugee women in their samples, although some of them included men and service providers, only the information reported by the women was considered. All the participants included in the studies come from Asian and African countries with a mean age range between 18 and 50 years. The characteristics of the included studies are described in Table 1.

Themes

The synthesis resulted in six main themes that can be further divided into a total of 21 subthemes, as depicted in Table 2. The six main themes were experiences of SGBV, perception of SGBV, perception of the risk factors increasing their vulnerability toward SGBV, coping with SGBV, barriers to help-seeking, and psychological consequences of SGBV.

Experiences of SGBV. Refugee women experience or come across many different types of SGBV including forced marriage, intimate partner violence (IPV), SV, physical violence, abductions, psychological violence, and even murder. These actions are perpetrated by their intimate partners (e.g., husbands), members of their community, local men, family members, employers, and even nongovernmental organization staff and police members. Although the focus of the present synthesis is on SGBV experiences during the transit, interception, and destination phases of the migration process, it is important to acknowledge that SGBV occurs in all stages. IPV is the most referenced theme, 58 times in total, in the included articles. Forms of IPV identified include marital rape, physical violence, psychological violence, and financial abuse. Both marital rape and physical violence are the most reported forms of IPV in the included articles; one-woman claims: "the husband will force them to have sex with them . . . he will beat her so much until she gets so weak, and then he will have sex with her forcefully" (Wirtz et al., 2013, p. 9). Secondly, reports of psychological abuse, characterized by emotional, social, or verbal abuse reflected in

Table 1. Characteristics of Included Studies.

Authors (Year)	Study Setting	Sample Size	Characteristics of Participants (Refugee Population).	Reporting of SGBV Experiences at the Following Migration Stage (Zimmerman et al., 2011).	Data Collection and Method of Analyses	Aim of the Study
Al-Natour et al. (2019)	Jordan	16 refugee women	Age: 22–68. Nationality: Syria	Interception stage	Interview; phenomenological analysis	Describe the lived experiences of marital violence toward Syrian refugee women
Al-Shdayfat and Hatamleh (2017)	Jordan	44 refugee women	Age: 19–42 Nationality: Syria	Destination stage	Questionnaire; thematic content analyses	Exploring Syrian refugee women's reasons for not reporting violence
Bartolomei et al. (2014)	Australia	Over 200 refugee women Service providers	Age: ≥15 Nationalities: India, Colombia, Jordan, Uganda, Zambia, Thailand, Finland, & others (unspecified)	Interception and destination stage	Interview; situational analyses	Examine the experience of refugee women at risk resettled in Australia
Damra and Abujilban (2022)	Jordan	30 refugee women	Age: 15–45 Nationality: Syria	Interception and destination stage	Interview; thematic content analyses	Exploring the reasons that refugee women, victims of IPV, have for not seeking professional help
Daoud (2021)	Jordan	23 refugee women 13 service providers	Age: 18–42. Nationality: Syria	Interception stage	Interview; thematic analyses	Examine the factors that trigger and perpetuate IPV toward Syrian refugee women in Jordan
Authors (Year)	Study Setting	Sample Size	Characteristics of Participants (Refugee Population)	Reporting of SGBV Experiences at the Following Migration Stage (Zimmerman et al., 2011)	Data Collection and Method of Analyses	Aim of the Study
Fineran and Kohli (2020)	Maine, United States	16 women ($n=15$ refugees, $n=1$ asylum-seeker)	Age: 23–73. Nationalities: Iraq; Jordan; Morocco, Somalia; Sudan	Destination stage	Interview; thematic analyses	Document the narratives of Muslim refugee women on IPV and identify barriers to help-seeking
Gebreyesus et al. (2019)	Israel	44 Eritrean refugee men and women 25 service providers	Age: 18–49 years Nationality: Eritrea	Transit and interception stages	Interview and focus group discussions; thematic analyses	Exploring the risk of SGBV that female Eritrean refugees experience during their journey from Eritrea to Israel
Gebreyesus et al. (2018)	Israel	44 Eritrean refugee men and women 25 service providers	Age: 18–49 years Nationality: Eritrea	Interception stage	Interview and focus group discussions; thematic analyses	Explore how political and economic marginalization increases the risk of violence among Eritrean refugee women living in Israel

(continued)

Table 1. (continued)

Authors (Year)	Study Setting	Sample Size	Characteristics of Participants (Refugee Population).	Reporting of SGBV Experiences at the Following Migration Stage (Zimmerman et al., 2011).	Data Collection and Method of Analyses	Aim of the Study
Jops et al. (2016)	Vikaspuri, Delhi, India	28 refugee women	Age: 18–55 Nationality: Chin State, Burma	Destination stage	Interview; constructivist grounded theory	Understanding women's pursuit of "livelihood" in Delhi, India
Author (Year)	Study Setting	Sample Size	Characteristics of Participants (Refugee Population)	Reporting of SGBV Experiences at the Following Migration Stage (Zimmerman et al., 2011)	Data Collection and Method of Analyses	Aim of the Study
Memela and Maharaj (2018)	Albert Park in Durban, South Africa	27 female refugees Officials in the park area	Age: ≥18 Nationality: Burundi; Democratic Republic of Congo (DRC); and Rwanda	Destination stage	Interview; narrative analyses	Exploring intimate partner and public violence encountered by female refugees
Smigelsky et al. (2017)	United States	9 refugee women	Age: 24–66. Nationality: DRC	Destination stage	Interview; consensual qualitative research (CQR)	Explore the lived spiritual experiences of Congolese refugee women survivors of SV
Usta et al. (2019)	Lebanon	29 refugee women	Age: 18–45. Nationalities: Syria and Lebanon	Interception and destination stages	Focus-group discussions; grounded theory methods	Exploring displaced refugee women's experiences in Lebanon
Wirtz et al. (2013)	Ethiopia	37 refugee women 77 service providers	Age: ≥15 Nationalities: Burundi; DRC; Eritrea; Somalia; and Sudan	Transit, interception and destination stages	Interviews and focus group discussion; grounded theory method	Identify the range of experiences of GBV and barriers to reporting among female refugees
Zannettino (2012)	South Australia	30–40 refugee women	Age: ≥15 Nationality: Liberia	Destination stage	Focus group discussions; inductive analyses.	Exploring the factors that have an impact on domestic violence in the Liberian refugee community

Note. IPV = interpersonal violence.

Table 2. Thematic Synthesis of Included Articles.

Themes		Total Number of References to Theme
Experiences of SGBV	Intimate partner violence	58
	Sexual violence	46
	Physical violence	12
	Psychological violence	12
	Forced marriage	5
	Abductions	5
	Murder	3
Perception of SGBV	Normal experience arousing from conflict/displacement	13
Perception of the risk factors increasing their vulnerability to SGBV	Disruption in traditional gender roles	14
	Being alone/isolated	14
	Lack of legal autonomy and economic marginalization	12
Coping of SGBV	Enduring and keeping silent	22
	Religious practices	10
	Self-destructive behaviors and hitting children	5
	Looking for family/community support	4
Barriers to help-seeking	Lack of support from family/community members and shaming/blaming/stigmatizing the victim	28
	Fear about the legal consequences	21
	Unaware of the services offered or lack of confidence in them	15
	Believing that disclosing is useless	10
	Lack of resources	5
	Lack of awareness of SGBV consequences	6
Psychological consequences		23

Note. SGBV = sexual and gender-based violence.

phrases like "when I came back home, he was always irritated and shouting at me . . ." (Memela & Maharaj, 2018, p. 436) and "men try to control everything, women have no right to say anything" (Fineran & Kohli, 2020, p. 205). Financial abuse is another common reported form of IPV, especially when women receive financial help from services, as seen in phrases like "if she does not let him have the money, he beats her and does not let her have any money at all" (Zannetinno, 2012, p. 818.).

SV is the second most referenced theme, 46 times in total, in the included articles. Women are subjected to different types of SV during all stages of the migration process, including survival sex, rape, attempted rape, gang rape, coerced sex, and sexual harassment. Survival sex is often done in return for basic assistance, during transit in return of guidance by smugglers and in interception and destination phases in return for money or basic resources (Bartolomei et al., 2014; Gebreyesus et al., 2019). This is illustrated in the following quote ". . . in the camps it happens a lot. You don't have anything and there are men there who have money. What will you do?" (Bartolomei et al., 2014, p. 49).

Rape is the most reported form of SV occurring during the migration process. During transit women are especially vulnerable to experience rape by smugglers or traffickers, "in general, the men smuggling us will be forcing girls to have sex at some point along the journey" (Gebreyesus et al., 2019, p. 10). Additionally, on the refugee camps women are continuously exposed to experiences of rape, gang rape, and/or attempted rape, "when girls just go out of the camps to fetch water, they threaten them to rape them right there" (Wirtz et al., 2013, p. 5). When rape is perpetrated by an employee, it is normally in the form of coerced sex, where they threaten or pressure the victim to engage in sexual relationships with them, using phrases like "if you don't allow me, you will not work" (Wirtz et al., 2013, p. 9). This was reported on some refugee camps, but mainly during the destination stage in the resettling process, when women are looking for jobs (Jops et al., 2020). Sexual harassment was also very common, as shown with phrases like "he heard my accent and started to touch me all over" (Memela & Maharaj, 2018, p. 438).

Physical violence, exerted many times in combination with SV, was also one of the most reported experiences of refugee women. It was mentioned 12 times in included articles. This is shown in the following phrases: "there were young men throwing stones at us" (Usta et al., 2019, p. 3772), "he would hit me with an electric wire . . ." (Gebreyesus et al., 2018, p. 7), and "he grabbed a metal pole and hit me over the head and left me for dead" (Gebreyesus et al., 2019, p. 13). Like the last phrase shows, physical violence sometimes was so extreme that it led to murder, which was mentioned in three of the articles included (Gebreyesus et al., 2018; Gebreyesus et al., 2019; Usta et al., 2019).

Psychological violence, often reflected in emotional and verbal abuse, isolation, and social violence, was also mentioned a total of 12 times in the articles. Most of the psychological violence identified was perpetrated by intimate partners. However, refugee women were also subjected to verbal abuse in public spaces by locals, for example the term "amakwerekwere" a derogatory term, was used to refer to refugee women in Durban, South Africa (Memela & Maharaj, 2018). They were further subjected to emotional and social violence and isolation by community and family members which stigmatize and reject women who have been sexually abused, blaming them for the occurrence of such actions (Bartolomei et al., 2014).

Finally, forced marriage and abductions are mentioned 5 times in the articles. Forced marriage occurs when the women, generally at a young age, are obliged by their family to contrive marriage with a man, with the objective of conserving her "honour" and/or gaining money (Daoud, 2021). Regarding abduction, it commonly occurred during transit by traffickers or smuggles, but it was also mentioned to happen in refugee camps, when women are both in densely populated areas and/or alone (Wirtz et al., 2013).

Perception of SGBV

Refugee women's perception of SGBV is influenced by their cultural and social norms. From the studies, it can be deduced that the participants come from patriarchal societies, with clear gender roles. The men are described as "strong," "leaders of the family," "providers," whereas women are expected to engage only in housekeeping duties, taking care of the family, and doing what the man wants (Daoud, 2021; Fineran & Kohli, 2020; Zannettino, 2012). The consequences of this are that women perceive SGBV through this patriarchal cultural lens, justifying, normalizing, and accepting it.

Women explain SGBV as a normal reaction of men, a response to the stress and irritability that the displacement causes them (Usta et al., 2019). This type of response is seen 13 times in the included articles. The violence they were enduring was perceived as an inevitable consequence of the war, ". . . he became so nervous, the war changed him" (Al-Natour et al., 2019, p. 33). These understandings led some women to blame the violence on themselves, "I provoked him to hit me," "It is my fault" (Daoud, 2021, p. 7). Particularly, SV perpetrated by the women's husband was culturally normalized, it was not even recognized as violence because women through socialization had learned that rape did not exist within marriage.

Perception of the Risk Factors Increasing Their Vulnerability to SGBV. Women particularly perceived: disruption of traditional gender roles, being alone and/or isolated, and lack of legal autonomy and/or economic marginalization as the main risk factors increasing their vulnerability toward SGBV. The first, disruption to traditional gender roles, was both the most common explanation provided specifically for IPV and hence the most identified risk factor for increases in IPV during interception and destination stages. These changes in traditional roles happen when individuals arrive at their host country and must adapt to the new social norms of that country. This is exemplified in "our men are worried that we will turn our backs on them because they think we want to live the way of here" (Zannettino, 2012, p. 816). From the perception of refugee women, it was this fear that led men into more controlling and abusive behaviors (Zannetinno, 2012). This is heightened by the fact that men either in refugee camps or in the host countries tend to be unemployed or working in non-fulfilling chores, bringing little money back to their family and losing their roles as "providers" (Wirtz et al., 2013). This is seen in the following quote: "he stayed home the whole day, cooking, cleaning . . . he took out all his frustration on me" (Memela & Maharaj, 2018, p. 436). Additionally, the gendered allocation of welfare payments by UN agencies to support women, threatens even more the "authoritarian," "strong," "provider" role of the men, increasing women's vulnerability to IPV (Daoud, 2021; Zannetinno, 2012).

Similarly, women also identified being alone and/or isolated as a main risk factor for SGBV. This is exemplified in phrases like "if a women came here and she was alone, she would have begged to stay with anyone . . . there was a chance they would rape her" (Gebreyesus et al., 2018, p. 4) and "what about single women? They are so much at risk. They struggle every day to resist rape" (Bartolomei et al., 2014, p. 49). Women report that experiencing SV normally led to their isolation, increasing the probability of experiencing further forms of SGBV (Bartolomei et al., 2014).

Finally, lack of legal autonomy and/or economic marginalization was mentioned a total of 12 times in the included articles. During transit stages, refugee women identify their dependence on smugglers due to their illegal status crossing from one country to another, as one of the factors increasing their vulnerability to SGBV (Gebreyesus et al., 2019). In interception and destination stages, the adjudication of joint refugee status permits with their intimate partner increased their vulnerability to IPV, "me and my kids were registered as his dependents . . . it was hard to just disappear" (Memela & Maharaj, 2018, p. 435). Moreover, being economically marginalized obliged them to engage in nonregulated jobs in the informal work area to make a living, enduring all types of violent experiences (Jops et al., 2016).

Coping with SGBV. The most reported behavior or action that refugee women took in dealing with SGBV was keeping silent and enduring the violence. It was their only way to avoid further conflict, "I avoid being battered by keeping silent" (Al-Natour et al., 2019, p. 35). These women were socialized into keeping silent, enduring the violence, and staying close to their families, "even if there are broken bones . . . they always send her back . . . your place is with

your husband, your family" (Fineran & Kohli, 2020, p. 205). Disclosing SGBV experiences generally leads to shaming and stigmatizing the victim and sometimes even her family. If the issue is brought up, the community tends to blame the victim for the abuse and perceives her as emotionally weak, ". . . they will use that against you because in my culture if you talk about your emotions, you are looked at as a weak person" (Fineran & Kohli, 2020, p. 207). As a result, violence becomes a secret, or a family secret (Al-Natour et al., 2019).

Apart from the resulting stigmatization that disclosure would bring on these women, endurance of the SGBV experiences, especially of IPV was further motivated by their perception of it and by their desire of maintaining their family together and protecting their children. As previously explained, their interpretation of IPV as something momentaneous, arising from the displacement, led them to stay with the perpetrator in hope that the situation would become better in the future and that he would return to the person he was before the war began, "It is a phase . . . but he is coming back" (Daoud, 2021, p. 10). Additionally, women strived to keep their families together to ensure the safety of the children and to avoid being left without the legal, social, and economic support of men (Al-Natour et al., 2019). In their situation, it seemed that SGBV experiences were the least of their problems: "I am a refugee woman, raised 5 children without any income resources, every morning I have opened my eyes to different needs, pains and suffering. IPV is not my priority now" (Damra & Abujilban, 2020, p. 7).

Although silence and enduring were the most common coping mechanisms, looking for family and community support is also recognized as a response that some women had to SGBV (Al-Natour et al., 2019; Usta et al., 2019). Another common coping mechanism for these women was engaging in religious practices. Smigelsky and colleagues (2017) report that Congolese refugee women's spiritual experiences strengthen after having experienced SGBV. Their beliefs that God was in control of everything, and that God would protect them, along with continuous prayer, gratitude and high spiritual commitment allowed the women to endure SGBV experiences and overcome the trauma. Syrian refugee women also report that reading the Quran, fasting, and offering prayers of forgiveness allowed them to bear their situation (Al-Natour et al., 2019). Finally, a very small number of women report engaging in self-destructive behaviors, like hitting themselves, smoking and/or drinking alcohol and/or abusing their children as coping mechanisms (Al-Natour et al., 2019; Usta et al., 2019).

Barriers to Help-Seeking. Refugee women identify a series of obstacles that prevent them from seeking help. The most frequently identified barrier is the lack of support they receive from their family/community, characterized by shaming, blaming, and stigmatizing the women victim of SV (Fineran & Kohli, 2020; Wirtz et al., 2013; Zannetinno, 2012). This is exemplified in the following quotes: ". . . people in the community will start to stigmatize and reject you" (Bartolomei et al., 2014, p.49), and ". . . the women are ashamed of the fact that they were raped so they won't tell" (Gebreyesus et al., 2018, p. 7). As previously explained, family and community members reinforce the abuse by prompting women to stay along the perpetrators, keep the family together, and keeping silent to avoid stigma or shame (Fineran & Kohli, 2020).

Women also report they feared the possible consequences of disclosing SGBV experiences, particularly IPV, at a legal level. One of the most common thoughts was reporting could lead to family breakdown, "we want to get help for our problems, but we don't want to leave our husbands and families" (Zannetinno et al., 2012, p. 821). They feared the legal system might victimize and be brutal against their husbands and that their husband's opportunities for education and employment would be undermined leaving them unable to provide for their families (Zannetinno et al., 2012).

This fear about the possible legal consequences arises from a lack of knowledge or awareness and/or of confidence about the services available. This was also frequently identified as a barrier to help-seeking. This is exemplified in the following quote: "this was the first time to know that such services were available for refugee women in Jordan" (Damra & Abujilban, 2020, p. 10). Other women report not trusting these services because they have had previous negative experiences with them (Daoud, 2021; Wirtz et al., 2013). A woman reports: "I talked with the counsellor about my case, but later found that other people know about it . . . I felt it in their eyes" (Daoud, 2021, p.8) Lack of reporting to the available services is further heightened by the common belief among refugee women that reporting their experiences is completely useless, ". . . and even if they know about it what can they do?", "they are unable to help me . . . at the end of the day I would go back to my husband" (Al-Shdayfat & Hatamleh, 2017, p. 99).

Two other factors were identified as hindering help-seeking: lack of resources and lack of awareness of the negative consequences of SGBV. Lack of resources, including poor language skills, lack of money and lack of transportation was identified as an obstacle for help-seeking a total of 5 times. Moreover, being unaware or minimizing the negative consequences of SGBV diminished the probability of seeking help, as a woman explains ". . . I did not think before that these complaints might be associated with IPV" (Damra & Abujilban, 2020, p. 9).

All these barriers for help-seeking further explain why the most reported coping mechanism for SGBV experiences is being silent and enduring. The consequence of this is a never-ending cycle of violence, as a refugee woman reports:

> Women's voices are suppressed, and women are oppressed, so there is no way that women can talk about violence that they're dealing with or abuse which means they will be shut down. And they will be subjected to more violence, extreme violence. (Fineran & Kohli, 2020, p. 207)

Psychological Consequences. Refugee women do not report explicitly or directly the presence of a psychological disorders due to SGBV experiences, however they do use psychological constructs like negative emotions, trauma, and mental health states to describe their SGBV experiences and the impact they had on their life. It is important to acknowledge that, although the focus of the present section is the psychological impact of SGBV experiences, the psychological state of the women is not the result of one SGBV experience, but rather of a continuous exposure to a series of traumatic events (e.g., war, displacement, loss of family members, etc.) including SGBV experiences.

Women express feelings of sadness and depression: "thinking about my past, I am not so happy," "Our mind's everything is weak weakened. Always depressing" (Jops et al., 2016, p. 90), "I have suffered from a low mood in the morning, no interest, long periods of crying and isolation" (Damra & Abujilban, 2020, p. 9), "depression for me came out of nowhere and hit me like a ton of bricks. I could not eat, sleep, or connect with pleasure and enjoyment. I was an IPV victim with a traumatic history, I could not stand up again" (Damra & Abujilban, 2020, p. 11).

The feelings are so severe that some of them even mention having the desire of dying: "sometimes I feel like dying or something . . ." (Jops et al., 2016, p. 92), "I wish I was buried under earth" (Al-Natour et al., 2019, p. 39), "I wish I had not come into this world" (Al-Natour et al., 2019, p. 34), "I have repeatedly had different suicidal thoughts . . ." (Damra & Abujilban, 2020, p. 9). In general, the women describe their lives drained of happiness, and express negative feelings such as guilt, sleep problems, loss of appetite, poor concentration, and lack of interest (Al-Natour et al., 2019; Damra & Abujilban, 2020).

When referring specifically to IPV, some participants described their domestic zones as spaces of fear, anxiety, abuse, and unhappiness (Memela & Maharaj, 2018), and others described feelings of emotional devastation and humiliation as reflected in the following quote: "I feel like a bird with broken wings. I cannot fly away from honour, nor can I stay and bear all this humiliation" (Al-Natour et al., 2019, p.34).

An important finding is that the refugee women included in the studies report that SGBV experiences have long-lasting effects on their well-being, some of them even claim that violence exacerbates the effects of war-related trauma (Fineran & Kohli, 2020; Zannetino, 2012). This is exemplified in the following quotes:

> We are away from war now, but when the men get violent it is just like we are back there . . . we feel just like we feel when we were in Liberia but there is no war here, it is only the relationship that makes us scared. (Zannetino, 2012, p. 822)

> We always remember. It is not easy to forget . . . you find lots of happiness in Australia, but you are injured in the heart, and you cannot fix it. Trauma is still in your heart . . . I may be smiling on the outside, but I am crying on the inside. (Bartolomei et al., 2014, p. 51)

Discussion

This qualitative thematic synthesis explores the SGBV experiences of women refugees during migration. Seven different types of SGBV were identified, IPV and SV being the most mentioned experiences. Research on the prevalence of GBV in complex emergencies supports these findings (Araujo et al., 2019; Keygnaert et al., 2012; Soria-Escalante, 2022; Stark & Ager, 2011). It was reported that women refugees, mainly due to their sociocultural background, perceive SGBV as a normal reaction of men and do not recognize IPV as a form of violence. Accordingly, literature shows that many refugee cultures, especially those coming from Asian or African countries, relegate women to a submissive role where they are considered the property of men; they've been socialized to accept men's violent behavior as normal and to stay beside their husbands and family (Friedman, 1992; Stamatel & Zhang, 2018). These also explain why the most reported coping mechanisms toward SGBV was keeping silent and enduring the violence, which has also been reported in other immigrant communities endorsing male privilege (Bhuyan et al., 2005; Soria-Escalante, 2022; Wachter et al., 2018).

This synthesis specifies the factors that increase women's vulnerability to SGBV, being disruption to traditional gender roles the greatest risk factor. This disruption occurs when the women arrive to new countries where they are provided with more freedom, power, and responsibilities. Accordingly, results show that IPV seems to occur with greater frequency during the interception and destination stages, phases in which both refugee men and women are settling and adapting to new living conditions. The finding is supported by Thomson and colleagues (2015) demonstrating a clear relation between increases in self-reported IPV and disruption in roles. It seems that IPV is a response from the men to reaffirm their power when traditional gender roles are at risk (Thomson et al., 2015).

Similarly, Metheny and Stephenson (2022) show how an individual's departure from community norms in unequal societies increases the risk of experiencing sexual IPV.

It is then especially important to counteract IPV by challenging restrictive social community norms and simultaneously providing education that increases female empowerment and changes hegemonic masculine tendencies that shape young men's perspectives regarding gender relations (El-Molesmany et al., 2020; Metheny & Stephenson, 2022).

Refugee women identify a series of obstacles to help seeking, which have been similarly reported in women experiencing SGBV (Prosman et al., 2014). This all suggests a clear gap between what these women require and the support they are receiving from their family/community and the services initially designed to support them. Practitioners within the field must be aware of these barriers, both individual (e.g., lack of resources) and structural (precarious immigration services) to be able to provide the best possible assistance (Sullivan et al., 2021).

Finally, the findings revealed that refugee women identify a range of psychological symptoms deriving from their SGBV experiences. These findings are consistent with previous literature reporting high levels of major depression and PTSD among the refugee population, with increased risk among women (Bhui et al., 2003; Fazel et al., 2005; Rizkalla et al., 2020; Tilbury & Rapley, 2004).

Services provided for these women are typically culturally insensitive, as Sundvall and colleagues (2018) demonstrate, communication between female refugees and clinicians is poor and impaired by difficulties in understanding the unbearable realities of these women, the sociocultural factors affecting them, and decoding their language. Professionals interacting must be aware of the diversity of SGBV experiences that these women encounter through the migration process and their diverse ways of responding. Their state is not an isolated illness caused by internal shortcomings, it is rather the consequence of a series of compounding traumatic experiences that do not end with resettlement and intersect with their gender, race, ethnicity, sociocultural norms, religion, coping mechanisms and understandings of mental health and wellbeing (Tilbury & Rapley, 2014; Yasmine & Moughalian, 2016). Sullivan and colleagues (2021) explored how GBV is often experienced as a continuum of violence throughout the refugee journey and resettlement with ongoing consequences across their lifetime.

Therefore, future approaches and interventions should adopt an integrated framework toward understanding and dealing with SGBV in the refugee population. These integrated frameworks must aim at treating individuals, but mainly at tackling the systemic inequalities faced by this population within migratory and resettlement countries (Sullivan et al., 2021). An example of this is Yasmine and Moughalian's (2016) social ecological model of violence against Syrian refugee women in Lebanon, where they emphasize that violence against women is the result of the interaction of individual, contextual and sociocultural factors. Thus, interventions should not only target the individual but rather the social, cultural, organizational, economic, and political systems propagating oppression. They suggest that health-care professionals should respect, understand, and recognize cultural differences while at the same time challenge unjust practices (James, 2010). Similarly, Sullivan and colleagues (2021) suggest that practitioners should aim at creating safe spaces by providing clear explanations, employing qualified interpreters, recognizing the impact of trauma on their experiences, being culturally responsive, hearing their stories and promoting community-led interventions. An example of this is working with the women to raise awareness and create sisterhood solidarity networks (Yasmine et al., 2016). Along these lines, other interventions that were identified in this research process and might be useful in understanding and treating SGBV in the refugee population are the Cultural Context Model (Almeida, 1999), the Constructing Violence-free Masculinities Program (Mitchell, 2013), the Participatory Video Program to reduce GBV (Gurman et al., 2014), the model of psychological reactions to refugee-related trauma (Nickerson et al., 2011) and the recommendations provided by Raftery and colleagues (2022) to enhance effectiveness in GBV coordination in diverse emergency settings.

Limitations and Future Research. The current study presents a series of limitations. Firstly, although specified in the search terms, all the information acquired is about women refugees, there is practically no information about asylum-seeking women. This is preoccupying considering the latter are not provided with international protection, heightening their vulnerability. Moreover, all the information acquired is about the SGBV experiences of women refugees from Asian and African countries, mainly from the Middle Eastern area, ignoring the reality of other refugee communities. This focus in the Middle East and other African countries might be explained taking into consideration that most refugees displaced abroad come from countries from the Middle Eastern area (UNCHR, 2021). Also, limiting the search to English-written articles led to a possible exclusion of information from Latin American refugees. Additionally, there is a lot of information regarding certain types of SGBV, particularly IPV and SV, but very little regarding other types of SGBV which are probably more difficult to identify and investigate, like psychological, verbal, emotional, and/or financial violence.

Secondly, although only studies selected in published journals were selected for the analysis, no further quality analysis was conducted on the studies, thus the results must be interpreted with caution. Thirdly, there is a possibility that the synthesis of the findings might result in a loss of relevance and integrity of each of the individual studies, thus they must be interpreted keeping in mind the context of the participants of each of the individual studies (Major & Savin-Baden, 2010). In this sense, it is especially important to think about the implications for the populations studied of both pertaining to certain sociocultural groups and resettling in different countries. Although not the focus of the present review, it would be interesting in future research to identify and discuss if there are any differences in women refugee's SGBV experiences based on their country of origin and/or resettlement.

Furthermore, while outlining the three stages of migration—travel, interception, destination—was convenient to limit the research to a population with similar SGBV experiences, almost no discrete findings by stage of migration were found. As shown in the results, the SGBV behaviors that occurred more during certain migratory stages are commented on the results, but only IPV notably increased during certain stages (interception and destination phases). It is clear from this that SGBV occurs during the whole migration process.

Finally, although the information reported is the one provided by refugee women on their SGBV experiences, it is

important to recognize that all the information recollected in this synthesis is firstly mediated by the researchers of the included studies and secondly by the authors of the review. Thus, the reported findings are not the experiences of these women per se but rather an interpretation of them.

Considering all of this, future research on this area should aim at identifying the complete range of SGBV experiences that refugee and asylum-seeking women from different nationalities might encounter. It is especially important that future research should focus on hearing the narratives of these women, acknowledging their perceptions, their experiences and examining the socio-contextual factors that shape their life experiences and mental health (Donnelly et al., 2011). This type of research should be further used to implement culturally sensitive interventions like the ones previously mentioned.

Conclusion

The present metasynthesis effectively integrates and synthesizes the available qualitative literature addressing the SGBV experiences of women refugees, offering a richer interpretation of the phenomena. From a multicultural intersectional feminist focus, their perceptions, experiences, coping mechanisms, and psychological discourses were identified. All in all, there are many implications to the present review. Firstly, findings underline the interaction of multiple risk factors that increase the vulnerability of refugee and asylum-seeking women toward SGBV. It is of increasing importance that these factors are identified by health-care providers and humanitarian organizations to increase women's awareness toward them and reduce their presence. Secondly, the findings demonstrate that women refugees are exposed to a continuous cycle of violence influenced by a series of sociocultural factors. These challenge both diagnostic practices that obliterate the experiences of these women and interventions only directed at treating the individual as if their problems were solely caused by personal and internal factors. Health-care providers must approach these women in culturally sensitive and nonjudgmental manners, providing confidence and hearing their stories to identify the complexity of their experiences. Moreover, future research and interventions should hold an integrated framework of SGBV and its consequences for refugee women. Finally, on a broader scale, this research adds to the increasing body of literature on this topic, raising awareness of the reality of these women and encouraging humanitarian organizations to prompt further research that empower these marginalized populations and implement interventions (e.g., medical, psychological, and social) that respond to their necessities.

Critical Findings

- Whereas previous literature highlights only the prevalence of SGBV experienced by women refugees, the present synthesis, using a qualitative-based methodology, describes their experiences, perceptions, psychological discourses, coping, and help-seeking behaviors in situations of SGBV.
- Patriarchal sociocultural norms influence the experience, perception, and response of women refugees toward SGBV. Correspondingly they normalize SGBV and choose to endure the violence in silence to avoid being rejected or stigmatized by family/community members.
- Disruption of traditional gender roles and economic, legal, and social marginalization of women refugees during migration increases their vulnerability toward SGBV.
- Women refugees identify a series of obstacles that prevent them from seeking help, suggesting a clear gap between their necessities and the services offered.
- Women report that SGBV has devastating and long-lasting psychological consequences.

Implications for Practice, Policy, and Research

- Diagnostic practices that further victimize these women and psychological interventions directed at only treating the individual as if their problems were caused by personal and internal factors are unlikely to be effective in this population.
- Interventions holding an integrated framework toward understanding and dealing with SGBV in the refugee population are suggested.
- Health-care providers must approach these women in culturally sensitive manners, hearing their stories to identify the diversity of their experiences.
- Workers and policy makers must hear these women, recognizing the multiple factors that increase their vulnerability to SGBV, and generate policies that protect and respond to their rights and necessities.
- Researchers must continue using qualitative-based methodologies to give voice to these women, exploring the way they provide meaning to their experiences.

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Supplemental Material

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