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Age-Differentiated Algorithm for the Assessment of Refugee Women Considering Stress-Associated Disorders

Kamilova N.M.[1], Mirzoeva Kh.M.[2], Guliyeva L.A.[3]
[1]DSc, Prof. Azerbaijan Medical University, Department of Obstetrics and Gynecology, Baku, Azerbaijan
ORCID: 0000-0002-7443-1503
[2]Associate Professor, Candidate of Medical Sciences, Azerbaijan Medical University, Department of Obstetrics and Gynecology, Baku, Azerbaijan, ORCID: 0009-0007-5418-6030
[3]General Practitioner, PhD Candidate, Azerbaijan Medical University, Department of Obstetrics and Gynecology

ABSTRACT

Background: Chronic stress is a key pathophysiological driver of neuroendocrine, psychological, and somatic disorders. Among refugee women, stress is typically prolonged and cumulative, and, when combined with social vulnerability and limited access to healthcare, contributes to a broad spectrum of health impairments.

Objective: To identify age-related patterns of stress response in refugee women and to develop a differentiated algorithm for clinical assessment and management, integrating clinical, neuroendocrine, and social determinants of health.

Methods: A total of 149 refugee women aged 18–70 years residing in compact settlements were enrolled in the study. Participants were stratified into three age groups: 18–35 years (n=54), 36–54 years (n=61), and ≥55 years (n=34).

All participants underwent comprehensive clinical evaluation, including medical history assessment, laboratory and instrumental investigations, and quality of life assessment using the SF-36 questionnaire. The analysis encompassed reproductive health status, gynecological and extragenital pathology, neurotransmitter profiling, and social determinants.

Comparative statistical analysis was performed, with significance set at $p<0.05$.

Results: Clear age-related patterns in health status were observed.

Women aged 18–35 years predominantly exhibited functional and stress-related disorders, including dysmenorrhea (55.6%), menstrual irregularities (35.2%), and a high prevalence of pelvic inflammatory disease (72.2%).In the 36–54 age group, organic gynecological pathology increased significantly, including uterine fibroids/endometriosis (45.9%) and cervical dysplasia (59%), alongside pronounced multimorbidity.In women aged ≥55 years, chronic somatic conditions and cognitive impairment predominated.

Neurotransmitter analysis showed reduced dopamine and serotonin levels with elevated norepinephrine and histamine in younger women, indicating sustained stress activation, with relative stabilization in older groups.Intergroup differences were statistically significant ($p < 0.05$).

Conclusion: Chronic stress is a key determinant of reproductive, somatic, and psychoemotional disorders in refugee women, with distinct age-related patterns.

An age-oriented clinical algorithm integrating psychoemotional, neuroendocrine, and social assessments may improve early detection and prevention of stress-associated disorders in this vulnerable population.

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KEYWORDS:
refugee women, chronic stress, stress-related disorders, age-related differences, neuroendocrine response, reproductive health, gynecological pathology, rehabilitation, preventive medicine; longevity, biomonitoring, public health

RELEVANCE

Stress is a universal pathophysiological mechanism underlying the formation of a wide range of neuroendocrine, psychoemotional, and somatic disorders. Its implementation is carried out primarily through activation of the hypothalamic–pituitary–adrenal axis and the sympathoadrenal system, which is accompanied by changes in hormonal and neurotransmitter balance [1,2]. The impact of psychological stress on ovarian function, neuroendocrine regulation, and women's reproductive health is discussed in detail in contemporary reviews [2,3].

In women, stress reactions have pronounced age-related specificity and are closely associated with characteristics of hormonal status. During different periods of life — from early reproductive to postmenopausal — significant changes occur in the regulation of the reproductive system, neuroendocrine mechanisms of adaptation, and sensitivity to stress. Disturbances in the "hypothalamus–pituitary–ovaries" system, as well as imbalance of serotonin, dopamine, norepinephrine, and histamine, play a key role in the development of anxiety, depressive, and psychosomatic disorders, as well as in the formation of menstrual dysfunction and reproductive health disorders [2,3].

The problem acquires particular significance in refugee women, who are characterized by a combination of prolonged psychoemotional tension, forced migration, social maladaptation, and limited access to medical care. Chronic stress in this population is not episodic but constant in nature, which leads to depletion of adaptive reserves of the organism and the formation of persistent pathological changes [4–7].

Social factors, including low employment level, limited educational opportunities, unstable living conditions, and insufficient medical accessibility, enhance the negative impact of stress and contribute to late detection of diseases. Under these conditions, a high prevalence of reproductive disorders, inflammatory diseases of the pelvic organs, pregnancy complications, as well as extragenital pathology, including anemia, cardiovascular and endocrine diseases, is formed [4–8].

Despite the existence of international clinical guidelines, they are mainly focused on the diagnosis of individual nosological forms and do not take into account the complex influence of psychoemotional and social factors, as well as age-related features of stress response. This is especially relevant for vulnerable population groups such as refugee women [8,11].

In this regard, there is a need to develop integrated, age-differentiated approaches to examination and follow-up based on a combination of clinical, neuroendocrine, and social parameters [4,6,8].

Corresponding Author: Kamilova N.M.

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OBJECTIVE OF THE STUDY

To identify age-related patterns of stress response in refugee women and to develop a differentiated algorithm for clinical assessment and management, integrating clinical, neuroendocrine, and social determinants of health.

MATERIALS AND METHODS

The study was conducted in the period from 2016 to 2021 and included 149 refugee women and internally displaced persons aged 18 to 70 years living in compact settlements (Mushfigabad settlement, Umid settlement, Bilgah sanatorium, Sabirabad region).

All participants were divided into three age groups:

- Group I — 18–35 years (n=54)
- Group II — 36–54 years (n=61)
- Group III — ≥55 years (n=34)

The study design was descriptive and comparative.

The study was conducted in three stages:

1. Analysis of the structure and prevalence of gynecological pathology among examined women
2. Assessment of the influence of social factors on reproductive health and formation of stress-associated disorders
3. Study of the features of organization of medical care at prehospital and hospital stages

Within the study, a comprehensive clinical-functional assessment was carried out, including:

- analysis of menstrual and reproductive function
- assessment of gynecological pathology
- identification of extragenital diseases
- analysis of the course of pregnancy and childbirth
- assessment of socio-demographic factors
- analysis of accessibility and timeliness of medical care

Data collection was carried out on the basis of clinical examination, questionnaires, and analysis of medical documentation. Special attention was paid to the identification of previously undiagnosed conditions and risk factors.

Comparative analysis was conducted between age groups in order to identify age-associated features of stress response, structure of pathology, and accessibility of medical care. To assess quality of life, the SF-36 scale was used, widely applied as an instrument for evaluating physical and mental components of health [12,13].

Statistical data processing was descriptive and comparative. Qualitative indicators are presented as absolute values and percentages. Intergroup differences were assessed by comparative analysis of frequencies with indication of the level of statistical significance ($p<0.05$). Statistical intergroup analysis was carried out between women aged 18–35 and 36–54 years. For the ≥55 years group, the analysis was predominantly descriptive due to the limited amount of quantitative data.

The study was conducted in compliance with the principles of medical ethics; all participants gave informed consent to participate.

RESULTS

The study included 149 refugee women divided into three age groups: 18–35 years (n=54), 36–54 years (n=61), and ≥55 years (n=34). The analysis showed that the health status of the examined women is characterized by pronounced age specificity and a combination of reproductive, somatic, and psychoemotional disorders.

In all age groups, a high degree of social vulnerability was noted, including low employment levels, limited access to education, and medical care. The most pronounced signs of social maladaptation were identified among young women, among whom the unemployment rate reached 44.4%, and the proportion of steadily employed did not exceed 29.6%. In the middle-aged group, social instability was combined with prolonged residence under conditions of limited access to medical care, which contributed to accumulation of chronic pathology.

Age-related differences were clearly manifested in the nature of reproductive function disorders. In women aged 18–35 years, functional disorders predominated, including menstrual cycle disorders (35.2%), dysmenorrhea (55.6%), and secondary amenorrhea (14.8%). In a significant proportion of patients, disturbances in the establishment of menstrual function were noted. In the 36–54 years group, disorders were more persistent and were accompanied by hypermenorrhea (45.9%) and deviations in menstrual cycle formation (55.7%), reflecting a combination of hormonal restructuring and chronic stress exposure. In postmenopausal age, menstrual function loses clinical significance, however the consequences of long-term neuroendocrine disorders come to the forefront.

Analysis of gynecological pathology revealed a pronounced age-related transformation. In the 18–35 years group, inflammatory diseases of the pelvic organs (72.2%), functional cycle disorders, and ovarian cysts (25.9%) predominated. At the age of 36–54 years, an increase in the frequency of organic pathology was noted, including uterine fibroids and endometriosis (45.9%), ovarian cysts (26.2%), and cervical dysplasia (59%). Thus, in middle age, a transition from functional to structural and chronic diseases is observed. In the older age group, gynecological pathology was combined with pronounced somatic burden.

Extragenital pathology was characterized by high prevalence in all age groups, however its structure changed with age. In the 18–35 years group, anemia (77.8%), respiratory infections (83.3%), and gastrointestinal diseases (48.1%) were most frequently detected. In women aged 36–54 years, pronounced polymorbidity was observed, including anemia (78.7%), arterial hypertension (59%), thyroid diseases (29.5%), and respiratory system diseases (67.2%). Varicose disease (59%) and neurocirculatory dystonia (85.2%) were also frequently observed in this group. In the older age group, the role of chronic diseases and cognitive decline increased.

Reproductive behavior of refugee women was characterized by early onset of sexual activity and low level of contraception use. In the 18–35 years group, only 33.3% of women used contraception, while the frequency of spontaneous miscarriages reached 28.2%. In the 36–54 years group, a high frequency of abortions (62.3%), preterm births (27.9%), and infertility (13.1%) was noted in the history.

The course of pregnancy and childbirth in all groups was accompanied by нарушения организации медицинской помощи, including late registration (on average after 20 weeks), a limited number of visits, and low frequency of prenatal screening. In the 18–35 years group, preterm births were observed in 12.8% of cases, cesarean section in 23.1%, and chronic fetal hypoxia in 15.4%. In women aged 36–54 years, a high level of pregnancy complications was observed, including anemia, gestosis, and placental insufficiency (Table1).

Table 1. Comparative characteristics of indicators among refugee women across different age groups

Indicator	18–35 years (n=54)	36–54 years (n=61)	≥55 years (n=34)	p-value*
Menstrual cycle disorders	19 (35.2%)	34 (55.7%)	—	$p < 0.05$
Dysmenorrhea	30 (55.6%)	22 (36.1%)	—	$p < 0.05$
Secondary amenorrhea	8 (14.8%)	2 (3.3%)	—	$p < 0.05$
Pelvic inflammatory disease (PID)	39 (72.2%)	57 (93.4%)	less frequent	$p < 0.01$
Uterine fibroids / endometriosis	isolated cases	28 (45.9%)	persistent	$p < 0.01$
Cervical dysplasia	—	36 (59%)	risk persists	$p < 0.01$
Anemia	42 (77.8%)	48 (78.7%)	persists	n.s.
Hypertension	rare cases	36 (59%)	more frequent	$p < 0.01$
Thyroid diseases	rare cases	18 (29.5%)	more frequent	$p < 0.05$
Miscarriages	15 (28.2%)	more frequent	—	$p < 0.05$

Indicator	18–35 years (n=54)	36–54 years (n=61)	≥55 years (n=34)	p-value*
Preterm birth	7 (12.8%)	17 (27.9%)	—	$p < 0.05$
Cognitive impairment	—	early signs	pronounced	—

Note: *p — level of statistical significance for differences between the 18–35 and 36–54 age groups; for the ≥55 group, a qualitative (descriptive) analysis was performed due to the lack of comparable quantitative data.*

Analysis of the neurotransmitter profile in combination with quality of life indicators according to the SF-36 scale revealed pronounced age-related differences reflecting the features of psychoemotional adaptation in refugee women.

In young women, a significant decrease in dopamine level (10.0 pg/mL) was noted, which was accompanied by low indicators of vitality (VT – 45) and mental health (MH – 36). This indicates a decrease in motivation, mental energy, and an increased risk of anxiety-depressive states. In older women, the dopamine level was closer to the physiological norm (18.0 pg/mL) and was combined with higher values of VT (80) and MH (84), which indicates better adaptation and stabilization of emotional state.

The serotonin profile also demonstrated age dynamics. In women of the younger group, the serotonin level was reduced (90.0 ng/mL) and was accompanied by extremely low indicators of emotional functioning (RE – 0), social activity (SF – 50), and mental health (MH – 36). In older women, an increase in serotonin level (140.0 ng/mL) correlated with improvement in emotional and social functioning (RE – 66.67; SF – 75; MH – 84). The obtained data indicate that serotonin deficiency at a young age is associated with chronic stress and social instability.

Analysis of histamine level showed that in young women it was elevated (2.0 ng/mL), which may reflect the presence of inflammatory processes, allergic reactions, or increased sensory sensitivity. This was accompanied by a decrease in general health indicators (GH – 45). In older women, the histamine level was significantly lower (0.5 ng/mL) and was combined with higher values of general health (GH – 82), which may indicate a decrease in the severity of somatoform reactions.

The level of norepinephrine in young women exceeded physiological values (600.0 pg/mL), which indicates increased activity of the sympathoadrenal system and a high level of stress tension. This was accompanied by decreased vitality (VT – 45) and limitation of role functioning. In older women, the level of norepinephrine was closer to normal (320.0 pg/mL), which reflects a decrease in acute stress response and transition to a more stable adaptive state. Comparative analysis of neurotransmitter levels revealed statistically significant differences between age groups ($p<0.05$). The most pronounced deviations were observed in young women, characterized by a decrease in dopamine and serotonin with simultaneous increase in norepinephrine and histamine (Table 2).

In general, the obtained data demonstrate that in young women, neurotransmitter changes characteristic of chronic stress exposure predominate, including a decrease in dopamine and serotonin with simultaneous increase in norepinephrine and histamine. In older age groups, relative stabilization of the neurotransmitter profile is observed, which is accompanied by improvement in quality of life indicators.

Table 2. Neurotransmitter levels in refugee women in different age groups

Neurotransmitter	Reference value	18–35 years	36–54 years	≥55 years	p-value*
Dopamine (pg/mL)	20.0	10.0	15.0	18.0	$p < 0.05$
Serotonin (ng/mL)	150.0	90.0	120.0	140.0	$p < 0.05$
Histamine (ng/mL)	0.6	2.0	1.2	0.5	$p < 0.01$
Norepinephrine (pg/mL)	300.0	600.0	450.0	320.0	$p < 0.01$

Note: p — level of statistical significance of differences between age groups; differences were considered significant at $p<0.05$.

Comparative analysis showed that at a young age, functional and stress-induced disorders predominate, at middle age — chronic and organic pathology, and at older age — cumulative somatic and cognitive disorders. In all groups, the key factors are chronic stress, social vulnerability, and limited access to medical care. The identified changes in the neurotransmitter profile confirm the leading role of chronic stress in the formation of psychoemotional and somatic disorders in refugee women and substantiate the need to include assessment of psychoemotional state in the examination algorithm.

The obtained results demonstrated a clear age differentiation of the structure of disorders, as well as the leading role of chronic stress and social factors in their formation. The revealed patterns indicate insufficient effectiveness of standard unified approaches to examination of this category of patients.

It has been established that at a young age functional and stress-induced disorders predominate, at middle age — chronic and organic pathology, and at older age — cumulative somatic and cognitive changes. At the same time, at all stages, the key determinants remain chronic stress, social vulnerability, and limited access to medical care.

Based on the identified clinical-age and neurotransmitter features, as well as taking into account psychoemotional and social factors, within the framework of the present study an age-differentiated algorithm for examination and management of refugee women was developed (Table 3).

The proposed algorithm is aimed at early detection of stress-associated, reproductive, and somatic disorders and is based on integration of clinical, neuroendocrine, and social parameters determining the health status of this category of patients.

Table 3. Age-differentiated algorithm for examination and management of refugee women

Stage / Age group	18–35 years (early reproductive)	36–54 years (perimenopause)	≥55 years (postmenopause)
1. Primary screening	Psychoemotional assessment (stress, anxiety, depression), menstrual cycle disorders, PMS	Complaints of insomnia, anxiety, hot flashes, emotional lability	Assessment of cognitive function, depression, social isolation
2. Medical history and social factors	Migration-related stress, living conditions, nutrition	Chronic stress, family burden, access to healthcare	Social isolation, dependency, level of support
3. Gynecological examination	Pelvic ultrasound, ovulation assessment, PMS/PMDD	Ultrasound, cytology, detection of fibroids and endometriosis	Ultrasound, cancer screening, urogenital atrophy
4. Laboratory diagnostics	CBC, ferritin, hormones (if indicated)	Hormonal profile (FSH, estradiol), metabolic screening	Vitamin D, calcium, basic laboratory parameters
5. Extragenital screening	Anemia, infections, gastrointestinal diseases	Hypertension, thyroid disorders, cardiovascular risks	Osteoporosis, cognitive impairment, cardiovascular diseases
6. Reproductive health	Fertility assessment, STIs	Perimenopausal changes, infertility	Postmenopausal changes
7. Management strategy	Psychological support, cycle regulation, treatment of infections	Treatment of gynecological pathology, correction of metabolic disorders	Cognitive support, prevention of complications
Goal	Preservation of fertility, early correction of disorders	Prevention of chronicity and complications	Maintenance of quality of life and autonomy

The proposed algorithm has a number of fundamental differences from existing clinical recommendations.

Firstly, unlike standard protocols primarily focused on diagnosing individual diseases, the proposed algorithm is based on an age-differentiated approach that takes into account the stages of reproductive aging and the specific features of neuroendocrine regulation.

Secondly, a key component of the algorithm is the prioritization of early-stage psychoemotional screening. In most international guidelines (ACOG, FIGO, WHO), psychoemotional disorders are considered secondary, whereas in the proposed model they represent a central element of pathogenesis.

Thirdly, the algorithm is adapted to conditions of limited access to healthcare, which are typical for refugee women. It includes elements of primary detection of previously undiagnosed conditions, making it not only a diagnostic tool but also an instrument of secondary prevention.

Fourthly, the algorithm incorporates the assessment of nutritional deficiencies (iron, vitamin D, calcium), which are often overlooked in standard diagnostic protocols despite their significant role in the development of chronic fatigue, cognitive impairment, and somatic pathology.

Thus, the proposed model represents a multilevel, interdisciplinary, and socially oriented system aimed at the early detection and prevention of stress-induced disorders in refugee women.

DISCUSSION

The obtained results demonstrate that the health status of refugee women is determined by a complex interaction of age-related, neuroendocrine, and social factors, among which chronic stress plays a key role [4–8]. Unlike the general population, where stress exposure is often episodic, in refugee women it is prolonged and cumulative, leading to exhaustion of adaptive mechanisms and the development of persistent pathological changes.

The identified age-related differentiation of disorders is consistent with current concepts regarding the role of hormonal status in stress-response regulation [2, 3, 12]. In

younger women, functional and potentially reversible disorders predominate, associated with hyperactivation of the sympathoadrenal system and neurotransmitter imbalance. Decreased levels of dopamine and serotonin, combined with elevated norepinephrine and histamine, reflect a state of chronic stress tension, accompanied by anxiety-depressive symptoms and menstrual cycle disturbances.

In middle age, against the background of hormonal restructuring, there is a transition toward chronic and organic pathology. The increased prevalence of uterine fibroids, endometriosis, cervical dysplasia, and somatic diseases indicates prolonged exposure to stress-related and metabolic factors. The polymorbidity identified in this group confirms the cumulative nature of pathological changes.

In older women, a cumulative somatic and cognitive burden is formed, which corresponds to data on reduced adaptive reserves and altered neuroendocrine regulation in postmenopause. Despite relative stabilization of the neurotransmitter profile, the clinical picture in this group is largely determined by the long-term consequences of chronic stress and social isolation.

Particular importance is attributed to the analysis of neurotransmitters, which confirms the biological basis of the identified clinical disorders. The observed dynamics of dopamine, serotonin, norepinephrine, and histamine reflect the staged nature of adaptive processes—from acute stress response to chronic conditions and subsequent partial stabilization. This allows the neurotransmitter profile to be considered an important marker of psychoemotional status and adaptive capacity.

Unlike existing clinical guidelines, which are primarily focused on diagnosing individual diseases, the obtained data confirm the need for a comprehensive approach that takes into account psychoemotional and social factors. In most international protocols, stress is considered a comorbid condition, whereas in the present study it acts as a central pathogenetic factor [13–15].

The developed examination algorithm reflects the identified patterns and represents an integrated model combining clinical, neuroendocrine, and social aspects. Its key feature is the inclusion of early-stage psychoemotional assessment, which enables the identification of latent disorders and prevents their chronic progression.

An additional advantage of the algorithm is its adaptation to conditions of limited access to healthcare. The inclusion of screening for previously undiagnosed diseases and nutritional deficiencies expands its potential as a preventive medicine tool.

It should be noted that the study has several limitations. Psychoemotional status was assessed primarily based on clinical-anamnestic data and rating scales, without the use of advanced psychometric tools in all cases. In addition, the quantitative analysis of neurotransmitters was comparative in nature and did not include advanced statistical modeling. Nevertheless, the obtained results allow for the identification of key trends and provide a rationale for the proposed algorithm.

CONCLUSION

This study identifies chronic stress as a central, unifying driver of reproductive, somatic, and psychoemotional disorders in refugee women, with distinct age-related patterns.

In younger women, stress predominantly manifests through functional and potentially reversible alterations; in midlife, it contributes to the development of chronic and organic pathology; while in older age, it results in cumulative somatic and cognitive burden. The observed neurotransmitter alterations provide biological evidence supporting these trajectories and highlight the role of maladaptive neuroendocrine responses to prolonged stress exposure.

These findings challenge conventional disease-centered diagnostic paradigms and underscore the need for a paradigm shift toward integrative, age-sensitive, and socially contextualized models of care.

The proposed algorithm offers a novel, multidimensional framework that integrates psychoemotional assessment, neuroendocrine evaluation, and social determinants of health. Importantly, its structure enables early identification of subclinical and stress-related disorders, thereby facilitating timely intervention and prevention of disease progression.

From a clinical and public health perspective, implementation of this model has the potential to substantially improve early detection of hidden pathologies, optimize resource allocation in low-access settings, and reduce long-term morbidity in this highly vulnerable population.

Overall, this work contributes to the growing body of evidence supporting the central role of chronic stress in women's health and provides a practical, scalable approach for advancing personalized and preventive care in refugee populations.

REFERENCES

1. Howard LM, Wilson CA, et al. Women's reproductive mental health: currently available evidence and future directions. *World Psychiatry*. 2025. doi: 10.1002/wps.21305.
2. Hu Y, Wang W, Ma W, et al. Impact of psychological stress on ovarian function: Insights, mechanisms and intervention strategies. *Int J Mol Med*. 2025;55(2):34. doi: 10.3892/ijmm.2024.5475.
3. World Health Organization. Refugee and migrant mental health. Geneva: WHO; 2025.
4. World Health Organization. Refugee and migrant health. Geneva: WHO; 2026.
5. Darebo TD, Spigt M, Teklewold B, et al. The sexual and reproductive healthcare challenges when dealing with female migrants and refugees in low

and middle-income countries: a qualitative evidence synthesis. *BMC Public Health*. 2024;24:520. doi: 10.1186/s12889-024-17916-0.

6. Endler M, Al-Mufti R, Gemzell-Danielsson K, et al. Sexual and reproductive health and rights of refugee and migrant women: gynecologists' and obstetricians' responsibilities. *Int J Gynaecol Obstet*. 2020;149(1):114-119. doi: 10.1002/ijgo.13111.
7. Ether ST, et al. Managing pre- and postpartum mental health issues of refugee women from conflict settings: a systematic review. *AJOG Glob Rep*. 2025.
8. American College of Obstetricians and Gynecologists. Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum: ACOG Clinical Practice Guideline No. 4. *Obstet Gynecol*. 2023;141(6):1232-1261. doi: 10.1097/AOG.0000000000005200.
9. American College of Obstetricians and Gynecologists. Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum: ACOG Clinical Practice Guideline No. 5. *Obstet Gynecol*. 2023;141(6):1262-1288. doi: 10.1097/AOG.0000000000005202.
10. World Health Organization. WHO recommendations on antenatal care for a positive pregnancy experience. Geneva: WHO; 2022.
11. UNFPA. Interwoven Lives, Threads of Hope. New York: UNFPA; 2024
12. Lins L, Carvalho FM. SF-36 total score as a single measure of health-related quality of life: scoping review. *SAGE Open Med*. 2016;4:2050312116671725. doi: 10.1177/2050312116671725.
13. Sima RM, Pleș L, Socea B, et al. Evaluation of the SF-36 questionnaire for assessment of the quality of life of endometriosis patients undergoing treatment: a systematic review and meta-analysis. *Exp Ther Med*. 2021;22(5):1283.
14. UNHCR. Mental health and psychosocial support. UNHCR; 2026.
15. WHO. Monitoring progress on the WHO global action plan on promoting the health of refugees and migrants, 2019–2030. Geneva: WHO; 2026.