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A Systematic Review of the Effect of Family-Centered Education on the Physical and Mental Health of Middle Eastern Refugee Women

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Abstract

Refugee women from the Middle East are underrepresented in research and meeting their physical and mental health needs remains a significant challenge for healthcare workers in countries of resettlement. In this systematic research review, we synthesize family-centered interventions to address mental, menstrual, and reproductive health within this population. Twenty-one relevant studies were identified, showing the benefits of providing culturally sensitive family-centered education through the integration of educational interventions focused on community outreaches, interpersonal relations, school-based education, social networks, and more. However, there is still a need for high-quality mental, reproductive, and menstrual intervention studies within resettled refugees from the Middle East, with explicit attention to collaborative partnerships within the healthcare system.

Keywords: *Women's health, mental health practices, mental health in nursing, Middle Eastern women, Middle Eastern refugee women, nursing practice, best nursing practice, patient and family-centered care, patient education, menstrual health, reproductive and sexual health.*

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Women's health among Middle Eastern refugee populations is an ongoing issue that requires critical attention. With the refugee crisis that has been occurring due to various wars in Syria and surrounding regions, there has been a great increase in the amount of displaced people around the world, causing a global refugee crisis. According to The World Bank (2022), in 2021 around nine million Middle Easterners were displaced and declared refugees. The United Nations High Commissioner for Refugees (UNHCR, 2022) announced that there were over 32.5 million refugees displaced all around the world in 2022, with over 25% of the total refugee population being displaced Syrians as a result of the war in Syria (UNHRC, 2022). The conflict over the last four decades in Afghanistan has added to the refugee crisis, with 6 million Afghans being displaced both within and outside their borders by the end of 2021. Of those most recently displaced in the year following the Taliban seizing power, 80% were women and children (Mantoo, 2021).

Because of different Middle Eastern religious and cultural taboos, women's health is a branch of care that is often overlooked. Many of these cultural taboos exist due to the association with infidelity, impurity, or pregnancy simply from a visit to a gynecologist (Amiri et al., 2019). Additionally, there is heavy patriarchal control that requires women to ask permission from their husband or father-in-law before a visit, which increases the incidence of speculation and persecution (Amiri et al., 2019). Among the refugee population, women do not receive adequate access to the healthcare resources that they need (El Arnaout et al., 2019). A significant deficiency exists in the availability of family-centered educational best practices which are culturally appropriate as well as identification of reproductive health issues in Middle Eastern refugee women. To provide refugee women with the care that they

need to maintain their well-being, it is essential to have open conversations about these issues.

Background

History of the Middle Eastern Refugee Crisis

The refugee crisis in the Middle East has been an ongoing and escalating issue for the last fifteen years due to the various wars and shifts of power within the region (Brand & Lynch, 2017). It is difficult to pin an exact starting point for the conflict due to the deeply rooted divisions resulting from the extensive and complex historical context. While the wars in Syria and Iraq have made the largest contribution to the Middle Eastern refugees population, many others have fled wars in Afghanistan, Libya, Somalia, Sudan, and Yemen as well (Brand & Lynch, 2017). The states neighboring these places have been faced with unprecedented responsibility to absorb the mass exodus of people seeking asylum. This has led to entire communities of refugees sequestering into rural areas, urban homes, and even refugee camps. For the Syrian refugee population, even though only 5% live inside these camps, 70% find themselves living in poverty with scarce job opportunities and dwindling prospects of returning home (UNHCR, 2022). While the conflicts in the Middle East continue, a whole generation of displaced people are growing up in the interim of this struggle.

Barriers to Healthcare

The displacement of a great number of Middle Eastern refugees caused them to be faced with the challenges of a new country, and the countries hosting these refugees are challenged by them. These host countries face barriers to providing competent healthcare services to the Middle Eastern refugee population in their countries (Silbermann et al., 2016). Impediments to healthcare for Middle Eastern women include cultural and religious beliefs, lack of health literacy, and language barriers (Amiri et al., 2019; Silbermann et al., 2016).

Cultural and religious barriers to healthcare are the most prominent when providing healthcare services to Middle Eastern refugee women. Cultures within Middle Eastern countries vary; however, some general common factors are apparent in most of these countries. Middle Eastern culture is greatly influenced by its traditional patriarchal system (Amiri et al., 2019; Kanal & Rottmann, 2021). Men serve as leaders of the households, and most aspects of daily life must be conducted through them—including healthcare. Social barriers such as stigmas surround aspects of the health of women including reproductive, menstrual, and mental health (Amiri et al., 2019; Samari, 2017). Some Middle Eastern refugees express superstition and fear about discovering a medical issue (Amiri et al., 2019). Religion plays an imperative role in Middle Eastern culture. According to Islamic practices, it is most appropriate for healthcare professionals to be the same sex as the patient. This can be a barrier to healthcare due to disproportional accessibility to same-sex healthcare workers (Attum et al., 2022). These cultural dimensions cause Middle Eastern refugee women to be reluctant to seek healthcare services.

Lack of health literacy and language barriers are also prominent in this population. Cultural and religious barriers, like the ones mentioned above, influence the lack of health literacy among Middle Eastern refugee women. The lack of health education impacts several aspects of health—especially reproductive, menstrual, and mental health (Samari, 2017). As a result, Middle Eastern refugee women are not aware of the early signs and symptoms of medical or mental illnesses and only seek help when the illnesses have progressed and more severe symptoms are apparent (Silbermann et al., 2016). Medical terminology is foreign to many not trained or active in the medical field. A language barrier causes issues for both the refugees needing healthcare services and for the healthcare professionals attempting to obtain information and conduct assessments (Al-Jumaili et al., 2020).

Mental Health

Displacement from one's home, loss of family members, and exposure to traumatic events all serve to drastically impact the mental health of refugees (Sijbrandij et al., 2017). Within Middle Eastern displaced populations, factors such as cultural beliefs, values, and expressions play a salient role in the understanding of mental wellness (Due et al., 2022). The issue of mental health among the refugee population—particularly women refugees—is an issue that requires urgent attention and intervention. Trauma which is undealt with can lead to severe cases of anxiety, depression, and post-traumatic stress disorder (Due et al., 2022).

Access to appropriate medical care—including mental health services—is limited for several reasons. Lack of a well-rounded understanding of mental health among certain refugee communities, language barriers, and different cultural practices can contribute to insufficient mental health care (Sijbrandij et al., 2017). Other issues hindering a refugee woman's access to mental health services pertain to the stigma surrounding unchaperoned visits to health services. Seeing as it may be viewed as inappropriate for a woman to visit a medical center without her husband, it may be more difficult for a woman to have the privacy she may need to disclose more sensitive information to healthcare providers (Burford-Rice, 2020). Interventions to effectively address this issue should consider the unique cultural background that these refugee women have, as well as the different experiences they have lived through.

Menstrual Health

Menarche refers to the first occurrence of menstruation in a person's life, typically marking the onset of puberty in females. It is a significant milestone in the physical maturation and reproductive development of girls. Across cultural contexts, menarche is construed to be the marker of womanhood and is largely associated with sexual maturation (Hawkey et al., 2020). While there are global similarities in the way menarche and

menstruation are experienced, cultural differences and perceptions play a large role in how women's menstrual cycles are practiced and acknowledged within their given culture. Namely, for women in the Middle East, there is a normalcy of both secrecy and silence surrounding menstruation even among women. Menses is largely connotated with feelings of shame and humiliation and discussions of the topic itself are considered to be disrespectful to talk openly about among other women (Ghandour et al., 2022). Due to this taboo, it is common for Middle Eastern women to receive little to no menstrual and pre-menarcheal education in their countries of origin.

Warning messages from women to younger menarcheal girls are often unclear with absent or incomplete information given regarding the relationship between menstruation, sex, and pregnancy. Insufficient knowledge on the function of menarche in relation to childbearing often plays out in immediate pregnancy after marriage for women of Middle Eastern origin. From an early age, it is instilled into girls by older women that sitting next to or flirting with a boy may lead to pregnancy. Without the young women having been provided with further physiologic explanation, they are often told to “watch [their] step” and to stay on guard if they want to avoid having babies. Commonly, women do not understand the role which periods have in the reproductive cycle until after they begin childbearing and have firsthand experience (Hawkey et al., 2020).

For Middle Eastern women in displaced populations, there is an even greater concern for girls and women regarding barriers to effective menstrual hygiene management (MHM), namely lack of proper access to water, sanitation, protection, education, health status, and camp management. They often experience insufficient access to safe and private facilities for MHM as well as displacement induced shifts in menstrual practices (Schmitt et al., 2017).

Reproductive Hygiene

Women of Middle Eastern origin deal with a wide array of barriers to reproductive health issues. Specifically, refugee women face several social and cultural obstacles in aiding their personal health and family planning. AlArab et al., (2023), focus on the reproductive health of Syrian refugee women living in Lebanon and breaks down a study that explains numerous reproductive health issues in Syrian refugee women. The study found that the reasons for these issues include poor access to healthcare services, poor hygiene practices, and high rates of sexually transmitted infections. The authors suggest that these findings highlight this population's need for increased education and access to reproductive health services. Because of the lack of education, over 90% of adolescent women drop out of school before reaching the age of fifteen, and before the age of eighteen, 60% of adolescent girls have experienced at least one pregnancy (Fahme et al., 2022). The cultural norms have a high impact on why many girls are experiencing pregnancies at a young age. The community-based education groups are discouraged from being involved, causing an increased risk of developing diseases such as HIV/AIDS within the refugee population (Fahme et al., 2022). Because of these poignant results, there is a critical need for an increase is sexual reproductive hygiene education within Middle Eastern refugee populations.

Significance

Importance to the Global Nursing Community

The health of Middle Eastern refugee women across the globe is an issue that continues to grow. Challenges to women's health can be particularly difficult, especially among refugee populations who have been abruptly displaced for their survival (Amiri et al., 2019; Samari, 2017). Middle Eastern refugees flee their countries bringing health issues from the conflict or situation they are fleeing, along with preexisting health concerns to host countries. A study conducted in Denmark concluded that about 65% of Middle Eastern

refugees arrive in the country with one or more severe somatic health issues (Silbermann et al., 2016). Likewise, the United States of America hosts about 3.7 million Middle Eastern refugees, half of them being women, many of whom have new or preexisting health concerns (Al-Jumaili et al., 2020). It is up to the healthcare systems of the host countries to acknowledge and address the health concerns of Middle Eastern refugee women.

Mental Health Outcomes

If refugee women are not provided with the resources and support which they need, their risk of developing negative mental health outcomes significantly increases. Issues such as high exposure to traumatic events, loss of family members and loved ones, and the stress of displacement can cause anxiety, depression, and post-traumatic stress disorder (Sijbrandij et al., 2017).

All these different factors can contribute to feelings of hopelessness, despair, impaired self-worth, and social isolation. These women may also experience nightmares and flashbacks, affecting their sleep hygiene and their ability to engage in activities of daily living, such as caring for their families and for themselves (Due et al., 2022). These adverse consequences underscore the importance of addressing these issues among Middle Eastern refugees to ensure that women are provided with holistic care.

Reproductive Health Outcomes

While conversations regarding menstruation may carry connotations of shame and discomfort for young women in Middle Eastern populations, it is vital for healthcare workers to address patient teachings with respect and transparency while remaining culturally sensitive. For proper menstrual preparedness, it is essential that healthcare workers offer access to accurate, timely, and pertinent information to pubescent teens. While younger women’s reproductive-related questions are often dismissed or carried with shame in home settings, it is essential that health professionals sensitively address misconceptions regarding

women's health and provide patients a space to ask questions and receive age-appropriate patient-teaching. Failure to provide effective patient teaching may contribute to worsening misconceptions around the topic, unwanted pregnancies, as well as a lack of autonomy for female patients in the right to understand their own bodies (Hawkey et al., 2020).

The lack of sexual and reproductive health (SRH) education leads many refugee women to have the misconception that having intercourse for the first-time discounts you from getting pregnant which, in turn, results in unintended pregnancies. Because of the cultural norm and lack of conversations about SRH education with parents, young women are receiving their education from their peers and the internet. Virginity of young women is of high value among the communities of refugees. As a result, there is decreased access to information related to reproductive hygiene questions. Lack of education or space to ask reproductive questions leads to unintended pregnancies and health issues such as HIV/AIDS to increase among the refugee population and will continue to be an issue if no change is made (Kumar et al., 2021).

Family Centered Education

When approaching issues of healthcare with Middle Eastern women, it is very important to keep the culture of the family dynamic in mind. Many Middle Eastern countries are characterized by dependent collectivism, which involves the whole family in health centered decisions (Alkhaibari et al., 2023). Additionally, because of Islamic influences, gender roles play a big part in health care because many women aren't comfortable with male providers and will often involve a male family member in the health care process (Alkhaibari et al., 2023). Gender therefore plays a key part in the operationalization of family centered care in these regions, and failure to provide culturally and religiously sensitive care can be a major hindrance to positive health outcomes. This statement is supported by a study conducted in the United States and Australia showing that it is crucial for nurses to

understand this cultural dynamic in order to facilitate sensitive and effective family centered education. As a population group, Middle Eastern refugee women withstand many oppositions and misconceptions; therefore, taking the time to empathize and understand the cultural background is taking steps towards closing this gap.

Significance to Nursing

The health of Middle Eastern refugee women is a concern that requires immediate attention and intervention by nurses. To facilitate the effective application of holistic nursing, nurses need to work together to ensure that these refugee women's health concerns are being met through the use of family-centered care and education. Exposure to traumatic events and the stress of displacement contribute to the formation of mental health disturbances in many of these refugee women. For nurses to effectively intervene, they need to be aware of these factors and provide culturally appropriate care. Nurses also need to learn how to effectively address menstrual and reproductive health concerns in a manner that is age-appropriate to these women. Lack of education about these topics may lead to health issues such as HIV and AIDS as well as unintended pregnancies. While providing this care, nurses must take into consideration the different gender roles, cultures, and family dynamics to which these women are accustomed. It is essential for nurses to keep holistic nursing care at the forefront of their minds, remembering to address the mental and physical aspects of a person's health.

Problem and Purpose

The nursing field is faced with multiple challenges associated with the Middle Eastern refugee populations around the world, especially as it pertains to women's health, including mental, menstrual, and reproductive health concerns. The purpose of this systematic research review was to identify educational practices and interventions to best address the health concerns of this population. This systematic review sought to answer the question, "What

family-centered educational best practices will improve mental, menstrual, and reproductive health practices in Middle Eastern refugee women?"

Definition of Variables

This systematic research review focuses on several key variables related to the health practices of Middle Eastern refugee women. These variables include family-centered education, best nursing practices, women's health practices, and mental health practices. By exploring these variables, this systematic research review aims to provide valuable insights and recommendations for the nursing field to use when providing care for Middle Eastern refugee women.

Family-centered Education

Family-centered education is a part of nursing practice that falls under the category of patient and family-centered care, which can be defined as collaborative care that partners with the patient, their defined family, and providers to identify the individual's goals, values, and needs (National Quality Forum, 2016). By recognizing that the family is an essential ally to the plan of care and a key to the actualization of educational concepts, there is greater quality and safety in practice (Institute for Patient- and Family- Centered Care, n.d.). Health education and promotion are one of the primary responsibilities of a nurse, so when looking at the overall care administered, it is crucial that the education provided is centered on both the patient and the family (American Nurses Association, n.d.). Therefore, this study defines family-centered education as patient education specifically given within the context of the patients' families, gender roles, and collectivist values. This partnership of education and care realigns the roles in healthcare to place a higher value on the collaboration, preferences, and values of the family at all levels of healthcare.

Best Nursing Practice

The "best practice" within the nursing field is a relatively new term introduced to medical literature in the early 1990s (Nelson, 2014). Best nursing practice includes the ability to recognize and modify nursing practice to the cultural and social needs of a population (Prowd et al., 2018). Best nursing practice involves the use of evidence-based knowledge and skills to make clinical decisions and provide interventions that improve patient outcomes and promote health (Nelson, 2014; Prowd et al., 2018; Ten Ham-Baloyi et al., 2020). It requires effective communication and collaboration with interdisciplinary healthcare teams, as well as patients and their families, to ensure that care is coordinated and patient-centered (Ten Ham-Baloyi et al., 2020). This study defines best nursing practice as referring to the delivery of safe, effective, and compassionate care that meets the individual needs and preferences of patients and families (Prowd et al., 2018; Ten Ham-Baloyi et al., 2020).

Middle Eastern Refugee Women

Middle Eastern refugee women come from various countries such as Syria, Iraq, Afghanistan, and Yemen. Often, due to emergent situations, these refugees must quickly flee, leaving their familiar worlds behind. They are fleeing their countries because of a lack of security due to war, violence, conflict and persecution regarding their race, nationality, religion or political opinion, and they are seeking safety in another country (Amnesty International, 2023; Safwan, 2018). They are relocated all over the world with the top two continents being North America and Europe (Resettlement Assistance, 2023).

The 1951 Refugee Convention was put in place to protect refugees from being subjected to penalties for illegal entry or presence in a country, recognizing that refugees may have to cross borders without proper documentation to flee persecution or conflict. It also safeguards their right to work, access education, and enjoy basic human rights and freedoms, ensuring that they are treated with dignity and respect wherever they may end up (UNHCR,

2023). This study defines Middle Eastern refugee women as Middle Eastern women who are forced to flee their countries in search of shelter and safety due to varying circumstances.

Mental Health Practices

The concept of mental health is one that applies to people regardless of their gender, ethnicity, age, and social class. Around 792 million people around the world suffer from mental health issues (Ritchie et al., 2018). Mental health practices pertain to the different habits, activities, and behaviors that individuals engage in to enhance their mental well-being (Lee et al. 2023). Such practices include seeking professional help, practicing mindfulness, sleeping adequately, exercising, and engaging in social support (Baumann & Devkota, 2023). Mental health practices can also include digital mental health interventions such as the use of mental health applications, finding online support groups, and virtual reality therapies (Ellis et al., 2022). This study defines mental health as a person's social, psychological, and emotional well-being as influenced by external and internal circumstances.

Women's Health

Given the rapidly growing field of research and practice in the area, it is essential to establish a comprehensive definition of women's health to ensure it is prioritized as a unified objective in global health, development, research, and funding frameworks (Hennegan et al., 2021). According to the International Federation of Gynecology and Obstetrics (2012), the term "women's health" encompasses the physical, mental, and holistic well-being of women throughout their life span and not merely the absence of disease or infirmity (IFGO, 2012). This definition highlights the importance of considering women's reproductive health throughout their entire life span, from adolescence to menopause and well after. This study defines women's health as a range of health concerns specific to women, such as menstruation, pregnancy, childbirth, and menopause, as well as the prevention and treatment

of reproductive disorders, sexually transmitted infections (STIs), and other health conditions affecting the female reproductive system (Hennegan et al., 2021).

Methodology

This systematic research review was conducted from January 2023 to September 2023, using these databases: CINAHL, National Library of Medicine, MEDLINE, Google Scholar, Academic Search Complete, and EBSCO. The key words used included “women’s health”, “mental health practices”, “mental health in nursing”, “Middle Eastern women”, “Middle Eastern refugee women”, “nursing practice", "best nursing practice”, “patient and family centered care”, “patient education”, “menstrual health” and “reproductive and sexual heath”. The keywords were used individually and in combination in order to obtain the greatest number of hits possible on the topic. The total number of articles found that pertained to these keywords and inclusion criteria were 1,144,689.

This number was quickly reduced by adding limitations and inclusion criteria. The inclusion criteria pertained to peer-reviewed, scholarly articles published within the last five years, in English, with full text available. The articles selected were first scanned by their title to determine relevance. If they appeared relevant to the topic, the abstract was read to further evaluate for pertinent information. If the article appeared fitting, the whole article was read and analyzed. Twenty-one articles were used to obtain the results of this research. Articles that assisted in answering the research question were saved and critiqued. Those that were critiqued were selected as part of the sample.

Findings

This systematic research review encompasses a total of 21 articles, featuring a diverse selection of study types, including 4 qualitative studies (Çelikkanat & Güngörmüş, 2021; Fahme et al., 2021; Hattar-Pollara, 2019; Majed & Touma, 2020), 5 systematic reviews (Alkhaibari et al., 2023; Bunn et al., 2022; Kokorelias et al., 2019; Torres-Cortés et al., 2023;

Villalonga-Olives et al., 2022), 3 randomized controlled trials (Bauman et al., 2021; Darabi & Yaseri, 2022; Hasha et al., 2022), 1 literature review (Barnes et al., 2020), 2 mixed-methods studies (Ellis et al., 2022; O'Toole et al., 2023), 1 scoping review (Krajnc & Berčan, 2020), 1 narrative review of existing literature (Kazdin, 2023), 1 integrative review (Siddiq et al., 2023), 1 quasi-experimental study (Darabi & Yaseri, 2022), 1 cross-sectional study (Eghbal et al., 2023), and 1 clinical trial interventional study (Metwally et al., 2019). The levels of evidence within this sample span across 8 level 1 studies (Alkhaibari et al., 2023; Bauman et al., 2021; Bunn et al., 2022; Darabi et al., 2017; Kazdin, 2023; Kokorelias et al., 2019; Torres-Cortés et al., 2023; Villalonga-Olives et al., 2022), 2 level 2 studies (Hasha et al., 2022; Metwally et al., 2019), 4 level 3 studies (Darabi & Yaseri, 2022; Eghbal et al., 2023; O'Toole et al., 2023; Siddiq et al., 2023), 1 level 4 study (Majed & Touma, 2020), 1 level 5 study (Çelikkanat & Güngörmüş, 2021), 3 level 6 studies (Fahme et al., 2021; Hattar-Pollara, 2019; Ellis et al., 2022), and 2 level 7 studies (Barnes et al., 2020; Krajnc & Bercan, 2020). In the subsequent sections, an overview of these studies and their respective findings are presented.

Family-Centered Education Findings

In the following section, the key findings derived from nine studies identify various family-centered educational interventions. The findings provide a deeper understanding of the effectiveness, challenges, and potential benefits associated with these educational interventions.

Table 1: Family-Centered Education

Author	Type of Study, Level of Evidence	Sample Size, Ethnic Demographic	Findings
Alkhaibari et al. (2023)	Systematic review, Level 1	50 articles	Family involvement was found to be both a barrier and facilitator of patient care. Family members often provide spiritual and financial support to hospitalized patients but may also interfere with treatment plans or even make decisions on behalf of the patient.

Barnes et al., (2020)	Literature Review, Level 7	6 perspectives, U.S.	Family is an important actor in public health, but each one is unique, so six principles were constructed for how to promote health and prevent disease. These include considering the larger family context, framing the importance of family heath for policy and funding decisions, partnering with and believing in families, strengthening family mentors in the community, strengthening capacity to model positive health, and empowering families and designing solutions.
Bunn et al., (2022)	Systematic Review, Level 1	10 interventions	Family communication strategies, psychoeducation about trauma's impact, social skills training, and family roles and identity.
Çelikkanat & Güngörmüş (2021)	Qualitative Study, Level 5	30 people	A multidisciplinary approach is needed to improve the refugee women's standing in terms of benefiting from the family planning and reproductive health services.
Fahme et al., (2021)	Qualitative Study, Level 6	18 people, Syrian	Adolescent sexual and reproductive health interventions among Syrian refugees in Lebanon should adopt a multi-pronged, community-based approach to address underlying health determinants and engage with men and parents of adolescents.
Hattar-Pollara, (2019)	Qualitative Study, Level 6	15 people, Syrian	Understanding the sociopolitical conditions, as well as the cultural and religious backgrounds, that shape the lived experiences of displaced girls is also essential for offering a congruent, culturally sensitive plan of care and for creating targeted and relevant educational and treatment intervention strategies and referrals.
Kokorelias et al., (2019)	Systematic review, Level 1	Fifty-five articles	Developing care plans with defined outcomes, incorporating patient and family perspectives, collaboration between healthcare professionals and family members, and flexible policies and procedures.
Krajnc & Berčan, (2020)	Scoping review, Level 7	15 articles	Five key characteristics are communication, family involvement, support for family members, organizational aspects, and nurses' attitudes toward involving families.
O'Toole et al., (2023)	Mixed-method research, Level 3	21 sites across the United States	Including families ensures equity, diversity of thought, and helps with buy-in.

Family-centered education interventions prioritize the central role of families in maintaining health and preventing disease (Bunn et al., 2022; Kokorealis, 2019). It emphasizes the need to consider the larger context of the total family, ensuring that health

promotion programming addresses the diverse dynamics within different family structures (Bunn et al., 2022; Kokorealis, 2019; Krajnc & Berčan, 2020). Furthermore, it underscores the importance of strengthening family mentors in the community to facilitate positive health practices and empowering families to assess their own needs and design solutions for improved well-being (Bunn et al., 2022).

Mental Health Findings

There were several interventions that were found for mental health concerns that pertain to family-centered education. This research review sought to identify appropriate mental health interventions that are relevant to the identified population of Middle Eastern refugee women.

Table 2: Mental Health Interventions

Author	Type of Study	Sample Size/Ethnic Demographic	Findings
Ellis et al., (2022)	Quantitative and Qualitative (data collection), Level 6	32 studies	Culturally adapted DMHIs were effective in reducing mental health symptomatology.
Hasha et al., (2022)	Randomized Controlled Trial, Level 2	76 randomized individuals	The Teaching Recovery Techniques (TRT) self-help group improved overall mental health.
Kazdin, (2023)	Narrative Review of Existing Literature, Level 1	168 articles and websites	Engaging in physical activity, such as exercise and regular walks, can have a positive impact on mental health, including reducing depressive symptoms and improving overall well-being.
Siddiq et al., (2023)	Integrative Review, Level 3	11 articles	The integrated therapies showed reductions in depressive symptoms, anxiety, and psychological distress, as well as beneficial impacts on psychosocial well-being.
Villalonga-Olives et al., (2022)	Systematic Review, Level 1	7 articles	Participants noted improved social links, resource access, and a sense of greater inclusion in their host communities when using social capital-based treatments.

The interventions found to assist with mental health in this population were using digital mental health interventions, enhancing social support networks, teaching healthcare

workers about the Teaching Recovery Techniques, and engaging in physical activity (Ellis et al., 2022; Hasha et al., 2022; Kazdin, 2023). The following interventions were found to be the most effective; engaging in physical activity to promote overall wellbeing and becoming integrated into a social support network to decrease isolation (Kazdin, 2023; Villalonga-Olives et al., 2022).

Menstrual and Reproductive Health Findings

This research review sought to identify appropriate menstrual and reproductive interventions that are relevant to the identified population of Middle Eastern refugee women. The following table includes the summary of the interventions that relate to a woman's health.

Table 3: Menstrual and Reproductive Health Interventions

Author	Type of Study	Sample Size/Ethnic Demographic	Findings
Bauman et al., (2021)	Randomized Controlled Trial, Level 1	397 participants youth aged 12-14	Girls showed greater positive changes in abstinence outcome expectancies and reduced endorsement of risky female sexual behavior. Sexual self-efficacy improved for girls in Prepared. Teach back method proved successful.
Darabi & Yaseri, (2022)	Quasi-experimental study, Level 3	578 students	The results of this study emphasize the effectiveness of two-hour educational session interventions in schools
Darabi et al., (2017)	Randomized Controlled Trial, Level 1	578 high school girls	Theory-based educational intervention can effectively reduce high-risk behaviors related to sexual and reproductive health in adolescent girls.
Eghbal et al., (2023)	Cross-sectional study, Level 3	110 ninth grade girls	Health Belief Model (HBM) is effective improving the health behavior of adolescent girls

Majed & Touma, H. (2020)	Qualitative & Community-Based Case Study, Level 4	130 female refugees	The main findings around MHM knowledge revealed that women and girls have little information on menstruation. Suggests intervention of WASH "Water, Sanitation, and Hygiene" technique.
Metwally et al., (2019)	Clinical Trial Interventional Study, Level 2	3 stages over 3.5 years: pre- interventional assessment of awareness (n = 1000), educational interventions targeting the health providers and all women in childbearing period in their communities (n = 20,494), and post-intervention evaluation of change in awareness of their rights for prenatal, natal and postnatal care (no = 1150)	Women before interventions weren't educated on their rights to have a health card once they know they are pregnant. The results showed that women aware of a health card increased, women possessing a health card doubled (more than 25%), and 75% of women with the knowledge of knowing it is their right to have a health card, deliver with a specialized doctor, trained nurse or a at an equipped facility, and those who knew it was their right to have at least 2 at home preparations necessary for a safe home delivery.
Torres-Cortés et al., (2023)	Systematic review of randomized controlled trials (RCT), Level 1	A total of 21 studies passed the inclusion test after the review of 8318 reports	The results established that components that should be present in the design of an effective A-SEI are behavior change theoretical models, the use of participatory methodology, be targeted at mixed-sex groups, facilitators' training, and at least ten hours of weekly intervention.

The most prevalent women's reproductive health teaching interventions included the use of a theory-based education intervention, Health Belief Model (HBM), Theory of Planned Behavior (TPB), Sexuality Education Interventions (SEIs), maternity educational interventions, and sexuality education interventions targeted at adolescents (A-SEIs) to enhance menstrual and reproductive health knowledge for women (Darabi et al., 2017; Darabi & Yaseri, 2022; Eghbal et al., 2023; Majed & Touma, 2020; Metwally et al., 2019; Torres-Cortés et al., 2023). The findings confirm that effective health education designs should include behavior change theories, employ participation methods, target mixed-sex groups, involve trained facilitators, and provide a minimum of ten hours of weekly

intervention (Torres-Cortés et al., 2023). In the following discussion, the broader significance, potential limitations, and avenues for future research will be explored. Moreover, it will be considered how these insights can inform policy, practice, and ongoing pursuit of educational best-practice within school systems and homes.

Discussion

Family-Centered Education

In the Middle East, family plays a pivotal role within the cultural fabric (Alhaibari et al., 2023). Patients are seen as part of a broader framework that includes individuals, families, and communities (Barnes et al., 2020; Korkorelias et al, 2019). Family-centered education places families at the heart of the learning process, fostering a collaborative and supportive approach to health literacy and personal development (Bunn et al., 2022; Korkorelias et al., 2019; O'Toole et al., 2023). In the Middle East, research underscores the need for family-centered educational interventions (Alkhaibari et al, 2023; Fahme et al., 2021). A study by Fahme et al., (2021) highlights the importance of family-based interventions, especially in the context of adolescent sexual and reproductive health. Their findings emphasize the significance of involving paternal figures in health education and health care planning and implementation, illuminating the cultural nuances and family dynamics central to the success of healthcare initiatives in the Middle East (Fahme et al., 2021).

In other countries, the implementation of family-centered healthcare practices has proven to be highly effective (Barnes et al., 2020; Kokorelias et al., 2019; Krajnc & Berčan, 2020). A study by Barnes et al., (2020) addresses an increasingly recognized importance in empowering community-based family mentors in family-centered education. These mentors serve as invaluable sources of support, knowledge, and guidance, aiding families in navigating the intricate landscape of healthcare (Barnes et al., 2020). By promoting family involvement, healthcare providers can better address the broader determinants of health,

which encompass social, environmental, and genetic factors (Kokorelias et al., 2019; Krajnc & Berčan, 2020; O'Toole et al., 2023). An essential aspect of family-centered educational interventions is the use of effective communication. This entails a thorough understanding of the communication techniques and styles that are attuned to the people and cultural context, facilitating effective engagement and understanding (Barnes et al., 2020; Bunn et al., 2022; Kokorelias et al., 2019; Krajnc & Berčan, 2020; O'Toole et al., 2023). Family-centered healthcare involves creating care plans with well-defined objectives, incorporating the perspectives of both patients and their families, nurturing collaborative partnerships between healthcare professionals and family members, and implementing adaptable policies and procedures to ensure comprehensive and effective care delivery (Barnes et al., 2020; Kokorelias et al., 2019).

Taking this information into account, the first step in implementing family-centered education into the population of Middle Eastern refugee women begins with the health care worker. According to Hattar-Pollara (2019), it is crucial to understand the sociopolitical, religious, and cultural backgrounds that form the experiences of displaced women to offer congruent, culturally informed and relevant care plans, education, intervention strategies, and referrals. To begin understanding such complex and varying cultural backgrounds and experiences, it is important to become familiarized with the cultural context of the population before developing a plan of care. A study by Kokorelias et al. (2019) on the universal model of family centered care orders the key components to facilitate family-centered care as first the collaboration between family members and health care providers, then the consideration of family contexts, then policies and procedures, and finally the patient, family, and health care professional education. Implementing these steps and strategies that have been proven to be effective both within the target population of Middle Eastern refugee women and among other populations could result in more positive health outcomes and reformed education.

Mental Health Interventions

Essentially, to address mental health concerns, the foundational base that must be addressed is social connectedness. Siddiq et al. (2023) addresses this concern as a primary focus of intervention. To improve mental health outcomes, refugees' interpersonal relationships with their families and peers were addressed and interventions were implemented to enhance those relationships. Educational programs were set in place to discuss the benefits of engagement and the best ways to implement engagement. In one of the articles studied, home visit programs were implemented to allow for interaction between caregivers and the refugees. To address social connectedness, Villalonga-Olives et al. (2023) discusses social capital, the networks that facilitate action and cooperation for mutual benefit. This idea of social capital focuses on social ties to overcome barriers to collective actions to help rebuild a sense of normality. This intervention enables groups to undertake and organize collective action. To navigate the new country that they are in and to encourage new social bonds, members of a network that have experienced displacement can conduct group sessions addressing these topics. Community kitchens for individuals to get together and cook meals are another idea suggested (Villalonga-Olives et al., 2023). This intervention promotes social support networks, reduces feelings of social isolation, and targets those at risk of food insecurity and hunger. Furthermore, to enhance educational interventions, informational sessions could be incorporated within community kitchens. These sessions could focus on educating the refugee women on cultural integration, language assistance, and local resources to foster a holistic approach to well-being by incorporating both support networks and informative education (Villalonga-Olives et al., 2023).

Hasha et al. (2022) emphasize the significance of implementing the Teaching Recovery Techniques (TRT) intervention within the healthcare community, including both collaborating interpreters and health professionals. Rooted in evidence-based methodologies

and cognitive behavioral therapy principles, TRT aims to address trauma efficiently and effectively. When well-trained health professionals are integrated with other interventions, there is a considerable potential to enhance mental health outcomes. Ellis et al. (2022) explores the utilization of digital mental health interventions (DMHI) to promote holistic well-being. These interventions target health-related activities, social support, and stress reduction by incorporating customized audio and visual content alongside language translation. In a separate study, Kazdin (2023) delves into the role of movement and physical activity in ameliorating mental health outcomes, particularly in reducing anxiety and affective disorders. Physical activity can be seamlessly integrated into various settings, encompassing activities like gardening, walks, and household chores.

Menstrual and Reproductive Health Interventions

To enhance reproductive and menstrual health outcomes, educational interventions play a pivotal role by empowering women to identify and mitigate risks associated with knowledge gaps. Successful strategies address various aspects, including contraception, HIV/STI risk reduction, sexual anatomy, reproductive systems, emotional recognition, self-efficacy, informed decision-making, and negotiations regarding abstinence and condom use (Bauman et al., 2021; Torres-Cortés et al., 2023).

Behavioral-change interventions such as Project Prepared and the WASH technique focus on preventative measures pertaining to disease susceptibility and high-risk behaviors (Bauman et al., 2021; Majed et al. 2020). Project Prepared focused on providing sexually inactive young individuals, ages twelve to fourteen, with essential tools to navigate their future sexual behavior. The project consisted of two segments. Initially, there was an 11-week interactive classroom-style intervention, succeeded directly by a 3-week internship or training period, totaling 14 sessions. The internship was a pedagogical tool in which participants used what they had learned in Project Prepared and taught it to others. Project

Prepared gathered every week for a duration of 2.25 hours. The sessions encompassed both large and small group discussions, gender-specific group discussions, icebreakers, and role-playing activities. This approach equips participants with essential tools, including knowledge about sexuality, STI transmission, pregnancy prevention, and risk mitigation strategies like condom use and contraception (Bauman et al., 2021).

Along with this, the WASH technique (Water, Sanitation, and Hygiene) is a behavioral change intervention utilized to empower individuals with comprehensive knowledge about menstrual hygiene management. The WASH technique is a vital approach in providing disease prevention and education on women's health, particularly in refugee camp settings. The WASH sector focuses on reinforcing the importance of access to clean water, adequate sanitation facilities, and promoting good hygiene practices to prevent illness related to contamination. These elements are crucial for public health promotion, preventing the spread of diseases, and improving overall well-being, especially in developing and resource-limited areas. This technique is effective in knowledge leading to practical application and bridging the gap in hygienic needs (Majed et al. 2020).

Theoretical frameworks regarding educational interventions include the use of the Theory of Planned Behavior (TPB) as well as the Health Belief Model (HBM) (Darabi & Yaseri, 2022; Eghbal, et al., 2023). To enhance sexual and reproductive health outcomes among Iranian adolescents, a recent study addressed factors including teen attitudes, norms, parental control, and behavior control (Darabi & Yaseri, 2022). The study implemented the Theory of Planned Behavior (TPB) as a framework to improve overall health outcomes. The findings pointed to the effectiveness of school-based education in changing sexual and reproductive health behaviors in adolescents in relation to perspective and health promotion. This resulted in a positive correlation with the policy makers to increase their commitment to improve performance and education on menstruation. In doing so, this will also align to

reduce social taboos related to puberty (Darabi & Yaseri, 2022). Additionally, the use of the Health Belief Model (HBM) on Iranian adolescents resulted in improved puberty health behaviors. Based on the targeted findings, it can be inferred that the use of the HBM would be beneficial to implement in Middle Eastern refugee groups for increased health promotion (Eghbal et al., 2023).

Community-based interventions in Egypt focused on reproductive rights awareness, particularly for newlywed women and those of childbearing age in impoverished areas. These initiatives increased knowledge about women's rights related to pregnancy, prenatal care, institutional delivery, and postnatal care, contributing to a reduction in maternal mortality rates. It specifically emphasized increasing health literacy about womens' rights related to pregnancy cards, prenatal care, access to institutional delivery with a qualified doctor or nurse and receiving postnatal care. The study utilized an Awareness Assessment Tool to gauge awareness levels of reproductive rights, ultimately contributing to education resulting in a reduction in maternal mortality rates (Metwally et al., 2019).

Implications

When analyzing the implications of these findings, there are strong motivators for generating change within the realm of nursing and health care education, as well as in practice and future research. In order to address the refugee health crisis, it is necessary to study the different variables and considerations that contribute to poor health outcomes and apply that knowledge into the current context. In doing so, potential areas of growth are identified and informed plans can be put in motion. The following implications have been drawn from the discussion of the articles across various cultures and establish the need to standardize these family-centered educational interventions within the Middle Eastern women refugee population.

Education

The implications of this systematic review emphasize the importance of implementing family-centered education within Middle Eastern refugee populations. To bridge the cultural divide and enhance healthcare services for this vulnerable population it is imperative that healthcare professionals receive thorough training in cultural competency. This will enable them to deliver care that is respectful, sensitive, and tailored to the unique needs and beliefs of Middle Eastern refugees. Equally significant is the promotion of family-centered education within the community, encouraging the involvement of families in healthcare decisions, and promoting open communication. Furthermore, these findings highlight the pressing need for improved mental health interventions and reproductive healthcare in these populations. Addressing mental health issues and reproductive health concerns in a culturally competent manner is essential for the overall well-being and resilience of Middle Eastern refugee women. Educating both healthcare professionals and the community on the necessity of these interventions is vital for the provision of equitable and effective healthcare services.

Practice

While health-care worker education is the primary step in promoting family-centered care into mental and reproductive health fields, there are many practical implications for practice both on the hospital floor and in the community. In the hospital setting, there are many different factors that can precipitate a visit and contribute to the degree that family-centered care is possible, such as the family being present in the room or not. A brief and focused intake interview can strategically identify a patient’s cultural background, preferences of care, social connectedness, reproductive health knowledge deficits, and potential familial engagement opportunities. By employing holistic nursing interventions, mental health screenings should be given to every individual to gain a comprehensive patient profile, but also a more informed perspective on the Middle Eastern refugee experience that

can more directly identify interventions. Health screenings for pregnancies, STI's, UTI's, and other menstrual and reproductive health detection can lead to early intervention as well as early identification of family support and care. These screenings can take place both in the hospital, and in the community, and case management can help provide a bridge between these two settings. Potential barriers include language differences, cultural health stigmas, strained familial relations, and family members who are displaced and separated from their communities.

Future Research

Despite the valuable insights gained from this systematic review, it is essential to acknowledge the limitations and gaps that exist in the existing literature. One notable gap in the literature is the scarcity of long-term outcome data related to family-centered education initiatives among Middle Eastern refugee populations. While this systematic review identified the immediate benefits of such programs, there is a need for further research to assess the impact on the health and well-being of these communities over time. Additionally, the literature lacks comprehensive studies that address the interplay between cultural competency training for healthcare professionals and the specific mental health and reproductive health needs of Middle Eastern refugee women. Furthermore, more research is required to identify an adequate mode of implementation of these practices in various Middle Eastern populations. Addressing these gaps will not only enhance the quality of care provided but also inform policies and interventions more comprehensively to better serve the unique needs of Middle Eastern refugees.

Strengths and Limitations

Strengths

Strengths of this review include a systematic approach and a comprehensive set of search terms. Furthermore, this review is timely and relevant. The majority of studies used

were published since 2018 and varying sizes and types of research were used within the research sample, including quantitative and qualitative research. Combining available literature in this manner provides a more comprehensive understanding of the topic and has the potential to inform future research.

Limitations

This review also consists of numerous limitations. The categories used for data extraction did not capture all multicultural nuances as there are limited sources that specifically address educational interventions for Middle Eastern refugee women. Additionally, this review did not include a comprehensive search of gray literature (i.e., unpublished manuscripts, dissertations). The inclusion criteria of studies available in English excludes papers on family-centered interventions published in other languages. Finally, it's important to note that some of the studies employed were limited to certain countries within the Middle East and may not be universally applicable to the entire Middle East region.

Recommendations

To improve study replication, it is recommended to use specific Middle Eastern country keywords rather than general terms like 'Middle East' or ‘Middle Eastern’ to refine search results. Establishing clear population inclusion criteria at the study outset would also serve to better the study’s systematic organization. Along with this, considering expanding access to timely articles beyond university databases would serve to enhance the comprehensiveness of the systematic review, as accessibility was limited in the databases available.

Conclusion

This systematic research review provides a useful framework for developing culturally appropriate care to Middle Eastern refugee women. These studies suggest that family-centered educational interventions such as community outreaches, theoretical-based,

school-based, and interpersonal-based interventions have the potential to improve mental, menstrual, and reproductive health, addressing the physical and psychosocial wellbeing of resettled female refugees from the Middle East. As resettled refugees become more diverse within the healthcare system, there is a critical need for healthcare workers to evaluate, define, and adopt effective culturally sensitive interventions to best provide holistic care to this population. In doing so, receiving countries contribute to the adjustment of displaced persons, as well as balance of humanitarian benevolence in the global community.

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