UNDERSTANDING ACCESS TO POSTNATAL HEALTHCARE SERVICES AND SUPPORTS FOR RESETTLED SYRIAN REFUGEE WOMEN IN NOVA SCOTIA: BARRIERS, FACILITATORS, AND NEED FOR SERVICES

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Dedication

This thesis is dedicated to the women of Syria and their families who have been displaced by the ongoing crisis. Your stories of strength and resiliency never cease to amaze me.

I also dedicate this thesis to my grandfather, Laird Stirling, who lost his battle with cancer halfway through my master's degree. He was the only other person in my family to have ever written a thesis. Before he passed away, he dedicated his type-written thesis to me, so I believe it's only fitting that I dedicate mine to him.

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Abstract

This manuscript-based thesis explores access to healthcare and the availability and use of informal supports for resettled Syrian refugee women during the postnatal period. This thesis took a qualitative approach, using elements of constructivist grounded theory. Eleven women completed individual interviews during the months of August and September 2020 in an urban area in Nova Scotia. Pre-pandemic experiences are reported in Manuscript 1; COVID-19 experiences are reported in Manuscript 2. All participants had been separated from their extended family and felt their absence of support during the postpartum period. Some women had developed a new social network, while others had only their partner to offer support in Canada. Similar systemic barriers existed for participants before and during COVID-19, including irregular access to interpretation services and limited childcare. Policy change, program development, and/or interventions are needed to improve access to postnatal services and supports for resettled Syrian women.

List of Abbreviations Used

IDP	Internally Displaced Person
IOM	International Organization on Migration
IRCC	Immigration, Refugees, and Citizenship Canada
ISANS	Immigrant Services Association of Nova Scotia
NS	Nova Scotia
UN	United Nations
UNESCO	United Nations Educational, Scientific, Cultural Organization
UNHCR	United Nations High Commission for Refugees
WHO	World Health Organization

Glossary

Asylum Seeker

The United Nations Educational, Scientific and Cultural Organization defines asylum seekers as, "people who move across borders in search of protection, but who may not fulfil the strict criteria laid down by the 1951 Convention. Asylum seeker describes someone who has applied for protection as a refugee and is awaiting the determination of his or her status. Refugee is the term used to describe a person who has already been granted protection. Asylum seekers can become refugees if the local immigration or refugee authority deems them as fitting the international definition of refugee… In most countries, the terms asylum seeker/asylee and refugee differ only in regard to the place where an individual asks for protection. Whereas an asylum seeker asks for protection after arriving in the host country, a refugee asks for protection and is granted this protected status outside of the host country (UNESCO, 2017)."

Blended Visa Office-Referred Program

This program matches UNHCR-identified refugees, who have already been vetted and approved by the Canadian government, with community-led private sponsorship groups in Canada. Private refugee sponsorship groups (e.g., Rainbow Refugee Association of Nova Scotia, Open Harbor Refugee Association; Open Harbour Refugee Association, 2019; Rainbow Refugee Association of Nova Scotia, 2019) agree to support the refugee(s) for 12-months, providing orientation services. The Canadian government funds half of the year-long costs to support the refugee(s) and the private sponsorship group supplies the other.

Formal Service

For the purposes of this study, a formal health service will include any care, resources, treatment, or support provided by a formal institution or program whose mandate is to care for or assist postpartum mothers. These services are widespread and can include, but are not limited to, services provided by a family physician, obstetrician, public health nurse, social worker, doula, nongovernment organization, or mental health professional.

Government Assisted Refugee Program

Refugees who have been identified and registered with the UNHCR are referred to Canada for admission through the government-assisted refugee program. Individuals cannot directly apply to this program. Refugees who are admitted through the government-assisted refugee program are eligible to receive income assistance from the federal government (Government of Canada, 2017c). Government-assisted refugees receive support from nongovernment organizations funded by Immigration, Refugees and Citizenship Canada (e.g., Immigration Services Association of Nova Scotia) for 12-months, or until the refugee(s) can support themselves independently. Support services helps refugees settle and orient to life in Canada. NGOs typically assist refugees in finding affordable housing and employment, offer orientation programs on accessing healthcare, provide English and French courses and basic education classes.

Immigrant

According to Statistics Canada, the term immigrant refers to a "person [who] has been granted the right to live in Canada permanently by immigration authorities. Some immigrants have resided in Canada for a number of years, while others have arrived

recently. Some immigrants are Canadian citizens, while others are not." Immigrants have chosen to emigrate from their country of origin, whereas refugees have been forced to leave (Statistics Canada, 2016b).

Informal Supports

For the purposes of this study, informal supports will include any non-formal support provided that contributes to improved postnatal health. Examples may include family or friends providing social support and guidance, offering childcare support, cooking or cleaning, or providing transportation to appointments.

Internally Displaced Person

According to the UNHCR (2018b), an internally displaced person (IDP), "has been forced to flee their home but has not crossed an international border. These individuals seek safety anywhere they can find it—in nearby towns, schools, settlements, internal camps, even forests and fields. IDPs, which include people displaced by internal strife and natural disasters, are the largest group that UNHCR assists. Unlike refugees, IDPs are not protected by international law or eligible to receive many types of aid because they are legally under the protection of their own government" (UNHCR, 2018b).

Migrant

The UNHCR states that, "A 'migrant' is fundamentally different from a refugee. Refugees are forced to flee to save their lives or preserve their freedom, but 'migrant' describes any person who moves, usually across an international border, to join family members already abroad, to search for a livelihood, to escape a natural disaster, or for a

range of other purposes. However, refugees and migrants often employ the same routes, modes of transport, and networks" (UNHCR, 2019a).

Postnatal/Postpartum Period

For the purposes of this study, the postnatal or postpartum period will refer to the first 12 months after childbirth.

Postnatal Health

For the purposes of this study, the term postnatal health will refer to maternal and not infant health within the first 12 months of childbirth. Healthcare will include biomedical care, psychological care/mental health (e.g., postpartum depression, anxiety), and social supports.

Private Refugee Sponsorship Program

This runs similarly to the blended visa office-reformed program, in that private refugee sponsorship groups, or individuals or groups can apply to sponsor UNHCR-identified refugees and people in refugee-like situations for consideration for resettlement in Canada (Refugee Sponsorship Training Program, 2021). If approved, the organization, group, or individual is solely responsible for supporting the sponsored refugees for a minimum of 12 months. They must provide full financial support and orient refugees to life in Canada (e.g., setting up them up with a health card, registering children for school, finding housing and furniture).

Refugee [1]

A refugee is an individual who has been forced to flee their home country as a result of a persecution, conflict, or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group. Refugees are unable to return to their country of origin or are afraid to do so and are seeking refuge in another country (UNHCR, 2018d).

[1] The author acknowledges that the label of refugee can be stigmatizing for many people. The term will be used in this paper to differentiate between the legal definition/experiences of refugees, immigrants, IDPs, migrants, and asylum seekers.

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Chapter One: Introduction

The postnatal period is a time when women need access to formal healthcare services and informal social supports to maintain and promote their own health and that of their children. Resettled refugee women, however, are known to encounter a variety of barriers when accessing or attempting to access services and supports for their health (Henry et al., 2020; Heslehurst et al., 2018; Higginbottom et al., 2016; Khanlou et al., 2017). Access to postnatal healthcare remains inequitable for refugee populations in Canada. Resettled refugee women are significantly more likely to have a poorer postpartum health status (Ganann et al., 2012) and a greater number of unmet physical and mental health concerns when compared to Canadian-born women (Gagnon et al., 2013). Rates of postpartum depression are five-times higher among refugee women when compared to Canadian-born women. Refugee women living in Canada rated community health services unfavorably (Ganann et al., 2012), underutilize healthcare services (Chan et al., 2018), and report encountering a myriad of individual and systematic barriers when accessing or attempting to access services for their postnatal health (Sword et al., 2006). These barriers, including a limited understanding of the Canadian healthcare system, language and communication differences, culturally inappropriate services or providers, stigma surrounding the use of mental health services, and a lack of informal social support, have been reported to negatively contribute to refugee women's uptake of postpartum health services, and ultimately, their health status (Gagnon et al., 2010; Sword et al., 2006). Moreover the onset of the COVID-19 pandemic appears to be further exacerbating health inequities for marginalized populations—yet the experiences of resettled refugee women are not fully known (Chandler et al., 2021; Elisabeth et al.,

2020). The purpose of this thesis was to understand the lived experiences of Syrian refugee women when accessing or attempting to access formal services and informal maternal health supports during the postnatal period, both before and during the early months of COVID-19 in Nova Scotia.

The Global Migration Crisis

The world is currently in the midst of the largest global migration crisis ever recorded, with people being forcibly displaced at an exponential rate (UNHCR, 2020b). The United Nations High Commissioner for Refugees (UNHCR) reported an estimated 79.5 million people displaced at the end of 2020 (UNHCR, 2020a). Over 45.7 million of these people are internally displaced, 25.9 million are refugees, and 4.2 million are asylum seekers (UNHCR, 2020a). Each day, 37,000 new people are forced to flee their homes as a result of persecution, conflict, or human rights violations (UNHCR, 2019b). One in every 110 people is now a refugee, asylum seeker, or is internally displaced (UNHCR, 2020a). The past decade has a seen a sharp increase in forced displacement, with over 100 million people forced to migrate. One of the major crises that has contributed to this rise in statelessness has been the outbreak of the Syrian conflict, which began in early 2011. Syria has been the main country of origin for refugees globally since 2014 (UNHCR, 2020b).

The Syrian Civil War and Mass Migration from Syria

The Syrian Arab Republic (Syria) has been in the midst of civil conflict for nearly 10 years (Encyclopaedia Britannica, 2018). As a result, the largest proportion of currently displaced refugees have fled from Syria – over 6.6 million people (UNHCR, 2020b). Conflict remains ongoing with no definitive end in sight (BBC, 2018, 2019;

Encyclopaedia Britannica, 2018). Estimates suggest that over 400,000 Syrians have been killed as a result of the civil war. Another million people have been injured (United Nations, 2019). Living situations in Syria remain tenuous. Once vibrant cities, Aleppo, Damascus, Raqqa, and Homs, have been almost completely destroyed (CNN, 2018). Public buildings, including schools, health clinics, and hospitals, have been ruined (BBC, 2018; Unicef: Middle East and North Africa, 2019). School attendance has declined by more than 50%; one-quarter of schools have been damaged or completely destroyed (United Nations, 2019). Water supplies have diminished to less than half of its pre-crisis supply, and over 6.5 million people are food insecure (World Food Programme, 2018).

Due to the ongoing violence and largely unlivable circumstances, many Syrians have had no choice but to flee. Reports from the UNCHR (2021) state that there are over 6.7 million Syrian refugees worldwide, with over 5.6 million hosted in neighbouring countries including Turkey, Lebanon, and Jordan. Refugees can remain in camps or temporary shelters for years, if not decades (Sheikh-Mohammed et al., 2006; UNHCR, 2018d). Long-term occupancy in such a situation is unsustainable. To mitigate long-term occupancy in refugee camps and shelters, the United Nations High Commissioner for Refugees resettles a small percentage of the world's refugees in high-income countries, in order to provide a more sustainable, long-term living solution (UNHCR, 2018a). International resettlement is a life-saving tool, playing a key role in housing some of the most vulnerable refugees (UNHCR, 2020b).

The International Resettlement of Refugees

Approximately 1% of refugees are resettled in one of 28 developed nations, including Canada, the United States of America, Australia, the United Kingdom, and

Germany (UNHCR, 2020b). Resettlement is defined by the UNHCR as the, "careful selection by governments for purposes of lawful admission of the most vulnerable refugees who can neither return to their home country nor live safely in neighbouring host countries (UNHCR, 2017)." The most vulnerable refugees are selected and transferred from the state in which they have sought refuge and are to be transferred to a third-party country which has agreed to admit them (UNHCR, 2017). Preference is given to women and girls, children, individuals with complex medical needs or disabilities, and survivors of torture or assault (UNHCR, 2018c, 2018a). Individuals and families can wait for years, even decades, to be assigned to a country for resettlement (UNHCR, 2018c). Syrians continue to represent the largest group of refugees worldwide, with over one-quarter of all recent refugees having fled from Syria. Keeping with global trends, the largest proportion of refugees coming to Canada over the past five years have originated from Syria (UNHCR, 2020b). Given their relatively recent arrival in Canada, research on Syrian newcomers' experiences has been limited.

Immigration and Resettlement in Canada

Multiculturalism and supportive immigration practices have become an integral component of Canadian identity (Statistics Canada, 2016a, 2017; Wayland, 1997). Between the years 1867 and 2017, over 17 million people have come to Canada through the immigration process (Statistics Canada, 2017). At present, immigrants (defined in the Glossary) account for approximately one fifth of the total Canadian population (Statistics Canada, 2016a). 300,000 immigrants are arriving annually to Canada, with that number expected to rise to 350,000 by 2021 (IRCC, 2018). Approximately 10-15% of newcomers are entering Canada as a refugee (Newbold & McKeary, 2018). As the number one

refugee admitting country in the world, Canada plays an integral role in the international resettlement of refugees (UNHCR, 2020b).

In light of the migratory crisis that ensued after the outbreak of the Syrian civil war, Canada committed to resettling 25,000 Syrian refugees in 2016 (Government of Canada, 2017b, 2017a, 2019b). Between January, 2015 and March, 2019, 44,620 Syrian refugees were resettled across Canada (Government of Canada, 2019c), with over 2,920 refugees resettled in Nova Scotia during that time (Government of Canada, 2019a).

Refugees are typically resettled in Canada through one of three routes (excluding those seeking asylum): the private sponsorship program, the blended visa office-referred refugee program, or the government-assisted refugee program. Programs differ in terms who provides financial support for the refugee(s) and who offers orientation to Canadian life. Definitions of each program are outlined in the Glossary. Through all of these methods of entry, refugees are given permanent residency in Canada. All resettled refugees, like other permanent residents, are entitled to all the social benefits Canadian citizens receive, including access to health coverage, the ability to live, work, and study, and will become eligible to apply for citizenship.

Immigrants and refugees are an important economic and social benefit to Canadian society. By 2031, migration could account for over 80% of Canada's population growth (Statistics Canada, 2018). As Canada's population ages, and fertility rates remain low, immigration will play an integral role in ensuring that Canada's population and labour force will continue to grow (IRCC, 2017, 2018; Statistics Canada, 2018). Indeed, Canadian-born individuals fill the majority of jobs available in the labour market, yet gaps remain. New immigrants help to fill employment shortages, in turn,

stimulating economic growth. Like all Canadian-born people, immigrants pay taxes and spend their income on housing, transportation, and other consumer goods, ultimately stimulating the economy.

The majority of incoming Syrian refugees are young women, many of whom are of childbearing age (Government of Canada, 2019a). Refugee resettlement agencies in Canada report that the majority of women they are supporting are pregnant, postnatal, or have arrived with a young family (IRCC, 2016). Presently, 20% of women giving birth in Canada are immigrants, refugees, or refugee claimants; these women are also bearing a greater number of children compared to Canadian-born women (Statistics Canada, 2006). As such, large proportions of refugee women are in need of appropriate and accessible prenatal, delivery, and postnatal healthcare services in Canada.

The Importance of Postnatal Healthcare and Informal Supports

The postnatal period is often an exciting time for new parents. It is also a critical period when mothers may need access to health services and informal supports to treat a variety of psychosocial and physical health concerns (Brown & Lumley, 1998). Nearly 95% of women report experiencing one or more maternal health concerns (i.e., relating to the health of the mother) within the first six months of childbirth, including mastitis, prolonged vaginal bleeding, urinary incontinence, vaginal or caesarian site pain, postpartum blues or depression, and social isolation (Brown & Lumley, 1998). Untreated health problems are directly related to a decrease in women's emotional wellbeing and functional abilities, including an inability to complete routine household activities, provide childcare, and return to work (Webb et al., 2008). Timely and effective postpartum healthcare provided by formal healthcare professionals (e.g., family

physicians, obstetricians, psychologists, doulas) can prevent short- and long-term consequences of unrecognized and poorly managed health morbidities (Haran et al., 2014).

In addition to the availability of formal health services, informal supports provided by spouses, relatives, friends or associates, plays a crucial role in the health and wellbeing of new mothers (Eastwood et al., 2012; Emmanuel et al., 2012; Webster et al., 2011). The World Health Organization states that access to informal support persons is necessary for maternal and infant wellbeing and contributes to a positive transition into motherhood (WHO, 2005). Women with low levels of informal support are more likely to report having postpartum depression and a lower quality of life, when compared to women who report feeling well supported (Webster et al., 2011). Persistent postpartum depression has been correlated with insecure infant attachment, and lower infant cognitive and psychomotor development (Cornish et al., 2005). Social support acts as a protective factor against depressive symptoms, enhances maternal parental self-efficacy, and improves coping during the postnatal period (Emmanuel et al., 2012; Higginbottom et al., 2014).

Access to Postnatal Healthcare and Informal Supports for Resettled Refugee Women

Resettled refugee women report experiencing a myriad of barriers when attempting to or actually accessing healthcare services, often as a result of the complex reality resettled refugee women experience (Peláez et al., 2017). Loss of employment status, financial insecurity, language discordance, change in family dynamics, and the adjustment to new social norms can all influence the ways in which resettled refugee

women access healthcare. Resettled refugee women are therefore required to cope with the challenges of new parenthood in conjunction with the stressors and transitions that often accompany resettlement (Iqbal et al., 2021; Khanlou et al., 2017).

Language and communication differences between patients and providers can influence women's abilities to convey their concerns and interpret healthcare providers' instructions and advice, leaving many resettled refugees dependent on interpretation services (Khanlou et al., 2017; Riggs et al., 2012; Wu & Rawal, 2017; Yeheskel & Rawal, 2019). While interpreters are sometimes provided, it is often inconsistent and not readily available, there can be issues of confidentiality, and appointments may not be long enough to accommodate patient-provider-interpreter communication (Correa-Velez & Ryan, 2012; Henry et al., 2020; Khan & DeYoung, 2019; Riggs et al., 2012; Wu & Rawal, 2017; Yeheskel & Rawal, 2019). Financial constraints—including the cost of prescription medications or a limited access to childcare and transportation—can deter women from engaging with the healthcare system and lead to missed or delayed appointments (Correa-Velez & Ryan, 2012; Gagnon et al., 2010; Heslehurst et al., 2018; Khanlou et al., 2017; O'Mahony et al., 2012; Riggs et al., 2012) Women further report feeling confused navigating the health system of their host country, not knowing that supports exist for particular concerns—especially in the treatment of postpartum depression (Higginbottom et al., 2014). Perceptions of racism, discrimination, and culturally unsafe or discordant care can negatively influence women's trust and future engagement with the healthcare system (Gurnah et al., 2011; Henry et al., 2020; Niner et al., 2013; O'Mahony et al., 2013).

It is also common for resettled refugee women to have lost or been separated from family or friends during their time spent as a refugee and throughout the resettlement process (Ahmed et al., 2008; Ahmed et al., 2017; Higginbottom et al., 2014; Niner et al., 2013). Many refugee women have reduced social networks upon arriving in their host country, resulting in lower levels of available informal supports during the postnatal period (Ahmed et al., 2008; Ahmed et al., 2017; Higginbottom et al., 2014; Niner et al., 2013; Teng et al., 2007; Zelkowitz et al., 2004). Linguistic and cultural barriers often impede resettled refugee women's ability to socially integrate into their host country. Resettled refugee women with social networks containing fewer women, relatives, and people from their own ethic background are more likely to experience high rates of depressive symptoms (Zelkowitz et al., 2004). Women have reported feeling overwhelmed and frightened about having to care for a new baby without the advice and support of their extended family (Ahmed et al., 2008). No informal supports to help with childcare has been connected to delayed or missed medical appointments (Higginbottom et al., 2016). Resettled refugee women with limited social supports also reported feeling unable to rest without their mothers or sisters around to help with cleaning, cooking, and infant care (Niner et al., 2013).

Inequities in Refugee Women's Health in the Postnatal Period

Reduced access to relevant postnatal health services and a reduced informal support network has been seen to negatively impact the health of resettled refugee women (Ahmed et al., 2008; Ganann et al., 2012; Sword et al., 2006). Refugee women are significantly more likely to have a poorer postpartum health status (Ganann et al., 2012) and a greater number of unmet physical and mental health concerns when compared to

Canadian-born women (Anita J. Gagnon et al., 2013). Rates of postpartum depression are five-times higher among refugee women when compared to Canadian-born women (D. E. Stewart et al., 2008). Refugee women underutilise healthcare services (Chan et al., 2018) and rate community health services unfavourably (Ganann et al., 2012).

COVID-19 and Postnatal Healthcare

Since early 2020, the SARS-CoV-2 virus has spread rapidly, infecting hundreds of millions of people with COVID-19 across the globe (WHO, 2021). To combat the spread of the virus, countries around the world implemented a variety of public health measures and restrictions, including stay-at-home orders, physical distancing measures, border controls, quarantine requirements, and hospital restrictions (Government of Canada, 2021). While these important public health measures have helped to curb the spread of the virus, they have had significant consequences on population mental health and access to healthcare (Ghebreyesus, 2020).

The effects of the COVID-19 pandemic on birthing and postnatal women have been profound, with particular, negative implications on women's mental health. Increased rates of depressive symptoms and anxiety, extreme loneliness, isolation, and exhaustion have been reported (Davenport et al., 2020; Dol et al., 2020; Hessami et al., 2020; Kotlar et al., 2021; Ollivier et al., 2021). Opportunities to share their infant's milestones and connect with other parents has largely been restricted to online platforms (Ollivier et al., 2021). Others further described feeling fearful around exposing their babies to COVID-19 (Dol et al., 2020). Though the impacts of COVID-19 on the general population have received considerable attention, limited work has been conducted with refugee populations, with no known studies reporting on the impacts of the COVID

environment on the postnatal experiences of resettled refugee women in Canada and more specifically, Nova Scotia.

Research Problem

The accessibility of formal healthcare services and the availability of informal social supports is crucial for supporting refugee mothers during the postnatal period (Asma Ahmed et al., 2017; Reitmanova & Gustafson, 2008). Few studies have been conducted to understand the experiences of resettled refugee women seeking maternal healthcare and the availability and importance of informal social supports during the postnatal period. Qualitative inquiry is needed to outline the barriers and facilitators facing resettled refugee women who have accessed or attempted to access formal maternal healthcare services and informal social supports during the postnatal period. Eliciting the first-person perspectives of postnatal refugee mothers is a critical step in improving the accessibility and availability of maternal health services and social supports.

Summary and Aims of Thesis Content

This thesis describes a qualitative program of research aiming to understand the lived experiences of resettled Syrian refugee women in an urban centre in Nova Scotia with a particular focus on access to maternal health services and informal supports during the postnatal period. Eleven resettled refugee women residing in the Halifax area participated in a semi-structured interview in August and September 2020.

The first manuscript (Chapter 3, Manuscript 1) of this thesis describes participants' postpartum experiences prior to the onset of COVID-19. All 11 women had given birth before the pandemic and their data were analysed and reported in Manuscript

1. This manuscript addresses the following overarching question with three additional sub-questions: What are Syrian refugee women's experiences accessing or attempting to access formal and informal maternal health services and supports during the postnatal period in an urban centre in Nova Scotia, Canada?

   a. What barriers and facilitators to formal maternal healthcare services are experienced by Syrian refugee women during the postnatal period in NS, Canada?
   b. What barriers and facilitators to informal supports are experienced by Syrian refugee women during the postnatal period in NS, Canada?
   c. What existing formal and informal supports are perceived to be most valuable by resettled Syrian refugee women and what, if any, services or supports are needed?

Eight of the 11 women interviewed were postnatal with their second or third Canadian baby during the early months of the COVID-19 pandemic. These women were asked a series of additional interview questions which ask specifically about their "COVID-19 babies". Their pandemic-specific experiences were analysed separately and are reported in Manuscript 2 (Chapter 4). This manuscript sought to address the following question:

   a. How did COVID-19 impact resettled refugee women's abilities to access healthcare services and informal supports during the first six months of the pandemic?

Chapter Two: Research Method and Design

This chapter describes the research design and methods that were used to explore the lived experiences of postnatal Syrian refugee women living in Nova Scotia who accessed postpartum-related formal and informal services and supports before and during COVID-19. The chapter describes the qualitative, constructivist approach that was taken for this research project and describes how elements of grounded theory were incorporated into the study design. An overview of participant inclusion criteria, recruitment strategies, data collection and analysis, and ethical considerations are also provided. This chapter provides a detailed overview of methodological considerations and study methods. Journal-specific method sections are included in each respective manuscript. This research project was approved by the Dalhousie University Research Ethics Board in 2020 (REB# 2019-5016; see Appendix M).

Conducting Qualitative Research

This study implemented a qualitative design embedded in constructivist theory, using elements of constructivist grounded theory to better understand the lived experiences of resettled Syrian refugee women in the context of Nova Scotia. Qualitative research takes an "interpretive, naturalistic approach" wherein researchers "study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meaning people bring to them" (Denzin & Lincoln, 1994, p.2.). Qualitative research seeks to understand complex social and human problems (Creswell & Poth, 2018, p.8) and helps to provide a "complex, detailed understanding of [an] issue" (p.46). Creswell and Poth (2018) state that qualitative research helps to provide a platform for "silenced voices" (p.45). Qualitative methods are most suitable for research projects seeking to

understand the lived or inner experiences of participants, explore under-researched topics, and take a comprehensive approach to understanding the phenomenon under study (Corbin & Strauss, 2015). A qualitative approach was deemed to be the most appropriate research methodology for this study, to develop a rich description of the lived experiences of resettled refugee women, something which has not been studied in Atlantic Canada.

Constructivist Paradigm

A paradigm is a set of world views, determining the ways in which researchers' study and interpret the world (Denzin & Lincoln, 1994; Mackenzie & Knipe, 2006). The constructivist paradigm acknowledges that all perspectives are socially constructed. It posits that all social realities are subjective and developed through individuals' mutual understandings, interpretations, and experiences and are further mediated by the dominant social and historical context (Guba & Lincoln, 1994). Constructivist approaches to research attempt to understand the human experience from the perspectives of individuals living in that world (Denzin & Lincoln, 1994; Mackenzie & Knipe, 2006). Researchers utilizing a constructivist approach do not attempt to remain objective during the research process, instead they recognize and accept the potential influence of their own biases on the interpretation of data (see Researcher Reflexivity statement below; Guba and Lincoln, 1994). The constructivist paradigm fit well with the study as the purpose of this research project was to better understand the lived experiences of Syrian refugee women who utilized postnatal health services in Nova Scotia.

Grounded Theory

This research project was conducted using elements of grounded theory. The practices of grounded theory, first developed by Glaser and Strauss (1967), are designed to aid the researcher in developing a set of concepts that theoretically explain a social phenomenon under study (Corbin & Strauss, 1990). Grounded theorists propose that theories should be 'grounded' in data from the field, through the actions, interactions, and social processes of people. A grounded theory seeks to capture the social process in a social context (Glaser & Strauss, 1967) and is well suited to research examining human behaviour relating to healthcare (Wuest, 2012, p.230). Grounded theory is an approach often taken to better contextualize an understudied phenomenon or experience (Wuest, 2012, p.230). Grounded theory coding allows data analysis to emerge from the data itself to construct themes grounded in participants' experiences (Charmaz, 2006).

Charmaz (2014) states that grounded theory is a "constellation of methods" (p.14). Similarly, Corbin and Strauss (2015) describe the variety of analytic strategies/methods available to researchers using grounded theory. They encourage researchers to develop their own "repertoire of strategies" (p.89) to fit their research project. In this study, we implemented grounded theory techniques including inductive line-by-line coding, focus coding, and constant comparisons. Inductive line-by-line coding was implemented first, wherein small segments of data were assigned a key idea (Charmaz, 2014). Focused coding followed and key ideas were organized into preliminary categories (Charmaz, 2014). Constant comparisons were used throughout the process of analysis to compare data between and within transcripts (Charmaz, 2014).

Ultimately, themes are not predetermined but arise through data analysis (Corbin and Strauss, 2015). The purpose of utilizing grounded theory for this research was not to

develop a theory, but to gain a conceptual understanding of the experiences of resettled Syrian refugees using postnatal services in Nova Scotia. Techniques of grounded theory were applied to data collection and analysis to develop a comprehensive understanding of the phenomenon. These methods were chosen to highlight the first voice and share the lived experiences of resettled refugee women.

Setting

Data were collected from women residing in the Halifax Regional Municipality. Halifax, Nova Scotia is the largest city among the Atlantic Canadian provinces with a population of 448,544 people as of 2020 (Ramesar & Tattrie, 2021). As of 2016, more than 37,200 of Halifax's residents were immigrants, refugees, or migrants with less than 20,000 other newcomers living outside of the urban centre (Ramesar & Tattrie, 2021).

Researcher Reflexivity

Reflexivity is an integral component of qualitative research, whereby the researcher "'positions' themselves" in the context of the research (Creswell & Poth, 2018, p.229). The researcher must understand their own "biases, values, and experiences" which are part of the research study (Creswell & Poth, 2018, p.229). Reflexivity is a continuous process of self-reflection, and self-evaluation. The researcher must be aware of how their personal attributes such as identity, perspectives, and biases could potentially impact all stages of research (McCabe & Holmes, 2009). Outlining these characteristics allows readers of the research study to understand how these elements may have influenced the researcher's interpretations and findings.

It is important to note that I am a Caucasian woman born and raised in Nova Scotia. I do not have any experience living as a refugee, I do not speak Arabic, and I am

not Muslim. Because of this, I am a distinct outsider to the population under study. I acknowledge that I will never be able to fully understand the experiences of resettled refugee mothers as I have never been in their position. However, I was motivated to begin this research after working in private refugee sponsorship for several years. During this time the organization was responsible for coordinating access to healthcare services for a new Syrian refugee family, which included a postpartum mother. Clients of our organization experienced a number of challenges, including lack of transportation, limited affordable and available translators, and difficulties navigating services. After experiencing these barriers as a volunteer provider, I wanted to understand more about the lived experiences of refugee women accessing services during the postnatal period.

Though I am still an outsider to the community under study, efforts were made to ensure this study's objectives and methods were appropriate and of benefit to resettled refugee women. When developing this research proposal, I met with several community stakeholders including Arabic-speaking obstetricians with significant experience caring for resettled Syrian refugee women, community health workers in refugee resettlement, and volunteer doulas to identify areas of research that would benefit the community and to ensure research methods were appropriate and feasible. After receiving ethics approval for the study, an English- and Arabic-speaking research assistant with lived experience as a newcomer was hired as an interpreter to allow participants to share their experiences in their preferred language (Arabic). The interpreter also acted as a cultural liaison, providing feedback on recruitment materials, interview guides, and data interpretation.

Study Population

Participants were Syrian women who came to Canada as a refugee and had a child in Halifax Nova Scotia within the previous five years. Given the financial and time constraints of the project, only one refugee women from one country of origin was selected to participate.

Participant Inclusion and Exclusion Criteria

There were five inclusion criteria as follows: (1) Participants must have been at least six weeks postpartum (to ensure that they have had time to attempt to or use services or supports). (2) Women must have had their baby in Nova Scotia within the previous five years in order to provide information on current or recently available services/supports. (3) Women must have spoken Arabic (as we did not have a Kurdish or Armenian translator) and have entered Canada as a refugee. (4) Participants must have originated from Syria and (5) Finally, participants had to be living in the Halifax Regional Municipality as the focus of the study is on access to services in the urban areas of Halifax.

Sampling and Recruitment

The number of participants needed for a qualitative research study remains highly debated. Wuest (2012, p.235) suggests that a masters-level study using grounded theory methodology can be successfully conducted with 10 to 15 participants—largely owing to the financial and time constraints of a two-year program. Therefore, a recruitment goal of 10-15 participants was set. In total, 11 women participated in this research study.

Several methods were used to recruit participants for this research. First, a gatekeeping method of recruitment was used. Gatekeeping methods of recruitment have been successfully implemented in other research studies seeking to recruit newcomer women (e.g., Asanin & Wilson, 2008; Campbell, Klei, Hodges, Fisman, & Kitto, 2014; Guruge, Roche, & Catallo, 2012; Higginbottom et al., 2016). A local community-based organization, the Volunteer Doula Program at the Chebucto Family Centre, agreed to contact any clients who fit the inclusion criteria of the study (Appendix J for a letter of support). Program staff connected with potential participants and informed them of the study. Information on the study was provided to the women by program staff through an electronic poster (Appendix E).

Second, the primary investigator emailed select community-based organizations (e.g., Veith House, the Refugee Clinic, YMCA), health clinics (e.g., Newcomer Health Clinic), and private refugee sponsorship organizations (e.g., Open Harbour Refugee Association) in the Halifax Regional Municipality who were involved in caring or providing healthcare services for Syrian refugee women (see Appendix B). The email asked if community staff member were able/interested in helping to distribute recruitment posters to any of their organization's clients who fit the inclusion criteria of the study (see Appendix E). If yes, the organization was emailed electronic copies of the poster for distribution. Last, study specific social media accounts were created to distribute the poster to a broader audience. Community organizations were also asked to share or retweet the study poster and information through their accounts (see Appendix K for a sample Tweet/Facebook descriptor).

All recruitment and study materials were made available in both English and Arabic. Any translated materials were verified by a second interpreter to ensure the accuracy of the translation. The recruitment poster instructed interested participants to contact an Arabic-speaking research assistant (RA). An Arabic-speaking RA was hired to schedule interviews and interpret interviews, as the primary investigator does not speak Arabic. The RA was paid and trained on the study by the primary investigator and signed a confidentiality form (Appendix A).

Data Collection Setting

Interviews were conducted over Teams through the "in-person" video call option, or via a 3-way conference call. Women were asked to find a quiet, private space in their home to complete the interview.

Data Collection Procedure

Potential participants who were interested in the study contacted the Arabic-speaking RA via email or phone. The study was explained to potential participants and their interview was scheduled. Women were asked whether they wanted to conduct a video call or phone call (through teleconferencing software to allow both the PI and interpreter to join the call). Participants were emailed copies of the consent form in advance (in Arabic) for their review. Participants also received a reminder call or email (depending on their preference) one day before their interview (see Appendix L). Participants were sent the relevant information to join the video or phone call.

The primary investigator and the Arabic interpreter completed interviews with participants over Microsoft Teams or over the phone. The interpreter began by verbally

reviewing the consent form with each participant (see Appendix F). The participant was asked to provide verbal consent, which was then recorded by the primary investigator, who signed and dated the consent form indicating that verbal consent from the participant had been received. After consent was obtained, the participants were asked a few demographic questions (see Appendix G). A short descriptor of the study was read to participants by the interpreter before the interview began. All participants consented to being audio-recorded. The interviews were led by the primary investigator, with the interpreter translating all questions and necessary responses into Arabic. Following the completion of the interview, the participants were asked if they would like to receive a list of services and supports for postpartum health (made available in Arabic, Appendix J). If yes, the list was mailed to participants in addition to an honorarium in the form of a $20 gift card.

Data Analysis

Audio-recordings were transcribed verbatim and translated into English by the same interpreter who was present for all interviews. The translated interviews were read a number of times to familiarize the primary researcher with its content. Any experiences shared related to postpartum experiences during the COVID-19 pandemic were isolated, analyzed separately, and reported in Manuscript 2 (Chapter 4). All pre-COVID data were analysed first and are included in Manuscript 1 (Chapter 3). Line-by-line coding was completed wherein each concept was given a key idea. Key ideas were organized into preliminary categories. Constant comparative analysis was used to identify similarities and differences between and within categories, after which related subcategories were collapsed into themes and subthemes through focused coding (e.g., theme: structural

barriers, subthemes: childcare, transportation, language and communication). Collaborative team meetings were held throughout the coding process to provide feedback and question the first author (Stirling Cameron) on the analysis. The research assistant who interpreted and transcribed all interviews (Kuri) reviewed final themes and associated quotes to ensure the results were grounded in the original data and reflected the experiences of the participants.

Data Retention

Once the study is over all data will be kept for five years before being physically destroyed. During this time any hard copies of forms or hard drives with electronic files will be kept in a locked cabinet at Dalhousie University. Any documents will be password protected and kept on password protected hard drives. All data and participant information will be kept in a locked cabinet.

Quality and Rigour

Guba and Lincoln (1985) describe four key components of trustworthiness which assesses the rigor of qualitative research data: credibility, transferability, dependability, and transferability. Corbin and Strauss (2008) posit that at least two components must be evident in a study in order for a study be rigorous.

A critical component of credibility is the development of trust between the researcher and participants (Bradshaw et al., 2017; Krefting, 1991). Several steps were taken to ensure the credibility or truthfulness of the research study. An Arabic interpreter who has lived experience as a newcomer was hired to support the research study. Participants were also recruited through local community groups who are well known to the population.

The confirmability of a study refers to its ability to be grounded within the participant's data. A reflective journal was used to track when and why changes were made to the study and its methods and to track the data collection and analysis (Bradshaw, Atkinson, & Doody, 2017). Memoing was undertaken by the researcher throughout the analysis process to form an audit trail (Cresswell & Poth, 2018). Direct quotes were included in the final written report and publications to provide evidence for the themes/sub-themes developed by the researcher. The same interpreter who was present at all interviews reviewed the developed coding schemes and final reports/publications to ensure the analysis appropriately reflected participants' experiences. All of these steps helped to ensure that the interpretation of the data was accurate and that the experiences of the participants have been expressed as accurately as possible.

Ethical Considerations

Risks and Benefits

The risks associated with taking part in this research were expected to be minimal given that interview questions focused on access to healthcare and informal support, however, it was possible that taking part in this research study could cause psychological distress or discomfort. Participants were told that they could refuse to answer any questions that made them feel uncomfortable and that they could withdraw from the interview at any time. Participants had up to two weeks after their interview to withdraw their data and remove it from the study. They were also told that not participating in the study would not impact their ability to use any services provided by partnering community organizations (e.g., ISANS, The Chebucto Family Centre).

Participants in this study may experience direct or indirect benefits as a result of taking part in this study. Participants had the opportunity to share their experiences accessing postnatal services and supports. Having the chance to voice one's opinions, be valued as an expert, and collaborate with researchers can be empowering for participants (Gibbs, 1997; Goss & Leinbach, 1996; Race et al., 1994). Results from this study may have the potential to create change to programs or policy in Nova Scotia. Scholarly publications may contribute to further advancements in the field of access to healthcare for refugee populations in Canada.

Informed Consent

Informed consent was free, informed, and ongoing. Gatekeepers were instructed to inform participants that they were under no obligation to take part in the research study and that deciding not to participate would not impact their access to services in any way. The study was explained in full, orally, by the interpreter in Arabic in addition to women receiving a written copy of the consent. The researcher stated that participation in the study was completely voluntary and that the participant was under no obligation to take part in the study. Participants were given the opportunity to ask any questions before providing oral consent.

Privacy and Confidentiality

The interpreter was privy to participants' personal information (e.g., full name, email) but was required to sign a confidentiality form before viewing any identifiable data (Appendix A). The researcher signed and dated a form indicating that they had obtained verbal consent from the participant. Verbal consent was obtained prior to the interview. The researcher completed a verbal consent form for each participant in this

study so that no name or signature was collected from any participant to protect their identity. Any identifying information, such as clinic names, children's names, locations, were removed from the transcripts. Any communication directly with participants took place through a study-specific email address and designated toll-free phone line. The study email account was deleted after data collection was completed.

Chapter Three Summary

This study took a qualitative approach, using elements of grounded theory, to collect information on the lived experiences of Syrian refugee women living in Nova Scotia who have accessed or attempted to access formal services or informal supports during the postnatal period. 11 women were purposefully selected via a gatekeeping method of recruitment. Findings from the research project will be shared in academic and community circles, to contribute to the field of research in refugee maternal healthcare and to inform policy and program delivery in Nova Scotia.

Chapter Three: Manuscript One

"I really needed my family:" Syrian refugee women's experiences accessing postnatal health services and social support in Nova Scotia, Canada

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Abstract

Aim: The purpose of this qualitative study was to understand Syrian refugee women's perceptions and experiences of access to formal health services and informal supports during the postpartum period in Nova Scotia, Canada and to identify valued and missing services and supports in the community.

Background: The postnatal period is a critical time when mothers may need access to health services (e.g., family physicians, psychologists) and informal supports (e.g., friends, family) to support their positive mental and physical health after birth. Resettled refugee women commonly encounter barriers when accessing care during the postnatal period and often have limited social supports.

Methods: Semi-structured, telephone or virtual interviews were conducted with 11 resettled Syrian refugee women who gave birth in Nova Scotia, Canada within the past five years. Data were collected in the summer of 2020. This study was conducted using elements of grounded theory.

Findings: Four key themes were identified from women's experiences: (i) postpartum social support was critical, but often lacking, (ii) structural barriers (e.g., irregular interpretation, limited childcare options) impeded women's access to healthcare, (iii) paternalistic healthcare providers limited women's decision-making autonomy, and (iv) the value and need for culturally competent care (e.g., newcomer specific healthcare centres), in-home services, and family support.

Conclusions: Resettled Syrian refugee women in Nova Scotia, Canada, experience a range of barriers that limits their access to postnatal healthcare. Policy change, program

development, and/or interventions are needed to improve access to postnatal services and supports for resettled Syrian women.

Introduction

In 2019, Canada was the number one refugee-admitting country in the world, (UNHCR, 2020c) resettling approximately 45,000 Syrian refugees between 2015 and 2020 (Government of Canada, 2019c). Large proportions of resettled Syrian refugee women are pregnant, postnatal (have given birth within the past 12 months), or have a young family and are in need of accessible reproductive healthcare (IRCC, 2021; Ross, 2017). During the postnatal period, mothers need access to health services and informal supports to help with a variety of psychosocial and physical health concerns (Brown & Lumley, 1998; Higginbottom et al., 2014). Yet access to postnatal healthcare and informal support remains a challenge for resettled refugee women in Canada (Higginbottom et al., 2016; Khanlou et al., 2017; O'Mahony et al., 2012).

The postnatal period is a critical time when all mothers need access to maternal healthcare and informal supports (Aston et al., 2018; Thompson et al., 2002). Nearly 95% of all women report experiencing one or more maternal health concerns within the first six months of childbirth, including mastitis, caesarian site pain, postpartum depression, and social isolation (Brown & Lumley, 1998). Untreated health problems are directly related to a decrease in women's emotional wellbeing and functional abilities, including an inability to care for their infant or return to work (Webb et al., 2008). Timely and effective postpartum healthcare provided by formal healthcare professionals (e.g., family physicians, midwives, psychologists) can prevent or improve short- and long-term consequences of health morbidities (Haran et al., 2014). In addition to the availability of formal health services, informal supports provided by partners, family, friends, or

community contribute to maternal self-efficacy and boosts emotional wellbeing in mothers (Leahy-Warren et al., 2012; WHO, 2005; Xie et al., 2009).

Resettled refugee women report experiencing a myriad of barriers when attempting to access healthcare services after birth, often as a result of the complex reality resettled refugee women experience (Heslehurst et al., 2018; Khanlou et al., 2017; Peláez et al., 2017). Language and cultural differences between women and care providers, unavailability of interpreters, and limited access to childcare and transportation can contribute to missed or delayed appointments (Heslehurst et al., 2018; Khanlou et al., 2017; Riggs et al., 2012). Moreover, experiences of discrimination and culturally insensitive care can negatively influence women's trust and future engagement with the healthcare system (Heslehurst et al., 2018; Khanlou et al., 2017). Many refugee women have reduced social networks upon arriving in their resettlement country, resulting in lower levels of available informal supports during the postnatal period (Higginbottom et al., 2016).

Disrupted access to healthcare and limited supports during the postpartum period contribute to health inequities among resettled refugee women, when compared to Canadian-born women. Resettled refugee women are more likely to have poorer postpartum health status (Ganann et al., 2012) and a greater number of unmet physical and mental health concerns compared to Canadian-born women (Gagnon et al., 2013). Resettled refugee women with social networks containing fewer women, relatives, and people from their own ethnic background are more likely to experience high rates of depressive symptoms and postpartum depression (Zelkowitz et al., 2004). The accessibility of formal healthcare services and the availability of informal supports is

crucial for supporting refugee mothers during the postnatal period. Impaired access to postpartum healthcare for resettled refugee women is an issue of reproductive justice—a fundamental human right that demands equitable access to reproductive care, regardless of one's immigration status, or ethnicity.

The purpose of this study was to understand the lived experiences of access to postnatal services and supports among refugee women who have resettled in Nova Scotia Canada. This study had two objectives. First, to identify women's experiences of barriers and/or facilitators to formal maternal healthcare services and informal supports during the postnatal period. Second, to outline what existing formal services and informal supports are perceived to be most valuable by resettled Syrian refugee women and what, if any, services or supports are needed. This study is one of few to bring forward the first-person perspectives of resettled Syrian refugee women in the context of the Canadian healthcare system (Ahmed et al., 2017; Guruge et al., 2018; Winn et al., 2018).

Methods

Methodology

This qualitative research study was conducted using elements of constructivist grounded theory. The practices of grounded theory (GT), first developed by Glaser and Strauss (1967), are designed to aid the researcher in developing a set of concepts that explain a social phenomenon under study (Corbin & Strauss, 1990). GT is an approach often taken to better contextualize an understudied phenomenon or experience (Wuest, 2012) whereby researchers scrutinize their own preconceptions and constructions as part of the analysis (Charmaz, 2014). The purpose of utilizing grounded theory for this research was not to develop a theory, but to use techniques of GT (e.g., thick and rich

description, line-by-line coding, constant comparisons) to analyse participants' experiences accessing postnatal services and supports and develop a comprehensive understanding of the phenomenon (Corbin & Strauss, 2015).

Recruitment and Procedure

Women were recruited through community centres, health clinics, and private sponsorship organizations within one urban area. Arabic and English versions of recruitment posters were distributed through the groups' social media, websites, email networks, and/or social media platforms. A designated research assistant who was fluent in Arabic was hired to assist with recruitment and interpretation. All recruitment and data collection materials were drafted and reviewed by two separate English- and Arabic-speaking research assistants to ensure an accurate translation. Interested participants contacted by a bilingual research assistant who confirmed eligibility. Participants selected whether they wanted to complete a telephone interview or a video call (Microsoft Teams), and then scheduled a time for the call. Women were eligible to take part in the study if they had a child within the last five years and were at least six-months post-partum. Women were emailed a copy of the consent form in advance of the interview in both Arabic and English. A recruitment goal of 10-15 women was set (Wuest, 2012). Before beginning the interview, the interpreter reviewed the consent form and verbal consent was recorded. This was done in lieu of signed consent to alleviate the burden on participants to print, sign, and scan, or electronically sign and email a consent form. Participants were then asked a series of demographic questions (e.g., marital status, number of children, years spent in Canada) before conducting the interview. The interview guide was comprised of a series of open-ended questions, that were guided by

the literature and suggestions from community stakeholders (e.g., Did you use any health or wellness services (e.g., family doctor, counsellor, doula) the first year after giving birth? Did you have any friends or family to support you after birth? If yes, who? How did they support you?). Eleven women completed individual, audio-recorded interviews during the months of August and September 2020. Seven of the eleven women had given birth to a child before and during the COVID-19 pandemic. Only the pre-COVID experiences are reported here. The experiences of women who had a child or were postnatal during COVID-19 will be reported in a separate paper (Stirling Cameron, Ramos, et al., 2021).

Analysis

Audio-recordings were transcribed verbatim and translated into English by the same interpreter who was present for all interviews. The translated interviews were read a number of times to familiarize the researchers with its content. Line-by-line coding was completed wherein each concept was given a key idea. Key ideas were organized into preliminary categories. Constant comparative analysis was used to identify similarities and differences between and within categories, after which related subcategories were collapsed into themes and subthemes (e.g., theme: structural barriers, subthemes: childcare, transportation, language and communication). Collaborative team meetings were held throughout the coding process to support the first author (Stirling Cameron) through analysis. The research assistant who interpreted and transcribed all interviews (Kuri) reviewed final themes and associated quotes to ensure the results were grounded in the original data and reflected the experiences of the participants. Coding was completed using QSR International's NVivo 12 software (QSR International Pty Ltd., 2021).

Results

Select details of participants' socio-demographics are included in Table 1. All eleven participants were married, spoke Arabic as their preferred language, and originated from Syria. Women had between two and eight children (M = 4.91, SD=1.87) and arrived between 2016 and 2018. Nine arrived through the government-assisted resettlement program, and two were privately sponsored. Four main themes emerged from the data: the importance of social support; impact of structural barriers on access to and quality of care; presence of provider paternalism; and valued and missing services. It is important to note that women in this study included labour and delivery as part of their discussion of the postnatal period, and therefore presentation of data includes such discussion.

The Importance of Social Support

Familial separation and the availability of informal support. Every participant described feelings of homesickness and isolation, especially within the first few years of arriving in Canada. All women had been separated from members of their extended family through the process of international resettlement. Their absence was felt strongly during the postpartum period. One participant noted, "It was hard for me to give birth when I had none of my family around me… I haven't seen my family in 10 years." (Participant 1). Women described the ways in which their family (mothers, sisters) had supported them through previous births, by preparing meals, taking care of other children, cleaning, offering advice and providing infant care. "In Syria it was better than here because I had my family, my mom to support and help me." (Participant 8). Women spoke at length about how valuable informal support from their family was and how

difficult it was to care for their baby without them, “I am lonely, my family is not with me. I was in a lot of pain and I had no one to help me when the baby was crying.” (Participant 2).

Though all women in this study had been separated from members of their family, several participants were able to find similar forms of support from other women who had also resettled in Nova Scotia. Participants spoke of friends and neighbours of a similar ethnic, cultural, or religious background who were described like a chosen family. These friends were able to provide similar types of informal support, that had previously been provided by family, “They were cooking for us, they brought us food. One of my neighbours was helping me clean the home. They helped me with my baby boy as well. They would bathe him, dress him, they were really supportive and helpful.” (Participant 4). Not all women, however, had supportive friends available. Many women did not have any local connections and reported feeling particularly isolated and alienated. For these participants their only support person was their husband, “Here I have no one. My husband and I have no relatives or family here with us… We have no friends.” (Participant 9). Even when friends were available to provide informal support, most women felt uncomfortable asking for help, recognizing that these friends had to care for their own families. As one woman said, “They are not always available as they have their own families and kids to take care of… I am very considerate and understand how busy they are.” (Participant 1). Participants clearly articulated that the comfort and ease they felt with family was irreplaceable, even by close friends.

The impacts of isolation on women’s mental and physical health. Women linked the separation from their extended family and low levels of informal support to

particular mental and physical health challenges after birth. Many participants described how difficult it was to cope with postpartum blues/depression, in addition to the emotional stress caused by resettlement and separation from their family: “It was the first year I had ever been away from my family. I was depressed.” (Participant 3). Others described feeling “highly stressed,” “lonely,” “isolated,” and “exhausted.” Women cited mothers and sisters as key confidants and sources of emotional support and strength and missed being able to visit with them in-person. Some women were able to connect with their family virtually though video or telephone calls or instant messaging, but family members’ access to technology and electricity was often limited. One participant noted, “The internet is very bad in Syria. They only have electricity for two hours a day. That is why it is almost impossible to talk to my sister.” (Participant 5). Several women had seen mental health professionals in Canada but did not finish treatment or felt that it was “pointless.” One woman saw a mental health professional for seven months before stopping; “I am isolated and homesick and the circumstances we are going through, no one would help or change them. I am so far away from my family. How could they [health professionals] help with that?” (Participant #).

For several women, a lack of social support had an impact on their physical functioning after birth. One participant described an inability to prepare food which resulted in a decrease in milk production: “I found it very hard to prepare food. When I bought any meals, my milk would become scarce, it was really hard on me.” (Participant 2). Several women who had given birth previously and had support felt that their recovery was delayed and impaired because they had to cook, care for their other children, etc. Two participants felt their caesarean site healed more slowly: “In Syria, I

swear, after the fourth or fifth day after the cesarian I was able to get around. Here it took me two months and I was in a lot of pain." (Participant 2). Participant nine had a similar experience: "With my other kids, I would be fully functioning only one week after birth, but with this last baby it took me a month and I could still barely cook a small meal of rice." (Participant 9).

Access and Quality of Healthcare Influenced by Structural Barriers

Language and communication differences. Barriers to healthcare as a result of language and communication differences were mentioned by every participant in this study. All participants spoke Arabic as their first language and were largely reliant on interpretation services for at least their first several years in Canada. One participant explained, "When we arrived in Canada, we could not speak any English except for hello and hi, yes and no. We started from zero here." (Participant 5). There were often delays to getting interpretation services: "I went to the emergency room and had to wait for six hours just to get an interpreter." (Participant 9). This same participant called 811 for medical advice and was told, "they would get back to me in three or four hours with an interpreter." Participants also spoke about feeling "shy" or "uncomfortable" sharing their medical history through an interpreter, especially if they were male.

Interpretation was commonly provided in-person, but in some situations, was provided over the phone. Some women noted that although telephone interpretation was better than not having any service, in-person translation was preferable: "When the interpreter is there with me, she sees me, my facial expressions, if she feels that I am not doing well she notices and asks what is going on, but with the interpreter over the phone, they can't see me, they can't notice if I am distressed or tired." (Participant 5). Where

interpreters were not provided, women relied on husbands, friends, or their own children to translate. Some women did not have access to any kind of interpreter and described these interactions as "traumatizing," "very hard" and "frightening." One participant was forced to labour and deliver without an interpreter, and in the end, did not receive any pain management as a result of the language barrier: "I desperately tried to tell them that I wanted an epidural. I tried to explain to the doctor and doula by pointing to my back, but they could not understand. They thought I wanted them to massage my back. I suffered a lot. I was in labour for eight hours… I just cried." (Participant 7). Women also reported finding it challenging to understand referrals and treatment instructions, prescription drug information, and had trouble booking and scheduling medical appointments over the phone.

Challenges obtaining childcare. Women described having difficulties finding affordable, trustworthy childcare in the absence of family. "Here I have no one, no family, no parents who would help me take care of my kids." (Participant 11). Some women reported missing healthcare appointments because they did not have access to childcare. One participant declined visiting a psychiatrist, because of limited childcare: "I seriously considered it, but my kids were little, and I had no one to take care of them." (Participant 5). Similarly, other participants said they felt reluctant to visit the emergency room because of lengthy wait times and no childcare. Several participants were forced to bring their children with them to the hospital while they laboured and delivered. One of these participants paid $200 for a private room in the hospital where her children could sleep while she gave birth. Participant 7 described how distressing it was to have her children present during delivery: "It was so hard on me because I didn't know where I

would leave my kids, so I took them with me to the hospital. The hospital remembers my case still. That is why I was so upset, because my kids had to be with me in the birth room. It was a tough time." Several participants used volunteer doulas to accompany them to their delivery so their husbands could stay home with their other children; though grateful for this service, many participants said they would have preferred their husbands with them and their children safe in childcare.

Transportation challenges and lack of proximity to services. High proportions of newcomer families are dependent on income assistance for the first few years of resettlement.(IRCC, 2019) Participants described limited income support to buy a vehicle, meaning some women were reliant on public transport to access health services. Most participants also lived outside the city centre and had to take three-to-four different buses to get to health clinics and hospitals. Dependence on public transportation was linked to delayed or missed medical appointments: "When we first arrived in Canada, we suffered a lot using buses. That's why we missed many doctors' appointments." (Participant 1). Snowy roads and winter conditions exacerbated these challenges. In cases where families had a car, many women did not have a licence and were dependent on their husbands to drive them to appointments.

Provider Paternalism and Women's Decision-Making Autonomy

Multiple participants described negative interactions with their healthcare providers where they felt as if their decision-making autonomy was limited and the choices concerning their care were not recognized. These interactions often meant women felt disrespected, frustrated, and caused feelings of mistrust with providers.

Participant nine described an encounter with her family physician where her appointment with a psychiatrist was cancelled without her consent:

> "In a meeting with my family doctor, she said that I was fine and there was no need for me to see a [mental health professional]. She said I knew how to care for my baby and there is no need to see someone. [Doctor] cancelled my appointment… I was very upset and disappointed because she didn't know what I went through and how I felt. She wronged me, I needed her to listen to me… I really needed to see a mental health professional so they could help me."

An interpreter was present for this appointment. At the time of the interview this participant was still struggling with feelings of depression and had not seen a psychologist, fearing her family physician would again deny her a referral.

In a similar experience, participant seven felt as though her decision-making autonomy concerning infant feeding was disregarded. This participant had chosen not to breastfeed after having encountered significant problems breastfeeding with her previous babies. She requested formula and was told "breast is best," and that she must at least try to breastfeed.

> "I told them my babies refuse to breastfeed from me… So they sent me a nurse to help me with breastfeeding. She tried and tried but it didn't work. They contacted the doula and sent her to me to help me to breastfeed… She brought a pumping machine. This machine caused inflammation in my breasts… I suffered a lot. I told them he won't want to breastfeed, but they insisted on trying to get him to breastfeed. I had 4 babies before, and I know how my babies refuse to breastfeed."

It wasn't until she was told to "go to the hospital… because of serious inflammation" that her choice to use formula was supported by her healthcare providers. This participant felt extremely frustrated, feeling like her expertise as a mother of five was not recognised.

Participant two described a visit with her obstetrician, who criticized and questioned her family planning decisions after giving birth, questioning the practices of her religion: "[Doctor] offered me to go through [tubal ligation] so I won't have more babies. Of course, I refused but he insisted on asking why I'm refusing… I told him I'm Muslim and my religion forbids this, and it is not acceptable to me. He kept asking questions and said if it is forbidden why is it okay to use contraceptives? He has no right to interfere with my personal life and the number of kids I would like to have… The way he treated me wasn't good." Similarly to the other participants, this woman was felt chastised, and unsupported by her care provider.

Valued and Missing Postnatal Health Services and Supports

Valued services and supports. Many participants were satisfied with healthcare services in Nova Scotia, and were grateful for the care available, particularly in contrast to their previous birthing experiences in Syria. Participant five said, "I gave birth to my second and third child during the war. My experience in Syria was hard beyond description… Medically, we had nothing there, no medications and no services. I couldn't feel the joy and the calmness that mothers feel after they delivered. The first thing we thought about was is how to get milk and diapers. But here, I didn't need to worry."

The majority of the participants in this study used a refugee-specific health clinic for the first few years after arriving in Canada. Given the current family physician

shortage in Nova Scotia,(Nova Scotia Health, 2021a) this was a critical service that helped bridge the gap while women waited to locate and transition to a long-term primary care provider in the community. Women reported that the clinic almost always provided interpretation services, and the care provided was culturally appropriate/sensitive. Participant three described her family physician at the clinic, "Honestly I wish I could stay with this doctor at the refugee clinic because she is excellent. [Doctor] is really famous and is an amazing doctor."

Doulas were also a critical support service for a number of participants. Many women were referred to a local volunteer doula program which assigns doulas to patients before delivery, at no cost. Doulas often met women in their homes before their due dates to build trust and rapport and offer support (e.g., health system navigation, emotional support). By providing interpretation and home visits, the program by-passed structural barriers, such as finding transportation and childcare, and language differences. Often, the same doula continued to accompany women to their delivery and checked in after the birth. "I met the doula one month before I delivered... She didn't leave me when I delivered my daughter. She stayed with me in the hospital. I was happy to have the doula because for me, I do have many friends, but I had no one to accompany me to the hospital." (Participant 5). Some women suggested it would be helpful for "the doula to come more frequently" (Participant 9) after birth, to provide informal support.

Several participants in this study arrived through Canada's private sponsorship program and found its approach beneficial. Private sponsorship organizations support resettled families for 12 months, providing financial, educational, and social supports.(Refugee Sponsorship Training Program, 2021) As most private sponsorship

groups are small, volunteer organizations, they are able to provide tailored, individualized care to families. Participants in this study who had arrived under this program stated that members of their sponsorship organizations helped fill part of the void caused by separation from family. Private organizations often provided a high level of informal support: cooking meals, providing childcare and transportation, and donating baby clothes and furniture: "They shopped for me, delivered groceries to our home. They booked appointments with doctors for me. They helped me with everything. I can't do things without them… They are my family here." (Participant 3)

Missing supports. None of the participants indicated that there were any services missing during their postpartum period. However, every participant stated that they were missing the supports provided by their extended family. Participant seven said, "I wish I had someone from my family, my sister or any relative of mine. If something bad happens to me, I know that my kids would be safe with my brother or sister. We are happy here, but we are missing our families. Everyone here needs family."

Discussion

The purpose of this study was to understand Syrian women's perspectives around access to formal health services and informal supports during the postpartum period in Nova Scotia, Canada. The social challenges commonly experienced by resettled refugees—separation from family, socioeconomic barriers, limited English language proficiency, and cultural dissonances—negatively impacted Syrian refugee women's access to healthcare and support during the postpartum period; an already demanding time for new mothers. Women in our study had varied postpartum experiences but many described limited social support during this time, irregular language interpretation,

limited access to childcare and transportation, and issues concerning medical autonomy, all of which contributed to inequitable access to reproductive care.

Informal social support is a critical component of a positive postpartum period for mothers of all backgrounds (Hung & Chung, 2001; Negron et al., 2013; Xie et al., 2009). Most participants in this study described the ways in which their extended family, especially mothers and sisters, had previously supported them, allowing women to heal and recuperate after birth. This support was absent for all participants when in Canada, which contributed to feelings of loss and isolation. Similar sentiments have been reported by other postnatal refugee and immigrant women in Canada (Ahmed et al., 2017; Higginbottom et al., 2016; Higginbottom et al., 2014; O'Mahony et al., 2012). Some participants in our study were able to mitigate some of these feelings through local support networks (e.g., private sponsorship organizations) and their nuclear family (Stewart et al., 2017). Some women in this study felt as though a lack of in-person familial support contributed to worsened mental health and slower recovery times. Other research has found that limited support can result in delayed or irregular access to healthcare (Higginbottom et al., 2016), increased stress and decreased emotional wellbeing (Quintanilha et al., 2016). Resettled Syrian women in this study confirmed the importance of informal support but cited its limited availability as a critical gap.

Language and communication challenges were significant drivers for negative healthcare experiences. Effective communication during labour and delivery is essential, and for many resettled refugee women, may only be achievable through an interpreter or interpretation service (Henry et al., 2020; Origlia Ikhilor et al., 2019). Failure to provide interpretation during labour and delivery led, for one woman in our study, to inadequate

pain management, anxiety, and birthing-related trauma. Previous studies have highlighted similar traumatic experiences among perinatal women in resettlement countries (Henry et al., 2020; Origlia Ikhilor et al., 2019). Inadequate interpretation can contribute to high rates of miscommunication and undermines the fundamental concept of informed consent and patient-centred care (Henry et al., 2020; Origlia Ikhilor et al., 2019). Henry et al., 2020 posits that the healthcare system's failure to freely and consistently provide interpretation should be seen as a form of institutional discrimination and should ultimately be viewed as structural violence. This systemic failure leaves newcomer women and their children vulnerable to being misunderstood, improperly diagnosed, and their health mismanaged.

Structural barriers have been widely cited as drivers of health inequity for resettled refugee women (Gagnon et al., 2010; Gagnon et al., 2013; Higginbottom et al., 2016). Our study and other studies demonstrate how access to healthcare remains largely an individual responsibility shaped by availability of social and financial capital; the onus remains largely on the individual to obtain not the healthcare system. As a high proportion of resettled refugees are dependent on income assistance—upwards of 93% of Syrian refugees depend on income assistance for their first year in Canada— and have reduced social networks after arrival (IRCC, 2019), this population is vulnerable to inequitable reproductive care during the postnatal period (Henry et al., 2020; Higginbottom et al., 2014).

Obstetrics and reproductive healthcare have a long history of paternalism which has particularly impacted women of colour (Roberts, 1997). Women in this study described encounters within the healthcare system in which decisions were made about

their care with which they did not agree, or where their medical autonomy was not recognized. Not only are refugee women at risk of encountering racial, religious, and gender-based discrimination, they may also experience prejudice related to their immigration status from healthcare providers. Providers may lack cultural competency, possess implicit or explicit biases, or perpetuate harmful stereotypes. Despite the presence of language barriers, providers must work to overcome their prejudices (whether they are cognisant of them or not) and support women to make their own informed choices. Few studies have examined reproductive liberty and healthcare decision-making among refugee women; future work is needed to better understand this important intersection (Ross, 2017).

Women in our study reported feeling that their postpartum care was supported by a local newcomer health clinic—a primary healthcare facility specifically constructed to care for former refugees. Newcomer or refugee-specific healthcare centres or clinics are often designed holistically to meet the unique needs of former refugees, sometimes offering interpretation, childcare, transportation, social supports, and culturally competent providers (Chan et al., 2018). Similarly, the holistic care and informal support provided by doulas were viewed positively. This freely available service was accessible for a number of women, as doulas were often accompanied by interpreters and could travel to women's homes, thus alleviating the need for women to obtain transportation and childcare. Several participants were also able to substitute missing family with networks of friends and private sponsorship groups. Though friends were not able to replace biological family, they offered informal support in similar ways, by cooking, offering emotional support and advice, and providing childcare.

Implications

Our study, in conjunction with previous research, demonstrates a need for policy change that increases and improves resettled refugee women's access to quality reproductive healthcare during the postpartum period. In some instances, informal supports are lacking for resettled women, which can be particularity impactful during the postnatal period. Future interventions and program development should target this area. This could be achieved by bolstering in-home supports (e.g., doulas, especially Arabic-speaking women; LaMancuso et al., 2016) patient navigation programming (Yee et al., 2017), and mother and baby community groups (Aching & Granato, 2018; Guest & Keatinge, 2009). It is evident that interpreters serve an essential role; failure to have them readily available during obstetrical procedures can result in traumatic and potentially dangerous birthing experiences (Henry et al., 2020). Institutions must consider policy change to ensure interpreters or interpretation services are readily available in order to ensure equitable service delivery. This language barrier could be more holistically mitigated by training and hiring culturally and linguistically diverse healthcare providers to more appropriately represent the patient population of Canada. Finally, healthcare providers and students must participate in accessible, anti-racist, cultural competency training that promotes patient-centredness and shared decision-making to improve the quality of care resettled refugee women experience (Stapleton et al., 2013).

Limitations

Several limitations of our study should be noted. First, recruitment for this research project was largely achieved through community and healthcare organizations. It is possible that women not connected with any of our recruitment groups/organizations

were not interviewed. By advertising the study recruitment on social media (independent of organizations), the team hoped to reach individuals not formally connected to any recruitment groups. All analyses were conducted based on English translations of the interviews, as the lead researcher does not speak Arabic. It is possible that particular sentiments or experiences could not be accurately maintained through the translation. However, the translator worked closely with the first author to review parts of the interviews where the Arabic to English translation was not straight-forward. In future, a second translator could be employed to verify the accuracy of the translation.

Conclusion

Reproductive justice is rooted in the belief that systemic inequities shape people's decision-making related to childbearing and parenting, particularly vulnerable women (Ross & Solinger, 2017). Institutional constructs such as racism, sexism, immigration status, and poverty influence people's individual freedoms and also affect whether people receive appropriate healthcare (Ross, 2017). These forces ultimately influence and impact the reproductive liberty of resettled Syrian refugee women. As access to reproductive healthcare remains a fundamental human right, it is crucial for researchers, clinicians, and policy makers to work collaboratively to support equitable care delivery for resettled refugee women.

Table 1. Participant demographic characteristics for Manuscript 1

Selected socio-demographic characteristics	N = 11
Marital status	
Married	11 (100)
SES	
We do not have enough money for basic necessities	0 (0)
We have enough money for basic necessities, but no extras	10 (90.9)
We have enough money to buy extra things beyond necessities, at least sometimes	0
Prefer not to answer	1 (9.1)
Number of children	
1-2	1 (9.1)
3-4	3 (27.3)
5-6	4 (36.4)
7-8	3 (27.3)
Sponsorship type	
Government assisted	9 (81.8)
Private sponsorship	2 (18.2)
Length of time in Canada in years	
2 years	1 (9.1)
3 years	1 (9.1)
4 years	9 (81.8)

Chapter Four: Manuscript 2

"COVID affected us all:" The postnatal healthcare experiences of resettled Syrian refugee women during COVID-19 in Nova Scotia, Canada

In preparation for submission to BMC Reproductive Health

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Abstract

Background: Prior to COVID-19, resettled refugee women in Canada reported experiencing barriers to healthcare and low levels of social support, contributing to high rates of maternal health morbidities. The COVID-19 pandemic appears to be further exacerbating health inequities for marginalized populations—yet the experiences of resettled refugee women are not fully known. This research article reports on analyses conducted on a subset of data collected as part of a larger project seeking to understand Syrian refugee women's experiences accessing postnatal healthcare services and informal support during the postnatal period.

Methods: Qualitative interviews were conducted with resettled Syrian refugee women living in Nova Scotia (Canada) about postnatal services and supports. Eight women from the broader data set experienced part of their postpartum period during the first six month of the COVID-19 pandemic and described their experiences accessing postnatal healthcare services and informal supports between March and August 2020. Data analysis was informed by constructivist grounded theory.

Findings: Women had varied postnatal health service and support experiences during the early COVID-19 months including socially and physically isolated deliveries, difficulties accessing in-person interpreters, and cancelled or unavailable in-home services. Provincial public health stay-at-home orders and physical distancing requirements resulted in some women reporting feelings of isolation and loss, as they were unable to share in person postnatal moments with friends and family. Increased childcare responsibilities and limited informal supports left some women feeling overwhelmed and exhausted.

Conclusions: To our knowledge, this is the first Canadian study to examine the postnatal experiences of resettled refugee women during the early months of COVID-19. COVID-19 and associated public health restrictions had significant impacts on postnatal Syrian refugee women. Data presented in this study demonstrated the ways in which the pandemic environment and related restrictions amplified pre-existing barriers to care and postnatal health inequalities for resettled refugee women—particularly a lack of postnatal informal supports and systemic barriers to care. Women's mental health was stretched with the competing challenges of new motherhood, lack of support, and fear of the virus, ultimately leading to feelings of isolation, anxiety, and sadness. This study provides vital information for clinicians, policymakers, and researchers, to inform next steps in postnatal care to improve access for resettled refugee women through the rest of the pandemic and beyond.

Introduction

The postpartum period, or the first 12 months after birth, is often a complex, yet exciting time for new parents (Brown & Lumley, 1998; Thompson et al., 2002). It is a time of rapid change when mothers often require timely access to formal maternal healthcare services and informal supports to facilitate a positive transition into parenthood and support their health and the health of their child(ren) (Aston et al., 2018; Darvill et al., 2010). Access to formal health services provided by obstetricians, primary care providers, doulas, and midwives help women address potential health concerns, including mastitis, cesarian site pain/infection, heavy bleeding, and postpartum depression (Brown & Lumley, 1998; Thompson et al., 2002). The availability of informal supports from partners, family, or friends aids new mothers in balancing the competing demands of early parenthood, supports women's physical recovery, and emotional wellbeing (Emmanuel et al., 2012; Leahy-Warren et al., 2012; Negron et al., 2013). Positive socioemotional supports in the postpartum period help to mitigate against depressive symptoms and improve maternal self-efficacy (Leahy-Warren et al., 2012; Xie et al., 2009).

COVID-19 and associated public health restrictions have had a profound impact on the physical and socioemotional health of mothers across the globe (Chandler et al., 2021; Connor et al., 2020), including those who have given birth or navigated postnatal services during the pandemic (Hessami et al., 2020; Kotlar et al., 2021). Physical distancing and changes in health service provision has disrupted healthcare access for peri-and postnatal women, with non-essential appointment cancellations, new personal protective equipment requirements, and in some instances, a transition to virtual care

(Bradfield et al., 2021; Dol et al., 2020). Labour and delivery experiences have been complicated by restrictions on the presence of support people, with some women having to choose between doulas and partners or friends (Davis-Floyd et al., 2020; Dol et al., 2020; Kotlar et al., 2021). Women have often been required to attend perinatal health appointments alone (Dol et al., 2020; Kotlar et al., 2021) and were forced to cope with rapid healthcare policy changes, impacting birth plans and postnatal preparation (Bradfield et al., 2021).

In addition to disrupted healthcare access, COVID-19 restrictions and physical distancing requirements have socially isolated many postnatal women and limited their access to in-person social and informal supports (Davenport et al., 2020; Joy et al., 2020; Thapa et al., 2020). Informal supports (e.g., meal preparation, childcare, advice sharing) provided by family, friends, or community member contributes to women's postnatal health, mitigates against postpartum depressive symptoms and contributes to maternal self-efficacy (Leahy-Warren et al., 2012; Xie et al., 2009). Limited in-person social contact during the pandemic has left many new mothers isolated and overburdened (Ollivier et al., 2021). Women across the globe have also reported a decrease in their postnatal mental health. Increased rates of depressive symptoms and anxiety, extreme loneliness, isolation, and exhaustion have been reported (Davenport et al., 2020; Dol et al., 2020; Hessami et al., 2020; Kotlar et al., 2021; Ollivier et al., 2021). Opportunities to share their infant's milestones and connect with other parents has largely been restricted to online platforms (Ollivier et al., 2021). Some women have described feeling fearful around exposing their babies to COVID-19 (Dol et al., 2020; Kotlar et al., 2021).

The COVID-19 pandemic has exacerbated pre-existing challenges to accessing healthcare for resettled refugees, which is likely to widen health inequities for this population (Elisabeth et al., 2020; Germain & Yong, 2020; Kluge et al., 2020). Prior to the onset of COVID-19, refugee and migrant women were already experiencing inequities when accessing postnatal healthcare (Ahmed et al., 2008; Ganann et al., 2012; Sword et al., 2006). Resettled refugee women often encounter barriers to care related to language and cultural differences with providers, lack of interpretation services, and limited access to childcare, which contributed to missed or delayed appointments (Heslehurst et al., 2018; Khanlou et al., 2017; Riggs et al., 2012). Moreover, refugee women often reported reduced social networks upon arriving in their resettlement country, resulting in lower levels of available informal support after birth (Higginbottom et al., 2016). These challenges have contributed to a greater number of unmet physical and mental health concerns among postnatal resettled refugees, (Gagnon et al., 2013) and a five-times higher risk of developing postpartum depression, when compared to women born in their host country (Ahmed et al., 2008).

Times of crisis often reinforce and exacerbate existing disparities for marginalized populations (Kantamneni, 2020). Given the impact COVID restrictions have had on non-refugee mothers, resettled refugee women are at an even greater risk of negative postnatal experiences, as a result of their existing barriers to care (Germain & Yong, 2020). Little research has been conducted to understand immigrant, migrant, or refugee women's postnatal experiences during COVID-19. The overarching aim of this paper is to present data on the postnatal experiences of resettled Syrian refugee women in the context of COVID-19. More specifically, to elucidate refugee women's experiences accessing

postnatal formal health services and informal social supports during the first six months of the COVID-19 pandemic.

Methods

This research article reports on analyses conducted on a subset of data collected as part of a larger project which interviewed resettled Syrian refugee women in Nova Scotia about their experiences accessing postnatal healthcare and social support. Eight women from the broader data set experienced part of their postpartum period during the first six month of the COVID-19 pandemic. Their experiences are reported here. Findings on women's experiences of postnatal services and supports prior to COVID-19 are reported elsewhere (Stirling Cameron, Aston, et al., 2021).

Setting

This study was conducted in the Atlantic Canadian province of Nova Scotia in the city of Halifax which entered a state of emergency on March 22, 2020 (Government of Nova Scotia, 2021). To slow the spread of COVID-19, a Health Protection Act Order and public health measures were put into place at this time. These measures included physical distancing requirements, gathering limits, travel restrictions, closure of public parks and trails, and the closure of schools and daycare centres. Related to healthcare, many non-essential appointments were cancelled or rescheduled, restrictions were placed on the presence of support people during childbirth and postnatal appointments (zero to one additional person allowed), visits from public health nurses were virtual and some doula services were cancelled, and many healthcare appointments were delivered via telehealth (Nova Scotia Health, 2021b). Nova Scotia's first wave lasted through March to late May, with restrictions easing in June 2020 (Government of Nova Scotia, 2021).

Methodology

This qualitative study was conducted using elements of constructivist grounded theory. The practices of grounded theory (GT), first developed by Glaser and Strauss (1967), are designed to aid the researcher in developing a set of concepts that explain a social phenomenon under study (Corbin & Strauss, 1990). GT is an approach often taken to better contextualize an understudied phenomenon or experience (Wuest, 2012) whereby researchers scrutinize their own preconceptions and constructions as part of the analysis (Charmaz, 2014). The purpose of utilizing grounded theory for this research was not to develop a theory, but to use techniques of GT (e.g., thick and rich description, line-by-line coding, constant comparisons) to analyse participants' experiences accessing postnatal services and supports and develop a comprehensive conceptual understanding of the phenomenon (Corbin & Strauss, 2015).

Recruitment and Procedure

Ethics approval for this project was received by [name of institution blinded for peer-review] (#2019-5016). Women were eligible to participate if they came to Canada as a refugee, originated from Syria, were living in the city of Halifax, and spoke Arabic. This paper presents data related to post-partum experiences during the early months of COVID-19 in Nova Scotia, and to be included in the analyses for this report, women had to have given birth after March 2020, or have a child under the age of 12 months at the time of the interview (i.e., had to be postnatal at some point during the months of the pandemic prior to data collection).

A research assistant who was fluent in Arabic and English was hired to assist with recruitment and language interpretation. All recruitment and data collection materials

were drafted and reviewed by two English- and Arabic-speaking research assistants to ensure an accurate translation. Women (both those who had COVID-19 postpartum experiences and those who did not) were purposefully recruited through community centres, health clinics, and private sponsorship organizations. Arabic and English versions of recruitment posters were distributed through the social media, websites, email networks, and/or social media platforms of these recruitment groups. Potential participants were instructed to contact the research assistant by phone or email to assess for eligibility. Interested participants selected whether they wanted to complete a telephone interview or a video call (Microsoft Teams), and then scheduled a time for the interview.

In advance of the interview, women were emailed a copy of the consent form in both Arabic and English. The primary investigator and an Arabic interpreter were present at each interview. Before beginning the interview, the interpreter verbally reviewed the consent form and verbal consent was recorded. Verbal consent helped to alleviate any burden on participants to print, sign, and scan, or electronically sign and email a consent form. Participants were asked a few demographic questions (e.g., marital status, number of children, years spent in Canada) before conducting the interview. They were also asked if part of their postnatal period (i.e., the first 12 months after birth) was during some months of the COVID-19 pandemic. If yes, they were asked a set of additional interview questions specifically related to COVID. The interview guide was comprised of a series of open-ended questions based on a review of the literature and suggestions from community stakeholders. Example COVID-related questions included: How did COVID-19 impact your ability to access healthcare services? Were any services unavailable or

only available virtually? How did the pandemic impact your ability to see family, friends? Did this affect you and your mental health/wellbeing? Interviews took place during the months of August and September 2020. All interviews were audio recorded.

Analysis

Audio recordings were transcribed verbatim and translated into English by the same interpreter who was present for all interviews. The translated interviews were read a number of times to familiarize the lead researcher with its content. Line-by-line coding was completed using Atlas.ti (version 8) data analysis software (Muhr, 2017) wherein each idea was labeled with a key idea. Key ideas were organized into preliminary categories. Constant comparative analysis was used to identify similarities and differences between and within categories, after which related categories were collapsed into themes and subthemes. Collaborative team meetings were held throughout the coding process to provide feedback on the coding process and developing analysis.

Results

Select details of the socio-demographics of the 8 women who had postpartum experiences during the early months of COVID-19 are provided in Table 1. All eight participants were married, spoke Arabic as their preferred language, and originated from Syria. Women had between two and eight children and most arrived in Nova Scotia in 2016. All women arrived through the government-assisted resettlement program.

Three main themes emerged from the data: the impacts of COVID-19 on postnatal healthcare; loss of informal support; and grief and anxiety caused by the COVID environment.

Impacts of COVID-19 on Postnatal Healthcare

Participants conveyed that COVID-19 changed their access to and use of postnatal healthcare services. Limitations on in-hospital support people, childcare restrictions, changes to services delivery, and a move towards virtual care created challenges and opportunities for women's postnatal care.

Isolated Birthing Experiences

Many participants who delivered during the pandemic discussed the impacts that hospital restrictions and larger public health measures had on their birthing experiences. A culmination of factors, including limited access to childcare, restrictions on support people, and the unavailability of doulas, meant that many women laboured and delivered alone, or with fewer supports than they would have liked.

With the temporary closures of public schools, and daycare centres, families had limited options for childcare for their additional children. Participants also did not have extended family (e.g., mothers) in Canada and many women did not feel comfortable asking friends to watch their children, given their friends' own responsibilities and the risk of spreading the virus. Several women in this study gave birth during the COVID-19 months with no support people, as their husbands took care of their children while they were in the hospital. Participant 1 described her experience: "No one could accompany me to the hospital because of COVID. I was alone. My husband drove me to the hospital, but I was all by myself during delivery. My husband helped me carry my things with me to the hospital, but other than that I was all by myself." Other participants who delivered without support people had similar feelings, describing their births during COVID as "hard," "scary," and "lonely."

Other women who wished for their friends to accompany them to the hospital discussed having to choose between their partners and friends, as only one support person was allowed to accompany women. Participant 7 said, "My friend was with me. My husband stayed with the kids at home, and he couldn't even come because during COVID only one person was allowed to accompany the woman who gives birth. He used to bring us food, give them to my friend outside the hospital, but he never entered." Visitation after birth was also limited, which was difficult for several participants who had hoped they could see their families or friends after delivery. Participant 3 described how emotionally challenging and isolating it was to not have her partner visit after her birth: "The hospital rules are strict during COVID. Visits are forbidden, friends can't come, and they could not be there to help me. My husband was allowed to visit me twice a day in the hospital. I stayed for two days. I felt really lonely, it was a hard experience." Participant 1 also mentioned how difficult it was to be separated from her other children while recovering after birth, stating, "I didn't see my children for two days, I wanted them to come to the hospital so I could see them, but it wasn't possible because of COVID. My little baby girl was crying all the time without me… I just wanted to be discharged from the hospital and go home to them" (Participant 1).

In addition to the restrictions on support people, several women who delivered during the first wave were unable to access doula services, as doulas were temporarily suspended with the rise in COVID cases. Doulas were frequently used by Syrian newcomer women prior to the pandemic, and as Participant 7 said, "before COVID, many Syrian women were offered doulas by [immigrant support group], but I was not offered one. Because of COVID they stopped this service." Not having access to doula support

services left women isolated and exhausted without their assistance. Even after doula services resumed, they were not classified as healthcare staff, and had to accompany women as one of their designated support people, limiting the additional family members or friends who could be with participants while they delivered.

Changes to Interpretation Service Provision

All participants spoke Arabic as their preferred language and were often dependent on interpretation services to effectively communicate with healthcare providers. Due to public health and hospital policies at the time of COVID-19, most participants reported that use of in-person interpretation services were largely restricted. Postnatal appointments that would have typically been translated by in-person interpreters were moved to telephone interpretation. Telephone interpretation was preferred over no translation at all, but it was often slow. Participant 7 said, “Before COVID I had an in-person interpreter. But during COVID, it was hard. The interpretation over the phone was not efficient.” Several women had to wait for telephone interpreters to become available, with one participant waiting six hours in the emergency department for interpretation services to be provided, delaying her access to urgent care. Most participants outlined their preference for in-person interpretation and described how important it can be for interpreters to read women’s body language and facial expressions. As stated by Participant 3, “The in-person interpreter feels and understands what I am going through just by seeing me. The phone interpreter on the other hand can’t see me and is waiting for me to talk in order to interpret.” This participant conveyed the added comfort of having a person be present with her and the ease that brings to the appointment.

Participant 3 described how crucial it was for her to have in-person interpretation, particularly during COVID-19, as her husband and friend were unable to be with her during her cesarian section. Not only did this interpreter ensure that the participant was able to communicate with her healthcare team, but she also acted in lieu of the participant's support people, providing comfort and support: "When I entered the surgical room I cried. I was so lonely. I was scared. I needed someone to be with me to ease my stress. So, the interpreter, who I thank from the bottom of my heart, told me not to worry and told me that she will be there for me" (Participant 3). This participant conveyed the added benefits of in-person interpretation, which go beyond reading body language, to providing emotional support. Other participants even discussed their interpreters acting as advocates for patient safety.

Several participants indicated that they were not given any interpretation at all and were forced to navigate healthcare interactions in English during COVID-19: "Sometimes they explained things to me by using signs and I understand a little English but it's hard to understand medical terms and they didn't use an interpreter for this" (Participant 6). This participant felt particularly frustrated by this experience and did not feel like she fully understood the health information shared by her care providers. Moreover, information shared online about changing public health restrictions and hospital-based restrictions was predominantly provided in English. This language barrier made it difficult for women to keep up with the constantly evolving guidelines and restrictions related to COVID and their understanding of access to postnatal care.

Transition to Virtual Care

The transition to telehealth and virtual care had both positive and negative implications for participants. Primary care services and in-home postnatal supports, such as those provided by doulas and public health nurses, were offered virtually. Telehealth appointments did pose some challenges for interpretation. Women described how complicated it was to connect with their primary care providers, and interpreters, over the phone. Appointments were carried out through separate, back-and-forth telephone calls with a translator, who would relay information to the physician and then separately call back the participant: "I ask the interpreter and she speaks to the doctor and then they get back to me with the answers. It is complicated, but what could we do?" (Participant 4). Some participants felt a sense of hopelessness around this form of interpretation, feeling as though they had no alternative ways to communicate with providers. Though it was inconvenient for them, they felt it was the only option in light of the restrictions caused by the pandemic.

Participants indicated that in-home services provided by doulas and public health nurses during the postnatal period were cancelled in the first wave. While public health nurses continued to follow-up with women virtually, the hands-on care they had provided pre-COVID-19 was not available. Primary healthcare services also transitioned to be mostly virtual during the first wave of COVID-19, impacting women's ability to access long-acting contraceptives after birth. Women were only able to access condoms or oral contraceptives through virtual care appointments. Participant 4 described her experience: "I asked the doctor for an IUD insertion. I was prepared for its insertion, but it didn't happen. Because of COVID, everything was delayed, and until now I haven't gotten it." Though this woman was able to access alternative contraceptive options in the interim,

she was particularly interested in long-acting contraceptive options, for their preferable side-effect profile (over hormonal contraceptives) and heightened effectiveness.

Though virtual care did create challenges for some women, it was actually preferred by others. Telehealth appointments alleviated the need for some women to find childcare and transportation to attend in-person appointments. Participant 1 described her preference for virtual care: "I found the services I got when I delivered during COVID much better than those with my first-born baby here. I liked the services while delivering and the period after. They kept calling me, checking on me and asking how I was doing." Similarly, participant seven said telephone appointments were "much easier" than in-person visits.

Loss of Informal Support

Stay-at-home orders, isolation requirements, and limitations on in-person gathering limited women's access to informal support people after birth. This was compounded by the temporary closure of schools and daycare facilities, leaving women to care for their children and newborn without external support people, causing exhaustion, fatigue, and isolation.

Missing Support People

Gathering limits and physical distancing requirements additionally meant that women had few sources of in-person, informal support during their postpartum period. Several participants described the ways in which their neighbours and friends had supported them through previous, non-COVID births in Canada by providing meals, cleaning, offering emotional support and advice, and caring for their other children. These supports were no longer available to women during the first wave of the pandemic

because of restrictions concerning household visitation. As all participants had already been separated from their extended family before COVID-19, as a result of forced migration and resettlement, their sense of loss was compounded by also not being able to see local friends after birth, who had become a kind of chosen family. Participant 7 described how difficult it was to be separated from her family and local friends, comparing her emotions to the experience of drowning: "It was really hard during COVID. In Syria I had my family… but to give birth here with no one with me?! It was really hard. I needed someone with me, my neighbours, my friends… I felt like I was drowning." Several other participants had limited social connections even before COVID-19. For these women, nothing had changed between prior births in Canada and their birth during COVID, and as one participant explained, "Things haven't changed because even before COVID I didn't have any friends here" (Participant 6). These women were already extremely isolated and lonely, having been separated from their family in the Middle East, and having limited or no support people in Canada. Their pre-COVID postpartum experiences were no different than the isolating periods women endured during the pandemic lockdowns.

Childcare Burden

COVID restrictions also resulted in the closure of schools and daycares between the months of March and June, 2020.(Government of Nova Scotia, 2021) As a result, all participants indicated that they had between one and seven additional children at home, fulltime after delivery. Participants discussed the stress and exhaustion experienced while juggling homeschooling or childcare for their additional children in addition to caring for their new baby. One participant stated, "There is a lot of stress. My son doesn't go to

daycare because of COVID, so both my sons are home all the time… It was very stressful at home, especially when I felt depressed, and the kids were there all the time… This was the hardest part" (Participant 6). Women discussed how tiring it was to have a newborn, let alone care for one in a context with limited support, and while caring for their additional children. Another participant described the social withdrawal that she felt while postpartum during COVID as a result of the physical exhaustion she was feeling, "I was so tired and fatigued that I didn't talk to anyone. I didn't have the energy for anything" (Participant 7).

Anxiety and Grief Caused by COVID-19

COVID-19 had significant impacts on women's mental health. The COVID environment overshadowed the joyous moments of childbirth, with women enduring heightened levels of anxiety triggered by a fear of the virus. Participants further reported feelings of sadness and disappointment as their expectations around their birth and postnatal period were disrupted by COVID-19.

Fear of COVID-19

A significant source of anxiety for many participants was the risk of themselves or their family being exposed to COVID-19. Women were particularly concerned for their infant's health, feeling as though they were particularly vulnerable to the virus: "I was scared of COVID. I was scared over my children's health and because I had recently delivered, I was afraid of my last baby's health" (Participant 1). Several participants' husbands were working in essential services (e.g., food delivery, construction) and continued to work during the first wave. This caused concern, for their husband's health and that the husband may carry the virus into their home: "I was really scared. Because

he was the only one who went outdoors and was exposed to people so I was afraid that he might get infected with the virus and carry it home" (Participant 6). Women were particularly hesitant to visit the hospital, or other healthcare clinics, fearing that it was a hotspot for the virus, "It was hard because I didn't know how the situation was in the hospital, I was scared that the hospital might be an epicenter of the pandemic. I was scared that the virus spreads easily in the hospital" (Participant 6). Fear of COVID was a severe enough that one participant skipped certain postnatal appointments at the hospital. Others described the sadness that it caused them to have to leave their partners and infants at home and visit the hospital alone:

> "I had to take all the precautions measurements and put on a mask and gloves. It was really hard. To go to the hospital a few days after birth, all by myself and to leave my baby at home because nobody is allowed to be with me was really very hard. I was thinking that even if I die, I will die alone. It saddened me" (Participant 7).

Several women also spoke of the concerns and anxieties they had for family members living in other countries (e.g., the United Kingdom, Lebanon, Syria), where there were high rates of COVID-19. "In Syria, where my husband's family is, the situation is very hard, so many COVID cases" (Participant 5). Women also spoke of the fear their older children had around the virus. Participant 8 said that her children were "terrified of COVID." Not only did they have to manage their own anxieties around their virus, but their children's as well, to ensure their mental health was supported through the pandemic.

Broken Expectations

Several women described the hopes and anticipations that they had about their postnatal experiences, prior to the onset of the pandemic. Many participants were eagerly anticipating their "Canadian baby" and were looking forward to sharing this event with their new, local social network of neighbours and friends. Yet physical distancing and gathering limits meant that there were few opportunities for friends to meet and socialize in person with mothers and their new babies. Participants described feeling saddened that this significant life event could not be celebrated in person: "We really wanted to have a new baby here and were excited... I had been dreaming of having a big party after my birth here, to invite my friends but suddenly COVID happened, and I had no one to support me" (Participant 7). Other participants were looking forward to enjoying more intimate moments with their husbands and children, such as having their children visit in the hospital, which was not possible because of COVID-19, leaving women and their families disappointed, "My kids at home were so upset that they couldn't visit me at the hospital and see the baby. They had been so excited during my pregnancy saying that they are waiting to visit me in the hospital after I give birth and to hold the baby, they wanted to bring me flowers but of course because of COVID none of that happened" (Participant 6). Most participants felt a sense of loss or grief, as they were not able to share in person the joys of having a new baby with their friends and community members—a key moment of the postpartum experience.

Discussion

This study has revealed the ways in which COVID-19 has impacted resettled Syrian refugee women's postnatal experiences of formal health care services and informal supports. Participants described experiences of limited support during birth,

poor access to in-person interpretation, cancelled in-person health services, and transition to virtual care. The COVID environment also impacted resettled refugee women's mental health during the postnatal period, causing increased feelings of fear, isolation, and disappointment. These findings are consistent with other recent reports on the experiences of non-newcomer women who are postpartum during COVID-19 in Atlantic Canada (Dol et al., 2020; Joy et al., 2020; Ollivier et al., 2021). The COVID-specific experiences of non-newcomer women parallels the pre-pandemic postpartum experience of resettled refugee women. Isolated birthing experiences (Ahmed et al., 2017; Henry et al., 2020; Stirling Cameron, Aston, et al., 2021), reduced access to informal support people (Henry et al., 2020; Hrabok et al., 2020; Niner et al., 2013; Stirling Cameron, Aston, et al., 2021), and high rates of postpartum depressive symptoms (Ahmed et al., 2008; O'Mahony & Donnelly, 2013; Stewart et al., 2008) were all experienced by resettled refugee women before the pandemic began.

Data presented in this study demonstrated the ways in which the pandemic environment and related restrictions amplified pre-existing barriers to care and postnatal health inequalities for resettled refugee women. Particularly, COVID-19 has limited already fragmented access to interpretation (Correa-Velez & Ryan, 2012; Henry et al., 2020; Niner et al., 2013; Origlia Ikhilor et al., 2019; Stirling Cameron, Aston, et al., 2021; Wu & Rawal, 2017). During the state of emergency in Nova Scotia, the healthcare system restricted access to interpretation, with a move towards telephone interpretation, which was described as cumbersome and slow to access, and less desirable than having an in-person interpreter. Women noted that the function of interpreters goes beyond being a conduit for effective communication between patients and providers. Our findings our

consistent with the literature, which has also shown that in-person interpreters provide emotional support and act as a medical advocate for women, ultimately assisting healthcare providers in administering safe, high-quality care (Wu & Rawal, 2017; Yeheskel & Rawal, 2019). Other studies have highlighted the maltreatment and trauma that can occur during birth when interpreters or interpretation services are not provided (Henry et al., 2020). Failure to provide interpreters leaves resettled refugee women vulnerable to inadequate pain management, violates the principle of informed consent, and can leave women distressed (Henry et al., 2020; Stirling Cameron, Aston, et al., 2021). This must be considered in the context of personnel restrictions in hospital and clinic settings as the pandemic continues.

Like other postnatal women in the pandemic, physical distancing requirements and the general fear and anxiety that accompanied the pandemic impacted some participants' mental health (Adhanom Ghebreyesus, 2020; Fallon et al., 2021; Hessami et al., 2020; Ollivier et al., 2021). Women in our study described the stresses and pressures they faced as a result of decreased informal support, increased childcare and homeschooling demands, and the closures/restrictions of valuable support services (e.g., doulas)—all of which have been reported in other literature with non-newcomer women (Chandler et al., 2021; Dol et al., 2020; Ollivier et al., 2021). These stressors were coupled with feelings of disappointment and loss related to missed or robbed birth- and postnatal-related moments and milestones (Dol et al., 2020; Joy et al., 2020; Ollivier et al., 2021). Studies with non-newcomer women have also found significant increases in postpartum anxiety (Hessami et al., 2020) and depression symptoms (Zanardo et al.,

2020) during the pandemic, in addition to a significant increase in healthcare visits for postpartum mental health concerns (Vigod et al., 2021).

Though most postnatal mothers in the context of COVID are experiencing worsened mental health outcomes, resettled refugee women in Canada are significantly more likely to experience postpartum depression symptoms—at a rate three-to-five-times higher the Canadian-born women—in a pre-pandemic context. Previous studies have found correlations between increased depressive symptomology and low levels of social and informal support among refugee women (Ahmed et al., 2008; Stewart et al., 2008). As a result of stay-at-home orders and physical distancing requirements, women were unable to access any in person support systems they may have established in Canada, which resulted in high rates of isolation and stress. Though this research study did not formally assess or evaluate mental health concerns among resettled refugee women, it could be posited that limited supports and added pressures of the COVID environment may have heightened the risk for postpartum mental illness among resettled refugee women.

The COVID-19 pandemic has posed ethical challenges regarding the implementation of policies that reduce the spread of the virus but may cause unintentional harm to women and their families (Kotlar et al., 2021). Most notably, COVID-related restrictions around the presence of in-person support people in-hospital and at home (e.g., family, friends, doulas) has had detrimental impacts on maternal mental health during the postpartum period (Dol et al., 2020; Joy et al., 2020; Ollivier et al., 2021). The unavailability of support people left women overwhelmed, exhausted, in a particularly vulnerable stage of life. Members of the Respectful Maternity Care Charter Global

Council have called for innovation and flexible programming and policies to deliver high-quality maternal healthcare in a way that respects the rights of mothers and newborns and is COVID safe (Jolivet et al., 2020). Of particular concern is the denial of critical in person support people during birth, which for our participants included spouses, friends, doulas, and interpreters. We would encourage policymakers to consider doulas and interpreters as necessary and important care team members, and allow them to be classified as such, rather than having to occupy a designated 'support person' space. Hospitals could also help to facilitate virtual family-centred care by offering technological supports (i.e., tablet with video capabilities) to connect women with their families virtually during birth and postnatal appointments (Hart et al., 2020).

Limitations

This study is not without limitations. Data included in this study were based on a sub-set of findings from a larger study. Although a number of questions were asked specifically about COVID-19, the focus of the parent study and of the interviews was not focused exclusively on women's experiences during COVID-19. Additional questions were not asked around COVID experiences, as a large portion of the interview was dedicated to pre-COVID experiences. Time did not allow for further probing around COVID-19. Moreover, all participants in this study were multiparous and married. Future research may seek to explore the experiences of single parents and first-time mothers, who may experience potentially different stressors during this time.

Conclusion

This research paper is one of the first to report on the experiences of resettled refugee women who were postnatal during the early months of the COVID-19 pandemic

in Canada. Public health restrictions had significant implications for Syrian refugee women in this study who were in the postnatal period during COVID-19. Participants encountered systemic barriers to postnatal care that had been amplified due to the pandemic. Women's mental health was also stretched with the competing challenges of new motherhood, limited support, and fear and exhaustion caused by the pandemic, ultimately leading many to feel isolated, anxious, and depressed. The particular barriers facing resettled refugee women must be considered as public health recommendations and restrictions continue to evolve. Many issues reported by participants are liable to persist in the aftermath of COVID-19 and must be addressed to ensure equitable access to care and support for postnatal women as we move into a post-pandemic environment.

Table 2. Participant demographic characteristics for Manuscript 2

Demographic characteristics	N = 8
Marital status	
Married	8 (100)
SES	
We do not have enough money for basic necessities	0 (0)
We have enough money for basic necessities, but no extras	8 (100.0)
We have enough money to buy extra things beyond necessities, at least sometimes	0 (0)
Prefer not to answer	0 (0)
Number of children	
1-2	1 (12.5)
3-4	2 (25.0)
5-6	3 (37.5)
7-8	2 (25.0)
Sponsorship type	
Government assisted	8 (100.0)
Private sponsorship	0 (0)
Length of time in Canada	
2 years	1 (12.5)
3 years	0 (0)
4 years	7 (87.5)

Chapter 5: Discussion

This thesis describes a qualitative study aimed at understanding resettled Syrian refugee women's experiences accessing postnatal healthcare services and informal supports in Halifax, Nova Scotia, Canada. Manuscript 1 (Chapter 3) reported on (i) barriers and facilitators to postnatal maternal healthcare and informal support, and on (ii) valued and missing services and supports for women who had children between 2015 and March 2020 (i.e., prior to the onset of the COVID-19 pandemic). Manuscript 2 (Chapter 4) reports on the experiences of resettled Syrian refugee women who were postnatal during the early months of the COVID-19 pandemic (i.e., between the months of March and August 2020). Each individual manuscript has its own specific discussion section. Please refer to Manuscript 1 (Chapter 3) and Manuscript 2 (Chapter 4) for their in-depth discussions related to each respective analysis.

The first and second manuscripts (Chapters 3 and 4) described the importance of social support for women during the postpartum period. Participants described the ways in which extended family (especially female relatives) had supported them after their births that had occurred in the Middle East. The absence of these critical support people, including mothers, sisters, and aunts was felt strongly by all participants during their Canadian births, whether the births occurred pre-COVID or during COVID. Women who had relied on their families and friends for support during the perinatal period noted a distinct lack of support after resettlement and during their postpartum period. This lack of informal supports is due primarily to the lack of nearby peers and family members who could physically help with the demands of carrying, delivering, and raising children. Other studies have reported similar experiences of separation and reduced levels of

support among immigrant and refugee women in Canada (Ahmed et al., 2017; Higginbottom et al., 2016; Higginbottom et al., 2014; O'Mahony et al., 2012)

Other studies conducted among resettled refugees described living apart from family as contributing to feelings of postpartum isolation, loss, and grief (Ahmed et al., 2017; Higginbottom et al., 2016; Higginbottom et al., 2014; O'Mahony et al., 2012.) A review by Heslehurst et al. (2018) found several studies identifying a lack of in-person social and family support to be critical risk factors for the development of postnatal mental health disorders in resettled refugees. Similarly, Zelkowitz et al (2004) found that resettled refugee women with more severe depressive symptoms had social networks with fewer women, fewer relatives, and fewer people from their own cultural background. In addition to the mental health impacts, women in our study attributed low levels of informal postnatal support to particular adverse physical health outcomes, including slow surgical recovery times, fatigue, and decreased breastmilk production. Indeed, other work has found that low informal support and feelings of isolation can contribute to breast-feeding challenges (Hufton & Raven, 2016).

Though many participants described feelings consistent with symptoms of postpartum depression or anxiety, only a select number of participants sought out professional services. Several participants in our sample had seen a psychiatrist or psychologist during their postpartum period, but both of these participants discontinued service use. Others felt as though seeking services for their mental health was "pointless." Feelings of shame and stigma around mental health services have been widely reported in the literature among other resettled refugees of Middle Eastern origin (Asma Ahmed et al., 2017; O'Mahony & Donnelly, 2010; O'Mahony & Donnelly, 2013; Riggs et al.,

2020; Yelland et al., 2014). Some studies reported that women did not conceptualize mental unwellness as a health concern, and that any discussion around symptoms of sadness or depression should be shared with close family members, not care providers (Yelland et al., 2014). Other studies articulated that newcomer women had a limited understanding of the Western conceptualization/label of 'postpartum depression' and were unaware that formal services existed to help with this or how to access them (G. M. Higginbottom et al., 2016; Merry et al., 2011). Though some women may not be interested in formal, labelled counselling or psychotherapy, offering non-labelled group social spaces or group discussions could be beneficial (Russo et al., 2019). Other research has found that the use of the term "wellness" rather than "mental health" is preferable for Syrian women (Ahmed et al., 2017).

Results as presented in the two manuscripts indicate that access to postnatal healthcare was not always easy for the resettled Syrian refugee women who participated in the study. Structural barriers including limited access to childcare, geographical and transportation challenges, language and communication challenges, impeded women's abilities to access and use maternal healthcare services. All of these barriers have been reported previously and have disrupted access to maternity care for immigrants, refugees, and asylum-seekers in Canada for decades (Gagnon et al., 2002; Ganann et al., 2012; Higginbottom et al., 2016; Khanlou et al., 2017; Stewart et al., 2008).

A critical, structural barrier to care for participants was the irregular provision of interpreters and telephone interpretation services. Successful communication between patients and their care providers is key to ensuring healthy outcomes for mothers and their infants during childbirth and the postpartum period (Henry et al., 2020; Origlia

Ikhilor et al., 2019). Some study participants faced delayed access to care, and inadequate pain management, as a result of language and communication barriers and lack of interpretation. Interpreters work to facilitate effective communication between patients and their healthcare teams, to facilitate the delivery of safe, high quality care to patients who are culturally and linguistically diverse (Wu & Rawal, 2017; Yeheskel & Rawal, 2019). Providing timely access to quality interpretation improves communication between patients and providers, improves quality of care, patient involvement, and has the capability to improve provision of health promotion information and uptake of preventative healthcare (Henry et al., 2020; Jaeger et al., 2019; Origlia Ikhilor et al., 2019).

Participant autonomy and cultural safety were also important barriers to care for study participants. Women reported having referrals cancelled by their physician, infant feeding preferences overlooked, and methods of family planning questioned. The common thread among these differing experiences was that participants did not feel that they were equal participants in the decision-making process, and ultimately, healthcare decisions were made for them without their expressed consent which appeared to have negative consequences for the women's health. This suggests a need for providers to better understand the prejudices and biases that they may hold which influences their behaviours when caring for women of a refugee background. In some instances, there was a clear power imbalance and lack of meaningful involvement or consideration of women's care preferences. Cultural and linguistic differences may create challenges for shared decision making between healthcare providers and newcomer patients, yet women must be supported to make their own informed choices.

Study findings indicate that even before the COVID-19 pandemic, obstetrical care was difficult to obtain for many resettled Syrian refugee women. This has been historically reported among other resettled populations in Canada and among other high-income resettlement countries around the world (Heslehurst et al., 2018; Khanlou et al., 2017; Riggs et al., 2012; Yelland et al., 2014). Canada's healthcare system appears "universal" and emergency and routine healthcare is provided for Canadians regardless of their residency or citizenship status, yet healthcare access remains inequitable. Language, migration background, and socioeconomic status, remain critical determinants of health, threatening access and use of postnatal healthcare.

Limitations of the Research Program

Specific limitations have been listed in each respective manuscript. To avoid redundancy, they have not been listed here but in chapters two and three.

Implications for Health Promotion

Recognize Interpreters as Essential Team Members

A recent publication by Jaeger et al., 2019 highlighted steps that must be taken to improve the availability of interpretation for refugees. Notably, healthcare providers must receive system-level support to accommodate and bolster the use of interpreters. Health systems must allow providers to book longer appointments with culturally and linguistically diverse patients, to accommodate the necessary back-and-forth with interpreters. This may involve adapting billing codes for fee-for-service providers to appropriately compensate for longer appointments (Andrulis & Brach, 2007). Care providers also need to be educated on the use of interpreters and telephone interpretation. Jaegar et al. (2019) found that over 40% of healthcare providers in Switzerland did not

know how to access interpretation or telephone interpretation for their patients. This and other studies have highlighted the benefits of in-person interpreters, particularly when compared to telephone interpretation, as body language and facial expressions are missed over the phone. However, on-site or in-person interpretation is often only available at larger tertiary care centres and is not always a feasible approach for smaller clinics and primary care offices. Telephone interpretation may be the only option in these settings, in emergencies, and for less commonly spoken languages. Jaegar et al. (2019) proposed a compromise for these circumstances, by using virtual, video-based interpretation to allow for the availability of telephone interpretation, but with the ability for the patient and interpreter to see one another.

The fact remains that interpreters, even at their best, are filters and can disempower patients (Wu & Rawal, 2017; Yeheskel & Rawal, 2019). Our participants ultimately wanted to converse with and be supported by healthcare providers of a similar linguistic and cultural background, removing any outstanding concerns related to shame, or confidentiality, posed by interpreters. Health professions needs to further diversify and provide language-concordant providers for linguistically diverse patients. This will require collaborative action from health systems, academic institutions, and governments to implement affirmative action programming, and recognize the value of culturally and linguistically diverse healthcare providers. To implement the above recommendations, sectors ranging from health administration, policy making, immigration, academic institutions, and more must come together to address the multi-sectoral actions that must be taken to improve interpretation use, access, and ultimately, the transition away from interpretation and towards linguistically concordant care providers and patients.

Unfortunately, many of these sectors remain siloed and independent from one another. Employing health promoters to connect these sectors to form working groups and develop policy action plans may help to break down these silos.

Cultural Safety and Humility

Findings reported in the first manuscript indicated a need for measures/strategies to improve patient safety, shared decision-making, and autonomy. Cultural safety encourages healthcare professionals to examine how their own biases, assumptions, stereotypes, and prejudices may influence patient interactions (Curtis et al., 2019). While cultural safety informs interactions between providers and patients on a small, person-to-person scale, cultural humility as a framework positions existing power structures in healthcare as needing to change to better meet the needs of marginalized patient populations, rather than the other way around. Providers must develop a "lifelong commitment to self-evaluation and critique, to redressing power imbalances . . . and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations" (p. 123; Tervalon & Murray-García, 1998).

Health systems and care providers must address issues of cultural humility and safety at individual and systemic/organizational levels. At an individual level, providers must work beyond acquiring information about different cultures and patient populations but rather engage in self-reflection to acknowledge and address potential power imbalances and biases that may be affecting their ability to provide culturally safe patient care. This can include anti-oppressive training for medical, nursing, social work, and

psychology students, but also supporting healthcare staff already engaged in the system to participate in continuing education around cultural safety and humility.

Culturally unsafe health systems and clinical spaces may also contribute to negative patient experiences (Curtis et al., 2019; Fisher-Borne et al., 2015). Previous literature has highlighted the benefits of offering childcare services, making relevant materials (referrals, treatment instructions, prescriptions) available in preferred languages, and offering flexible, drop-in hours to accommodate potential delays caused by transportation/childcare challenges (Chan et al., 2018; Lau & Rodgers, 2021). Other considerations include co-locating medical care alongside community service spaces and committing to hiring bilingual and culturally diverse staff across disciplines (Lau & Rodgers, 2021; Yeheskel & Rawal, 2019). Interpreters or tele-interpretation services should be used when language-concordant providers are not available (Wu & Rawal, 2017). It is crucial for any health system working towards making spaces safe for newcomers must meaningfully engage in consultations with prospective service users to ensure spaces and policies meet their needs and the needs of the community.

Other interventions have targeted patient-empowerment, providing women with education on maternity care and available services and how to navigate them. Previous studies have highlighted the benefits of hiring social workers, cultural brokers, or peer health advisors to connect with refugee patients to assist with scheduling/understanding referrals, obtaining prescriptions, navigating health systems, and connecting families with other social resources (e.g., income assistance, housing, language services) (Lau & Rodgers, 2021; Reavy et al., 2012).

Postnatal Social Support Programming

One of the most commonly discussed challenges reported in this study was a lack of in-person social support. Cultural and linguistic differences pose key barriers for newcomer women seeking to build new friendships in their host countries (Aching & Granato, 2018). Mainly White, English-speaking spaces may not be accessible or approachable for newcomers. Other studies have called for and/or implemented programs to facilitate networking and social connection among resettled refugee women. Examples have included women-only social activities (e.g., walking groups; Ahmed et al., 2017), mother and baby play groups (Aching & Granato, 2018), and even group wellness sessions facilitated by trained counsellors. It is critical that spaces be made culturally safe and appropriate, held in trusted community spaces, linguistically and culturally appropriate (O'Mahony et al., 2013). Very limited research and evaluation has been conducted on postnatal social programming for newcomer women of any country of origin. Community needs-assessments and program implementation and evaluation are needed to trial social interventions for resettled refugee women to bolster mental health and social connectedness.

Ideally, women wanted to have in person access to their family during significant moments, particularly during labour and delivery. Even after resettlement, women maintain transnational networks of relatives and friends who often continue to offer socio-emotional support, health information, and advice from a distance (e.g., through instant messaging, video and telephone calls; Henry et al., 2020). While physical support from family remains difficult to facilitate, overseas family members (and even local family and friends while COVID restrictions persist) could attend appointments virtually. COVID-19 has pushed healthcare teams to use more virtual methods of communication

to keep family members and patients connected through pandemic restrictions (Hart et al., 2020). Providing stable internet, the time and opportunity for women to connect with their family, or even providing a tablet or laptop to facilitate videoconferencing would help to promote family-centred care during critical moments.

Knowledge Mobilization

Knowledge dissemination will occur at the community and academic level. A written community report (available in English and Arabic) will be developed and distributed to relevant stakeholders and community-based organizations who participated in recruitment. It will also be emailed or mailed to any women who indicated they would like to receive a copy at the time of their interview. Findings will also be shared with specific, interested stakeholders, who have been engaged with the research since its inception either through discussions, written reports, or presentations.

The researcher has prepared and defend the study as a thesis. Research findings have been presented locally to BRIC Nova Scotia, the Women's Health Interest Group, The Centre for Transformative Nursing, and Health Research. Abstracts will be submitted to the North American Primary Care Research Group (NAPCRG) Conference, the Canadian Association for Perinatal and Women's Health Nursing Conference, and the Association for Health Services and Policy Research Conference (CAHSPR). A commentary on the need to consistent interpretation provision will also be prepared and submitted to the Canadian Medical Association Journal or The Conversation following publication of the main thesis papers. Manuscript 1 has been submitted to Midwifery (April 2021) and Manuscript 2 has been submitted to BMC Reproductive Health (July 2021).

Future Directions

There are several directions future research could take. Healthcare providers who care for newcomer patients could be surveyed to understand the opportunities and challenges they face when caring for this population. Particular attention should be given the inconsistent provision of interpretation and the possible solutions needed to boost usage among healthcare provides. Other research could pilot and evaluate programming, such as postnatal social support groups or peer navigation services for first-time perinatal newcomers. Future research could also target the development and testing of cultural safety training and education for health professional students or healthcare providers as well as research around the implementation of affirmative action policies. It is critical to note that all work should incorporate a participatory approach, including newcomer women and other relevant stakeholders, throughout the research process.

Conclusion

Findings from this thesis have demonstrated that access to healthcare for postnatal Syrian refugee women remains difficult to access. Despite Canada touting a 'universal' healthcare system, access to care is not experienced equitably among all of its citizens. For women in this study, language differences, socioeconomic limitations, gender, and immigrant status shaped their experiences accessing care, sometimes resulting in communication errors, missed and delayed appointments, and reduced decision-making autonomy. Moreover, separation from extended family and friends through the process of forced migration left many women isolated and in need to extra support during the postpartum period. Participants highlighted the important role extended family has traditionally played after birth, and how much that was missed in Canada. Friends and

some community members were able to fill these gaps for some women, yet others were left with only their husbands to support them postnatally.

COVID-19 restrictions further disrupted women's access to care by limiting the presence of in-person interpreters, reducing access to childcare, and leaving women isolated during delivery. Other social supports that may have been available before the onset of the pandemic were largely unavailable during periods of lockdown in the early months of the pandemic, further isolating women—many of whom were already isolated before COVID-19 during this critical life event. It is important to highlight that the conditions created by the pandemic have amplified existing health inequities to care for resettled Syrian refugee women. These issues may persist in the aftermath of COVID-19 and must be addressed to ensure equitable access to care and support for postnatal women as we move into a post-pandemic environment.

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Appendix A: Confidentiality Agreement for Interpreters

This agreement is between:

Emma Cameron and Dalhousie University
and
[interpreter/transcriptionist/research staff name and affiliation]
for

Project Title: Understanding Access to Postnatal Healthcare for Syrian Refugee Women in Nova Scotia: Barriers, Facilitators, and Need for Services

Summary of job description/service provision:
[describe work expectations here]

I agree to:

1. Keep all the research information shared with me confidential. I will not discuss or share the research information with anyone other than with the Researcher(s) or others identified by the Researcher(s).
2. Keep all research information secure while it is in my possession.
3. Return all research information to the Researcher(s) when I have completed the research tasks or upon request, whichever is earlier.
4. Destroy all research information regarding this research project that is not returnable to the Researcher(s) after consulting with the Researcher(s).
5. Comply with the instructions of the Researcher(s) about requirements to physically and/or electronically secure records (including password protection, file/folder encryption, and/or use of secure electronic transfer of records through file sharing, use of virtual private networks, etc.).
6. Not allow any personally identifiable information to which I have access to be accessible from outside Canada (unless specifically instructed otherwise in writing by the Researcher(s)).
7. Other (specify):

Transcriptionist/Research staff:

_____	_____	_____
(Print Name)	(Signature)	(Date)

I agree to:

1. Provide detailed direction and instruction on my expectations for maintaining the confidentiality of research information so that [transcriptionist/research staff] can comply with the above terms.

2. Provide oversight and support to [transcriptionist/research staff] in ensuring confidentiality is maintained in accordance with the Tri Council Policy Statement Ethical Conduct for Research Involving Humans and consistent with the Dalhousie University Policy on the Ethical Conduct of Research Involving Humans.

Researcher(s):

_____	_____	_____
(Print Name)	(Signature)	(Date)

Appendix B: Email to Community Organizations

Dear [insert community organization name],

My name is Emma Cameron and I am a master's student at Dalhousie University in the School of Health and Human Performance under the supervision of Dr. Lois Jackson. I am writing to ask for your assistance in recruiting participants to help with a research study looking at access to postnatal healthcare services for Syrian newcomer women. Your organization has been selected as you provide services to Syrian women who may recently have had children in Nova Scotia.

For my master's thesis, I am conducting a research project titled, "Understanding Access to Postnatal Healthcare for Syrian Refugee Women in Nova Scotia: Barriers, Facilitators, and Need for Services." The purpose of the study is to understand the experiences of Syrian mothers who have used or tried to use any healthcare services in Halifax and to understand what role any family and friends may play in helping them after they have had their baby. This study has been approved by Dalhousie University's Research Ethics Board.

The study is looking for Syrian women, who have had a baby within the past five years in Nova Scotia, who are at least 6 weeks postpartum, can speak Arabic, have come to Canada as a refugee (not immigrant or refugee claimant), and who live in the Halifax Regional Municipality. Anyone interested in participating will be asked to take part in one 45-60 minute virtual interview. Participants will be asked a series of open-ended questions about their experiences with postnatal healthcare services and supports. The interview will be conducted in Arabic. Participants will be compensated with a $25 gift card.

You or your organization will not be held responsible for the study or any issues that arise as a result of it. Please let us know if your organization would be willing to distribute our recruitment flyer (which will be available in English and Arabic) electronically or in person (COVID-19 restrictions allowing). Or if you would be willing to hang up posters in your centre (COVID-19 restrictions allowing).
If you have any further questions, I would be happy to discuss over email or phone.

Thank you for considering,

Emma Cameron
[email signature]

Appendix C: Email Response for RA
[This was made available in Arabic]

Dear [name],

Thank you for your interest in our study, titled, "Understanding Access to Postnatal Healthcare for Syrian Refugee Women in Nova Scotia: Barriers, Facilitators, and Need for Services." This study is being conducted as part of a master's student's thesis within the Faculty of Health at Dalhousie University. The purpose of the study is to understand the experiences of Syrian mothers who have used or tried to use any healthcare services in Halifax and to understand what role any family and friends may play in helping them after they have had their baby. Anyone interested in participating will be asked to take part in one 45-60 minute interview online or over the phone.

The study is looking for Syrian women, who have had a baby within the past five years in Nova Scotia, are at least 6 weeks postpartum, can speak Arabic, have come to Canada as a refugee (not immigrant or refugee claimant), and who live in the Halifax Regional Municipality. You will be asked a series of open-ended questions about your experiences, particularly about the barriers you encountered when trying to use postnatal health services, if you family and friends helped you with your baby, what services you really like, and what are missing. The lead researcher and an interpreter will be present. Your responses will be audiotaped, and you will need access to a private, quiet space to complete the interview.

Please note that you are under no obligation to partake in this study. Choosing to take part or not take part will have no effect on your ability to access any healthcare services. The research team will do everything possible to make sure any information you share will be kept private and confidential. Your name will not be attached to anything you say, it will be kept completely anonymous.

Please let me know if you are interested in taking part or if you have any questions. We can schedule interviews for any time that is convenient for you and your family, including evenings and weekends. You will be given a $25 gift card for participating. If you are interested, I will send you a reminder email or call two days before the interview.

Best,

[Name]

Appendix D: Telephone Script for Interested Women Calling the Phone
[This was made available in Arabic]

Hello [name],

Thank you for your interest in our study, titled, "Understanding Access to Postnatal Healthcare for Syrian Refugee Women in Nova Scotia: Barriers, Facilitators, and Need for Services." This study is being conducted as part of a master's student's thesis within the Faculty of Health at Dalhousie University. The purpose of the study is to understand the experiences of Syrian mothers who have used or tried to use any healthcare services in Halifax and to understand what role any family and friends may play in helping them after they have had their baby. Anyone interested in participating will be asked to take part in one 45-60 minute interview online or over the phone.

The study is looking for Syrian women, who have had a baby within the past five years in Nova Scotia, are at least 6 weeks postpartum, can speak Arabic, have come to Canada as a refugee (not immigrant or refugee claimant), and who live in the Halifax Regional Municipality. You will be asked a series of open-ended questions about your experiences, particularly about the barriers you encountered when trying to use postnatal health services, if you family and friends helped you with your baby, what services you really like, and what are missing. The lead researcher and an interpreter will be present. Your responses will be audiotaped, and you will need access to a private, quiet space to complete the interview.

Please note that you are under no obligation to partake in this study. Choosing to take part or not take part will have no effect on your ability to access any healthcare services. The research team will do everything possible to make sure any information you share will be kept private and confidential. Your name will not be attached to anything you say, it will be kept completely anonymous.

Please let me know if you are interested in taking part or if you have any questions. We can schedule interviews for any time that is convenient for you and your family, including evenings and weekends. You will be given a $25 gift card for participating.

Does this sound like something you are interested in?
[If no] – No problem at all. Thanks for taking my call.
[If yes] – Wonderful. When are you available to complete the interview?

Would you prefer to complete the interview over the phone or through a video call?

I just need to ask several questions to make sure you are eligible to complete the study:

Are you from Syria?

Did you arrive in Canada as a status refugee?

Do you live in the Halifax Regional Municipality?

Have you had a baby within the past five years?

Are you at least 6 weeks postpartum?

[If all of the above criteria are met]: Can I get your email to send you further information about the study?

I will call you two days before the interview as a reminder.

Thank you for calling!

Appendix E: Recruitment Poster

[This was made available in Arabic]

Looking for New Syrian Mothers to Share their Story

The research study "Understanding Access to Postnatal Healthcare for Syrian Newcomer Women in Nova Scotia: Barriers, Facilitators, and Need for Services" is looking for recent mothers to participate in an online or phone interview.

We are interested in learning about your experiences accessing or trying to access healthcare services for your own health and if any family or friends helped with your new baby. You will receive a $25 gift card for participating. Interviews can be conducted completely in Arabic and will be private and confidential.

To participate, you must:

- Have had a baby in Halifax in the past 5 years
- Be at least 6 weeks postpartum
- Speak Arabic or English
- Have come to Canada from Syria as a refugee
- Have access to a phone, tablet, or computer and a quiet, private space to complete the interview

Participation is completely voluntary. Choosing to participate or not will have no impact on the services provided by any community or health services organization.

If you are interested in participating, contact us in Arabic or English:

[Emma Cameron & Research Assistant name(s), study email & phone number]

Social Sciences and Humanities Research Council of Canada | Conseil de recherches en sciences humaines du Canada | Canada | IWK Foundation | DALHOUSIE UNIVERSITY

Appendix F: Consent Form– Individual Interview

[This was made available in Arabic]

CONSENT FORM

DALHOUSIE UNIVERSITY

Project title: Understanding Access to Postnatal Healthcare for Syrian Refugee Women in Nova Scotia: Barriers, Facilitators, and Need for Services

Lead researcher:
Emma Cameron (BSc)
Masters Student
School of Health and Human Performance
Dalhousie University
emmacameron@dal.ca

Other researchers:
Lois Jackson (PhD)
School of Health and Human Performance
Dalhousie University
Lois.jackson@dal.ca

Megan Aston (PhD)
School of Nursing
Dalhousie University
Megan.Aston@dal.ca

Howard Ramos (PhD)
Department of Sociology and Social Anthropology
Dalhousie University
Howard.Ramos@dal.ca

Introduction

You are invited to take part in a research study that is being conducted by, Emma Cameron, who is a master's student in Health Promotion at Dalhousie University. Choosing whether or not to take part in this research is entirely your choice. There will be no impact on your ability to use any healthcare services if you decide not to participate in the research. The information below tells you about what is involved in the research, what you will be asked to do and about any benefit, risk, inconvenience or discomfort that you might experience.

Please ask as many questions as you like. If you have questions later, please contact Emma Cameron.

Purpose and Outline of the Research Study
The purpose of this study is to examine Syrian newcomer women's experiences accessing or trying to access postnatal healthcare services in Halifax during the first year after childbirth. I am also interested if you had access to any family or friends for support during this time. Specifically, I want to know what helped you access services, what made accessing services challenging or impossible, if you had family/friends available to help you with your new baby, and how they may have helped your health and wellbeing, what healthcare services you really appreciated, and what healthcare services you feel might be missing in Halifax.

Who Can Take Part in the Research Study
You are able to participate in this study if the following applies to you:

- You have had a baby within the past five years in Nova Scotia and are at least six weeks postpartum
- Have come to Canada from Syria as a refugee
- Speak Arabic
- Live in the Halifax Regional Municipality

What You Will Be Asked to Do
If you decide to participate in this research, you will be asked to take part in a one-on-one interview and answer several demographic questions. The interview will last about 45-60 minutes. You will be asked a series of open-ended questions about your experiences after you had a baby. We will ask you specifically about your experiences accessing healthcare services for your own health, if you had family and friends to help you after your baby was born, what health services you really liked, and what might be missing. I will also ask you whether COVID-19 had an impact on your postnatal experiences.

Possible Benefits, Risks and Discomforts
Benefits: Participating in this study may not directly benefit you; however, you will be contributing to research that may help us learn more about how newcomer mothers experience healthcare services and supports in Halifax during the postnatal period. It is possible that results from this study may have the potential to create change to programs or policies in Nova Scotia to improve newcomer women's access to postnatal-related healthcare.

Risks: The risks associated with this study are minimal, it is possible that taking part in this research study could cause some distress or discomfort. However, you do not have to answer any questions that make you feel uncomfortable. You may choose how much information you would like to share with us.

Compensation / Reimbursement
To thank you for your time, you will receive a $25 gift card.

How your information will be protected:
Privacy: The information that you provide to us will be kept confidential. Your identity will be known only to myself and the interpreter. It will not be shared with anyone else. All electronic files will be password protected and kept on a password protected hard drive. The hard drive and any paper materials will be kept in a locked cabinet in the home of the primary investigator. We may describe and share our findings as part of a thesis, presentations, public media, journal articles, report, etc. We will only report deidentified quotes. Demographic information will be presented together for the entire group of participants. This means that you will not be identified in any way in our reports.

Limits to confidentiality: We will not disclose any information about your participation except as required by law. If you inform us about abuse or neglect of a child, we are required by law to contact authorities.

Data retention:
Once the study is over your data will be kept for five years before being physically destroyed. During this time any hard copies of forms or hard drives with electronic files will be kept in a locked cabinet at Dalhousie University. Any documents will be password protected and kept on password protected hard drives.

If You Decide to Stop Participating
You are free to leave the study at any time. If you decide to stop participating in the study, you can decide if you want to withdraw the information you have contributed up to that point, or if you want to allow us to still use that information. You will have up until 2 weeks after your participation to inform the researcher if you want your data to be removed. It will be analyzed after that point.

How to Obtain Results
At the end of this form, you will be asked whether you would like a copy of the final results sent to you when the study is over.

Questions
We are happy to talk with you about any questions or concerns you may have about your participation in this research study. Please contact Emma Cameron at emmacameron@dal.ca, [Research Assistant name(s)] at [study email address], or Lois Jackson at Lois.Jackson@dal.ca at any time with questions, comments, or concerns about the research study. If you have any ethical concerns about your participation in this research, you may also contact Research Ethics, Dalhousie University at (902) 494-3423, or email: ethics@dal.ca (and reference REB file # 2019-5016).

Signature Page

Project title: Understanding Access to Postnatal Healthcare for Syrian Refugee Women in Nova Scotia: Barriers, Facilitators, and Need for Services

Lead researcher:
Emma Cameron (BSc)
Masters Student
School of Health and Human Performance
Dalhousie University
emmacameron@dal.ca
902-456-0575
English only

Research Assistant (or Assistants):
[Contact information of RA(s)]

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I understand that I have been asked to take part in a one-on-one interview and that it will be audio recorded. I understand direct quotes of things I say may be used without identifying me. I agree to take part in this study. My participation is voluntary, and I understand that I am free to withdraw from the study at any time.

If you decide to stop participating at any point in the study, you can decide if you want to withdraw any of the study information you have contributed up to that point, or if you want to allow us to still use that information. You will have up until 2 weeks after your participation to inform the researcher if you want your data to be removed. It will be analyzed after that point.

Do you consent to take part in this one-on-one interview?

Yes___ No___

_____	_____	_____
Name of Researcher	Signature	Date

Following the completion of the study, we will be creating a summary of the results. Would you like to receive a copy of the final results from this study? If so, could you please provide us with your email or mailing address?

Yes___ No___

If yes,

Email or mailing address: _____

_____	_____	_____
Name of Researcher	Signature	Date

Appendix G: Demographics Form

[This was completed orally]

Thank you, [PARTICIPANT NAME] for agreeing to participate in this research project. My name is [RESARCH ASSISTANT NAME]. I am a research assistant on this study and I will be interpreting today. Emma Cameron is the primary researcher on this study. She is a master's student in Health Promotion at Dalhousie University. We are doing this interview today to learn more about your experiences using or trying to use healthcare services during the first year after you had your baby in Halifax. We are specifically interested in your health, not your baby's. These healthcare services can include visiting a family physician, walk-in clinics, the emergency department, or mental health or wellness services (counsellors, psychologists, social workers), or community groups (Veith House, Fairview Family Centre, doula program).

We are also interested in the role any family, friends, or community members may play in helping you after you've had your baby. Any information you share about them will be kept private. Services you receive from them will not be affected in any way.

First, we do want to ask you some basic demographic questions. Please let us know if there are any questions you do not feel comfortable answering. We will skip them.

1. How long ago did you first arrive in Canada? _____

2. Under which government program did you come to Canada? (e.g., government assisted refugee, blended visa office referred refugee, privately sponsored refugee) _____

3. How many children do you have? _____

4. What is your relationship status?

   Married
   Widowed
   Divorced
   Separated
   Other: _____
   Prefer not to answer

5. Yearly family income
   We do not have enough money for basic necessities
   We have enough money for basic necessities but no extras
   We have enough money to buy extra things beyond necessities, at least sometimes
   Prefer not to answer

6. Did any part of your postnatal period (the 12 months after you had your baby) take place during the COVID-19 pandemic?
   Yes
   No

   If yes, what part of your postnatal experience was during the pandemic?

   _____

Appendix H: Interview Guide
[This was made available in Arabic]

Now we are going to ask you some open questions about your experiences with your new baby. Our questions will focus on your use and access to health and wellness services and what support you had from family and friends. We also want to know about the services and supports you found to be most helpful, if there were any services or supports missing, and how being a new Canadian affected your postnatal experiences. Please feel free to speak about whatever you are comfortable sharing. You do not have to answer any questions that make you feel uncomfortable.

[Please note that the same questions may not be used in all individual interviews. Probes used may differ between interviews. Probes are in italics.]

1. Can you tell me a little bit about what it's like to be a mother in Nova Scotia?

2. Did you use any health or wellness services (e.g. family doctor, counsellor, doula) during the first year after giving birth?
    a. If yes, can you tell me about your experience(s)?
    b. How did you decide where to go? What services did you use? Why?
    c. Were there any services or supports you wish you had access or that you tried to access but couldn't?
    d. Did you use any mental health or mental wellness services? Why or why not?
    e. Did you experience any barriers to accessing services?
        i. If so, what were they?
        ii. Transportation? Childcare? Language barrier? Interpreter? Unsure where to go? Sigma?
    f. Were there any things that helped you access services?
        i. Having childcare? Access to interpretation? Family/friends to drive you there? Someone to help you navigate available services?
    g. [If the participant answered yes to COVID-19 demographic question] How did COVID-19 impact your ability to access healthcare services?
        i. Were any services unavailable? Available virtually?

3. Did you have any friends of family nearby after you had your baby?
    a. If yes, can you tell me about your experience(s)?
    b. How were they able to support you?
        i. Childcare? Housework? Transportation? Emotional support? Advice/guidance?
    c. Who did you go to? Why?
    d. Were there any support people you wish you had access to but didn't?
    e. Were you always able to use family and friends to help you?
        i. What challenges did you face?
        ii. Do you have family and friends somewhere else? Were you always able to talk to your partner?

    f. Did they contribute to your physical health or mental health and wellbeing?
    g. [If the participant answered yes to COVID-19 demographic question] How did COVID-19 impact your ability to see family, friends, or your community?
        i. How did this affect you and your mental health and wellbeing? How do you think COVID-19 changed your postnatal experience?

4. What do you think about the services and supports available to newcomer mothers in Halifax?
    a. Of the services or supports you did use, which did you find most valuable?

5. What supports or services could you have used? Did you feel like some services were missing?

6. Does being a newcomer affect your using or not using of services?
    a. Why or why not?

7. Is there anything else you would like to add?

Thank you for participating in our research project. As a thank you for your time, we have a $25 gift card for you. Are you okay if we send an electronic gift card to your email address? If that is not possible, you have the option to provide us with your mailing address and we can mail you a hard copy card.

Email: _____

Mailing address (if requested): _____

[If receiving hard copy card] Please send us an email or give us a quick call once you have received your gift card so we know it was not lost in the mail. Please contact us again in one month if you still have not received it and we will send a replacement.

Appendix I: Lists of Services/Supports

For a mental or physical health emergency, please call 911 or visit your local emergency department.

24-Hour Mental Health Crisis Line

- 902-429-8167
- Toll Free: 1-888-429-8167

Family Doctor or General Practitioner

This is the first step to get referred into the Public Mental Health Service in Nova Scotia. Mental Health services provided by the Public Mental Health Service are free. If you need a family doctor, see below:

- Register for a family doctor: https://needafamilypractice.nshealth.ca/; Call 811
- Newcomer Health Clinic (provides health services for government assisted refugees, privately sponsored refugees, and refugee claimants): 844-762-8080; 902-487-0501

Private Mental Healthcare Practitioners

These services are typically provided at a cost. With a referral and pre-approval from a family doctor, the Interim Federal Health Plan may cover the fees. If you or a spouse has health insurance through an employer, you may have coverage through there.

- Social Worker Registry: https://onlineservice.nscsw.org/webs/nscsw/register/
- Psychologist Directory : https://apns.ca/find-a-psychologist/
- Counselling Therapist : https://nscct.ca/find-counselling-therapist/

Veith House

Veith House offers counselling services provided by a social worker, with a focus on trauma informed empowerment.

- https://www.veithhouse.com/counselling
- (902) 453-4320
- veithhouse@hfx.eastlink.ca

Halifax Refuge Clinic

In-house volunteer counselling services.

- http://halifaxrefugeeclinic.org/?page_id=30
- (902) 422-6736
- halifaxrefugeeclinic@gmail.com

Fairview Family Centre

On-site social worker and crisis intervention services.

- https://www.ffcns.ca/about

- (902) 443-9569
- info@FFCNS.ca

COVID-19
If you think you should get tested for COVID-19 you will need to call 811 to determine if there is a need for an in-person assessment. Visit https://novascotia.ca/coronavirus/ for more information.

Appendix J: Social Media Post

Join our research study! We are looking for Syrian newcomer moms to talk to us about their experiences using health services & social supports after having a baby & what services are missing & needed. Complete a 60-minute interview in Arabic or English and receive a $25 gift card.

Appendix K: Reminder Email

Dear [PARTICIPANT NAME],

Please note that you are scheduled to complete an interview on [DATE] at [TIME] to talk about your experiences after having a baby in Halifax. See below for call information:

[Teams link or conference call line]

If you can no longer attend and need to reschedule, please contact the research team at [email] or by calling [phone number].

Sincerely,

Email signature

Appendix L: Ethics Approval

Health Sciences Research Ethics Board
Letter of Approval

March 04, 2020

Emma Cameron
Health\School of Health and Human Performance

Dear Emma,

REB #: 2019-5016
Project Title: Understanding Access to Postnatal Healthcare for Syrian Refugee Women in Nova Scotia: Barriers, Facilitators, and Need for Services

Effective Date: March 04, 2020
Expiry Date: March 04, 2021

The Health Sciences Research Ethics Board has reviewed your application for research involving humans and found the proposed research to be in accordance with the Tri-Council Policy Statement on *Ethical Conduct for Research Involving Humans*. This approval will be in effect for 12 months as indicated above. This approval is subject to the conditions listed below which constitute your on-going responsibilities with respect to the ethical conduct of this research.

Sincerely,

Dr. Lori Weeks, Chair

Social Sciences & Humanities Research Ethics Board
Amendment Approval

August 11, 2020

Emma Cameron
Health\School of Health and Human Performance

Dear Emma,

REB #: 2019-5016
Project Title: Understanding Access to Postnatal Healthcare for Syrian Refugee Women in Nova Scotia: Barriers, Facilitators, and Need for Services

The Social Sciences & Humanities Research Ethics Board has reviewed your amendment request and has approved this amendment request effective today, August 11, 2020.

Effective March 16, 2020: Notwithstanding this approval, any research conducted during the COVID-19 public health emergency must comply with federal and provincial public health advice as well as directives issued by Dalhousie University (or other facilities where the research will occur) regarding preventing the spread of COVID-19.

Sincerely,

Dr. Karen Foster, Chair
DALHOUSIE UNIVERSITY
Research Services