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**The Everyday Experience of
Somali Women in Canada:
Implications for Health**

By

Robin Lynn Buckland

**Thesis submitted to the school of Graduate Studies and Research
in partial fulfillment of the requirements for the
degree of Master of Science in Nursing**

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Abstract

Access to health care is considered a basic right in Canadian society. However, health services are frequently inappropriate, unacceptable and thus inaccessible to immigrant and refugee women. The everyday concerns of immigrant and refugee women are germane to establishing appropriate, acceptable and accessible health care services. Thus, the purpose of this study was to examine the everyday life experiences of Somali, exploring how these experiences affect their. Grounded theory, a qualitative research method, in which data collection and analysis occur in tandem, was utilized, and enhanced by the perspective of feminism, in this study. This feminist perspective facilitated a non-oppressive, non-hierarchical, interactive and reflexive research process.

'Rebuilding' in Canada was identified as a central process. Two main categories were discovered in the process of rebuilding; 1) adjusting to the refugee reality & 2) finding a new safety in Canada. Running from flames reflects on the initial experiences of Somali women in Canada. Despite the fact that they are safe in Canada, coming to terms with their reality as refugees is not easy. Safe in Canada Somali women begin the day-to-day trials of dealing with intercultural communication in an unfamiliar Canadian system. Once the initial shock of the refugee reality has passed, Somali women reflect on a plethora of losses incurred. Taking the time to grieve these losses is a short but essential part in the process of rebuilding.

Somali women in Canada are without their usual systems of support in a time when they are most required. Redesigning these systems of support is an essential part of rebuilding. Further, health care providers can and do in many instances, provide a valuable source of support for Somali women. However, experiences within the health care system, such as language difficulties, fear and racism were found to hinder Somali women's ability to access health care. Somali women, many as single parents, experience intrafamilial difficulties with their children and their newly arrived husbands. Adjusting to a new family structure is an important part of ultimately rebuilding their lives in Canada. As well, the public discourse and media sensationalization of female circumcision negatively affect Somali women in many ways.

In response to the difficulties experienced as refugees in their everyday lives Somali women are increasingly seeking and finding solace in their religion as Muslims. Islam was further described as a prescription for health: Health which, according to Somali women, includes their physical, mental and spiritual well being; a health from which their everyday experiences as female Somali refugees can not be removed. Given this, the study finding encourage nurses and other health care providers to consider the context and history of clients ultimately broadening their conception, as health care providers, of health and the multiple factors that determine it.

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As my journey towards completion of this thesis winds to an end, I am left only to reflect on the incredible sacrifice and effort provided by many toward this work. Without their vigilant support and interest, I would not have been able to successfully weather the turbulence of this thesis in progress.

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Chapter One - Introduction

1.1 Background

Canada has historically encouraged immigration as a means to spur social and economic growth (Bollini 1992; Masi, Mensah & McLeod 1993; Rafuse 1993). Within the past three decades Canada has facilitated immigration and refuge from politically and racially diverse countries (Health and Welfare Canada 1988a; Lalonde & Cameron 1993). In response to these changing demographics, the federal Multiculturalism Act of 1988 was passed. This policy aimed to preserve and enhance multiculturalism in Canada by recognizing its ethnocultural diversity. The act strives to achieve economic, social, cultural and political equality for all Canadians. It advises policy makers to ensure that policies and programs respond to the needs of all Canadians, and that the delivery of services is accessible to all (Heritage Canada 1995).

The extent to which health policies and health services respond to the needs of immigrant and refugee women is disputable (Bergin 1993; Bollini 1992; Equal Opportunity Consultants 1991; Lipson 1991; Mardiros 1988; Ministry of Health 1993; Social Planning Council of Ottawa-Carleton 1988). To be responsive and acceptable, services must be congruent with client's perceptions of health and illness (Rosenbaum 1991; Meleis, Lipson & Paul 1992). Further, research suggests that understanding the everyday concerns or factors affecting immigrant and refugees assists in the provision of effective and efficient health services (Waxler-Morrison, Anderson & Richardson 1990; Health and Welfare Canada 1988a). The appropriateness of health care services to immigrants and refugees continues to be a source of national concern (Health and Welfare Canada 1990).

1.2 Literature Review

The following review examines the current literature reflecting the health of immigrant and refugee women. The review reflects the current state of Canadian knowledge in the area of immigrant and refugee women's health. This is based on the assumption that the Canadian context is considerably different from, for example, the American or British context. Never-the-less, some international studies have been included. For example, American studies reflective of the Canadian paradigm were included to provide as broad a perspective as possible. Ultimately, the review aims to reflect the health of immigrant and refugee women in Canada.

The review begins by delineating the importance of feminism and an analysis of gender in research with immigrant and refugee women. It continues with, a section entitled 'Determinants of Health', which documents the many health concerns of immigrants and women within a broad determinants of health framework, ultimately suggesting that the everyday experiences of immigrant and refugee women are reflective of the determinants of health. Health care access, an important determinant of health is then reviewed, suggesting that given the many health concerns of immigrant and refugee women, accessible services are essential. The review ends with a critique of the current research involving the Somali community. The review demonstrates the limits of these studies, suggesting the need for further research into the everyday concerns of Somali women within a feminist perspective.

1.2.1 An Analysis of Gender

In the past, the experiences of immigrant and refugee women were subsumed under those of men (Ralston 1991). Increasingly, women have become the focus of many cross cultural studies (Ministry of Health 1993). However, such studies have often imposed andocentric methodologies in the process of knowledge development (Maguire 1987).

Immigrant, refugee and racial minority women are demanding an end to such practices. These sources exhort researchers to adopt research methods that are consistent with women's beliefs in holism and humanism and reflect their everyday realities and concerns (Gottschalk & Teymour 1993; Health and Welfare Canada 1988a; 1988b; 1990; Ministry of Health 1993; Wuest 1993).

Feminist inquiry is both pragmatic and reflective of women's voices and experiences (Campbell & Bunting 1991). Feminist inquiry seeks to discover a reflective truth by eliminating the biases of gender, race and class in the research process (Wuest 1995). Examining the experiences of women without an explicit analysis of gender and their everyday experiences contributes to a superficial analysis, that is potentially andocentric, patriarchal, and reinforcing of the structures of power imbalance and oppression (Maguire 1987).

A trend of feminist analysis, i.e., examining the impact of gender, has recently informed studies of immigrant and refugee women (Anderson 1985; Anderson 1986; Ralston 1991; Gupta 1994; Lee & Cochran 1988). Questions such as; How does gender influence one's experience as either an immigrant or a refugee, Is the experience of being a refugee easier for women because their role as 'mother' remains intact, Is the experience of immigration more difficult for women because of their role as caregiver and culture keeper, form an important part of such analysis. Clearly, the possible impact of gender on migration is considerable.

Gender analysis informed a study of Indo-Canadian and Greek immigrant women. This study found that women's perception and experiences are shaped by social, economic, ethnic and political factors (Anderson 1987). Dunk (1989) took a similar approach in a study examining the problems of 'nerves' amongst forty five Greek immigrant women. Dunk's (1989) findings suggest that the sexually prescribed roles Greek women hold

contribute to their experience of 'nerves' and further serve to relegate the problem to the private domestic sphere; that is, nerves are not considered or discussed outside family relations.

Ralston (1991) examined the effects of gender, race and class on immigrant and refugee women's experience of paid labor. This author, like others, found that immigrant and refugee women's experience of work was confounded by the double duty of work and domestic responsibility (Ralston 1988; Dunk 1989; Lee & Cochran 1988; Anderson 1987; Anderson & Lynam 1987). Not unlike the reality of many Canadian born women (Ford 1990; The Federal/Provincial/Territorial Working Group on Women's Health 1993), these women maintained ultimate responsibility for the domestic sphere in addition to the contributions made in the paid work force.

For both immigrant and refugee women, the perils of the double work day are compounded by their status as immigrants and refugees. Several researchers have found that discrimination based on their status as migrants and visible minorities impacted on occupational options, advancement and ultimately economics (Anderson 1987; Anderson & Lynam 1987). At the same time, studies have also found that the double work day was mediated by the psychological benefits of paid employment. Benefits from paid employment were found to include increased self worth, confidence and sense of mastery (Ralston 1988; 1991; Miedema & Nason-Clark 1989; Anderson 1987; Anderson & Lynam 1987; Ford 1990; The Federal/Provincial/Territorial Working Group on Women's Health 1993). Ng's (1993) findings, in a grounded theory study with Chinese immigrant and refugee women in the volunteer work sector, were similar.

Thus, given the recent analysis of gender within immigrant and refugee women's research, the factors considered to be important to these women are becoming increasingly

clear. Further work is required to ensure that this analysis of gender explicitly includes the day-to-day experiences of immigrant and refugee women that impact their health.

1.2.2 Determinants of Health

Canadians are beginning to recognize the multifaceted nature of health and illness . In fact, the model adopted by the Premier's Council on Health, in Ontario, espouses multiple determinants of health. These determinants of health include; social support, one's living and working environment, socio-economics, individual behavior, and finally, health care services (Premier's Council on Health, 1991). There is a dynamic relationship between these determinants of health, one's everyday experiences and health. Health goes beyond our specific perceptions of health and beyond the traditional definitions of health. Health is grounded in everyday experiences and in life more broadly. The determinants of health are encountered, for the most part, in our day-to-day experiences. For example, every day we negotiate our social supports, interact within our living and working environments, are impacted by our socio-economic situation and make choices as to our personal behavior. Further, not infrequently as women and as mothers, we interact with the health care system. It is only by examining and addressing these variables that we will effectively achieve optimal health status. Thus the literature pertaining to immigrant and refugee women's health will be reviewed within this determinants of health framework.

Social support has been described as an important determinant of health (Blane 1995; Gillis 1993; Kuo & Tsai 1986; Lambert & Lambert 1985; Lantican & Corona 1992; Lynman 1985; Rosenthal 1986). Several studies have found the support network of immigrant and refugee women to be limited (Ralston 1988; Anderson 1991; Lynam 1985; Moghaddam & Taylor 1989; Lambert & Lambert 1985; Yusuf 1995). Frequently isolation, boredom and loneliness are described in the absence of such support networks

(Anderson 1985; Ralson 1988; 1991; Lee & Cochran 1988; Miedema & Nason-Clark 1989; Anderson 1987; 1991; Lynam 1985; Anderson & Lynam 1987; Chan 1983; Franks & Faux 1990). These studies suggest that the health of immigrant and refugee women is compromised by such limited support networks.

A supportive environment is closely related to one's support network and further contributes to the determination of health (Epp 1986; Health and Welfare Canada 1988c; Kuehnert 1991; Stokols 1992). The environment of immigrant and refugee women has been the focus of several studies. For example, immigrant and refugees living in geographically and ethnically condense regions have been studied in the Canadian context (Moghaddam, Taylor & Lalonde 1989; Chan 1983). Moghaddam et al (1989) found little support for the practice of ethnic segregation amongst a population of Haitian and Indian immigrant and refugee women, while Chan (1983) reports relative support for the concept amongst a population of widowed Chinese women. However, it has been suggested that geographic and ethnic segregation contributes to and is a result of discrimination and an overall lack of acceptance of ethnic minorities by the Canadian born population (Miedema & Nason-Clark 1989; Ng 1993; Moghaddam et al 1989).

Individual health behaviors, including one's perceptions of health and illness and our patterns of help seeking affect the determination of health (Premier's Council on Health 1991). Anderson (1985), in a case study comparison of Indo-Canadian and Greek women found loneliness, tension and depression to be a primary concern. Interestingly, these respondents did not perceive such problems to be within the realm of health care. These problems were perceived as simply 'part of life'. Thus, health professional were not routinely consulted about these psychosocial concerns. These findings are similar to Anderson's (1991) study with a group of Chinese women, Anderson's (1987) phenomenological study with Indo-Canadian and Greek women and Dunk's (1989) case

study series of Greek immigrant and refugee women in Montreal . These studies also found the experiences of immigrant and refugee women to be compounded by discrimination and racism. This in turn affected their comfort with Canadian health professionals and their patterns of help seeking.

Immigrants and refugees are in fact, considered at high risk for the development of both physical and mental health problems (Dillmann, Pablo, Wilson 1993a; Dillmann, Pablo, Wilson 1993b; Wittebrood & Robertson 1991 Ministry of Health 1993; Health and Welfare Canada 1988a; 1988b; 1988c; 1990). Immigrants and refugees experience a plethora of difficulties in their experiences as migrants. Immigrants and refugees leave behind not only their native countries, but their friends, family, support networks, language and culture. In short, they leave behind a complete way of life and a known way of being.

Several studies have delineated the mental and physical health problems that are distressing to immigrants and refugees. Lipson (1993), in a grounded theory study with sixty female and male Afghan refugees in California, found depression, nightmares, and survivor guilt to be the health sequelae related to war and the migration experience. Beiser, Cargo & Woodbury (1994), also found refugees to be suffering from depression. In this Canadian study, the authors compared psychiatric disorders between Southeast Asians and Vancouverites in a longitudinal study of the resettlement process of refugees. In another longitudinal Canadian study, Noh, Speechley, Kaspar & Wu (1992a) found Korean immigrants to be more depressed than the general public. In this study, depression was associated with being female, unmarried, having a lower income, or being unemployed and wishing to return to Korea. These authors, through further analysis, found women to be 2.6 times more likely to be depressed than men. In short they discovered that role overload was related to the higher rate of depression among women

(Noh, Wu, Speechley, Kaspar 1992b). Bagheri (1992), in a descriptive study with 111 male and female Iranian immigrants in Canada, found 60% of those participating to be suffering from adjustment disorders including depression, anxiety, loss of appetite and weight, poor concentration, memory difficulties, crying spells and fear of failure. Clearly, the health concerns of immigrants and refugees are many. However, these health concerns are even more profound among female refugees in comparison to immigrants.

Refugee women's experiences as migrants are complicated by a variety of realities that place them at risk for mental and physical health concerns. Admittedly, immigrants and refugees share the experiences of leaving their home land, adjustment to a new country and culture, strained social networks and role adjustment (Dillmann et al 1993a; 1993b; Gilad 1990). However, the refugee experience is compounded by the course of their migration. Immigrants presumably plan their migration, while refugees leave their home with little or no planning while under great duress (Allodi & Stiasny 1990; Dillmann et al 1993a; 1993b; Gilad 1990; Jacob 1994; Keely 1992). The atrocities that commonly accompany a refugee's flight such as violence, rape, and substandard living conditions in over crowded refugee camps, further expose refugees to physical and psychological risk (Allodi & Stiasny 1990; Dillmann et al 1993a; 1993b; Gilad 1990; Jacob 1994; Keely 1992).

An additional factor compounding the risk factors for refugees is lack of choice regarding the decision to move. Immigrants often choose to relocate. Immigrants leave their homeland voluntarily to improve their standards of living. In the case of the refugee, these options and choices are limited at best. The Canadian Dictionary defines 'refugee as "a person who flees for refuge or safety, especially to a foreign country, in a time of persecution (and) war" (Gage 1997 p. 1234). Thus, refugee women leave their homes because of war and natural or political disaster. Given this lack of choice as well as the

physical and mental hardships endured, refugees are further at risk for physical and mental health problems. These factors must inform the examination of research with immigrants and refugees. Refugees share the trials of immigrant women, but they also carry an added burden as refugees (Jacob 1994).

'Access to health services' is an important determinant of health (Premier's Council on Health 1991). The Canada Health Act purports to ensure access to health care for all Canadians (Manga & Weller 1985). Further, the Federal Multiculturalism Act purports to ensure that Canadian services, including health care services are accessible to all (Heritage Canada 1995). Yet, a plethora of literature exists stating that health care services are *not* accessible to the Canadian population of immigrants and refugees (Thompson 1993; Peters 1993; Auger 1993; Bergin 1993; Bollini 1992; Equal Opportunity Consultants 1991; Health and Welfare Canada 1988a; Lipson 1991; Mardiros 1988; Ministry of Health 1993; Social Planning Council of Ottawa-Carleton 1988). Health care services are inaccessible because they are often perceived as inappropriate.

Several pragmatic issues have been identified as constraints to immigrants and refugees accessing available health services. These constraints include, but are not limited to; language barriers, insufficient knowledge on the part of the consumer regarding access to services, as well as transportation and financial constraints (Thompson 1993; Peters 1993; Auger 1993; Bergin 1993; Bollini 1992; Equal Opportunity Consultants 1991; Health and Welfare Canada 1988a; Lipson 1991; Mardiros 1988; Ministry of Health 1993; Social Planning Council of Ottawa-Carleton 1988). Faced with these pragmatic barriers, accessing the services of health care is exceptionally difficult for newcomers to Canada.

The Women's Health Bureau (Ministry of Health 1993), conducted a study with immigrant, refugee and minority women and found that health professionals often

approach immigrant and refugee women and their needs in an aloof and insensitive manner. This study and others (Waxler-Morrison et al., 1990), suggested that accessible health care system must understand the consumer's everyday experiences, how these experiences affect their health and how they affect their ability to maintain health (Ministry of Health 1993; Rosenbaum 1991; Meleis et al., 1992; Waxler-Morrison et al., 1990; Health and Welfare Canada 1988a). Without understanding these everyday concerns and how they affect the health of immigrant and refugee women, accessible health care services cannot be appropriately designed.

In summary, immigrant and refugee women have been studied extensively within the Canadian context. Their experiences prior to coming to Canada and their experiences as immigrant and refugee women in Canada impact their health in many ways. Immigrant and refugee women suffer a plethora of mental health sequelae related to these experiences. Stress, depression, poor concentration, memory difficulties, crying spells and anxiety are just some of the mental, social and personal difficulties experienced by these women. The mental health sequelae appear to out-weigh the physical health concerns of immigrant and refugee women.

The everyday experiences of immigrant and refugee women in Canada impact their health. For instance, language barriers, discrimination and being in an unfamiliar environment greatly increase the need for social supports. However, because of their reality as immigrants and refugees, their usual systems of support are less than adequate. These depleted systems of support decrease the ability of immigrant and refugee women to manage these same difficulties.

Although the experiences of immigrant and refugee women are similar, they are not the same. Immigrants choose to migrate to Canada (presumably) for an improved quality of life. Economic, educational and even political forces 'pull' immigrants to Canada.

These positive 'pull' factors, as well as the choice itself, positively impact one's perception of the move. This positive evaluation impacts one adjustment and mental health here in Canada. Conversely, refugee women migrate under considerably different circumstances.

Refugees seldom choose to leave their country and, further, they have little power in deciding to which country. In fact, war, famine and political unrest 'push' refugee women from their homes and families. This in itself negatively impacts their evaluation of migration. Further, enroute refugee women often endure the uncertainty of refugee camps, malnutrition, torture and even rape. Ultimately these experiences affect both the physical and mental health of refugee women, and as such they are further at risk in their host country.

Thus, immigrant and refugee women are at high risk for a plethora of difficulties because of their past and present experiences. However, the experiences of one group of immigrants or refugees is not necessarily reflective of the experiences of others. With few exceptions, the literature does not have much to offer on the refugee experience of Somali women. Thus, the importance of delineating the experiences of these new comers is underlined. The following section reflects the research done to date within the Somali community.

1.2.3 Somali Women

Since 1988 Canada has witnessed a dramatic influx of Somali immigrants and refugees (Somali Women's Health Group [SWHG] 1991). The vast majority of these newcomers have been women and children. Many Somali men stayed in Somalia during the civil war to protect family, land and other possessions, whereas others were killed in the war or died in the process of leaving (SWHG 1991). As a result, many Somali women in Canada are single parents, without their usual systems of supports.

Everyday concerns, such as lack of language ability, poverty, child care and employment are seen as central to the Somali community's present day concerns (Hussein personal communication March 1996). Yusuf (1995) in an attempt to delineate such concerns conducted a needs assessment with eighty four female Somali participants. Concerns about child care, employment, language and housing surfaced as primary concerns. Damianakis (1992) studied a concept reflective of the everyday concerns in a racially and culturally diverse population, including the Somali population, in Hamilton Ontario. Damianakis (1992) in a needs assessment, examined the attitudes and beliefs toward family planning. The Somali women and men participating in the study reported family planning practices to be deeply tied to religious beliefs. The study compared beliefs held in Somalia with the beliefs held in Canada. It was determined that these beliefs remain predominately unchanged. However, life in the Canadian context was recognized as different, thus requiring adjustment in family planning. For example, practical and financial concerns of supporting a large family in Canada were acknowledged and taken into consideration with family planning. This study purports to include an analysis of gender, however, the results fail to inform the reader about how this was operationalized.

Arbesman, Kahler & Buck's (1993) descriptive study with twelve refugee participants reviews the complications of female circumcision. The women consistently reported gynecological and urinary difficulties. However, this study did not examine the perceptions that Somali women hold toward this practice beyond stating that the majority of Somali women approved of the practice at the time the study was conducted. Ntiri (1993), reviewed the same practice with a sample of 859 women residing in Somalia. In contrast to the study by Arbesman et al (1993), this study provided an in-depth analysis of the attitudes and beliefs held by Somali women about the practice. The women reported a strong cultural and religious belief in the practice. Further, Ntiri's (1993), analysis

included gender and socioeconomic variables. This author suggested female circumcision is seen as part of the journey towards full womanhood as well as an instrument for the control of female sexuality in Somalia.

Hussein & Shermarke (1995), examine female circumcision within the Canadian context. Like Arbesman et al's (1993) findings, female circumcision was perceived by participants as an acceptable practice. However, participants reported that the practice is not being practiced in Canada because of lack of acceptance by the Canadian community as well as subsequent legal sanction against the practice. Despite this, participants expressed concern over pressure from certain members within their community to perpetuate the practice. The participants stated that the practice is seen as insurance against losing their daughters to a Western standard of behavior. Consistent with Ntiri (1993), this study found the practice to be perceived as a religious requirement of Islam. In spite of these studies, Hussein (personal communication March 1996), suggested that the Somali community objects to perusing the issue of female circumcision as a topic for scientific inquiry.

1.3 Purpose of Study

The purpose of this study is to examine the everyday life experiences of Somali women, exploring how these experiences affect their health through a grounded theory approach within a feminist perspective. Although the studies involving Somali participants provide some insight into the belief and concerns of Somali women, they are profoundly limited in scope and fail to examine the everyday life experiences and how the variable of gender influences these experiences. Understanding the factors that affect immigrant and refugees through their everyday experiences, and understanding how these experiences impact their health, is integral to providing effective and efficient health services (Waxler et al 1990; Health and Welfare Canada 1988a). Feminism provides the perspective for

analyzing the factors that affect these women and the relationships between these factors and gender, race, and class.

1.4 Research Objectives

1. To delineate the everyday concerns of Somali women in Canada.
2. To delineate how these concerns impact their health.
3. To delineate how Somali women manage these everyday concerns.
4. To delineate how these everyday concerns affect Somali women's experiences within the system of health care.

1.5 Research Questions

1. What are the everyday concerns of Somali women in Canada?
2. How do these concerns impact their health?
3. How do Somali women manage these everyday concerns?
4. How do these everyday concerns affect Somali women's experiences within the system of health care?

1.6 Benefits Provided by the Study

The process of the study will benefit the community of Somali women in the following ways:

1. The process of participation in this study and their potential contribution to an overall understanding of women's perceptions and experiences will potentially have empowering effects (Stern & Pyles 1985; Maguire 1987; Wuest 1995).
2. In reviewing the study results, health care professionals will be informed about the experiences of Somali women in Canada. These providers will then be in a position to address the needs of Somali women in an acceptable and appropriate manner.

1.7 Assumptions

The following list outlines the assumptions that are held true for the purpose of the proposed study:

1. Western medicine reflects the rational individualism of Western capitalism (Anderson 1987 p.429).
2. Social, economic and political factors, play a crucial role in determining peoples subjective experiences (Anderson 1985 p. 562).
3. The subjective experiences of individuals are determined by the objective organization of their society (Anderson 1985 p.70-71).
4. Everyday concerns affect our experiences of health and illness which in turn affect our actions or reactions to health and illness.
5. Human experiences shape perceptions. In turn perceptions direct our actions.
6. Gender impacts experiences, options and actions.

1.8 Limitations

Two limitations were acknowledged apriori:

1. Given that respondents must be fluent in English, they will not be representative of all Somali women. Those who do not speak French or English fluently are potentially more marginalized than the participants of this study. However, it was beyond the scope of this research to include these women.
2. A important difference exists between immigrants and refugees. The realities of both groups are recognized as potentially very important. Amalgamating their experiences is not ideal methodologically, however, due to limited sample frames, a woman's status as immigrant or refugee did not prevent her from participating in the study.

Chapter Two - Research Approach & Theoretical Perspective

2.1 Introduction

The three sections within this chapter are dedicated to describing the research approach taken in this study, the rationale for this choice and the theoretical perspective that informed these methods. Section one demonstrates the rationale for the choice of a qualitative method by demonstrating a fit between nursing's philosophical tenets and those of qualitative research. From here, I demonstrate the need for qualitative methods given the research questions posed, i.e. given that very little was known about the everyday experiences of Somali women in Canada and how these experiences impact their health. Next, I argue that qualitative methods are well suited to studies involving immigrant and refugee women. The last part of section one provides the rationale for choosing the specific qualitative methods of grounded theory.

Section two presents the theoretical perspective of feminism that was taken in conducting this research. I begin by discussing the difference in the terms, methodology, and methods. This provides an essential prelude to a discussion of feminist epistemology. These two sections together demonstrate the fit between the methods of grounded theory and of a feminist perspective based on an epistemological congruence. From here, a brief review of the literature pertaining to studies using the methods of grounded theory within a feminist perspective is provided. With this information as background, I next present the tenets of research within a feminist perspective to demonstrate the contours of the feminist lens through which the researcher examined the research problem.

The third section of the chapter discusses the limitations of 'Western feminism'. First, I discuss the allegations of hegemony in the application of a Western ideology of feminism in the research of black women, third world women, or marginalized women. I briefly review the history of colonization and its effects on women, ultimately suggesting that

Western women risk colonizing third world women by imposing Western ideologies of feminism. This said, the possibilities of feminism, a feminism in which Western women do not define what is important to women, is discussed. This discussion qualifies the theoretical perspective of feminism that informed the research process and product. In the final section of this chapter I qualify the use of a theoretical perspective in a grounded theory study.

2.2 Rationale for Qualitative Research Methods

Over the past few decades qualitative research methodologies (QRM) have increased in popularity among nursing researchers (Morse & Field 1995). The methods within the qualitative paradigm are multiple, and include, but are not limited to, ethnoscience, ethnography, phenomenology, and grounded theory. The purpose of the next several paragraphs is to demonstrate the inherent link between qualitative methods and the discipline of nursing. Following this, I outline the fit between the research problem and QRM, followed by an argument demonstrating the fit between QRM, women in general and immigrant and refugee women in particular.

2.2.1 Qualitative Research Methods and Nursing

Qualitative research methods befit nursing's epistemology and the research performed within the discipline: QRM are holistic and primarily inductive, providing the tools for examining everyday life as experienced by research participants. The participant's reality and their social world is described and explained, thus allowing nurse researchers to develop models and theories explaining the relationships between delineated variables . This inductive holism is consistent with the philosophical underpinnings of nursing (Morse 1992; Morse & Field 1995).

The goals of qualitative research; theory development, explanation and understanding, are similar to the goals of nursing research (Morse 1994). Qualitative research methods

are invaluable tools which assist nurses to delineate the dimensions of nursing (Morse 1994). They provide a new lens through which phenomena of interest to nursing can be examined (Morse 1992; Morse & Field 1995). Examining nursing phenomena through a qualitative lens challenges the status quo of current nursing practice and theory (Morse 1992). Research challenging current knowledge results in new theoretical frameworks from which significant variables and hypothesis can be identified. This in turn results in the advancement of nursing's body of knowledge and thus the discipline. Qualitative research methods are also germane to the discipline of nursing in that they frequently provide information that is immediately relevant to nursing practice (Morse 1991).

2.2.2 Qualitative Methods & The Research Questions

Morse & Field (1995), underline the importance of versatility in choosing research methods. No single qualitative or quantitative method is adequate to answer the array of questions that are of interest to nursing. The appropriate research method stems, in part, from the research questions asked (Morse & Field 1995). The research questions asked in this study lend themselves well to the methods of qualitative inquiry. Few studies have specifically posed these questions. As well, a paucity of research on the everyday experiences of Somali women in Canada existed prior to this research. QRM are well suited to problems about which little is known (Morse 1992; Morse & Field 1995; Morse & Johnson 1991), and thus were an appropriate choice in the case of this research.

2.2.3 Qualitative Methods & Immigrant and Refugee Women

Qualitative methods are ideally suited to the study of immigrant and refugee women (Lipson & Meleis 1989). The need for harmony between immigrant and refugee women's beliefs in holism and humanism, and the research methods employed to address their health concerns has been underlined in several research efforts (Health and Welfare Canada 1988a; 1990; Lipson & Meleis 1989; Ministry of Health 1993; Wuest 1993;

Zichi & Tripp-Reimer 1988). Qualitative methods ideally meet these dictates (Munhall & Oiler 1986).

Traditional biomedical research methods reflect Western ideologies and norms. Thus, applying traditional research methods in the study of immigrant and refugee women may not be appropriate (Henderson et al., 1992). Qualitative methods, on the other hand, allow the research problems to be examined from the emic perspective, that is, from the perspective of the participants (Morse & Field 1995), thus decreasing the likelihood of imposing orthodox ideologies (Henderson et al., 1992; Lipson & Melies 1989; Cohen & Tripp-Reimer 1988; 1989). This is consistent with the demands of women in general and immigrant and refugee women in particular.

Finally, the Somali community is an oral society, with a rich oral history (personal communication S. Habbani Feb. 1996). Somali has only been a written language since 1975 (SWHG 1991). Given this, the researcher queried the acceptability of a quantitative questionnaire and a quantitative research method. Morse & Field (1995), suggest that the application of inappropriate and culturally irrelevant methods may illicit erroneous information. In contradistinction, QRM, with an emphasis on participant observation and interactive interviews, provided the researcher with a window through which to observe and understand the participant's world.

In summary, qualitative research methods are well suited to the discipline of nursing and the research study conducted. They challenge the status quo of nursing knowledge in a holistic, humanistic, and inductive fashion that is consistent with nursing's underlying philosophy. They further provide the discipline and the participants with information and insight that is immediately useful. Qualitative research methods are ideal when little knowledge is held about the phenomena under consideration. Finally, by using QRM, the

phenomena is approached devoid of a preconceived conclusion, aiming to describe it from the emic perspective.

2.2.4 Rationale for Grounded Theory & Study Participants

Grounded theory research aims to understand how a group of people define their reality vis-à-vis social interactions. It, like other qualitative methods, is a tool for examining a problem about which little is known, or for examining a problem from a new perspective (Stern, Allen & Moxley 1984). In examining a problem such as the everyday experiences of Somali women in Canada, grounded theory methods strive to facilitate the dismantling of dogmatic beliefs, thus contributing to a clearer perception of the participant's reality (Hutchinson 1986).

Grounded theory is a holistic method of inquiry that serves as a valuable heuristic in understanding and explaining human experience (Stern & Pyles 1985). This research method strives to delineate the social process present in human interaction. The basic social psychological process is then described and conceptualized. This conceptualization provides the grounds upon which nursing can prognosticate behavioral variation within a group (Hutchinson 1986). Thus, grounded theory is a means of inductive theory generation grounded in the reality of participants (Hutchinson 1986).

The methods employed to study issues affecting immigrant and refugee women should not serve to further marginalize these women (Personal communication I. Williams, Health Canada, January 10 1996). Grounded theory refrains from marginalization as it is conducted from the ground up (Hutchinson 1986). That is, participants contribute to the development of the research and the developing theory by sharing their reality and experiences (Hutchinson 1986). This notion is further explored in the latter sections of this chapter.

Grounded theory has been advocated as a research method in cross cultural research (Cohen & Trip-Reimer 1988; 1989; Stern & Pyles 1985; Stern et al 1984). Stern & Pyles (1985), suggested that grounded theory goes beyond inconsequential description, thus, serving to expand nursing's body of knowledge about the phenomena investigated. Grounded theory portrays the processes occurring within the phenomena of interest, thus, enhancing the professions ability to understand and predict situations (Stern & Pyles 1985).

Stern & Pyles (1985), suggested that the nature of grounded theory, that is, its qualitative and holistic approach, serves as a valuable aid in cross cultural studies. This value lies in the theory derived from the study and its applicability. This is consistent with immigrant and refugee women's demands from research (Yusuf 1995; Ministry of Health 1993). Women demand relevance and applicability as prerequisite to their involvement in research endeavors. Grounded theory ideally generates knowledge that is immediately applicable and relevant (Hutchinson 1986).

Gottschalk & Teymour (1993), suggested that investigators conducting women's health research must strive toward a balanced perspective, and consider the socioeconomic and political realities of women's lives. Grounded theory attempts to explain the nature of the phenomenon in the social world and the nature of the social processes surrounding it (Strauss & Corbin 1990). The everyday experiences of Somali women in Canada reflect the social context in which they live; thus the methods of grounded theory meet Gottschalk & Teymour's (1993) requisites.

The above sections have explicated the rationale for choosing qualitative research methods in general, and grounded theory in particular, given the problem researched. The following section explores the theoretical perspective of feminism that was employed during this study. Also, a glimpse at the current debate surrounding feminism and minority, third world or marginalized women is presented as background information.

2.3 Theoretical Perspective

The theoretical perspective of feminism is explained within these final sections. The first part of this section provides some background information by differentiating between the concepts of feminist methodology and feminist methods. Next the epistemology of feminist thought in general is explored. Finally, an argument as to why nurse researchers should adopt a feminist perspective is presented.

The second part of this section, entitled 'Grounded Theory and Feminism', discusses the fit between grounded theory and feminism's epistemological roots. This analysis suggests that a feminist perspective ultimately enhances the methods of grounded theory. The section ends with a brief review of currently published feminist grounded theory studies.

In the final section the above sections are synthesized and incorporate the works of Maguire (1987) as well as others, delineating how the feminist perspective informed the grounded theory methods utilized in this study.

2.3.1 Methodology Vs. Method

Considerable confusion exists about whether or not a single feminist research method exists (Harding 1987). It is suggested that no such method exists per se and, in fact we avoid explicating a single set of methods in our feminist research endeavors (Maguire 1987). Several scholars have attempted to clarify the confusion around 'feminist methods', or 'feminist research', by distinguishing between the terms 'method and methodology'. The current discourse is presented in the next two paragraphs.

Methods are the prescriptions for obtaining answers to the research questions asked; for example the methods of grounded theory seek to answer questions about a particular social phenomenon. King (1994) suggests that the methods chosen logically differ depending on the particular research questions asked and depending upon the

epistemological perspective taken. This said, there is a need for the methods and the underlying perspective taken by the researcher to be congruent (Harding 1987).

"The concept of methodology is much more philosophical and value-laden than that of method" (King 1994 pp. 20). 'Methodology' is not reducible to a single unit or set of techniques. The methodology chosen encompasses and informs the methods used for answering the research questions. 'Methodology' is not necessarily prescriptive. Feminist research strives toward maximum flexibility and thus, there is truly no single feminist methodology (King 1994). Instead it is a series of themes, not prescriptions, that define feminist methodology. These themes and tenets will be expanded and explicated further in the final sections of this chapter.

2.3.2 Feminist Epistemology

Epistemology is the study of the origins and the limits of knowledge; in this case feminist knowledge (Webster 1991 p. 419). Campbell and Bunting (1991) suggested that feminist epistemology, or knowledge, is non-dichotomous and indivisible. Personal knowledge, and experience is inherently political and the affective is as important as the cognitive. Feminist knowledge is woman-centered, in contradistinction to being andocentric (male centered). Further, feminist knowledge is relational and contextual (Campbell & Bunting 1991 p. 9). Harding (1991) suggested that feminist thought has three epistemologies; feminist empiricism, feminist standpoint, and feminist postmodernism. This epistemology suggests that research within a feminist perspective seeks to discover a truth through the process of eliminating biases of gender, class and race. This suggests further that the social context of the knower shapes knowledge and that no single truth exists inasmuch as there is a multiplicity of realities (Wuest 1995 p.126).

2.3.3 Why A Feminist Perspective

There are two ways of looking at and doing research; the traditional paradigm, that is, scientific inquiry based on objectivity, neutrality, reductionism and empirically observable data (Duffy 1985), and an alternative research paradigm, which concerns itself with subjectivity, closeness to the research participants, uniqueness vs. generalizations, qualitative vs. quantitative and self determination of individuals (Maguire 1987 p.17). Historically, the traditional paradigm was sanctioned as the only means of constructing significant disciplinary knowledge (Duffy 1985). Duffy (1985), in a classic paper, suggested that this dominant paradigm is laden with male bias. As a result, women's experiences and values are not studied or studied only in terms of a male defined norm. Because of this, women have effectively been written out of scientific discourse. Further, knowledge and power are closely connected, thus without a knowledge about women, little power can be obtained and the status quo remains unchanged (Belenky, Clinchy, Goldberger & Tarule 1986; Duffy 1985; Maguire 1987).

The alternative paradigm fares considerably better than the traditional paradigm in terms of examining subjective forms of knowledge and creating knowledge and research about women and their experiences (Maguire 1987). Building a knowledge base is essential for not only women but for the professions that serve them. It is through the creation of knowledge about women that the status quo can be challenged (Duffy 1985). Conducting alternative paradigm research within an explicitly feminist perspective enhances our ability to achieve this end (Maguire 1987).

2.3.4 Grounded Theory and Feminism

The epistemology of grounded theory lies in symbolic interactionism (Chenitz & Swanson 1986) and pragmatism (Annells 1996; Corbin & Strauss 1990). Symbolic interactionism is not only a philosophy of human life and social experience, but a

distinctive approach to the study of human life (Chenitz & Swanson 1986). "The researcher needs to understand behavior as the participants understand it, learn about their world, learn their interpretation of self in the interaction and share their definitions" (Chenitz & Swanson 1986 p. 7). Given this, Wuest (1995), suggested that grounded theory is consistent with the postmodern feminist epistemology inasmuch as it recognizes multiple explanations of reality.

Strauss & Corbin (1990), utilized a 'conditional matrix' to examine the wider variables that may be influencing any one particular action or interaction. Campbell & Bunting (1991), suggested that such a consideration for context is consistent with feminist thought. Further, Annells (1996), suggested that the conditional matrix in particular, and grounded theory in general, as conceptualized by Strauss & Corbin (1990), has moved grounded theory toward a postmodern constructionist (i.e. there is no single truth or reality and the social structures and context in which we find ourselves construct our reality) research paradigm. This is consistent with the epistemological and ontological roots of a feminist perspective (Annells 1996).

2.3.5 Congruent Methods and Methodologies

Charmaz (1989), suggested that analysis using grounded theory methods can be enhanced if the researcher clarifies their own epistemological premises. As well, Annells (1996), suggested that the basic philosophical beliefs about inquiry, held by the researcher, as well as the research questions asked, guide the researcher in choosing the most appropriate methods because each aspect of the research process is influenced by the particular methods and methodologies chosen. Maguire (1987), suggested that the most problematic scenario is the one in which the researcher takes a blind and tacit acceptance of a paradigm without exploration and consideration for the implications of the choices (Maguire 1987 p. 27). Further, our basic assumptions about what constitutes truth, reality

and the origins of knowledge shapes the manner in which we see and thus investigate the world (Belenky et al., 1986).

2.3.6 Reviewing the Feminist Grounded Theory Literature

Merritt-Gray & Wuest (1995) and Seibold, Richards & Simon (1994), articulated a grounded theory method within a feminist perspective. Howell (1994), used the grounded theory method within a perspective that is reflective of feminism, as she explored the phenomenon of chronic pain for which women are often "treated in a very derogatory manner by ...physicians and nurses" (Howell 1994 p. 95). Howell embarked on the study in light of a paucity of theory containing both subjective perspective and gender sensitivity (1994 p. 95). Merritt-Gray & Wuest (1995) examined rural survivors of abusive relationships. These authors suggested that using an explicitly feminist perspective allowed them to look beyond the traditionally held views about women who remain with abusive partners, and discovering 'the process of leaving' as their core category. This alternate way of conceptualizing and creating knowledge about women and domestic violence adds to the literature that can potentially challenge the status quo in our thinking as researchers and professionals.

Seibold et al.'s (1994), study examined the experience of menopause among single women within a feminist perspective, using the methods of grounded theory. Like Merritt-Gray & Wuest (1995), these authors suggested that the feminist perspective is necessary to see beyond the current state of knowledge; in this case pertaining to menopause (knowledge which has been, predominately, constructed within an andocentric positivistic paradigm). The ultimate aim of this research study was to develop a substantive theory of single women's experiences of mid-life and menopause. This is in keeping with their feminist methodology as well as the methods of grounded theory; i.e. developing knowledge about and for women that can ultimately change the way we look

at a uniquely female concern. Others have combined the perspective of feminism and the methods of grounded theory in the study of women including; Davidson 1995; Duffy 1992 and Lueing 1992, who all found similar benefits in employing the methods of grounded theory within a feminist perspective.

Merritt-Gray & Wuest (1995), summarized the congruency between feminism and grounded theory by acknowledging that both grounded theory and feminism recognize, value and explore multiple realities. This, by extension, acknowledges the validity of women as sources of knowledge and subjective experience as a valid source of inquiry. Further, women are recognized as experts of their experiences. Grounded theory examines the context in which processes occur. This is consistent with feminism's concern for the micro as well as macro level of influences on women's realities. The epistemological roots of grounded theory and feminism are cognate, thus together they facilitate quality research with immigrant and refugee women.

2.3.7 Research Within A Feminist Perspective

Feminism provided the lens for the researcher in conducting this study. Feminism, as a theoretical perspective fosters a non oppressive, non-hierarchical, interactive and reflective research process in which knowledge is created for and about women (Armstead 1995; Duffy 1985; King 1994). Research conducted within this perspective is built on a critique of the positivistic and andocentric underpinnings of traditional research. As well, it gives the discussion of gender, race, culture and class central positions on the research agenda (Maguire 1987). The feminist perspective utilized in this study was an inclusionary feminism, recognizing and celebrating diversity.

Research conducted within a feminist perspective, in general, is concerned with what is possible. Knowledge gained through a feminist lens is ideally used to emancipate people from the oppressive structures in which they exist. By looking through a feminist lens,

researchers build a body of knowledge about women and for women (Duffy 1985; Maguire 1987).

In summary, the logic of the grounded theory method within a feminist perspective has been demonstrated: Women as knowers or sources of knowledge have historically been ignored or belittled (Belenky et al 1986). Our knowledge of women has come predominately from men and it has been obtained through an andocentric lens (Maguire 1987). If we are to increase our understanding of women's experiences we must listen to the voices of women (Belenky et al 1986). Qualitative methods have been advocated as ideal in the study of immigrant and refugee women. The grounded theory method is a particularly efficacious qualitative method in the study of women in general and immigrants and refugees in particular (Cohen & Trip-Reimer 1988; 1989; Stern & Pyles 1985; Stern et al 1984). However, grounded theory, itself as a research method, can be further enhanced if conducted within a feminist perspective. Finally, grounded theory methods and a feminist perspective are well matched because of their like epistemological routes which deny the existence of a single reality and respect the perspective of research participants as knowers (Charmaz 1989). A feminist grounded theory study enhances our ability as researchers to hear the voices of women.

2.3.8 Qualifying A Feminist Perspective

Western women are accused of being hegemonic and ethnocentric in their attempts to impose Western discourses of feminism in their research efforts with third world women, marginalized or minority women (Johnson-Odim 1991; Mohanty 1991; Phillips 1996; Rajan 1993; Ong 1994). This said, feminism can be a useful and powerful ideology, which *if* inclusive (i.e. open to the ideas and concerns of women in general) can be used to redress the forces that compromise women.

Ultimately this section suggests how feminism may be conceptualized, if it is to be acceptable to all women. The section considers primarily third world women and feminism because the research participants are originally from the third world continent of Africa. The arguments presented are not specific to any one third world country, but provide an overview of the present debate.

This section begins by considering the context from which many third world women arise; colonialism and post-colonialism. Next, third world women's critique of Western feminism is examined in a section labeled 'Is Sisterhood Universal?'. Finally, the notion of an inclusionary feminism is reviewed.

2.3.9 Colonialism & Women: Considering Context

It has been suggested that the position of women relative to men deteriorated with the advent of colonialism (Rajan 1993; Ward 1996). Many examples of pre-colonial matrifocal and matrilineal societies, in which women's roles and position were acknowledged and valued, exist (Ward 1996). Colonizers, be they Europeans in Africa, Americans in Alaska or Japanese in China, brought with them not only their systems of government and language, but their ideologies of patriarchy (Ward 1996). Ironically, colonizers were quick to label the roles and relationships between men and women as 'backward and non-progressive': Colonizers suggested that women were without a voice in these communities (Ward 1996). However, the colonizers own ethnocentrism prevented them from seeing the true position of women and the power they held within these societies (Ward 1996). Unfortunately, in post-colonialism, the position of women in many post-colonial states has improved little (Rajan 1993; Ward 1996). If Western colonizers contributed to the deterioration in the position of women in colonized nations; does it not follow that superimposing an ideology of Western feminism could be seen as a form of colonization in itself? Considering not only the context in which women live, but

their historical context is critical if feminists are to refrain from the colonial ideology (Mohanty 1991).

2.3.10 A Universal Sisterhood?

Western feminists have historically examined third world women as the oppressed 'other': That is, they see themselves as liberated and modern and they see the 'other' as backward and traditional. Western views and values based on individuality and capitalism are used, for example, to evaluate the position of women in third world societies. By examining third world women according to Western standards, Western feminists reaffirm *their own* beliefs and concerns that women are universally oppressed *primarily* by patriarchy (Johnson-Odim 1991; Mohanty 1991; Ong 1994). However, this paradigm prevents scholars from seeing and examining the broader context in which third world women's position is compromised, i.e. poverty, war, and oppressive economic conditions (Johnson-Odim 1991; Judd 1996; Mohanty 1991; Ong 1994). Western feminists' examination of third world women satisfies Western concerns and curiosities, but does little to challenge the conditions in which third world women live.

Western feminists, whether studying the position of third world women, as mentioned above, or conducting research with third world women, marginalized or minority women within the Western world, are often the sole dictators of the issues and concerns that are labeled feminist (Johnson-Odim 1991). Mainstream Western feminism is grounded primarily in an ideology of liberalism, that is; given equal access to the institutions of education and employment, women will achieve a gender-based equality with men (Johnson-Odim 1991). The paramount concern for Western feminists is gender inequality, oppression perpetuated by men and unequal access for women to the above mentioned institutions. However, these concerns are based on a Western reality, that is; Western feminists, primarily white middle class heterosexual women, are not preoccupied with

issues of hunger, poverty, war and unsafe living environments (Judd 1996). If the agenda of feminist concern is defined exclusively by Western feminists, it will exclude the reality of the majority of the world's women by default (Johnson-Odim 1991).

Given the fact that Western feminists have examined third world women as 'other' and given that Western feminists have defined that which is appropriate for feminist inquiry, one can justifiably question the notion of a universal sisterhood predicated on a like gender (Mohanty 1991). Our biology does not pre-define our values, our beliefs or the issues that we see as important in our lives. Perhaps it has been on this assumption of universal sisterhood that Western feminists justified their examination of third world women from within a Western paradigm. Western feminists are justifiably criticized in these instances, however; what results is the dismissal of feminism altogether as a useful tool in solving the problems of women throughout the world. Recognizing and accepting our differences as women is the first step in establishing a feminism that is acceptable to women throughout the world (Johnson-Odim 1991).

2.3.11 A Universal Feminism

If feminism is a Western ideology, how can we ethically offer it to third world women (without ourselves becoming colonizers of third world women) and why should third world women accept it (given the historical reality of colonialism and post-colonialism)? Who needs feminism? First of all, the social, economic and political position of women in post-colonial states as well as first world countries, continues to be lower than that of men in similar circumstances. Women suffer the injustices of poverty, war and exploitive economic systems more profoundly than do men (Johnson-Odim 1991; Ong 1994; Ward 1996). Further, women have concerns that are uniquely women's, from birth control to patriarchy in both third world and first world nations. Pooling our resources, experiences

and priorities enhances the capacity for feminism to do something about the social, economic and political position of all women (Mohanty 1991).

If feminism is not employed to address the concerns of third world women, if these concerns are addressed under the umbrella of 'human concerns', the issues and concerns that are uniquely feminine become secondary, unimportant and thus not addressed (Johnson-Odim 1991; Judd 1996). By employing a feminism in which the issues are not solely defined by Western feminists, the issues of concern to third world women can be addressed specifically as they affect women themselves, and their families.

Such a feminism resembles something *other* than the presently envisaged paradigm of liberal feminism in which Western feminists willingly relinquish some of the power and control traditionally held in defining what is on the feminist agenda. Feminism in this context is about allowing and valuing diversity in thought, values, religions and day-to-day practices (Phillips 1996). Such a feminism is about creating an environment void of hegemony and imperialism (Judd 1996).

In summary, feminism is a powerful philosophy which, if inclusionary, can be employed to redress the concerns of the world's women. The majority of women are not white middle class individuals who have the luxury of debating gender relations. Given this, it is ludicrous to expect that such a minority dictate the priorities and concerns of women throughout the world. An inclusionary feminism is not only necessary but ethically imperative to redress the concerns that so desperately need to be redressed throughout the world.

2.3.12 Qualifying A Theoretical Perspective Within Grounded Theory

Grounded theory research does not normally espouse a theoretical framework per se (Strauss & Corbin 1990). Theoretical frameworks are employed to guide the study in

terms of asking questions about the relationship between already proposed concepts (Meleis 1991). Thus, they greatly influence both what is asked and how it is asked.

Grounded theory research strives to establish concepts and their relationships as seen in the data. A preconceived theoretical framework would not allow the true framework (concepts and their relationships) to emerge from the data, and thus the emerging theory would not be grounded in reality (Strauss & Corbin 1990). Grounded theory is a largely inductive method of theory construction and as such a theoretical perspective is not normally taken.

Given this argument, why has the researcher taken a feminist perspective and why has she gone to great length to describe it? First of all, researchers have basic philosophical beliefs which ultimately influence what research questions are asked, how they are asked and the manner in which data are analyzed and ultimately presented. This is irrespective of the research paradigm, be it traditional or alternative. Explicitness about the philosophical assumptions of the researcher is necessary as it allows future consumers and reviewers of this research to determine where the researcher, and thus the research, was coming from (Charmaz 1989).

In the past, women's experiences were not researched because they were not seen as important (Maguire 1987). More recently, women's 'problems' have been addressed, but only in terms of a male norm (Maguire 1987). Finally, it is with the advent of feminist research that women and their experiences are being explored and legitimated on their own terms (Maguire 1987). Adopting a feminist perspective for the purposes of this research project facilitated knowledge development for and about Somali women in Canada.

2.4 Conclusion

This chapter began by providing the rationale for using qualitative research methods in this study. To begin with, qualitative research methods are well suited to research within the nursing profession because of their holistic nature. Further, since prior to this study very little was known about the everyday experiences of Somali women in Canada, and given that qualitative research methods are ideal in the study of phenomena about which little is known, qualitative methods were rationally chosen. In addition to this, the methods of qualitative research have been demonstrated to be well suited to the study of problems which concern immigrant and refugee women. They are well suited inasmuch as qualitative methods are consistent with immigrant and refugee women's beliefs in holism and humanism. The final rationale presented is for the use of the specific qualitative method of grounded theory. Again, grounded theory is well suited in studying the problems that concern immigrant and refugee women because of its inductive and participatory nature. Further, a grounded theory method facilitates research beyond inconsequential description and contributes to a body of knowledge that can ultimately be used by the participants involved. Thus, given the arguments for qualitative methods within nursing, given the research questions and given the research participants, the qualitative method of grounded theory was suitably applied in this study.

The importance of distinguishing between methodology and methods was discussed. Methodology includes the philosophical tenets held by the researcher that influence the choice of methods and ultimately how methods (the tools with which we answer research questions) are operationalized. From here the researcher discussed feminist epistemology and ontology ultimately drawing a parallel between the epistemology of feminist thought and grounded theory. Given the discussion on methodology and methods, an important congruence between the epistemology of feminist thought and

grounded theory was underlined. From here a brief review of the literature in which researchers have utilized grounded theory methods within a feminist perspective was provided, thus demonstrating the feasibility of the match.

Finally, the feminist perspective in which the study was conducted was outlined. The final sections of the chapter qualify the use of a feminist perspective, given the present critique of feminism as a Western ideology which does not reflect of all women's beliefs or concerns. These critiques were acknowledged and an attempt has been made to incorporate them into the feminist perspective used in this study. In addition to this qualification, the use of a theoretical perspective when employing the methods of grounded theory was presented.

Chapter Three - Methods

This chapter reviews the research methods used in this study. The chapter begins by describing the process of participant recruitment and the process of obtaining informed consent. The sample and the setting are then described. Following this, a description of how the methods of grounded theory within a feminist perspective were utilized in the process of data collection, reduction and analysis, is provided. The qualitative data analysis program; NUDIST is described outlining how it was utilized in this study. The chapter ends with a discussion of credibility and transferability of the research results.

3.1 Participant Recruitment and Obtaining an Informed Consent

Purposive sampling was applied in the process of participant recruitment by selecting individuals possessing knowledge about the phenomena under study. Participants were recruited from the Ottawa-Carleton region. A list of potential participants was established with the aid of the 'Somali worker' at a local Community Health Center. This list was based on the Somali worker's personal and professional knowledge of the Somali community. Criteria for inclusion as a potential participant to this study were as follows:

- 1) female
- 2) ethnically Somali
- 3) immigrated to Canada within the last 12 years
- 4) aged between 18 and 60 years
- 5) proficiency in the English language sufficient to understand and respond to interview questions
- 6) refugee, landed immigrant or Canadian citizen status

Ethnicity was based on self-report, as this involves subjective interpretation of ethnicity (Lalonde, Taylor & Moghaddam 1992) as well as a shared common culture, including language, religion and national identity (Damianakis 1992). Participants were

sought who had been residents of Canada for less than twelve years, in an effort to limit the effects of acculturation (Lalonde et al., 1992). Adults between the ages of 18 and 60 were included as the study sought to report on the experiences of female adult Somali immigrants and refugees.

The prospective participants were recruited by phone by the Somali worker after the study received ethical approval by the University of Ottawa (Appendix A) and the Community Health Center (Appendix B). Potential participants were informed of the nature of the study, the need for participants and what involvement in the study would include. Those who articulated an interest in being involved were sent a letter of information (Appendix C). The researcher telephoned these individuals three weeks after the letters were mailed. An initial interview was arranged with those individuals who still wished to be involved.

The researcher met with participants individually, at a time and place that was convenient for them. Once again, the purpose of the study was reviewed and an informed consent to participate was obtained (Appendix D). This consent verified that the participant had been notified of the nature of the project, understood what involvement entailed, the purpose of the study and any risks involved in participating. The written consent indicated that the participant agreed to participate, and understood that she was free to withdraw from the study at any time without penalty to them. Further, the consent indicated that her status as a refugee (if applicable) would not be jeopardized by either agreeing or not agreeing to participate in the study. Participants who were reluctant to sign a written consent form were given an opportunity to verbally consent, as approved by the University of Ottawa Human Research Ethics Committee. This occurred in the case of one participant. Consents were kept in a locked cabinet, separate from the data.

3.2 The Sample and Setting

3.2.1 The Somali Community

In the early 1990's many Somalis came to Canada as refugees. Thousands of Somalis fled the "horn of Africa" in the late 1980's and early 1990's because of a civil war (SWHG 1991). En route to Canada, many individuals and their families endured refugee camps, hardships and loss of family members.

Determining the actual number of Somalis in the Ottawa-Carleton region is difficult (personal communication, A. Reden, Citizenship and Immigration, October 25, 1995). Some Somalis have entered Canada as refugees and immigrants, others as students and visitors. Inter-city and inter-provincial movement contributes to the difficulty in determining the exact size of the population in this region. In 1993, an estimated 20,000 Somalis immigrated to Canada. The majority were destined for Ottawa, Montreal and Toronto. The Regional Planning Committee reports a total of 122,085 immigrants living in the Ottawa-Carleton region, of which 7660 report Africa as their place of birth (personal communication R. Calledine Oct. 25 1995). The exact number of these immigrants originally from Somali is unknown.

Somali is traditionally an oral culture. In fact, Somali has only been a written language and the official language of education in Somalia since 1972 (Catholic Immigration Center 1991). In addition to the Somali language, French, English or Italian are common second languages. These second languages can be attributed to a long history of colonization within Somalia by the French, British and Italians. Somalia received independence from the colonizers in the 1960s. Still, many Somalis claiming refugee status in Canada are without either of Canada's two official languages. Most Somalis belong to the Islamic faith. Arabic, the language of the Koran, is understood and spoken to some extent by most Somalis (SWHG 1991).

3.2.2 The Participants

It can be said that the Somali community in Ottawa-Carleton is small in comparison to the Somali communities within Montreal and Toronto. Even without exact population numbers, many Somalis within the region live in neighborhoods that are geographically close and attend the same educational, community and religious gatherings (personal communication, M. Aawed Oct. 15 1994). In order to protect the identity of the women who participated in the study, the sample description is presented in very general terms (see Table 1).

Eight women participated in this study. Of the eight participants, seven spoke English fluently before coming to Canada. The one participant who did not speak English before coming to Canada gained her English, in part, through 'English As A Second Language' classes. All participants articulated a willingness to participate in the study using the English language.

Half of the women were single parents, having left their husbands behind in Somalia because of the war and continued difficulty in husbands obtaining refugee or landed immigrant status. Employment status varied amongst the women and, many of the women were both workers and students, as well as mothers. Three of the participants were employed in 'helping professions' (i.e. such as health care and/or social services). One participant was a full time homemaker, and four of the participants were students.

This cursory description is presented to conceal the identity of those who participated: It does not reflect the richness and diversity of the sample.

Table 1 Participant Demographics

Demographic Variable	Interval	N=8
Age	18-28	1
	29-39	2
	40-50	5
Employment	Helping Professions	3
	Homemaker	1
	Student	4
Education	< Secondary School	1
	Secondary School	1
	> Secondary School	6
Number of Children	0-2	2
	3-5	5
	6-8	1
Years in Canada	1-4	3
	5-8	3
	9-12	2
Original Status	Refugee	7
	Landed Immigrant	1
Present Status	Refugee	1
	Landed Immigrant	1
	Citizen	6

3.3 Grounded Theory Methods

Within grounded theory, data collection and analysis are intertwined (Hutchinson 1986). It has been referred to as a method of constant comparison (Stern & Pyles 1985). Data are collected, reviewed, compared and analyzed, leading to further collection and comparison. All grounded theory procedures are aimed at identifying, developing and relating concepts. The following section reviews the process of data collection and analysis. The process of data collection, through participant observation and audio-taped interviews is described. The analysis, which includes three levels of coding, namely open coding, axial coding and selective coding, is then described. Throughout these levels of coding the researcher selectively samples data through the process of theoretical sampling. Theoretical sampling occurs in distinct ways at each level of coding; these processes are described briefly. The cycle of data collection and analysis is ideally continued until

theoretical saturation is reached. Theoretical saturation and the process of memoing, which occurred throughout the research process, are described in the final paragraphs of this section.

3.4 Data Collection

Data collection was multifaceted. A combination of interviews and observations were employed to discover core variables of the phenomena which often transcend finite times, places and people (Stern & Pyles 1985). These sources of data allowed for the discovery of different vantage points from which to understand the phenomena (Wilson 1977 as cited in Stern & Pyles 1985).

3.4.1 Participant Observation

Data collection began with participant observation. Six 'participant observation' sessions within the Somali community were completed. A total of fifteen hours of participant observation including two cross cultural parenting classes at a community health center occurred. At these classes, all of the women in attendance were Somali. The classes were presented in Somali, but written materials were in English. The researcher spoke with the women, ate dinner with them, shared parenting stories, and watched while others sang and danced. In addition to these cross cultural parenting classes, the researcher attended an Ede celebration (the religious celebration following the month of Ramadam) at a community center. Again, participant observation included speaking with community members, eating dinner, watching others sing and dance and assisting with clean up after the celebrations. An after school club appreciation dinner comprised the fourth participant observation session and finally, two community cook-off competitions comprised the last. Participant observation in these latter events was similar to the first, with a strong involvement and interaction with community members. Field notes were used to record data obtained during the process of participant observation.

3.4.2 Interviewing Within A Feminist Perspective

Interviews were conducted on a one-to-one basis over a period of five months. Interviews were audio-tape recorded. Field notes were utilized to record data, observations, and the reactions of both the participant and the researcher throughout the interview period. Tape recorded interviews and field notes were transcribed following each interview (Morse & Field 1995). Two interviews, approximately one and a half hour in length were conducted with each participant. Interviews were interactive and semi-structured. An interview guide facilitated the initial interviews (Appendix E). A minimally structured format allowed the interviews to proceed spontaneously. This allowed specific areas of interest to be developed as data collection continued. As hypotheses were formed, the researcher changed and supplemented the proposed questions to clarify information (Stern & Pyles 1985).

An interview environment conducive to the sharing of information and personal histories was created. The traditional paradigm for interviewing i.e. distance and objectivity was actively avoided. The interviewer attempted to establish a non-hierarchical relationship with participants. Each interview began by sharing a personal, professional and academic history with the participants. Sharing personal histories facilitated the establishment of a non-hierarchical relationship between the researcher and the participants while also contributing to the building of rapport (Oakley 1991).

A working relationship with the participants inclusive of reciprocity was actively pursued. Questions were answered during the interview process as completely and honestly as possible. When unable to provide the information, the researcher referred participants to the appropriate individual or searched for the information on behalf the participant. For example, the researcher assisted one women in finding a math tutor for her child. With another participant, the researcher agreed to "keep my eyes open for any

good sewing classes in this end of town". As well, participants were offered assistance with transportation to and from both interviews. Oakley's (1991), interviewing etiquette, described in her classic 1982 study of women and the pregnancy process, was utilized as a guideline for the interviews conducted in this project.

Interviews were conducted at the participant's convenience, in their homes, at the home of the researcher, at their places of employment, or at any place that was agreed upon. Some interviews were conducted during the day while children were at school, others on the weekend when other family members were at home and able to help with the children and the participant was free from school or employment responsibilities. In one instance, the researcher brought her daughter to baby-sit the participants children while the interview was conducted (all of the children stayed in the room with the participant and the researcher while the interview was being conducted). Of paramount importance was the acceptance and the accommodation of the responsibilities of the women involved.

Consistent with feminist inquiry, the researcher obtained information on feelings as well as facts (Oakley 1991). For example, the participant and the researcher would discuss a particular event; coming to Canada as a refugee. The facts were obtained, however, the richest data was obtained when the researcher asked: "How did it feel to be a refugee"...to which one participant replied:

"...I couldn't say that I was a refugee. I couldn't even say that word. It was so much a...you know when you are coming it's very hard to get away from your country, you're so attached and I just cried. You know I said, I can't say that I'm a refugee claimant, coming from another country. So I will never forget that day. It changed my life, that day".

Many of the participants spoke passionately as they were interviewed. In many instances both the participant and the interviewer held back tears as participants recounted their

experiences. Asking questions about feelings as well as facts was done intentionally and elicited rich data. Many of the women suggested that the interviews were in a way 'therapeutic' for them, inasmuch as someone was listening to both their experiences and their feelings.

3.4.3 Reflection Within Research

One requirement of research conducted within a feminist perspective is critical self reflection throughout the research process (Hall & Stevens 1991; Sigsworth 1995). At each stage of the research process, from its conceptualization to the final research report, the researcher kept a diary of critical reflections. The researcher challenged herself first on the need for the study: Does this study really need to be done or is it being conducted solely for academic purposes? An affirmative answer to the former part of this question became clear through the literature review, self reflection, and through discussions with members of the Somali community.

Consideration was given, throughout the research process, to the effects interviewing would have on the participants. For example, the free time available to the participants, as relative new-comers, as women, as workers, as students and as mothers was very limited. What impact was the research having on participants' day-to-day lives? As discussed in the section on interviewing within a feminist perspective, an attempt to balance these concerns with small efforts of reciprocity was made.

The interview schedule, the questions asked, and the effect they would have on the participants was constantly considered. Such consideration is an important part of critical reflection within feminist interviewing (Hall & Stevens 1991; Oakley 1991). Similarly, critical reflection occurred throughout the analysis. Through this reflection, efforts were made to refrain from what Mohanty (1991), labels as Western feminist colonization of research participants through the imposition of a hegemonic feminist ideology.

The researcher's position as a white middle class professional and the possible effects that this had on participants, data collection and data analysis was regularly reviewed. This was reflected upon personally, among academic peers and members of the Somali community. For example, did the women agree to participate because the researcher was a nurse associated with the community health center? Would participants have responded differently to a non white nurse, or to a lay person? Admittedly some of these questions were difficult to answer definitively. For example, the researcher's biases as a white middle class professional were difficult to articulate in spite of continued critical self reflection. This said, the researcher recognized her position as one of privilege. Recognizing this, and constantly working to raise one's own consciousness toward this and its potential effect on participants is an essential part of research conducted within a feminist perspective.

3.5 Data Analysis

3.5.1 Open Coding.

Open coding is the process of breaking down, examining, comparing, conceptualizing, and categorizing data. Two analytical procedures informed the open coding process; first, the making of comparisons and secondly, asking questions of the data. The processes of open coding started after the first interview and continued until all interviews, field notes and participant observation sessions were coded in this manner.

3.5.1.1 Labeling Concepts.

Data were broken down and conceptualized sentence by sentence. Each discrete idea was given a name, or a conceptual label, which represented the phenomenon to which it referred. For example, the following passage was examined at length: "Whenever the conflict is there, no child would tell their mom or their dad...(to get lost)...(there was a

certain respect)". At this stage of analysis the sentence was given the conceptual label 'new problems with the kids'.

Once the data were coded in this manner and concepts identified; like concepts were grouped with like concepts. For example, the following sentence was examined in the same manner as described above: "(When the husband is unable to rectify in his profession and find a job) they start to, family crisis happen. They fight, a lot of divorce sometimes too". The conceptual label given to this sentence was, at this stage of the analysis; 'problems with husband'. These two concepts, 'new problems with the kids' and 'problems with husbands', were then examined for similarities, differences and an identification of the phenomena the concepts represented or were associated with. They were then grouped together and placed in the category 'intrafamilial problems' which was more abstract than either of the concept labels and broad enough to encompass both concepts and bring the analysis to a more conceptual and less descriptive level.

Categories, according to Strauss and Corbin (1990), have conceptual power because they are able to pull together around them other groups of concepts.

Categories were then developed by listing properties and dimensions. Properties are attributes or characteristics pertaining to a category while dimensions are the location of properties along a continuum. The properties and dimensions of a category assisted the researcher in delineating the relationship between categories and sub categories. Continuing with the 'intrafamilial problem' example; incidents of intrafamilial problems were examined, as an example pertaining to intrafamilial problems between a single parent and her child. The property of frequency was considered along the dimensional lines often/never; the property extent of intrafamilial problems between the dimensions death/disagreement; the property intensity between the dimensions immoral/un-sanctioned and the property duration between the dimensions forever/short term.

Another example is paraphrased here: A mother, as a new refugee, wished to take some computer courses to upgrade her work skill in hopes of getting a job. However, each time she left for school her child would misbehave and not do his home work. As a result, the women eventually had to drop the course. This incident can be analyzed by examining the above mentioned properties along their concomitant dimensions. For example, the child 'misbehaves' in terms of frequency, some of the time, i.e. when his mother goes out to her course. The extent of the problem is 'considerable', that is, the mother wants the child to do his homework however the child disagrees and refuses to do it. In terms of intensity, the problems would be classified as un-sanctioned, that is, learning an expected duty within the Somali culture and within the Islamic religion. As for duration, the child continued the behavior until the parent dropped out of her course.

Events within each category were examined for their properties and dimensions. Specification in this manner assisted in the development of categories (Corbin & Strauss 1990). These categories later became the basis of theoretical sampling. Further open coding stimulated generative and comparative questions to guide the researcher upon return to the field. For example, participants were asked specifically about types of intrafamilial problems; 'Do you experience more difficulty with male children than female children? Or visa-versa, and why?'

3.5.2 Axial Coding.

Axial coding is a set of procedures whereby data are put back together in new ways after open coding, by making connections between categories. This was done by utilizing a 'coding paradigm' consisting of;

- conditions giving rise to the phenomenon,
- context in which the phenomenon is imbedded,
- action/interaction strategies,

- the intervening conditions that impact action/interaction strategies and
- the consequences of these strategies.

By developing categories in terms of this coding paradigm, the researcher was better able to see the connections between categories and sub-categories. This hypothetical relating of sub-categories to categories by means of statements denoting the nature of that relationship was then verified against actual data. As an illustration of this process, the development of the sub-category 'passing through hardships as a single parent' will now be presented. The phenomenon that was under consideration at this point was the difficulties in being a female Somali single parent. The conditions that gave rise to these *difficulties* are many. To begin with, prior to migration, mothers had extensive support systems in their extended families as well as in their communities. Raising a child *alone* rarely occurred. Being the sole decision maker and diminished finances are further conditions that lead to the phenomenon in question. To consider the context, the researcher looked to the broader factors in which difficulties as a single parent are embedded. For example, perceived negative attitudes towards single parents as well as a fear on the part of single mothers that their children are not safe in their own neighborhoods. Two actions taken, or strategies used, to deal with these difficulties as a single parent include, tightening the reins on the children and seeking support for oneself as a single parent by consulting other women in similar situations. However, the intervening conditions, or the factors that impact these strategies are for example, the age of the children; once the children are a certain age and physical size it becomes difficult to demand that they stay in and secondly, the limited number of women that are within close proximity who are experiencing similar difficulties. If an individual does not have access to the support system and does not have access to a car she is less able to take the required action to deal with the phenomenon. Consequences for this latter scenario would be isolation on the part of the single parent.

By developing categories in such a manner, the relationships between categories became evident. For example, one's ability to deal with the problems associated with being a single parent are related to the possible support systems one has access to. Analysis continued in this manner with each of the developing categories.

3.5.3 Selective Coding.

Selective coding is the process of selecting the core category, systematically relating other categories to it, validating those relationships, and filling in the gaps in categories that need further refinement and development. The core category is the central phenomenon around which all other categories are related. This level of coding and integrating is simply a higher, more abstract, level of analysis. This was done through several steps. First, explicating the story line; this was the conceptualization of the main theme occurring in the data, or the core category. The specifics will not be presented here as they are presented at length in chapter five. However, the process of discovering the core category will be described. Explicating the story line was accomplished by determining the essential message from the analysis that the researcher wanted to convey to others. As well, the core category is related to themes that are reflected over and over again in the data. In delineating the story line the researcher attempted to show movement or change over time. The core category in this case was determined to be what Glaser (1978) refers to as a basic social process (see the section that follows for further description).

The second step consists of relating subsidiary categories around the core category by means of 'the paradigm'. This step basically answers the questions;

- what are the causal conditions that give rise to the phenomena,
- what is the context in which it occurs,
- what are the action/interaction strategies employed in response to the phenomena,

- what are the intervening conditions that affect those action/interaction strategies
- what are the consequences of those strategies?

Categories were then related at the dimensional level. From here, relationships were validated against data. Finally, categories that may need further refinement and/or development were filled in.

3.6 Process & Basic Social Processes

3.6.1 Process

Bringing process into data analysis was an important part of research studies using the methods of grounded theory (Glaser 1978). According to Strauss & Corbin (1990), in order to capture process analytically, one must show the changing nature of events. Analyzing the data according to the coding paradigm facilitated the development of process. Further, by incorporating process into the analysis, the phases through which the participants passed before ultimately adjusting to Canada (see Chapter 5) were outlined, while also showing the intervening conditions that changed action/interactions and ultimately consequences. Process was ultimately utilized to identify and develop the core category which, in this study, was a basic social process as defined by Glaser (1978).

3.6.2 Basic Social Processes

A basic social process (BSP) is the core category in a study or a category which describes the main theme resulting from the research which demonstrates process and change (Glaser 1978). The BSP in this study surfaced repeatedly. It was clearly identifiable as the core category by its prevalent relationship to other categories and sub-categories and its ability to integrate the whole.

The BSP was discovered after many months of data collection, analysis and reflection. Originally the researcher had two competing themes. However, Glaser (1978), admonishes the researcher to fully develop only one BSP. He suggests that the

researcher, through a process of further data collection and analysis will discover the 'true' BSP. If this does not occur, which did not originally in this study, the researcher is encouraged to 'choose' one BSP and subsume the other under it. One BSP was chosen over the other by sharing the dilemma with co-students and thesis adviser. As the analysis continued, the second BSP was easily subsumed under the core category and acted as a condition to the main BSP.

3.7 Theoretical Sensitivity

Theoretical sensitivity refers to a personal quality in a researcher. It is the attribute of having insight and the ability to give meaning to data. A researcher with theoretical sensitivity is able to understand data and separate the pertinent from that which is not pertinent. The benefits of this theoretical sensitivity are many. Assumptions and biases are challenged, looking beneath the obvious. Further, theoretical sensitivity assists in the development of a theory which is grounded in the data, conceptually dense and well integrated (Strauss & Corbin 1990).

Theoretical sensitivity developed as the research project progressed. Several sources were drawn upon to enhance theoretical sensitivity, including both technical and non-technical literature, as well as personal and professional experience (Strauss & Corbin 1990). Still, little theoretical sensitivity existed with respect to several evolving concepts. For instance, little was known about Islam as a religion and an ideology. Fortunately, Strauss & Corbin (1990), suggest that this can favor the research since it prevents researchers from superimposing pre-established ideas onto the data. Thus, without an in-depth knowledge of Islam, religion was able to emerge on its own as an important concept in this study. However, once it emerged, gaining further theoretical sensitivity to it became an important part of understanding and analyzing the data pertaining to it.

In an effort to increase theoretical sensitivity with respect to Islam, several sources pertaining to women and Islam were reviewed. A seminar based on readings (Abdoul-Rahman & Amana 1991a; Abdoul-Rahman & Amana 1991b; Afshar 1995; Mernissi 1991; Puchniak 1990; Taraki 1995) was then presented to a class of graduate students. The materials reviewed for this seminar, as well as the class discussion served to demonstrate polar opposites in opinion toward Islam; 'Islam as the answer and Islam as the problem'. Strauss & Corbin (1990), recommend such comparisons increase the researchers sensitivity toward the research data. The materials reviewed assisted the researcher in delineating relevant questions for data analysis. For example;

- Have Somali women become more religious since their migration?
- What is the relationship between this (if it exists) and their experience as refugees?
- Do they feel that Islam is a panacea or a burden of ideology ?

By reviewing various sources pertaining to women & Islam, theoretical sensitivity was enhanced, thereby augmenting the value of the analysis.

Theoretical sensitivity further increased as the study progressed and data were analyzed (Strauss & Corbin 1990). This was accomplished by asking questions about the data, making comparison, making hypothesis and constantly drafting mini frameworks outlining hypotheses and comparisons. For example, one interesting comparison came out of comparing the experience of the participant who came to Canada many years ago, as a refugee and who is now a citizen, with a participant who came several years ago as a refugee and remains a refugee to this day. The first participant suggested that her experience as a refugee was mediated by the fact that she had her working papers in the course of three months, had a job and was working within a very short period of time. This participant has since received her Canadian citizenship, moved on and is advancing in her career. The second participant remains a refugee, finds being a refugee 'very

frustrating', and finds it next to impossible to get a job because when one is a refugee 'your social insurance number starts with 9 and they don't want to hire you'. The researcher compared the experiences of these two participants. What is the difference? Is it the time of migration? Were Canadians more accepting of refugees many years ago than they are today? Are the economic conditions now making it difficult for refugees to obtain employment? Is one doing better than the other? What is the relationship between being a refugee, employment and health? By conducting such comparisons and by asking such questions the researcher's theoretical sensitivity was continually enhanced.

3.8 Theoretical Sampling

Theoretical sampling is sampling on the basis of concepts that prove theoretically relevant to the evolving study. The objective is to sample events or incidents that are indicative of categories, their properties, and dimensions. By doing this the researcher developed and conceptually related concepts. Theoretical sampling occurred throughout data collection and analysis at all three levels of coding. Each will be briefly described below.

3.8.1 Sampling in Open Coding.

The aim of sampling in open coding is to uncover as many potentially relevant categories as possible, along with their properties and dimensions. Sampling occurred with those persons, places, and situations which provided the greatest opportunity to gather the most relevant data about the phenomenon under investigation. Openness, rather than specificity, guided the initial sampling choices.

3.8.2 Sampling in Axial Coding.

Sampling in axial coding focuses on uncovering and validating the relationships between categories. Sampling within axial coding is referred to as relational and

variational sampling. Within this sampling the researcher tried to find as many differences as possible at the dimensional level of the data.

3.8.3 Sampling in Selective Coding.

The aim of sampling in selective coding or 'discriminate sampling', is to integrate the categories along the dimensional level, validate the integrative statements of relationships, and complete any categories that need further development. Sampling at this point became very directed and deliberate.

3.9 Theoretical Saturation

Sampling should ideally occur until theoretical saturation of each category is reached. At this point; no new and relevant data emerges regarding a category, category development is dense, insofar as all of 'the paradigm' elements are accounted for, along with variation and process, and the relationship between categories are well established and validated. The analysis continued with this aim in mind. However, given the scope of the study, only the categories proving to be most relevant to this study were fully developed in terms of properties, dimensions and the coding paradigm. It was within these more relevant categories that theoretical saturation was approximated.

3.10 Memoing

Memoing occurred throughout the research process. Memoing is a way of documenting theoretical ideas, hunches, and emerging hypothesis. Memos are conceptual elaborations of ideas about codes, categories and their relationships. Memos were recorded in the two inch margins of the transcribed interviews. These memos were then transcribed and further developed in the files designated for memoing within the NUDIST program. Memos were continually documented and enhanced as data were reviewed and reflected upon. Memos contained the conceptual groundwork for working toward theory

generation (Hutchinson 1986). For example, one participant explained how difficult it was to deal with the loss of a family member when you are in Canada:

...(he) died...But when you are far, far away, it's not always the same because, you are not seeing that person's grave...and the hardest of all now is his family, that we couldn't bring them (over so we could help them out).

The following reflects the memo written in response to this data: ...'Difficulty grieving from afar. Loss, loss of even the ability to grieve your dead family members. Not being able to help family members out makes the grieving process even more difficult and incomplete'. This memo was then taken and further expanded under within the category loss, a sub-category of adjusting to the refugee reality. Memos became increasingly complete ultimately containing documentation of the properties, dimensions and the coding paradigm elements.

3.11 Utilizing NUDIST In Analysis

NUDIST stands for Non-numerical Unstructured Data Indexing and Theorizing. It is a computer package designed to aid users in handling and analyzing qualitative data. NUDIST assists the researchers to manage, explore and search interview text. The designers of NUDIST suggest that as a data analysis program, NUDIST can assist the researcher in managing and exploring ideas about the data, link ideas and construct theories about the data while at the same time testing ideas about the data (Qualitative Solutions and Research Pty Ltd. 1996).

3.11.1 Using NUDIST

Considerable time was dedicated in exploring and studying the NUDIST software and its accompanying manual. During this period through to the completion of analysis, the researcher explored ideas on *how* NUDIST could be used while remaining true to the methods of grounded theory. With this in mind, all interviews and field notes were

formatted according to NUDIST specifications. Interviews were then introduced into a created file entitled 'MYPROJECT--Somali Women In Canada'.

In order to code the interviews, the researcher required a place to store coded data and emerging concepts. An index tree was created based on concepts that the researcher suspected might be important to the project. Concepts within NUDIST are referred to as 'nodes'. NUDIST suggests that creating an apriori indexing tree facilitates data management and analysis as the researcher examines and codes documents (interviews or participant observations). However, this apriori conceptualization is an antithesis to grounded theory (i.e. within grounded theory concepts should emerge from the data, not from pre conceptualized ideas about what may be found). Thus, in accordance with grounded theory, the indexing tree and its concomitant nodes were considered provisional until they actually emerged from the data. The designers of NUDIST suggest that this apriori indexing system can be adjusted and reformulated as the emerging conceptualization of data becomes clear.

The initial indexing tree, in accordance with the program's capabilities, was set up in a hierarchical fashion. The first level is referred to as the root, from here it expands like an inverted tree. Seven 'second level' concepts were originally envisaged, including migration, single parent, religion, class, race, gender, health. Beneath these concepts, lower level concepts such as, but not limited to, refugee, problems with children, and racism were created. As data collection and analysis continued, in tandem and in accordance with grounded theory methods, the indexing tree was re-configured as concepts emerged.

With an indexing tree already designed, data were then examined and coded. The document systems (which included both transcribed interviews and field notes from participant observations) were searched using both string searches and pattern searches.

To explain: Pattern searches were used to find occurrences of different words with similar meanings. For example, pattern searches consisting of [religion|hijab|Muslim|Islam|faith] retrieved many of the passages pertaining to the concept religion. These retrievals would then be placed into the node 'religion'. The program kept track of which interviews the retrieval came from and how they were retrieved. String searches retrieved all text in which a particular word was found, for example 'refugee'.

Very little analytical insight was gained through these searches. Further, it was somewhat difficult to follow the methods of grounded theory using the NUDIST program in this manner. Fortunately, a parallel analysis was conducted manually; determining concepts, categories and developing each category in terms of its properties dimensions and according to the coding paradigm (see section on grounded theory methods). This manual analysis facilitated the acquisition of the theoretical insight required to re-configure the indexing tree and the theoretical sensitivity to conduct searches within NUDIST.

Eventually the researcher abandoned the contents of the index tree found by the above searching methods. Emphasis was then placed on the manual analysis method as a guide to index or code the particular passages that pertained to a concept at the appropriate node, from that point. Open coding continued using the NUDIST program. Similar concepts were grouped together to develop categories which were then developed in terms of their properties and dimensions. Here NUDIST proved useful. The higher order nodes became the categories and the lower order nodes became the sub-categories and concepts of a given category. For example, the concept 'problem with children' and 'problems with husband' evolved through the analysis to become 'intrafamilial problems'. This concept was compared to and eventually grouped with the concept 'single parent'. Together, along with concepts pertaining to 'being a woman' these concepts became

conceptualized as the category 'readjusting family'. Readjusting family was a second order node within NUDIST with its subcategories and concepts below it.

The memoing feature of the program became increasingly important as the project proceeded. In accordance with grounded theory, extensive memos were written throughout the analysis process (refer to the section pertaining to memos). NUDIST allows the researcher to write lengthy memos about each node (category, sub-category and concept). The researcher sorted and incorporated memos pertaining to each of these levels of conceptualization from the manual analysis. This allowed the researcher to examine all the memos pertaining to, for example, the category 'readjusting family'. This memoing feature contributed to the overall organization of the research project. However, the memoing feature within NUDIST also posed some difficulties. For example, the line by line analysis feature within the program was limited by the fact that the researcher is not able to stop and write a memo about a particular line immediately after reading it. Memos are limited to 'node memos' and 'entire document memos'.

The second difficulty experienced by the researcher when using NUDIST was in the area of data reduction. String and pattern searches invariably retrieved data that was not pertinent to the concept being searched for. These searches usually had to be expanded several 'text units' above and below the target phrase to allow the researcher to evaluate the context of the find. Because of these two points, node contents expanded quickly, became cumbersome and were difficult to manage. If the researcher wished to omit sections from a node, she would first have to examine the node, note the text unit, then examine the document that contained that text unit and remove the indexing of that text unit to the node.

As well, when developing categories in terms of properties, dimension and the coding paradigm, the researcher was again delayed by NUDIST's inability to memo instantly.

Notes were recorded manually, and then entered as a memo under the appropriate node.

This greatly decreased the efficiency of the analysis.

3.12 Ensuring Rigor Throughout Data Management and Analysis

Several steps were taken throughout the research process to ensure trustworthiness in the research process and product. Rigor in all research methods is required to prevent error in interpretation and presentation (Morse & Field 1995). Miles and Huberman's (1994), standards for quality conclusions was employed to ensure rigor in the research process and product on their own terms (p 277). These standards approximate the standards of reliability and validity used in quantitative research. However, they are necessarily different given the underlying differences in philosophy and methods between qualitative and quantitative research.

3.12.1 Confirmability

Confirmability reflects 'external reliability' with an emphasis on the replicability of the study by others. In an attempt to ensure confirmability, several safeguards were put in place. First, the study methods and procedures have been described in great detail. Second, explicit back-ground information about the research, the setting and the participants has been provided. Practitioners can follow the sequence of how data were collected, analyzed and how conclusions were drawn. Finally, study data have been retained for potential future use and re-analysis. This is also reflective of an audit trail which will enable future researchers to develop a similar conceptualization of the data. This audit trail is presented in the following chapters.

3.12.2 Credibility

Credibility refers to internal validity. In an effort to ensure credibility, the following individuals were consulted; a practitioner working in a local community health center serving many Somali immigrants and refugees, a university faculty member, and a key

informant from the Somali community. The following questions were asked of each: Do the research results make sense and are they reflective of reality? Especially important was the feedback received by the female key informant from the Somali community. It was the opinion of the female key informant, that the analysis and ultimately the results were reflective of the difficulties encountered by Somali women through their day-to-day experiences. Appleton (1995), reviews the importance of those with similar experiences being able to identify with study results as an important measure of credibility. Polit and Hungler (1995), working from Lincoln and Guba's (1985) framework, suggest that prolonged engagement with the community in which the study is conducted increases credibility. Participant observation and involvement within the Somali community for a period of over 12 months prolonged engagement and ultimately credibility. Further, 'thick' and rich data rang true to those reviewing the study analysis and results.

3.12.3 Transferability

Transferability refers to external validity. Study results are said to have transferability if they are deemed to have larger import. That is, are they transferable to other contexts? For example, do the results fit with the experience of South East Asian female refugees? Or, more immediately, do the results fit or reflect the experiences of other female Somali immigrants and refugees in Canada?

In an attempt to increase transferability, the characteristic of the sample, setting and research process are described fully to permit adequate comparison with other populations. As well, any possible threats to transferability have been reviewed. For example; the women within this sample were well educated, spoke English and the possibility for elite bias exists. Those considering the transferability of the results must take this into consideration.

3.12.4 Action Orientation

This refers to the possible utilization and applications of study results. These concepts are reflective of rigor in all research studies. That is, how accessible and useful are the research results to future users? Grounded theory purports to stimulate knowledge that is immediately relevant and useful to both research participants and practitioners (Strauss & Corbin 1990). Ultimately publishing in both professional and lay journals will increase the accessibility and utility of these results.

3.13 Conclusion

In conclusion, the methods of data collection, data management and data analysis were reported in this chapter. Participant observation and one to one interviews with eight Somali women in the Ottawa-Carleton region were analyzed according to the methods of grounded theory within a feminist perspective. The qualitative data analysis program NUDIST assisted primarily in data management and organization. Throughout these processes several steps were taken to ensure trustworthiness in the research results. These results, the product of the methods described here, are presented in the following chapter.

Chapter Four - Results

4.1 Introduction

The results of data analysis are presented in this fourth chapter. Pseudonyms replace the names of the study participants. Some identifying factors have been removed or altered to protect the anonymity of the study participants. For example, a child's age may be altered or their sex may be reported as male, when, in fact, it is female. The altered facts within this chapter do not alter the overall meaning implied by participants. Further, participant quotes have been edited for clarity and flow while safe guarding the original overall meaning. For example, a participant may have repeated a word several times, in this case, provided it did not alter the meaning of the quote, the repeated word would be removed. Quotes were edited in this manner and in accordance with More & Field's (1995), guidelines.

Through data analysis, using the methods of grounded theory within a feminist perspective, the process of 'rebuilding' was discovered. 'Rebuilding' refers to the process through which Somali women travel in reestablishing their lives in Canada. A brief overview of the process of rebuilding is provided. The reader is referred to Table 2 and Figure 2.

Table 2 Rebuilding

Category	Sub-categories
Adjusting to the refugee reality	Running from flames Dealing with intercultural communications Summing up your losses Giving self permission to grieve
Finding a new safety	Redesigning supports Finding support in health care provider Readjusting family Dealing with perceptions of female circumcision Returning to religion

The first category described in the process of rebuilding is 'adjusting to the refugee reality'. In essence, the category encompasses the experience of coming to Canada as a refugee and the disbelief that accompanies this experience. The category is comprised of four sub-categories; running from flames, dealing intercultural communications, summing up your losses and giving yourself permission to grieve. 'Running from flames' reflects on the initial experiences of Somali women in Canada. Despite the fact that they are safe in Canada, coming to terms with their reality as refugees is not easy. Newly arrived Somali women in Canada are troubled by a multitude of emotions: On the one hand, a sense of relief that they and their families are safe and on the other hand, disbelief and fear of their reality as refugees.

Safe in Canada, Somali women begin the day-to-day trials of 'dealing intercultural communications. Language is a problem for even those women who come to Canada knowing English. This in turn makes dealing with the unfamiliar Canadian system exponentially difficult. Attempting to navigate a new system of health, social services, education and transportation is compounded for Somali women by the language barriers.

'Summing up your losses' is the third sub-category described. Eventually, once the initial shock of the refugee reality has passed, Somali women reflect on the plethora of losses incurred. Losses are both human and material. Loved ones have been lost in the Somali civil war, family members have been left behind in Somalia and ultimately a way of life has been lost, or at least forever changed.

Despite the multitude of losses, many Somali women never take, or are never given, the time to grieve their losses. Within the Canadian system, individuals are expected to be self-reliant and efficient. Single Somali mothers, for instance, are expected to settle, enroll their children in school, manage their families and get on with their lives. This reality clashes with the difficulties experienced as refugees and the lack of knowledge regarding the very system in which they are expected to be self-reliant and efficient. This again is further compounded by difficulties in language communication.

'Giving yourself permission to grieve' is the last sub-category described within the category 'adjusting to the refugee reality'. It includes taking the time to stop and reflect on the difficulties encountered as a refugee and taking the time to mourn your losses. This sub-category is relatively brief and reflects the reality of Somali women; little time can be afforded to grieving. Moving beyond the grieving and beyond the adjustment of the refugee reality gives way to 'finding a new safety'.

'Finding a new safety' is the second category in the process of rebuilding. In essence, 'finding a new safety' is about filling the holes left by the refugee experience and comprises the bulk of the work in the process of rebuilding. 'Finding a new safety' is comprised of five sub-categories; redesigning supports, finding support in health care providers, readjusting family, dealing with perceptions of female circumcision and returning to religion.

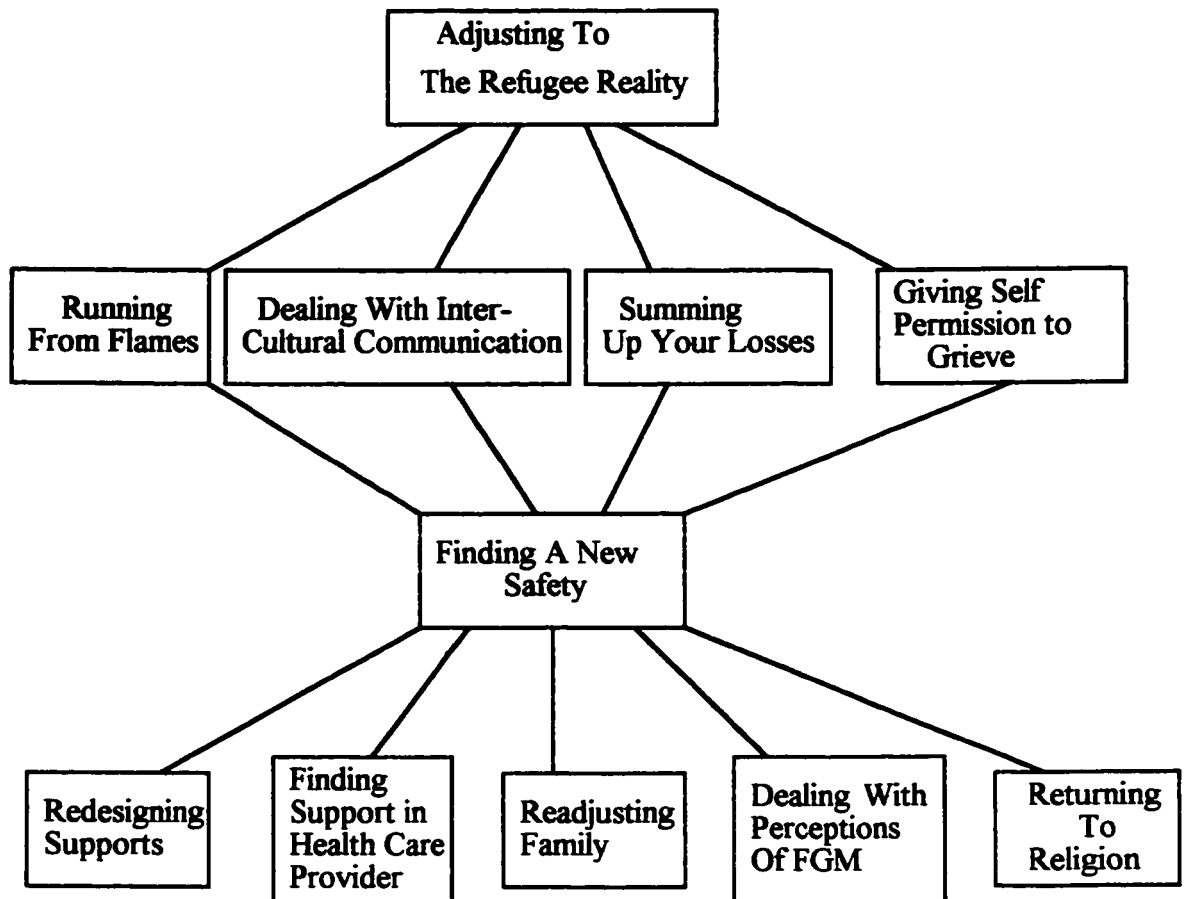
'Redesigning supports' is the first sub-category described. Somali women had an extensive system of support in their families and extended families back home. Here in Canada the need for such supports is accentuated, however, because of their reality as refugees, these usual systems of support are diminished and forever changed. Thus, Somali women begin the process of redesigning new systems of support. These systems of support include family members within the region, neighbors and friends. In redesigning supports, Somali women are discovering new ways to access friends and family members.

'Finding support in health care providers' is the second sub-category described. Health care providers within the Canadian system can and do in many instances, provide a valuable source of support for Somali women. However, Somali women experience several barriers in accessing health services and health care providers. Experiences of alienation within the health care system, such as language difficulties, fear and racism hinder health care access. In spite of these barriers, Somali women do access health services and providers in some instances and describe experiences of connecting with and being validated by health care providers. Ultimately, finding support from a health care provider assists Somali women in the process of rebuilding their lives in Canada.

'Readjusting family' is the third sub-category described. Many Somali women arrive in Canada as single parents. As such, a plethora of difficulties are experienced including intrafamilial problems between them and their children. As well, husbands are increasingly joining their wives here in Canada. Although their arrival is welcomed, changed roles and relations within the family, and the difficulties they themselves experience because of the refugee reality (for example unemployment and altered systems of support) are fueling intrafamilial problems between husbands and wives. Ultimately, all Somali families must readjust here in Canada.

'Dealing with perceptions of female circumcision' is the fourth sub-category described in the category of 'finding a new safety'. Somali women coming to Canada are met by a barrage of media coverage pertaining to female circumcision. In fact, so extensive is this media coverage that 'FGM' (female genital mutilation) has become a public discourse; that is, anyone on the street, at a dinner party, or at a public meeting, has the right to discuss female circumcision. Female circumcision is not, for the most part, being practiced in Canada. However, the discourse and media sensationalism threatens Somali women's sense of identity within Canadian society.

Finally, the sub-category 'returning to religion' is explored. Somali women are increasingly returning to their religion as Muslims. Wearing the hijab (the veil and the traditional long dress) is an outward display of this renewed faith. Due to their reality as refugees as well as all the difficulties experienced and described in the previously mentioned categories and sub-categories, Somali women are seeking and finding solace in Islam. This said, Somali women have always been devout Muslims. As such, they bring with them from Somalia, Islam and the Koran. Ultimately Islam is described as a prescription for health. A health which, to Somali women, includes their physical, mental and spiritual well being. A health from which their everyday experiences as female Somali refugees can not be removed.

Figure 2. Route of Rebuilding

4.2 Adjusting To The Refugee Reality

The state female Somali refugee is fraught with difficulties. Refugees, unlike immigrants seldom plan their migration. Where you land as a refugee is a matter of serendipity. You do not control when, where, how, or with whom you migrate. Refugees are seldom free to return to their homeland, a freedom that many immigrants enjoy.

4.2.1 Running from Flames

Coming to Canada as a refugee is a memorable experience with a multitude of mixed emotions of relief and fear. Awrala explains;

"Your expectation is, reach this place, where you can not hear fights and violence, and airplanes bombarding somewhere, and heavy artillery bombardment and, you are thinking of that. Somewhere where your children are safe. But when you come to the place, there are a lot of other problems (different) from what you were running away from".

Refugees arriving in Canada a decade ago were a relatively new phenomenon and the Canadian community welcomed them. Accommodation, and employment were comparatively easy to find. Obtaining a new start in Canada was a relatively straightforward process. However, today things are becoming increasingly difficult. Habiba, in Canada now for some time reflects on this point;

"...when I came, there was such a small number (of Somali refugees), there was more welcoming. (More understanding)...absolutely...understanding, help, we were all working within (a short period of time). So...I found job...I didn't have my (landed) papers or anything like that, but at (that) time (they) gave work permits... I found work in three months.....I actually had my...status within fifteen months from when I landed. We all had, so it was completely different at the time".

Today, the context in which Somali women live in Canada is considerably different. This in turn makes adjusting to the refugee reality exponentially more difficult.

4.2.2 Dealing With Intercultural Communication

Assuredly, the ability to speak one of Canada's official languages conditions one's experience as a new comer to Canada. Being without English or French results in an inability to articulate your needs, concerns or fears. Difficulties in dealing with a new

language range from an inability to understand and speak the language, to not being understood because of an accent. Ayan describes;

"So one of the things you simply can do is to raise your voice a little, you know, and you see the person backing up because...the person is backing up because he can hear you. (So) please talk slowly! One of things (that is) frustrating for people is (Canadians)...talk so fast and use (a lot of) expressions...I always say, excuse (me) can you please...repeat what you said very slowly. But not everyone can say that, you know...they didn't understand...And if I don't know English I can't (communicate). So, put (yourself) in that situation...always have in mind; this person has English as a second language, you know...English as a second language! You will know from their expression where he is, (if he understands)."

Not speaking either of Canada's two official languages makes communicating and living within a bureaucratic Canadian system difficult. Saynab describes difficulties with the elementary schooling system that result, in part, because of difficulties with intercultural communications;

"When they (Somali kids) go to school, maybe the other children, Canadian, or maybe another refugee who came before us, bothering them. They saying rude words and always pushing...they tell the teachers; something wrong. Maybe this child doesn't understand what the teacher, (or) other student (are) saying about (him). Maybe they...it (causes) very very very madness. And maybe they kick something, maybe they fighting...maybe they say something. The teacher is always calling the mothers. But unluckily, the mothers don't understand what happened between child and the teacher. And no other translator is there. The mother don't understand what has happened to her child. When the child is coming in home, the mother screaming and shouting, and maybe pushing him and saying, you are wrong, always, you are wrong.

Maybe the child is not wrong. It is ...a misunderstanding. So always that is the big problem the mothers and the children don't understand too. And sometimes the mother is disappointed and just take silent, because they are scared, if they screaming always, and pushing her child, maybe the child doing something and maybe sometimes the children calling the 911 and sometimes...Children's Aid will take the children".

Somali women employ several strategies in dealing with the difficulties of intercultural communication. Learning the language, either at home, with friends or through 'English as a Second Language' classes, are frequently the first step taken. As well, Somali women look to family and neighbors to translate on their behalf. The women also described the strategy of insisting on being listened to and insisting on being understood. This strategy, however, is contingent upon the women's confidence, knowledge and understanding of the situation.

The consequences of not learning to communicate or navigate the Canadian system are many. For instance, those who do not learn English become increasingly dependent on family members. This in turn strains family relations and depletes the individual woman's self efficacy. Isolation and depression from this inability to communicate and the resulting decreased self efficacy ultimately compromise Somali women's health. Moving beyond these difficulties is essential for Somali women in adjusting to their reality as refugees and ultimately rebuilding.

4.2.3 Summing Up Your Losses

'Summing up your losses' was discovered as an important sub-category in 'adjusting to the refugee reality'. Coming to Canada as a refugee means leaving behind material possessions, family, community and all else that contributed to a total way of being . The magnitude of these loses is realized over a period of time. Summing these losses up was discovered as a precursor to the process of rebuilding. The losses invariably affected the

mental well-being of these women. Jamala describes the confusion and loss she and her family suffered as a result of the war and the concomitant results;

"...Then the civil war happened. (My mother, who came to Canada with me), she never really said good-bye. My mother lost a lot...when the civil war happened. And it didn't register. And my youngest brother, her youngest child was missing, and my aunts were missing and my (sister) that my mother had adopted was also missing. For four months we had no idea whether they were alive or dead...I mean my mother just visibly aged...In Somalia, in Mogadishu, she was someone, she was a very independent person who did her own thing. And now I see this fear in her, where she is afraid to do certain things".

Some of the losses incurred by Somali women, such as the loss of a total way of being and the loss of a system of support that once contributed to the overall well being of Somali women is further described by Awrala;

"Actually, uh, somehow or another, it causes me with a lot of sadness or holleness inside me, but again when I think of Somalia, and where I lived and my friends and my neighbors; everyone of them is gone. I have some of my friends or my family members all over the world. So somehow, that is (the) confuse in my missing home because, home to me is not home because the people I use to (know), are not there. The people I am missing are not there. It is only the land...I still have some family members back there. But most of my family members are (out of Somalia). They are scattered all over the world. So home is not going to be the same anymore, even if I go back and settle down there. I know that inside me, home is not going to be the same. Home is not going to be the home I use to know. The family members, the friends I depended on for my mental well being, and social well being are not there

anymore. My job is gone. I am not going to get back the job I had...So, it seems to me there is a sort of big, very huge confusion somewhere in the middle of my life".

In spite of the incredible losses suffered by Somali women as a result of the civil war in Somalia and their migration as refugees to Canada, Somali women employ many strategies in dealing with their losses. Rationalizing with self is but one strategy: Being Somali, and being a Muslim means enduring adversity and accepting all outcomes and circumstances because it is the will of Allah (God). This strategy was labeled 'just doing it'. The women deal with their losses by 'just getting on with their lives' the best they can.

As well, increasing one's identity as a Somali and becoming increasingly religious are strategies employed in dealing with the losses suffered. Ayan explains the strategy of turning to others and thinking in terms of the future. She also suggests why this strategy is perhaps more efficacious for women than it was for men;

"I remember three years ago when one woman...we talked...We were happy, we were crying. We were talking about the loss, what they were. (Women) support each other. When it comes to woman and man, it's different. Because man, men, their losses are completely different...because back home the men are bread winners and they are the ones affected by not getting the jobs here. And there (they were) ..engineers...that...identity is gone...So it seems that their conversation (is) guarded, they talk back home. Why women come unguarded? They talk today. And what's happening in Canada. That is the two differences".

This said, Somali women do continue to concern themselves with Somalia and the family members who remain back home. Sending money back to Somalia is a common strategy employed in response to their losses. One participant explains that even though she was unable to bring her mother and father to Canada, 'somehow sending money back' makes her feel a little better. At least she is 'trying to help them out'. Others sponsor family

members to Canada, thus attempting to decrease the multitude of losses suffered by 'recreating their world over here' in Canada.

Given that one has lost her way of life in Somalia, turning to the future is a frequently used strategy. Turning to the future for many of these women means turning to and investing in the future of their children. Sacrificing one's own career and educational goals in favor of facilitating those of one's young is not uncommon.

The consequences of employing the described strategies in the face of the multiple losses were predominately positive. However, a variety of intervening conditions invariably make utilizing the various strategies difficult. For example, the ability to turn to other women is related to the proximity of other female family members. For instance, having one's sister next door, or within the same neighborhood increases the likelihood that she will be called upon for emotional support. One's ability to send money home, to sponsor family members to Canada and one's ability to access those family members here in Canada were further impacted by economics. The consequences of not effectively employing these strategies were invariably diminished mental health, in the form of stress, loneliness, isolation and guilt.

4.2.4 Giving Self Permission To Grieve

Despite the multitude of losses, many Somali women do not take, or are not given, the time to grieve their losses. Within the Canadian system, individuals are expected to be self reliant and efficient. Single Somali mothers of four, for instance, are expected to settle, enroll their children in school, manage their families and get on with their lives. This reality clashes with their difficulties experienced as refugees and a lack of knowledge regarding the very system in which they are expected to be self reliant and efficient in. This again, is further compounded by difficulties in language communication.

'Giving yourself permission to grieve' includes taking the time to stop and reflect on the difficulties encountered as a refugee and taking the time to mourn your losses. This sub-category is relatively brief and reflects the reality of Somali women; little time can be afforded to grieving. Ayan explains;

"During that time there was a lot of trauma too. There was misplacement, there was refugee camps, there was children who witnessed their parents being killed in front of them, witnessed brothers being slaughtered in front of them. Well, it is coming to (Canada) and telling yourself to bury everything deep down, and not to talk about it because we don't have the time to talk about it...Tell yourself that you are here, I am refugee, I am expected in the eyes of the Canadians to be efficient to be workable, to be understandable, to be part of Canada...At (the same) time...she is in the middle of a country where she is the bread (winner), where she is the head of the family, where she is the financial ruler of the family, where she is the discipliner of all the children...And she is overwhelmed, overwhelmed. And (the woman who's) husband is with her...for him, he came here, he has NO FOOD to put on the table. Even if he is very educated, it is very hard to get a job in Canada. He is, his self esteem runs down. His family is suffering and he can not help them....'I was a doctor, I can't be a doctor. I was a teacher, I can not be a teacher'. And I (can't take the time) to grieve for that too...You have to accept it...it is very difficult for people to cope...And then, the other thing was...(there are problems with) the schools, the immigration, the institutions that the people were (are) dealing with...That mother...her children, they may be witnesses to slaughter...(she) is coming to the border, and she is expected to take the kids to the school and become efficient as any other parent. The kid is expected from the schools, as understandable, as workable...And here are the rules, (make sure you) go by the

rules: You're not allowed to do this, you're not allowed to do this...So nobody (is there) to help them through the process!"

Somali women cannot afford extended time to the process of grieving their losses. As Muslims and as Somalis they are encouraged to accept the circumstances as the will of Allah (God), and to get on with their day-to-day lives. This is further reinforced, as Ayan describes above by a Canadian system that encourages independence and efficiency. However, Somali women's reality as refugees makes 'getting on with life' extremely difficult.

Taking the time out to grieve is often a brief and passing moment in the busy lives of Somali women. Formal and informal forums give rise to the ability to grieve, they include; prayer, personal reflection and talking with other women who have suffered similar losses. However, regardless of the mode chosen or taken, Somali women afford, and are afforded, little time to the process of grieving.

The work of 'adjusting to the refugee reality' is never complete. Obtaining status as a landed immigrant and as a Canadian citizen increases one's ability to attend school, to travel and even to find employment. However, one's history as a refugee, the losses incurred and the involuntary nature of a refugee migration are not easily forgotten. This said, the women described several processes in 'finding a new safety' enroute to rebuilding. These processes will be described in the following sections.

4.3 Finding A New Safety

'Finding a new safety' is the second category in the process of rebuilding. In essence, 'finding a new safety' is about filling the holes left by the refugee experience and comprises the bulk of the work in the process of rebuilding. It consists of five sub-categories; redesigning supports, finding support in health care providers, readjusting family, dealing

with perceptions of female circumcision and returning to religion. Each sub-category is described below.

4.3.1 Redesigning Supports

In Somalia, an extensive system of support revolved around the family, the extended family and the community. This support system provided a system of health and social well-being. Enroute to rebuilding, Somali women employ many strategies in attempt to re-configure the system of support that was so central to their lives and their concomitant well being.

4.3.1.1 Usual Systems of Support

The system of support that existed in Somalia, that of extended family and community, assisted women in many ways including household management, health maintenance and illness management. Upon arrival in Canada, realization of a diminished support system occurs quickly. In response, Somali women attempt to rebuild their prior systems of support here in Canada. Atika describes;

"I've sponsored my aunt, my mother's older sister, my uncle, my mother's younger brother. And now I'm trying to sponsor my uncle, he is my mother's older brother...I mean it's almost like my mother trying to recreate her life in Mogadishu. With surrounding herself with (family), I mean my mother is very conscious of family situations. She's trying to bring everybody here, including the neighbors..."

Where possible Somali women try to recreate their prior systems of support. Still, whatever attempts are made, Somali women's systems of support will never be the same.

Without the usual systems of support Somali women were at risk; increased stress in parenting several children on their own contributes to isolation and loneliness. As well, given the missing systems of support, taking care of one's own needs and health ultimately is compromised. Farhia explains;

"I have very stomach problems...They put the prescription (in at the drug store), I never went there and take it. I have (these) problems still. I stay two days, three days on the bed and I have no chance to take that. But if I was in Somalia, then they (my family members) could help...that's my worst part. Because, you know, I am sick, I have (many) kids...so and then I forgot all my health...I don't know. I am not good at take care of myself...I take care of them (my kids), but I forgot myself".

4.3.1.2 Emerging Systems of Support

Given that their support systems will never again be the same, Somali women build new and different support systems. Most of these efforts are within the Somali community itself, preferably with immediate or extended family members, *but* in new ways. For example, the telephone is an invaluable tool in establishing new systems of support. An aunt may not live with you any longer, but by using the telephone, a Somali woman can access her for both advice and support. A sister living next door is called upon to assist with child care and cooking chores. An aunt drives a niece to the grocery store and two sisters share the shopping. New systems of support, in many ways, replicate the system of support that existed back home.

Many factors affect the establishment and continuity of these new and emerging systems of support. For example, Islam and the Somali culture in general, positively influence these systems of support. Within Islam in general, and amongst Somalis in particular, there exists an obligation to support and assist those in need. At the same time, the women described themselves as proud and independent. In Somalia, a woman's existence was one of discursive interdependence and independence within an extensive and elaborate system of support. Thus, at times asking for help was moderately difficult.

Further factors influence the establishment of new systems of support. For example, those called upon for support are experiencing difficulties of their own in adjusting to life

in Canada. Financial difficulties also impede one's ability to assist, as does the physical distance between family members. For instance Awrala explained that although she had many family members in Montreal, visiting them, and obtaining support from them was difficult;

"Even if I travel to Montreal, there are a lot of close family members...the best I could do is call about three or four of them, and see about two or three of them. And the best they could do is, three of them could visit me. It is never the same...I can not manage to visit all of them, (they live in) so many different places that are very very far away from each other...It is impossible for me. And it is impossible for all of them to come and visit me because they don't have cars, most of them, or they have smaller children, they cannot leave, they have no one to leave (the kids) with. So the best I can do is I can talk to three or four of them...isolation is a very very (big problem)".

Another difficulty in establishing support systems here in Canada was identified as an increased emphasis on the individual and a decreased emphasis on the family and community as a whole. Habiba noted a decreased commitment to the family in younger people which translated into a decreased willingness to assist others;

"...especially the younger people don't have the same commitment. One of the main things about the traditional families is that there is no individual, you act as the family as a unit, your own needs include the needs of the group. But it's not anymore, young people who are here they are not going to make the same commitment....I think that you could say that they're changing ideas, but you could also say that the circumstances are changing them. One of the things that happened when you lived in a community in Somalia was the people also financially supported each other. One was not so dependent upon a single salary, there was different places where money came from...there were many people working so that you had multiple incomes so that if

someone stayed home... like here where the individual is struggling to make a living.

In Somalia, the way that it was structured was that the individual didn't have to depend so much upon his own salary, they were a part of the community and the community supported each other. So the daughter could take a long time off work or leave work if her mother was sick, because there were other people to support them. But here its not so, so that's a circumstance that are changing them, people are more focused upon themselves".

Another strategy used in the establishment of a new and different system of support is an increased reliance on the nuclear family. Husbands, who eventually reunite with their wives, are asked to assist in the day-to-day management of the home and the family. Awrala explains how she turned to her husband for support when he finally joined the family here in Canada;

"It contributed a lot (when my husband came). A lot of heavy weight has been lifted off of my shoulders. Most of the times he's dealing with the homework...And since he has a fresh start now, he came while I was already tired, so I told him to take over, and the disciplining, especially of the boys. I always say when (the boys) comes to ask me, mom can I go out to the park for awhile, I say, go ask your father. So he has taken a lot of the responsibility. We are sharing the responsibility. It helped me a lot, really".

Finding support within the nuclear family is contingent upon several factors. To begin with, in Somalia, labor within the household was divided along the lines of gender. The women took care of the home and the children, and the men were responsible for financially maintaining the family. Crossing these lines was an unusual occurrence. Thus finding support, instrumental support, within the nuclear family is contingent upon the newly arrived husband's willingness and ability to redefine and take on new and different roles. Awrala explains;

"The role that a man has to take in Canada is different from the role that a man in Somalia used to take. In Canada, the family, you have to cooperate with each other in managing the daily life. But in Somalia, it was different, there was a lot of other support. Maybe the husband's role was to provide for his family well enough so that they can be financially OK. In Canada, it is sort of different. Like the family maybe here as one family that came from their entire extended family. And they are the only family members who are here. So they have no other support. It is only the mother, the father and the children. So I think, according to my own experience, I think, my husband takes a role, different from what he use to take in Somalia in managing the family here. And he knows when one of the children has an appointment with a doctor. Sometimes he takes them there, to the doctor's appointment. He takes his own appointments and a lot of the times, he is aware of my appointments too. I mean he is compelled to do that. Whether he is good or not, he has to be doing that in Canada. Because we are a large family, we have (many) children, he has to take a role otherwise I cannot manage on my own. I mean it is very very important for me and for him to cooperate in everything".

Jamala also talked about finding support within the nuclear family as a new and emerging pattern of support contingent upon the willingness of the man to take on new roles;

"...like it is happening more and more...(men realize that if they don't help out), then the woman will say 'you are a burden' and divorce. So those of them who want to keep their families together change their act. And those who are concerned about their image don't. And they suffer for it".

Finding new systems of support within the nuclear family was found to be occurring out of necessity and in many cases was found as a precursor to the process of rebuilding.

Somali women have traditionally been and continue to be in the new and emerging systems of support, the most important source of support for each other. The women explained that for support, in the event of an illness or a death, they would turn to the help of a female family member or a female member in the Somali community. Abdia explains how Somali women have and continue to offer each other support. She describes this support in the event of a husband's death;

"They are bringing food, they are taking care of the house. They are keeping company. Some of them are reading Koran for her. Telling them that it is OK, everybody is going to die so, we are all grieving and...In two hours, the lady was OK. She was sitting with us talking. It took her only two hours to grieve and cry and for three days, she won't do anything for her children...everything is done for her. Imagine you get all this support. And everyone who comes in will tell you that this is the reality. Everyone is going to die...We just don't know who is going first, that's all. It is a fact that everyone is going to go. Nobody grieves after that...Finished, and in three days a women...is the same like you are".

Abdia further describes the support women find in each other;

"They are. They (other women), help in a way, you know...you know you have someone to depend on. For example, if somebody, if you get sick, your neighbors can take care of your children. You know they can go to the doctor and pick up your daughter. If something, they are replacing the extended family, you had...And they do help, they help each other a lot. Especially those who have the common children of four years....They are more closer to them, I am for example I don't have much contact with them because my children are older. But those, they are very close to each other. They help each other".

So central are other women to Somali women's support systems that women are often preferred over men as members of one's support system. Atika describes;

"But women can make their social networks better than men can, in terms of helping each other out, in terms of...because they do a lot of the cooking, I think that...they tend to take care of themselves better...(Somali women) they amaze me with some of the things that they do...A lot of them are survivors. Women are taught to value. Men are not taught to talk, to communicate how they feel, how to deal with frustrations in life, how to cope...Women take care of each other...the kids...We have a connectedness in the community...To lose a parent is to be orphaned, if you lose your mother, it is doubly worse...And that says something about the importance of women. Someone could offer me the choice between my husband or my grandmother, I would go for my grandmother in a shot...because you can always get married again...it is the woman in the family, because you know that they love you unconditionally, you know that, no matter what you do, they always love you.. (the role of the woman) is one of respect".

Establishing new forms of support ultimately contributes to the process of rebuilding. Those who do not establish new forms of support, are described as suffering increased stress, isolation, loneliness and diminishing mental health.

4.3.2 Finding Support in Health Care Providers

Health care providers were described as having the potential for being vital in terms of support for Somali women. Somali women generally hold health care providers in esteem. However, a health care provider can do one of two things; validate or invalidate the experiences of the Somali women they see. Validating the woman's experiences contributes to the establishment of a supportive working relationship between the Somali woman and their health care provider. This supportive working relationship in turn

contributes to the ability of the woman to rebuild in Canada. Invalidating the experiences of female Somali patients, or not taking their concerns seriously contributes to an experience of alienation which ultimately decreases the likelihood that services will be accessed.

4.3.2.1 Experiences of Alienation

A variety of factors contribute to the experience of alienation for Somali women when trying to access health care providers. In spite of the regard held for health care providers, a certain amount of hesitation exists on the part of some Somali women when accessing health care providers. A variety of variables contribute to this phenomenon including language and what Awrala describes as fear;

"...There are a lot of people who may not be comfortable going to the doctor's...For example I have my mother here, she is over (sixty) years old. I feel that she has a lot of fears. I mean she is not fearing from the human being who is looking at her, but because she doesn't understand. The language, and this whole environment is new to her. She has to depend on another person; for her daily life, she can't go on the bus alone because she cannot read the numbers. Or the letters, or whatever, she does not know which bus to take whenever she is going somewhere. She can't go to the clinic on her own because she doesn't know which number to press when she is on the elevator...She cannot go to the clinic alone because she doesn't understand the receptionist. And the receptionist doesn't understand her!".

In addition to the barriers that exist to accessing health services and ultimately establishing a supportive relationship with a provider, 'an unresponsive system' is a reality encountered by many women. 'An unresponsive system' ranges from inaccessibility due to language to unacceptability due to racism and attitude on the part of the individuals staffing the health

clinics. Awrala describes the common problem of 'not being taken seriously' which results in not accessing the services required:

"...(A) hesitation because of the type of services that they get. Some people feel that they don't get enough of what they need, for example; they go to the clinic, and maybe the doctor they have seen doesn't think seriously of what they are telling them. And he thinks that that is a little problem and that can be taken care of by taking Tylenol or something. So, that person will hesitate to go back to the clinic..."

Ayan describes her experience of alienation in the hospital and attributes it to the assumption on the part of health providers that she was a refugee and as a Somali refugee, talking about her problems was outside her cultural norm;

"That was very hard...I was sometimes crying in the middle of the night. And looking around me, and saying, why I am here? I cry, I cry, I cry...Would you believe, I am in the hospital and nobody knows what I am going through? ...The assumptions around there is that, well you are a refugee...If I don't talk about my problem, it is my culture (that is the) assumption...I was having a language barrier! And then, I was...in the middle of a difficult situation, but I felt that the nurses were not trying to understand me...if there is a difficulty in communication, there is always a way to communicate, you know?"

Racism is a considerable barrier encountered by Somali women in accessing health care providers. The racism encountered is both overt and covert; the latter being most difficult to articulate and to combat. Being spoken to in a rude and abrupt manner, not having procedures and practices explained, and being told 'out and out' that they had no right to be using Canadian tax payers dollars by accessing emergency services are but a few examples. Habiba describes;

"They were rude...Racism is not something that you can explain in words...racism is...that has to do with (assuming) people who don't speak the language and don't understand anything because you come from another country, is that you're stupid!...The nurses...they assume you're stupid because you don't speak the language or (you) speak with an accent".

In the eyes of Somali women, racism and racism toward Somalis, has increased in severity over the past several years. Atika suggests that it has become 'almost acceptable to be racist to a Somali';

"...In the current climate, in Ottawa at least, it is OK to be racist to a Somali, it really is. I mean people can make racist comments about a Somali and nobody bats an eye. It gets me really angry. I wait for somebody to use the proverbial Somali example. Well for instance, the Somali community does this...Because you know what it is? You see someone doing something and someone comes to your office and acts extremely rude, very abrupt, very ungrateful, and you think OK, it is that person. If it is a Somali...(you assume) it is the Somalis. There is this tendency to generalize about who we are. It is a serious problem..."

Being a 'very visible minority', that is wearing traditional African attire, wearing the hijab (the veil), increases the likelihood that one will encounter racism within the system of health care. Ayan describes;

"Two nurses, the emergency nurse and another nurse (saw my friend and I)...Some how I was dressing in the Somalian way that day, and that day we were moving so I was cleaning the house...(my hair) wasn't good, so I decided to cover my head (with the veil) (laugh). So I went there and somehow they decided they couldn't understand me, *they* decided. One nurse asked the other one and then she said: 'how come this (visit) happened?...How do you (feel)...spending the health care and taxpayers money

like that? How do you feel?...I was feeling...like, and then I talked to myself inside, how to answer?...I am in pain and that's why I came here and it doesn't matter to where I've been... And then I said (to myself), why I am here, I ask myself, I'm here because I just want this to be dealt (with). I will not say anything, I decided not to say anything but to deal with (the problem)... And sometimes I have a doubt too, and you say maybe they are right, am I spending the taxpayers (money)."

Confronted by racism, accessing the health care system becomes increasingly difficult. Somali women are dealing with racism in a variety of ways, including 'rationalization'. For example suggesting to one's self that it was just the particular person in contradistinction to institutionalized racism and learning the system as well as the rules that apply. As well, learning the system includes discovering where and to whom to complain if one felt the need.

Lack of familiarity with the Canadian health care or social system hinders the establishment of a supportive working relationship with a provider difficult. Several strategies are employed as a result of the difficulties encountered in the health care system by Somali women. First of all, 'holding off' or not seeking the assistance of a health care provider is as a common response to an in accessible and un-welcoming system. Not speaking either French or English was a intervening condition that further made visiting a clinic difficult. Having a friend or a family member to advocate on your behalf mediated this condition considerably.

4.3.2.2 Connecting & Validating Experiences

Those who do establish a positive working relationship with their primary health care provider describe a process of 'training the provider'...Ayan explains;

"Well, I dare to say...we train her (laugh)...the first time, like meeting her, we talked, we, you know, had the information, she talked, but at the time...explaining to

her...through the process, she learned a lot. She learned a lot...I think it was her willingness to learn and listen...It's not uncommon to see someone who will, you know, shut you down or whatever, something else, kick you out and taking over, and forgetting about the human being...And, but for her, I think she, somehow, I don't know, maybe I was pushing to, to, try, to try to make her understand our life, you know, make her more sensitive. On the other hand, she was not uncomfortable, she was also willing to learn."

Others describe the qualities in health care providers that were conducive to establishing a supportive and working relationship. These qualities include listening and respecting the woman, talking about everyday concerns and understanding the woman's experience as a refugee. When faced with a practitioner who does not demonstrate these qualities, the consequences include; not establishing trust, not establishing a relationship and ultimately not going back to the health care provider.

Taking the time to understand and to be understood were described by Saynab as the essential elements to building a supportive and working relationship between the health care provider and the individual Somali woman;

"...The kind of talking (makes a difference). Talking easy. The first of all, the doctor, you see an immigrant and refugee person...(who) can't speak (English) fluently. Or maybe you can't understand, very well, all the words the doctor tell you. So he (is) talking easily. Word by word. So that he makes sure you understand his words or not. So that maybe sometimes, you can't understand, (what) the word (means), the doctor's word. So that, (he) holds your hand and show; how to lie or how to change your (position)...or how to... (he) holds your hand. He makes action with his hands...Because if somebody (is) talking (fast)...you can't understand. Even if you think you know the word, the words go fast".

Establishing a relationship with health care providers coupled with positive experiences within the system of health contributes to a sense that the system was there for them as Somali women. Establishing a supportive working relationship with a health provider further facilitates maintaining your health as a Somali women as it increases acceptability and accessibility of the services offered by the health care provider.

4.3.3 Readjusting Family

Family is a central concern of Somali women. Within the Somali culture, family structure is traditional and patrilinear. That is, the male is the head figure within the family, the children take his name and become descendants of his family clan. However, the women also describe family in Somalia and even more so in Canada as matrifocal. That is, women hold a central and valued position within the family. The instrumental and supportive assistance gained through women for women increased their power and influence within the family. However, the Somali family in Canada is different because of their reality as refugees. Family members have been lost, relocated and changed in ways that preclude the existence of 'family' as it was in Somalia.

A variety of subsections within 'readjusting family' were discovered. Each impacts the process of readjusting family here in Canada. This readjustment of family is inevitable and in many ways necessary to the continued well being of the women's families and ultimately to Somali women themselves.

4.3.3.1 Passing Through Hardships as a Single Parent

Being a single parent, of often four to five children, is a new and difficult reality for many Somali women. Many of the women who came to Canada as refugees, came without their husbands. Husbands often stayed behind to protect family, farms or other assets and many were killed during the war. As well, being a single parent in Canada is further impacted by a diminished system of support.

A great deal of fear accompanies being a single Somali mother in Canada. This fear ranges from fear of their children losing their Somali and Islamic identities and values to the fear of losing their children to violence out on the streets or to The Children's Aid Society. In Somalia prior to the civil war, the community as a whole was responsible for and assisted in the rearing of all children. No individual was solely responsible. Children were safe within their homes and within their communities.

Many of the women described a process of self sacrifice for the sake of their children. Examples of such sacrifices include wearing second hand clothes so that their children can have new clothes as well as the personal sacrifice of staying at home and not taking the mandatory re-certification courses in their professions in order to ensure that there will be enough money for the children to attend post secondary education. Farhia explains;

"I take care of them, but I forget myself...I just think I focus (on) my kids and I like to help them as best I can...I cook, I don't go to high school in order to buy what they like. So I try to make them the priority, not myself...But it is difficult sometimes, you feel difficult, the way I am trying to keep them good and they are not understanding...they are not working as hard as I am doing because they don't know the situation...In that case I ask myself to be patient for them".

For those that remain refugees, this is further compounded by the reality that as refugees their children can not attend post secondary school due to exorbitant tuition fees. This in turn adds to the difficulty of being a single parent as it fuels resentment in the children and ultimately intrafamilial problems erupt. Farhia describes;

"I want to take some (college) courses...And I am sure, if my husband were (here), I can manage myself to have a small (business). It is not a lot of money. If you have the skill it doesn't need a lot of money. But I can't do it as a single mom, I can't do it!"

The strategy of 'just doing it' is used by Somali women in 'passing through hardships as a single parent'; "The only thing that makes it easier is that I convince myself that I have that responsibility..." (Farhia). One simply has to accept one's reality as a refugee and as a single parent. As well, Somali women use the strategy of self reflection to overcome the difficulties and resentment of being a single parent; reflecting on their difficulties, the hurdles they have over come, and the strength in women to do so.

In response to the difficulties of being a single parent, many Somali women have become increasingly traditional in their child rearing: Not allowing their children to go out with friends and encouraging them to stay within the boundaries of their home. However, in response to this, many children retaliate with disrespect and disobedience. This in turn exacerbates intrafamilial problems. Saynab's daughter had this to say;

"The kids, they watch TV or what ever, and then they want to go out and have some freedom. But freedom, us Somalis, we have (a) strict religion, and (a) strict culture. And it's hard for a mom to tell her kids stay in your culture. They just want to explore other things and then the kid goes out and he doesn't want to come back in, there is nothing she can do about it".

The women also describe a sense of resentment toward their husbands and the fathers of the children that they are caring for here in Canada. They feel that they, as mothers, are fulfilling their responsibilities, but the men, as husbands and fathers, are not working as hard as they in fulfilling their obligations to the family. The women described being proud of themselves, their efforts and their commitment to their families. This rationalization serve to mitigate the ill effects of being a single parent. Abdia describes;

"...We have all the responsibilities...and the husband's far away. We feel they neglect us. They should be much more better than what they are doing. And yes, there are difficulties with coming, they could help us, financial help. They should try harder,

wherever they are. Even if they are not with you, they could support you otherwise...we are much stronger, try harder, because we can still go along with all the difficulties. When you compare to the men, yes, they are back home and trying hard. But they are not (trying) as hard as we are".

4.3.3.2 Intrafamilial Problems

Intrafamilial problems are a difficult and unfortunately common dilemma for Somali women. As such, dealing with and finding solutions to intrafamilial problems is essential in readjusting family. Intrafamilial problems cut across generations as well as between generations. Mothers experience difficulty with children, siblings fight among themselves, and difficulties between spouses are increasingly part of a Somali woman's reality.

Intrafamilial problems between parent(s) and children were described as an extremely common and troublesome occurrence. Many Somali women, coming to Canada as single parents, without their usual support networks and extended family are destined for difficulty in parenting their children. Children, often coming at a young age, adapt quickly to the Canadian environment, learning the language and the Canadian system with relative ease. Awrala explains

"Because there are a lot of women who are losing their children...When they come to Canada, the child adjust very very easily. They learn the language, faster than the mother, and they learn all the rules of the relations and the law. So they try to, sort of, exercise a lot of freedom. And when the mother feels she is not in control anymore, that makes the mother very angry...And it is also causing them their health!"

As a result, Somali mothers are disadvantaged with respect to dealing with school difficulties and conflicts between their children and other children in Canada. Many participants describe the difficulties in dealing with these problems when you as a single mother do not understand the language or the system. Saynab's daughter explains;

"Most of the Somali parents, they don't speak French or English...Whenever their kids have problems at school, they (the parents) can't really understand what is going on. And most of the time the Somali kids are the ones who have the most problems in school. Not only because of the language barrier, but every single time they have a problem they can't count on their parents because they don't understand the system, they don't understand the language, it is like a foreign country. So whenever they come in, it was too late already. Most of the time it is too late for them, even if you call a person to translate...I am not talking about academically, I am talking about the social things. It is too late for them. Like they have problems at school, and the teacher says, I am going to call your mom. And the kid will say, well she doesn't understand French or English. Then the kid will go home, and he will tell his mom a different story from the one that really happened at school. And the mom, she already had her mind set up. There is a lack of communication between the schools and the Somali parents".

As single mothers, the women described multiple difficulties in disciplining their children in the absence of their husbands as figures of authority. They themselves are unfamiliar with being sole discipliner and care giver. As a result, the women describe difficulties in disciplining their children. Thus the children are doing as they desire and the mother suffered the consequences of their actions. Saynab explains;

"In Somalian...the relations between the children and the parents, it's so tough, and it's so hard...Very strict...The parent always has the power. And the children always keep the respect for the parents until they are twenty or upper twenty, maybe when they get married, they get free from their family. But it's still...even if they're old, they have the respect for the parent...But when we came here, the culture is different. Relations between the family and the children are different...I think children take power. Parent

does not have the power. Cause if you tell (your child) something important the next day your child goes to school, (and) maybe the teacher telling him something (different), the child likes what the teach says more than than (what the) parent says".

The women describe a fear of losing their children on another dimension. As a single parent trying to discipline children without their usual systems of support and without the presence of the 'traditional male authority figure', the women describe conflict between parent and child that often results in a call to The Children's Aid Society. The calls are often instigated by a neighbor or even a child. A condition adding to the difficulty is the image portrayed on television and to some extent within the school system that children have exclusive rights and that parents do not have a right to discipline or curtail their children's activities. The following sentiments were shared;

"And for some children, teenagers or maybe not teenagers, under ten years old, there are also problems with children who are under ten years old, they have a concept of what is new to them, saying that your mother or your father can not control your life. So some of them may think that if they call 911, for example, and the police come and the parents will be punished because they are not giving the child their freedom or her freedom".

In response to such difficulties the women describe a strategy of 'turning to the system' to mitigate the conflicts. Awrala described turning to the police and to those within the social and health care system to reaffirm for themselves and their children that they as parents were obligated and sanctioned to discipline their children. Another strategy include turning to extended family members or someone within the Somali community to 'talk some sense into the child'. Those within the Somali community are perceived as best suited to this function as they would reaffirm the traditional Islamic values held by the mother. Awrala explains;

"It is more effective (to have someone from within the Somali community) because, although the child may be a little bit wild, yet he has some sort of, or some values what you were trying to teach him from day one. So that child may associate him or herself with a person from the same culture as you, than from another culture that is completely different. That person who is counseling him, may be younger than the parents and a little bit older than him, and maybe he will associate himself with that person, or herself with that person, because of some common values that they have, than someone who's completely, trying to teach him completely different, I mean values. And maybe this person who is counseling him will have some experience himself in doing these things when he was that age. So that may help him a lot too. It works for some people".

An additional fear is for the safety of their children. In Canada, Somali women are bombarded by media images and reports of violence against children and between children. Saynab explains;

"And sometimes (women) watch the television or the media...(they see) friends killed other children (on television). Especially small children. Very, very, very small children...Because in Somalia, nobody bother children. Nobody bother the children, nobody kill, nobody...abuses them or or uh, how can I say this, nobody use them sexual....never, never. The children are free. Two years old, go outside and playing with other children and be safe...So many, many problems. Maybe the Canadians think there rules are good for children but other way is worse for children."

In response, the women further tighten the reins, discouraging their children from going out into the community. However, this in turn results in increased conflict between

mother and child as well as increased stress on the part of the mother who has no respite because her children were constantly underfoot.

Intrafamilial problems among siblings was described as a considerably less significant problem. Never-the-less, older siblings are less likely to assist with younger siblings because in their eyes it was not 'cool' and they feel that the behavior of their younger siblings was too difficult for them to handle. This again contradicts the meaning of family as it was in Somalia. Older siblings, much like the extended community, would assist in the rearing of younger children back home. In Canada this is less likely to occur.

Intrafamilial problems between spouses are particularly problematic and are increasing in occurrence. Several factors contribute to this conflict between spouses. To begin with, when husbands eventually join their wives here in Canada they enter a changed family structure. They too are accustomed to the assistance of an extended family in the rearing of their children. Moreover, the fact that they were not previously involved in the day-to-day rearing of children makes things difficult. Out of necessity these newly arrived husbands were compelled to assist with the responsibilities of child and of maintaining a home. Awrala explains;

"It is not easy. It was not easy for (my husband)...Up to this day, it is difficult for my husband to cook. And if he tries, maybe he will burn the food...I can understand that, because in Somalia, men don't cook...It is almost a taboo for a husband, or for a brother or for a son in Somalia to cook...So, it is difficult for men who came here, who are encountering different kinds of roles in Canada, it is not easy to adjust. But it is a must for all of them."

This coupled with the reality that husbands can not easily find paid employment sets the stage for intrafamilial problems: The husband has lost his role as bread-winner here in Canada, whereas the wife's traditional role of child care giver and housewife remained

intact. Problems reported ranged from verbal disagreement to ultimately family breakdown and divorce. Awrala explains again;

"For a man (unemployment is difficult). Some men are here and they are saying that we are not important to our families anymore, my wife doesn't respect me anymore because I don't provide for her. She is provided by social assistance, and I feel that the only connection we had was the money, the financial support I use to give her. And I feel that was the only thing that gained me respect. And that was the only thing that was holding us together. That is gone, and I can't get employment. It is getting more and more difficult for him to cope...It is heart breaking. It is very sad for a family to break up because of that. It is hard. I mean there is no way that you can deal with that kind of problem".

Abdia further explains the consequences of unemployment;

"They start to...family crisis happen (when the husband is unemployed). They fight, a lot of divorce sometimes (happens) too. That was not there at home. The rate of misunderstanding becomes more here because the men is always at home, it is a burden. And the women, finds it hard to cope".

Somali women are working through a process of compromise in redefining the traditional roles and responsibilities in an effort to mitigate the conflict experienced between spouses. Those who chose this route are able to readjust their family and their family structure thus staying together. Those who do not, encounter increasingly difficult problems as a family unit;

"So there are families who are sticking together and understanding this concept, and cooperating with each other, there are families who are not adjusting very well as the others and who are not integrating and they are just falling apart. And it is very very

sad. There are a lot of break-ups in families, regarding that issue...of (changing) roles".

The consequences of intrafamilial problems include an increased stress level among the women involved. Frustration, feelings of isolation and depression occurs in response to the intrafamilial problems experienced. Those who are able to effectively employ the strategy of role redefinition and work together as a family are able to readjust their family ultimately contributing to the process of rebuilding.

4.3.4 Dealing With Perceptions of Female Circumcision

Several women (N=4) spoke of female circumcision in response to the following question; Is there anything else that you feel we should be discussing about health and illness? The women who raised the issue of female circumcision suggested that the issue has been sensationalized by the media and this has negatively effects their mental well-being in many ways.

4.3.4.1 "FGM" The Label

One participant explain that 'gundee' is the Arabic word used to refer to circumcision in both boys and girls. The women admit that the two procedures (circumcision in girls and boys) are not equivalent but to label female circumcision 'female genital mutilation' or 'FGM' affixes a derogatory label to the women as well as the procedure. Ayan describes what the label "FGM" means to her:

"(Labeling it as FGM)...Oh my God it...offended for a lot of people...(Labeling it FGM), that is very unhealthy...we don't like that (word). Because cruelty is behind 'mutilation'...I was nine years of age. It was something I did with my parents. Because at *that* time, she was trying me to fit the society. It is society; circumcised or she would not be married. I am not saying it was a good tradition. It was a bad tradition and that is why it is stopped now...But it is just 'circumcision' for us. Not

'mutilation'...But (by labeling it as FGM) we are showing the public; what kinds of people are doing this?"

Atika explains the effect of the label FGM on her; "Well, I get resentful, because you have...Usually, the quickest to judge are white people".

4.3.4.2 Media Sensationalization

The women were surprised by the media attention female circumcision receives in North America. Media coverage of the issue has a disconcerting consequence for Somali women. Jamala explained;

"You know, especially when it pops up in the media, I mean this issue (of female circumcision) pops up in a lot of unusual places. When it pops up in the media, you know people are going to give you strange looks. As if you are missing some very vital part, like you can't express yourself!"

4.3.4.3 A Public Discourse

Due to the media sensationalization of female circumcision, the women feel that the issue had become fair game for light banter to be discussed much like the weather, by whomever and whenever they saw fit. Further, the women feel that other Canadians assumed that all Somali women are circumcised. Atika explains;

" In Canada, you know, there is a lot of myth around Somali women. I mean I am sure you have heard of female circumcision? And everybody is just like; oh my God! You know. And they don't exactly know what it is, but they are pretty sure you have it, even though they don't bother to ask you about it".

4.3.4.4 'FGM' The Oppressive Icon

The women feel that the issue of female circumcision was an issue of concern as defined by Western Society. Participants feel that Canadians looked upon them as oppressed and in desperate need of emancipation. Jamala explains;

"But their reaction is; oh, poor you. For some of them it's this issue of feminism (Jamala is a self-proclaimed feminist). Let me liberate you. Well female circumcision is forbidden in Somalia. It was on the books!...And then you come here and you're told, you don't know what's good for you! Well guess what? Here, we've been fighting it for a long time!"

As well, female circumcision is not seen as a priority issue within the Somali community.

"You ask someone what they think about this issue, and they are like no, no, no, it's not an issue, stop (talking about) it". Abdia explains her reaction to the attention afforded to an issue, that to her, is not a priority for herself or the Somali women she knows;

"I thought it was like something; propaganda. Because it has nothing to do with the health of Somali women. And instead of helping them other ways, they put a lot of money in there. The people needed more guidance to adjust to this country. Because people are getting away from 'mutilation' now. It, there is no use of repeating and coming back, because what ever we saw in the television is what has happened. It was history...Revisiting it, it wasn't good at all. Nobody benefits. Some people were even angry and upset about it because they say, why bother now, we're not doing it with our children"!

Ayan explains;

"It is not a priority with a lot of people. You know why? Because most of the people stop it".

Other issues are seen as more seminal to the well being of Somali women. Atika suggests;

"When your children don't have basic needs (satisfied), this (female circumcision) is not a priority".

4.3.4.5 Invalidating Membership in Canadian Society

The label FGM, the media sensationalization, the public discourse and 'FGM' as the oppressive icon are most detrimental in that it makes Somali women feel as though they are somehow not equal to other Canadian women. Atika said;

"I mean it says that Somali women are not valid in this Society. (Some Somali boys) they don't want anything to do with...Somali girls, because there is something missing from them. Uh, it's on my body, it's off my body, it's none of your business"...(It is not the be all and the end all issue), but that's how it's seen. But for me it doesn't define who I am...I mean I don't go out and think; oh my God, this part of my genitals. But that (is) how people define it. You're something less, there is something missing from you and how do you deal with it? It's like, I don't deal with it, it's not an issue. And they don't understand"!

Anger, embarrassment and frustration result in response to the Western discourse on female circumcision. One participant could not believe when she was questioned about the procedure of female circumcision by a dignitary at a public dinner party. In addition to the emotions, many of the women identified action strategies used in response to the FGM discourse. Some cope by educating the public about the practice, giving in-services to health professionals or lay people questioning the practice. Other use the discourse as impetus to find out the facts themselves. Learning about the history of female circumcision, its connection to tradition and culture and the absence of connection between religion and the practice. Others educate themselves on the feminist colonial discourse which warns against Westerners defining the problems for the marginalized other. These tactics were used to give strength to these women to stand up for what they believed in; that female circumcision is a negative practice and that it should not be practiced, but not by eliminating their self-worth as Somali women.

4.3.5 Returning To Religion

'Returning to religion' as a category has two main sub-sections; seeking solace in religion and religion as a prescription for health. 'Returning to religion' is in fact a series of strategies used to deal with the above difficulties faced by Somali women. As such, it has been introduced throughout the above sections. However, its importance is emphasized by presenting it as a distinct sub-section unto itself.

4.3.5.1 Seeking Solace

Somali women have become increasingly religious since their migration from Somalia. This includes an increased inner faith and an increased outward display of faith. For example Ayan, prior to her migration did not wear a scarf. This and an increased reliance on God is reportably true for others;

"Well, for me religion...It was a coping mechanism. (A women said) 'oh my God, when I saw this, I thought the world was ending. I saw people crying, ...and then I was so confused'...(It is) the same thing (with) any religion, people run to church when they are in crisis. They (say) 'oh my God, let me do something. Just let me hold my religion. And that will save me'. And so people were praying a lot. And Somali women are more religious than ever. You see women having veils? We didn't have veils back home. Veils became a coping mechanism for what people went through. It worked for them though. It helped 90%...The religion helped them. They start (to) pray five times (a day), they say 'God I have no power'. They give up all their power to God. And then when you give your power to God, then it gets you lots off your shoulders. 'So God help me. You sent me down here, in this strange world. Help me". And they calm down".

However, several factors make using religion as a strategy difficult. First of all, wearing the hijab (the scarf and the traditional long dress) increases Somali women's visibility as

minority women with a society that dresses according to Western standards. This in turn affects how they are treated within the Canadian culture. For example, Habiba and Ayan described feelings of discrimination and decreased access to health care services as a result of their traditional dress. Never-the-less, wearing the hijab and increasingly turning to Islam gave the women an inner peace not found elsewhere.

4.3.5.2 A Prescription For Health

Health is central to Islam and within the Koran a plethora of prescriptions for health are delineated. These prescriptions refer to both mental and physical well being. Atika describes the physical part of 'religion as a prescription for health';

"(Health is central to Islam), so smoking...it belongs to the category of things that cause harm to your body. Alcohol is strictly forbidden...drugs, that comes under (the category of) something that is not healthy...The Koran talks about being clean and things like that...it is considered to be a health issue...I mean taking care of your body is a responsibility in Islam".

Islam as a prescription for health, emphasizes hygiene and cleanliness. Cleanliness is next to Godliness, as Atika describes and the daily rituals involved in being a Muslim ensure this;

"For instance during prayer...we have a...washing ritual...It's called Wudu. It's an Arabic word and it just means washing...We pray five times a day. And what you do is, for instance if you've gone to the bath room, if you've passed gas, you have to wash again, you're not considered to be clean. So you wash your hands, your face, your mouth, your nose, your face, your arm all the way to the elbow and then, you always do the right one first. You don't wash it with soap, you just put water, like three times. And then you wash your ears. You don't have to wash your neck, I do that. And then you wash your feet. And ...(cleanliness is) next to Godliness. It is also

considered to be a health issue as well, like being clean. Before we eat we have to wash our hands. Because we eat with our hands in most customs...We mostly eat with our hands. So you have to wash your hands. I mean it even talks about brushing your teeth...I mean taking care of your body is a responsibility in Islam because it says that on the day of Judgment your body will say 'this soul has done this to me and that to me' even your hands and your mouth and your eyes, like all parts of your body will testify against you....And your like thanks a lot!"

Islam as a prescription for health includes exercise as an essential part of keeping healthy. Atika explains again: "like keeping your self in shape, I mean the Prophet recommended exercising and walking."

Abdia further explains the direct link between health and religion. Islam provides a day-to-day prescription for health inclusive of diet:

"Because, my healthy habits that I had was to eat good food. And the main bulk of our food was meat, milk and vegetables...I was taught in the Islam religion, it has a lot to do with health. I was prepared very early. I went to school, I studied the Koran, not only for the sake of religion, but I really studied it...I came to know many things that are useful and applicable (to health). I have applied them".

Islamic holidays and festivities further create opportunities and prescriptions for health.

Again Abdia describes:

"Fasting is another thing to keep healthy because once a year you fast. I always lose my weight during Ramadam. You lose four or five kilos a year. You eat very healthy food during Ramadam, you know you select the food, the best food, and you keep away from the bulky food, a lot of starch. Because at night you can only eat so much, that should be very, very good food: fruit, vegetables, fresh prepared food always. You don't have to eat from the fridge, it's prepared and eaten right away."

Within Islam one is expected to maintain both physical and mental health. Here in Canada, Islam provides a strategy for dealing with the stresses encountered in everyday life. Jamala explains:

"(The Koran) talks about (mental health): things that cause you...stress, problems and things like that...Hatred is one thing...(a) person is suppose to be forgiving...having patience...Basically, what individuals do to you is not the end. Ultimately they have to answer to God...I find that very soothing and very comforting...It talks about equity, and how...important equity is. Not identical equality, but being treated as people. And it gives you advice on how to live, how to survive. For instance, when you are angry, it tells you that you should go pray...it is a suna, which means that it is not obligatory, but that it is recommended. It tells you to pray, so that will cool you down."

Religion as a prescription for health ultimately has many positive consequences for Somali women; assisting them in difficult experience of being a refugee as well as assisting them in managing their everyday frustrations. Atika explains:

"Like for me, sometimes when I get angry, I get so angry that I start shaking, and I go to the bathroom, and I do the washing...for the prayer, I instantly calm down, things are not as important as I think they are. It encourages people to be kind to others, not because you want a favor, but because you want God's blessing...(I think), that is something that is going to save the Somali community, in terms of, it provides an inner strength. You make a racist slur, and I dismiss it. The anger doesn't go away and the hurt doesn't go away."

Abdia also controls her stress and enhances her mental health through Islam. Here Abdia also describes the direct link between everyday difficulties and her health:

"I mean there is a lot of stress in keeping healthy here. Because there are so many things that are new. And at the same time there are frustrations from, for example from the immigration, economically...and it's difficult to adjust to a small amount of money. So it is frustrating, to prioritize, what you need, and to keep up with that. Forget about anything else. But, I...personally I control my stresses by, I study the Koran, I am very conscious and I pray. Praying actually helps me a great deal. It's more relaxing, and then you think everything is (falling apart)...You know, why I came here? Some times you can not answer certain questions. It is in the name of the Creator, what ever happens. Sometimes, you don't know, why am I doing this? Why am I stressed this way? All these answers are (not easily answered). I don't waste my time saying 'why am I here? why am I doing this'? It's something...in my life and I have to pass through it".

Awrala reiterates Islam's contribution to health, but she also admits that there is still something missing here in Canada. Given this, Islam remains a prescription for health but it does not prevent the occurrence of mental health problems:

"Actually, we are talking about the psychological part of health. Actually, in my country, the psychological part of our health is; since we have faith in our religion, most of the people are spiritually healthy. So they have faith and how they live, doesn't effect their inner part...spirituality. Because it's always, they are always full...content with what they have. Even if they are the poorest of the poor they are content. They will look up and say Thank God, was also said in Somali. So people had no psychological difficulties. But lately I am experiencing a lot of Somali people who are are either in the psychiatric hospitals or sick, psychologically not OK. I often see a lot of people talking to themselves in the streets, Somali people. And that gets me concerned."

Awrala further connects mental health concerns to everyday concerns within the lives of Somali women:

"I think that one of the things that is happening is isolation. In Somalia, there was no (nuclear family)...the nuclear family didn't count. There was always the extended family. You have always people around you; who care about you, who are concerned about you. Yourself, who are supporting you, with the children. And if there is a conflict in the family there are always family members to do the conflict resolution. You don't go outside for advice. So this is not there for them...If they come to Canada, some people come alone, no family at all. They have no family support. So their is a lot of isolation affecting them. And there is no Mosque near their house...So...Something is missing. Some very, very big things are missing".

4.4 Conclusion

Two categories of the process of rebuilding are presented in this chapter; 1) adjusting to the refugee reality and 2) finding a new safety. In the process of rebuilding, the women within this study were found to have traveled through both of the described stages.

In adjusting to the refugee reality, newly arrived Somali women begin the process of discovering what exactly one's new reality is as a female refugee. This occurs through the processes of summing up and discovering ways of dealing with the losses they have incurred. After this point begins the long process of adjusting one's self to the Canadian context and discovering a new safety for one's self and for one's family.

Redesigning one's systems of support was discovered to be central to the process of finding a new safety in Canada. Health care providers can be part of that system of support. However, in many instances they also were found to be barriers to Somali women in accessing health care services. In readjusting family, the Somali women in this study contended with the difficulties of being a single parent and with many intrafamilial

problems between family members. Both of these factors were found to be mediated by their strength as Somali women. However, this strength itself, was battered by a public discourse surrounding female circumcision. Finally, religion is described as both a mechanism of relief and a prescription for health. Religion was ultimately found to assist these women in the process of rebuilding their lives in Canada.

These findings are discussed further, in the following chapter. They will be contrasted and compared with the literature available today. As well, the connection between nursing, health and feminism will be explored.

Chapter Five - Discussion

This chapter compares the study results to the currently available literature. Both the similarities and the differences between what was discovered in this study and the currently available literature are explored .

5.1 Adjusting To The Refugee Reality

The everyday experiences of Somali women in Canada today are impacted significantly by their status as Somali refugees. As refugees these women did not plan their migration to Canada and came largely unprepared for the stresses they would encounter in Canada.

In the process of rebuilding their lives, Somali women first evaluate their status as refugees and then, begin the process of adjusting to their reality as refugees. Several studies have examined a similar process, referred to in the current literature as acculturation and/or social adjustment among both immigrants and refugees. For example, Bauer & Priebe (1994), found the process of social adjustment in refugees from East Germany to be compromised by their experiences as refugees. Lipson (1993), also found the difficulties in adjustment were compounded by the multiple losses suffered by Afghan refugees in California. These losses ranged from the loss of family members to the loss of one's country and one's way of life. Lipson's (1993), findings as well as Bauer & Priebe's (1994), findings are consistent with the difficulties female Somali refugees in Canada encounter in adjusting to the refugee reality. Lipson (1993), further found that these difficulties in adjustment compromise the mental health of Afghan refugees as do they the mental well being of Somali women in Canada. Pernice & Brook (1994) found, in a comparison of British immigrants and Indochinese refugees in New Zealand, that refugees experienced more mental health problems than did immigrants. This is consistent with findings of this study, in that participants feel their experiences as refugees, i.e. coming

from a war-torn country without any preparation or planning compounded their stresses and ultimately affected their mental well-being.

Mental health concerns related to the stresses of being a refugee, including the trauma and losses suffered, were found in Lipson, Omidian & Paul's (1995) study with Afghan refugees in the San Francisco Bay area. Difficulties in adjusting to host countries are not new phenomena. However, the difficulties Somali women face in their day-to-day experiences have previously not been studied in depth. As well, the findings in this study suggest that the status of refugee renders adjustment exponentially difficult for Somali women in Canada.

Dealing with intercultural communication within the Canadian context was discovered as a difficulty in adjusting to the refugee reality. All of the study participants spoke English well. In fact seven out of the eight women were able to converse in English prior to coming to Canada. However, all of the women described difficulties in communicating within Canada's bureaucratic system. These difficulties go beyond language barriers and thus are more difficult to deal with. For instance, one participant described two hospital nurses deciding they would not understand her, not because of an inability to speak English, but because of her accent and the fact that she wore a hijab (a veil and a traditional long gown). Further, intercultural communications were made difficult by a system that assumes Somali women's inability to communicate.

5.2 Finding A New Safety

5.2.1 Support Systems

The importance of social support networks among immigrants and refugees has been identified in previous research studies (Ralston 1988; Anderson 1991; Lynam 1985; Moghaddam & Taylor 1989; Lambert & Lambert 1985; Yusuf 1995). Inadequate systems of support have been identified as precursors to mental health concerns (Anderson

1985; Ralson 1988; 1991; Lee & Cochran 1988; Miedema & Nason-Clark 1989; Anderson 1987; 1991; Lynam 1985; Anderson & Lynam 1987; Chan 1983; Franks & Faux 1990). Furnham & Shiekh (1993), examined the concepts of social support and mental health in a study with 100 Asian immigrants in Britain. These authors found that the psychological costs of migration were mitigated by social support networks. They also found that for second generation immigrants and refugees, traditional support networks were more burdensome than helpful.

The findings within this study indicate that Somali women's systems of support are directly related to and affected by their reality as a refugee. Leaving as a refugee means leaving one's family and one's system of support behind. This was done without planning or preparation or even a desire to do so. Coming to Canada as a refugee often means coming without husband but with one's children and sometimes the children of other family members. This reality increased the need for old systems of support here in Canada. In the absence of these support systems, Somali women build and recreate new and different systems of support. Where possible, these systems of support resemble those at home. Family, extended family members and other women constitute the primary actors in these new systems of support. Those who establish systems of support are better able to mitigate the stressors experienced in day-to-day life as well as the stresses of being a female refugee in Canada. Those who do not establish a system of support risk isolation, loneliness and ultimately mental health concerns.

Health care providers serve, in many ways, as part of Somali women's system of support. Establishing a working and supportive relationship between the health care provider and the individual Somali woman was found to be a process that requires work on the part of both parties. This is similar to the findings of previous studies. For example Hamilton (1996), reported the importance of effective communication between provider

and patient as the fulcrum of a good working relationship. She suggested that effective communication skills are in fact more important than descriptions of various cultural groups as the latter tends to generalize and stereotype. This too is consistent with the finding in this study. Participants emphasized the need to consider each person as an individual with a particular history which may dictate actions more accurately than their Somali ethnicity. Similarly, Cave, Maharaj, Gibson & Jackson (1995), in a study with thirteen immigrant patients in Edmonton, Alberta found communication between doctors and patients to be crucial to an effective working relationship. Interestingly though, they found that patients did not always understand why their physicians asked questions about their culture, finding that these questions were sometimes irrelevant or intrusive. This contradicts in part the findings of this study; study participants felt questions about them as Somali women and their history were essential in establishing a supportive and working relationship. Admittedly, they suggest that establishing such a relationship takes time. Taking the time and making incremental progress was found to be key to establishing such a relationship. This is consistent again with Hamilton (1996), who quotes Masi (1988), reporting that time taken initially in establishing a patient provider relationship ultimately pays off.

Not establishing a working and supportive relationship with health providers and experiences of alienation within the health care system hinder health care access. Furthermore, racism decreases the relative accessibility of health care services. Accessibility of health care services has been described extensively, as well, by other researchers (Thompson 1993; Peters 1993; Auger 1993; Bergin 1993; Bollini 1992; Equal Opportunity Consultants 1991; Lipson 1991; Mardiros 1988; Ministry of Health 1993; Social Planning Council of Ottawa-Carleton 1988). These researchers found health care services to be inaccessible to immigrants and refugees within Canada. Health care

services were perceived by immigrants and refugees as inappropriate in a variety of ways. For example, studies found several pragmatic issues to constrain immigrants and refugees from accessing the available health services. These pragmatic constraints include, but are not limited to language barriers, insufficient knowledge on the part of the consumer regarding access to services, and transportation and financial constraints (Ministry of Health 1993; Lipson 1991; Bergin 1993; Equal Opportunity Consultants 1991; Health and Welfare Canada 1988a). This is consistent with the difficulties delineated in this study. However, racism has not, for the most part, been reported elsewhere as a significant barrier to health care services, with the exception of Anderson (1985; 1987; 1991) and Dunk (1989). The findings in this study indicate that racism acts not only as a barrier to access but as a barrier to establishing supportive relationships with health providers. Further, the study findings suggest, from the perception for participants, racism ultimately impacts one's mental health, by leading to further isolation, stress, anger and depression.

The study findings suggest that providers within the health care system can be valuable components of a Somali women's system of support, provided a positive working relationship has been established. The role of health providers as components of support systems for immigrant and refugee women has not been extensively documented elsewhere. However, these study findings suggest an important role for health care providers for female Somali immigrant and refugees who have been through the experiences of being a refugee lost their previously utilized systems of support.

5.2.2 Readjusting Family

Adjusting to a changed family structure in Canada was found, in this study, to be essential. The women spoke of the considerable difficulties that accompanied being a single parent, itself a new experience and a new concept. Single parenthood is compounded by the reality of being a refugee which involves being without their usual systems of support, new economic pressures and being in a new and unfamiliar environment.

Single parenthood increases the roles required of these women, ultimately increasing their levels of stress, anxiety and even resentment toward husbands and to some extent children, who were not helping out in ways that the women expected of them. This in turn contributed to difficulties associated with trying to be both a mother and a father, to their children. Solving these conflicts was itself hampered by the woman's reality as a single parent.

Intrafamilial problems between mother and children were complicated by two factors. First, the woman's reality as a single parent and a refugee and secondly by the expeditious rate at which children were learning English and integrating into the Canadian system. When husbands and fathers join their families in Canada, problems were found to be ameliorated to some extent, that is, at least the woman could delegate some of her responsibilities to her husband. However, intrafamilial problems between parent and children continued. Health and Welfare Canada (1988a) found problems between young immigrants and refugees and their parents were augmented by internal conflicts within the young person. For example, a strong pressure exists for youth to quickly integrate and acculturate. This federal study found school, peers and mass media as contributors to the pressures felt by immigrant and refugee youth (Health and Welfare Canada 1988a). These external pressures were complicated by a need on the part of the youth to remain true to

the values of their parents and grandparents (Health and Welfare Canada 1988a). This too is supported by the findings of this study.

Intergenerational conflict between adult children and elderly parents has been found elsewhere as a problems for immigrant and refugee families. Stahl (1993), reported several factors contributing to intergenerational conflict between adults and elderly parents. For example, elderly parents frequently arrive in a host country under the family class of immigrants and thus they are labeled as dependent. Stahl (1993), suggested that this status alters the traditional hierarchy between adult children and elderly parents. Family structure in multigenerational families within their countries of origin place the eldest male at the head of the family. Immigrating as a dependent family member alters this arrangement. Gelfand (1989) also found, in a study with older Salvadorans and their children living in Washington DC, that the traditional sources of power for elderly family members were depleted through the process of immigration. Traditional authoritative power, economic, and decision making power were found to be diminished (Gelfand 1989). Interestingly, Bond & Harvey (1991), in a study with 139 pairs of middle-aged children and their parents in Manitoba, found the father's (the middle-aged child) influence and power in decision making to be diluted as he became the sole decision-maker. Hooyman & Kiyak (1993) reported that within multigenerational families, the grandparent's position of authority is eroded as both parents and children gain an understanding of the language and the Canadian culture. Grandparent's views and their traditional knowledge is seen as irrelevant. Intergenerational conflict between adult children and elderly parents was not explored extensively within this study. However, an increased reliance by older parents on adult children was reported as problematic for the parents and something that required adjustment for grown children who were not used to having parents dependent on them.

Ali (1995), found an increase in the incidence of intergenerational conflict as traditional roles and relationships within the family were challenged. This is consistent with the findings in this study between wives and husbands. The traditional roles for both the husband and wife have shifted because of their reality as refugees in Canada. Difficult economic times, being a refugee and not being able to transfer one's working credentials, for example, were found to make it difficult for the husband to assume his role as breadwinner. The altered state of the family altered the role of the mother in her traditional responsibilities.

Intrafamilial problems within this study were found to be consistent with the literature on intergenerational conflict. Somali women's reality as single parents compounds the problems experienced with children. Prolonged absence by the father, with his eventual return to the family was found to contribute to problems between spouses. Those family members willing to change and adapt to new roles stay together as a family, but in new ways. Those unable to change and adjust experience considerable anguish, at times, ending in divorce.

5.2.3 Dealing With Perceptions of Female Circumcision

A plethora of research exists on the issue of female circumcision. The vast majority of this research has been conducted from a paternalistic and hegemonic perspective. The research conducted to date has implied that those practicing female circumcision must be informed by Westerners. For example the editor of the New England Journal of Medicine (1994) referred to the practice as "a form of child abuse" (p.739). While the editor of the British Medical Journal (1995) suggested an urgent need for the abolishment of female mutilation. The findings of this study suggested that by labeling it as female genital mutilation researchers are stigmatizing Somali women more than then they are discouraging the continuation of the procedure. Further, the stress that results from the

label of FGM and the media sensationalization of the practice was found to negatively impact the mental health of Somali women in Canada.

Some less biased writings do, however, exist. Lalonde (1995), wrote of her personal experience as a physician working with women who have been circumcised. She found that her "patients have not wanted to discuss the...experience of FGM, but indicated that they wanted to get on with their lives" (p.950). This is consistent with the study findings here. Somali women do not feel that the issue of female circumcision is central to their health and well-being. In essence it is not the 'be all and end all' issue for Somali women. Wright (1996), in an overview of female circumcision discussed the problems with Western preoccupation with female circumcision, and the ill effect such preoccupation has on the women from countries that practice the procedure. Again, Wright's (1996) findings are consistent with the findings of this study. The Somali women in this study admittedly had mixed feelings about female circumcision and the media attention it has received. On the one hand, they were pleased that there now exists an intense pressure in Canada not to have their daughters and granddaughters circumcised. However, this positive outcome of media coverage was outweighed by the negative label of being a 'victim of FGM' in the eyes of Canadians. The stress of being stigmatized as an oppressed woman who was subjected to female circumcision by an abusive mother and being seen as less than whole as a woman make the emotional sequelae of the label FGM most difficult to manage.

Some might suggest that the women discussing female circumcision, and those suggesting that 'it is not an issue within the Somali community' are denying the existence of a problem. However, to what extent are those who would suggest this imposing their own hegemonic beliefs and biases? Research conducted within a feminist perspective presumes women to be truth tellers and valid sources of knowledge in their own right

(Belenky et al 1986; Maguire 1987). Thus, if Somali women suggest female circumcision is not an issue to the Somali community, it is not an issue.

5.2.4 Returning to Religion

Turning to one's religious faith in times of trouble is not a new coping strategy (Taraki 1995). The women in this study were found to have profound faith in Islam as an ideology and religion. Wearing the hijab signified their increased faith and acted as sign to other Somalis, other Muslims and other Canadians that they are Muslim. Being Muslim accords them a respect and a sense of identity. The Koran provides them with a prescription for health, from diet to exercise, as well as a source of answers which enabled them to maintain their spiritual and mental well being. Meleis (1995), in a study with thirty Jordanian American immigrant women also found religion to be a source of strength, identity and a means of ensuring the traditional values and beliefs as Jordanians in the United States. Islam was found to be not only an important source of identity for Somali women, but an important source of solace.

5.3 Conclusion

The study findings have been discussed vis-à-vis currently available literature within the field of study, that is immigrant and refugee women's health. For the most part, the study findings reiterate what others have discovered in past research efforts: That is, one's status as an immigrant and as a refugee impacts many dimensions of one's life, and by extension one's health.

In the final chapter, these findings will be examined for their limitations. Implications and recommendations will be put forward for nursing, health and the Clinical Nurse Specialist in advanced practice.

Chapter Six - Final Conclusions

6.1 Limitations

The study has several limitations. To begin with, the majority of women who participated in this study spoke English well, were well educated and had been in Canada for some time. They are not necessarily reflective of the entire Somali community. Many Somali women coming to Canada as refugees have no English and comparatively less education. The difficulties of this latter group of women are conceivably more profound and complex. Thus transferability of the study result must be done with considerable caution. The study results are transferable inasmuch as they have delineated several concepts relevant to the process of rebuilding among Somali women in Canada.

A further limitation lies in the extent to which the methods of grounded theory were employed. The methods of Strauss and Corbin (1990), were closely followed with the exception of integration at the level of the conditional matrix. The conditional matrix is an analytic aide useful for considering the wide range of conditions, for example socio-economic class, politics and immigration policies, related to the phenomenon under study (Strauss & Corbin 1990 p. 158). Integration at this level is essential in theory building, however such integration was beyond the scope of this study. Further, the author can not claim theoretical saturation was reached in all the emerging concepts. Further work toward theoretical saturation of concepts as well as integration at the level of the conceptual matrix is required in establishing a theory about the everyday experiences and stresses of female Somali refugees in Canada. Thus, the study results are bound by these method limitations.

6.2 Implications and Recommendations

6.2.1 Nursing & Primary Health Care

The study results provide direction for nursing and health. To begin with, they reiterate the importance of a determinants of health framework. Clearly multiple factors impact Somali women's lives and ultimately their health. 'Health' to a relatively healthy group of Somali women surfaced as important in two ways 1) the obligation to maintain health within Islam and 2) Islam as a prescription for health. Health clearly transcends traditional definitions of health as well as specific perceptions of health. Health is grounded in the everyday experiences of Somali women. Thus, exploring Somali women's everyday experiences vis-à-vis a determinants of health framework is important for not only nurses, but all health care workers.

The study findings encourage nurses and health care providers, including those who espouse a humanistic and holistic approach in their practice, to further expand the boundaries of their conception of health and the factors that determine it. For instance, the researchers view toward health and the factors that determine it expanded throughout the research process. Admittedly, the researcher's view of health was broad and holistic prior to the study. However, the researcher had not consciously considered, a priori, the integral role religion could play in health. Ultimately, the researcher came to realize that the determinants of health are not limited to those espoused by the Premier's Council on Health (1991); social support, one's living and working environment, socio-economics, individual behavior and health care services. Rather, the researcher came to realize a multitude of factors determine one's health. Thus, nurses and health care professionals alike are encouraged to similarly expand their conceptions of health.

6.2.2 The CNS & Advanced Practice

The study findings have implications for the Clinical Nurse Specialist (CNS) specifically and advanced practice in general. The CNS, according to Hamric and Spross (1989), functions within six sub-roles. These sub-roles include, CNS as clinical practitioner, consultant, educator, collaborator, leader and researcher. The study implications and recommendations will be explored within these sub-roles.

There are several implications for the CNS in their direct patient care or clinical role. The CNS practicing in Canada can use the findings of this study to better understand the concerns of Somali clients. In fact, the study results can be applied in clinical practice to better understand the potential concerns of all clients. By considering the context in which clients live, their past and present, the CNS is more likely to provide appropriate, acceptable and thus accessible health care services. Considering the everyday experiences of all individuals is essential in the advanced practice of the Clinical Nurse Specialist.

As a consultant, the CNS can encourage those with whom they consult to consider the broader context of client's lives. The CNS in community health centers may be consulted about a community of immigrants, refugees or minority clients. The study results encourage nurses to consider client history and context; taking the time to find out what is important, not only to a particular community, but to the individual. Individuals within a culture are as unique as the culture itself. A willingness to learn and from communities and individual clients is essential.

The CNS in the role as educator can facilitate staff and student practitioners' sensitivity to the concerns of Somali women in particular and immigrant and refugee women in general. This can be done in part by encouraging nursing to emphasize the psychosocial and cultural assessment of clients. The CNS educator's role is not necessarily to educate nurses as to 'what the Somalis do' in relation to health or illness,

rather, it is the CNS's role to inculcate positive attitude to multiculturalism that values and accepts diversity. Further, it is important to ensure that the client plays the central role in defining the issues of importance to them.

The study findings hold implications for the CNS in their role as collaborator and leader, as well as for the larger Canadian population, government, policy and the media. Given the study findings, the CNS can serve as an advocate and a leader in change in the factors that impact the lives of Somali women in particular and immigrant and refugee women in general. As health care professionals, it is the responsibility of nurses to work intersectorially with government. As health providers we must advocate for policies and programs that 1) assist the refugee in managing the stressors that impact their everyday experiences and 2) inform the general population of the plight of refugees and encouraging an environment of cooperation and understanding as refugees work within the Canadian context, rebuilding both their health and their lives. Finally, media must be lobbied to present fair and honest accounts of refugees and the difficulties they encounter as newcomers to Canada.

The implications for the CNS in the role of researcher are many. As researchers, CNSs can facilitate and advocate for research that takes a feminist perspective to the study of newcomers to Canada. Recommendations are that CNSs advocate for a participatory model in research with immigrant and refugee women. For example, one study participant underlined the need for members of the Somali community to be involved in future research endeavors. She suggested that there is a wealth of untapped talent within the Somali community; unemployed or under-employed nurses, doctors and highly educated individuals who would and could become involved in future work. It is recommended that the study be replicated, within a participatory research model, with Somali women here in Canada who do not speak English as fluently as the participants of this study. Obtaining

the perspective of these women is vital in delineating the everyday experiences of being a female Somali immigrant and refugee in Canada. These recommendations further increase the credibility and transferability of future studies.

Finally, in conclusion, Canada continues to receive Somali refugee claimants as the situation in Somalia remains unstable and unsafe. Recommendations for further research within the Somali community is required to truly understand not only the everyday experiences and stresses of Somali women, but of Somali men, Somali children and Somali families. Delineating these experiences will assist health care providers in offering services that are appropriate, acceptable and thus accessible.

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Appendix A: Letter of Ethical Approval



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Faculté des sciences de la santé
Cabinet de la doyenne

Faculty of Health Sciences
Office of the Dean

July 9, 1996

Student Robin Lynn Woods
Professor Marilyn Mardiros
School of Nursing
Faculty of Health Sciences
Roger Guindon Hall
INTRA

Subject: Your project entitled "Somali Women's Perceptions of Health and Illness"

Dear Student:

It is my pleasure to inform you that the Faculty of Health Sciences, Human Research Ethics Committee, after study of the documentation provided, concluded that your project met the appropriate standards of ethical acceptability and falls within **CATEGORY 1A**.

I hereby attach a copy of the certificate of clearance granted by the University Human Research Ethics Committee.

This certificate is valid for a period of one year from the time of issuance. I would also like to remind you that, in accordance with the policies of the UHREC, it is your responsibility to notify the Committee of any major changes in this project.

On behalf of the Committee, I wish you success in your project.

Sincerely,

J. Roger Proulx, Ph.D.
Chair, Human Research Ethics Committee

Encl.



Université d'Ottawa · University of Ottawa

Faculté des sciences de la santé
Cabinet de la doyenne

Faculty of Health Sciences
Office of the Dean

CERTIFICATION OF INSTITUTIONAL HUMAN RESEARCH ETHICS COMMITTEE FACULTY OF HEALTH SCIENCES

This is to certify that the Institutional Human Research Ethics Review Committee of the Faculty of Health Sciences has examined the research proposal by **Robin Lynn Woods**, a Student from the **School of Nursing** for the project entitled: *"Somali Women's Perceptions of Health and Illness"* and concludes that, in all respects, the proposed research protocol meets the appropriate standards of ethical acceptability, at a **Category 1A** level.

MEMBERS OF THE COMMITTEE

<u>Name (Optional)</u>	<u>Position held</u>	<u>Department of discipline</u>
Victor Boucher	Professor	Audiology and Speech-Pathology Program
François Tremblay	Professor	Physiotherapy Program
Claire-Jehanne Dubouloz	Professor	Occupational Therapy Program
Ann Watters	Student	School of Nursing
Jocelyne Tourigny	Professor	School of Nursing
Julian Roberts	Professor	Department of Criminology
Roch Paquin	Member-at-Large	
J. Roger Proulx	Chair	Human Research Ethics Committee School of Human Kinetics

SIGNATURE

09/07/1996

Date

Committee Chairperson - J. Roger Proulx, Ph.D.

Appendix B: Letter to CHC Executive Director



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Faculté des sciences de la santé
Ecole des sciences infirmières

Faculty of Health Sciences
School of Nursing

Dear Executive Director,

I am a registered nurse presently completing a Masters of Science in Nursing at the University of Ottawa. I have concentrated my studies on the health of immigrant and refugee women. I have recently completed a clinical placement at Pinecrest-Queensway Health and Community Center (P.Q.). This experience was invaluable as it was well suited to my interests in immigrant and refugee health, as P.Q. serves a large population of immigrants and refugees.

Please accept the enclosed; requesting permission to conduct a research study with Somali women within the catchment of P.Q. The proposed study would commence in September of 1996. The purpose of this research project is to understand Somali Women's Perceptions of Health and Illness and the every day concerns which affect Somali women in Canada. Furthermore, the study will examine how these things affect the manner in which Somali women seek help when they are ill as well as how they keep themselves healthy. The women who agree to be involved in the study will be interviewed at least twice. I will be asking questions about their health in both Somalia and in Canada. We will talk about the every day things that make it easier for them to keep themselves healthy as female Somali immigrants or refugees living in Canada. Each interview will have a duration of about one and a half hours and will be audio tape recorded. The women will be given an identification number and their name and identity will not be associated with the tapes or any documents that results from the study. Only myself, my thesis committee and a typist will have access to these tapes. The tapes will be kept in my home in a locked cabinet. Upon the completion of the research, the tapes will be erased.

There may be no direct benefits to the women as participants of this study, but there may be changes in the care immigrant and refugee women receive following the completion of the study. There are no physical risks associated with this study, however, because we will be talking about their experiences as Somali refugees or immigrants there is a small potential for psychological discomfort. If this should occur they will be free to discuss their feelings with myself or I will refer them to the appropriate person within Pinecrest Queensway.

The women participating may refuse to answer any questions during the interviews. They will be free to withdraw their consent and terminate their participation in this study at any time without penalty. They will be given the opportunity to ask, and have answered, whatever questions they desire. A summary of the study's findings will be made available to them upon completion of the project.



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Faulté des sciences de la sant 
Ecole des sciences infirmi res

Faculty of Health Sciences
School of Nursing

I have been working with Sahra Habbane (outreach worker) and Victoria Stafford (RN Nurse Practitioner) in the preparation of this study. Sahra Habbane has agreed to assist me in the recruitment of participants. We will be distributing a letter requesting the involvement of Somali women in July 1996.

The study has received approval from the University of Ottawa, University Human Research Ethics Committee, Faculty of Health Sciences and Thesis Committee. Please contact Dr. Roger Proulx, President, Human Research Ethics Committee, at xxx-xxxx, ext. xxxx if you have specific questions regarding the University of Ottawa's research ethics approval for this study.

Thank you for considering this proposal. I look forward to your response.

Robin L. Woods RN, BScN, MScN (candidate)

Street.

City, Province. Postal Code

Phone: xxx-xxxx

Appendix C: Participant Letter of Information



Université d'Ottawa • University of Ottawa 145

Faulté des sciences de la santé
Ecole des sciences infirmières

Faculty of Health Sciences
School of Nursing

Dear Potential Participant,

I am a registered nurse and am presently enrolled in the Masters of Science in Nursing program at the University of Ottawa. My studies have focused on immigrant and refugee women's health. I am conducting a research study with Somali women. The purpose of this research project is to understand Somali women's perceptions of health and illness and the every day concerns which affect Somali women in Canada. Furthermore, the study will examine how these things affect the manner in which Somali women seek help when they are ill as well as how they keep themselves healthy. I believe understanding these perceptions is the first step to providing acceptable health care services to the Somali community.

The study will begin in September of 1996. If you agree to be involved in the study, I will interview you at least twice. I will be asking questions about your health in both Somalia and in Canada. We will talk about the every day things that make it easier for you to keep yourself healthy as a female Somali immigrant or refugee living in Canada. Each interview will have a duration of about one and a half hours and will be audio tape recorded. You will be given an identification number and your name and identity will not be associated with the tapes or any documents that results from this research. Only myself, my thesis committee and a typist will have access to these tapes. Only I will know your name and identification number. The tapes will be kept in my home in a locked cabinet. Upon the completion of the research, the tapes will be erased.

There may be no direct benefits to you as a participant of this study, however there may be changes in the care immigrant and refugee women receive following the completion of the study. There are no physical risks associated with this study, however, because we will be talking about your experiences as a Somali refugee or immigrant there is a small potential for psychological discomfort. If this does occur you will be free to discuss your feelings with myself or I will refer you to the appropriate person within Pinecrest Queensway.

You may refuse to answer any question during the interviews. You will be free to withdraw your consent and terminate your participation in this study at any time without penalty. If you should decide to terminate your participation the audio tapes would immediately be destroyed. You will be given the opportunity to ask, and have answered, whatever questions you desire. A summary of the study's findings will be made available to you upon completion of the project.

451, ch. Smyth
Ottawa (Ontario) K1H 8M5 Canada

451 Smyth Rd.
Ottawa, Ontario K1H 8M5 Canada

(613) 562-5473 • Téléc./Fax (613) 562-5443



Université d'Ottawa • University of Ottawa 146

Faulté des sciences de la santé
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Faculty of Health Sciences
School of Nursing

The study has received approval from the University of Ottawa, University Human Research Ethics Committee, Faculty of Health Sciences and Thesis Committee. Please contact Dr. Roger Proulx, President, Human Research Ethics Committee, at 562-5800, ext. 4251 if you have specific questions regarding the University of Ottawa's research ethics approval for this study.

Thank you for taking the time to consider my request. If you are interested in participating please feel free to contact me at the address and phone number provided below.

Sincerely,

Robin L. Woods RN

Phone: xxx-xxxx

Supervisor : Marilyn Mardiros, RN Ph.D.

Phone: xxx-xxx-xxxx, ext. xxxx

Appendix D: Consent



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Faulté des sciences de la sant 
Ecole des sciences infirmi res

Faculty of Health Sciences
School of Nursing

Project Title: Somali Women's Perceptions of Health and Illness
Investigator: Robin L. Woods, RN BScN MScN student
Address: Street. City, Province Postal Code
Phone: xxx-xxx-xxxx
Supervisor: Marilyn Mardiros, RN Ph.D. Associate Professor, Thesis Committee Chair
Phone: xxx-xxx-xxxx, ext. xxxx
Affiliation: University of Ottawa

The purpose of this research project is to understand Somali women's perceptions of health and illness and the every day concerns which affect Somali women in Canada. Furthermore, the study will examine how these things affect the manner in which Somali women seek help when they are ill as well as how they keep themselves healthy. You will be interviewed at least twice. I will be asking questions about your health in both Somalia and Canada. We will talk about the every day things that make it easier for you to keep yourself healthy as a female Somali immigrant or refugee living in Canada. Each interview will have a duration of about one and a half hours and will be audio tape recorded. You will be given an identification number and your name and identity will not be associated with the tapes or any documents that results from the study. Only myself, my thesis committee and a typist will have access to these tapes. Only I will know your name and identification number. The tapes will be kept in my home in a locked cabinet. Upon the completion of the research, the tapes will be erased.

There may be no direct benefits to you as a participant of this study, but there may be changes in the care immigrant and refugee women receive following the completion of the study. There are no physical risks associated with this study, however, because we will be talking about your experiences as a Somali refugee or immigrant there is a small potential for psychological discomfort. If this does occur you will be free to discuss your feelings with myself or I will refer you to the appropriate person within Pinecrest Queensway.

You may refuse to answer any questions during the interviews. You will be free to withdraw your consent and terminate your participation in this study at any time without penalty. Your status of refugee will not be jeopardized by accepting or not accepting to participate in this study. You will be given the opportunity to ask, and have answered, whatever questions you desire. A summary of the study's findings will be made available to you upon completion of the project.



Université d'Ottawa · University of Ottawa

Faulté des sciences de la santé
Ecole des sciences infirmières

Faculty of Health Sciences
School of Nursing

Consent Con't

The study has received approval from the University of Ottawa, University Human Research Ethics Committee, Faculty of Health Sciences and Thesis Committee. Please contact Dr. Roger Proulx, President, Human Research Ethics Committee, at 562-5800, ext. 4251 if you have specific questions regarding the University of Ottawa's research ethics approval for this study).

THIS IS TO CERTIFY THAT I, _____ HEREBY agree to participate as a volunteer in the above-named project.

I understand that there will be no health risk to me resulting from my participation in the research.

I hereby give permission to be interviewed and for these interviews to be tape-recorded. I understand that, at the completion of the research, the tapes will be erased. I understand that my name and identity will not be associated with the tapes or any documents resulting from this research.

I understand that I am free to deny any answer to specific questions during the interviews. I also understand that I am free to withdraw my consent and terminate my participation at any time, without penalty. I understand that my status of refugee will not be jeopardized by accepting to participate in this study.

I have been given the opportunity to ask whatever questions I desire, and all such questions have been answered to my satisfaction.

Participant: _____

Witness: _____

Researcher: _____ Date: _____

Appendix E: Interview Schedule

Part A: Socio Demographics

Languages Spoken:	
Employment:	
Present Immigration Status:	
Number of Children:	
Household Constellation in Canada:	
Age:	
Languages Written:	
Time of Migration:	
Immigration Status upon Arrival:	
Household Constellation in Somalia:	
Route of Migration:	

Part B: Health in Somalia

The following questions are a sample of the potential questions to be asked. Questioning may change during the interviews to reflect areas of interest to the participants, the researcher and evolving concepts.

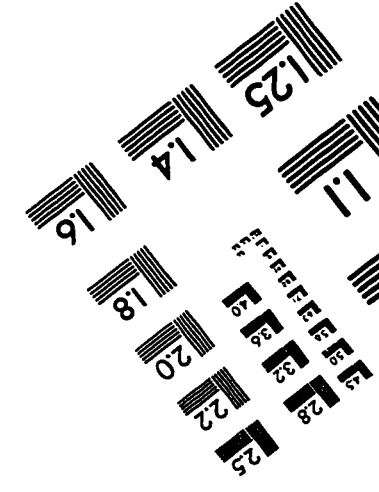
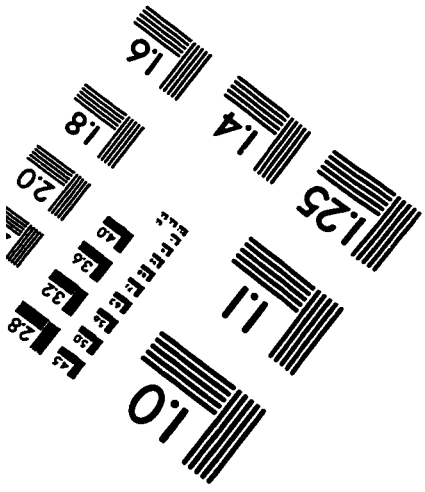
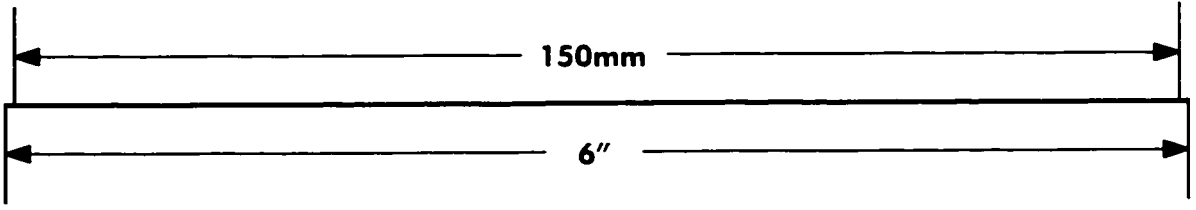
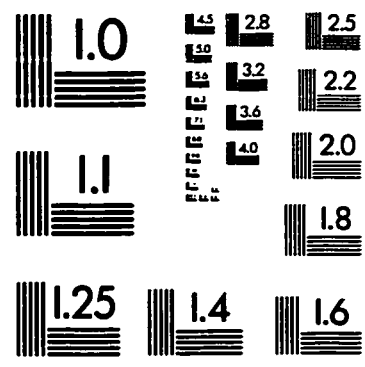
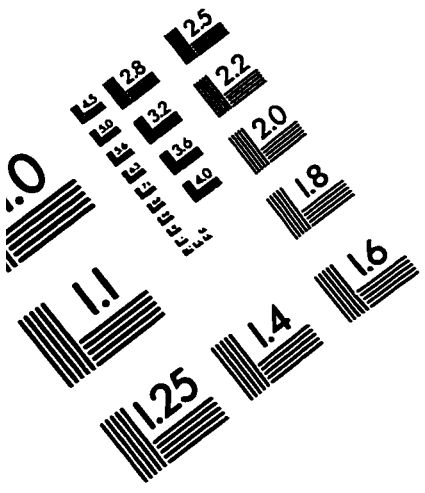
1. How did you keep yourself/ healthy in Somalia?
2. Describe a healthy person/family/community.
3. What things made it easy/difficult for you to keep yourself healthy in Somalia?
4. In Somalia who took care of a sick family member?
5. How did you/other take care of a sick family member/yourself?
6. Who would take care of you if you were sick?

- 7. What made it difficult for a women when she was sick in Somalia?**
- 8. How did it feel to take care of a sick family member?**
- 9. Who did you go to see when you were sick?**
- 10. Who made the decision to seek this person's help?**
- 11. How was the decision made?**
- 12. What things made it easier/difficult for you to care for yourself when you were sick?**
- 13. What things made it easy/difficult to seek help for yourself/family when they were sick?**
- 14. Has your health changed since coming to Canada?**

Part C: Health in Canada

15. Questions 1 - 14 within the Canadian context.
16. How has being a women without her husband made it difficult/easier to keep yourself/family healthy?
17. How has being a women without her husband made it difficult/easier to get help when you/family are sick?
18. How do child care problems impact how you keep yourself/family healthy?
19. How do child care problems impact how you seek help when you are sick?
20. How do child care problems impact how well you can do what the health provider recommends?
22. How does your job or lack of employment affect 18-20?
23. How does language affect 18-20?
24. How do your living arrangements affect 18-20?
25. Who are your support systems?
26. How do these people affect 18-20?
27. Do you have any present health concerns?
28. How do you deal with this problems?
29. What is it like living with and treating ?

IMAGE EVALUATION TEST TARGET (QA-3)



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