

---

Electronic Thesis and Dissertation Repository

---

4-9-2021 10:00 AM

## Syrian Refugee Women's Experiences with the Ontario Health Care System: A Critical Ethnography Study

Areej Al-Hamad, *The University of Western Ontario*

Supervisor: Cheryl Forchuk, *The University of Western Ontario*

A thesis submitted in partial fulfillment of the requirements for the Doctor of Philosophy degree in Nursing

© Areej Al-Hamad 2021

Follow this and additional works at: <https://ir.lib.uwo.ca/etd>



Part of the [Psychiatric and Mental Health Nursing Commons](#), and the [Public Health and Community Nursing Commons](#)

---

### Recommended Citation

Al-Hamad, Areej, "Syrian Refugee Women's Experiences with the Ontario Health Care System: A Critical Ethnography Study" (2021). *Electronic Thesis and Dissertation Repository*. 7804.  
<https://ir.lib.uwo.ca/etd/7804>

This Dissertation/Thesis is brought to you for free and open access by Scholarship@Western. It has been accepted for inclusion in Electronic Thesis and Dissertation Repository by an authorized administrator of Scholarship@Western. For more information, please contact [wlsadmin@uwo.ca](mailto:wlsadmin@uwo.ca).

## Abstract

There has been growing interest in migration and refugee research; the vulnerability of Syrian refugee women and how they adapt to their host communities. However, there is limited evidence regarding the pre- and post-migration trauma and its impacts on the health of Syrian refugee women in the Canadian context. The purposes of this critical ethnography using intersectional perspectives were: (1) to explore and describe Syrian refugee women's experiences and meanings of pre- and post-migration trauma and its impact on their health in the context of repeated displacement and migration from their homes and families; (2) to critically examine how the intersection of gender, trauma, and contextual factors (e.g., social and cultural norms, policies, and economic factors) of Syrian refugee women shapes their everyday lives and health; and (3) to understand gender roles, dynamics, and cultural and contextual factors among Syrian refugee women across different periods, starting from the civil war period to the post-migration period in Canada. Data collection occurred over six months through online, synchronous, and in-depth individual interviews. Data drew upon a sample of 25 Syrian refugee women in southwestern Ontario. This research used intersectionality as a theoretical lens, where trauma, empowerment, marginalization, and forced migration concepts were thoroughly integrated into the dissertation. Data analysis, an iterative process, was used to identify and describe relevant themes, relationships, and power relations through the participants' representations of their lives and experiences. Overall, the findings suggest that previous trauma, sociocultural factors, and the conceptualizations of Syrian refugee women's health and health-care system must be recognized. This recognition may assist in developing culturally informed and gender-

sensitive interventions for this population in post-migration contexts. In addition, there is an urgent need to find creative solutions and strategies for the pressing issues of the lengthy wait time in the emergency department, for specialist appointments, and the cost of dental care to meet Syrian refugee women's physical and mental health needs. Finally, nurses in practice and research need to be actively involved in the collaborative and creative strategies that are necessary for change in the current health-care system and services provided to Syrian refugees.

*Keywords:* refugee women, migration, trauma, gender, intersectionality, critical ethnography

## Summary for Lay Audience

This dissertation aims at exploring and describing the pre- and post-migration experiences of Syrian refugee women in Ontario, Canada, and the impacts on their physical and mental health. This study examines how the intersection of gender, trauma, and contextual factors (e.g., social and cultural norms, policies, and economic factors) of Syrian refugee women shapes their everyday lives and health. The study also explores gender roles, dynamics, and different contextual factors among Syrian refugee women across different periods, starting from the civil war period to Canada's post-migration period. Overall, the findings suggest that previous trauma, sociocultural factors, and the Syrian refugee women's health are essential to modify current health practices for this population in a Canadian context. In addition, there is an urgent need to find creative health-care models and strategies to meet Syrian refugee women's physical and mental health needs.

## Co-Authorship Statement

Dr. Areej Al-Hamad was the primary researcher and completed the initial analysis and drafting of the articles under the supervision of Dr. Cheryl Forchuk, Dr. Abe Oudshoorn, and Dr. Gerald Patrick McKinley. Each co-author provided important intellectual insights and contributions to the study design, interpretation, analysis, and drafting of the three articles for publications resulting from this dissertation.

## Dedication

I thank the Almighty God for observing and guiding me through this journey. This accomplishment is by his special grace. I dedicate this study to my family, particularly my parents, for their constant support and belief in my potential. To my husband Yasin, I appreciate all the love, care, encouragement, constant support, and understanding you demonstrated throughout this journey. This achievement would not have been possible without you, and I would never have completed; and I am deeply indebted to you, and this degree belongs to you as much as it does to me. I would like to thank my brothers and sisters, and most importantly, my siblings Lujain, Yara, to the soul of my angel Rahaf, Mohammad, and Warrd for their both tangible and intangible support. I love you to the moon and back.

## Acknowledgments

I would like to acknowledge the millions of Syrian refugee women, men, and children who, indeed, have been repeatedly forced to displace and migrate to different countries with no choice but to leave their families and home. I would like to thank the women of this study who gave of themselves when they were facing their challenges and struggles. I sincerely thank the Syrian refugee woman I met and those who agreed to participate in this research. I am proud and impressed by their strength, resilience, creativity, and sense of responsibility under challenging circumstances and their ability to navigate the available resources to promote their health while nurturing themselves and others.

Special thanks and appreciation to my supervisor, Dr. Cheryl Forchuk, for her excellent guidance and direction throughout the doctoral process. I could not have achieved this milestone without your assistance. I am indebted to my supervisor, Dr. Cheryl Forchuk, for her expertise and constant guidance, her endless patience and support, and for teaching me how to be a critical researcher. Honestly, I have been very fortunate to have you as my supervisor with your phenomenal academic expertise, your calm insightful manner, and your “down-to-earth” approach. I also wish to thank my committee members, Dr. Abe Oudshoorn and Dr. Gerald Patrick McKinley. All the feedback you provided significantly and immensely improved my study and knowledge. Moreover, your thoughtful and rigorous comments strengthened my research and writing at every step in my Ph.D. journey.

Thank you to all my friends for their encouragement and support. Lastly, and most importantly, I would like to thank and acknowledge all those who volunteer and work in communities and health care organizations, most often with scarce resources, to learn about the lives of Syrian refugees while they are here in Canada. I hope this work can be meaningful for all women and workers to advocate for meaningful change in our community, and I will do my best to ensure that the findings of this study can help improve the lives of other refugees.



# Table of Content

Abstract .....	ii
Summary for Lay Audience.....	iv
Co-Authorship Statement.....	v
Dedication .....	vi
Acknowledgments.....	vii
Table of Content .....	ix
List of Tables .....	xii
List of Figures .....	xiii
List of Appendices .....	xiv
Chapter 1:.....	1
Syrian Refugee Women's Experiences with the Ontario Health Care System: A Critical Ethnography Study.....	1
1.1. Introduction .....	1
1.2. Background and Significance .....	3
1.3. Research Purpose and Questions .....	9
1.4. Research Approach.....	10
1.5. Method .....	12
1.6. Researcher Positionality .....	16
1.7. Definition of Terms .....	18
1.8. Integrated Thesis Article Format .....	19
References .....	23
Chapter 2:.....	32
Health Seeking Behaviors among Syrian Refugee Women: A Scoping Review .....	32
2.1. Introduction .....	32
2.2. Review question/objective .....	33
2.3. Phenomena of interest.....	34
2.4. Methods .....	34
2.4.1. Stage 1: Identifying the research question .....	35
2.4.2. Stage 2: Identifying the relevant studies .....	35

2.4.3. Stage 3: Selecting studies.....	37
2.4.4. Stage 4: Charting the data .....	39
2.4.5. Stage 5: Collating, summarizing and reporting the results .....	39
2.5. Results.....	47
2.5.1. Accessibility of health care services: .....	47
2.5.2. Awareness of health care needs and available health care services.....	49
2.6. Discussion.....	51
2.7. Conclusion.....	53
References.....	54
Chapter 3:.....	60
The Potential of Merging Intersectionality and Critical Ethnography for Advancing Refugee Women’s Health Research Introduction.....	60
3.1. Introduction .....	60
3.2. Critical Ethnography and Intersectionality in Refugee Women’s Research .....	63
3.3. Mapping the Terrain of Emancipation and Empowerment.....	63
3.4. Online Synchronous Interviewing: A method for change in the time of COVID- 19 .....	71
3.5. Refugee Women’s Health and Nursing Research .....	75
3.6. Discussion.....	79
3.7. Conclusion.....	82
References.....	84
Chapter 4:.....	92
Listening to the Voices of Syrian Refugee Women in Canada: A Critical Insight into the Journey from Trauma to Adaptation.....	92
4.1. Background .....	92
4.1.1. Design .....	95
4.1.2. Theoretical Framework .....	96
4.1.3. Setting and Participants.....	96
4.1.4. Trust building with participants .....	97
4.1.5. Data Collection .....	99
4.1.6. Data Analysis .....	100
4.2. Findings .....	102
4.2.1. Compounded trauma and hardship .....	103

4.2.2. Fear and worries.....	106
4.2.3. Vulnerabilities and intrusions of dignity.....	110
4.2.4. Perception of healthcare.....	113
4.3. Reflections and Discussion .....	118
4.3.1. Strengths and Limitations of the Study.....	121
4.4. Conclusion.....	122
References.....	124
Chapter 5:.....	128
Integrated summary and its implications .....	128
5.1. Discussion.....	128
5.2. Key Findings .....	129
5.2.1. Health Seeking Behaviors of Syrian Refugee Women .....	129
5.2.2. Blended Approach of Critical Ethnography and Intersectionality.....	129
5.2.3. Syrian Refugee Women’s Journeys from Trauma to Adaptation.....	130
5.2.4. Compounded Traumas and Hardship.....	131
5.2.5. Fear and Worries.....	132
5.2.6. Vulnerabilities and Intrusions of Dignity .....	133
5.2.7. Perception of Healthcare.....	134
5.3. Implications .....	137
5.3.1. Implications for Nursing Practice.....	137
5.3.2. Implications for Nursing Education .....	140
5.3.3. Implications for Future Research .....	141
5.4. Conclusions .....	143
References.....	145
Appendices.....	150
Curriculum Vitae .....	168

## List of Tables

Table 2.1: Search terms .....	36
Table 2.2: Selected Scoping Review Items .....	40

## List of Figures

Figure 2.1: Selection flow diagram.....	38
Figure 4.1: The Key Themes and Related Sub-Themes .....	103

## List of Appendices

Appendix A: Ethics Approval Letter.....	150
Appendix B: Letter of Information (Arabic) .....	151
Appendix C: Letter of Information (English) .....	155
Appendix D: Interview Guide (Arabic) .....	160
Appendix E: Interview Guide (English) .....	163
Appendix F: Recruitment Flayer (Arabic) .....	166
Appendix G: Recruitment Flayer (English).....	167

# Chapter 1:

## Syrian Refugee Women's Experiences with the Ontario Health Care System: A Critical Ethnography Study

### 1.1. Introduction

The Syrian crisis has been described as the biggest humanitarian and refugee crisis of our time since the end of World War II (United Nations High Commissioner for Refugees, 2018, p. 1). About six million Syrians, three-quarters of whom are women and children, have been displaced around the world, mainly in Turkey, Lebanon, Jordan, Europe, and North America (Alwan et al., 2020; Keung, 2018; Senthana et al., 2020; Yayan et al., 2020). This number of Syrian refugees creates a significant impact on the socioeconomic and health-care systems of the host countries, of which Canada is one such country (Alwan et al., 2020; Keung, 2018; Senthana et al., 2020; Yayan et al., 2020). Such an influx of Syrian refugees during a short period marks a remarkable shift in Canada's refugee intake (Cullen & Walton-Roberts, 2019). A refugee is defined as “someone who has been forced to flee his or her country because of persecution, war, or violence. Refugees have a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group” (United Nations High Commissioner for Refugees, 2018, p. 1). Many of the world's refugees find themselves feeling hopeless and trapped in a different country with no hope of finding a solution by repatriation, local integration, or resettlement (Anteh, 2018; Crisp, 2017; Knappert et al., 2018).

Trauma, migration, and displacement significantly impact individual and community well-being (Cho et al., 2017; Keung, 2018; Myers, November 9, 2016). In Canada, more than 50,000 Syrian refugees arrived over the past three years through sponsorships by federal government and private community groups (Keung, 2018). The federal government is still processing applications for around 20,000 more sponsored refugees, including 15,927 from private sponsorship groups and 4,006 under government assistance (Hansen et al., 2016; Keung, 2018). According to Immigration, Refugees, and Citizenship Canada, around 63,938 Syrian refugees arrived in Canada between 2015 and 2019 (Britten, 2019). Between half and three-quarters of all forcibly displaced Syrian refugees are women and their children (Drolet et al., 2017), giving rise to a unique set of challenges for both refugees and the host country. Previous exposure to trauma and violence as well as the vulnerability of specific groups such as women and children entail unique challenges (Agic et al., 2016; Anteh, 2018; Gkiouleka et al., 2018; Knappert et al., 2018).

In general, Syrian refugees have faced catastrophic war crimes, human rights violations, poverty, forced migration, and repeated displacement, with potential physical and mental health implications (Acarturk et al., 2015; Drolet et al., 2017; El-Khani et al., 2017; Hansen et al., 2016). Syrian refugee women, particularly those with children, are a highly vulnerable population in Canada (Cho et al., 2017), with severe implications for their health, for instance, their access to health services, living conditions, and quality of life. Syrian refugees, specifically women, maybe conceptualized as either victims lacking in capacity or victims of circumstances beyond their control (Cho et al., 2017; Myers, November 9, 2016). These circumstances include adverse external forces, being a female,



and the structure of the hosting country's social institutions and norms (Ahmed et al., 2017). Moreover, Syrian refugee women may experience physical and mental health problems prompted by previous trauma, violence, and repeated displacement (Ahmed et al., 2017; Chung et al., 2017; El-Khani et al., 2017; Gaebel et al., 2016; Jefee-Bahloul et al., 2016); these are compounded by various stressors, including unstable income and housing, loss of family, prolonged grief, settlement and integration challenges, language barriers, social isolation, discrimination, powerlessness, and uncertainty about the future (Acarturk et al., 2015; Agic et al., 2016; El-Khani et al., 2017; Hadfield et al., 2017).

## 1.2. Background and Significance

Exploring Syrian refugee women's experiences in relation to migration and health care might enhance the health care that these women receive; this could be achieved by understanding the experiences of those who work in the host health-care system and, consequently, promoting these women's physical and mental health. Thus, understanding Syrian refugee women's experiences of the Canadian health-care system is of particular importance, as it is within these experiences that they will encounter positive or negative attitudes. The complexity of how quickly and how often these attitudes can change over time calls for the need to include the refugees' experiences within the scope of practice of health services.

It is worth noting that striving to improve Syrian refugee women's mental health is not just a one-way street and one without rewards to the host country. Refugees participate in economic growth and bring with them considerable positive human and social capital that might benefit Canadian society (Drolet et al., 2017; Duncan, 2015; Hilado & Lundy, 2017). In particular, Syrian refugees are relatively skilled workers who

might help Canada's growth and reduce the country's struggles with economic stagnation (Tencer, 2015). Canadian authorities are committed to adopting an approach to resettlement and integration that prioritizes refugees' needs related to gender-related trauma and violence. The selected approach should address specific health challenges on arriving in Canada to provide diversified care. At the broader systems level, policymakers need to recognize the impacts of the complex intersection among the biophysical, socioeconomic, and cultural conditions on the overall health conditions of these women, who are themselves influenced by policy choices and respond to changes in policy frameworks (Agić et al., 2016; Crosby, 2013; de Bocanegra et al., 2017). Policymakers also need to realize that these circumstances do not exist in isolation; hence, providing health care to Syrian refugee women must be addressed concurrently along with the related issues of migration and previous exposure to violence.

In terms of existing solutions, many researchers and policymakers are adding their voices to calls to improve and promote the physical and mental health of the Syrian refugee (Agić et al., 2016; Ahmed et al., 2017; Butler et al., 2011; Drolet et al., 2017). The United Nations High Commissioner for Refugees (UNHCR) has called for urgent health-care guidelines for the Syrian refugee population due to their increased medical needs. This call makes intuitive sense, as comprehensive health and social programs would potentially assist all Syrian refugees regardless of the current social, political, and structural challenges they might be facing. To yield fruitful directions in providing total holistic support to these refugees, federal programs need to be coordinated and complemented provincially. For example, in Ontario, the Central Local Health Integration Network sponsors "Across Boundaries," which provides culturally specific

and gender-sensitive mental health services (Cho et al., 2017). Such an organization can stimulate healthy discussions and act as a model for stakeholders and policymakers regarding planning for relevant and gender-specific services to address the mental health needs of the target population (Ontario Ministry of Health and Long-Term Care, 2018). Regional coordination is essential, because not all provinces pay for the same list of medical services and health-related benefits (Taylor, 2013).

Determining the scope and diversity of Syrian refugee women's mental health concerns is challenging, requiring massive efforts both nationally and globally. There is a need to determine the scope of the problem by exploring the current available initiatives, services, and programs dedicated to assisting these women. As such, Canada has committed to \$653.5 million in international humanitarian assistance funding in response to the Syrian crisis (Tyyskä et al., 2017). From a solution-oriented perspective, it is pivotal to understand how the intersection of gender, violence, culture, and the political and economic conditions of Syrian refugee women, on the one hand, and the structure and the operation of Ontario's health-care system, on the other, meet their health-care needs. It is worth noting that Syrian refugee women, as trauma survivors, require a delicate and gender-sensitive system of care since some current health-care practices might be unfamiliar to many refugee women and their needs.

Providing trauma-informed care for Syrian refugee women is not a treatment plan; rather, it is an approach that calls for the tenet of "*primum non nocere*" or "first, do no harm," while taking into consideration the symptoms, occasions, and context of previous trauma. Interestingly, some scholars have described the trauma and violence-informed care as a paradigm shift, representing a change in the ways of providing care by

understanding clients and the context of their presenting problems or complaints (Agić et al., 2016; Alisić & Letschert, 2016; Gaebel et al., 2016; Hansen & Huston, 2016). Syrian refugee women's experiences of pre- and post-migration trauma can compromise their health and well-being (Chung et al., 2017; Drolet et al., 2017; Kazour et al., 2017). Significantly, the health impacts of trauma and migration have to do with more than physical and mental illness of the refugees and include the social determinants of health, such as income and employment/working conditions. In addition, the experiences of trauma could affect healthy child development, health services utilization, and the coping skills adopted by these women. Sadly, during migration, much can occur that might exacerbate the existing health concerns of the refugees or the development of new ones. The pathway of how the experiences of multiple sources of trauma including the war they endured prior to the migration as well as the trauma of the migration affects women's health is still vague and under investigation; however, some scholars have described possible mechanisms, including (1) neuroendocrine, inflammatory, and epigenetic changes that affect the brain and body; (2) psychological and social factors such as constant anxiety and stigma; and (3) maladaptive and unhealthy coping behaviors (Bowes & Jaffee, 2013).

Addressing Syrian refugee women's experiences of trauma and violence is a pressing need and requires strategies for prevention. Helping this population cope and heal from migration-related trauma and its consequences will create healthier and less traumatized families and communities. In addition, exploring Syrian refugee women's experiences of trauma and violence is a powerful opportunity that has the potential to transform the experiences and efficacy of primary care for both providers and trauma

survivors. This argument echoes what Huckshorn & LeBel (2013) and Machtinger et al. (2015) have concluded in terms of moving from traditional treatment to informed healing.

On the other hand, neglecting the women's histories of trauma can trigger new trauma symptoms or responses due to the resemblance to occasions and circumstances of past experiences of trauma (Duncan, 2015). This negligence can result in (1) a failure to understand the women's current problems and their connection with previous trauma exposure; (2) a failure to treat or capture the triggering events or minimize the consequences of previous trauma; and/or (3) re-traumatization of women by adopting standard clinical practices that may hamper their progress, affect openness to treatment, or result in their withdrawal from therapy altogether (Butler et al., 2011; Hocking et al., 2015; Huckshorn & LeBel, 2013; Mollica et al., 2015). These assertions fit with the findings of Butler et al. (2011), that ignoring previous trauma can initiate new trauma responses due to similar occasions such as flashbacks, depression, withdrawal, and aggression. Therefore, delivering traditional treatment plans for Syrian refugee women within the current norms of the available structures might result in undermining the women's willingness to share their underlying symptoms of trauma, the building of trust in the provider, and eventually affect their treatment progress.

In essence, the aim should be to build a system that is trauma- and violence-informed, which, according to Butler et al. (2011), requires multilevel changes. Such a system particularly requires that "all aspects of services and programs be organized with an awareness of the pervasiveness of trauma, its impact, and its self-perpetuating nature, as well as familiarity with the multiple and complex paths to healing and recovery."

(Butler et al., 2011, p. 181) This also echoes Elliott et al. (2005)'s conclusion that "to provide trauma-informed services, all staff of an organization, from the receptionist to the direct care workers to the board of directors, must understand how violence impacts the lives of the people being served, so that every interaction is consistent with the recovery process and reduces the possibility of re-traumatization." (Elliott et al., 2005, p. 462) Thus, health-care providers who work with Syrian refugee women need to evolve and consider women's migration history and trauma to meet their needs better.

Research into the needs of Syrian refugee women, if and how they have been met, and their experiences, in general, is required to evaluate current approaches and identify the need for change and/or improvement. Many studies exist that address refugees' challenges in accessing and utilizing health-care services in Canada (Cho et al., 2017; Guruge et al., 2018; Oda et al., 2017); however, there is a paucity of research on how their experiences of pre-and post-migration trauma and violence impact their health and their navigation of the available health resources and services. Further, more research is needed to explore how the intersection of gender, trauma, culture, and political and economic conditions of the women shapes their everyday lives and health, the strategies they are currently using to promote their own physical and mental health, as well as the availability and effectiveness of the present and potential models of care in place for these women in Ontario.

As a population, Syrian refugee women have gender-specific health-care experiences and require a multiplicity of health interventions. These women have repeatedly reported violence, sexual abuse, or fear of rape before fleeing the country and coming to Canada (Cho et al., 2017; Myers, November 9, 2016). They are an increasingly

vulnerable population with a constant and growing sense of insecurity (Myers, November 9, 2016), which, compounded with feelings of isolation and desperation, leads to mental health issues such as post-traumatic stress syndrome, uncertainty about their future, despair, anxiety, and suicidal thoughts (Abu-rass, 2018; Cho et al., 2017; Myers, November 9, 2016). Some may have been involved in “survival sex” during their migration between countries.

In summary, the points of view of refugees, in general, and Syrian refugee women, in particular, are seldom incorporated in research, planning for service provision, and policy design (Abu-rass, 2018). Thus, this study aims at providing an opportunity for the marginalized and vulnerable refugee women’s voices to be heard by improving services that are meant to serve them. It also attempts to fill the gap in the current understanding of Syrian refugee women’s pre- and post-migration trauma experiences, forced migration, displacement, and connection to the health-care system as well as their physical and mental health outcomes in Ontario. This study also attempts to understand the impact of migration and trauma on Syrian refugee women’s roles, responsibilities, gender dynamics, and interaction with Ontario’s health-care system to improve their health.

### 1.3. Research Purpose and Questions

The purpose of this study was to explore and describe the pre- and post-migration experiences of Syrian refugee women in Ontario and the impact on their physical and mental health. This study critically examines how the intersection of gender, trauma, and violence; political and economic conditions of Syrian refugee women shape their everyday lives and health. The study also investigates the strategies and practices by

which Syrian refugee women are currently addressing their health-care needs and the models of care they suggest, thereby meeting their physical and mental health needs. In order to achieve this purpose, the following research questions were used to guide the study:

1. How does the pre-and post-migration trauma impact Syrian refugee women's experiences in Ontario with regard to forced migration, repeated displacement, settlement and integration, and their physical and mental health?
2. How does the intersection of gender, trauma and violence, culture, settlement, and political and economic conditions of Syrian refugee women shape their everyday lives and health?
3. What strategies are Syrian refugee women currently using to promote their physical and mental health?
4. What are the proposed models of care to meet the physical and mental health care needs as suggested by Syrian refugee women?

## 1.4. Research Approach

This study used intersectionality as a theoretical framework to promote the robustness of the study findings. Intersectionality is one of the promising approaches to analyzing unequal social power structures and processes that produce unequal health outcomes (Bowleg, 2012; Collins, 2000; Crenshaw, 1989; Hankivsky et al., 2014). The central core of intersectionality is that it moves beyond examining individual factors such as gender and race to focus on the interactions and relationships between such factors across multiple society levels (Collins, 2000; Crenshaw, 1989). This interaction explains



how health is shaped across various population groups, including the one under consideration. The intersectionality theory suggests that an individual comprises multiple identities that interact on simultaneous levels and that contribute to systemic oppression or social inequality (Crenshaw, 1989).

Further, individuals' social and cultural identities, such as gender, class, ethnicity, sexual orientation, and religion, are seen as interlocking rather than additive categories (Crenshaw, 1989). The black feminist sociologist, Patricia Hill Collins, stated that "intersectionality provides an interpretive framework for thinking through how intersections of race and class, or race and gender, or sexuality and class, for example, shape any group's experience across specific social contexts" (Collins, 2000, p. 43). A similar approach can be applied to Syrian refugees' experiences of the health-care system.

An intersectional orientation meets two crucial objectives. First, it emphasizes the differences within population groups that are often claimed as being relatively homogenous, such as women, migrants, Indigenous peoples, and visible minorities (Knappert et al., 2018). For instance, Syrian refugee women from a lower socioeconomic group may find it more difficult to access care than those from a higher class, even in a host country. Second, it clarifies that individual and group inequities are shaped and informed by interactions between multiple levels of power (Kapilashrami & Hankivsky, 2018), such as institutional structures, structures of discrimination and processes of marginalization, globalization, and neoliberalism. Indeed, an intersectionality-informed analysis allows examining various factors affecting Syrian refugee women's experiences of trauma and violence both systematically and simultaneously. Further, it helps bring

attention to the synergistic effects of multiple risk factors, vulnerabilities, and experiences. Thus, Syrian refugee women's health is informed by the intersection of multiple levels of power structures and discrimination structures in the host country.

## 1.5. Method

This research utilized critical ethnography as a methodology to assist with a deep understanding of the perceptions of Syrian refugee women in elaborating a critical analysis designed to show how these perceptions relate to broader social structures of oppression and through a cultural lens. The methodology was informed by Carspecken's critical ethnography theory and it attempted to move beyond describing "what is going on" to examining the "why it is going on" (Carspecken, 1996). Palmer and Caldas (2017) have argued that critical ethnography is a qualitative approach that is utilized to critique hegemony, oppression, and unequal social power relations to achieve social change. The approach critiques the structures of marginalized communities' power differentials and inequities and allows for ongoing dialogue with those suffering from marginalization and oppression (Palmer & Caldas, 2017). Critical ethnography applies ethnography to shared experiences within cultures or subcultures, in specific settings rather than throughout entire communities (Carspecken, 1996; Carspecken & Walford, 2001; Hammersley & Atkinson, 2007). This method helps the researcher situate what is seen in the field in the broader political context to figure out the links between everyday interactions or experiences and broader cultural formations (Morse, 2016; Savage, 2000, 2006).

Moreover, this method offers a holistic approach to exploring the links between the different kinds of power and evidence that underpin clinical practice (Carspecken & Walford, 2001; McCabe & Holmes, 2014; Mills, 2007). Critical ethnography proved its

potential and was particularly suited to this study since it is concerned with social inequities, and its ultimate goals are directed toward positive social change through legislative reform or policy formation. Critical ethnography helps us engage in cultural critique; it examines the broader social, political, historical, and economic differences that influence Syrian refugee women's situations and, thus, shapes their trauma and migration experiences and the impact of these experiences on their health and well-being.

This study draws on a critical ethnographic exploration of the 25 Syrian refugee women's journeys from the beginning of the civil war to Canada today. Purposive and snowball sampling were utilized to recruit 25 Syrian refugee women from urban communities in Southern Ontario. Recruitment was continued until data saturation was reached, with no new themes being identified (Madison, 2019). Interviews were conducted at the participant's residence and according to the participant's preference. Due to the COVID-19 pandemic, an online synchronous interviewing (OSI) approach through a secure academic version of "Zoom platform" was utilized to conduct individual, in-depth, open-ended semi-structured interviews in Arabic that lasted between 1 and 2 hours.

The researcher is a competent bilingual scholar who translated the interviews from Arabic to English. There were no challenges in capturing contextual or connotative values during the translation. The OSI, albeit limited, allows for some participant observation and a broad general examination of the physical architecture of the participants' residences and their social relations with their children within the camera's scope during the interview. Participant observation was noted with respectful, nonjudgmental, and nonthreatening engagement. This engagement helps us gain better

insights into participants' perceptions of themselves and others and the meanings that they attach to their actions, perceptions, thoughts, and behaviors. Participant observation in ethnographic studies offers the researcher a chance to be with the participants in their lives and learn how they do things, their worldviews, perceptions, and experiences with a minimal disturbance of their everyday routines (Lederman, 2016).

Observations and reflections on what went on during and after the interaction with the participants were documented through regular note-taking. The participant–observation stage involves reflection on the participants' responses, participants' ways of communication with their children, body language, eye contact, nonverbal communication, and interpretation of their voices to enrich the meaning. The first author immersed herself in the participants' contexts for around six months to develop insights on how sociocultural processes emerge and change. Indeed, ethnographic observation and reflection provide a method to facilitate the description and reflection of people's interactive relationships (Morse, 2016; Zulfikar, 2014).

Each interview was transcribed verbatim, and the researcher ensured immersion in the data to get a sense of the whole text and dataset. Data were analyzed, as they were obtained by using thematic analysis and intersectionality tenets to understand the cultural norms and interlocking identities of the participants. Intersectionality supports this process by enabling the researcher to focus on the multiple identities of Syrian refugee women. These influences through language, gender, culture, ethnicity, and refugee status were used to examine their experiences of pre- and post-migration trauma and health and to understand that links exist between gender, social and political processes, minority status, and social actions. The “meaning context” was used as the unit of analysis for

coding and description (Braun & Clarke, 2006). Analysis of the data began with describing the cultural context or site where participants were interviewed; identifying social interactions, routines, roles, and power relations (Carspecken, 1996). Member checking was conducted with five participants, providing feedback about emerging interpretations; obtaining their reactions; and verifying that the analyses reflected the participants' experiences. NVIVO 11 software was used as a qualitative data management and analysis program. Data analysis started during data collection, coding was continued to develop analytic categories, and major themes were formulated to understand the participants' cultural norms and interlocking identities.

Triangulation is a key in an ethnography study and it assists in producing another set of comparative, dialogical data based on verbal interaction with participants (Carspecken, 1996; Hammersley & Atkinson, 2007). Two triangulation strategies were adopted in this study: first, data triangulation by using multiple data sources to validate conclusions such as interviewing women in time, space, homes, backyards, and cars; second, method triangulation by using multiple methods of data collection (e.g., interviews, participants, and context observation). Moreover, informal dialogue was also conducted with participants to obtain the perspectives of their experiences of migration and trauma. The initial findings were compared with emerging codes in subsequent stages of data collection. This progressive comparison facilitates capturing cultural themes that might have meaning during interactions, such as interaction patterns, social practice, power relations, and roles (Carspecken, 1996). Finally, we linked the analyzed data to broader sociopolitical aspects by developing a findings matrix (see Figure 4.1) to

capture Syrian refugee women's trauma, migration experiences, and their behavioral routines and practices within Ontario's health-care system.

## 1.6. The Researcher's Positionality

Throughout the research, particularly while conducting interviews, similar to most of the participants, I remained conscious and aware of my own positionality as a Muslim immigrant woman. The insider status derives from belonging to the Muslim community and being a woman who speaks the same language (Arabic), living in Canada for the past six years. On the other hand, the outsider status comes from having experienced different ways of being an immigrant woman and having lived mostly in different settings and circumstances from the participants. While I have tried to remain impartial and have taken the back seat during the interviews, my own experiences of being an immigrant woman and my own perspectives on struggle and hardship may have come through in the research, particularly during the informal discussions with the participants.

Being an insider researcher enabled me to gain the participants' trust and also to interact with them, as well as to acquire some insights on the participants' backgrounds and feelings. Moreover, I had gained some insights about the study participants during my previous work with Syrian refugee women and their settlement in London, Ontario. I worked as a volunteer helping Syrian refugees during their transition and settlement through interpretation and by offering different settlement-related clarifications. In this manner, being an insider researcher helps in the construction of questions that could be effective in encouraging participants' responses during the interviews, especially since I speak their language. In fact, my insider status may also confer certain disadvantages,

such as being influenced to make assumptions about participants, using my own personal characteristics and background as a yardstick for viewing participants.

Being an immigrant woman from Jordan with a PhD in rural health, I consider myself an outsider, whereas participants who were born and/or grew up in Muslim families lived in Syria and migrated to different countries. Because of this difference in living environments and educational backgrounds, my experiences as an immigrant woman will also be different from those of participants as women with a refugee status. This was not an issue, as I made it clear from the beginning that I am an immigrant woman with different experiences and circumstances.

My positionality also had a significant impact on my ability to interview Syrian refugee women about their experiences of trauma, migration, and Ontario's health-care system. Given that I shared several identity markers with many participants, including skin color, gender, and religion, it was relatively easy to create a relationship of trust and rapport with the participants. It is worth mentioning that over the course of the research process, I have tried to minimize the power imbalance when I conducted the interviews with Syrian refugee women about their pre- and post-migration experiences. For instance, during the interview, I have directed the research agenda, considered myself as a "detached" researcher, and taken a back seat during the discussion. This detachment was not always easy to achieve, nor was it necessarily welcomed by the participants. At some points during the interview discussion, it was not easy to remain "neutral" and not to get involved in Syrian refugee women's interesting personal stories. Although I have tried to often reflect on my own positionality throughout the course of research and writing this dissertation, I cannot be certain of the extent to which my varied position has impacted

my research. I believe that it is worth acknowledging the uncertainties and the potential for multiple interpretations of the study findings within my own research.

## 1.7. Definition of Terms

**Culture:** For this dissertation, culture is defined as “a way of life that consists of people collectively using all the resources in their environment to achieve; is a part of all human groups; is learned, shared, and regulated by political, legal, and social systems; is socially transmitted; represents both external (observable behaviors) and internal (inferred traits) aspects of an individual; and is an abstraction of people's knowledge and beliefs about themselves, other people, and the world” (Zusho & Clayton, 2011, p. 240).

**Vulnerability:** For the purpose of this study, vulnerability is defined as “the lack of power or the violation of human rights that can be linked to the sociological and political conditions which can foster vulnerabilities with the need for justice and fairness and with the possibility of exploitation when these conditions are not met” (Zion et al., 2000, p. 615).

**Victimization:** For this dissertation, victimization is defined as “a concept that is widely perceived as problematic because of the way it is associated both with femininity and femaleness and with dependency, weakness, susceptibility to harm, and violability” (Gilson, 2016, p. 72). In addition, victimization is generally compounded with vulnerability and is usually “deployed to describe individuals (or populations), where real or perceived deficiencies limit the ability to function and to protect themselves from risks” (Ries & Thomson, 2020, p. 295).



Trauma: For the purpose of this study, trauma is defined as “a multidimensional experience of mostly targeted rather than random occurrences, which is situated within a social context and a temporal sequence where socio-cultural factors continued to influence the trauma response model” (Suarez, 2016, p. 142).

Model of health care: For the purpose of this study, the definition for the adopted model of health care is based on Syrian refugee women’s experiences with different health-care systems. A model of care is defined as the way in which health care and services are delivered to these women in different contexts. It includes the health practices and services for these women as they progress through different stages of migration or trauma.

## 1.8. Integrated Thesis Article Format

This dissertation is structured in the integrated article format as regulated by the School of Graduate and Postdoctoral Studies at Western University, London, Ontario. Chapter 1 provides an introduction, background, and significance of the foundations for the dissertation research. Chapters 2, 3, and 4 are original articles that resulted from this study and that were submitted for publication in peer-reviewed journals relevant to each article’s content. Chapter 5 provides an integrated summary of the study findings and dissertation work.

The research team had agreed to conduct a review around the health-seeking behaviors of Syrian refugee women, reflecting on their experiences with Ontario’s health-care system and how these women navigate the current health system to find an appropriate remedy for their health issues. The intention of this methodology paper is to

explain the potential of merging both intersectionality and critical ethnography for advancing refugee women's health research. The paper was grounded in our experiences while working with Syrian refugee women during the COVID-19 pandemic; however, it did not explicitly discuss the data collection technique. Data collection and analysis are presented in Chapter 4, Chapter 4 is the actual empirical paper that presents the study themes and subthemes.

## **Chapter 2, “*Health Seeking Behaviors among Syrian Refugee Women: A Scoping Review*”**

This is the first of three articles in this dissertation that has been published in the International Journal of Healthcare. This scoping review was undertaken to explore what is known about the health-seeking behaviors among Syrian refugee women within hospital and community settings. It also seeks to uncover the potential obstacles/barriers that Syrian refugee women face while seeking health care. Arksey and O'Malley's (2005) framework for a scoping review was utilized to guide the review process. Their findings reinforced the importance of having available and accessible health-care services for Syrian refugee women in host countries. More importantly, an awareness of the potential health-seeking behaviors, obstacles/barriers, and challenges that Syrian refugee women face may help promote their accessibility to health-care services and, consequently, improve their health and well-being.

## **Chapter 3, “*The Potential of Merging Intersectionality and Critical Ethnography for Advancing Refugee Women's Health Research*”**

This is the second article for publication. This paper outlines the potential of using a blended approach of critical ethnography with intersectionality to inform the marginalized group's health research. It also seeks to contribute to the methodology by detailing and providing insights into the strength and potential of merging critical ethnography and intersectionality into a combined approach. Finally, this paper supports the synergetic effect of merging critical ethnography with intersectionality in advancing refugee women's health research.

**Chapter 4, *“Listening to the Voices of Syrian Refugee Women in Canada: An Ethnographic Insight into the Journey from Trauma to Acculturation”***

The third article of this dissertation explores and describes the pre- and post-migration experiences of Syrian refugee women in Ontario, Canada, and the impact on their physical and mental health. This article critically examines how the intersection of gender, trauma, and political and economic conditions of Syrian refugee women shapes their everyday lives and health. It also investigates the strategies and practices by which Syrian refugee women's health-care needs are currently being addressed as well as the models of care that are suggested to meet their physical and mental health needs. The study findings reveal that Syrian refugee women, as a population, have gender-specific health-care experiences and require a multiplicity of health services. The women's narratives in this study provide a comprehensive contextual picture of the acculturation process and the practices that Syrian refugee women are currently using in daily life. Finally, the study findings offer a powerful depiction of these women's strengths and the adaptation that they make in response to residing in a new culture with a new health-care system.

### **Chapter 5, “*Integrated summary and its implications.*”**

The final chapter discussed in this dissertation is an integrated summary of the study findings, as identified in the articles included in this dissertation. The exploration of Syrian refugee women’s experiences of trauma and migration-related hardship and acculturation within their host community as well as the intersection of various social identities that informed their experiences were reviewed. The discussion includes some recommendations, solutions, and strategies that best meet this particular population’s needs. Further, implications for nursing practice, policy, education, and future research were presented.

## References

- Abu-rass, S. (2018). UN reports review the impact of displacement on Syrian women in Iraq, Jordan and Lebanon  
<http://arabstates.unwomen.org/en/news/stories/2018/12/press-release-syrian-refugees>
- Acarturk, C., Konuk, E., Cetinkaya, M., Senay, I., Sijbrandij, M., Cuijpers, P., & Aker, T. (2015). EMDR for Syrian refugees with posttraumatic stress disorder symptoms: Results of a pilot randomized controlled trial. *European Journal of Psychotraumatology*, 6(1), 1-9. <https://doi.org/10.3402/ejpt.v6.27414>
- Agic, B., McKenzie, K., Tuck, A., & Antwi, M. (2016). Supporting the mental health of refugees to Canada. Mental Health Commission of Canada.  
[https://www.mentalhealthcommission.ca/sites/default/files/2016-01-25\\_refugee\\_mental\\_health\\_backgrounder\\_0.pdf](https://www.mentalhealthcommission.ca/sites/default/files/2016-01-25_refugee_mental_health_backgrounder_0.pdf)
- Ahmed, A., Bowen, A., & Feng, C. X. (2017). Maternal depression in Syrian refugee women recently moved to Canada: a preliminary study. *BMC Pregnancy and Childbirth*, 17(1), 240-251. <https://doi.org/10.1186/s12884-017-1433-2>
- Alwan, R. M., Schumacher, D. J., Cicek-Okay, S., Jernigan, S., Beydoun, A., Salem, T., & Vaughn, L. M. (2020). Beliefs, perceptions, and behaviors impacting healthcare utilization of Syrian refugee children. *PloS One*, 15(8), 1-16.  
<https://doi.org/10.1371/journal.pone.0237081>
- Anteh, E. (2018). *Understanding the needs of refugee women in navigating the Canadian healthcare system* (Doctoral dissertation). University of Lethbridge.  
<https://hdl.handle.net/10133/5432>

- Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology*, 8(1), 19-32.  
<https://doi.org/10.1080/1364557032000119616>
- Bowleg, L. (2012). The problem with the phrase women and minorities: Intersectionality—an important theoretical framework for public health. *American Journal of Public Health*, 102(7), 1267-1273.  
<https://doi.org/10.2105/AJPH.2012.300750>
- Braun, V., & Clarke, V. (2006, 2006/01/01). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*, 3(2), 77-101.  
<https://doi.org/10.1191/1478088706qp063oa>
- Britten, L. (2019). Canadians may not be as 'obsessed' over immigration this election, but it remains a key issue for parties. *CBC News*.  
<https://www.cbc.ca/news/canada/british-columbia/refugees-2019-election-1.5310154>
- Butler, L. D., Critelli, F. M., & Rinfrette, E. S. (2011). Trauma-informed care and mental health. *Directions in Psychiatry*, 31(3), 197-212.
- Carspecken, P. F. (1996). *Critical ethnography in educational research: A theoretical and practical guide*. Psychology Press.
- Carspecken, P. F., & Walford, G. (2001). *Critical ethnography and education* (1st ed., Vol. 5.). Emerald Group Publishing.

- Cho, S., Hartman, M., Khalid, A., Mok, J., & Sreeram, P. (2017). Syrian refugee women: A vulnerable population struggles to find care. *The Meducator*, 1(30), 7-8.  
<https://journals.mcmaster.ca/meducator/article/view/1877>
- Chung, M. C., AlQarni, N., Al Muhairi, S., & Mitchell, B. (2017). The relationship between trauma centrality, self-efficacy, posttraumatic stress and psychiatric co-morbidity among Syrian refugees: Is gender a moderator? *Journal of Psychiatric Research*, 94, 107-115. <https://doi.org/10.1016/j.jpsychires.2017.07.001>
- Collins, P. H. (2000). Gender, black feminism, and black political economy. *The Annals of the American Academy of Political and Social Science*, 568(1), 41-53.  
<https://doi.org/10.1177/000271620056800105>
- Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, 1989(1), 139-167.  
<https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8>
- Crosby, S. S. (2013). Primary care management of non-English-speaking refugees who have experienced trauma: a clinical review. *JAMA*, 310(5), 519-528.  
<https://doi.org/10.1001/jama.2013.8788>
- Cullen, B. T., & Walton-Roberts, M. (2019). The role of local immigration partnerships in Syrian refugee resettlement in Waterloo Region, Ontario. *The Canadian Geographer/Le Géographe canadien*, 63(3), 374-390.  
<https://doi.org/10.1111/cag.12558>
- Bocanegra, H. T., Carter-Pokras, O., Ingleby, J. D., Pottie, K., Tchangalova, N., Allen, S. I., Smith-Gagen, J., & Hidalgo, B. (2017). Addressing refugee health through

- evidence-based policies: a case study. *Annals of Epidemiology*, 28(6), 411-419.  
<https://doi.org/10.1016/j.annepidem.2017.05.010>
- Drolet, J., Enns, R., Kreitzer, L., Shankar, J., & McLaughlin, A.-M. (2017). Supporting the resettlement of a Syrian family in Canada: The social work resettlement practice experience of Social Justice Matters. *International Social Work*, 61(5), 627–633. <https://doi.org/10.1177/0020872817725143>
- Duncan, G. F. (2015). Refugee healthcare: Towards healing relationships. *Canadian Social Science*, 11(9), 158-168. <https://doi.org/10.3968/7547>
- El-Khani, A., Ulph, F., Peters, S., & Calam, R. (2017). Syria: coping mechanisms utilised by displaced refugee parents caring for their children in pre-resettlement contexts. *Intervention*, 15(1), 34-50. <https://doi.org/10.1097/WTF.0000000000000136>
- Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, 33(4), 461-477.  
<https://doi.org/10.1002/jcop.20063>
- Gaebel, W., Falkai, P., Sartorius, N., & Zielasek, J. (2016). Mental healthcare for refugees. *Die Psychiatrie*, 13, 61-64.
- Gilson, C. E. (2016). Vulnerability and victimization: Rethinking key concepts in feminist discourses on sexual violence. *Signs: Journal of Women in Culture and Society*, 42(1), 71-98.
- Gkiouleka, A., Huijts, T., Beckfield, J., & Bamba, C. (2018). Understanding the micro and macro politics of health: Inequalities, intersectionality & institutions-A



research agenda. *Social Science & Medicine*, 200, 92-98.

<https://doi.org/10.1016/j.socscimed.2018.01.025>

Guruge, S., Sidani, S., Illesinghe, V., Younes, R., Bukhari, H., Altenberg, J., Rashid, M., & Fredericks, S. (2018). Healthcare needs and health service utilization by Syrian refugee women in Toronto. *Conflict and Health*, 12, 46-55.

<https://doi.org/10.1186/s13031-018-0181-x>

Hadfield, K., Ostrowski, A., & Ungar, M. (2017). What can we expect of the mental health and well-being of Syrian refugee children and adolescents in Canada?

*Canadian Psychology*, 58(2), 194-201. <https://doi.org/10.1037/cap0000102>

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice* (3rd ed.). Routledge.

Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., Ferlatte, O., & Clark, N. (2014). An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity. *International Journal for Equity in Health*, 13(1), 119-135. <https://doi.org/10.1186/s12939-014-0119-x>

Hansen, L., Maidment, L., & Ahmad, R. (2016). Early observations on the health of Syrian refugees in Canada. *Canada Communicable Disease Report*, 42, 8-10.

<https://doi.org/10.14745/ccdr.v42is2a03>

Hilado, A., & Lundy, M. (2017). *Models for practice with immigrants and refugees: Collaboration, cultural awareness, and integrative theory*. SAGE Publications.

<https://doi.org/10.4135/9781506300214>

- Jefee-Bahloul, H., Bajbouj, M., Alabdullah, J., Hassan, G., & Barkil-Oteo, A. (2016). Mental health in Europe's Syrian refugee crisis. *The Lancet Psychiatry*, 3(4), 315-317. [https://doi.org/10.1016/S2215-0366\(16\)00014-6](https://doi.org/10.1016/S2215-0366(16)00014-6)
- Kapilashrami, A., & Hankivsky, O. (2018). Intersectionality and why it matters to global health. *The Lancet*, 391(10140), 2589-2591. [https://doi.org/10.1016/S0140-6736\(18\)31431-4](https://doi.org/10.1016/S0140-6736(18)31431-4)
- Keung, N. (2018). Years after Canada opened its doors, thousands of Syrian refugees are still waiting to come here. *The Star*.  
<https://www.thestar.com/news/immigration/2018/01/02/years-after-canada-opened-its-doors-thousands-of-syrian-refugees-are-still-waiting-to-come-here.html>
- Knappert, L., Kornau, A., & Figengül, M. (2018). Refugees' exclusion at work and the intersection with gender: Insights from the Turkish-Syrian border. *Journal of Vocational Behavior*, 105, 62-82. <https://doi.org/10.1016/j.jvb.2017.11.002>
- Lederman, R. (2016). Fieldwork double-bound in human research ethics reviews: Disciplinary competence, or regulatory compliance and the muting of disciplinary values. In W. C. van den Hoonaard & A. Hamilton (Eds). *The Ethics Rupture* (pp. 43–72). University of Toronto Press. <https://doi.org/10.3138/9781442616653-005>
- Madison, S. (2019). *Critical ethnography: Method, ethics, and performance* (3rd ed.). Sage Publications.
- McCabe, J., & Holmes, D. (2014). Nursing, sexual health and youth with disabilities: a critical ethnography. *Journal of Advanced Nursing*, 70(1), 77-86.  
<https://doi.org/10.1111/jan.12167>

- Mills, K. A. (2007). Access to multiliteracies: A critical ethnography. *Ethnography and Education*, 2(3), 305-325. <https://doi.org/10.1080/17457820701547310>
- Morse, J. M. (2016). Underlying Ethnography. *Qualitative Health Research*, 26(7), 875-876. <https://doi.org/10.1177/1049732316645320>
- Myers, K. (November 9, 2016). *Five unique challenges facing syrian refugee women/ why women*. <https://www.concernusa.org/story/five-unique-challenges-facing-syrian-refugee-women/>
- Oda, A., Tuck, A., Agic, B., Hynie, M., Roche, B., & McKenzie, K. (2017). Health care needs and use of health care services among newly arrived Syrian refugees: a cross-sectional study. *CMAJ Open*, 5(2), 354-358. <https://doi.org/10.9778/cmajo.20160170>
- Palmer, D., & Caldas, B. (2017). Critical ethnography. In K. A. King, Y.-J. Lai, & S. May (Eds.), *Research methods in language and education*. Springer. <https://doi.org/10.1007/978-3-319-02249-9>
- Ries, N. M., & Thomson, M. (2020). Bioethics and universal vulnerability: exploring the ethics and practices of research participation. *Medical Law Review*, 28(2), 293-316. <https://doi.org/10.1093/medlaw/fwz026>
- Savage, J. (2000). Ethnography and health care. *BMJ*, 321(7273), 1400-1402. <https://doi.org/10.1136/bmj.321.7273.1400>
- Savage, J. (2006). Ethnographic evidence: The value of applied ethnography in healthcare. *Journal of Research in Nursing*, 11(5), 383-393. <https://doi.org/10.1177/1744987106068297>

- Senthanar, S., MacEachen, E., Premji, S., & Bigelow, P. (2020). Entrepreneurial experiences of Syrian refugee women in Canada: A feminist grounded qualitative study. *Small Business Economics*, 55(4), 1-13. <https://doi.org/10.1007/s11187-020-00385-1>
- Suarez, E. B. (2016). Trauma in global contexts: Integrating local practices and socio-cultural meanings into new explanatory frameworks of trauma. *International Social Work*, 59(1), 141-153. <https://doi.org/10.1177/0020872813503859>
- Taylor, P. (2013). Gaps in health care coverage when moving between provinces. *Healthy Debate*. <https://healthydebate.ca/personal-health-navigator/health-care-coverage-when-moving-between-provinces>
- Tencer, D. (2015, September 26). Syrian refugees will boost economy in Canada's have-not regions, experts say. *Huffington Post*. [https://www.huffingtonpost.ca/2015/11/26/refugees-economy-canadan\\_8658076.html#:~:text=02%3A59%20EST-,Syrian%20Refugees%20Will%20Boost%20Economy,Have%2DNot%20Regions%2C%20Experts%20Say&text=The%20recent%20news%20that%20settling,mission%20is%20worth%20the%20price.](https://www.huffingtonpost.ca/2015/11/26/refugees-economy-canadan_8658076.html#:~:text=02%3A59%20EST-,Syrian%20Refugees%20Will%20Boost%20Economy,Have%2DNot%20Regions%2C%20Experts%20Say&text=The%20recent%20news%20that%20settling,mission%20is%20worth%20the%20price.)
- Tyyskä, V., Blower, J., DeBoer, S., Kawai, S., & Walcott, A. (2017). *The Syrian refugee crisis: A short orientation*. Ryerson Centre for Immigration and Settlement.
- United Nations High Commissioner for Refugees. (2018). *What is a refugee*. <https://www.unhcr.org/what-is-a-refugee.html>
- Yayan, E. H., Düken, M. E., Özdemir, A. A., & Çelebioğlu, A. (2020). Mental health problems of Syrian refugee children: post-traumatic stress, depression and

anxiety. *Journal of Pediatric Nursing*, 51, 27-32.

<https://doi.org/10.1016/j.pedn.2019.06.012>

Zion, D., Gillam, L., & Loff, B. (2000). The Declaration of Helsinki, CIOMS and the ethics of research on vulnerable populations. *Nature medicine*, 6(6), 615-617.

Zulfikar, T. (2014). Researching my own backyard: inquiries into an ethnographic study. *Ethnography and Education*, 9(3), 373-386.

<https://doi.org/10.1080/17457823.2014.919869>

Zusho, A., & Clayton, K. (2011). Culturalizing achievement goal theory and research. *Educational Psychologist*, 46(4), 239-260.

## Chapter 2:

# Health Seeking Behaviors among Syrian Refugee Women: A Scoping Review<sup>1</sup>

### 2.1. Introduction

Syrian refugees expose to various stressors, challenges, trauma and high stress during their migration journey (Javanbakht et al., 2019). Due to growing challenges and burden of health care needs among both Syrian refugees and host communities, an evidence-based recommendation to address these burden and needs are crucial (Naja et al., 2019). In particular, refugee women may encounter various challenges in accessing healthcare services in their host communities because of the fear of uncertainty, language barriers, cultural differences, and economic problems (Erenoglu & Yaman Sozbir, 2019). For instance, Tayfur et al. (2019) conclude that one of the major concerns for countries hosting refugees from Syria is the ability to accommodate the health care needs of Syrian refugees. Another deficiency in refugee health care has been the availability of preventative services for infectious diseases (Doocy et al., 2015). The aim of the current review is to explore what is known about the health-seeking behaviors among Syrian refugee women and what are the potential obstacles that face Syrian refugee women

---

<sup>1</sup> A version of this chapter has been published:  
Al- Hamad, A. Forchuk, C., Oudshoorn, A., & McKinley, G. (2020). Health Seeking Behaviors among Syrian Refugee Women: A Scoping Review, *International Journal of Healthcare*. 6 (2), 54-61.  
<https://doi.org/10.5430/ijh.v6n2p54>

while seeking for health care. Therefore, this review will offer opportunities for multidisciplinary collaboration to develop relevant insights and potential responses to the health-seeking behaviors among Syrian refugee women and, ultimately, the impact on their health. Arksey and O'Malley (2005) framework was used to explore and recognize health-seeking behaviors among Syrian refugee women. This framework aims to map the existing research but does not address the issue of quality of studies (Arksey & O'Malley, 2005). Utilizing such a holistic framework can enhance our knowledge and understanding of the Syrian refugee women's needs and concerns and help empower and fulfill their needs and promote their health and well-being. To confirm that no other reviews existed about health-seeking behaviors among Syrian refugee women, an exploration of the literature was conducted. An extensive search of various databases did not find any current or planned reviews on this topic.

## 2.2. Review question/objective

The primary research question that guided this study was 'what has been published with regards to health-seeking behaviors among Syrian refugee women? more specifically, 'what is the current evidence with regards to health-seeking behaviors and the potential obstacles that face Syrian refugee women while seeking for health care? This research question will lead to the identification of gaps and opportunities in the existing knowledge of health-seeking behaviors among Syrian refugee women. The objectives of the present study were to:

1. Explore health-seeking behaviors of Syrian refugee women.
2. Highlight specific issues that are important to Syrian refugee women related to seeking health care.

3. Uncover potential obstacles/barriers that face Syrian refugee women while seeking health care.

## 2.3. Phenomena of interest

This scoping review exploring health seeking behaviors of Syrian refugee women over the age of 18 years who have been forcibly displaced or migrate from their home country. For the purpose of this review, health-seeking behaviors of Syrian refugee women are defined as “any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy” (Olenja, 2003, p. 2). *Syrian refugee woman* is defined as a “Syrian citizen who, owing to the ongoing war in Syria, was compelled to leave ... place of habitual residence in order to seek refuge” (Naja et al., 2019). The review highlights issues facing Syrian refugee women while they are seeking healthcare in host countries and identifies specific needs in relation to their health and wellbeing. Also, obstacles and barriers that Syrian refugee women encountered while they are seeking health care have been elucidated. This review considers studies that have been conducted among Syrian refugee women in hospital or community settings.

## 2.4. Methods

The scoping review has become a popular approach for knowledge synthesis of research evidence that allows for mapping broad topics (Pham et al., 2014). Dowling et al. (2017) argued that scoping reviews are rigorous and using methods that allow for replication; however, it lacks the step of synthesizing or aggregating the findings to the extent customary in systematic reviews. This scoping review is based on the Arksey and O'Malley (2005) framework. This framework summarizes the evidence available on a



topic to convey the breadth and depth of that topic. Moreover, this framework consists of five iterative steps: (1) identifying the research question; (2) identifying relevant studies; (3) selecting relevant studies; (4) data charting and finally; (5) collating, summarizing, and reporting the results (Arksey & O'Malley, 2005). It is worth noting that scoping reviews unlike systematic reviews provide an overview of the research activity rather than evaluate its quality. In other words, the methodology used in scoping reviews is more flexible that allowing the researcher to include grey literature as well as studies with diverse study designs (Arksey & O'Malley, 2005; Pham et al., 2014).

### 2.4.1. Stage 1: Identifying the research question

Our research question was: "what has been published with regards to health-seeking behaviors among Syrian refugee women? More specifically, the present review aims to address the following objectives:

1. Explore health-seeking behaviors of Syrian refugee women.
2. Highlight specific issues that are important to Syrian refugee women related to seeking health care.
3. Uncover potential obstacles that face Syrian refugee women while seeking health care.

### 2.4.2. Stage 2: Identifying the relevant studies

A comprehensive search strategy to identify relevant literature was conducted and involved searching various electronic databases such as Academic Search Complete, CINAHL, PubMed, Scopus, PsycINFO, Science direct, and SocINDEX were utilized in the review. Only English language papers published from 2011 on, from the time the

Syrian conflict started (March 2011), were considered in this review. With professional librarian help, a double-strand search strategy was applied, running the thesauri terms first and then keywords. These two searches were then combined using the OR operator. Search terms used independently and then in combination included: women, health and wellbeing, Syrian refugee, and health-seeking behaviors (see Table 2.1).

**Table 2.1:**

Search terms

Health seeking behaviors	Syrian refugee	Women	Health and wellbeing
“health-seeking behavior*”	Syria* N2 refugee (EBSCO databases)	(Women OR Female* OR Woman)	Health and wellbeing
“health-seeking behavior*”	Syria* ADJ2 refugee (Ovid databases)		
(Utilize* OR access*) AND (healthcare OR “health care” OR “medical care” OR “health service*”)	Syria* AND refugee* Syrian* AND refugee*		

The search strategy was repeated for each selected concept (health and wellbeing, refugee, women, and health seeking behaviors); at the end, these four different concepts were combined together using AND: Concept 1 AND Concept 2 AND Concept 3 AND Concept 4 were combined to yield the results. This strategy was initially created within Scopus and then adapted for all other databases searched using keywords and database-specific subject headings where applicable.

Inclusion criteria for this review were: (a) studies involving Syrian refugee women aged over 18 years who have been forcibly displaced or migrate from their home

country, (b) articles written in the English language, (c) the main topic of the document was Syrian refugee women's health-seeking behaviors in hospitals or community settings, and (d) the selected documents had to be a journal article, conference paper, book chapter, short paper, literature review, report, or case study and e) the document had to be published from 2011 on, that is, from the time the Syrian conflict started (March 2011). A document was excluded from the study if it was published before 2011 or was targeting a different refugee population, or in a language other than English.

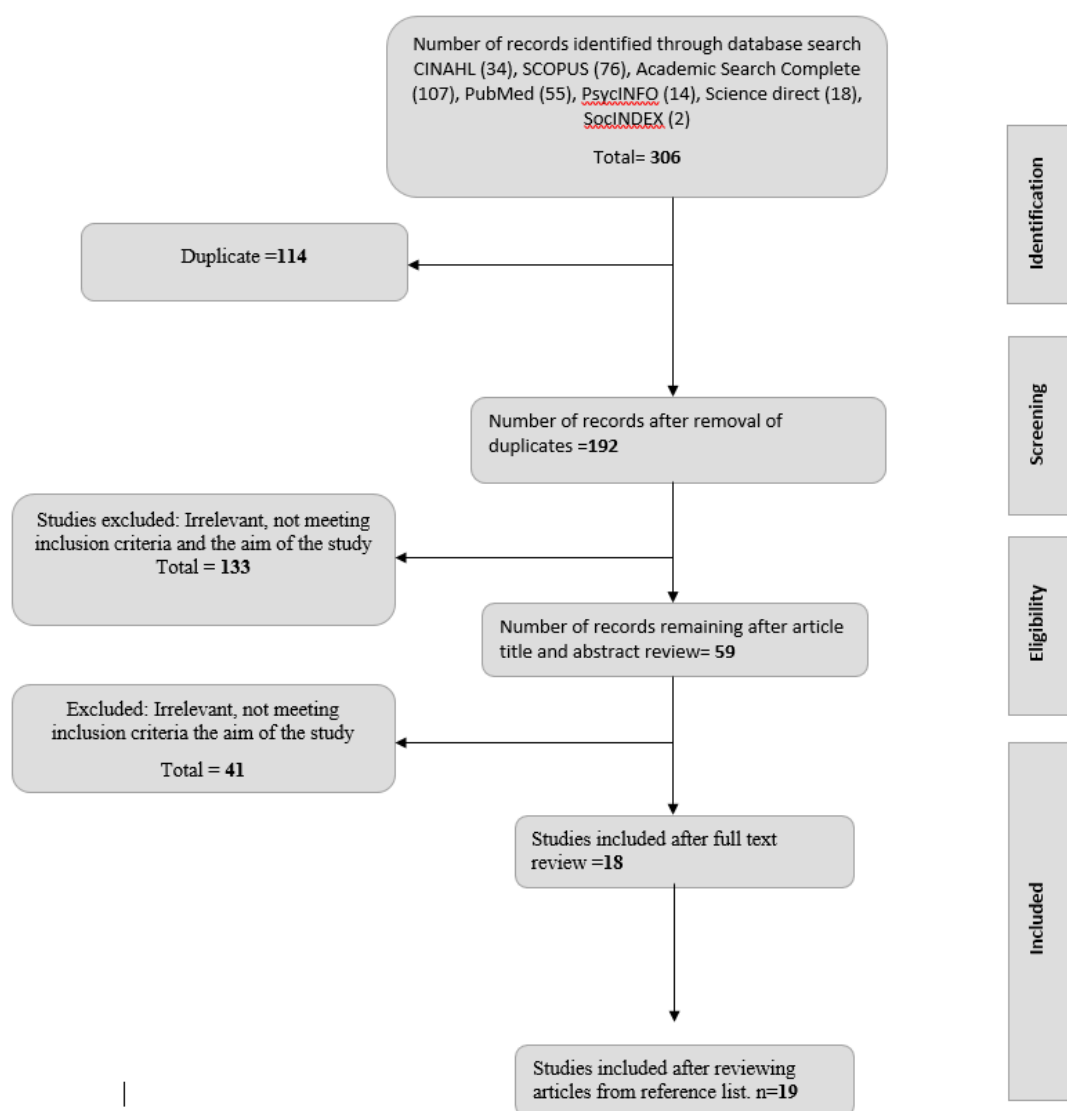
### 2.4.3. Stage 3: Selecting studies

The selection process was most closely aligned with the research question. This was then followed by an analysis of the keywords in the title, abstract, the index terms used to describe the articles retrieved during the search, and the review of full texts for the selected studies. The reviewers only included studies published from 2011 on, that is, from the time the Syrian conflict started (March 2011) and were limited to those in English. The search for unpublished or gray literature included ProQuest Dissertations and Theses, and the relevant key was included. The full-text versions of eligible documents were retrieved and screened, followed by a hand search and review of reference lists of all included studies for any additional relevant studies. The initial search retrieved 306 articles. All references retrieved from the database were added to reference management software (Endnote 9.2). The exclusion of duplicates reduced this number to 192, and a further 133 were excluded since the inclusion criteria were not met in the title or abstract. A review of the full text resulted in 59 studies. The selection process resulted in 18 relevant items that were most closely aligned with the research question, and one more study was added after the hand search of reference lists of the selected studies to

end up with a total of 19 studies involved in this scoping review. See Figure 2.1 for the selection flow diagram.

**Figure 2.1:**

Selection flow diagram.



#### 2.4.4. Stage 4: Charting the data

The fourth stage of the scoping review is charting the data, which involves extracting data using a “narrative review” method to presents contextual or process-oriented information from each item included in the review (Arksey & O'Malley, 2005). The remaining 19 articles were summarized in a data extraction table. Thematic analysis was undertaken to synthesize extracted data. The data extraction table includes the study characteristics such as author information, publication year, where the study took place, study aim and design, sampling, and the actual results or findings (see table 2.2).

#### 2.4.5. Stage 5: Collating, summarizing and reporting the results

Arksey and O'Malley (2005) clarify that the fifth stage of the scoping framework is collating, summarizing, and reporting the results. A total of 19 articles were reviewed for this study. The following overview describes the two themes identified within this scoping review. The data from this review were organized along with two thematic categories (accessibility of health care services) and (awareness of health care needs and available health care services).

**Table 2.2:**

## Selected Scoping Review Items

Author/Date/Country	Aim/Research questions	Method	Sample	Results
Abdin, 2018, Lebanon	to understand antenatal care for woman while she is pregnant and circumstances of her pregnancy in the refugee setting context.	semi- structured interviews.	42 Syrian refugee women	1-cost barriers for antenatal services. 2- awareness, knowledge and how to access available antenatal services.
Winn, Hetherington and Tough, 2018 Calgary, AB, Canada	to understand the experiences of health care professionals caring for pregnant refugee women in Calgary, AB,	semi- structured interviews.	10 health care professionals	1-barriers when caring for pregnant refugees (language barriers, difficulty navigating the health care system, and cultural barriers only wanting a female provider and differences in medical practices.  2- no adequate health coverage and funding cuts for refugee women
Henry, Beruf, and Fischer, 2019 Germany	1-How do conceptions about pregnancy, childbirth, and puerperium, premigration experiences, health literacy, and language skills influence refugee women's perceived needs and	A qualitative phenomenological design / semi- structured interviews	12 Arabic-speaking refugee who had lived in Syria.	1-lack of knowledge, health literacy and premigration experiences impact on the women's perceptions of health care needs.  2-barriers in accessing health care (health literacy, poor language skills, lack of information, and missing translators).

	<p>expectations of health care?</p> <p>2- How do refugee women experience care during pregnancy, childbirth, and puerperium?</p> <p>3- What strategies do refugee women develop to compensate for restricted access to health care?</p>			<p>3- compensation mechanism for access barriers.</p> <p>4- health-care-related costs for pregnancy and its effect on the access to appropriate health care for pregnant refugees and mothers.</p>
<p>Guruge, Sidani, Illesinghe, Younes, Bukhari, Altenberg, Rashid and Fredericks, 2018 Greater Toronto Area (GTA), Canada</p>	<p>to explore the healthcare needs of newcomer's Syrian refugee women, their experiences in accessing and using health services, and the factors and conditions that shape whether they access and utilize health services in the Greater Toronto Area (GTA).</p>	<p>A community-based qualitative descriptive interpretive study/focus group</p>	<p>58 Syrian refugee women in the GTA.</p>	<p>1- health insurance and coverage and financial resources were significant factors to access to health services.</p> <p>2- barriers to access and use of healthcare services (socio-cultural and, language and, limited public transportation, lack of linguistically, culturally, and gender-appropriate health services.)</p>
<p>Erenoğlu &amp; Sözbir, 2019.</p> <p>Turkey</p>	<p>to evaluate the effect of health education on Syrian refugee women in their own language on breast and cervical cancer awareness.</p>	<p>a randomized controlled trial</p>	<p>60 Syrian women in Hatay/Turkey.</p>	<p>1- difficulty in accessing healthcare services and the barriers for access (fear of uncertainty, security concerns, language barriers, cultural differences, and financial problems.)</p> <p>2- health education given to Syrian refugee women in their language with respect to their cultural changes had a</p>

---

				good effect on attitude and motivation of seeking care for breast and cervical cancer.
Doocy, Lyles, Robertson, Akhu-Zaheya, Oweis and Burnham, 2015.	to characterize the prevalence of non-communicable diseases and better understand issues related to care-seeking for non-communicable diseases among Syrian refugees in non-camp settings in Jordan.	A cross-sectional survey	1550 Syrian refugees	<p>1- challenges that encounter Syrian refugees include the provision of appropriate secondary and tertiary services, continuity of care, access to medications, and costs.</p> <p>2- Syrian refugees with arthritis, with post-secondary and primary education, had the lowest care-seeking rates compared to the non-educated refugee.</p> <p>3- cost and funding limitations are the primary barriers to access health services.</p>
Doocy, Lyles, Akhu-Zaheya, Burton and Burnham, 2016.	to assess utilization and access to health services among Syrian refugees in non-camp settings in Jordan. As well as to characterize health-seeking behaviors of Syrian refugees and issues related to accessing care.	A cross-sectional survey	1500 Syrian refugees	<p>1- Care-seeking among adult refugees was sought medical care from public sector facilities.</p> <p>2- cost was a substantial barrier to health service access for Syrian refugees in Jordan.</p>

---



Torun, Karaaslan, Sandıklı, Acar, Shurtleff, Dhrolia and Herek, 2018.  Istanbul, Turkey	to assess the health needs of urban Syrian refugees' women living in Istanbul	mixed-method approach	891 survey, and 31 semi-structured interviews with Syrian refugee women, nine key informants, and two focus group discussions were held with Turkish managers.	1-barriers to accessing health care (language barrier and a lack of knowledge of the Turkish health care system, and how to seek care for specific health issues.) 2- Waiting time at hospitals and negative attitudes of health care staff 3- the cost of antenatal care, medications, and chronic diseases.
Tappis, Lyles, Burton and Doocy, 2017 Lebanon and Jordan	to characterize health-seeking behaviors and better understand issues related to accessing and utilization of maternal health services among Syrian refugees and provide insights into disparities in the continuum of care available to Syrians living in non-camp settings in both Lebanon and Jordan.	Two cross-sectional survey of Syrian refugees in both Lebanon and Jordan.	100 for Lebanon household survey, and 112 for Jordan households	1- households in both countries reported out-of-pocket costs for essential maternal and newborn health services. 2- Cost was a significant factor in care-seeking decisions in both locations.
Samari, 2017 Lebanon, Turkey, and Jordan	to explore the vulnerabilities of Syrian women and girls in Lebanon, Turkey, and	literature search, international policy and	Eleven peer-reviewed articles and 18 national and	1-cost, distance, and fear of mistreatment were the primary barriers to accessing health care in Lebanon.

	Jordan, and how these countries approach Syrian refugee women's health care needs, access, and utilization of health services in the selected countries.	development reports on Syrian refugee women's health in Lebanon, Turkey, and Jordan	intergovernmental reports were included.	2- economic disparities, lack of services, and lack of access to reproductive health care were common barriers in Turkey.  3- cost was a primary barrier for seeking care in Jordan.
Oda,Hynie,Tuck,Agic, Roche and McKenzie, 2019. Canada.	to assess healthcare access and perceived physical and mental health status of both governments assisted GARs and privately sponsored PSRs Syrian refugees.	A cross-sectional study	A sample size of 386 (177 GARs and 209 PSRs) Syrian refugees	1- GARs reported lower perceived physical and mental health, as well as higher unmet healthcare needs compared to PSRs. 2- PSRs were older with better education and socioeconomic background, better health with different levels of support for service navigation
Lyles, Hanquart, Chlela, Woodman, Michael, Fouad, Sibai and Doocy, 2018. Lebanon	to characterize health-seeking behaviors and service access.	A survey of Syrian refugees and Lebanese host communities	1,376 refugee and 686 host community households	1-access to health care and medication was worse among Syrian refugees as compared to the Lebanese host community.  2- Cost was the primary barrier to care in both groups
El Arnaout1, Rutherford, Zreik, Nabulsi, Yassin, and Saleh, 2019.	to identify the primary health needs of displaced Syrians in Iraq, Jordan, Lebanon, Turkey, and Syria.	a systematic review	Sixty-three articles were included in the analysis.	1- most common health problems for Syrian refugees were non-communicable diseases in Jordan, women's health in Lebanon, and mental health in Turkey.

Iraq, Jordan, Lebanon, Turkey, and Syria.					2- barriers to accessing health services included (geographical barriers, lack of awareness about the availability of services, and access to these services.)
Doğan, Dikeç, and Uygun, 2019.	to examine Syrian refugee adults’ experiences with mental health services due to a mental complaint.	A qualitative phenomenological design. / semi - structured interviews and focus group	24 individuals	1-difficulties making appointments and obtaining medicine.  2-personal rights, lack of information, language barrier, discrimination, and confidence versus anxiety were common barriers to seek health care.	
Turkey					
Ay, González, and Delgado, 2016.	to identify the most needed health care services, accessibility of various health care services, and barriers to access as perceived by a group of Syrian refugees living in non-camp settings in Jordan and to compare accessibility among different groups.	A cross-sectional study.	196 surveys	1- Preventive and primary health care were more accessible than advanced services.  2-Structural and financial barriers hindered access to health services.	
Jordan					
Assi, Ozger-Ilhan and Ilhan, 2019.	to determine the health needs and document the healthcare services	Literature review	Thirteen full-text articles	1- barriers to adequate access to health services include language	

Turkey	available to Syrian refugees in Turkey.		were included in the study.	barriers, mobility of the refugees, and some legal restrictions.
El Arab and Sagbakken, 2018. Jordan	to explore the healthcare needs and access to healthcare services among Syrian refugees in Jordan. Furthermore, to identify possible ways of responding to such needs	Literature review	Nine articles were included in the study.	2-Mental health and rehabilitation services are inadequate and fragile because of the inadequate number of qualified practitioners. 1- financial and structural barriers were common factors to hinder access to health services
McNatt, Freels, Chandler, Fawad, Qarmout, Al-Oraibi, and Boothby, 2019. Jordan	to understand the depth and nuances of Syrian refugees' experiences accessing non-communicable diseases services in urban and semi-urban settings in Jordan.	A descriptive qualitative study.	68 in-depth interviews with Syrian refugees	1- health services are inadequate, expensive, and fragmented. 2- financial constraints and cost of services affect participants decisions to seeking care
Al Qadire , Aljezawi , and Al-Shdayfat , 2019. Jordan	to explore the level of cancer knowledge and barriers to seeking care among Syrian refugees in Jordan.	A descriptive cross-sectional survey design.	241 Syrian refugees	1- the cost of services and having no medical insurance was the most common barrier to seeking care among Syrian refugees in Jordan.  2- Refugees' awareness of available services and knowledge of disease symptoms and risk factors were another barrier to seeking care among Syrian refugees in Jordan.

## 2.5. Results

### 2.5.1. Accessibility of health care services:

Most of the literature examining health-seeking behaviors of Syrian refugee women reported difficulty with the accessibility of health care services. Accessibility difficulties included financial barriers, language barriers and availability of culturally and gender-appropriate health services. Fifteen of the articles selected for this scoping review reflected the financial barriers or inadequate health insurance or coverage. In general, financial barriers were the dominant impediment to accessing health care among Syrian refugee women (Abdin, 2018; Doocy et al., 2016; Doocy et al., 2015; Guruge et al., 2018; Henry et al., 2019; Lyles et al., 2018; McNatt et al., 2019; Samari, 2017; Tappis et al., 2017; Winn et al., 2018).

Abdin (2018) conducted a qualitative study using semi-structured interviews with 42 women in Lebanon. The study sought to understand antenatal care, what it takes to treat a woman while she is pregnant and the circumstances of her pregnancy in the refugee setting context. Findings revealed cost barriers of antenatal and contraceptive services. As well, the women are unaware of available antenatal services. Similarly, Winn et al. (2018) conducted a qualitative study with ten health care professionals who provided care for pregnant Syrian refugee women in Calgary, AB, to understand the professional's experiences. The study findings support that language, culture, and cost were the main barriers when caring for pregnant refugees. In a similar context, Guruge et al. (2018) conducted a community-based qualitative descriptive, interpretive study that was informed by Yang and Hwang's (2016) health service utilization framework. The aim of the study was to explore the health care needs of newly arrived Syrian refugee women

and their experiences of accessing and using the services in the Greater Toronto Area (GTA). Fifty-eight focus groups were conducted with newcomer Syrian refugee women. The study findings revealed that socio-cultural, language, social disconnection, lack of public transportation, and the lack of culturally and gender-specific health services were common barriers for accessing health care services.

The second most frequently reported barrier that affects access to health services was the language barrier (Assi et al., 2019; Doğan et al., 2019; Erenoglu & Yaman Sozbir, 2019; Guruge et al., 2018; Henry et al., 2019; Torun et al., 2018; Winn et al., 2018). For instance, Henry et al. (2019) performed a phenomenological study with 12 Arabic-speaking women from Syria in Germany. The aims of the study were to understand Syrian refugee women's experiences, perceived needs, and expectations of health care, as well as the strategies that Syrian refugee women adopt to compensate for restricted access to health care. The authors also concluded that poor language skills, lack of information, cost of services, and appropriate health care services were common barriers in accessing health care services among Syrian refugee women.

Similarly, Torun et al. (2018) conducted a mixed-methods approach to assess the health care needs of urban Syrian refugee women living in Istanbul, Turkey. For the quantitative component, 891 household surveys were distributed, and 31 semi-structured interviews were conducted with Syrian refugee women, key informants, and Syrian NGO managers. The findings support that difficulty in accessing health care was due to language barriers, lack of awareness about the Turkish health care system, as well as the cost of care. In a similar way, Assi et al. (2019) conducted a literature review on Syrian refugees published between 2011 and 2019 to determine health care needs and the

available services to Syrian refugee women in Turkey. One hundred twenty-two documents were retrieved, and 13 full-text articles were included in the study. The study findings revealed that language barriers and the availability of health care practitioners were the significant factors that limited the effectiveness of health care services for Syrian refugees.

Five studies discussed the availability of gender and culturally appropriate services (Erenoglu & Yaman Sozbir, 2019; Guruge et al., 2018; Henry et al., 2019; McNatt et al., 2019; Winn et al., 2018). In particular, Erenoglu and Yaman Sozbir (2019) conducted a randomized controlled trial to evaluate the effect of health education given to Syrian refugee women in their language on breast awareness and cervical cancer in Turkey. A sample consisted of 60 Syrian refugee women (30 experiments and 30 controls). The study findings support that language, cultural and economic problems were the major contributing factors that hinder accessing health care services by Syrian refugee women. Similarly, Winn et al. (2018) concluded that cultural and language barriers and the cost and differences in medical practices, were the main barriers for pregnant refugees to navigate health care services in Canada. Moreover, Guruge et al. (2018) concluded that socio-cultural factors, lack of linguistically, culturally, and gender-specific health services were among the common factors and barriers that affect access and use of health services by Syrian refugee women.

## 2.5.2. Awareness of health care needs and available health care services

Eight studies supported the second theme identified as knowledge and awareness of health care needs and available health care services. El Arnaout et al. (2019) conducted a systematic review to identify the primary healthcare needs of displaced Syrian in Iraq, Jordan, Lebanon, Turkey, and Syria. A total of 63 articles were included in the analysis. Findings revealed that among commonly reported barriers to accessing health services were lack of awareness and education about the availability of health services and access to these services. Similarly, Al Qadire et al. (2019) conducted a descriptive cross-sectional survey design to explore the level of cancer knowledge and barriers to seeking care among Syrian refugees in Jordan. The Cancer Awareness Measure was completed by 241 Syrian refugees. The authors concluded that refugees' knowledge and awareness of available services, disease symptoms, and risk factors as well as the cost of services, were the common barriers to seeking care in Jordan.

Abdin (2018) sought to understand what it takes to treat pregnant refugee women in the refugee context. The author concluded that awareness and knowledge of available antenatal care and how to navigate and access these services was crucial to understanding refugee women's pregnancy-related needs and circumstances. In the same vein, Henry et al. (2019) conducted a phenomenological study with 12 Arabic-speaking refugees who had lived in Syria to explore their experiences and perceived needs during pregnancy. The study findings revealed that limited health literacy and lack of information around health care needs and available services were barriers in accessing health care in Germany.

Doocy et al. (2016) conducted a cross-sectional survey with 1550 Syrian refugees to better understand issues related to care-seeking for non-communicable diseases in



Jordan. The authors concluded that Syrian refugees with prior medical knowledge and education had the lowest rate of health seeking care compared to non-health-educated refugees. As well, access to medication, cost and the provision of secondary and tertiary services were common barriers to seeking care.

Oda et al. (2019) conducted a cross sectional study of 386 Syrian refugees. The purpose was to assess access to health care and their perceived physical and mental health. The study concluded that government-assisted refugees had lower perceived health and access to health care compared to privately sponsored refugees. This difference was due to the fact that the sponsored refugees tended to have better education as well as support system to navigate the available health services.

El Arab and Sagbakken (2018) sought to identify Syrian refugee health needs and barriers to access to health care. They concluded that financial and structural barriers, including awareness about the availability of health services, affect access to health care. Similarly, Ay et al. (2016) conducted a cross-sectional study with 196 surveys to identify needed health care services and accessibility of Syrian refugees concluded that financial and structural barriers, including the awareness of the available health services, were common barriers for Syrian refugees to accessing health care services.

## 2.6. Discussion

This scoping review is to our knowledge, the first review that explored health-seeking behaviors of Syrian refugee women. The studies were mostly conducted in the hosting countries for Syrian refugees such as Canada, Jordan, Lebanon, and Turkey, with a large variety in the methodological approaches implemented in the different

community- and hospital settings. This scoping review highlights the need for further efforts to adopt a comprehensive approach to improve Syrian refugee women's access to health care and awareness of their host communities' available health services.

The study findings were consistent with previous studies about health-seeking behaviors of the different refugee populations. For instance, Marume et al. (2018) conducted a study to explore if health-seeking behaviors and social capital affected the quality of life among refugees in Zimbabwe. The authors concluded that various factors affect refugees' health-seeking behaviors and their access to health care services, such as low economic status and psychosocial support that exist within refugee populations. Similarly, Cropley (2004) conducted a study to explore health education interventions on child malaria treatment-seeking practices among mothers in rural refugee villages in Belize, Central America. The study findings were consistent with our study in terms of the effect of knowledge and awareness of healthcare needs and when to seek care. Another study that echoes our findings but in a different refugee context is a study conducted by Yun et al. (2016) to explore barriers to care, help-seeking behaviors, and the impact of a community-based patient navigation intervention on patient activation levels among Bhutanese refugees in the U.S. The authors concluded that financial coverage, being bilingual, and having literate family members with social networks assist in the overcome of healthcare access.

Our finding of knowledge and awareness about health needs and available health services were consistent with the study conducted by Odwe et al. (2018). The authors concluded that promoting awareness and progressive attitudes towards available health

care services and support or sexual and gender-based violence may encourage positive help-seeking attitudes and behaviors among Rwamwanja refugee women in Uganda.

This study shares limitations common to scoping reviews in general. Difficulties include synthesizing quantitative and qualitative methods in the same review while maintaining a balance between breadth and depth of analysis (Pham et al., 2014). In this review, we aimed to identify both the breadth and depth of health-seeking behaviors, barriers, and challenges that Syrian refugee women encounter while seeking health care. It is worth noted that this review might not have captured all relevant published articles and grey literature. Searching other databases may have identified additional relevant studies, and relevant studies in other languages than English may have been excluded. Our definition of health-seeking behavior was broad to include a wide range of studies. However, we may have unintentionally excluded some studies. From a quality perspective, knowledge synthesis in this review relied on the individual studies included to capture the breadth of exploring health-seeking behaviors of Syrian refugee women (Arksey & O'Malley, 2005; Pham et al., 2014).

## 2.7. Conclusion

This scoping review has provided an overview of studies that address health-seeking behaviors for Syrian refugee women and has highlighted the barriers and challenges that those women encounter to access and navigate health care services in the host communities. A substantial evidence base supports the conclusion that Syrian refugee women face several challenges and barriers that can hinder their access to health care services and influence their health-seeking behaviors in their host countries.

## References

- Abdin, L. (2018). Challenges for pregnant Syrian refugees in Lebanon. *Eastern Mediterranean Health Journal*, 24(10), 1026-1029.  
<https://doi.org/10.26719/2018.24.10.1026>
- Al Qadire, M., Aljezawi, M., & Al-Shdayfat, N. (2019). Cancer awareness and barriers to seeking medical help among Syrian refugees in Jordan: A baseline study. *Journal of Cancer Education*, 34(1), 19-25. <https://doi.org/10.1007/s13187-017-1260-1>
- Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology*, 8(1), 19-32.  
<https://doi.org/10.1080/1364557032000119616>
- Assi, R., Özger-İlhan, S., & İlhan, M. N. (2019). Health needs and access to health care: the case of Syrian refugees in Turkey. *Public Health*, 172, 146-152.  
<https://doi.org/10.1016/j.puhe.2019.05.004>
- Ay, M., González, P. A., & Delgado, R. C. (2016). The perceived barriers of access to health care among a group of non-camp syrian refugees in Jordan. *International Journal of Health Services*, 46(3), 566-589.  
<https://doi.org/10.1177/0020731416636831>
- Cropley, L. (2004). The effect of health education interventions on child malaria treatment-seeking practices among mothers in rural refugee villages in Belize, central America. *Health Promotion International*, 19(4), 445-452.  
<https://doi.org/10.1093/heapro/dah406>

- Doğan, N., Dikeç, G., & Uygun, E. (2019). Syrian refugees' experiences with mental health services in Turkey: "I felt lonely because I wasn't able to speak to anyone". *Perspectives in Psychiatric Care*, 55(4), 673-680.  
<https://doi.org/10.1111/ppc.12400>
- Doocy, S., Lyles, E., Akhu-Zaheya, L., Burton, A., & Burnham, G. (2016). Health service access and utilization among Syrian refugees in Jordan. *International Journal for Equity in Health*, 16, 1-15. <https://doi.org/10.1186/s12939-016-0399-4>
- Doocy, S., Lyles, E., Robertson, T., Akhu-Zaheya, L., Oweis, A., & Burnham, G. (2015). Prevalence and care-seeking for chronic diseases among Syrian refugees in Jordan. *BMC Public Health*, 15(1), 1-10. <https://doi.org/10.1186/s12889-015-2429-3>
- Dowling, A., Enticott, J., & Russell, G. J. B. h. s. r. (2017). Measuring self-rated health status among resettled adult refugee populations to inform practice and policy—a scoping review. *BMC Health Services Research*, 17(1), 817-839.  
<https://doi.org/10.1186/s12913-017-2771-5>
- El Arab, R., & Sagbakken, M. (2018). Healthcare services for Syrian refugees in Jordan: a systematic review . *European Journal of Public Health*, 28(6), 1079-1087.  
<https://doi.org/10.1093/eurpub/cky103>
- El Arnaout, N., Rutherford, S., Zreik, T., Nabulsi, D., Yassin, N., & Saleh, S. (2019). Assessment of the health needs of Syrian refugees in Lebanon and Syria's

neighboring countries. *Conflict and Health*, 13(1), 31-45.

<https://doi.org/10.1186/s13031-019-0211-3>

Erenoglu, R., & Yaman Sozbir, S. (2019). The effect of health education given to Syrian refugee women in their own language on awareness of breast and cervical cancer, in Turkey: A randomized controlled trial. *Journal of Cancer Education*. 35(2), 241-247. <https://doi.org/10.1007/s13187-019-01604-4>

Guruge, S., Sidani, S., Illesinghe, V., Younes, R., Bukhari, H., Altenberg, J., Rashid, M., & Fredericks, S. (2018). Healthcare needs and health service utilization by Syrian refugee women in Toronto. *Conflict and Health*, 12(1), 1-9.  
<https://doi.org/10.1186/s13031-018-0181-x>

Henry, J., Beruf, C., & Fischer, T. (2019). Access to health care for pregnant Arabic-speaking refugee women and mothers in Germany. *Qualitative Health Research*, 30(3), 437-447. <https://doi.org/10.1177/1049732319873620>

Javanbakht, A., Amirsadri, A., Abu Suhaiban, H., Alsaud, M. I., Alobaidi, Z., Rawi, Z., & Arfken, C. L. (2019). Prevalence of possible mental disorders in Syrian refugees resettling in the United States screened at primary care. *Journal of Immigrant and Minority Health*, 21(3), 664-667. <https://doi.org/10.1007/s10903-018-0797-3>

Lyles, E., Hanquart, B., Chlela, L., Woodman, M., Fouad, F. M., Sibai, A., & Doocy, S. (2018). Health service access and utilization among Syrian refugees and affected host communities in Lebanon. *Journal of Refugee Studies*, 31(1), 104-130.  
<https://doi.org/10.1093/jrs/fex014>

- Marume, A., January, J., Maradzika, J. J. I. J. o. M., Health, & Care, S. (2018). Social capital, health-seeking behavior and quality of life among refugees in Zimbabwe: a cross-sectional study. *International Journal of Migration, Health and Social Care*, 14(4), 377-386. <https://doi.org/10.1108/IJMHSC-04-2017-0017>
- McNatt, Z. Z., Freels, P. E., Chandler, H., Fawad, M., Qarmout, S., Al-Oraibi, A. S., & Boothby, N. (2019). "What's happening in Syria even affects the rocks": a qualitative study of the Syrian refugee experience accessing noncommunicable disease services in Jordan. *Conflict and Health*, 13(1), 26-32. <https://doi.org/10.1186/s13031-019-0209-x>
- Naja, F., Shatila, H., El Koussa, M., Meho, L., Ghandour, L., & Saleh, S. (2019). Burden of non-communicable diseases among Syrian refugees: a scoping review. *BMC Public Health*, 19(1), 637-613. <https://doi.org/10.1186/s12889-019-6977-9>
- Oda, A., Hynie, M., Tuck, A., Agic, B., Roche, B., & McKenzie, K. (2019). Differences in self-reported health and unmet health needs between government assisted and privately sponsored Syrian refugees: A cross-sectional survey. *Journal of Immigrant and Minority Health*, 21(3), 439-442. <https://doi.org/10.1007/s10903-018-0780-z>
- Odwe, G., Undie, C., Obare, F., & Rights, h. (2018). Attitudes towards help-seeking for sexual and gender-based violence in humanitarian settings: the case of Rwamwanja refugee settlement scheme in Uganda. *BMC International Health and Human Rights*, 18(1), 15-27. <https://doi.org/10.1186/s12914-018-0154-6>

- Olenja, J. (2003). Editorial health seeking behaviour in context. *East African Medical Journal*, 80(2), 61-62.
- Pham, M. T., Rajić, A., Greig, J. D., Sargeant, J. M., Papadopoulos, A., & McEwen, S. A. (2014). A scoping review of scoping reviews: advancing the approach and enhancing the consistency. *Research Synthesis Methods*, 5(4), 371-385.  
<https://doi.org/10.1002/jrsm.1123>
- Samari, G. (2017). Syrian refugee women's health in Lebanon, Turkey, and Jordan and recommendations for improved practice. *World Medical and Health Policy*, 9(2), 255-274. <https://doi.org/10.1002/wmh3.231>
- Tappis, H., Lyles, E., Burton, A., & Doocy, S. (2017). Maternal health care utilization among Syrian refugees in Lebanon and Jordan. *Maternal and Child Health Journal*, 21(9), 1798-1807. <https://doi.org/http://dx.doi.org/10.1007/s10995-017-2315-y>
- Tayfur, I., Günaydin, M., & Suner, S. (2019). Healthcare service access and utilization among syrian refugees in Turkey. *Annals of Global Health*, 85(1), 42-48.  
<https://doi.org/10.5334/aogh.2353>
- Torun, P., Mücaz Karaaslan, M., Sandıklı, B., Acar, C., Shurtleff, E., Dhrolia, S., & Herek, B. (2018). Health and health care access for Syrian refugees living in İstanbul. *International Journal of Public Health*, 63(5), 601-608.  
<https://doi.org/10.1007/s00038-018-1096-4>
- Winn, A., Hetherington, E., & Tough, S. (2018). Caring for pregnant refugee women in a turbulent policy landscape: perspectives of health care professionals in Calgary,



Alberta. *International Journal for Equity in Health*, 17(1),17-31.

<https://doi.org/10.1186/s12939-018-0801-5>

Yun, K., Paul, P., Subedi, P., Kuikel, L., Nguyen, G., & Barg, F. (2016). Help-seeking behavior and health care navigation by Bhutanese refugees. *Journal of Community Health*, 41(3), 526-534. <https://doi.org/10.1007/s10900-015-0126-x>

## Chapter 3:

# The Potential of Merging Intersectionality and Critical Ethnography for Advancing Refugee Women's Health

## Research Introduction

### 3.1. Introduction

This exploration of the intersection of theory and methodology is inspired by a research program exploring the health needs of refugee women. Globally, refugee women continue to experience a combination of catastrophic war crimes, human rights violations, poverty, forced migration, and repeated displacement, with significant health implications (Acarturk et al., 2015; Drolet et al., 2017; El-Khani et al., 2017; Hansen et al., 2016). These health impacts are compounded by various stressors, including unstable income and housing, loss of family, prolonged grief, settlement and integration challenges, language barriers, social isolation, discrimination, powerlessness, and uncertainty about the future (Acarturk et al., 2015; Agic et al., 2016; El-Khani et al., 2017; Hadfield et al., 2017). Understanding these women's experiences about migration and health care has the potential to guide the host's health-care system policy and design to enhance health outcomes. Therefore, understanding refugee women's experiences, struggles, and health impacts are of particular importance, as it is within these experiences that we find the necessary knowledge to guide change for marginalized groups. A key element of focus in this work is to understand relationships with care providers, including both positive and negative attitudes related to refugee women. The

complexity of these attitudes calls for the need to conduct refugee- engaged research that includes the refugee women's and other vulnerable populations' experiences within health services.

It is worth noting that striving to improve refugee women's health is beneficial for both the women and the host country. Refugees participate in economic growth and bring along with them considerable positive human and social capital that benefits host societies (Drolet et al., 2017; Duncan, 2015; Hilado & Lundy, 2017). However, conducting research with refugee populations is challenging at this time of constant global crisis and the increased politicization of migration. Although the current philosophical approaches to studying refugee women's health and other vulnerable populations in nursing do focus on empowerment and social change (Hankivsky et al., 2014; McBride et al., 2015; Walby et al., 2012), they do not adequately address how gender, race, class, refugee status, sexuality, and culture intersect in a way that creates further oppression for refugee women. Such intersections can influence a change in nursing practices to empower refugee women in their host communities. From a solution-oriented perspective, it is pivotal to understand how the intersection of gender, violence, culture, and the political and economic conditions of refugee women, on the one hand, and the structure and operation of the host countries' health-care system, on the other, come together to drive the experiences of health services.

To address the gap in nursing knowledge engendered by the dearth of research regarding refugee women and other marginalized groups that particularly addresses how multiple factors intersect to negatively influence these women and kick-start a movement

for their empowerment in their host countries, an effective methodological approach is required. This approach must be grounded in a well-established theoretical framework while providing clear methodological guidance. In particular, research into the needs of refugee women, considering their sociocultural context, how their needs are being met, and their experiences in general, is required to evaluate current approaches and identify opportunities for change and improvement.

From a nursing perspective, conducting critical ethnographic research with an emphasis on various forms of oppression creates valuable practice knowledge. This echoes De Chesnay's (2014) conclusion for the need of conducting ethnographic research while focusing on state-of-the-art methodologies from a nursing perspective. Such an exploration can offer a platform for critique and further exploration for those wanting to improve refugee women's health by deploying the combined value of critical ethnography and intersectional analysis. The proposed approach includes a clear conceptualization of vertical and horizontal integration of critical ethnography and intersectional analysis.

Vertical integration may include, but is not limited to, various levels of power and influence, and it spans across micro to global levels. On the contrary, horizontal integration may include factors related to particularly vulnerable individuals or groups and connecting peer groups based on gender, culture, refugee status, race, and beyond. Horizontal and vertical integration of critical ethnography and intersectionality have received little attention to date. When used well, this integration optimizes research methods with marginalized groups, such as refugee women. Moreover, such a

combination may offer a more profound analysis and guide the marginalized population's theoretical analysis.

This paper is grounded within our personal experiences of using intersectionality with critical ethnography during our research with Syrian refugee women. In this paper, we intersperse our considerations regarding critical ethnography blended with intersectionality and clarify the complexities, strengths, and limitations of this combination. While exploring the compatibility of both positions philosophically, we also touch upon the practical impacts of engaging this methodology and theoretical perspective in research during the COVID-19 pandemic. Also, we draw upon other research studies that have used critical ethnography and intersectionality with the potential for empowerment and social change.

### 3.2. Critical Ethnography and Intersectionality in Refugee Women's Research

Critical ethnography is a popular research methodology spanning across disciplines such as anthropology, nursing, and other health and social disciplines. The basic tenet of this approach is that reality is socially constructed (Higginbottom et al., 2014; McCabe & Holmes, 2014; Morse, 2016). In addition, critical ethnography has several central elements, including value-informed orientation, questioning the status quo, and addressing unequal power relations and individual empowerment (Palmer & Caldas, 2017). This research methodology explains both the ways in which societal structures and institutions shape the Syrian refugee women's experiences and their capabilities to work rationally within these power structures. The epistemological

assumption of critical ethnography is that all knowledge is rooted in structural, sociopolitical, historical, and cultural reality where the knowledge over time becomes “taken for granted” (Berman et al., 1998; Burnett et al., 2015). Thus, critical ethnographic researchers should understand their lens and their participants within their social settings and/or contexts to understand an expressed reality.

Critical ethnographers engage with their participants in the naturalist tradition, which guides the researcher to focus on a particular cultural group to understand their natural life and challenges. Therefore, to understand the participants, the researchers should spend time in their social settings, such as in family homes and community environments, which would enable them to adopt a more appropriate data collection approach (De Chesnay, 2014; Morse, 2016). Critical ethnography applies ethnography to focus more particularly on inequities and oppression experienced in and perpetuated by cultures or subcultures in specific settings rather than throughout entire communities (Carspecken, 1996; Carspecken & Walford, 2001; Hammersley & Atkinson, 2007).

Critical ethnography helps the researcher situate what is seen through data collection into the broader political context to understand the links between everyday interactions or experiences and wider cultural formations (Morse, 2016; Savage, 2000, 2006). It has been noted that critical ethnography is particularly valuable, because it pays attention to social, cultural, historical, and political contexts (Hammersley & Atkinson, 2007; Madison, 2005; Savage, 2006). Moreover, the methodology offers a holistic approach to exploring the links between the different kinds of power and evidence

underpinning empowerment-based practices (Carspecken & Walford, 2001; McCabe & Holmes, 2014; Mills, 2007).

Thomas (1993) described critical ethnography as a unique style of thinking and writing that connects various elements of cultural descriptions to social organizations, social structures, and action. It engages in cultural critique, allowing scholars to examine broader social, political, historical, and economic differences. Similarly, Palmer and Caldas (2017) have argued that critical ethnography is a qualitative approach that is used to critique hegemony, oppression, and unequal social power relations to achieve social change. The approach facilitates critiques of the structures of power differentials and the inequities experienced by marginalized communities, and it allows for ongoing dialogue with those enduring marginalization and oppression (Palmer & Caldas, 2017).

Another key aim of critical ethnography is a call for social change. This aim provides the philosophical and theoretical foundation for the critical ethnographer to question and challenge dominant discourses, structures, and power relationships that disadvantage and oppress various groups in contemporary society (De Chesnay, 2014). It is worth mentioning that critical ethnography is widely viewed as being compatible with intersectionality (Beck, 2013). In our study, critical ethnography was used as a method for gathering data to be analyzed with an inter-sectoral lens. Ethnographic methods, such as interviews and case studies, can illustrate the complexities of individual and collective identities and social dynamics (Morse, 2016). Such methods, thus, contribute to an understanding of the relationships between social locations and the processes and the meanings that those processes and relationships hold (Morse, 2016).

Likewise, intersectionality is one of the promising theoretical lenses that is used for analyzing unequal social power structures and processes that produce unequal health outcomes (Bowleg, 2012; Collins, 2000; Crenshaw, 1989; Hankivsky et al., 2014). The central core of intersectionality is that it moves beyond examining individual factors such as gender and race independently, and instead it focuses on the interactions and relationships between such factors across multiple society levels (Collins, 2000; Crenshaw, 1989). Crenshaw (1989) argued that marginalized groups' social and cultural identities, including gender, class, ethnicity, sexual orientation, and religion, are seen within an intersectional lens as interlocking rather than additive categories. Specifically, the intersectional theory draws upon three crucial tenets. First, it emphasizes the differences within population groups that are often falsely perceived as being relatively homogenous. By understanding locational differences, we can be open to noting how various forms of oppression can work together to create a complex matrix of power (Knappert et al., 2018). For instance, refugee women from a lower socioeconomic group may find it more difficult to access care than those from a higher class, even within the same host country. Therefore, intersectionality provides a foundation for examining the experiences of marginalized groups who navigate the various forms of oppression at their intersection and examine processes of power and inequity (Aspinall et al., 2019). Second, the intersectionality theory clarifies that individual and group inequities are shaped and informed by interactions between multiple levels of power (Kapilashrami & Hankivsky, 2018), such as institutional structures and discrimination structures as well as processes of marginalization, globalization, and neoliberalism. In other words, intersectionality shows that those with power maintain the status quo of inequity by making norms that are



visible for examination in relation to the dominant culture, ethnicity, gender, and status (Aspinall et al., 2019). The third tenet of intersectionality is that examining only one aspect of a person's social location and identity will result in neglecting the simultaneous processes of the multiple experiences of oppression and marginalization that that person may experience (Aspinall et al., 2019; Bilge, 2013; Hankivsky et al., 2014). Thus, health, for example, is informed by the intersection of multiple levels of power structures and discrimination structures (Dagkas, 2016).

Therefore, each of the two approaches of critical ethnography and intersectionality has established strengths, and combining these approaches results in potential synergies. Similarities are seen in the underpinning goals and philosophical positions reflecting the harmony between intersectionality and critical ethnography, as both perspectives share the same aim of an empowerment agenda with marginalized groups. Another reason to consider a blended approach is that intersectionality alone, as a theoretical perspective, does not give us the specific guidance of a methodology (Aspinall et al., 2019). However, a blended approach of critical ethnography and intersectionality can illuminate the connection between the intersecting sources of oppression that people may experience and the ideologies and structures of a dominant culture.

### 3.3. Mapping the Terrain of Emancipation and Empowerment

In this section, we will align the philosophical underpinnings and methodology of critical ethnography with an intersectionality-based analysis to demonstrate a coherent fit between the two. To begin with, both critical ethnographers and those concerned with

intersectionality aim at contributing, in some way, to the emancipation of oppressed populations and people (Miled, 2019). Moreover, critical ethnography as a methodology and intersectionality as an analytical lens share the same critical characteristics by pointing to an awareness of the complex diversity of any people, group, or culture. Addressing the consideration of the interlocking nature of multiple axes of power relations (race, class, culture, gender, location, nationality, and religion) that shape experiences and social exclusion processes within a particular cultural context can be one way of understanding social inequalities and of uncovering health inequalities (Rodriguez et al., 2016).

Engaging in research and knowledge exchange through an intersectional lens may help those on the margins confront various forms of oppression and enable them to empower themselves (Chun et al., 2013). In addition, deploying an intersectional perspective contributes to promoting our understanding of the complex interactions of different forms of refugee women's disadvantages, including social identity, status, displacement, and gender, that are jeopardized either at the level of everyday life experiences or as a component of broader social and organizational practices (Grabham et al., 2008). In a similar fashion, critical ethnography explicitly enacts a political agenda rather than a simple description of the insider's and/or researcher's perspective that is common in traditional ethnography (Morse, 2016; Ponce de León-Calero, 2017; Zulfikar, 2014). A key feature of critical ethnography is the need to study power and empowerment, inequality and inequity, dominance, hegemony, and victimization (Carspecken & Walford, 2001; Madison, 2005; Savage, 2006; Thomas, 1993). This feature of critical ethnography springs from the notion of emancipatory action, whereby

the knowledge of why certain situations of marginalized groups occur in a particular cultural context can provide the power to change them (Ponce de León-Calero, 2017).

The aforementioned feature of critical ethnography works synergistically with intersectionality, which looks at the intersection of multiple systems of oppression.

The issues of multiple oppression force ethnographers and intersectional scholars to design their research in such a way that describes and explores how the intersected vulnerabilities influence particular cultural groups, albeit along different lines.

Ethnographic research provides researchers with a unique way of describing the details and context of the study and equips them with tools to navigate the contextual and social resources, whereas intersectionality examines the interlocking systems of oppression that might contribute to people's marginalization and disadvantages. For instance, the vast array of issues that Syrian refugee women face in host countries, paired with various challenges such as children's responsibilities, language barriers, and financial burdens, force these women to be further disadvantaged and marginalized and affect their physical and mental health. Thus, deploying a critical ethnographic methodology with an intersectional analysis provides an emancipatory approach in the nursing discipline that aims at empowering marginalized groups and freeing them from oppressive social structures.

The literature informs our argument on intersectionality, and critical ethnography, which we propose, supports that both approaches have similar epistemological assumptions. These assumptions include that all knowledge is rooted in structural, sociopolitical, historical, and cultural reality where the knowledge over time becomes

“taken for granted” (Berman et al., 1998; Burnett et al., 2015). Here, we explain how the merging of both critical ethnography and intersectionality might enhance our understanding of the intersecting aspects of people’s lives and struggles in a cultural context that continues to challenge policymakers and those desirous of social change. Using such a blended approach may help critical ethnographers explain refugee women’s inequality and struggle in an interactive and mutually constitutive way. Moreover, this blending may also help policymakers expand their understanding of people’s experiences and facilitate more effective political and policy-oriented solutions (Campbell, 2015). From a policy perspective, a blended approach may address the political role of the public policies, including government agencies’ positions, policy programs, and policy-making processes, toward Syrian refugees and the conditions under which these policies can be labeled as critical (Dubois, 2015). In addition, this merging of critical ethnography and intersectionality may assist in understanding the various experiences and circumstances of this particular social group that is targeted by policy programs and the processes of policy-making, with an emphasis on the main contributions of this approach and how it is aligned with the dominant views on public policies (Dubois, 2015).

The process of blending both approaches to further understand refugee women’s everyday experiences of marginalization and oppression requires conceptualizing, differentiating, and classifying various forms of social identities and how they intersect in a way that further marginalizes them. This conceptualization of the intersecting identities and the interplay of these identities are crucial for any ethnographer-applied intersectional analysis. For instance, for refugee women, the intersecting identities include being female, different cultures, governmental institutions, current political

dispensation, health-care systems, and each individual's circumstances and refugee status.

Deploying an intersectional perspective contributes to promoting our understanding of the complex interaction of different forms of refugees' disadvantages. These disadvantages include the jeopardization of their social identity, migration, culture, religion, displacement, and gender either at the level of everyday life experiences or in the social organizational practices (Grabham et al., 2008). These contributions of intersectionality echo what critical ethnography calls for in terms of empowerment and social change. Therefore, deploying an approach that includes both intersectionality and critical ethnography in the field of refugee women's research and other marginalized populations calls for more attention to the disruption of the unacceptable oppressive norms currently being lived by refugee women.

### 3.4. Online Synchronous Interviewing: A method for change in the time of COVID-19

The COVID-19 pandemic has raised some particular challenges, dilemmas, and opportunities confronting ethnographers, such as how physical presence and face-to-face interaction are deemed risky for disease transmission. Such unavoidable circumstances forced us to modify and adjust our data collection strategies to offer a sense of intense engagement with the participants while simultaneously mitigating the risk of spreading the disease. One noticeable challenge that we encounter during our research is how to conduct participant and field observations with the current social distancing regulations. However, this challenge stimulates us to be creative and to move beyond the classical

techniques toward an innovative data collection method that governs critical ethnography principles, practices, and transparency while simultaneously maintaining researchers' and participants' safety (Fine & Abramson, 2020). Moreover, such a challenge offers an arena for reflection on our data collection experiences and how these experiences can contribute and provide opportunities for developing creative styles of conducting future ethnographic research during a pandemic. The following reflections draw from our personal experiences over the past six months of data collection and analysis and how social distancing during crisis time can still remind us about how to be creative and use different ways to conduct ethnographic research (Chao, 2020). As university professors, we conduct virtual lectures and use video conferencing applications to deliver online classes during the outbreak. Similarly, the outbreak has given us an impetus to conduct research projects virtually and to utilize the current video conferencing platforms, such as a secure academic version of "Zoom" for data collection.

Online synchronous interviewing (OSI) undeniably has its benefits and challenges. During our experiences of working with Syrian refugee women, most participants asserted that conducting online interviewing using the Zoom platform was a feasible option with an increased comfort zone. All participants also appreciate the OSI during the COVID-19 pandemic in terms of safety for themselves and their families, selecting their preferred date, time, and place for the interview. Moreover, all the participants comment on the comfort they experience while conducting the interviews in their homes or backyards in terms of saving the time spent on getting dressed, transporting, making arrangements for day care for their kids, and possessing the option to have personal control to turn on the camera and to terminate the interview at any time.

For instance, one of the participants valued the OSI, and she positively commented on the joy of being homebound and the comfort she experienced during interviewing while she was wearing her pajamas and having her coffee in the backyard. Such features of the OSI, including a sense of safety, comfort, and personal control over conducting the interview, allow for a deep engagement with meaningful explorations of the experiences (Lenette & Boddy, 2013); rich and thick description of cultural, sociopolitical, and power differences rather than focusing on the conversation itself (Lenette & Boddy, 2013).

Based on our experiences of working with Syrian refugee women, the OSI proved that it is suited to understanding the refugees' narratives and experiences (Lenette & Boddy, 2013). Their experiences are complex and intersectional in nature, and they cannot always be conveyed through narrative textual representations only. The additional value that the OSI method brings to our research highlights the need to consider the significant impact of such a method, particularly when social distancing is enforced for both participants and researchers. In relation to Syrian refugee women's narratives, the OSI method assists us in developing knowledge on resilience, trauma and migration, pathways to acculturation, and health and well-being in the host countries through representations of these women's experiences and struggles. In addition, the OSI provides a platform and opportunities that could potentially alleviate the risk of face-to-face interviews, especially during pandemic illnesses and when social distancing precautions are enforced, and there are now various options of digital technology that can be used to conduct research while tackling the COVID-19 pandemic.

From the participants' perspective, our interviewees were Internet users and those who were familiar with virtual communication methods. Arranging mutually convenient times and dates for the interview proved feasible and was appreciated by all the participants; due to this, the women had to organize their time to meet their demands, including childcare and home chores. Therefore, the OSI seemed to be a logical, feasible, low-cost, convenient, and innovative method, particularly during respiratory illnesses. Another exciting feature of the OSI is confidentiality and control over the research process, which is, undoubtedly, an integral part of our research for ethical and practical reasons. For instance, our participants had a high degree of control over the research and terminated the interview at any time, and no one could join the session because the interviews took place at specified times, dates, and places known only to those invited to or interested in participating in the study.

On the negative side, conducting an OSI has several challenges, such as gaining access to the initial participants and familiarizing them with the Zoom video conferencing option and how to install the Zoom on their digital devices, such as cellphones or computers, in order to send them the link to join the meeting. The recruitment of subsequent participants was less challenging, because we adopted the snowball sampling technique. In our research with Syrian refugee women, data collection challenges are technical and depend on building trust with the participants virtually. To mitigate the aforementioned challenges, we considered various measures, such as hiring a research assistant (facilitator) to arrange for interview dates, ensure that all the interested participants had installed the Zoom application on their phones or computers, and that would enable them to log on without trouble. Moreover, the interviews were conducted



by an interviewer who had a similar ethnicity and background and spoke the participant's language. To build trust and rapport, the interview was started by expressing gratitude and appreciation for the women's participation in the study and by allowing them to enjoy ongoing conversations about themselves, their families, their achievements, and their talents. These measures were combined with therapeutic communication strategies involving frequent checks about their comfort to continue the interview with constant encouragement and appreciation for giving more details about their experiences. On the other hand, the OSI might limit the potential for observing interpersonal interactions between family members that we might have observed with in-person interviewing. For instance, most of the interviewed women tend to instruct their family to remain out of sight during their interviews.

In summary, the OSI seems uniquely suited for critical ethnography research within the virtual collectives while the social distancing measures are being enforced. Moreover, as more researchers are gearing up to use digital technologies to conduct their research during the ongoing COVID-19 pandemic, the OSI method shows a promising option to leverage other data collection techniques in our quiver. It has much to offer to refugee women's research if adapted appropriately.

### 3.5. Refugee Women's Health and Nursing Research

A blended approach of critical ethnography and intersectionality can provide an in-depth, rich, contextual, and valuable tool in instances where uncovering refugee women's oppression, power differential, meaning, and experience is at the heart of the research question. From our experience, the use of a blended approach with the OSI in

our study yielded in-depth and nuanced meanings to the Syrian refugee women's concepts of trauma, migration hardship, vulnerability resistance, and acculturation. Further, adopting such an approach allows an in-depth exploration of the sociocultural determinants of trauma, migration hardship, resilience, acculturation, and well-being. Moreover, the use of a blended approach and the OSI method produced a rich, emotional, and enjoyable journey for the researcher and the participants. All the participants in our study appreciated the OSI and its related benefits, and they explained that they had been engaged in research earlier; however, being involved in our study allows them to unravel their preconceived notions about being involved in research. Also, most of the women in our study assured us that being involved in our study with such a data collection technique allows them to be actively and genuinely engaged in the study's entire process with a great sense of control. Moreover, the women in our research positively reported that although they might have shared aspects of their stories with different researchers, they had never been involved with the OSI method earlier. Therefore, through our blended approach and the OSI method, the Syrian refugee women shared significant experiences and stories previously unexplored.

This appreciation of our research and method contributed to the women's sense of their own empowerment and illustrated our approach and the method's strengths in making their resilience and resistance apparent. For example, one of the participants (Tamara) shared that she barely discussed the meaning of discrimination or violence with previous researchers during face-to-face in-depth interviews compared with the OSI method, during which she felt more comfortable to express her feelings while still being in control to terminate the interview at any time. Similarly, Sarah and Basha emphasized

the feasibility of interviewing by the OSI and the significant role of technology as an innovative way to depict their trauma and migration journey in an audio or video platform. They also asserted that the OSI technique triggered a strong attachment to their culture and showed some of their cultural norms, such as decorations and preparation during Ramadan (the fasting month for Muslims).

Some participants described the OSI as one way by which they could share their resilience strategies in the host communities; for instance, in Noor's case, her tone expressed her talent and creativity while she displayed her crochet pieces. While using the Zoom platform, the participants commented that the OSI offers a new way of describing their narratives of trauma, migration hardship, and resilience. Therefore, a blended approach has great potential for nursing research, especially in refugee women's health, where health-care practice is focused on their experiences of giving and receiving care in the host communities. A blended approach can also help illuminate the culturally shared experiences of refugee women, particularly the role of culture and the social construction of the interpretation of events. This argument mirrors Clark's (2018) argument, that such illumination can help bring refugee women's voices to the knowledge production process.

A blended approach is crucial to the nursing discipline, where refugee women's health-care needs may challenge nurses to understand how they practice and how supportive, trauma-informed, and culturally sensitive care might be enhanced in the future. Moreover, such an approach of critical ethnography and intersectionality can provide an empowering method that ensures that participants can share and understand

their experiences through their worldview, perspectives, and preferences, thus stimulating a sense of agency and resistance (Lenette & Boddy, 2013). In addition, this approach can provide an alternative view of the current nursing care provided to refugee women and, ultimately, their health outcomes. Such an approach may complement other views and methodology to construct a more comprehensive and holistic body of knowledge about different nursing phenomena and refugee women's health (Draper, 2015; Hammersley & Atkinson, 2007). Of significance, a blended approach assists researchers in capturing cultural narratives, behaviors, and stereotypical roles that might be neglected by traditional analysis or discourse interpretation (Lenette & Boddy, 2013).

From a clinical perspective, nurses can use this blended approach of research in their workplaces to question various assumptions underpinning the health-care practices provided to refugee women in their host communities. A further point of application is that a blended approach can provide a unique theoretical position that draws from a philosophical underpinning of critical ethnography and intersectionality and it can simultaneously mitigate the confusion and ambiguity regarding the value and the potential of intersectionality as a paradigm, lens, or theory (Aspinall et al., 2019).

Therefore, our argument suggests that merging intersectionality and critical ethnography can result in a fruitful methodological dialogue in the future. We believe that a blended approach sheds light on the intersecting matrix of oppression that refugee women experience; this poses an obstacle to refugee women's empowerment and the provision of safe nursing care to those women with respect to their sociopolitical and cultural contexts.

### 3.6. Discussion

A blended approach is relevant to the knowledge development of nursing and the advancement of the nursing discipline, because this approach calls for a critical reflection and appraisal of the social, cultural, and political status quo (Aspinall et al., 2019). The blended philosophical framework supported the rigor in preparing any refugee women's study design that searches for a more nuanced understanding of the relationship between the nursing phenomenon and women's empowerment and health. Such an understanding can be achieved only by considering a transparent reflection of integrating critical ethnography and intersectionality tenets into data collection tools and data analysis strategies. The combination assists nursing research in adopting a more nuanced approach to studying refugee women's health, including the effects of oppression, privilege, and culture that can further enable refugee women's empowerment.

To illustrate the added value of using a blended approach of intersectionality and critical ethnography, we considered previous studies that used these approaches. The discussion that follows will present some examples of research studies that implemented critical ethnography and intersectionality within refugee women's health research. This approach can be applied for other marginalized groups and address each potential as a method for empowerment and social change. We hoped that the combined approach would have brought to the fore the inherent value of blended approach to not just the refugee women but other marginalized groups as well.

The capacity of utilizing the blended approach of critical ethnography and intersectionality to capture and address the complexities of inequity and marginalization

in order to advance social justice and address issues of power within the marginalized group such as refugee women's health is well demonstrated in the paper by Gkiouleka, Huijts, Beckfield, and Bamba (2018). The authors concluded that integrating intersectionality with ethnography and institutional approaches allows for the understanding that institutions as heterogeneous entities may influence the production of social privilege and disadvantage beyond purely socioeconomic factors. Such an understanding can be achieved by addressing the interaction of sociocultural contexts with the micro and the macro facets of health politics for refugee women.

In another example that supports the congruence between critical ethnography and intersectionality, Edmunds (2016) in studying temporary agricultural workers argued that adopting critical ethnography was strengthened through the use of intersectional analysis. Furthermore, the adoption of critical ethnography demonstrated the appropriateness of the aforementioned methodology for critiquing temporary agricultural worker social structures, gender roles and power relations (Edmunds, 2016). Similarly, Knappert et al. (2018) asserted that a key success factor of social change and refugees' societal integration is inclusion, thus focusing on the intersection of refugee status and gender. Therefore, understanding the interplay between gender, culture, and health for these groups requires an in-depth understanding of their struggles and experiences in their cultural context, access to resources and services, and the impact of an embedded sociopolitical context in their lives.

In the same fashion, O'Mahony et al. (2012), in their study on refugee women with postpartum depression, argued that critical ethnography assists researchers in

understanding how immigrant and refugee women's circumstances are embedded within a broader social context and how structural inequalities and oppressive forces shape their health and illness experiences. The authors suggest that adopting a critical ethnography perspective helps researchers explore the mental health-care needs of immigrant and refugee women and increases their understanding and awareness of what would help meet their needs (O'Mahony et al., 2012).

Judging from a public health perspective and moving to discussions of critical ethnography and intersectionality in public health nursing and its relevance for public health, Bowleg (2012) concluded that intersectionality is a substantially useful critical theoretical framework for public health. The author posits that this success of intersectionality in public health, in general, and refugee women, in particular, is due to its broad embrace of multiple intersecting identities and multiple interlocking aspects of privilege and oppression (Bowleg, 2012). Kapilashrami and Hankivsky (2018) illustrated the added value of intersectional research to inform public health analysis by initially mapping health inequalities and proposing more effective policy and program development for marginalized groups, such as refugee women. Likewise, Kapilashrami et al. (2015) encouraged researchers to focus on the intersection of various social dynamics in recognizing the experiences of oppression and privilege among refugee women. In addition, they called researchers to address health inequalities and different axes of inequality and to move beyond micro-level behaviors of refugee women to critically evaluate the matrix of oppression and the structural drivers of these inequalities (Kapilashrami et al., 2015).

Finally, Gkiouleka, Huijts, Beckfield, Bamba, et al. (2018) argued that intersectionality offers a robust analytical approach to understanding health inequalities beyond the purely socioeconomic status by addressing the multiple layers of privilege and oppression, including gender, culture, migration, and refugee status, ethnicity, and sexuality. To sum up, this paper's primary argument confirms what De Chesnay (2014) concluded about ethnography's contribution to nursing; a blended theoretical approach of critical ethnography and intersectionality has much to offer to the nursing profession, and nursing has much to gain from such a blended approach.

### 3.7. Conclusion

This paper highlights the paradigmatic dimensions of complexity, empowerment, and the pragmatic potential of utilizing a blended approach of critical ethnography and intersectionality at the methodological level. This paper's argument addresses to the methodological challenges facing refugee women's research, and it supports the synergetic effect of merging critical ethnography with intersectionality in advancing refugee women's health research. As we have discussed, a blended approach of critical ethnography and intersectionality can investigate and illuminate the complexities of refugee women's health and their social world. It can help us understand both the individual and collective experiences of these women and is, therefore, highly appropriate for nursing and allied health-care practices.

The combination of critical ethnography with intersectionality may provide a new philosophically robust underpinning approach to inform refugee women and nursing research. It can be used by a range of policymakers and stakeholder groups to explore a



wide variety of issues, including the experiences of refugee women, their identities, and their power relations with the host communities and health-care practices. Promisingly, using a blended approach of critical ethnography and intersectionality can inform and expand our understanding of refugee women's health, as shaped by their intersecting identities and socio-structural contexts.

## References

- Acarturk, C., Konuk, E., Cetinkaya, M., Senay, I., Sijbrandij, M., Cuijpers, P., & Aker, T. (2015). EMDR for Syrian refugees with posttraumatic stress disorder symptoms: Results of a pilot randomized controlled trial. *European Journal of Psychotraumatology*, 6(1), 1-9. <https://doi.org/10.3402/ejpt.v6.27414>
- Agic, B., McKenzie, K., Tuck, A., & Antwi, M. (2016). *Supporting the mental health of refugees to Canada*. Mental Health Commission of Canada. [https://www.mentalhealthcommission.ca/sites/default/files/2016-01-25\\_refugee\\_mental\\_health\\_backgrounder\\_0.pdf](https://www.mentalhealthcommission.ca/sites/default/files/2016-01-25_refugee_mental_health_backgrounder_0.pdf)
- Aspinall, C., Jacobs, S., & Frey, R. (2019). Intersectionality and critical realism: A philosophical framework for advancing nursing leadership. *Advances in Nursing Science*, 42(4), 289-296. <https://doi.org/10.1097/ANS.0000000000000275>
- Beck, C. T. (2013). *Routledge international handbook of qualitative nursing research*. Routledge.
- Berman, H., Ford-Gilboe, M., & Campbell, J. C. (1998). Combining stories and numbers: a methodologic approach for a critical nursing science. *Advances in Nursing Science*, 21(1), 1-15. <https://doi.org/10.1097/00012272-199809000-00002>
- Bilge, S. (2013). Intersectionality undone. *Du Bois Review: Social Science Research on Race*, 10(2), 405-424. <https://doi.org/10.1017/S1742058X13000283>

- Bowleg, L. (2012). The problem with the phrase women and minorities: intersectionality—an important theoretical framework for public health. *American Journal of Public Health, 102*(7), 1267-1273.  
<https://doi.org/10.2105/AJPH.2012.300750>
- Burnett, C., Ford-Gilboe, M., Berman, H., Ward-Griffin, C., & Wathen, N. (2015). A critical discourse analysis of provincial policies impacting shelter service delivery to women exposed to violence. *Policy, Politics, and Nursing Practice, 16*(1-2), 5-16. <https://doi.org/10.1177/1527154415583123>
- Campbell, M. L. (2015). Intersectionality, policy-oriented research and the social relations of knowing. *Gender, Work and Organization, 23*(3), 248-260.  
<https://doi.org/10.1111/gwao.12083>
- Carspecken, P. F. (1996). *Critical ethnography in educational research: A theoretical and practical guide*. Psychology Press.
- Carspecken, P. F., & Walford, G. (2001). *Critical ethnography and education* (1st ed). Emerald Group Publishing.
- Chao, S. (2020). *When crisis brings us closer: Reflecting on family, fieldwork, and faraway homes in the COVID-19 pandemic*. Somatmosphere.  
<http://somatosphere.net/2020/when-crisis-brings-us-closer-reflecting-on-family-fieldwork-and-faraway-homes-in-the-covid-19-pandemic.html/>

- Chun, J. J., Lipsitz, G., & Shin, Y. (2013). Intersectionality as a social movement strategy: Asian immigrant women advocates. *Signs*, 38(4), 917-940.  
<https://doi.org/10.1086/669575>
- Clark, N. (2018). Exploring community capacity: Karen refugee women's mental health. *International Journal of Human Rights in Healthcare*. 11(4), 244-256.  
<https://doi.org/10.1108/IJHRH-02-2018-0025>
- Collins, P. H. (2000). Gender, black feminism, and black political economy. *The Annals of the American Academy of Political and Social Science*, 568(1), 41-53.  
<https://doi.org/10.1177/000271620056800105>
- Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, 1989(1), 139-167.  
<https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8>
- Dagkas, S. (2016). Problematizing social justice in health pedagogy and youth sport: intersectionality of race, ethnicity, and class. *Research Quarterly for Exercise and Sport*, 87(3), 221-229. <https://doi.org/10.1080/02701367.2016.1198672>
- De Chesnay, M. (2014). *Nursing Research Using Ethnography: Qualitative Designs and Methods in Nursing*. Springer Publishing.
- Draper, J. (2015). Ethnography: Principles, practice and potential. *Nursing Standard*, 29(36), 36-41. <https://doi.org/10.7748/ns.29.36.36.e8937>

- Drolet, J., Enns, R., Kreitzer, L., Shankar, J., & McLaughlin, A. (2017). Supporting the resettlement of a Syrian family in Canada: The social work resettlement practice experience of Social Justice Matters. *International Social Work*, 61(5), 627–633. <https://doi.org/10.1177/0020872817725143>
- Dubois, V. (2015). Critical policy ethnography. In F. Fischer, D. Torgerson, A. Durnová & M. Orsini (Eds.), *Handbook of critical policy studies*. (pp. 462–480 ). Edward Elgar Publishing. <https://doi.org/10.4337/9781783472352.00034>
- Duncan, G. (2015). Refugee healthcare: Towards healing relationships. *Canadian Social Science*, 11(9), 158-168. <https://doi.org/10.3968/7547>
- Edmunds, K. (2016). *Uprootedness and health of women temporary agricultural workers: A critical ethnography* [Doctoral dissertation, Western University]. Electronic Thesis and Dissertation Repository. <https://ir.lib.uwo.ca/etd/3716>
- El-Khani, A., Ulph, F., Peters, S., & Calam, R. (2017). Syria: coping mechanisms utilized by displaced refugee parents caring for their children in pre-resettlement contexts. *Intervention*, 15(1), 34-50. <https://doi.org/10.1097/WTF.0000000000000136>
- Fine, G. & Abramson, C. (2020). Ethnography in the time of Covid-19: Vectors and the vulnerable. *Etnografia e ricerca qualitativa*, 13(2), 165-174. <https://doi.org/10.3240/97802>
- Gkiouleka, A., Huijts, T., Beckfield, J., & Bambra, C. (2018). Understanding the micro and macro politics of health: Inequalities, intersectionality & institutions-A

research agenda. *Social Science and Medicine*, 200, 92-98.

<https://doi.org/10.1016/j.socscimed.2018.01.025>

Grabham, E., Cooper, D., Krishnadas, J., & Herman, D. (2008). *Intersectionality and beyond: Law, power and the politics of location*. Routledge.

Hadfield, K., Ostrowski, A., & Ungar, M. (2017). What can we expect of the mental health and well-being of Syrian refugee children and adolescents in Canada? *Canadian Psychology*, 58(2), 194-201. <https://doi.org/10.1037/cap0000102>

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice* (3rd ed.). Routledge.

Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., Ferlatte, O., & Clark, N. (2014). An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity. *International Journal for Equity in Health*, 13(1), 119-135. <https://doi.org/10.1186/s12939-014-0119-x>

Hansen, L., Maidment, L., & Ahmad, R. (2016). Early observations on the health of Syrian refugees in Canada. *Canada Communicable Disease Report*, 42, 8-10. <https://doi.org/10.14745/ccdr.v42is2a03>

Higginbottom, G. M. A., Rivers, K., & Story, R. (2014). Health and social care needs of Somali refugees with visual impairment (VIP) living in the United Kingdom: A focused ethnography with Somali people with VIP, their caregivers, service providers, and members of the horn of Africa blind society. *Journal of Transcultural Nursing*, 25(2), 192-201.

<https://doi.org/10.1177/1043659613515715>

Hilado, A., & Lundy, M. (2017). *Models for practice with immigrants and refugees: Collaboration, cultural awareness, and integrative theory*. SAGE Publications.

<https://doi.org/10.4135/9781506300214>

Kapilashrami, A., & Hankivsky, O. (2018). Intersectionality and why it matters to global health. *The Lancet*, 391(10140), 2589-2591. [https://doi.org/10.1016/S0140-6736\(18\)31431-4](https://doi.org/10.1016/S0140-6736(18)31431-4)

Kapilashrami, A., Hill, S., & Meer, N. (2015). What can health inequalities researchers learn from an intersectionality perspective? Understanding social dynamics with an inter-categorical approach? *Social Theory and Health*, 13(3-4), 288-307.

<https://doi.org/10.1057/sth.2015.16>

Knappert, L., Kornau, A., & Figengül, M. (2018). Refugees' exclusion at work and the intersection with gender: Insights from the Turkish-Syrian border. *Journal of Vocational Behavior*, 105, 62-82. <https://doi.org/10.1016/j.jvb.2017.11.002>

Lenette, C., & Boddy, J. (2013). Visual ethnography and refugee women: nuanced understandings of lived experiences. *Qualitative Research Journal*, 13(1), 72-89.

<https://doi.org/10.1108/14439881311314621>

- Madison, S. (2005). *Critical ethnography: method, ethics, and performance*. SAGE Publications.
- McBride, A., Hebson, G., & Holgate, J. (2015). Intersectionality: are we taking enough notice in the field of work and employment relations? *Work, Employment and Society*, 29(2), 331-341. <https://doi.org/10.1177/0950017014538337>
- McCabe, J., & Holmes, D. (2014). Nursing, sexual health and youth with disabilities: a critical ethnography. *Journal of Advanced Nursing*, 70(1), 77-86. <https://doi.org/10.1111/jan.12167>
- Miled, N. (2019). Muslim researcher researching Muslim youth: reflexive notes on critical ethnography, positionality and representation. *Ethnography and Education*, 14(1), 1-15. <https://doi.org/10.1080/17457823.2017.1387063>
- Mills, K. (2007). Access to multiliteracies: A critical ethnography. *Ethnography and Education*, 2(3), 305-325. <https://doi.org/10.1080/17457820701547310>
- Morse, J. M. (2016). Underlying ethnography. *Qualitative Health Research*, 26(7), 875-876. <https://doi.org/10.1177/1049732316645320>
- O'Mahony, J., Donnelly, T., Este, D., & Bouchal, S. (2012). Using critical ethnography to explore issues among immigrant and refugee women seeking help for postpartum depression. *Issues in Mental Health Nursing*, 33(11), 735-742. <https://doi.org/10.3109/01612840.2012.701707>



- Palmer, D., & Caldas, B. (2017). Critical ethnography. In K. A. King, Y.-J. Lai, & S. May (Eds.), *Research methods in language and education* (3rd ed., pp. 381-392). Springer. <https://doi.org/10.1007/978-3-319-02249-9>
- Rodriguez, J., Holvino, E., Fletcher, J., & Nkomo, S. (2016). The Theory and praxis of intersectionality in work and organisations: Where do we go from here? *Gender, Work & Organization*, 23(3), 201-222. <https://doi.org/10.1111/gwao.12131>
- Savage, J. (2000). Ethnography and health care. *BMJ*, 321(7273), 1400-1402. <https://doi.org/10.1136/bmj.321.7273.1400>
- Savage, J. (2006). Ethnographic evidence: The value of applied ethnography in healthcare. *Journal of Research in Nursing*, 11(5), 383-393. <https://doi.org/10.1177/1744987106068297>
- Thomas, J. (1993). *Doing critical ethnography*. SAGE publishing.
- Walby, S., Armstrong, J., & Strid, S. (2012). Intersectionality: Multiple inequalities in social theory. *Sociology*, 46(2), 224-240. <https://doi.org/10.1177/0038038511416164>
- Zulfikar, T. (2014). Researching my own backyard: inquiries into an ethnographic study. *Ethnography and Education*, 9(3), 373-386. <https://doi.org/10.1080/17457823.2014.919869>

## Chapter 4:

# Listening to the Voices of Syrian Refugee Women in Canada: A Critical Insight into the Journey from Trauma to Adaptation

### 4.1. Background

The Syrian civil war crisis has been described as the biggest humanitarian and refugee crisis of our time since the end of World War II (United Nations High Commissioner for Refugees [UNHCR], 2018). About six million Syrians, three-quarters of whom are women and children, have been displaced around the world and create a significant impact on the socioeconomic and health-care systems of the host countries. According to the UNHCR (2020), Canada admitted the largest number of refugees who had resettled the previous year and it had the second-highest rate of refugees who gained citizenship. With these numbers, it is understandable that measures need to be put in place for the health needs of the migrant population. Thus, the UNHCR has called for urgent guidelines to address the health care for the Syrian refugee population due to their high medical needs. This call for health-care guidelines makes intuitive sense for the need of different initiatives to support Syrian refugees. Health and social programs would potentially assist all Syrian refugees regardless of the current social, political, and structural challenges that they might be facing.

In general, Syrian refugees have faced catastrophic war crimes, human rights violations, poverty, forced migration, and repeated displacement, with potential physical

and mental health implications (Acarturk et al., 2015; Drolet et al., 2017; El-Khani et al., 2017; Hansen et al., 2016). Specifically, Syrian refugee women may experience physical and mental health problems prompted by previous trauma, violence, and repeated displacement (Ahmed et al., 2017; Chung et al., 2017; El-Khani et al., 2017; Gaebel et al., 2016; Jefee-Bahloul et al., 2016), compounded by various stressors, including unstable income and housing, loss of family, prolonged grief, settlement and integration challenges, language barriers, social isolation, discrimination, powerlessness, and uncertainty about the future (Acarturk et al., 2015; Agic et al., 2016; El-Khani et al., 2017; Hadfield et al., 2017). Syrian refugee women, particularly those with children, are a highly vulnerable population in Canada (Cho et al., 2017), with severe implications for their health regarding access to health services, better living conditions, and a better quality of life. These refugees may be conceptualized as either victims lacking in capacity or victims of circumstances beyond their control (Cho et al., 2017; Myers, 2016), including adverse external forces, being a female with a different cultural background, and the structure of the social institutions and norms of the hosting country (Ahmed et al., 2017).

The points of view of refugees, in general, and Syrian refugee women, in particular, are seldom incorporated in research, planning for service provision, and policy design (Abu-rass, 2018), leading to an imbalance between what is provided and what is required. It is worth noting that striving to improve Syrian refugee women's health is not just a one-way street, but it is also one without rewards to the host country. Refugees participate in economic growth and bring along with them considerable positive human and social capital that might benefit Canadian society (Drolet et al., 2017; Duncan, 2015;

Hilado & Lundy, 2017). Exploring these women's experiences in relation to migration and health care might influence their relationships with the host health-care system and their physical and mental health, improving their ability to contribute to the development of their host country. Thus, understanding Syrian refugee women's experiences of trauma and migration, in terms of their interaction with the Canadian health-care system is of importance, as it is within these experiences that they will encounter positive or negative attitudes. The complexity of how quickly and how often these attitudes can change over time calls for the need to include the refugees' experiences within the scope of practice of health services.

Although several studies currently address refugees' challenges in accessing and utilizing health-care services in Canada (Cho et al., 2017; Guruge et al., 2018; Oda et al., 2017), there is a paucity of research on how the experiences of pre- and post-migration trauma impact Syrian refugee women's health and their navigation of the available health resources and services. Further, research is needed to explore how the intersections of gender, trauma, culture, and political and economic conditions of the women shape their everyday lives and health, the strategies they are currently using to promote their own physical and mental health, as well as the availability and effectiveness of the present and potential models of care that are in place for these women in Ontario. This study attempted to fill the gap in the existing understanding of Syrian refugee women's experiences of pre- and post-migration trauma, forced migration, displacement and wellbeing. Furthermore, this study explored Syrian refugee women's experiences with the health-care system as well as their physical and mental health outcomes in Ontario. In addition, this study attempted to providing an opportunity for Syrian refugee women's

voices to be heard in improving services that were meant to serve them. Further, the study offered a better understanding of the impact of migration and trauma on Syrian refugee women's roles, responsibilities, gender dynamics, and interaction with Ontario's health-care system to improve interaction and outcomes.

The purpose of this article was to explore and describe the pre- and post-migration experiences of Syrian refugee women in Ontario, Canada, and the impact on their physical and mental health. We aimed to critically examine how the intersection of gender, trauma, and violence, and the political and economic conditions of Syrian refugee women shaped their everyday lives and health. The study explored the strategies and practices which Syrian refugee women used for meeting their physical and mental health needs.

#### 4.1.1. Design

Initially, this study intended to utilize critical ethnography with an intersectional analysis lens that would have included participant observation. However, due to the COVID-19 pandemic with the enforced social distancing and safety measures, the research team modified the methodology. This research utilizes critical qualitative inquiry with an intersectional lens to have a closer understanding of the journey of Syrian refugee women from the civil war stage to their adaptation in Ontario, Canada. Critical qualitative inquiry is a qualitative approach that is used to critique oppression, and unequal social power relations with the aim of achieving social change with an emancipatory vision (Denzin, 2017). Critical qualitative inquiry scholars are committed to critique various forms of inequality and discrimination that operate in the everyday

experiences of the marginalized population by elaborating upon a critical analysis to show how these experiences relate to broader social structures of oppression (Cannella et al., 2016; Denzin, 2017). Therefore, critical qualitative inquiry is particularly suited to this study since it is concerned with capturing the social inequities of Syrian refugee women, and its ultimate goals are directed toward positive social change.

#### 4.1.2. Theoretical Framework

This study uses intersectionality as a theoretical framework to promote the robustness of the study findings. Intersectionality is one of the promising approaches that is used to analyze unequal social power structures and processes that produce unequal health outcomes (Bowleg, 2012; Collins, 2000; Crenshaw, 1989; Hankivsky et al., 2014). The central core of intersectionality is that it moves beyond examining individual factors such as gender and race toward focusing on the interactions and relationships between such factors across multiple society levels (Collins, 2000; Crenshaw, 1989). In this case, the interactions explain how inequity and social power differential influence the Syrian refugee women's experiences of trauma, migration, and health. Thus, Syrian refugee women's health is informed by the intersection of multiple levels of power structures and the structures of discrimination in the host country.

#### 4.1.3. Setting and Participants

This study was conducted in urban communities in Southern Ontario. Syrian refugee women residing in the urban core of the selected cities were considered for the study if they met the inclusion criteria at the time of the study. Women were allowed to participate if they were Syrian refugees, spoke English or Arabic, were aged 18 years or

older, had been in Canada for a minimum of 1 year, and were currently residing in Ontario. Participants were excluded from the study if they were non-Syrian refugees, were unable to speak English or Arabic, and were not currently residing in Ontario. The setting consists of agency premises and sites in Southern Ontario, where settlement services have been provided to Syrian refugees. These areas show a higher proportion of Syrian refugees, as nearly half of the recent governmentally assisted Syrian refugees have resettled in Hamilton, Ontario (Cummings, 2016; Seto, 2016; Smith, 2015). However, only a few studies have addressed the refugees' experiences of pre- and post-migration trauma and their access to health care in these areas.

#### 4.1.4. Trust building with participants

The first author adopted various strategies to build and sustain trust with the participants. For instance, the researcher adopted an approach that was characterized by patience, clarity, openness, and transparency; a receptive approach was employed during the interview with Syrian refugee women. Moreover, since the researcher spoke the same language and had a similar ethnic heritage, potential problems with cultural nuances that may not be known to outsiders were avoided. Another cornerstone and crucial feature of trust-building with research participants is the comprehension of informed consent since it serves as a way of acknowledging women's choice, autonomy, and voice (List & Sempeera, 2009).

Another strategy for building trust with research participants involved the creation of a safe environment that maximized participants' involvement and reflection (List & Sempeera, 2009). For instance, in this study, Syrian refugee women were given the

chance to select the place and the time of the interview so they could feel comfortable to participate and also so that they could feel that they were in control of this study. To promote the participants' sense of privacy, Syrian refugee women were assured that their data and narratives were secure and that only the research team had access to it. The first author conducted a pre-interview call with the participants to provide a guide of what would be happening during the interview (e.g. types of interview questions, expectations, contexts). This strategy assisted Syrian refugee women in addressing any of their concerns before they stepped into the actual interview session and also in preventing any surprises during the interview.

I started welcoming the participants with a smile and thanking them for taking time off to participate in the interview. I also paid attention to the participants' tone of voice, gave participants sufficient time to respond, as well as monitored their body language during the interview to ensure their comfort. When the participants gave short answers, but actually further elaboration was required, I held the silence, especially for questions that touch on emotions. I found that silence strategy is one key means to offer participants the space to reflect on sensitive questions and it was one that encouraged them to unpack their feelings and concerns. Adopting the silence strategy was also one way to show participants that I am an active listener and that they owned the space to share their experiences. To sum up, adopting an approach that was welcoming, flexible, caring, transparent, and encouraging silence can empower the participants to share their insightful experiences and stories.



#### 4.1.5. Data Collection

After obtaining ethical approval from Western University, data collection was conducted over six months in the year 2020. Purposive and snowball sampling techniques were utilized to recruit 25 Syrian refugee women into the study. Due to the challenges imposed by the COVID-19 pandemic, a total of 25 in-depth, open-ended, semi-structured synchronous online interviews were conducted with the recruited women. The average interview time was 1 to 2 hours, which enabled the participants to get an in-depth understanding of the cultural context and a general idea of the study. The participants were recruited initially through the English as a Second Language Center, direct referrals, and communications with the community and settlement agency partners. Participants were interviewed individually in a private area based on their preferences, such as their residences, backyards, and cars, with their permission. An observation of the participants' environment was included, such as observation of their homes, the meaning of their physical space, the people involved, and interactions occurring in this space with their children as well as any expressed emotions.

Interviews were conducted in Arabic and were recorded digitally. Field notes were taken after each interview to summarize observations and impressions about the interview. During the participants' observation, the first author was a participating observer, which helped her to engage in social interactions with those being observed (Lederman, 2016). Such engagement helped the researcher to gain better insights into Syrian refugee women's lives to develop insights on how sociocultural processes

emerged and changed how a specific sociocultural aspect related to the broader processes and contexts. The informal dialogue was conducted with participants to obtain their perspectives on their experiences of migration and trauma.

#### 4.1.6. Data Analysis

Each interview session was transcribed verbatim, and it was read in its entirety with good immersion in the data to get a sense of the whole text and dataset. Thematic analysis with an intersectional lens was used to understand the participants' cultural norms and interlocking identities, such as language, gender, culture, ethnicity, and refugee status. The analysis included the narrative data and observation field notes, and the meaning context was used as the unit of analysis for coding and description (Braun & Clarke, 2006; Terry et al., 2017). Exploring Syrian refugee women's multiple social identities systematically and simultaneously allowed for an understanding of the links between gender, social and political processes, minority status, and social actions.

Analysis of the data began with a description of the cultural context or site where participants were interviewed, identifying their routines, roles, and power relations (Carspecken, 1996). Data analysis started during data collection and continued with coding and analysis to leading to categories and formulating major themes. During the initial phases of analysis, data were coded to develop categories. The meanings and relationships between concepts were explored, compiled, and reorganized multiple times to form tighter hierarchical schemes (Carspecken, 1996; Carspecken & Walford, 2001).

The initial findings were compared with emerging codes during the subsequent stages of data collection. This progressive comparison facilitates capturing cultural

themes that might have meaning during interactions, such as interaction patterns, social practice, power relations, and roles (Carspecken, 1996). The last stage of data analysis involved engaging in a critical dialogical approach to address interviewees' sociopolitical processes and conditions and linking these to broader sociopolitical aspects. Based on the research team's advice, decoding and further analyses were conducted to ensure their consistency was in line with the cultural context and the selected theoretical framework. The major themes were labeled, and all the potential subthemes, connections, and intersections that emerged from the data were listed together.

Various strategies were adopted in this study to enhance trustworthiness, rigor, and quality, as suggested by Lincoln and Guba (1994). For instance, member checking was conducted with three participants to verify that the analyses reflected the participants' experiences and to validate and improve the credibility of the study findings. The primary researcher ensured that the study results were returned to the interested participants to check for accuracy, resonance, and relevance to their experiences. Further, triangulating between data collection and analysis was considered to produce another set of comparatives, dialogical data based on verbal interaction with participants (Carspecken, 1996; Hammersley & Atkinson, 2007). The analysis was conducted in relation to intersectionality tenets, and NVIVO 12 software was used as a qualitative data management and analysis program. Finally, pseudonyms were used for the participants to ensure confidentiality.

## 4.2. Findings

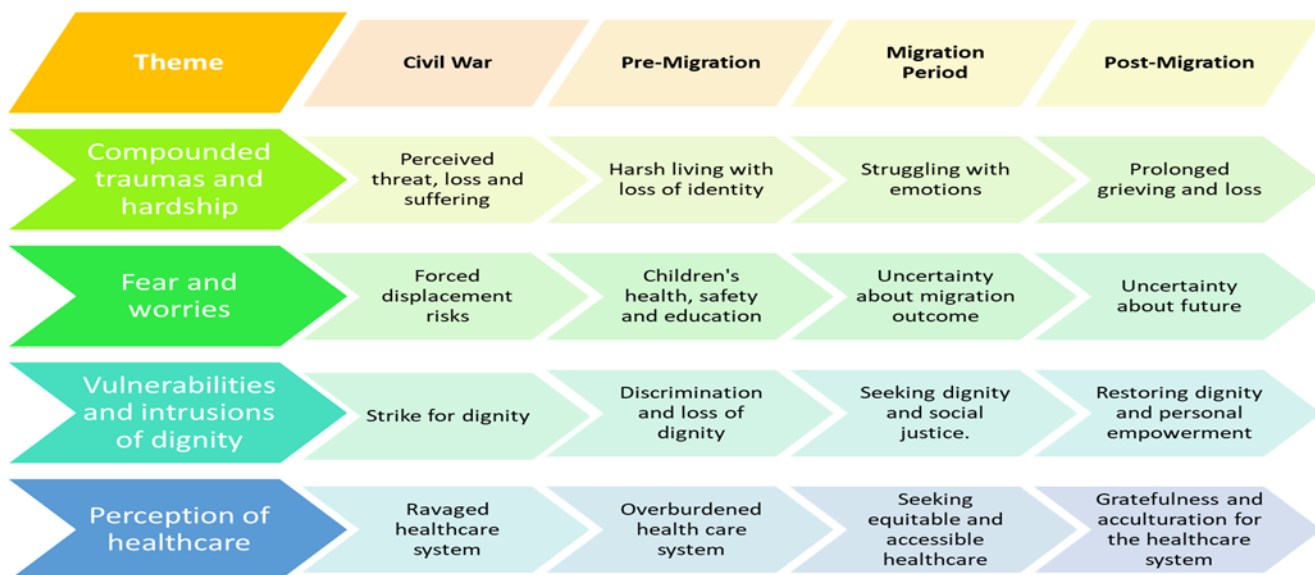
A total of 25 Syrian refugee women participated in this study. This study included a diverse group of women of different ages, educational backgrounds, locations of initial migration, religion, and different types of sponsorship. The participants' ages ranged from 21 to 60 years. Most of these women (19) were married, three were widows, two were single, and one was divorced. Of the 25 women, 23 were Muslims, and two were Christians. The number of children ranged from 0 to 8. On average, these women had stayed in a hotel for around 30 days when they initially arrived in Canada and they had lived in Canada for 4 years. Eighteen women came to Canada through governmentally assisted sponsorships, whereas the other seven came through private sponsorships. All the women spoke Arabic at home and also during the interview. More than half of these women (13) had high school level education, four had a diploma, and eight had a bachelor's degree. Out of the 25 women, 22 were unemployed, and three were employed part-time; their primary income source was welfare or spousal income. The countries from which they migrated to Canada were Jordan (13), Lebanon (five), Turkey (four), and Egypt (three).

In this section of the article, we present the common findings that emerged from the study. Figure 4.1 illustrates the key themes and the related subthemes that reflect Syrian refugee women's experiences for each time frame of their journey in a finding matrix developed for this study. The data analysis led to four major proposed themes that cover different periods, including the civil war, premigration, migration, and post-migration. The emergent themes were: compounded trauma and hardship, fear and

worries, vulnerabilities, and intrusions of dignity and health-care perception. Indeed, Syrian refugee women's narratives reflected the porous temporality of their experiences over different periods and showed how difficult it was to determine when to begin and move through the stages or whether they even had the choice to move. The key themes and subthemes regarding Syrian refugee women's experiences during different time frames are described next.

Figure 4.1:

The Key Themes and Related Sub-Themes



#### 4.2.1. Compounded trauma and hardship

Syrian refugee women's narratives revealed that the decision to leave their homes and to move to another city in Syria or another country for the sake of safety and security was an extremely traumatic experience for each of the women interviewed. These data highlight a severe issue of trauma, threat, loss, and suffering and its impact on these

women's health, particularly for those away from their families and thus did not have any family support. The majority of the women labeled the journeys they made to the borders as harsh, tormenting, dangerous, risky, unforgettable, and uncertain.

“It was scary and terrific times. It looks like a judgment day. We moved from one city to another inside Syria, but it was getting worse, and we could not tolerate it anymore; and it was hard and like torment when we decided to go to another country. It was risky, hard, and like a death trip. It was the hardest point in my life, and it is still in my life, and I will never forget the time when we crossed the borders” (Khitam).

The interviews show that Syrian refugee women who stay in refugee camps have distinct experiences of suffering that illustrate the complex interaction of poverty, loss of home, food insecurity, and poor health outcomes. For instance, more negative physical, mental, and emotional health impacts were predominantly reported by women residing in the refugee camp than women residing in their homes. Yasmin and Iman explained how camp residency and weather challenges impacted their health and their children's health and food security.

“When we moved to another country away from my family, I was damaged, then we stayed at a refugee camp there. The camp was a group of tents if your tent gets burned nobody will know about you. They gave us a food coupon, but it was inadequate for my family” (Yasmin).

“The life was expensive there. It was ok to stay in a refugee camp. You know, when you don't have your home and family, it is hard, but I survive. The weather was hot, fasting was hard, and during winter, it was freezing and muddy, and some kids, especially newborns, died from cold weather. A lot of people, including women and children, didn't have enough food or a clean place to sleep; it was a miserable experience” (Iman).

Most women also asserted that, although they were faced with difficult decisions about moving to another country, they endured their struggling with ambivalent emotions and constant worries as a part of what made their experiences of trauma, migration, and

suffering more harmful and problematic. The majority of the women explained the multiple difficulties, hardships, and challenges that they encountered regarding their initial migration. However, the concern that was predominantly articulated invariably by all the participants was the financial constraints and burden that was worse with children's responsibilities and hardships. Indeed, the financial burden constantly shapes these women's daily lives. Food security and housing challenges were defining features of the Syrian refugee women's experiences of premigration hardship. These features continually affect both their physical and mental health. For instance, Rabeah spoke about the hardship of paying house rent and raising kids with no partner support.

“It was so hard, high house rental and expensive life, I was worried about house rental with raising kids and the food was costly. I rent a one-room house, and it was so expensive there, and I struggled a lot because, at any time, you can find yourself in the street due to the crazy house rental. It is a struggle with raising children and paying house rental with no partner support; it is unfair, and a big struggle for me, and I know that this will have an impact on my health” (Rabeah).

The decontextualization of Syrian refugee women's sense of responsibility to providing for their children by having adequate food and proper housing circumstances associated with multiple social identities contributes to various forms of oppression, marginalization, and discrimination. This sense of responsibility in the face of challenging food prices and house rentals is frequently molded by various rules and regulations that ignore the complex and intersecting vulnerabilities that these women face in their lives. Waeed spoke about how paying house rentals compounded with a sense of oppression and marginalization: “life was costly there; I even offer the house owner to be a servant for her because we could not pay the house rental. It was tough mentally and

physically that all people there abuse Syrian refugees and consider them as worthless servants” (Waeed).

Syrian refugee women seemed to be aware of the consequences of food insecurity and housing challenges on their health and their family’s health, and they perceived this awareness as an explicit form of inequality and marginalization in the host country. It is worth noting that most women constantly express that they are still experiencing prolonged grieving and loss, even now in Canada. These grieving experiences include the loss of their homes, families, culture, and the hardship of forced displacement with its related challenges, especially during the harsh winter or other challenging weather. Loss of home, culture, and family consistently emerged across several subthemes in this study; one such subtheme concerned the impact of the loss of either home or family on women’s mental health. Some women even went as far as describing the loss of home and culture as losing their dignity.

#### 4.2.2. Fear and worries

One of the extremely disturbing aspects of the Syrian refugee women’s narratives during the war was the constant worries and fear experienced by these women. Syrian refugee women talked about how they spent days and hours of each day in tears and worries about themselves or their families’ safety. For example, Noor spoke about the fear of snipers and that every day when they slept, they did not know whether they would wake up the next morning.

“We witness constant worries and fear every time we tried to go outside; we were scared of snipers. It was like a horror movie that was full of snipers. I suffered during the war, and I had constant fear, and I get scared of any sounds. We were



carrying our souls in our hands; we do not know when we will die and if we might wake up or not the next morning. The fear was lived with us” (Noor).

Similarly, Fadla explained how the constant worries and fear made it difficult for women to concentrate, affected their decisions, and, ultimately, their health and well-being. “It was scary in Syria during the war. It was harsh and like death, and I had a panic attack that time, and I did not know what to do. I wish that no mom will experience that feeling” (Fadla). Indeed, most women touched upon the hardship of repeated displacement and of moving from one city to another. Most women agreed that their travel to another country was risky and challenging, with unforgettable moments, and they perceived these circumstances and moments as a part of their journey toward overcoming their sense of insecurity and of ensuring a safe place for their families. The participants consistently asserted the various impacts of their worries about their children’s safety and future on their health and well-being and the role that children-related worries played regarding women’s health in the context of the civil war. Indeed, the worries about children’s safety, health, education, and future seemed to pose various challenges and health impacts such as stress, anxiety, and insomnia on Syrian refugee women during the premigration stage. Waeed and Fatimah spoke about their worries regarding their children’s safety and the future.

“I kept praying to God; I have five kids please help me and save my kids. All my kids were small. It is hard to move from one place to another, but at the same time, I need to find a safe place for my kids, and I should be strong for my kids” (Waeed).

“When my husband died, I become responsible for everything, and I have five girls, and I was so worried about my girls during displacement from the rape or violence on the borders. It was hard, and I was so worried about their safety and future” (Fatima).

Specifically, most of the participants were worried about their children's education and future since their children had not attended classes, and the educational system in the first migration countries did not seem to be well prepared enough to accommodate the influx of the Syrian refugee students. Some women reported that due to the financial burden and the high cost of living and housing, some of their older children did not attend school and decided to assist their parents to cover the cost of living in the host countries. Some women also highlighted the low quality of the educational system in the host countries, coupled with the discrimination that Syrian refugee students encountered in the schools by other students and teachers. For instance, Barchan stated that her children did not want to go to school either because they decided to help their families or because other students labeled them as "refugees" and asked them to return to their country.

"You know they forced Syrian refugee kids to go to afternoon schools. Their education was bad, and most of the students struggled, and definitely, that will affect their future. The teachers were already too exhausted to teach the Syrian refugees. My son didn't go to school there because his friends used to say hey Syrian refugees go back to your country, and he decided to work and help me" (Barchan).

The Syrian refugee women's decisions to leave for Canada emerged as a result of the fear of the unknown and an uncertainty about the migration outcomes and their future. All the women reported that they were initially hesitant to go to Canada. All the participants shared their concerns about moving to a new country with different people, religions, and cultures. Moreover, most of the participants were worried about raising their children in a country with different social norms, religious rituals, and cultures and where people spoke a different language. Some women explicitly stated that they had

never heard about Canada earlier, and they had perceived going to Canada as being the end of the world. Some of them expressed their worries about the ability to practice their religious rituals or cultural practices in a country with a different culture, language, and system.

“When we decided to go to Canada, I was scared, but I don’t know why. You know I feel that I am far away in a different country, different in everything, their people, their weather, their culture. It’s not like when I was in (the initial migration country), I didn’t feel like that. In (the initial migration country) it was similar to Syria, but in Canada, it is a different culture, different languages, and different rituals” (Shahla).

The women explained that every desire that demands satisfaction and every need to be filled or hope to be accomplished forces them to initiate an action and navigate the available options. Most of the participants reported that they felt despair and worthlessness in their initial country of migration, and many explained that they were always praying and looking for other options to improve their quality of life and change their living conditions. Some women expressed that going to Canada was a life-changing decision; for instance, they described moving to Canada as moving from the hell to heaven, and they were dreaming of going there to have a better life. Most of the participants stated that going to Canada was a good chance that should not be missed to change themselves, their family, and their life.

“Coming to Canada was a big relief for us, and of course, this is our chance. You know I was hesitant to go and, at the same time, happy to go. Happy to get a ride from the hardship in (the initial migration country). We escaped from the hell to heaven, and I convinced myself that here (Canada) is the heaven” (Yasmin).

The women stated that their decision to leave for Canada was only undertaken to find another place or option that protected their family members with a better quality of life, education, good opportunities, and a future for their children. All the participants

explicitly reported that going to Canada was a valuable option to secure a future with proper education and opportunities for their children. On the other hand, the women explained that although Canada was a secure and safe place and could mitigate the effects of trauma and the migration hardship on their children, their feeling of uncertainty about their future and their children's future intensified their anxiety. Salam spoke about how her decision to move to Canada was accompanied by uncertainty about her children's future.

“I don't want to go to Canada. It is far, and it is hopeless to see my family, but my husband said Canada is a good option for our kids. Then I agreed to go to Canada for my kid's future. Indeed, Canada has a good education system with good opportunities for my kid's future, but I don't know if we really took the right decision for our children or not” (Salam).

#### 4.2.3. Vulnerabilities and intrusions of dignity

This theme illuminates the complexity and intersecting nature of these women's various experiences and how their lives are being shaped by the predominant and interlocking structures of domination. Specifically, most participants repeatedly described feelings of discrimination, desperation, exclusion, and being different in the host countries. Indeed, the women's perception of vulnerability and marginalization arises from interlocking systems of oppression and various forms of social exclusion such as their gender, being a Syrian refugee with its related negative stereotyping, being perceived as a burden on the host country, and poverty that hinders or prevents them from being effectively engaged and involved with the host countries. Sarah shared her experience of vulnerability:

“We encountered some discrimination because we are Syrian refugees. Being a Syrian refugee woman was not a good thing because there were bad stories about

trading sex in the refugee camp. I don't like to be labeled as Syrian refugees not because of being refugees but due to the context and how people perceive it. You know, being a refugee woman is not a shameful thing, but the people start conceptualizing Syrian refugee women as something cheap. We are Syrian refugees, and we are respected persons" (Sarah).

Most women reported frequent discrimination and abuse. They reiterated that they continually found themselves disadvantaged by various constraints imposed by their gender, refugee status, financial insecurities, place of residency, and socioeconomic contexts of their countries of initial migration. The majority of the initial migration countries excluded Syrian refugee women from employment, which ultimately confined them within lower income levels compared with other women. The core narrative of disrespect, loss of dignity, and perception of being a burden on the host country implies that the women's premigration hardship was accompanied by multiple tensions. These tensions arose from the detachment from their home country, which are associated with the women's multiple social identities and the intersection of various individual, social, cultural, and political dimensions. All the women experienced and reported some forms of disrespect and loss of dignity. Further, they stated that their premigration hardship experiences were intertwined with their marginalized circumstances, including financial burdens and being unable to work or be employed in the host country where discrimination and oppression were prevalent.

"They beat us on the borders like sheep. I know that every refugee is a victim that has been forced through various circumstances to leave his or her country. Then I told my husband I will go back to my house in Syria because the one who leaves his home will lose his identity, dignity, and value (proverb). I said to my husband that I don't care if I will die in Syria, I will go back to my home" (Waeed).

All participants reported that despite their initial misgivings, deciding to move to Canada was the best choice to seek a safe and secure life, human rights, peace, social

justice, and dignity. Further, most of the women repeatedly articulated that they found the freedom they had dreamed about, accompanied by peace, and that there was no discrimination in Canada. The majority of the interviewees explained that they had heard about Canada as being one of the most welcoming and multicultural countries and that they wanted to settle in such a country where they could find peace and safety, freedom, respect, and dignity.

“Here in Canada, I feel freedom, and I can talk and express my opinion. I am grateful now I am in Canada. Here in Canada, they are caring, and they treat us nicely with respect and no discrimination. They are good, kind, welcoming, and honest people here in Canada. You know Canada open its door for us and welcomed us” (Fadla).

All the study participants reported that they felt a strong sense of vulnerability and oppression in their lives compounded by a sense of discrimination, feelings of contempt, and marginalization in their countries of initial migration but not in Canada. In general, most participants perceived that their frequent displacement and migration-related struggles coupled with being Syrian refugee women made them stronger people and contributed to a part of their personal growth, such as learning new things and becoming different and responsible people. In particular, they all reported that they were welcomed in Canada and described about how residing in Canada gave them more power, freedom to speak, and human rights, with no feelings of discrimination. For instance, Iman spoke about the difference in the treatment between the country of her initial migration and Canada:

“NO NO NO I didn’t feel any kind of discrimination here in Canada instead, we have voices and freedom to speak. They are kind and friendly here, and I feel I am a strong woman and more responsible. We witness a lot of discrimination and hate

in the (country of initial migration), and they used to throw out our papers when they knew that we are Syrian refugees” (Iman).

A frequently articulated idea was that Syrian refugee women have changed a lot, shaped by the various struggles and migration hardships that contributed to their personal growth, and they have become strong women with a voice here in Canada. Salam spoke about her personal change and growth:

“I was so sensitive, and now I become a strong woman, and the previous emotions have changed, and I become a strong person now. I have been forced to change, and I have become a stronger woman with a voice and opinion. I am surprised by myself and my strengths here in Canada, but I know that I have been forced to change due to the previous struggles, and it is not with my choice” (Salam).

#### 4.2.4. Perception of healthcare

All the women shared various stressful circumstances and health-related challenges before their arrival in Canada; these challenges include Syria’s ravaged health-care system, the overburdening of the initial migration countries’ health-care systems, and how they have been perceived as a burden on the host countries with different forms of discrimination. For instance, Syrian refugee women who migrated from Lebanon reported extreme discrimination and loss of dignity compared to other women’s experiences from Jordan and Turkey. Syrian refugee women reported that seeking an equitable and accessible health-care system was key to their decision to migrate to Canada. After their arrival in Canada, the women’s challenges were depicted as “being different/their language, their food and their people are different/trying to get rid of depression/it’s my daily routine being anxious, tense and frustrated/nothing to do just stay at home/I don’t know anything here.” One of the commonly reported challenges was the lack of social ties and its impact on their mental health and adaptation in a new

country with different people and cultures. All government assisted refugee women as compared to the privately sponsored women, stated that they felt socially isolated and found it hard to integrate with the new country and culture. All women spoke about the language barriers, housing and financial challenges and how residing in a country where the people spoke a different language made it hard and difficult for them to be engaged and to be able to navigate the available resources and options during the settlement.

Syrian refugee women with big families reported housing and financial stability as compared to women with small families. For instance, Yasmin spoke about how her language barrier prevented her from questioning about her telephone and Internet bill:

“The first challenge here in Canada besides housing was the English language. You know the Roger bill came this month more than usual but the problem I can’t discuss with them because I can’t speak English well to ask them why.”

Most of the women also touched on the change in weather and how these weather-related challenges impacted their settlement, family, engagement with the community, and health, noting that Canada’s weather was new for them as they were not accustomed to such cold or snow, which may have led to some health or other issues. In addition, most of the participants talked about expensive house rent, coupled with the difficulty in finding a job in Canada without having any Canadian experience and being unable to speak the English language. Some women described difficulties in reviewing their credentials, occasionally leading to the need to start their studies over again; some women labeled the process, saying “I think I need to start from zero again.” Shahla shared her challenges:



“I encountered many challenges like cold weather, housing, no social ties, but the most significant was the English language. Especially when you go grocery shopping, you don’t know some stuff names, and if you need to go to the doctor, we struggled to explain to the doctors. In the beginning, we had interpreters, but later, there were no interpreters, but our friends helped us” (Shahla).

Indeed, all women perceived that regardless of the extant challenges, they still considered being in Canada a wise decision and a good option for themselves and their children, and they hoped that things would get better. On the other hand, most women explicitly stated that a lack of social ties and activities and being afraid to go outside or to get involved with the Canadian context made it difficult to maintain their health and prevent specific health issues. The women discussed how living alone, lack of exercise, weather challenges, and being hesitant and afraid to go outside influenced their physical health in terms of, for example, weight gain. Inherent to women’s narratives was an intense sense of mental health deterioration associated with post-migration challenges. Most women perceived their previous trauma and migration as linked to their anxiety, depression, insomnia, and other psychiatric disorders. The participants perceived striving for good mental health and well-being as “a day-to-day struggle” compounded with child rearing responsibilities and the lack of awareness of the available health services. For instance, Bushra perceives herself as healthy if her mental health is good: “I am healthy if my mental health is good; you know I have insomnia sometimes because I am worried about my kids, but this is my life, and this is normal for me.”

All women appreciate the free, advanced public health-care system in Ontario and how the system is committed to providing follow-up and screening with the available and accessible services. In contrast, however, all the participants asserted that the health-care system is too slow, with long wait times in the ER and to get an appointment with a

specialist and expensive dental care. Adeba and Layla described their perceptions of the current health-care system in Ontario.

“In the ER we stayed a lot of time. You know the healthcare system in Canada is slow with long waiting, but we are used to it. The good thing that we receive good care for free also. I know a lot of people struggled with the healthcare system here in Canada. The health services here are adequate, available, accessible, but you can’t say it is perfect or fast compared to our country but still is for free, and you don’t worry about if you have money or not. In Syria, we used to sell our gold just to cover the cost of healthcare, and we don’t have this stress here in Canada” (Adeba).

“The healthcare system here has advantages and disadvantages. You know everything here, including imaging and investigations and follow up, is for free. This is good compared to my country. However, the issue here the waiting is lengthy you need to wait a long time I don’t know why; maybe a lack of doctors. When it comes to the specialist appointment, it is too lengthy. You know my family doctor referred me to a specialist doctor for my back, and I get an appointment after seven months” (Layla).

All the women shared some adaptation strategies to overcome Canada’s current challenges, such as going to schools to learn English as a second language to improve their English. Some women find that helping people or other refugees gives meaning to their own traumatic experience and transforms it into a positive change. The majority of the women asserted that they rely on herbal medicines or over-the-counter medications to manage simple and easy health complaints rather than going to the ER and staying there for a long time. One of the key strategies that the women employ to cope with the ER’s delay is to call the ambulance so they will be seen and examined by the doctors without having to wait for long hours. Nidal stated that relying on herbal remedies and calling the ambulance were some of her ways of coping with Ontario’s current health-care system:

“Sometimes, if it is an emergency, we used to call the ambulance and pay the bill of around 50 dollars rather than to stay in the ER. Most of the time, we stayed home rather than going and wait 6 hours in the ER. When my mom complained from stomach pain, we used to do what our grandfather used to do some herbal tea

and hot compressor rather than going to ER and wait for 6 hours and they always told us to go drink much water, so we drink water without going there” (Nidal).

Some women talked about delaying complete dental care and checkup to when they would be allowed to go to their country or other countries because of the terrible dental care cost in Canada. For instance, Shahla reported that it would cost her less to book a flight and do the dental checkup in another country than to do it in Canada.

“I used to have herbal tea, and we treat ourselves with herbal tea rather than going to ER, I don’t go to a family doctor unless there is something weird, and I have my Tylenol with me if my kids have a fever. I am always worried that my kids get injured because I don’t want to go to the hospital or the ER. You know I am waiting to go to Syria to do all checkups and dental care there rather than waiting here for their slow healthcare system and expensive dental care” (Shahla).

In addition, most of the women spoke about the need to book an appointment with the specialist without going through family doctors. Moreover, they highlighted the need to have more doctors, hospitals, and culturally sensitive care and services so they would not encounter any culturally inappropriate questions or health-care practices. All the women called for ways to reduce the waiting times in the ER and to have a unique system that minimizes the specialists’ waiting lists. Importantly, all the participants suggested that Canada needs to plan for the incoming Syrian refugees to settle directly in their homes rather than in hotels, as all the women in this study were dissatisfied with their hotel stay and settlement services. Adeba spoke about their experiences with the family doctors and the waiting list for the specialist, and how she was adapting to the current health-care system:

“The specialist access is challenging here, and the family doctor is the one who should refer you to a specialist. I hate the protocols for referring through a family doctor; it is annoying. I think they need to bring more doctors or open more hospitals to minimize the waiting time, but this is their system, and we cannot change, and we need to adapt and respect” (Adeba).

Some women asserted the need for more trauma-informed and culturally appropriate health-care services. For example, Nadia was disappointed with the culturally inappropriate questions that she had encountered in the ER when she had an abortion:

“You know their questions like do you have multiple partners and with how many men did I slept with. When they asked me that question, I said WHAT WHAT. I am a Muslim lady; why you asked me this question? The interpreter told them that I am annoyed by that question, and it is inappropriate to ask, but they said we should ask this question” (Nadia).

Most of the women stated that they would like to see some changes in the current Ontario health-care system and the settlement services. Some of the proposed solutions and models of health care they would like are booking an appointment with the specialist without going through family doctors and bringing more physicians. Moreover, all women called for changes in the settlement services, such as having the newly arrived Syrian refugees settle in their homes rather than stay in hotels. Sarah spoke about some of the proposed changes that she wished to see:

“I didn’t like the idea of going to the family doctor till he/she will transfer you, and sometimes the family doctor might not take your complaints seriously. In the ER you need to exaggerate your complaint in order to get some attention from the doctor. I think if there are more doctors, maybe the waiting time will be less. One more thing I would like to change; is the hotel stay. Canada needs to plan to prepare houses for future refugees to settle rather than to let them struggle and stay in the hotels” (Sarah).

### 4.3. Reflections and Discussion

The study findings reveal that Syrian refugee women, as a population, have gender-specific healthcare needs and experiences and they require a multiplicity of health services. The findings also showed that Syrian refugee women have repeatedly reported trauma and suffering from constant worries, fear, and migration hardship before fleeing

the country and coming to Canada. These findings are consistent with previous studies about Syrian refugee women (Cho et al., 2017; Myers, November 9, 2016). Moreover, this study showed that Syrian refugee women are an increasingly vulnerable population with histories of trauma, migration struggle and hardship, constant worries, and a growing sense of insecurity and marginalization, which is also consistent with the burgeoning literature on Syrian refugee women in terms of being a marginalized group, with negative experiences compounded with feelings of isolation and desperation, despair and uncertainty about their future (Abu-rass, 2018; Cho et al., 2017; Myers, November 9, 2016).

It was found that Syrian refugee women face extant challenges in Canada that jeopardize almost every aspect of their life, including language barriers, housing challenges, lack of social ties, weather-related challenges, and health-care-related challenges. The findings also highlight various coping strategies that the women used to adapt to the new culture and health-care system and to promote their health and well-being. These findings are congruent with previous research aimed at improving and promoting the physical and mental health of Syrian refugees in their host countries (Agić et al., 2016; Ahmed et al., 2017; Butler et al., 2011; Drolet et al., 2017).

While reflecting on the analysis undertaken for this study, we argue that the findings reveal the significance of utilizing the intersectionality theory with its key assumptions, particularly the notion of the multiple interactions of various aspects of vulnerability among Syrian refugee women. Moreover, the study findings support the rationale of adopting critical ethnography to capture Syrian refugee women's experiences

of pre- and post-migration in different countries, which were influenced not only by a particular country's sociopolitical context but also by its cultural context. Nevertheless, the numerous health-care-related challenges that Syrian refugee women continue to experience in Canada showed that there was still a general lack of understanding about these women's experiences, challenges, and coping with the current Ontario health-care system. The narratives of the women in this study provided a comprehensive contextual picture of the acculturation process and practices that Syrian refugee women, in general, used in their daily life. Further, the study findings offered a powerful depiction of these women's strengths and the adaptation that they made in response to residing in a new culture with a new health-care system.

Understanding the dynamic relationship between Syrian refugee women's experiences of trauma, health, and the cultural context of the host country may be useful for exploring the health-seeking behaviors of these women's practices and their coping with the current health-care system. The findings imply that there is a need to find ways to promote the women's awareness about the available local health services, which might, in turn, inform more widespread changes to the current practices pertaining to Ontario's health-care system. Thus, they may lead to practice and policy changes to ameliorate the effects of residency, language, and host countries' culture on Syrian refugee women's health-related issues. These changes may inform some modifications to the current practices and policies about settlement and health care, such as those offering trauma and culturally informed care for Syrian refugee women.

Research into the needs of Syrian refugee women, how they have been met, and their experiences of trauma and migration hardship, in general, is required to evaluate current approaches and identify the need for change and improvement. Listening to the women, we identified challenges and constraints in the provision of trauma-informed, culturally appropriate, effective, and timely health services to these women. It is worth noting that these women, as trauma survivors, require a delicate, trauma-informed, and gender-sensitive system of care since certain current health-care practices might be unfamiliar to, or unaccommodating of, many refugee women and their needs.

#### 4.3.1. Strengths and Limitations of the Study

This study has reflected a diversity of Syrian refugee women's viewpoints and experiences about their trauma, migration journeys, adaptation to a new culture, and their perceptions about the health-care system and services in Canada. The findings from this study might be relevant to other Syrian refugee women who have been resettled in Canada and other countries that are accepting refugees. Utilizing critical ethnographic methodology with an intersectional lens to analyze Syrian refugee women's narratives helped to gain a deep understanding of their tragedy by allowing them to voice their experiences and concerns by using their own words. A key strength is that the first author is a qualified bilingual immigrant woman who shares a common ethnic heritage with the Syrian refugee participants; therefore, gaining entry to the group and building trust and rapport was quickly established. Moreover, I conducted private individualized interviews based on the participants' preferred time and place promoted their comfort and improved

their ability to share freely. The interviews were also conducted separately from the men to ensure that the men's presence did not constrain the women's voices.

Although this study contributed to a better understanding of Syrian refugee women's perspectives regarding their trauma, migration, and acculturation, the study's limitations must be acknowledged. The study relied extensively on the participants' ability to recall past events, which might lead to bringing up specific memories and experiences that might trigger undesirable emotions, or in other instances, some relevant information might be forgotten. The study was also conducted with one specific refugee population group, comprising mostly governmentally sponsored refugees compared with privately sponsored refugees who might have different experiences.

In terms of the findings' transferability, this study's findings specifically targeted Syrian refugee women residing in Canada and might not reflect the situation in Syrian or other refugee population groups in other countries. Moreover, conducting synchronous online interviewing due to the COVID-19 pandemic and the consequent social distancing precautions limited capturing the physical space beyond the camera zoom. On the other hand, utilizing online interviewing offered a greater sense of control and voluntary participation for the participants, and they were able to terminate the conversation and leave at any time.

#### 4.4. Conclusion

Repeated and forced migration of Syrian refugee women raises significant issues around health equity and equality issues. Exploring the extraordinary journey of the Syrian refugee women has convinced us to believe that these women deserved more.



Their voices must be heard, and there is more to do for them. Syrian refugee women believe that they deserved to have culturally appropriate and trauma-informed healthcare and settlement services.

In this critical ethnography study, we analyzed 25 Syrian refugee women's journey over four time frames starting from the civil war trauma, through to departure suffering, and the burden of leaving and resettling in different and new places to their current life in Canada. By reflecting on these women's experiences of hardship, constant fear and worries, desire to thrive and change, and how these experiences shape their everyday lives, this article highlights the intersectional nature of Syrian refugee women's experiences. Moving forward, listening to these women's voices provided insight into some of the extant challenges and sociocultural needs of other women living in an unfamiliar place and interacting with different sociocultural norms by immersing themselves in their new environment to adapt to the new life and health-care systems.

## References

- Abu-rass, S. (2018). *UN reports review the impact of displacement on Syrian women in Iraq, Jordan and Lebanon*.  
<http://arabstates.unwomen.org/en/news/stories/2018/12/press-release-syrian-refugees>
- Acarturk, C., Konuk, E., Cetinkaya, M., Senay, I., Sijbrandij, M., Cuijpers, P., & Aker, T. (2015). EMDR for Syrian refugees with posttraumatic stress disorder symptoms: Results of a pilot randomized controlled trial. *European Journal of Psychotraumatology*, 6(1), 1-9. <https://doi.org/10.3402/ejpt.v6.27414>
- Agic, B., McKenzie, K., Tuck, A., & Antwi, M. (2016). *Supporting the mental health of refugees to Canada*. Mental Health Commission of Canada.  
[https://www.mentalhealthcommission.ca/sites/default/files/2016-01-25\\_refugee\\_mental\\_health\\_backgrounder\\_0.pdf](https://www.mentalhealthcommission.ca/sites/default/files/2016-01-25_refugee_mental_health_backgrounder_0.pdf)
- Ahmed, A., Bowen, A., & Feng, C. X. (2017). Maternal depression in Syrian refugee women recently moved to Canada: a preliminary study. *BMC Pregnancy and Childbirth*, 17(1), 240-251. <https://doi.org/10.1186/s12884-017-1433-2>
- Bowleg, L. (2012). The problem with the phrase women and minorities: intersectionality—an important theoretical framework for public health. *American Journal of Public Health*, 102(7), 1267-1273.  
<https://doi.org/10.2105/AJPH.2012.300750>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.  
<https://doi.org/10.1191/1478088706qp063oa>
- Butler, L., Critelli, F., & Rinfrette, E. (2011). Trauma-informed care and mental health. *Directions in Psychiatry*, 31(3), 197-212.
- Cannella, G. S., Pérez, M. S., & Pasque, P. A. (2016). *Critical qualitative inquiry: Foundations and futures*. Routledge.

- Cho, S., Hartman, M., Khalid, A., Mok, J., & Sreeram, P. (2017). Syrian refugee women: A vulnerable population struggles to find care. *The Meducator*, 1(30), 7-8.
- Chung, M. C., AlQarni, N., Al Muhairi, S., & Mitchell, B. (2017). The relationship between trauma centrality, self-efficacy, posttraumatic stress, and psychiatric co-morbidity among Syrian refugees: Is gender a moderator? *Journal of Psychiatric Research*, 94, 107-115. <https://doi.org/10.1016/j.jpsychires.2017.07.001>
- Collins, P. (2000). Gender, black feminism, and black political economy. *The Annals of the American Academy of Political and Social Science*, 568(1), 41-53. <https://doi.org/10.1177/000271620056800105>
- Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. *University of Chicago Legal Forum*, 1989(1), 139-167.
- Cummings, M. (2016, December 14). Syrian refugee shares story of escape at Burlington church. *Burlington Post*. <https://www.insidehalton.com/community-story/7020220-syrian-refugee-shares-story-of-escape-at-burlington-church/>
- Denzin, N. K. (2017). Critical qualitative inquiry. *Qualitative inquiry*, 23(1), 8-16. <https://doi.org/10.1177/1077800416681864>
- Drolet, J., Enns, R., Kreitzer, L., Shankar, J., & McLaughlin, A. (2017). Supporting the resettlement of a Syrian family in Canada: The social work resettlement practice experience of social justice matters. *International Social Work*, 61(5), 627-633. <https://doi.org/10.1177/0020872817725143>
- Duncan, G. F. (2015). Refugee healthcare: Towards healing relationships. *Canadian Social Science*, 11(9), 158-168. <https://doi.org/10.3968/7547>
- El-Khani, A., Ulph, F., Peters, S., & Calam, R. (2017). Syria: coping mechanisms utilised by displaced refugee parents caring for their children in pre-resettlement contexts. *Intervention*, 15(1), 34-50. <https://doi.org/10.1097/WTF.0000000000000136>

- Gaebel, W., Falkai, P., Sartorius, N., & Zielasek, J. (2016). Mental healthcare for refugees. *Die Psychiatrie*, 13, 61-64.
- Guruge, S., Sidani, S., Illesinghe, V., Younes, R., Bukhari, H., Altenberg, J., Rashid, M., & Fredericks, S. (2018). Healthcare needs and health service utilization by Syrian refugee women in Toronto. *Conflict and Health*, 12, 46-55.  
<https://doi.org/10.1186/s13031-018-0181-x>
- Hadfield, K., Ostrowski, A., & Ungar, M. (2017). What can we expect of the mental health and well-being of Syrian refugee children and adolescents in Canada? *Canadian Psychology*, 58(2), 194-201. <https://doi.org/10.1037/cap0000102>
- Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., Ferlatte, O., & Clark, N. (2014). An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity. *International journal for equity in health*, 13(1), 119-135. <https://doi.org/10.1186/s12939-014-0119-x>
- Hansen, L., Maidment, L., & Ahmad, R. (2016). Early observations on the health of Syrian refugees in Canada. *Canada Communicable Disease Report*, 42, 8-10.  
<https://doi.org/10.14745/ccdr.v42is2a03>
- Hilado, A., & Lundy, M. (2017). *Models for practice with immigrants and refugees: Collaboration, cultural awareness, and integrative theory*. SAGE Publications.  
<https://doi.org/10.4135/9781506300214>
- Jefee-Bahloul, H., Bajbouj, M., Alabdullah, J., Hassan, G., & Barkil-Oteo, A. (2016). Mental health in Europe's Syrian refugee crisis. *The Lancet Psychiatry*, 3(4), 315-317. [https://doi.org/10.1016/S2215-0366\(16\)00014-6](https://doi.org/10.1016/S2215-0366(16)00014-6)
- Lederman, R. (2016). Fieldwork double-bound in human research ethics reviews: Disciplinary competence, or regulatory compliance and the muting of disciplinary values. In W. C. van den Hoonaard & A. Hamilton (Eds.), *The ethics rupture* (pp. 43-72). University of Toronto Press. <https://doi.org/10.3138/9781442616653-005>

- Lincoln, Y. S., & Guba, E. G. ((1994). Competing paradigms in qualitative research. *Handbook of qualitative research*, 2(105), 163-194.
- List, J., & Sempeera, H. (2009). Do you trust me? Challenges and methods of trust-building among research participants in Kampala, Uganda. *Global Pulse*, 5(1), 1-4
- Myers, K. (2016, November 9). *Five unique challenges facing Syrian refugee women/ why women*. <https://www.concernusa.org/story/five-unique-challenges-facing-syrian-refugee-women/>
- Oda, A., Tuck, A., Agic, B., Hynie, M., Roche, B., & McKenzie, K. (2017). Health care needs and use of health care services among newly arrived Syrian refugees: a cross-sectional study. *CMAJ Open*, 5(2), 354-358.  
<https://doi.org/10.9778/cmajo.20160170>
- Seto, C. (2016, May 11). *Syrian refugees in Hamilton: By the numbers*  
<https://www.cbc.ca/news/canada/hamilton/headlines/syrian-refugees-in-hamilton-by-the-numbers-1.3573475>
- Smith, D. (2015). Burlington anticipates welcoming 120 Syrian refugees. *Burlington Post*. <https://www.insidehalton.com/news-story/6159467-burlington-anticipates-welcoming-120-syrian-refugees/>
- Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. In C. Willig & W. S. Rogers (Eds.), *The Sage handbook of qualitative research in psychology* (2nd ed., pp. 17-37). SAGE Publications.
- United Nations High Commissioner for Refugees. (2018). *What is a Refugee?*  
<https://www.unhcr.org/what-is-a-refugee.html>
- United Nations High Commissioner for Refugees. (2020). *1 percent of humanity displaced: UNHCR global trends report*.  
<https://www.unhcr.org/news/press/2020/6/5ee9db2e4/1-cent-humanity-displaced-unhcr-global-trends-report.html>

## Chapter 5:

### Integrated summary and its implications

#### 5.1. Discussion

In this chapter, a summary of the study's key findings is presented, followed by a discussion of the implications and recommendations for nursing practice, policy education, and research. The purpose of this dissertation was to: (a) explore and describe the pre- and post-migration experiences of Syrian refugee women in Ontario and the impact on their physical and mental health; (b) critically examine how the intersection of gender, trauma, and violence, as well as political and economic conditions of Syrian refugee women shapes their everyday lives and health; (c) investigate the strategies and practices by which Syrian refugee women are currently addressing their health-care needs; and (d) describe the models of care suggested by these women to meeting their physical and mental health needs.

The research questions addressed by the study were: (a) How does the pre- and post-migration trauma impact the experiences of Syrian refugee women in Ontario with regard to forced migration, repeated displacement, settlement and integration, and their physical and mental health?; (b) How does the intersection of gender, trauma and violence, culture, settlement, and political and economic conditions of Syrian refugee women shape their everyday lives and health?; (c) What strategies are Syrian refugee women currently using to promote their physical and mental health?; and (d) What are the proposed models of care to meet the physical and mental health-care needs as suggested by Syrian refugee women?

## 5.2. Key Findings

### 5.2.1. Health Seeking Behaviors of Syrian Refugee Women

The scoping review of health-seeking behaviors of Syrian refugee women revealed two themes: (a) accessibility of health-care services and (b) awareness of healthcare needs and available health-care services to fulfill these needs. The accessibility of health-care services was the most frequently reported theme throughout this area of the literature and it most often included financial barriers, language barriers, and availability of culturally- and gender-appropriate health services. The awareness of healthcare needs and available health-care services was the second most encountered theme within the area of Syrian refugee women's health-seeking behaviors. The findings demonstrated the importance of having available and accessible health-care services for Syrian refugee women in host countries. The availability and accessibility of health-care services are required and can enhance Syrian refugee women's health, well-being, and quality of life. An awareness of the Syrian refugee women's potential health-seeking behaviors and the obstacles/barriers that they face might help to modify current practices in the host countries to promote their health and well-being.

### 5.2.2. Blended Approach of Critical Ethnography and Intersectionality

From a methodological perspective, based on our experience, the combination of critical ethnography with intersectionality has provided its potential as a philosophically robust underpinning method to inform nursing research targeting refugee women. Both of

these approaches have much in common, including the call for social change and justice. Using a blended approach of critical ethnography and intersectionality informs and expands our understanding of refugee women's health as shaped by their intersecting identities and socio-structural contexts. This blended approach allows us to investigate and illuminate the complexities of refugee women's health and social world. It also helps us understand both the individual and collective experiences of these women and is, therefore, has value in being used in nursing and allied health-care studies.

Moreover, the blended approach of critical ethnography and intersectionality has the potential to inform a methodological approach for health-care studies and it could also be used for advancing refugee women's health research. Such a blended approach can be used by a range of policymakers and stakeholder groups to explore refugee women's experiences, their identities, health-care practices, and power relations within their host communities.

### 5.2.3. Syrian Refugee Women's Journeys from Trauma to Adaptation

The analysis of the Syrian refugee women's narratives about their pre- and post-migration experiences and the impact on their health and well-being revealed four common themes: 1) compounded traumas and hardship; 2) fear and worries; 3) vulnerabilities, and intrusions of dignity and; 4) perception of health care. The study findings included detailed information on the role of social, cultural, and contextual factors in the expression of trauma, hardship, and health and how this is interwoven with cultural and contextual notions of Syrian refugee women in the host country. The



findings revealed diversity both within and across Syrian refugee women and these diversities within these refugees demonstrate powerful manifestations of agency and resistance. Moreover, the study findings have demonstrated that the complex interactions between and among refugees are seemingly distinct and have important implications for how displacement and migration-based trauma are conceptualized and understood in post-migration contexts. The following section provides a detailed discussion of these themes, implications of these findings for nursing practice, education, and policy, and the need for future research.

#### 5.2.4. Compounded Traumas and Hardship

This study offers a snapshot of the role of political, social, cultural, and contextual factors in expressing Syrian refugee women's trauma and hardship and how these factors are interwoven with the cultural, sociopolitical, and health-care systems of their host countries, including Canada. Participants in this study reported that they had experienced tremendous physical and mental health problems prompted by previous trauma, violence, and repeated displacement. These experiences were consistent with those reported by other authors (Ahmed et al., 2017; Chung et al., 2017; El-Khani et al., 2017; Gaebel et al., 2016; Jefee-Bahloul et al., 2016). Experiences were compounded by various stressors, including unstable income and housing, loss of family, prolonged grief, settlement and integration challenges, language barriers, social isolation, discrimination, powerlessness, and uncertainty about the future (Acarturk et al., 2015; Agic et al., 2016; El-Khani et al., 2017; Hadfield et al., 2017).

Understanding Syrian refugee women's experiences of compounded trauma and hardship was important, as these experiences informed their quality of life in the host communities. The complexity of how these traumas and struggles changed their lives, health, and well-being over time calls for the need to include the refugees' experiences within the scope of health services. Therefore, it is argued that there is a need to evolve durable solutions and services for Syrian refugee women in Canada that take into consideration their previous trauma and migration struggles. These solutions may include, but are not limited to, reassessment and evaluation of the current health-care models that serve this particular population and the adoption of initiatives that are gender-inclusive and positively link Syrian refugee women's experiences of trauma, culture, and health.

### 5.2.5. Fear and Worries

The effects of constant fear and worries on Syrian refugee women's mental health and well-being are profound. Experiences of civil war-related fear and worries about the safety, security, and health of their children are compounded by the daily stressors of forced displacement, ongoing risks of violence and abuse, isolation and discrimination, poverty and unemployment, loss of family, and uncertainty about migration outcomes and the future. This study finding is similar to a study conducted by Yotebieng et al. (2019), where they reported that the uncertainty about refugees' futures can have an impact on their well-being and the ways in which they can adapt in the host countries. A central issue in these women's worries is loss and grief with ongoing concern about family members and children's safety, which were reported to be a significant source of

their stress and worries. This finding was consistent with the study conducted by Renner et al. (2021) around traumatized Syrian refugees with ambiguous loss, where Syrian refugees often have missing significant others without confirmation with uncertainty about who belongs to the family system. This study finding was similar to other study findings reported by Killikelly et al. (2021), where they reported that the potential predictors for prolonged grief among Syrian refugees are loss of homeland, lack of social network, and ambiguous loss. Also, Syrian refugee women asserted in their narratives that their uncertainty about their safety and their children's health and education added further distress and complicated their worries and fear. This echoes the study conducted by Perez and Arnold-Berkovits (2018) around ambiguous loss, which may express confusion about whether to maintain hope for an eventual return or to grieve the loss of a homeland or beloved family member who they will never see again. Similarly, Jones (2020) concluded that the psychological impact of ambiguous loss and traumatic loss can further complicate refugees' life and future uncertainty. Many of them explicitly stated that they had become isolated and struggled to adapt to life as refugees within a foreign host community or in camps. In some countries, women reported various forms of discrimination against refugees, which contributed to additional fear, worries, and isolation.

#### 5.2.6. Vulnerabilities and Intrusions of Dignity

The decontextualization of Syrian refugee women's sense of vulnerability and intrusion of dignity evolved across different time frames from the civil war to the post-migration stage. For example, women asserted that they often strove for their dignity

during the civil war and then became exposed to various forms of discrimination and loss of dignity in the premigration countries. This sense of vulnerability was frequently molded by various rules and regulations that ignored the complex and intersecting vulnerabilities that these women face in their lives. Moreover, it was compounded by the loss of dignity associated with multiple social identities that contributed to various forms of oppression, marginalization, and discrimination, which, in turn, forced these women to seek social justice and preserve dignity during the stage of migration. Finally, all participants asserted that their residency in Canada allowed them to restore their dignity, by experiencing personal empowerment and having the freedom to express their thoughts and feelings.

### 5.2.7. Perception of Healthcare

This study reports that the Syrian refugee women faced various stressors, and many of them were displaced from their homes, causing them to experience challenges both during and after migration. Exposure to such stressors made these women susceptible to different forms of psychological distress and placed them at a higher risk of developing physical and mental health disorders such as post-traumatic stress disorder, anxiety disorders, and depression. This study's findings are consistent with other studies (Chung et al., 2017; Clark, 2018; El-Khani et al., 2017; Eltokhy, 2020; Hilario et al., 2015; O'Mahony & Donnelly, 2013; Shishehgar et al., 2017). In addition, the unmet health-care needs reported by the Syrian refugee women in Canada were similar to those reported in previous studies, including long wait times in the ER and for specialist appointments, unavailability of culturally informed services at the time required, and the

costs of dental care (Cho et al., 2017; Clark, 2018; Dagkas, 2016; Hilario et al., 2015; Jefee-Bahloul et al., 2016; Majumder et al., 2015; Senthanaar et al., 2019).

The women described their experiences with various health-care systems across different stages of their migration. For instance, although they described their home country's health-care system as a ravaged system, they concurred that it was cheaper than the current Canadian health-care system. This is a notable consideration in the context of a health-care system that was perceived as being free; however, in reality, 30% of Canadian health-care services are covered out of pocket. Moreover, all the participants perceived that the premigration health-care systems were overburdened and exposed them to significant discrimination and health disparities. Seeking good, equitable, and accessible health care was, therefore, one driver to influence their decision to migrate to Canada. In Canada, the women interviewed were grateful for the public health-care system but were either mostly unaware of the available health services or of additional expenses beyond the public system.

All women appreciated the health coverage by their province's health plans, and they reported that Ontario was expediting the process to give refugees an Ontario's health care plan (OHIP) number within 24 hours of their arrival. They also reported the additional services, such as dental and vision care, that were covered by the federal government's Interim Federal Health Program. However, privately sponsored refugee women reported that they were not eligible for Ontario Works benefits or subsidized housing during the period of sponsorship (one year) and that impacted their experiences with Ontario's health-care system. Moreover, the privately sponsored refugees reported

being in tight budgets with no income or housing support compounded with frequent appointments and subsequent investigations forced them to hold off on seeking further health care. Another strategy that privately sponsored refugee women reported to adapt with Ontario's health-care system was relying on walking to appointments because they could not afford transportation. Another issue that has been reported by privately sponsored refugee women was the previous Conservative Government's cuts to the Interim Federal Health Program, which means that these women were left without health coverage for some care.

On the other hand, most participants reported that the long wait time in the ER and for specialist appointments in Canada hindered their current health-care system engagement. To overcome this, the women explained that they adopted specific coping strategies as part of their acculturation with this health-care system, such as relying on herbal medicines or calling for an ambulance when they needed to go to the hospital. The women repeatedly asserted that it was imperative to allow them to contribute to policy discussions and changes in health care policies. They were most directly affected and felt they needed to be actively included in designing or developing health-care services or models for Syrian refugees. The wide diversity of ethnic, socioeconomic, and cultural backgrounds among Syrian refugee women and their trauma-related health issues influenced their relationships, dynamics, social tensions within their host communities, perceptions of health and illness, coping mechanisms, and health-seeking behaviors. Therefore, current health-care models for Syrian refugees in Canada need to be challenged to be revised for ways to meet their healthcare needs and to counter prevailing discourses of such women being a socioeconomic threat or burden to host communities.

## 5.3. Implications

### 5.3.1. Implications for Health Care Policies

From a practical perspective, Syrian refugee women are often exposed to various forms of disadvantage. Service providers may assume that these women's culture substantially influences their experiences of trauma and violence and ultimately creates barriers to seeking care and support. With the current trend of moving the financial incentives for health-care systems away from hospitalizations and therapeutic procedures toward prevention and primary care (Machtinger et al., 2015), Canada's federal government has a responsibility to ensure the overall well-being of Syrian refugees. Developing and designing interventions and health-care services for Syrian refugee women requires a clear understanding of their history of trauma and migration-related struggles and hardship. This understanding can help health-care professionals minimize further harm by preventing further trauma and offering supportive services tailored to these women's experiences.

In light of Canada's commitment to resettling more Syrian refugees and given the prevalence of recurrent and frequent traumatic experiences among the refugees, many scholars and policymakers have called for accessible health services (Agić et al., 2016; Ahmed et al., 2017; Cho et al., 2017; Chung et al., 2017; de Bocanegra et al., 2017; Myers, 2016). Moreover, recently, there has been a movement to develop, implement, and adopt trauma- and violence-informed approaches in dealing with Syrian refugees that strive to treat compounded traumas and related health outcomes, particularly in relation to mental health (Agić et al., 2016; Ahmed et al., 2017; Cho et al., 2017; Chung et al.,

2017; de Bocanegra et al., 2017; Myers, 2016). However, there is a scarcity of health practices informed by the refugees' previous exposure to displacement, trauma, and violence and designed to address their specific needs (Duncan, 2015; Habib, 2015). Nesson (2021), in a study of Iraqi refugees in Canada, concluded that there is a need for mental health services and public sectors in Canada to develop or modify their services to attend to the needs of the refugees and immigrants by adapting more culturally informed approaches. Ultimately, Syrian refugee women experiencing trauma and violence may be forced to use existing services despite their unwillingness to do so; however, when such services are not accessible, sufficient, or culturally informed, new and creative programs need to be created to bring health care to those needing it.

Although trauma and culturally informed health-care practices for Syrian refugee women can be implemented widely, they do require multi-sectoral collaboration and strategies at organizational and service-provider levels. This collaboration assists in implementing practices in many different contexts, including public health, social work, settlement services, and housing. Implementing trauma- and culturally informed practices across different sectors provides an essential foundation and a conceptual framework that enhances efforts to develop multi-sectoral trauma precautions, strategies, and responses to people impacted by trauma. These precautions and strategies can also create opportunities for health professionals and health and social systems to improve the services they provide to this particular population.

### 5.3.2. Implications for Nursing Practice

Defining trauma-informed approaches requires an understanding that it is crucial not to focus on the treatment or disclosure of traumatic events, rather it is important to



ensure that people who have undergone traumatic experiences in their lives are not further traumatized when they access health or social services (Registered Nurses' Association of Ontario, 2013). There are six key principles of trauma-informed care, including safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues.

Another key aspect of designing, developing, and delivering trauma- and culturally informed care for Syrian refugee women is the availability and accessibility of these services to this target population. Moreover, the manner in which these services are designed within the current health-care system or organization and how health-care professionals engage with these women to recognize and respond to their experiences of trauma is of importance. For instance, in Canada, Syrian refugee women's circumstances, including language barriers, residing in a country with a different culture, income, housing, and employment, influence both their perceptions of trauma and their willingness to access the available supportive services. Therefore, offering health-care services that are accessible, approachable, and trauma- and culturally informed can mitigate these influences and result in a tremendous change in not only how these women are treated, but also how they will respond to the treatment in the future. In addition, it helps to focus on Syrian refugee women's various experiences of previous trauma to assist service providers in taking action at all levels, including their daily practices within their organizations and society at large, to minimize the women's exposure to potentially traumatizing services. This paradigm shift in focus and emphasis also allows for a greater understanding of these women's experiences, particularly in cases of compounded trauma with negative health impacts.

Importantly, when adopting trauma- and culturally informed approaches as well as gender-inclusive modalities, health-care professionals need to consider how power relations and the socioeconomic and political aspects of Syrian refugee women's lives shape their health-seeking behaviors. This is particularly imperative in the host communities where these women might experience multiple forms of disadvantage and marginalization, affecting their access to the available services.

To sum up, the findings from this study can inform the design, development, and delivery of interventions to promote the physical and mental health as well as the well-being of Syrian refugees. The integration of trauma- and culturally informed models of care is fundamental to supporting Syrian refugee women and it aids their recovery from previous trauma.

### 5.3.3. Implications for Nursing Education

Integrating the issues of vulnerability, migration, and trauma and the impact of these issues on refugees' health and well-being into the nursing curriculum can have multiple benefits. First, it provides both educational institutions' faculty and nursing students as future service providers with the opportunity to create a support system that responds to refugees' healthcare needs and, thus, has a more positive impact on their lives. Second, it provides a common language and consistent platform of support to women who have experienced trauma across multiple service systems, including health, settlement and social services, and employment and housing services. Third, since previous experiences of trauma feed into cycles of vulnerability, uncertainty, prolonged grieving, loss, and intergenerational conflict, a strong multi-sectoral response by the higher educational system, particularly undergraduate and graduate nursing programs,

can help break these cycles by preventing future trauma and reinforcing the acculturation of Syrian refugees in their host communities. Further, incorporating various teaching pedagogies and simulation scenarios that are based on an understanding of the impact of trauma on refugees' lives and behaviors will create better opportunities for change and justice. Finally, embedding the principles of victimization, marginalization, oppression, social justice, empowerment, and gender- and culturally sensitive practices into nursing curricula and programs creates a trend for nursing care that minimizes harm and provides positive change and support for all people.

#### 5.3.4. Implications for Future Research

Moving health and social systems toward new paradigms of policy analysis and research changes such as trauma- and violence-informed approaches, gender sensitivity, and cultural safety may be one option toward enhancing the acculturation process of Syrian refugee women in Canada. Multi-sectoral collaboration, policy analysis and strategic planning both locally and nationally are required for this shift to be effective; these are also needed to create a support system that responds to this particular group's needs in safe, gender- and culturally sensitive ways, and to thus have a more positive impact on their lives. For progress along this line, future research and replication studies that extend on the findings of this study are needed. For instance, a comparison study can be undertaken to explore the experiences of privately sponsored versus governmentally assisted Syrian refugees, allowing for a further exploration of the impact of the type of sponsorship on the pre- and post-migration experiences, hardship, acculturation, and health and well-being of the refugees.

Other lines of research that may be of significance include longitudinal studies to examine the relationship between various sociodemographic variables of Syrian refugee women, such as level of education, ability to speak English, age, number of children, employment, length of stay, and their coping mechanisms and degree of acculturation in Canada. Further, quantitative research is needed to explore Syrian refugee women's perceptions about Ontario's health-care system and the current models of care, for instance, to examine whether there is a difference in the perception of Ontario's health-care system between Syrian refugee women who enact effective coping practices and those who do not. A mixed-method study would also illuminate our understanding of the Syrian refugee women's experiences, identifying possible gaps in the current model of care.

Although some research exists in the area of Syrian refugee women, there are still gaps in the knowledge of migration-related trauma experiences, access to health care, and impact on the physical and mental health of these women in Ontario in particular. Moreover, the role of public policies needs to be further studied with an emphasis on the culture and circumstances in which health care is provided. This can include studying ways to promote timely access to primary care for newcomers. Further, public policies that govern health-care access and practices for Syrian refugee women need to pay close attention to these women's traumatic experiences, which might empower them and prevent prolonged trauma-related stress and negative health impacts.

The current refugee policies need to be continuously evaluated, and future policies need to be sensitive to the impact of refugee status on the mental health and well-being of Syrian refugee women. Also, there is a pressing need to transform health

policies and practices based on an understanding of the impact of compounded trauma and migration hardship on Syrian refugee women's lives and behaviors. Therefore, future studies on Syrian refugee women's experiences of migration and trauma and their navigation of health-care settings are required to inform policies and practices that improve health-care delivery for these women.

## 5.4. Conclusions

To the best of the authors' knowledge, this study is the first in the Canadian context to examine the pre- and post-migration experiences of Syrian refugee women and their experiences with Ontario's current health-care system. The study findings reveal that Syrian refugee women, as a population, have gender-specific health-care experiences and require a multiplicity of health services. Specifically, the study findings showed that Syrian refugee women have repeatedly reported trauma and suffering from constant worries, fear, and migration hardship before fleeing their country and coming to Canada. The findings also showed that Syrian refugee women have coexistence challenges in Canada, including language barriers, lack of social times and challenges associated with housing weather, and health-care, that jeopardized almost every aspect of their lives. Further, the study findings highlight various coping mechanisms and strategies that Syrian refugee women used to adapt to the new culture and health-care system and to promote their health and well-being.

The women's narratives in this study provided a comprehensive and contextual picture of the acculturation process and practices that Syrian refugee women are currently using in their daily lives. The study findings offer a powerful depiction of these women's strengths and adaptations that they made in response to residing in a new culture within a

new health-care system. These findings also assisted in providing a foundation for continuing research that targets this unique population. Practitioners can use this study's findings to inform future policies, education, and developments in practice. Further research is required to develop and evaluate the initiatives that target the identified barriers and help Syrian refugee women fulfill their unmet health-care needs.

## References

- Acarturk, C., Konuk, E., Cetinkaya, M., Senay, I., Sijbrandij, M., Cuijpers, P., & Aker, T. (2015). EMDR for Syrian refugees with posttraumatic stress disorder symptoms: Results of a pilot randomized controlled trial. *European Journal of Psychotraumatology*, 6(1), 1-9. <https://doi.org/10.3402/ejpt.v6.27414>
- Agic, B., McKenzie, K., Tuck, A., & Antwi, M. (2016). *Supporting the mental health of refugees to Canada*. Mental Health Commission of Canada. [https://www.mentalhealthcommission.ca/sites/default/files/2016-01-25\\_refugee\\_mental\\_health\\_backgrounder\\_0.pdf](https://www.mentalhealthcommission.ca/sites/default/files/2016-01-25_refugee_mental_health_backgrounder_0.pdf)
- Ahmed, A., Bowen, A., & Feng, C. X. (2017). Maternal depression in Syrian refugee women recently moved to Canada: A preliminary study. *BMC Pregnancy and Childbirth*, 17(1), 240-251. <https://doi.org/10.1186/s12884-017-1433-2>
- Cho, S., Hartman, M., Khalid, A., Mok, J., & Sreeram, P. (2017). Syrian refugee women: A vulnerable population struggles to find care. *The Meducator*, 1(30), 7-8. <https://journals.mcmaster.ca/meducator/article/view/1877>
- Chung, M., AlQarni, N., Al Muhairi, S., & Mitchell, B. (2017). The relationship between trauma centrality, self-efficacy, posttraumatic stress, and psychiatric co-morbidity among Syrian refugees: Is gender a moderator? *Journal of Psychiatric Research*, 94, 107-115. <https://doi.org/10.1016/j.jpsychires.2017.07.001>

Clark, N. (2018). Exploring community capacity: Karen refugee women's mental health.

*International Journal of Human Rights in Healthcare*, 11(4), 244-

256. <https://doi.org/10.1108/IJHRH-02-2018-0025>

Dagkas, S. (2016). Problematizing social justice in health pedagogy and youth sport:

intersectionality of race, ethnicity, and class. *Research Quarterly for Exercise and Sport*,

87(3), 221-229. <https://doi.org/10.1080/02701367.2016.1198672>

Bocanegra, H., Carter-Pokras, O., Ingleby, J., Pottie, K., Tchangalova, N., Allen, S.,

Smith-Gagen, J., & Hidalgo, B. (2017). Addressing refugee health through

evidence-based policies: A case study. *Annals of Epidemiology*, 28(6), 411-419.

<https://doi.org/10.1016/j.annepidem.2017.05.010>

Duncan, G. F. (2015). Refugee healthcare: Towards healing relationships. *Canadian*

*Social Science*, 11(9), 158-168. <https://doi.org/10.3968/7547>

El-Khani, A., Ulph, F., Peters, S., & Calam, R. (2017). Syria: coping mechanisms utilised

by displaced refugee parents caring for their children in pre-resettlement contexts.

*Intervention*, 15(1), 34-50. <https://doi.org/10.1097/WTF.0000000000000136>

Eltokhy, S. (2020). Towards belonging: Stability and home for Syrian refugee women in

Milan. *Journal of Identity & Migration Studies*, 14(1), 134-149.

Gaebel, W., Falkai, P., Sartorius, N., & Zielasek, J. (2016). Mental healthcare for

refugees. *Die Psychiatrie*, 13, 61-64.



- Habib, R. (2015). The changing status of Syrian women migrant farmworkers: from seasonal worker to refugee and worker. *Proceedings 19th Triennial Congress of the IEA*, 9, 14-26.
- Hadfield, K., Ostrowski, A., & Ungar, M. (2017). What can we expect of the mental health and well-being of Syrian refugee children and adolescents in Canada? *Canadian Psychology*, 58(2), 194-201. <https://doi.org/10.1037/cap0000102>
- Hilario, C., Oliffe, J., Wong, J., Browne, A., & Johnson, J. (2015). Migration and young people's mental health in Canada: A scoping review. *Journal of Mental Health*, 24(6), 414-422. <https://doi.org/10.3109/09638237.2015.1078881>
- Jefee-Bahloul, H., Bajbouj, M., Alabdullah, J., Hassan, G., & Barkil-Oteo, A. (2016). Mental health in Europe's Syrian refugee crisis. *The Lancet Psychiatry*, 3(4), 315-317. [https://doi.org/10.1016/S2215-0366\(16\)00014-6](https://doi.org/10.1016/S2215-0366(16)00014-6)
- Jones, L. (2020). Grief and loss in displaced and refugee families. In *Child, Adolescent and Family Refugee Mental Health* (pp. 123-149). Springer.
- Killikelly, C., Ramp, M., & Maercker, A. (2021). Prolonged grief disorder in refugees from Syria: qualitative analysis of culturally relevant symptoms and implications for ICD-11. *Mental Health, Religion & Culture*, 24(1), 62-79.
- Machtinger, E., Cuca, Y., Khanna, N., Rose, C., & Kimberg, L. (2015). From treatment to healing: the promise of trauma-informed primary care. *Women's Health Issues*, 25(3), 193-197. <https://doi.org/10.1016/j.whi.2015.03.008>

- Majumder, P., O'Reilly, M., Karim, K., & Vostanis, P. (2015). 'This doctor, I not trust him, I'm not safe': The perceptions of mental health and services by unaccompanied refugee adolescents. *International Journal of Social Psychiatry*, 61(2), 129-136. <https://doi.org/10.1177/0020764014537236>
- Myers, K. (2016, November 9). *Five unique challenges facing Syrian refugee women/ why women*. <https://www.concernusa.org/story/five-unique-challenges-facing-syrian-refugee-women/>
- Nessan, N. (2021). The Experiences of Iraqi Refugees in Canada: A Life History Study of War and Resilience in the Aftermath of Migration. Electronic Thesis and Dissertation Repository. 7652. <https://ir.lib.uwo.ca/etd/7652>
- O'Mahony, J., & Donnelly, T. (2013). How does gender influence immigrant and refugee women's postpartum depression help-seeking experiences? *Journal of Psychiatric and Mental Health Nursing*, 20(8), 714-725. <https://doi.org/10.1111/jpm.12005>
- Perez, R. M., & Arnold-Berkovits, I. (2018). A conceptual framework for understanding Latino immigrant's ambiguous loss of homeland. *Hispanic Journal of Behavioral Sciences*, 40(2), 91-114. <https://doi.org/10.1177/0739986318761058>
- Registered Nurses' Association of Ontario. (2013). *Crisis Intervention for Adults Using a Trauma-Informed Approach: Initial Four Weeks of Management (Crisis Intervention, Issue)*. <https://bpgmobile.rnao.ca/sites/default/files/Key%20principles%20of%20a%20trauma%20informed%20approach.pdf>

- Renner, A., Jäckle, D., Nagl, M., Plexnies, A., Röhr, S., Löbner, M., Grochtdreis, T., Dams, J., König, H.-H., & Riedel-Heller, S. (2021). Traumatized Syrian Refugees with Ambiguous Loss: Predictors of Mental Distress. *International Journal of Environmental Research and Public Health*, 18(8), 3865.  
<https://doi.org/10.3390/ijerph18083865>
- Senthanar, S., MacEachen, E., Premji, S., & Bigelow, P. (2019). “Can someone help me?” Refugee women’s experiences of using settlement agencies to find work in Canada. *Journal of International Migration and Integration*, 21(1), 273-294.  
<https://doi.org/10.1007/s12134-019-00729-1>
- Shishehgar, S., Gholizadeh, L., DiGiacomo, M., Green, A., & Davidson, P. (2017). Health and socio-cultural experiences of refugee women: An integrative review. *Journal of Immigrant and Minority Health*, 19(4), 959-973.  
<https://doi.org/10.1007/s10903-016-0379-1>
- Yotebieng, K. A., Syvertsen, J. L., & Kum Awah, P. (2019). Cessation clauses, uncertain futures and wellbeing among Rwandan urban refugees in Cameroon. *Journal of Refugee Studies*, 32(3), 436-455. <https://doi.org/10.1093/jrs/fey037>

## Appendices

### Appendix A: Ethics Approval Letter



**Date:** 2 December 2019

**To:** Dr. Cheryl Forchuk

**Project ID:** 114519

**Study Title:** Syrian Refugee Women's Experiences with the Ontario Health Care System: A Critical Ethnography Study

**Application Type:** HSREB Initial Application

**Review Type:** Delegated

**Full Board Reporting Date:** 17December2019

**Date Approval Issued:** 02/Dec/2019 09:22

**REB Approval Expiry Date:** 02/Dec/2020

Dear Dr. Cheryl Forchuk

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above mentioned study as described in the WREM application form, as of the HSREB Initial Approval Date noted above. This research study is to be conducted by the investigator noted above. All other required institutional approvals must also be obtained prior to the conduct of the study.

**Documents Approved:**

Document Name	Document Type	Document Date	Document Version
information letter	Translated Documents	26/Nov/2019	5
Interview guide	Interview Guide	31/Oct/2019	3
interview guide	Translated Documents	26/Nov/2019	5
letter of information	Written Consent/Assent	04/Nov/2019	4
participant observation guide	Participant Observation Guide		
Recruitment Flyer	Recruitment Materials	31/Oct/2019	3
recruitment poster	Translated Documents	26/Nov/2019	5
Research protocol	Protocol	31/Oct/2019	3

**Documents Acknowledged:**

Document Name	Document Type	Document Date	Document Version
information letter_arabic	Translation Certificate	26/Nov/2019	5

No deviations from, or changes to, the protocol or WREM application should be initiated without prior written approval of an appropriate amendment from Western HSREB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

REB members involved in the research project do not participate in the review, discussion or decision.

The Western University HSREB operates in compliance with, and is constituted in accordance with, the requirements of the TriCouncil Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2); the International Conference on Harmonisation Good Clinical Practice Consolidated Guideline (ICH GCP); Part C, Division 5 of the Food and Drug Regulations; Part 4 of the Natural Health Products Regulations; Part 3 of the Medical Devices Regulations and the provisions of the Ontario Personal Health Information Protection Act (PHIPA 2004) and its applicable regulations. The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Nicola Geoghegan-Morphet, Ethics Officer on behalf of Dr. Philip Jones, HSREB Vice-Chair

## Appendix B: Letter of Information (Arabic)

Al Rayyan Al Gedid - Al Shafi st.  
opposit Apple bees  
Building No. (112) Office (4)  
C.R : 97392  
Tel. :  
Mob. :



### خطاب معلومات

: عنوان الدراسة: تجارب اللجان السوريات في نظام أونتايريو

للعناية الصحية: دراسة إثنوغرافية حرجة

اسم الباحث الرئيسي: الدكتورة/ شيريل فورشوك

أستاذ جامعي متميز في كلية آرثر لابات للتمريض في جامعة ويسترن أونتايريو غرفة:

هاتف: ١

البريد الإلكتروني: \_\_\_\_\_

اسم الطالبة: أريج الحمد ، طالبة دكتوراه في التمريض في كلية آرثر لابات للتمريض في جامعة ويسترن أونتايريو

كلية آرثر لابات للتمريض

جامعة ويسترن أونتايريو

هاتف: \_\_\_\_\_ داخلي:

البريد الإلكتروني: \_\_\_\_\_



اسم الجهة الراعية: لا يوجد جهة راعية لهذه الدراسة

تضارب المصالح: لا توجد أي ارتباطات أو مشاركة في أي منظمة أو كيان له أي مصلحة مالية أو غير مالية في الموضوع أو المواد التي تمت مناقشتها في هذا المشروع البحثي.

المقدمة: أنت مدعو للمشاركة في دراسة بحثية عن تجارب اللجان السوريات. ستغطي هذه الدراسة تجارب الهجرة والصدمات قبل وبعد الوصول إلى كندا. بالإضافة إلى ذلك ، سوف يناقش تأثير كونك لاجئة وتأثيرها على الصحة.

الخلفية/ الغرض: تهدف هذه الدراسة إلى فهم كيفية تأثير تجربة الانتقال إلى كندا على صحة اللجان السوريات. الغرض من هذا الخطاب هو إمدادك بمعلومات لاتخاذ قرار مستنير بشأن

Al Rayyan Al Gedid - Al Shafi St.  
opposit Apple bees  
Building No. (112) Office (4)  
C.R : 97392  
Tel. :  
Mob. :

  
**Alamal Certified Translation**  
الأمل للترجمة المعتمدة

ع آل شافي  
بي رقم (112) مكتب (4)  
٩٧٠  
+٩٧٤ / ٤٤١٣٩٠٠  
+٩٧٤ / ٦٦٠٦٨١٢٣  
act\_2014@hotmail.com

المشاركة في هذا البحث. أنا طالب دكتوراه في كلية التمريض بجامعة ويسترن أونتااريو وسيتم استخدام المعلومات التي أجمعها في أطروحتي.

#### تصميم الدراسة:

تهدف هذه الدراسة إلى فهم كيفية تأثير تجربة الانتقال إلى كندا على صحة اللاجئين السوريين. نحن نخطط للقيام بذلك من خلال المقابلات والملاحظة. ونحن نتطلع لتجنيد 20-40 مشاركا.

الإجراءات: يمكنك المشاركة إذا كنت:

- لاجئين سوريين
- يمكنك التحدث باللغة الإنجليزية أو العربية
- تبلغ 18 عاما أو أكثر
- تقيم حاليا في أونتااريو لمدة 36 شهر أو أقل

إذا شاركت في الدراسة ، فسيطلب منك:

- مشاركة في مقابلة شخصية معي

سيتم طرح أسئلة عليك نستطيع من خلالها فهم ما تشعر به حول:

- أن تكون لاجئة سرية بعيدة عن موطنك
- صحتك و الحياة اليومية
- الاستراتيجيات الحالية التي تستخدمها حاليا لتعزيز صحتك
- خبرتك مع أنظمة الرعاية الصحية بأونتااريو



قد تستغرق المقابلات ما يقرب من 1-2 ساعة لإكمالها أو اعتمادًا على مقدار المعلومات التي يجب على المشاركين مشاركتها. يتم إجراء المقابلات في الأماكن التي تختارها و تشعر بها بالراحة مثل:

- المساجد أو الكنائس

سيتم تسجيل المقابلات الصوتية حتى أتمكن من الانتباه بدقة بما تقوله. سيقوم الباحث بمراقبتك وتكوين الملاحظات أثناء تفاعلاتك ومحادثاتك مع الآخرين بموافقتك وإذنتك في المساجد والكنائس. وهذا يشمل مراقبة وتكوين الملاحظات الميدانية حول تفاعلاتك ومحادثاتك بين اللاجئين السوريين

Al Rayyan Al Gedid - Al Shafi st.  
opposit Apple bees  
Building No. (112) Office (4)  
C.R :  
Tel. :  
Mob. : \



ع ل شافي  
م رقم (١١٢) مكتب (٤)  
٩٧  
+٩٧٤ / ٤٤١٢٩٠  
+٩٧٤ / ٦٦٠٦٨١٢٢  
act\_2014@hotmail.

أو مع الآخرين. سيطلب الباحث جهة الاتصال الخاصة بك في المستقبل (رقم الهاتف) لدعوتك إلى منتدى مجتمع لمشاركة نتائج الدراسة إذا كنت ترغب في الحضور. سيتم نقل المقابلة حرفياً وتحويلها من صوت إلى كتابة. ستضمن هذه العملية أن كل ما قلته سيكون مكتوباً حرفياً بدون إضافة. ثم سيتم استخدام هذه الوثائق المكتوبة لتحليلها في نهاية المطاف مع بعض النتائج.

**المشاركة التطوعية/ الانسحاب من الدراسة:** مشاركتك في هذه الدراسة تطوعية. يمكنك رفض المشاركة أو رفض الإجابة عن أي أسئلة أو الانسحاب من الدراسة في أي وقت عن طريق ذكر "مرور" دون أي تأثير على حالتك المستقبلية أو الخدمات التي تتلقاها في كندا. يمكنك أيضاً طلب سحب المعلومات التي قدمتها لي من الدراسة حتى وقت نشر النتائج.

**المخاطر و الفوائد:** لا توجد مخاطر معروفة لمشاركتك. ومع ذلك ، فإن التحدث عن أي تجارب من الابتعاد عن عائلتك أو الهجرة ، أو مع صحتك يمكن أن يسبب لك بعض الانزعاج العاطفي وقد يكون هناك بعض خطر انتهاك الخصوصية. سوف يأخذ الباحث في الاعتبار استراتيجيات تخفيف مختلفة لحماية السرية. سيتم أيضاً إخطار الباحث الرئيسي فوراً بالحكم إذا كان هناك حاجة لاتخاذ مزيد من الإجراءات. لا يمكنك الاستفادة مباشرة من مشاركتك في هذه الدراسة. تشمل الفوائد العامة المحتملة زيادة التبصر والفهم لكيفية تأثير تجربتك وغيرها من اللاجئين السوريين من الصدمات على صحتك وتحسين البرامج والسياسات التي تلبي الاحتياجات الصحية للنساء اللاجئين السوريين.

**السرية:** يتم استخدام المعلومات التي حصلنا عليها منك بغرض البحث فقط. لن يتم نشر أو نشر أي معلومات تكشف عن هويتك دون موافقتك. تصبح سجلات البحث الخاصة بك ، بما في ذلك محاضر المقابلات والتسجيلات الصوتية للمقابلات وملاحظات الملاحظة ، متاحة فقط للباحث عن الدراسة ومشرفها ، وسيتم تخزين النسخ الورقية من الوثائق مثل الخطاب / الموافقة الموقعة في خزانة ملفات مغلقة مؤمنة في مكان آمن في مدرسة آرثر لابات العائلية للتمريض في حرم جامعة ويسترن. بينما سيتم تخزين الإصدارات الإلكترونية بما في ذلك المقابلات في محرك أقراص مؤسسي محمي بكلمة مرور ومشفرة. سيتم تدميرها بعد 7 سنوات. قد يتصل بك ممثلو مجلس أخلاقيات أبحاث العلوم الصحية بجامعة ويسترن أونتااريو أو قد يطلبون الوصول إلى سجلاتك المتعلقة بالدراسة لمراقبة سير البحث.

**التكاليف والتعويضات:** سيتم توفير التعويض عن المصاريف مثل النقل و / أو الوقت اللازم للمشاركة. ستتلقى 20 دولار كندي مقابل كل مقابلة تشارك فيها. ستحصل على نسخة من خطاب المعلومات ونموذج الموافقة هذا بمجرد التوقيع عليه.





Al Rayyan Al Gedid - Al Shafi st.  
opposit Apple bees  
Building No. (112) Office (4)  
C.R :  
Tel. :  
Mob. :

  
Alamal Certified Translation  
الأمال للترجمة المعتمدة

الشارقي  
ب. رقم (١١٢) مكتب (٤)  
٩٩  
+٩٧٤ / ٤٤١٢٩٠  
+٩٧٤ / ٦٦٠٦٨١٢٢  
act\_2014@hotmail.

الحقوق كمشارك / أسئلة حول الدراسة: إذا كنت ترغب في الحصول على نسخة من النتائج الإجمالية للدراسة ، يرجى وضع اسمك ورقم هاتفك على قطعة فارغة من الورق وتركه معي. إذا كان لديك أي أسئلة حول الدراسة أو حقوقك كمشارك بالبحث، يمكنك التواصل مع د/ شيريل فورشوك (محقق رئيسي) البريد الإلكتروني: \_\_\_\_\_ ، رقم الهاتف: \_\_\_\_\_ داخلي: \_\_\_\_\_ أو أريج الحمد (طالب دكتوراه) البريد الإلكتروني: \_\_\_\_\_ في حالة الحاجة لمزيد من الأسئلة باعتبارك مشارك بالبحث أو منهجية الدراسة يمكنك التواصل مع مكتب أخلاقيات البحث \_\_\_\_\_ البريد الإلكتروني: \_\_\_\_\_

#### الموافقة

لقد قرأت خطاب المعلومات ، وقد أوضحت لي طبيعة الدراسة ، وأنا أوافق على المشاركة في المقابلة و تدقيق المشاركين. تم الرد على جميع الأسئلة بما يرضيني. أدرك أنه لن يتم التنازل عن أي حقوق قانونية من خلال التوقيع على هذه الموافقة.

اسم المشارك (يرجى طباعته)

التاريخ توقيع المشارك

اسم الباحث (يرجى طباعته)

التاريخ توقيع الباحث

شكرا

نسخة خطاب المعلومات 4

4 نوفمبر 2019





## Appendix C: Letter of Information (English)



### LETTER OF INFORMATION

**Study Title:** Syrian Refugee Women's Experiences with the Ontario Health Care

**System:** A Critical Ethnography Study

**Name of Principal Investigator:** Dr. Cheryl Forchuk, RN, PhD

Distinguished University Professor,

Arthur Labatt Family School of Nursing, University of Western Ontario

Room: \_\_\_\_\_

Phone: \_\_\_\_\_

e-mail: \_\_\_\_\_

**Student Name:** Areej Al-Hamad, RN, MScN, Ph.D., Ph.D. (c)

Doctoral Student, Arthur Labatt Family School of Nursing, University of Western Ontario

Arthur Labatt Family School of Nursing

University of Western Ontario

Phone: \_\_\_\_\_

e-mail: \_\_\_\_\_



**Name of Sponsor:** No sponsor for this study.

**Conflict of Interest:** No affiliations with or involvement in any organization or entity with any financial or non-financial interest in the subject matter or materials discussed in this research project.

**Introduction:** You are invited to participate in a research study about Syrian refugee women's experiences. This study will cover the experiences of migration and trauma before and after

arriving to Canada. In addition, it will discuss the impact of being a refugee woman and trauma on health.

**Background/Purpose** The aim of this study is to understand how the experience of moving to Canada, may affect Syrian refugee women's health. The purpose of this letter is to provide you with information to make an informed decision about participating in this research. I am a Doctoral student in the School of Nursing at the University of Western Ontario and the information I am collecting will be used in my thesis.

**Study Design:**

The aim of this study is to understand how the experience of moving to Canada, may affect Syrian refugee women's health. We plan to do this through interviews and observation. We are looking to recruit 20-40 participants.

**Procedures:** You may be able to participate if you:

- ☐ are a Syrian refugee women
- ☐ able to speak English or Arabic.
- ☐ are aged 18 years or more
- ☐ are currently residing in Ontario for 36 months or less

**If you take part in the study, you will be asked to:**

- ☐ participate in one interview with me.

You will be asked questions that will help me to understand how you feel about:

- ☐ being Syrian refugee women and away from your home
- ☐ your health and everyday life
- ☐ your current strategies that you are currently utilizing to promote your health
- ☐ your experiences with the health care system in Ontario



Interviews may last approximately 1–2 hours to complete or depending on how much information the participants has to share. The interviews will be held at a place you choose and feel comfortable, such as:

☐ Churches or Mosques

The interviews will be audio-recorded so that I can pay careful attention to what you are saying. The researcher will observe you and take notes during your interactions and conversations with others with your consent and permission at the mosques and churches. This includes observing and taking field notes on your interactions and conversations among Syrian refugee women or with others. The researcher will ask your future contact (telephone number) to invite you to a community forum to share the study findings if you will be interested to attend. The interview will be transcribed verbatim and converted from audio to written. This process will assure that everything you said will be written word by word with no addition. Then this written documents will be used to analyse it to end up with some findings.

**Voluntary Participation/ Withdrawal from Study:** Your participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time by stating “pass” with no effect on your future status or services you are receiving in Canada. You can also request that the information you have given me is withdrawn from the study up to the point when the results are published.

**Risks & Benefits:** There are no known risks to your participation. However, talking about any experiences from being away from your families or migration, or with your health could cause you some emotional discomfort and there might be some risk of privacy breach. The researcher will consider various mitigating strategies to protect confidentiality. The PI will also be notified immediately to judge if further action is required. You may not benefit directly from your

participation in this study. Potential general benefits include increased insight and understanding of how your experience and other Syrian refugee women experiences of trauma impact your health and improved programs and policies that address the health needs of Syrian refugee women.

**Confidentiality:** Information provided by you will be used for research purposes only. No information that discloses your identity will be released or published without your consent. Your research records, including interview transcripts and audio recordings of the interviews and observation notes, will only be available to the study investigator and her supervisor, the paper versions of the documents such as signed letter/consent will be stored in a special locked filing cabinet at a secure place at the Arthur Labatt Family School of Nursing at Western University campus. While the electronic versions including interviews will be stored in a password protected and encrypted institutional drive. They will be destroyed after 7 years. Representatives of the University of Western Ontario Health Sciences Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research.

**Costs & Compensation:** Reimbursement for expenses such as transportation, and/or for the time required to participate will be provided. You will receive CAD20 cash for each interview in which you participate. You will be given a copy of this letter of information and consent form once it has been signed.

**Rights as a Participant/ Questions about the Study:** If you would like to receive a copy of the overall results of the study, please put your name and phone number on a blank piece of paper and leave it with me. If you have any questions about the study or your rights as a research participant, you may contact Dr. Cheryl Forchuk (Primary investigator) email \_\_\_\_\_ or Phone, \_\_\_\_\_ ) or Areej Al-Hamad (PhD student)

email? If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Research Ethics email:

### Consent

I have read the letter of information, have had the nature of the study explained to me, and I agree to participate in the interview and participants observations. All questions have been answered to my satisfaction. I understand that no legal rights will be waived by signing this consent.

\_\_\_\_\_

Name of participant (please print)

\_\_\_\_\_

Signature of participant

Date

\_\_\_\_\_

Name of investigator (please print)

\_\_\_\_\_

Signature of investigator Date

Thank you

## Appendix D: Interview Guide (Arabic)

Al Rayyan Al Gedid - Al Shafi st.  
opposit Apple bees  
Building No. (112) Office (4)  
C.R : ٥٧٩٩٢  
Tel. :  
Mob. :



أربع آل شافي  
نم رقم (١١٢) مكتب (٤)  
+٩٧٤ / ٤٤١  
+٩٧٤ / ٦٦٠٦٨١٢٣  
act\_2014@hotmail.com

### دليل مقابلة

عنوان الدراسة: تجارب اللاجئين السوريين في نظام أونتااريو

للعناية الصحية: دراسة إثنوغرافية حرجة

### مقدمة:

شكرا لك على المشاركة في هذه المقابلة. أود أن أعرف قدر الإمكان عن تجاربك كونك لاجئات سوريات في كندا. يمكن للمشاركين تخطي أي سؤال يقول "مرور Pass" ويمكن بدء التسجيل الصوتي.

### الهجرة ، الصدمة ، والمستوطنة:

- 1- أخبرني عن نفسك؟
- 2- صف حياتك في كندا؟
- 3- صف حياتك وأنت تنتقل من بلد إلى آخر؟ ما هي الظروف المحيطة بالانتقال والهجرة؟
- 4- منذ متى وأنت هنا في كندا؟ كيف هو الانتقال إلى كندا؟
- 5- هل هناك صعوبات و / أو فوائد في حياتك هنا؟ كيف تعاملت مع هذه؟
- 6- أخبرني عن تجربتك مع خدمات الاستيطان والرعاية الصحية والسكن عندما وصلت إلى كندا؟
- 7- كيف تؤثر الهجرة والنزوح عليك وعلى أسرتك ، وخاصة أطفالك وزوجتك / شريكك؟
- 8- كيف تشعر عندما تتحدث عن "المنزل"؟ هل تغير هذا الشعور بعد الانتقال إلى كندا بطريقة ما بمرور الوقت؟
- 9- ما هي الطرق التي تشعر بها أن هجرتك ونزوحك شكلا حياتك والشخص الذي أنت عليه اليوم؟
- 10- هل واجهت أي تمييز / كراهية من مجتمعك هنا في كندا؟ إذا كانت الإجابة بنعم ، كيف يؤثر ذلك عليك وعلى أسرتك؟
- 11- ما معنى أن تصبحن لاجئات سوريات في كندا؟





Al Rayyan Al Gedid - Al Shafi st.  
opposit Apple bees  
Building No. (112) Office (4)  
C.R. : 97392  
Tel. :  
Mob. :



Alamal Certified Translation  
الأمّل للترجمة المعتمدة

ال شافى  
رقم (١١٢) مكتب (٤)

+٩٧٤ / ٤٤١  
+٩٧٤ / ٦٦٠٦٠  
act\_2014@ho

### قصص صحية:

- 1- ماذا يعني "أن تصبح بصحة جيدة" بالنسبة لك؟ ما الذي يجعلك تشعر بصحة جيدة و / أو غير صحية؟
- 2- كيف تعتني بنفسك وعائلتك وصحتك؟
- 3- كيف تؤثر الهجرة إلى كندا على شعورك تجاه نفسك؟ حياتك؟ صحتك؟
- 4- ما هي المخاوف أو القضايا الصحية التي لديك الآن؟ كيف تتعامل مع هذه المخاوف؟
- 5- أخبرني عن تجربتك مع نظام الرعاية الصحية هنا في كندا؟ هل هناك صعوبات في طلب الرعاية الصحية هنا في كندا؟
- 6- هل تلبى برامج وخدمات الرعاية الصحية الحالية احتياجات الرعاية الصحية الخاصة بك؟
- 7- ما هي الحلول التي ترغب في اقتراحها من أجل تلبية احتياجات الرعاية الصحية الخاصة بك؟
- 8- ما هي التغييرات التي ترغب في رؤيتها في نظام أونتااريو للرعاية الصحية ، إن وجد؟

### استخلاص المعلومات

هذه كلها أسئلتي ؛ انتهت المقابلة. لقد ساعدت حقًا في الموافقة على إجراء المقابلة. كيف كان ذلك بالنسبة لك؟

أود أن أطرح عليك بعض الأسئلة حول العملية إذا كان هذا جيدًا معك.

- 1- هل هناك أي شيء تريد مشاركته لم تتم تغطيته بالفعل في المقابلة؟ هل هناك أي شيء آخر تشعر أنه من المهم أن نقوله عن تجاربك الصحية والهجرة في حياتك؟
- 2- ما هو شعورك الآن حول المشاركة في المقابلة؟ هل تشعر بخير الآن؟ هل ترغب في التحدث أكثر عن بعض الأشياء التي ذكرتها في المقابلة؟
- 3- هل تعرف أين يمكنك الذهاب إذا كنت تريد التحدث إلى شخص ما؟ (مثل وكالة). (ملاحظة: يمكن أن يشمل الدعم مجموعة متنوعة من الخدمات / الوكالات)
- 4- هل هناك أية أسئلة تود توجيهها لي؟



ayyan Al Gedid - Al Shafi st.  
osit Apple bees  
ding No. (112) Office (4)  
: 07392



**Alamal Certified Translation**  
الأمّل للترجمة المعتمدة

ل شافي  
رقم (١١٢) مكتب (٤)

+٩٧٤ / ٤٤١  
+٩٧٤ / ٦٦٠٦٠  
act\_2014@ho

- 5- هل تريد بعض الدعم بعد هذه الجلسة بأي شكل من الأشكال؟
- 6- هل يمكنني الاتصال بك في المستقبل لأدعوك عندما أشارك نتائج الدراسة؟ ما هي أفضل طريقة للاتصال بك؟
- 7- هل يمكن أن تمرر ملصق التوظيف هذا إلى من تعتقد أنهم مهتمون بالاتصال بفريق البحث للمشاركة في الدراسة؟
- سأعقد منتدى مجتمعي مع المنظمات المجتمعية في نهاية الدراسة لتبادل النتائج التي توصلت إليها ، وسأدعو النساء المشتركين إذا رغبين في ذلك.
- هل هذا يبدو وكأنه شيء سيكون به مصلحة لك؟
- نعم ( ) لا ( )
- شكرا على المشاركة و نوفر 20 دولار كهدية لك
- المحاور:

محل المقابلة:

نسخة دليل المقابلة 3

31 أكتوبر 2019





## Appendix E: Interview Guide (English)



### Interview Guide

**Study Title:** Syrian Refugee Women's Experiences with the Ontario Health

Care System: A Critical Ethnography Study

### Introduction

Thank you for participating in this interview. I would like to know as much as possible about your experiences being Syrian refugee women in Canada. Participants can skip any question by saying "Pass" and that audio-recording can start.

### Migration, Trauma, and Settlement

1. Tell me about yourself?
2. Describe your life in Canada?
3. Describe your life moving from one country to another? What were the circumstances around moving and migration?
4. How long have you been here in Canada? What is it like to move to Canada?
5. Are there difficulties and or benefits in your life here? How have you handled these?
6. Tell me about your experiences with settlement services, health care and housing when you arrived in Canada?
7. How does migration and displacement affect you and your family, especially your children, and your spouse/partner?
8. How do you feel when you talk about 'home'? Has this feeling changed after moving to Canada in some way over time?
9. In what ways do you feel that your migration and displacement has shaped your life and the person you are today?

10. Have you experienced any discrimination/hate from your community here in Canada? If yes, how does that affect you and your family?
11. What does it mean to you to be Syrian refugee women in Canada?

### **Health Stories**

1. What does 'being healthy' mean to you? What makes you feel healthy and/or unhealthy?
2. How do you take care of yourself, your family and your health?
3. How does migrating to Canada affect how you feel about yourself? Your life? Your health?
4. What health concerns or issues do you have right now? How do you handle these concerns?
5. Tell me about your experiences with the health care system here in Canada? Are there difficulties in seeking health care here in Canada?
6. Do current health care programs and services meet your health care needs?
7. What solutions would you like to suggest in order to meet your health care needs?
8. What changes would you like to see in the Ontario health care system, if anything?

### **Debriefing**

Those are all of my questions; the interview is over. You have been really helpful in agreeing to do the interview. How was it for you?

I would like to ask you a few questions about the process if that's ok with you.

1. Is there anything you'd like to share that hasn't already been covered in the interview? Is there anything else that you feel is important to say about your migration and health experiences in your life?

2. How do you feel now about participating in the interview? Are you feeling okay right now? Would you like to talk more about some of the things you mentioned in the interview?
3. Do you know where you can go if you ever want to talk to someone? (i.e. an agency).  
(Note: support can include a variety of services/agencies)
4. Are there any questions you would like to ask me?
5. Do you want some support after this session in any way?
6. Can I contact you in the future to invite you when I will share the study findings? What is the best way to get in touch with you?
7. Can you please pass this recruitment poster to those you think might be interested in contacting the research team to participate in the study?

I will be holding a community forum with community organizations at the end of the study to share my findings and would invite women how participate if they wish.

Does this sound like something that would be of interest to you?

Yes \_\_\_\_\_ No \_\_\_\_\_

\*Thank the participants and provide the \$20 thank you gift.

**INTERVIEWER:** -----

**PLACE OF INTERVIEW:** -----

## Appendix F: Recruitment Flayer (Arabic)

**Al Rayyan Al Gedid - Al Shafi st.**  
**opposit Apple bees**  
**Building No. (112) Office (4)**  
**C.R : 97392**  
**Tel. :**  
**Mob. :**



**Alamal Certified Translation**  
الأمّل للترجمة المعتمدة

شارع آل شافى  
مبنى رقم (١١٢) مكتب (٤)  
٩٧  
+٩٧٤ / ٤٤١٢١  
+٩٧٤ ٩٦٠ ٢٨١٢٣  
ac2014@hotmail.com

## نشرة التوظيف

**: عنوان الدراسة: تجارب اللاجئات السوريات في نظام أونتاريو**

### للرعاية الصحية: دراسة إثنوغرافية حرجة

الدكتورة شيريل فورشوك باحثة رئيسية في كلية آرثر لايت للتمريض في جامعة ويسترن أونتاريو وطالبتها أريج الحمد ، طالبة دكتوراه في التمريض في جامعة ويسترن أونتاريو تخطط لإجراء دراسة. سيقوم الباحثون بإجراء دراسة حول تجارب اللاجئين السوريين في نظام أونتاريو للرعاية الصحية بعد وصولهن إلى كندا. تركز الدراسة على فهم كيفية تأثير تجارب الصدمات النفسية والانتقال إلى كندا واللاجئين السوريين على صحتك في كندا.

يمكنك المشاركة إذا كنت:

- لاجنات سوريات
- يمكنك التحدث باللغة الإنجليزية أو العربية
- تبلغ 18 عاما او أكثر
- تقيم حاليا في أونتاريو لمدة 36 شهر أو أقل

إذا كنت مهتم سيطلب منك إجراء مقابلة شخصية مع الباحث لمدة 1-2 ساعة و سيقوم الباحث بمراقبة المكان الذي ستجرى فيه المقابلة (المساجد و الكنائس).

لمزيد من المعلومات و التواصل باللغة العربية/ الانجليزية:

الباحث الرئيسي: د/ شيريل فورشوك- البريد الإلكتروني:

الطالبة: أريج الحمد- البريد الإلكتروني: 1

هاتف: ۱

نسخة النشرة: 3

31 أكتوبر 2019



C.R. : 30668 / 1 - Tel.

## Appendix G: Recruitment Flyer (English)



### Recruitment Flyer

**Study Title: Syrian Refugee Women's Experiences with Ontario Health**

**Care System: A critical Ethnography Study**

Dr. Cheryl Forchuk a principal investigator from Arthur Labatt Family School of Nursing at the University of Western Ontario and her student Areej Al-Hamad, a doctoral student in nursing at the University of Western Ontario planning to conduct a study. The researchers will conduct a study about Syrian refugee women's experiences with Ontario health care system after arriving to Canada. The focus of the study is to understand how the experiences of trauma, moving to Canada and being Syrian refugee women may influence your health in Canada.

**You may be able to participate if you:**

- ☐ are a Syrian refugee women
- ☐ able to speak English or Arabic.
- ☐ are 18 and above years old
- ☐ are currently residing in Ontario for 36 months or less

If you are interested you will be asked to do interview with the researcher last between 1-2 hours and the researcher will do observation of the setting where the interview will be taken place (Mosques and churches).



For more information and contact in English/ Arabic:

**Principal Investigator: Dr. Cheryl Forchuk**

**Email**

**Phone:**

**Student: Areej Al-Hamad**

**Email:**

**Phone:**

Flyer version 3



October 31 ,2019

## Curriculum Vitae

<b>Name:</b>	Areej Al-Hamad
<b>Post-secondary Education and Degrees:</b>	<p>Western University London, Ontario, Canada 2017-2021 PhD.</p> <p>Laurentian University Greater Sudbury, Ontario, Canada 2014-2019 PhD.</p> <p>Jordan University of Science &amp; Technology Al-Ramtha, Jordan 2003-2005 MScN.</p> <p>Jordan University of Science &amp; Technology Al-Ramtha, Jordan 1998 to 2002 BScN.</p>
<b>Honours and Awards</b>	<p>Irene E. Nordwich Foundation Award for Academic Achievement 2018</p> <p>Ontario Graduate Scholarship 2018-2019</p> <p>Ontario Graduate Scholarship 2014-2015</p> <p>Pitblado Award for Rural Health/ Laurentian University 1,000\$. (2015).</p> <p>Ministry of higher education scholarship for academic excellence 1999-2001, 2001-2002, 2002-2003</p>
<b>Related Work Experience</b>	<p>University of Calgary in Qatar 2019- 2020</p> <p>Graduate Teaching Assistant Western University 2017-2019</p> <p>Lecturer/Western University 2015- 2016</p>

Graduate Teaching Assistant  
Laurntian University  
2014- 2019

Lecturer  
International Academy for Health Science  
2007- 2008

Lecturer  
Philadelphia University  
2005-2007

**Managerial and Clinical Experience** Assistant Director of Care  
Wyndham Manor nursing home  
Oakville, Ontario, Canada  
2018-2019

Registered Nurse  
Chelsey Park nursing home  
London, Ontario, Canada  
2016- 2017

Head Nurse/Nurse Educator  
Dr. Sulaiman Al-Habib Hospital  
Al-Qassim, Saudi Arabia  
2009-2013

Registered Nurse, then Charge Nurse in Cardiac surgery  
King Abdullah University Hospital  
Al-Ramtha, Jordan  
2002-2006

### **Publications:**

Al- Hamad, A. Forchuk, C., Oudshoorn, A., & McKinley, G. (2020). Health Seeking Behaviors among Syrian Refugee Women: A Scoping Review. *International Journal of Healthcare*. 6 (2), 54-61. <https://doi.org/10.5430/ijh.v6n2p54>

Al- Hamad, A. (2020). Toward health equities, social justice, and emancipatory calls for knowledge development in nursing. *Journal of Nursing Education and Practice*. 10 (8), 66-73. <https://doi.org/10.5430/jnep.v10n8p66>

- Al- Hamad, A, Kauppi, C., Montgomery, P., & Virchez, J. (2019). Food Security and the Health Perceptions of Women in Ontario. *The International Journal of Interdisciplinary Social and Community Studies*. 14 (1), 61-82. <https://doi.org/10.18848/2324-7576/CGP/v14i01/61-82>
- Al- Hamad, A, Kauppi, C., Virchez, J.& Johnson, J. (2019). Quotidian Practices by Women Facing Food Insecurity in Northeastern and Southwestern Ontario. *Food Studies: An Interdisciplinary Journal*. 9 (3), 55-70. <https://doi.org/10.18848/2160-1933/CGP/v09i03/55-70>
- Al- Hamad, A, Kauppi, C., Montgomery, P., & Virchez, J. (2018). Food Insecurity and Women's Health in Canada: Does Northern and Southern Ontario Residency Matter? *The International Journal of Health, Wellness, and Society*. 9 (1): 1-18. <https://doi.org/10.18848/2156-8960/CGP/v09i01/1-18>.
- Orchard, C.A., Sonibare, O., Morse, A., Collins, J., & Al-Hamad, A. (2017). Collaborative leadership, Part 1: The nurse leader's role within interprofessional teams. *Canadian Journal of Nursing Leadership*, 30(2), 14-25. <https://doi.org/10.12927/cjnl.2017.25258>
- Orchard, C.A., Sonibare, O., Morse, A., Collins, J., & Al-Hamad, A. (2017). Collaborative leadership, Part 2: The role of the nurse leader in interprofessional team-based practice – Shifting from task- to collaborative patient-/family-focused care. *Canadian Journal of Nursing Leadership*, 30(2), 26-38. <https://doi.org/10.12927/cjnl.2017.25257>
- Yasin, Y.M., Al-Hamad, A., Bélanger, C.H. Boucher, A. & Abu-Rubeiha, M.A. (2017). Expatriate Health Professionals in the Saudi Private Sector. *British Journal of Healthcare Management*, 4(23), 176-185. <https://doi.org/10.12968/bjhc.2017.23.4.176>
- Yasin, Y., & Al-Hamad, A. (2015). Anxiety and Depression as Key Determinants of Cancer Related Fatigue among Patients Receiving Chemotherapy. *European Scientific Journal*, 11(33), 39-52.

### Conferences and Symposia

- Al-Hamad, A. (2018, September 26-28). Trauma and Violence Informed Practices to Care for Syrian Refugee Women: A Critical Ethnography Study. Paper presented at the 22nd Conference of the Nursing Network on Violence Against Women International (NNVAWI), Niagara on the lake, Canada.
- Al-Hamad, A. (2016, May 30-31). Cultural Competency Among Canadian Nursing Students: Are We There Yet? Paper presented at the Canadian Nursing Education Conference, Toronto, Canada.



- Al-Hamad, A. (2016, May 9). Cultural Competency Among Canadian Nursing Students: Are We There Yet? Paper presented at the (Thriving to change) 29th Annual Research Conference, Western University, London. ON. Canada.
- Al-Hamad, A., O’Gorman, L. (2015). Northern Ontario health care priorities: Access to culturally appropriate care for physical and mental health. Northern Policy Institute, 1-13. URL:  
<https://www.northernpolicy.ca/upload/documents/publications/briefing-notes/paper-health-policy-4-english-15.06.22.pdf>
- Al-Hamad, A. (2015, June 4-6). Strengthening and Reinforcing the Infrastructure of Rural Communities in Northern Ontario: Poverty and Homelessness as Key Social Determinants of Health. Paper presented at the Northern Health Research Conference, Timmins, Ontario.
- Al-Hamad, A. (2015, November 2-4). Food Insecurity, Poverty and Homelessness as Key Social Determinants of Health in Northern Ontario. Paper presented at the Canadian Alliance to End Homelessness Conference, Montreal, Quebec.
- Al-Hamad, A. (2015, October 19-21). Food Insecurity, Poverty and Homelessness as Key Social Determinants of Health in Northern Ontario. Paper presented at the Qualitative Health Research Conference, Toronto, Canada.
- Al-Hamad, A. (2008). Impact of social support on depression among Jordanian coronary artery bypass graft surgery patients. Paper presented at the International Nursing Conference. Amman-Jordan.