Exploring Syrian refugee women's sexual and reproductive health experiences: A multi-methods qualitative study in Ottawa, Ontario

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Abstract

Since 2015 Canada has welcomed 44,620 Syrian refugees. The research on Syrian refugees in Canada has mainly focused on their immediate health needs, communicable diseases, and chronic illnesses. Aside from maternal health, the sexual and reproductive health (SRH) needs of Syrian refugee women is undocumented in Canada. To address this gap in the literature we conducted a qualitative study in Ottawa, Ontario that involved in-depth interviews with Syrian refugee women and individuals who provide health services to them.

When accessing SRH services Syrian women identified a preference for women providers, faced difficulty adjusting to societal norms during the perinatal period, felt that contraception counselling was not culturally informed, and struggled with their maternal mental health. Key informants mainly echoed these findings and expressed a need for more cultural competency/humility training, interpretation services, and trauma-informed counselling. The path to improving SRH services for Syrian women is complex, but highly warranted.

Résumé

Depuis 2015, le Canada a accueilli 44 620 réfugiés syriens. La recherche sur les réfugiés syriens au Canada se préoccupe surtout sur leurs besoins de santé immédiats, les maladies transmissibles, et les maladies chroniques. Autre que la santé maternelle, la santé sexuelle et reproductive (SSR) des femmes réfugiées syriennes n'est pas documentée au Canada. Afin d'adresser cette pénurie de littérature scientifique, nous avons conduit un projet de recherche qualitative à Ottawa en Ontario, consistant d'entretiens en profondeur avec des femmes réfugiées syriennes et les individus qui leur fournisse des soins de santé.

Les réfugiées syriennes ont exprimé : qu'elles préféraient avoir une femme comme fournisseur lorsqu'elles recevaient des soins SSR, elles ont eu de la difficulté à ajuster aux normes sociales lors de la période prénatale, les conseils sur la contraception n'étaient pas adaptés à leur culture, et elles ont vécu des troubles de santé mentale maternelle. Les entretiens avec les informateurs clés supportent ces données, et de plus, surligne une nécessité pour des formations sur les compétences culturelles et la sensibilisation, des services d'interprétation, et des services centrés sur le traumatisme. L'amélioration des services SSR pour les femmes réfugiées syriennes est impérative, et va nécessiter un effort important.

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List of acronyms and abbreviations

CHC	Community Health Center
FHT	Family Health Team
FIGO	Federation of Gynecologists and Obstetricians
GAR	Government assisted refugee
IDI	In-depth interview
IFHP	Interim Federal Health Plan
IPV	Intimate partner violence
IUD	Intra-uterine device (non-hormonal IUD)
IUS	Intra-uterine system (hormonal IUD)
KI	Key informant
LHIN	Local Health Integration Network
MENA	Middle East and North Africa
MISP	Minimum Initial Service Package
OB/GYN	Obstetrician gynecologist
OCPs	Oral contraceptive pills
ODSP	Ontario Disability Support Program
OHIP	Ontario Health Insurance Plan
OLIP	Ottawa Local Immigration Partnership
ONHC	Ottawa Newcomer Health Center
OW	Ontario Works Program
Pap test	Papanicolaou test
PPD	Postpartum depression

PSRs	Privately sponsored refugees
REB	Research Ethics Board
SRH	Sexual and reproductive health
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Chapter 1: Introduction

1.1 Background

1.1.1 *Sexual and reproductive health in pre-conflict Syria*

Prior to the 2011 Syrian civil war, modern sexual and reproductive health (SRH) services for Syrian women were available. However, many socio-cultural and religious influences shaped use of and access to these services. Syria is a predominantly Muslim country where the creation of a traditional family unit and fertility within a marriage is central to society (Bowen, 1997). Thus reproductive health services were developed for married women of reproductive age; unmarried women were often unable to ask for or receive services and risked moral judgement by providers and breaches of confidentiality when they did (Roudi-Fahimi et al., 2012). As a result, SRH services were practically non-existent for unmarried youth (DeJong et al., 2005).

In pre-war Syria, education was often cited as the "single most important determinant of both age at marriage and age at first birth in MENA [Middle East and North Africa] countries, since women in the region tend to give birth soon after marriage." (Roudi-Fahimi & Moghadam, 2006, p. 6). According to the United Nations Children's Fund (UNICEF) in 2012 the secondary school enrolment for Syrian girls was 67.8% (UNICEF, 2013). Early marriage, defined as marriage under the age of 18, affects access to and knowledge of SRH, and rates were estimated in Syria at 8.5% in 2009 and increased to 12% in 2011 and 18% in 2012 after the conflict began (Abdulrahim et al., 2017; Sieverding et al., 2020). Finally, employment affects women's knowledge and use of SRH services and around 20% of women ages 15 or older in MENA countries are employed, which is one of the lowest rates of female employment in the world (Roudi-Fahimi & Moghadam, 2006).

Modern methods of contraception were available in pre-conflict Syria but the broader dynamics mentioned above impacted use. Although Islam highly values fertility, non-permanent methods of contraception are deemed religiously permissible with both Sunni and Shi'a jurisprudence when used within the context of marriage; socio-cultural norms favor use of contraception after the birth of one or more children (Boonstra, 2001). The Population Reference Bureau looked at Arab women's unmet need for contraception in 2012, before most Syrians fled the country. In Syria at that time, the total fertility rate was 3.5 children per woman, 41% of women aged 20-24 were married, and 47% of married women aged 15-49 were using some form of contraception (Roudi-Fahimi et al., 2012). This study showed that 21% of married Syrian women who wished to avoid pregnancy were not using any form of contraception and this was mainly due to fear of side effects (19%), husband's disapproval (13%), a fatalistic belief that conception is God's decision (12%), dislike of available options (9%), and religious prohibition (3%) (Roudi-Fahimi et al., 2012). The majority (63%) of married women in Syria involved their husband in the decision to use contraception, 27% stated that their husband had the final say, and 30% of husbands were opposed to contraception (Roudi-Fahimi et al., 2012). Notably, no information about unmarried women was collected as part of this study because of the social taboos surrounding sex outside of marriage.

In Syria, abortion is only legally permissible to save the life of a woman; it is not allowed in the case of rape, incest, fetal impairment, or to preserve the woman's physical or mental health (United Nations (UN), 2014). Bowen explains that according to Islamic theologians there is a wide range of positions regarding the religious permissibility of abortion, ranging from complete prohibition after ensoulment has occurred to abortion being acceptable within the first 120 days of pregnancy without restriction as to reason (Bowen, 1997). Between 1995 and 2000 it was

estimated that 653,985 unsafe abortions were performed in Syria, 580 women "officially" died due to complications of their abortions during this period (Hessini, 2007). However, post-abortion care is part of the Syrian national sexual and reproductive health program (Hessini, 2007).

In pre-conflict Syria, women had routine access to maternity services; 97% of births were attended by a skilled professional and the maternal mortality ratio was 49 deaths per 100,000 live births (World Health Organization [WHO], 2015a). In terms of antenatal care, according to UNICEF in 2012, 87.7% of women had at least one antenatal visit before birth and 63.7% had at a least four visits (UNICEF, 2013). The most noticeable outlier in maternal health indicators in pre-war Syria was the rate of births by caesarean section; at 26.4% the Syrian caesarean section rate was roughly double the WHO's suggested rate of 10-15% (WHO, 2015b). One study suggested that this higher rate was related to "over-medicalization" of delivery and the liberal use of caesarean section by men physicians (Jurdi, 2004). Syrian women tend to prefer women health care professionals when dealing with reproductive health concerns and childbirth in particular; in one survey more than 85% of women reported that they would prefer a woman obstetrician (Bashour & Abdulsalam, 2005). The dynamics shaping maternal health in pre-war Syria set the context for how SRH services may be perceived and used once displacement occurs.

A recently published study that interviewed women in Aleppo just before the Syrian civil war began showed that Syrian women perceive their communities and neighbourhoods to be important factors in their health and well-being (Ahmad et al., 2019). This is not unexpected, but gives insight to the health challenges these women may face in both displacement and resettling in a new country. There is some evidence from just before the conflict began that indicates Arab

women were already experiencing more incidents of postpartum depression related to lack of support, experiences of violence, increased expectations of motherhood, and patriarchal kinship (Yount & Smith, 2012). Postpartum depression and social support from one's community in the postpartum period could impact Syrian women's experiences of maternal health in other countries.

1.1.2 *SRH of displaced Syrian women*

The Syrian civil war began in 2011 and the large influx of Syrians fleeing the country began in January of 2013 and then steadily increased (UNHCR, Government of Turkey, 2020). According to the United Nations High Commissioner for Refugees (UNHCR), at the end of 2019 there were 26 million refugees globally and 6.6 million, or 25% of those refugees, were from Syria (UNHCR, 2020). As of August 2020, 5.6 million Syria refugees were registered, 2 million by the UNHRC and 3.5 million by the Government of Turkey (UNHCR, Government of Turkey, 2020). The vast majority (65%) of Syrian refugees were living in Turkey with the remaining in Lebanon, Jordan, Iraq, Egypt, and North Africa; 93% of refugees are living in urban, peri-urban, or rural settings and only 5% reside in refugee camps. Nearly 20% of all refugees are women between the ages of 18 and 59 (UNHCR, Government of Turkey, 2020).

Syrian women's access to maternal health services was unquestionably affected by their displacement from Syria. Following Turkey, Lebanon hosts the next largest number of Syrian refugees, mainly in urban settings (UNHCR, Government of Turkey, 2020). A field-based survey in 14 geographic areas of Lebanon found that pregnant Syrian refugee women were receiving antenatal care at a similar rate to the rate in pre-conflict Syria: 87.7% for one visit and 63.7% for three or more visits (Benage et al., 2015; UNICEF, 2013). This study also documented that

Syrian women over the age of 35 were particularly vulnerable due to more insecure living arrangements, less frequent antenatal visits, less desire to have current pregnancy, and decreased access to contraception (Benage et al., 2015). The rate of caesarean section was reported as 35% for Syrian women in Lebanon, largely due to Lebanon's "over medicalized" birth process and the large private health care sector encouraging non-medically indicated caesarean sections due to lack of physician accountability (Huster et al., 2014).

In Lebanon, Benage and colleagues found that almost three quarters of pregnant Syrian women wished to prevent future pregnancy and over half did not want their current pregnancy. However, 42.3% had not been using contraception prior to pregnancy and their desired method was oral contraceptive pills (OCPs) (33.6%) followed by the intrauterine device (IUD) (21.3%) (Benage et al., 2015). Studies in Turkey indicated that the IUD was the most preferred method of contraception and there was a high preference towards traditional methods such as withdrawal, with one study citing that 47.9% preferred this method (Çöl et al., 2020; Gümüş Şekerci & Aydın Yıldırım, 2020). A study by Masterson and colleagues found that 69.3% of Syrian women in Lebanon knew about contraception but only 34.5% were using a method (Masterson et al., 2014). In their qualitative study with women living in a refugee camp in Lebanon, West and colleagues identified barriers to contraception as lack of awareness of services, overburdened health services, cultural pressures regarding fertility, and poorly trained service providers (West et al., 2017). Similar to pre-conflict Syria, women were concerned about the side effects of contraceptive methods and had many misconceptions about potential side effects with one study in Turkey citing that half their participants had false beliefs about the side effects of contraception (Gümüş Şekerci & Aydın Yıldırım, 2020). One example of a misconception is that many women were concerned if contraception is used before the birth of the first child it will

make the woman sterile or less fertile (West et al., 2017). Finally, a qualitative study in Lebanon showed that Syrian women's interest in contraception increased after displacement because of situational uncertainty, but women aged 18-25 who had not reached desired family size or had not had a boy reported no desire for contraception (Kabakian-Khasholian et al., 2017).

General barriers to accessing SRH services in Lebanon were reported as cost, distance or transportation, fear of mistreatment, security concerns, shame, unavailability of a woman physician, and insufficient provision of services (Masterson et al., 2014). Studies in both Turkey and Lebanon suggest that some Syrian refugee women were concerned that their husbands would take a second wife if they did not produce or continue to produce children, especially boys (Dikmen et al., 2018; Kabakian-Khasholian et al., 2017). Finally, a study in Turkey on Syrian refugee women's reproductive health found that 55.8% of participants were in consanguineous marriages, defined as a marriage between close familial relations, a practice that is relatively common in Arab countries (Şimşek et al., 2018). This type of marriage increases the risk of still birth, congenital abnormalities, recessive genetic conditions, and infant morbidity and mortality (Bittles, 2013).

Displaced Syrian women living in Lebanon were at an increased risk of facing violence from both their partners and their community, which is shown to cause an increase in reproductive health and pregnancy complications (Usta & Masterson, 2012). Syrian women's reproductive health in displacement is disproportionately affected by the increase in gender-based violence (GBV) "particularly intimate partner violence, early marriage, transactional sex, sexual assaults, as well as lack of access to emergency obstetric care, limited access to contraception, forced caesarean sections, and the high cost of healthcare services" (Yasmine & Moughalian, 2016, p. 28). A qualitative study in Lebanon showed that Syrian women felt

pressured into early marriage due to financial hardship and situational uncertainty (Cherri et al., 2017). Early marriages are known create barriers to accessing contraception such as minimal knowledge of contraception and lack of acceptance from partners and community (El Arab & Sagbakken, 2019).

During a humanitarian crisis the Minimum Initial Service Package (MISP) for reproductive health is a set of services and priorities that are implemented, but there are many barriers to accessing these services and transitioning to comprehensive SRH care (Amiri et al., 2020; IAWG, 2018). Amiri and colleagues outlined barriers that displaced Syrian women had accessing SRH services through the MISP and they included, living outside a refugee camp, cost of services, poor SRH health literacy and misconceptions, gender-based violence, especially early marriage, and inadequate HIV and STI coverage (Amiri et al., 2020).

1.1.3 Syrian refugees in the Canadian context

The Government of Canada indicates that 44,620 Syrian refugees arrived in Canada between November 4, 2015 and October 31, 2020, and resettled in 36 cities across the country. Just over half of those were government-assisted refugees (GARs) with the remaining as mainly privately sponsored refugees (PSRs) and a few thousand blended visa office-referred refugees (Government of Canada, 2017a). In 2015, Ontario accepted 11,400 Syrian refugees in six cities, Windsor, London, Ottawa, Toronto, Kitchener, and Hamilton (Government of Ontario, 2018). These cities were chosen because they had existing refugee supports in place and the government also helped them set up Resettlement Assistance Programs (RAPs) designed to provide immediate and essential support for the Syrian refugees' most basic needs (Government of Canada, 2017a). The health care costs incurred by Syrian refugees in Ontario is paid for through

the Interim Federal Health Program (IFHP) for up to 12 months after which the Ontario Health Insurance Plan (OHIP) covers health care expenses (Government of Ontario, 2018). IFHP covers dental care, vision care, and prescription medications which would not be covered once transitioned to OHIP (Hansen & Huston, 2016).

A report by Immigration, Refugees and Citizenship Canada evaluated the first year after Syrian refugee resettlement and indicated that privately sponsored refugees (PSRs) had their immediate needs met more often than government assisted refugees (GARs). The report further indicated that due to the rapid nature of the resettlement there were issues with lack of permanent housing and inadequacy of income support for GARs (Immigration, Refugees and Citizenship Canada, 2016). The Government of Canada reflected on the Syrian refugee resettlement initiative and disclosed that GARs had much more complex health needs, specifically related to trauma, than anticipated and this had not been properly communicated to the organizations and health care professionals preparing for their arrival (Government of Canada, 2017b).

In Canada, research on the health of Syrian refugees initially focused on preparing for their arrival by anticipating their health needs and then moved towards evaluating their experiences and health outcomes. The most immediate needs of Syrian refugees were identified as immunizations and dental care (Hansen et al., 2016). A major consideration when addressing immediate health needs was understanding that newly arrived Syrians were simultaneously trying to find housing and schools, integrate into their community, and create social networks; a health equity lens is necessary with this population (Hansen & Huston, 2016; Pottie et al., 2018). Later studies showed that the main chronic health concerns for Syrian refugees were cardiovascular disease, diabetes, musculoskeletal diseases, mental and physical disabilities, and

mental illness (Oda et al., 2017). This research has been a substantial start but there is a notable absence of Syrian voices from all of the studies.

In Canada, there has been some research on Syrian women's maternal health but no research on other reproductive health needs. This gap aligns with the findings of a systematic review looking at reproductive health of migrant women to Western countries that found that when it comes to migrant women's reproductive health research, it tends to focus on maternal health and ignores important aspects such as menopause, sexual health, contraception, and abortion (Gagnon & Redden, 2016). In Calgary, Winn and colleagues interviewed 10 health care professionals who provided prenatal care to Syrian refugee women and found that challenges navigating the health care system, language barriers, and cultural barriers, including wanting a woman provider, shaped use of and experiences with care (Winn et al., 2018). Another study team in Saskatoon interviewed 12 Syrian refugee women to assess maternal depression and found that half of the participants had depressive and anxiety symptoms and two had symptoms of post-traumatic stress disorder (Ahmed et al., 2017). It was expected that mental health would be a top priority for Syrian refugees, but there were concerns that Canada's health care system was not equipped to respond in a trauma-informed and culturally sensitive manner to these needs (Colborne, 2015). Most recently, Guruge and colleagues interviewed 58 Syrian women in multiple focus groups throughout the Greater Toronto Area. Their article highlighted that Syrian women faced chronic health issues exacerbated by trauma from the conflict, significant language and system barriers to accessing health care services, unmet expectations of health care in Canada, and they briefly touched on gender-appropriate services for reproductive health (Guruge et al., 2018).

There have also been several studies in Canada assessing the reproductive health needs of immigrants, migrants, and refugees but most were done before the arrival of Syrian refugees or do not focus specifically on this population. However, their findings could be relevant to the Syrian population. A systematic review by Pottie and colleagues identified a clinical guideline for immigrants and refugees migrating to Canada; the section on women's health emphasized the need to immediately screen for unmet contraceptive needs and give women full autonomy over their choice of method (Pottie et al., 2011). A study in Calgary assessed differences in the use of abortion services between immigrant and Canadian-born women and found there was no difference. However, the authors did identify that immigrant women more than Canadian-born women were not using contraception prior to obtaining the abortion because of fear of side effects (du Prey et al., 2014). In 2009, Newbold and Willinsky looked at health care providers' experiences providing SRH care to immigrants and identified four themes shaping the care dynamic: language barriers, the role of gender in contraception decisions, misconceptions or lack of knowledge about contraception, and cultural sensitivity (Newbold & Willinsky, 2009). Finally, Aptekman and colleagues interviewed women at a refugee health clinic in Toronto and found that 26.8% of women had unmet contraceptive needs and the reasons cited included lack of access, lack of knowledge about various methods, and having priorities other than contraception upon resettlement (Aptekman et al., 2014). Urindwanayo and colleagues identified through a narrative review that immigrant women in Canada face increased antenatal and postpartum mental health issues due to structural barriers in the health care system including lack of cultural competency training, lack of social support, and poverty (Urindwanayo, 2018). In a retrospective cohort study looking at gynecological referrals for refugee women in Toronto, only 29% the of women who were referred to a gynecologist had had a previous Papanicolaou test

(Pap test) before arrival to Canada (Silverberg et al., 2018). Finally, a recent Canadian scoping review by Zivot and colleagues investigated the gendered experiences of health care for refugees and propose that the health barriers refugees face are often exacerbated by gender-based inequities, particularly for women (Zivot et al., 2020). Some examples were that refugee women have less opportunity to learn English because of their traditional caregiving role in the home, and separation from their social networks impacted women's ability to obtain health information (Zivot et al., 2020). These studies, although not specifically on Syrian refugees, do identify barriers that could be transferable to Syrian refugee women.

Research conducted in other countries on immigrants and refugees SRH needs after resettlement can offer some insight. A cross-sectional study in Sweden by Åkerman and colleagues identified that one third of immigrant women lacked knowledge of where to access contraception and one quarter stated that their culture did not allow them to use contraception (Åkerman et al., 2019). In regards to sexually transmitted infections, a rarely researched topic in this population, over half of the participants did not know where to access HIV testing and the odds of this were higher in women from Syria and Afghanistan (Åkerman et al., 2019). A study in Germany comparing the labour and birthing experiences of non-immigrants and immigrants mainly from Syria, Turkey, and Lebanon, showed that there was no difference in satisfaction of care even though there was a significant language barrier for immigrant women (Gürbüz et al., 2019). Inci and colleagues conducted a study in Germany exploring the family planning needs of refugees, mainly from Syria and Afghanistan, and 47% of participants had unmet family planning needs and the remaining 53% were mainly using the withdrawal method, calendar method, or intrauterine devices (Inci et al., 2020). These international studies showing SRH

preferences and unmet needs among refugees further emphasizes why this research needs to be conducted in Canada to see where the gaps in our health services exist.

1.1.4 *Syrian refugee health programs and support in Ottawa, Ontario*

Ottawa and the Champlain region local health integration network (LHIN) was highlighted in a report on Syrian refugee health as a champion, and commended on the creation of the Ottawa Refugee Task Force which included representation from many key health care organizations in the city (Hansen & Huston, 2016). Ottawa's success came from a long history of community mobilization to support refugees, including the establishment of the Ottawa Local Immigration Partnership (OLIP) in 2009, and specifically in response to the Syrian refugees, the creation of Refugee613 in 2015, which is an organization that fostered community support and coordination of information for refugees in the Ottawa area (Veronis, 2019).

Specifically in regards to health, Community Health Centers (CHCs) coordinated the health care response for Syrian refugees in Ottawa and expanded the services of The Ottawa Newcomer Health Clinic which became an initial screening hub that cared for Syrian refugees immediate health needs, and then connected them with a primary health care provider in the community (Hansen & Huston, 2016; Veronis, 2019). Ottawa has a long history of supporting refugees (Carrière, 2016), and was relatively well prepared to provide primary health care compared to other cities because it had established refugee networks, immigrant-friendly clinics, and had access to a fair number of Arabic-speaking health care providers (Pottie et al., 2018). Darwish and Muldoon, reported on the main health needs of Syrian refugees in Ottawa when they were initially receiving care in temporary hotels clinics. Among Syrian women, the top five diagnostic assessments, in order of most number of visits, were acute respiratory infection,

problems with social-cultural systems, skin infestation, pharyngitis, and contraception (Darwish & Muldoon, 2020). Contraception being in the top five primary health care needs for Syrian women in Ottawa shows a clear need to assess how these services are being accessed and utilized by this population.

With respect to women's health services in Ottawa, Immigrant Women Services Ottawa is one of the only community-based agencies that offers support specifically to immigrant and refugee women. Their mandate is to support women and children who face violence and offer counselling and resettlement services; they provide only mental health support (*Immigrant Women Services*, 2020). Somerset West CHC offers prenatal and breastfeeding classes for Arabic speaking women (*Somerset West CHC*, 2020). Other than maternal health classes, there are no specific programs or services tailored towards SRH for refugee or immigrant women that exist outside of primary health care visits.

1.2 Rationale

The exploration into the experiences of Syrian refugee women accessing SRH services in Canada has been minimal and does not highlight the voices of the women. As previously mentioned, there have been studies in Canada on Syrian women's maternal health, but they tend to avoid the other topics of SRH, so the research that exists is not comprehensive. The initial response to the health needs and organizing primary health care for Syrian refugees in Ottawa has been well organized, but there has been no investigation into Syrian women's SRH in the community.

This thesis project aims to help address this gap in the literature by highlighting the SRH experiences of Syrian refugee women, including facilitators and barriers to accessing

contraception, abortion, and pregnancy and delivery services. The aim is to highlight their voices and document what they feel are their SRH priorities and needs. This project also aims to explore the perspectives of health service providers and community leaders with the intent of offering concrete suggestions as to how services could be improved to better meet the needs of Syrian refugee women in Ontario and more specifically in the Ottawa community.

1.3 Research questions

My specific research questions for this thesis project are:

1) What are the lived experiences of Syrian refugee women in Ottawa accessing reproductive health services?
2) How are the experiences of Syrian refugee women receiving reproductive health care in Ottawa shaped by their pre-displacement knowledge, attitudes, and experiences?
3) What are the facilitators and barriers Syrian refugee women face when accessing reproductive health services in Ottawa?
4) What can be done to improve reproductive health services for Syrian refugee women?

1.4 Study objectives

Receiving comprehensive, appropriate, and tailored sexual and reproductive health care is an essential aspect of women's health. If barriers and facilitators to receiving this care for Syrian refugee women are identified this has the potential to inform health care providers, guidelines, and health service delivery. Our specific study objectives are to:

1) Describe the lived experiences of Syrian refugee women in Ottawa accessing sexual and reproductive health services

2) Explore how the experiences of Syrian refugee women receiving sexual and reproductive health care in Ottawa were shaped by their pre-displacement knowledge, attitudes, and experiences
3) Identify the facilitators and barriers Syrian refugee women face when accessing sexual and reproductive health services in Ottawa
4) Explore what can be done to improve sexual and reproductive health services for Syrian refugee women

For the purposes of this study we intended to focus on contraception, abortion, and pregnancy and delivery care. As often happens in qualitative research, the participants led us to frequently discussing other SRH topics we did not anticipate exploring such as early marriage, motherhood as a newcomer, perinatal mental health, intimate partner violence, and sexual health education for children; these will also be discussed.

1.5 Outline of thesis

This is a "thesis by articles", it is divided into five chapters. Chapter 1 includes background research on Syrian women's access to SRH care in Syria prior to the conflict. It then details how Syrian women accessed care once they were displaced due to conflict, focusing on the main countries they fled to, Lebanon, Turkey, and Jordan. The chapter then details their current context in Canada after resettlement, and finally more specifically their context in the Ottawa community. The first chapter also includes the rationale for this study, our specific study objectives, and the outline of this thesis.

Chapter 2 describes the methods employed to conduct this study including the recruitment and data collection for both the in-depth interviews with Syrian women and the key

informant interviews. It further discusses our analytic approach, the conceptual framework that underpins this research, and ethical implications.

Chapters 3 and 4 are two research articles written from the results of this study and are the bulk of this thesis. Chapter 3 is a paper entitled ""I was scared on my own. What will I face there?" Documenting the experiences of Syrian refugee women accessing sexual and reproductive health services in Ottawa, Canada". This paper focuses on facilitators and barriers to Syrian refugee women accessing SRH services and also integrates perspectives from key informants who provide this care in the Ottawa community. This paper has been formatted for submission to the peer-reviewed journal *Contraception.*

Chapter 4 is a paper entitled ""I like it here, but there's so much pressure. You have to give up your life [for] your kids and forget yourself here": Exploring the maternal health of Syrian refugee mothers in Ottawa, Ontario", which seeks to describe the complex experiences of Syrian refuge women's maternal mental health and motherhood. This paper takes an in-depth look into the complex personal experiences of Syrian refugee women trying to navigate motherhood and maternal mental health as a newcomer to Canada, and after facing significant trauma as a result of the Syrian conflict. We have formatted this paper for *Women's Health Issues.*

Finally, chapter 5 is an integration of the results including how the two articles relate to each other. After integrating the results of both articles, I describe the main overarching themes of this thesis. This chapter then explores potential areas for improving SRH care for Syrian women in Ottawa, including future directions for research. The final chapter also outlines my positionality in the context of this research and the limitations of this study. This chapter ends with a statement of contribution and final conclusions.

Chapter 2: Methods

After reviewing the literature, we decided to address the proposed research questions by conducting a multi-methods qualitative study that involved in-depth interviews with Syrian refugee women and interviews with key informants who provide services to this population. We conducted semi-structured interviews which allowed us to explore the lived experiences of Syrian women accessing SRH health services in the Ottawa community, and document their stories. Using a multi-methods qualitative design, we gained insight into the attitudes, opinions, and knowledge of Syrian refugee women, living in Ottawa, in the context of their sexual and reproductive health.

We conducted 17 in-depth interviews with Syrian women and 12 interviews with key informants from July 2019 through December 2019. For the in-depth interviews, we recruited self-identified Syrian refugee women between the ages of 15-45, who had immigrated to Canada on/after November 4, 2016, resided in Ottawa, Ontario at the time of the interview, had received any form of SRH care in Ontario, and were sufficiently fluent in English, French, or Arabic to complete an interview. Of the 17 Syrian refuge women, 12 were PSRs and 5 were GARs. The key informants we recruited provided services, mainly health services, to Syrian women in the Ottawa community and included: nurse practitioners (3), physicians (2), registered nurses (2), a midwife, a psychotherapist, a resettlement worker, a dietician, and a health care administrator. Most of the key informants came from several key health care organizations in the Ottawa community that helped coordinate care for Syrian refugees after their arrival including the Ottawa Newcomer Health Clinic, Somerset CHC, Sandy Hill CHC, Bruyère Family Health Team (FHT), Pinecrest-Queensway CHC, Southeast Ottawa CHC, and the Catholic Center for Immigrants. We gave participants the option of completing the interview in-person or over the

phone. One Syrian woman and three key informants had phone interviews and the remainder were in-person interviews. I conducted all of the key informant interviews in English as well as five of the in-depth interviews with Syrian women. I conducted the remaining interviews with Syrian refugees in Arabic in partnership with an Arabic speaking colleague in Dr. Foster's research group.

Ottawa is one of six cities in Ontario to resettle Syrian refugees. There has been minimal research conducted in the region on Syrian refugee women and none on Syrian women's experiences accessing SRH care. I am a registered nurse and have experience working with Syrian women in a primary health care setting in another city in Ontario. I noticed that this population seemed to have complex challenges and barriers to receiving comprehensive SRH care. In Ottawa, there are support programs specifically in place for refugees, including support groups for Arabic speaking woman refugees, but none specifically for women's health or SRH. For these reasons I chose to conduct this study in Ottawa, Canada.

2.1 Data collection

2.1.1 *In-depth interviews with Syrian refugee women in Ottawa*

We recruited participants using a community-based multi-modal strategy including connecting with and advertising through CHCs, refugee organizations, health care clinics, Arab community centers, mosques, and community housing for refugees. We posted ads on social media, engaged in early participant referral, and utilized key informants to advertise within their networks. All advertisements were in Arabic, English, and French, and participants could respond to the ads in any of those languages. When participants made contact we then confirmed

eligibility, emailed the consent form, and booked an interview time that was convenient for the participant.

After reviewing the literature, we formed an interview guide with open ended questions geared towards the research objectives and adapted to each participant's responses. Each interview began with questions about the participant's demographics including age, family composition, education level, employment status, date of immigration to Canada, and living situation before immigration to Canada. The next section focused on the participant's reproductive health history including her experiences with contraception, abortion, maternal health services, and cervical cancer screening prior to immigrating to Canada, including in Syria and after displacement. In this section, we also explored the women's knowledge of and attitudes toward SRH. The next domain of inquiry centered on the participant's experiences in Ontario with SRH services and explored facilitators and barriers to accessing care. Finally, we asked all participants to reflect on how SRH services could be improved for Syrian refugee women in Ottawa or more broadly in Ontario. We gave or mailed each participant a $40 gift certificate to Shoppers Drug Mart as a token of appreciation for their time and offered to send them a report of our findings if they wished. The interviews lasted from 30-90 minutes and mainly took place in the women's homes, which was most convenient for them, with a few occurring in the study office on the University of Ottawa campus.

With consent from the participants, all interviews were audio-recorded and field notes were taken throughout. I conducted a formal memoing immediately after each interview, and for the Arabic-language interviews my Arabic speaking colleague and I would memo together. The recordings were transcribed in their entirety and the Arabic-language interviews were translated into English by research assistants.

Before beginning each interview, we reviewed the consent form with the participant. We explicitly ensured the participants understood that all of their information is confidential and all identifying information will be masked and/or redacted. Finally, we ensured participants knew that the interview is voluntary, they could withdraw their consent at any time, and they did not have to answer any questions that they did not want to. Several of the interviews with Syrian women brought up emotional memories related to their experiences as a refugee and with intimate partner violence. For every interview, we let the women know that they were in control of the interview and could ask to take a break or end the interview at any time. Participation in this study posed minimal to no risks, as these were voluntary and confidential interviews. The only benefits of participating in this study were enjoyment and the opportunity to contribute to research that seeks to improve care for Syrian women's SRH needs. Overall, our participants were happy to participate in the interviews and were enthusiastic about sharing their stories with us.

2.1.2 *Key informant interviews*

We interviewed key informants who were direct service providers, mainly health service provider, for Syrian women or worked for organizations that provided services and care to Syrian women in the Ottawa community. The intent of key informant interviews was to give insight into the experiences of those coordinating and providing care to Syrian refugees in Ottawa.

To recruit key informants, I researched different organizations and health care clinics in the Ottawa community that provide services and health care to Syrian refugees and sent professional emails outlining the study and inviting them to participate in an interview.

Additionally, I used early participant referral and asked all key informants if they had recommendations on potential candidates for an interview and if they could connect us with them. After key informants agreed to an interview I emailed them a consent form and asked to review it prior to the interview where they would express verbal consent to participate.

The interviews were scheduled at a time that was convenient for the participant. I went to all the participants workplaces for the in-person interviews and all interviews were conducted in English lasting approximately 60 minutes. The interviews were audio-recorded with the participant's consent. The participants were informed that any information they shared about specific clients would be confidential and identifying information would be masked and/or redacted. However, we did obtain consent to use their organizations description and their professional title, such as "registered nurse working at a community health center", in our published reports. I informed all participants that they do not have to answer any questions they did not feel comfortable with and could stop the interview at any time. The participants were not compensated for their time but will all receive a report of the findings.

Each interview began with gathering basic information about the key informant's educational background, position, affiliated organization, and role in Syrian women's sexual and reproductive health. I used a guide developed specifically for this project and tailored to each participant, I then asked open-ended questions to explore their experiences of providing care, counselling, and/or working with Syrian refugee women. The interviews focused on perceived facilitators and barriers to providing quality care to Syrian refugee women. I ended the interviews by asking about ways that SRH services could be improved in the Ottawa community and more broadly in Ontario.

Throughout the interviews, I took field notes and immediately after each interview engaged in a formal memoing exercise to identify themes and reflect on subjective influences. Myself and research assistance transcribed the interviews in their entirety.

2.2 Data analysis

Qualitative data analysis is an iterative process and began during data collection. The data for this study are field notes, memos, and interview transcripts. The field notes and memoing helped us to reflect continuously on the content of the interviews, address personal biases and subjective influences, and notice themes developing throughout the data collection process. These analytic techniques helped us to determine when we had reached thematic saturation (Clarke & Braun, 2012). After 14 interviews with the Syrian women we believe we had reached thematic saturation, we then completed three more interviews to confirm and at that point we had enough experiences to be able to highlight Syrian women's voices and outline their complex experiences accessing SRH care. The purpose of the key informant interviews was not to reach thematic saturation but to broaden our understanding of SRH services in Ottawa and gain a range different of perspectives.

After conducting, transcribing, and reviewing the transcripts, we developed a code book using *a priori* (pre-determined) codes from the interview guide, literature review, and research questions. We then used inductive reasoning throughout the analysis process and derived several emergent codes from the interview content (Saldaña, 2009). We conducted a multi-phase analysis of content and themes, assessing for coherence within and between interviews. We managed the data with ATLAS.ti software. For in-depth interviews, we initially assessed them

separately from the key informant interviews, but in the final analytic phase we integrated the findings and paid specific attention to concordance and discordance.

2.3 Theoretical framework

This study was conducted within an interpretivist paradigm using a practical action research approach. Interpretivist interactionism is a type of qualitative research that uses participants' lived experiences to articulate a more complex story of how these experiences connect to larger public issues and responses (Lewis-Beck et al., 2004). Practical action research and more specifically community-based action research is used to "generate contextual knowledge about specific community needs that dominant research practices ignore" (Bradbury, 2017, p. 13). The intent of this framework is to affect social change and advocacy by giving primacy to participants' experiences. Syrian women's access to sexual and reproductive health care has not been investigated in this way in Ontario and this type of framework gives the participants the opportunity to decide what barriers and issues are priorities to them and their community in Ottawa. Finally, action research requires that findings be disseminated in ways that promote capacity-building and social change. This is in part why we connected with community partners and the key informants so that those who directly provide care to this population can be empowered to utilize the findings of this research.

2.4 Ethical Considerations

This study received approval in June 2019 from the Social Sciences and Humanities Research Ethics Board at the University of Ottawa (File #04-19-3906). The letter of approval from the University of Ottawa REB can be found in Appendix A.

Chapter 3: Article 1

I have drafted this manuscript as an original research article for submission to *Contraception*. The manuscript adheres to the structural, formatting, and length requirements of this peer-reviewed journal, except for the referencing style which remains APA.

"I was scared on my own. What will I face there?" Documenting the experiences of Syrian refugee women accessing sexual and reproductive health services in Ottawa, Canada

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Abstract

Objectives: The Syrian civil war has displaced more than 11 million people. Since 2015 Canada has welcomed 40,081 Syrian refugees. We aimed to explore Syrian refugee women's experiences accessing sexual and reproductive health (SRH) services in Canada's capital city, Ottawa.

Study design: We conducted 17 in-depth interviews with Syrian refugee women and 12 key informants, mainly healthcare providers. We managed our data using ATLAS.ti and performed content and thematic analyses using inductive and deductive techniques.

Results: Overall, Syrian refugee women participants were satisfied with their SRH care in Ottawa. When accessing SRH services our participants identified strong preferences for having a woman provider and more Arabic-speaking clinicians and interpreters. Adjusting to different societal norms during the perinatal period in Canada that differ from those in Syria posed challenges for accessing maternal health care. Contraception counselling was often not culturally informed and did not meet Syrian women at their baseline knowledge level.

Conclusions: Syrian refugee women face a number of challenges accessing SRH services in Ottawa. Identifying ways to cultural competency/humility training within Ontario's health care system, incorporate more Arabic-speaking women providers into the health system, increase funding for interpretation services, and create culturally tailored SRH educational resources and opportunities appear warranted.

Implications: Despite Ottawa's efforts to create systems that are responsive to the needs of newcomers and refugees, generally, and Syrian refugees in particular, more needs to be done to advance culturally resonant, high quality, SRH services. Our study points to specific policy and structural reforms that could better meet the SRH needs of Syrian refugee women.

Keywords: Canada, contraception, immigrants, maternal health, refugees, sexual and reproductive health

1. Introduction

Since the Syrian civil war began in 2011, 5.6 million Syrian refugees have fled and been displaced into surrounding countries, with the majority in Turkey, and the remaining in Lebanon, Jordan, Iraq, and Egypt (UNHCR, Government of Turkey, 2020). Nearly 20% of all refugees are women between the ages of 18 and 59 (UNHCR, Government of Turkey, 2020). Syrian women's access to sexual and reproductive (SRH) health care was unquestionably affected by the conflict and subsequent displacement (Benage et al., 2015; Gümüş Şekerci & Aydın Yıldırım, 2020; Masterson et al., 2014; West et al., 2017).

Canada has accepted 40,081 Syrian refugees since November 4, 2015 and they have been resettled in 36 cities across the country; half are government-assisted refugees (GARs) with the remaining as mainly privately sponsored refugees (PSRs) and a few thousand blended visa office-referred refugees (Government of Canada, 2017a). The province of Ontario accepted 11,400 Syrian refugees into six cities, Windsor, London, Ottawa, Toronto, Kitchener, and Hamilton (Government of Ontario, 2018). The health care costs for Syrian refugees in Ontario is paid for through the Interim Federal Health Program (IFHP) for 12 months after which they transfer to the Ontario Health Insurance Plan (OHIP) (Government of Ontario, 2018). Ottawa, the nation's capital, has a long legacy of supporting refugees, and after mounting a large community effort they were able to accept 1,112 Syrian refugees (Carrière, 2016).

The initial research in Canada on the health of Syrian refugees focused on preparing for their arrival by assessing for communicable diseases, anticipating their health needs, and focusing on chronic health conditions (Hansen et al., 2016; Hansen & Huston, 2016; Oda et al., 2017; Pottie et al., 2018). As of 2021, there has been minimal research on the SRH needs of Syrian refugees in Canada; the research that has been done focuses mainly on maternal health and avoids topics such as contraception, abortion, or sexual health, topics that are often ignored in migrant women's reproductive health research (Gagnon & Redden, 2016).

Prior to the arrival of Syrian refugees, the SRH research on immigrant and refugee women in Ontario identified access challenges related to language barriers, gender dynamics, misconceptions or lack of knowledge about contraception, lack of access to culturally sensitive interpreters and providers, and women's autonomy in decision making (Newbold & Willinsky, 2009; Redwood-Campbell et al., 2008; Wiebe, 2013). A refugee health clinic in Toronto found that 26.8% of women had unmet contraceptive needs (Aptekman et al., 2014) and in 2011, a clinical guideline was created for immigrant and refugee health in Ontario, which emphasized the importance of immediately screening for contraceptive needs (Pottie et al., 2011).

In Canada, the maternal health research on Syrian refugees indicates that Syrian women faced challenges with maternal depression and accessing mental health services (Ahmed et al., 2017). Health care providers for pregnant Syrian refugees identified issues with language barriers, cultural differences in medical practices, managing traditional gender dynamics, and navigating the health care system (Winn et al., 2018). In Toronto, Ontario, researchers found that Syrian refugee women face language and social disconnection barriers to accessing health care services, experience chronic health issues exacerbated by trauma, have unmet expectations of health care in Canada, and desire more gender-appropriate services (Guruge et al., 2018). In Ottawa,

contraception was in the top five assessment diagnoses for Syrian refugees in 2016, shortly after their arrival (Darwish & Muldoon, 2020).

Although efforts have been made to research Syrian refugees' health in Ontario and Ottawa, Syrian women's voices have been minimal and an exploration into their experiences accessing SRH care is absent. This study aims to fill this gap in the literature and explore Syrian refugee women's experiences accessing SRH services in Ottawa, Ontario, with the intent of identifying barriers to comprehensive care and offering insight for health care providers on the unique SRH needs of this population.

2. Methods

For this multi-methods qualitative study, from July to December 2019, we conducted 17 in-depth interviews with Syrian refugee women and 12 interviews with key informants living in Ottawa, Ontario. We recruited self-identified Syrian refugee women if they were between the ages of 15-45, immigrated to Canada on/after November 4, 2015, reside in Ottawa, Ontario at the time of the interviews, had received any form of SRH care, and were sufficiently fluent in Arabic, English, or French to complete an interview. We recruited key informants who provide health and social services to Syrian women in the Ottawa community.

2.1 Recruitment

We recruited our participants using a community-based multi-modal strategy including connecting with and advertising through community health organizations (CHCs), refugee organizations, various health care clinics, Arab community centers, and community housing for refugees. We also posted ads on social media, engaged in early participant referral, and utilized key informants (see below) to advertise within their networks. We distributed advertisements in Arabic, English, and French. Once we made contact with a participant, we confirmed eligibility, emailed the consent form, and booked an interview time that was convenient for the participant.

We recruited key informants by reaching out to organizations in the Ottawa community that provide health services to Syrian refugees and sending email invitations to participate in an interview. In addition to using publicly available information and personal networks, we used early participant referral and asked all key informants if they had recommendations on potential candidates for an interview.

2.2 Data collection

LC, a master's student in the Interdisciplinary Health Sciences program at the University of Ottawa and a registered nurse, conducted all of the interviews. For interviews in Arabic, we worked with a PhD student in the same research group who served as an interpreter. Interviews lasted on average 60 minutes and we conducted them in-person or over the phone. AMF, a medical anthropologist and medical doctor, who has extensive research experience in the field of SRH for refugee populations and in the Middle East and North Africa, provided guidance throughout the study.

Interviews with Syrian women began with questions about the participant's demographics and immigration experience. The next section focused on the participant's SRH health history including her experiences with contraception, abortion, maternal health services, and cervical

cancer screening prior to immigrating to Canada, including in Syria and after displacement. We then explored the women's knowledge of and attitudes toward SRH. Finally, we focused on the participant's experiences in Ontario, and specifically in Ottawa, with SRH services and asked all participants to reflect on how these services could be improved. Key informant interviews began with gathering basic information about the participant's role in Syrian women's SRH. We then explored their experiences of providing care, counselling, and/or working with Syrian women. The interviews focused on perceived facilitators and barriers to providing quality SRH care to Syrian refugee women.

With consent from the participants, we audio-recorded all interviews and took notes throughout. A formal memoing process took place immediately after each interview to identify themes and reflect on positionality. For the Arabic-language interviews, LC and the interpreter would memo together. We offered the Syrian women a CAD40 gift card to Shoppers Drug Mart.

2.3 Data analysis

Data analysis began during data collection and was an iterative process. Members of the research team transcribed all audio-recordings in their entirety and translated Arabic-language interviews into English. The field notes and memoing helped us to reflect continuously reflect on the content of the interviews, address subjective influences, and identify themes that emerged during the data collection process. These analytic techniques helped us to determine when we had reached thematic saturation (Clarke & Braun, 2012). After 14 interviews with Syrian women we believed we had reached thematic saturation; we conducted three additional interviews as confirmation.

We used ATLAS.ti software to manage our data and LC developed a codebook using *a priori* (pre-determined) codes from the interview guide, literature review, and research questions. We then used inductive reasoning throughout the analysis process and derived several emergent codes from the interview content (Saldaña, 2009). We conducted a multi-phase analysis of content and themes. We initially analyzed the two study components separated; we integrated the results from the interviews with Syrian women and key informants in final analytic phase, paying specific attention to concordance and discordance.

The University of Ottawa Research Ethics board approved this study. In the results section we will use illustrative quotes from participants to highlight the three main themes from this research related to Syrian women's experiences utilizing SRH health services. We masked or redacted all identifying information and use pseudonyms for all participants.

3. Results

3.1 Participant characteristics

The 17 Syrian women we interviewed were between the ages of 18 and 41 years old. The majority of participants were married (n=12) or widowed (n=3). Over half of the women were married before the age of 18 (n=9). Most of our participants had children (n=15), with the majority having three or more children (n=13). Our participants were mainly government sponsored refugees (n=12). Before their arrival to Canada, our participants sought refuge in Jordan (n=10), Turkey (n=3), Lebanon (n=2), and Iraq (n=1). We provide more detailed demographic information for the Syrian women in our study in Table 1.

All of our 12 key informants worked with Syrian refugee women in Ottawa, and most were direct health service providers (n=10). These providers were nurse practitioners (n=3), family physicians (n=2), registered nurses (n=2), a midwife, a dietician, a psychotherapist, a resettlement worker, and a health care administrator. Our key informants mainly came from organizations that were tailored to refugees such as CHCs, family health teams (FHTs), and resettlement agencies. A few worked in private practices and had personal motivations that led them to care for Syrian women, such as being a refugee themselves or speaking Arabic. Our key informants had a wealth of refugee health knowledge and many had been involved in the preparation and planning for the arrival of Syrian refugees to Canada in 2015.

3.2 Syrian women refugees have strong preferences for characteristics of their sexual and reproductive health care providers

Participants reflected differently on SRH care providers in comparison to general health care providers, and frequently asserted that it was either mandatory or highly preferred that their provider was a woman and preferably Arabic-speaking. Although an Arabic-speaking woman provider was most preferred, participants repeatedly noted they would choose gender over language. Syrian women's reasoning behind preference for a woman provider involved personal comfort. Some participants also cited compliance with religious conventions as a reason for wanting a woman practitioner; other participants specifically stated that requiring patient-provider gender-alignment was a misinterpretation of Islam.

The Syrian women we interviewed felt that their request for a woman provider was well respected and accommodated for in Ottawa. Mina, aged 25 explained, "They always make sure – they always ask you the first things first, would you like a female or male?" However, a few of our participants did have to advocate more insistently for a woman provider.

Giving birth in hospital was the greatest challenge to ensuring a woman provider because the gender of on-call staff and learners could not be predicted. Participants' reactions to this uncertainty ranged from understanding and acceptance, to distress and discomfort. Ayla, aged 33, gave birth in the hospital and described her experience, "When she told me about a group and men may come in, I said 'I wish I didn't get pregnant. How can men come in? How will I deliver?'"

Both Syrian women and key informants discussed how the gender of interpreters also affected SRH care. Marwa, aged 29, was having an intrauterine device (IUD) inserted and had a male interpreter for her appointment. Marwa describes the procedure,

> I was embarrassed a little. He [the interpreter] was behind the curtain when they put it in, telling me to move, lift my leg, and so on. It's normal, but I was embarrassed. Like he wasn't looking, only talking...I was honestly embarrassed. I wished for a woman.

A concern expressed by key informants was that constantly referring Syrian women to a woman provider for SRH needs could delay and affect continuity of care. Even with these concerns our key informants were very supportive of Syrian women's preferred provider characteristics. A man nurse practitioner at a CHC explained,

> I think that in general women prefer to have reproductive health knowledge from other women and especially women that speak their language. If there's cultural and language concordance I think that that actually improves people's understanding and uptake.

3.3 Syrian women struggled to adjust to differences in care during the perinatal period

Overwhelmingly, our participants reflected positively on the clinical and medical care that they received in Ottawa, but they struggled with the social and cultural norms surrounding delivery. Yasmine, age 33, gave birth in Ottawa and reflected on her experience,

> The treatment is elegant; the doctors are very respectful. I used to tell the nurse that was responsible for me that she was like an angel. But, in Syria, we're used to the mother and the sister being there; I was scared on my own. What will I face there?

The majority of the women we interviewed echoed Yasmine's compliments and fears. They found delivery in the hospital isolating and without the robust family and community supports they are used to in Syria. Many of the women we interviewed were either separated from their families or had lost them in the conflict.

Language barriers added to their feelings of fear and isolation. When in the hospital giving birth, Syrian women did not have access to an interpreter for their entire stay, which led to miscommunication and the inability to express one's self. Dalal, age 30, described her experience with a Caesarean section,

> When I first gave birth, [the physician] spoke to me in English. So, I spoke to him in English because I did not have anybody. After he took all my information, and prepared me for the surgery, an Arab guy came to help me with [interpretation]. He asked if I needed help and I said yeah because I did not know what was going on. He asked, 'what are you doing here?' I said delivery. He told me, 'no you're doing tube tying.' I told him I'm not coming for that. I came for delivery.

Dalal had spoken to the physician in English, even though she was not proficient in the language, because there was no interpreter present. She then ended up being unaware that she had consented to tubal ligation after her Caesarean section.

Many of our participants also expressed being overwhelmed as a newcomer by the expectations of perinatal care in Canada. Elham, age 41, explained,

> Here in Canada, [for pregnancy], a lot of appointments, a lot appointments, a lot of appointments. I don't drive, so I go [on the] bus for everything. So they are very, very nice doctors but a lot of blood tests, a lot of ultrasounds, a lot of appointments.

Several participants also expressed perplexity around medical paradigms that they were not accustomed to. Alaa, age 33, said "Treatment and medicine are different here, like I had to sign to give permission for a blood transfusion and they asked me how I would like to deliver...like in

water?". Key informants noticed this confusion when trying to explain confidentiality to Syrian women, especially in relation to SRH issues.

Finally, the postpartum period was challenging for our participants who had given birth in Canada because they were used to extensive community support for several weeks after delivery. Wafaa explained, "I don't have anybody here. Just me, my kids and husband. And my neighbors, thank God." Living in communities with other Syrian refugees was an essential facilitator to our participants' wellbeing in the perinatal period.

3.4 Baseline contraception knowledge is low and preferences are culturally shaped, so counselling needs to be different

Most of our key informants emphasized that Syrian women's baseline knowledge of contraception was significantly lower than most Canadian-born individuals. Although our Syrian participants did not have Canadian-born referents, the Syrian women we interviewed explained that SRH is not taught in Syrian schools and almost all of our participants did not learn that contraception existed until after the birth of their first child. Marwa explained what normally happened in Syria, "After I gave birth I started knowing [about contraception]. I went to the doctor and [she] gave me a lecture and started telling us." Key informants explained that Syrian women from rural communities usually had even less knowledge of and access to contraception that their urban counterparts.

Many of our participants had misconceptions related to contraception use. A main concern being that contraception could cause infertility, specifically if started before the birth of the first child. Mina, our only participant who was married without children explained her experience accessing contraception counselling in Ottawa,

> I was a little bit afraid because it was my first experience and the cultural background tells you that – here's the ignorance part – people think that having taken [oral contraceptive pills] for a few years will affect your fertility. It took a lot of courage for me to actually get going and keep going. [My doctor] really explained to me how they work and that it won't affect anything for my health as well.

Due to fear from misconceptions, Syria women had trouble being consistent with contraception use, and needed extra encouragement from their providers during contraception counselling. Our participants were specifically very hesitant when it came to hormonal forms of contraception, most notably oral contraceptive pills (OCPs). Their main concerns were the side effects such as weight gain, mood changes, fatigue, and lack of menstruation. A few participants did try OCPs because it was often the first suggestion by their health care provider, but most did not continue use for long which resulted in unwanted pregnancies. Fatin describes her perception of OCPs, "[T[he pills would make women angry, so I didn't take it for the sake of my kids and my family."

Our key informants also noted these challenges when providing contraception counselling to Syrian women. A family physician, who often received referrals for contraception counselling with Syrian women, said, "the counselling for a lot of these women is inadequate."

4. Discussion

Syrian refugee women's barriers to accessing comprehensive SRH care in Ottawa, Ontario is impacted by several factors related to being a newcomer, cultural norms, and health system inequities. Our participants clearly expressed that provider characteristics, most notably gender and proficiency in Arabic, are very important to Syrian women accessing SRH services. Perinatal research in Canada has shown that immigrant women are used to women providers for maternal health and found it challenging in Canada to receive this care from men (Brar et al., 2009). Research on Syrian refugee women in Toronto indicated that gender of the interpreter was also a barrier to accessing health care (Guruge et al., 2018). Although health care providers in our study were concerned that referrals made to accommodate these preferences could delay care and impact continuity of care, a systematic review in Australia showed that accommodating preferences for providers can significantly impact the uptake of SRH services among culturally and linguistically diverse women (Mengesha et al., 2016). Supporting more Arabic-speaking women to seek careers in health care and interpretation services would be an ideal way to ensure Syrian refugee women are receiving the comprehensive SRH care they desire.

Immigrants and refugees are generally very satisfied with the maternal health care they receive in Global North countries, but face challenges adjusting to the different maternal health expectations, while coping with minimal social support and difficulties navigating unfamiliar health care systems (Boerleider et al., 2013). One way some of our participants mitigated these challenges was by connecting with other Syrian refugee women that were living in neighbourhoods and buildings mainly populated by Syrian families. A Canadian scoping review indicates that community engagement, spousal relations, and self-care are critical for immigrant women to have positive maternal health outcomes, and recommend a multidimensional approach to maternal health, including targeted prenatal support groups for immigrant populations (Khanlou et al., 2017). Expanding these efforts to include a range of SRH issues may be warranted.

Childbirth is a vulnerable time for women and our participants faced heightened vulnerability due to insufficient interpretation services while in the hospital coupled with the loss of power when communicating through an interpreter. This combination resulted in several Syrian women not being able to advocate for themselves in the delivery room and intensified feelings of fear and isolation during an already stressful life event. As highlighted by our key informants, there are insufficient Arabic-speaking women providers and interpreters in Ottawa. According to Boerleider and colleagues, provision of care in women's native language is the most important facilitator for accessing SRH services (2013), but securing funding for professional interpretation services has been problematic in Ontario communities for decades (Newbold et al., 2013).

Research from Canada and globally show that there is often an unmet need for contraception among refugee populations after resettlement (Aptekman et al., 2014; Chan et al., 2018; Guruge et al., 2018; Inci et al., 2020). In our study, we found that Syrian refugee women have knowledge gaps and misconceptions and health care providers were unprepared to conduct culturally-informed contraceptive counselling. Our result echo findings from other Canadian studies that indicate that fears and misconceptions, specifically around hormonal forms of contraception, lead to unmet contraceptive needs in newcomer populations (Wiebe, 2013). In Ontario, immigrants and refugees often express that there are gaps in their SRH knowledge and

consequentially struggle to understand health teaching during appointments; and when they seek out information they cannot find educational classes that start at their baseline level of knowledge (Maticka-Tyndale et al., 2007; Newbold & Willinsky, 2009).

The International Federation of Gynecologists and Obstetricians recently released an article calling out the minimal research and training on cultural competency when providing SRH care to migrant and refugee women (Endler et al., 2020). Clearly, contraception counselling needs to be more targeted and culturally informed for Syrian refugee women in Ottawa, and it would be important to inquire about their knowledge, attitudes, and behaviours before proceeding with counselling. Our participants also desired tailored educational opportunities to learn about SRH with other Syrians or culturally similar women.

Over the last several decades Ottawa, and Canada more broadly, has championed accepting refugees (Carrière, 2016) and the research on refugee women's health continues to recommend that cultural competency and interpretation services need to be permanently integrated into the health care system (Higginbottom et al., 2015; Redwood-Campbell et al., 2008; Zivot et al., 2020). When the Canadian government accepted Syrian refugees in 2015, they committed to only 12 months of funding, and once again there has been no permanent financial support established, especially for costly interpretation services. More recent research proposes a team-based approach to mitigate Syrian refugee women's barriers to SRH care (Winn et al., 2018), such as supporting CHCs, facilities that have increased access to interpretations services, and often a more diverse range of providers. CHCs in Ottawa advocate for refugees and try to support Syrian women's needs, but they have limited capacity due to the increased volume, budget cuts, and private practices refusing to accept refugee families. Finally, when Syrian refugees arrived clinical guidelines were quickly established by researchers and practitioners (Pottie et al., 2018), but SRH care was largely ignored and there has yet to be a culturally informed clinical care guideline created for Syrian refugee women's SRH in Ontario.

4.1 Limitations

This qualitative research study is able to give voice to Syrian refugee women's attitudes, behaviours, and experiences accessing SRH care in Ottawa. However, these results are not generalizable to other groups of refugees, and although experiences may be similar, they are not generalizable to Syrian refugees living in other Ontario communities. We did have a variety of income and education levels in our participants, but only one unmarried participant. For future research, studies in other Ontario cities that accepted Syrian refugees could be conducted to compare experiences. Finally, our study team did not include any members from Syria or from the Syrian refugee community in Ottawa. Although members of the study team reflected on their positionalities throughout the life of the project, these positionalities undoubtedly influence our interpretation.

4.2 Conclusions

It is clear that Syrian refugee women face barriers when accessing SRH services in Ottawa, Ontario. These challenges were intricately connected to being a newcomer and the vulnerability associated with accessing and receiving SRH care. Syrian women's experiences coupled with insights from their health care providers indicated a significant need for cultural competency/humility training within Ontario's health care system, more Arabic-speaking women

providers, increased funding for interpretation services, and culturally tailored SRH educational opportunities.

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Table 1: Characteristics of Syrian refugee women participants in our study (N= 17)

Characteristic	***n***
Age during study period	
18-25	3
26-35	8
35-41	6
Number of children during study period	
0	2
1-2	2
3-4	7
5-6	6
Marital Status	
Unmarried	1
Married	12
Widowed	3
Separated	1
Age at marriage	
14-16	7
17-19	4
20+	4
ND	1
Refugee status	
Government assisted refugee (GAR)	12
Privately sponsored refugee (PSR)	5
Country of displacement	
Jordan	10
Lebanon	2
Turkey	3
Iraq	1
ND	1
Language interview conducted in	
Arabic	14
English	3

References

Ahmed, A., Bowen, A., & Feng, C. X. (2017). Maternal depression in Syrian refugee women recently moved to Canada: A preliminary study. *BMC Pregnancy and Childbirth*, *17*(1). https://doi.org/10.1186/s12884-017-1433-2

Aptekman, M., Rashid, M., Wright, V., & Dunn, S. (2014). Unmet contraceptive needs among refugees: Crossroads clinic experience. *Canadian Family Physician*, *60*(12), e613–e619. Scopus.

Benage, M., Greenough, P., Vinck, P., Omeira, N., & Pham, P. (2015). An assessment of antenatal care among Syrian refugees in Lebanon. *Conflict and Health*, *9*(1), 8. https://doi.org/10.1186/s13031-015-0035-8

Boerleider, A. W., Wiegers, T. A., Manniën, J., Francke, A. L., & Devillé, W. L. (2013). Factors affecting the use of prenatal care by non-western women in industrialized western countries: A systematic review. *BMC Pregnancy and Childbirth*, *13*(1), 81. https://doi.org/10.1186/1471-2393-13-81

Brar, S., Tang, S., Drummond, N., Palacios-Derflingher, L., Clark, V., John, M., & Ross, S. (2009). Perinatal Care for South Asian Immigrant Women and Women Born in Canada: Telephone Survey of Users. *Journal of Obstetrics and Gynaecology Canada*, *31*(8), 708–716. https://doi.org/10.1016/S1701-2163(16)34274-8

Carrière, A. (2016). *History and Legacy of Refugee Resettlement In Ottawa: A Primer* (p. 32). Catholic Center for Immigrants. http://cciottawa.ca/wp-content/uploads/History-and-Legacy-of-Refugee-Resettlement-In-Ottawa_A-Primer.pdf

Chan, M., Johnston, C., & Bever, A. (2018). Exploring Health Service Underutilization: A Process Evaluation of the Newcomer Women's Health Clinic. *Journal of Immigrant and Minority Health*, *20*(4), 920–925. https://doi.org/10.1007/s10903-017-0616-2

Clarke, V., & Braun, V. (2012). Thematic Analysis. In *APA handbook of research methods in psychology* (Vol. 2, pp. 57–71). America Psycholgical Association.

Darwish, W., & Muldoon, L. (2020). Acute primary health care needs of Syrian refugees immediately after arrival to Canada. *Canadian Family Physician*, *66*, 9.

Endler, M., Haidari, T. A., Chowdhury, S., Christilaw, J., Kak, F. E., Galimberti, D., Gutierrez, M., Ramirez-Negrin, A., Senanayake, H., Sohail, R., Temmerman, M., & Danielsson, K. G. (2020). Sexual and reproductive health and rights of refugee and migrant women: Gynecologists' and obstetricians' responsibilities. *International Journal of Gynecology & Obstetrics*, *149*(1), 113–119. https://doi.org/10.1002/ijgo.13111

Gagnon, A. J., & Redden, K. L. (2016). Reproductive health research of women migrants to Western countries: A systematic review for refining the clinical lens. *Best Practice & Research Clinical Obstetrics & Gynaecology*, *32*, 3–14. https://doi.org/10.1016/j.bpobgyn.2016.01.005

Government of Canada. (2017, January 29). *#WelcomeRefugees: Key figures*. http://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/welcome-syrian-refugees/key-figures.html

Government of Ontario. (2018, September 8). *Syrian refugees: How you can help*. https://www.ontario.ca/page/syrian-refugees-how-you-can-help

Gümüş Şekerci, Y., & Aydın Yıldırım, T. (2020). The knowledge, attitudes and behaviours of Syrian refugee women towards family planning: Sample of Hatay. *International Journal of Nursing Practice*, *26*(4). https://doi.org/10.1111/ijn.12844

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

Hansen, L., & Huston, P. (2016). Health considerations in the Syrian refugee resettlement process in Canada. *Canada Communicable Disease Report*, *42*(S2), S3–S7. https://doi.org/10.14745/ccdr.v42is2a02

Hansen, L., Maidment, L., & Ahmad, R. (2016). Early observations on the health of Syrian refugees in Canada. *Canada Communicable Disease Report*, *42*(S2), S8–S10. https://doi.org/Hessini

Higginbottom, G. M., Morgan, M., Alexandre, M., Chiu, Y., Forgeron, J., Kocay, D., & Barolia, R. (2015). Immigrant women's experiences of maternity-care services in Canada: A systematic review using a narrative synthesis. *Systematic Reviews*, *4*(1), 13. https://doi.org/10.1186/2046-4053-4-13

Inci, M. G., Kutschke, N., Nasser, S., Alavi, S., Abels, I., Kurmeyer, C., & Sehouli, J. (2020). Unmet family planning needs among female refugees and asylum seekers in Germany – is free access to family planning services enough? Results of a cross-sectional study. *Reproductive Health*, *17*(1), 115. https://doi.org/10.1186/s12978-020-00962-3

Khanlou, N., Haque, N., Skinner, A., Mantini, A., & Kurtz Landy, C. (2017). Scoping Review on Maternal Health among Immigrant and Refugee Women in Canada: Prenatal, Intrapartum, and Postnatal Care. *Journal of Pregnancy*, *2017*, 1–14. https://doi.org/10.1155/2017/8783294

Masterson, A., Usta, J., Gupta, J., & Ettinger, A. S. (2014). Assessment of reproductive health and violence against women among displaced Syrians in Lebanon. *BMC Women's Health*, *14*(1). https://doi.org/10.1186/1472-6874-14-25

Maticka-Tyndale, E., Shirpak, K. R., & Chinichian, M. (2007). Providing for the Sexual Health Needs of Canadian Immigrants: The Experience of Immigrants from Iran. *Canadian Journal of Public Health/Revue Canadienne De Sante'e Publique*, *98*(3), 183–186.

Mengesha, Z., Dune, T., & Perz, J. (2016). Culturally and linguistically diverse women's views and experiences of accessing sexual and reproductive health care in Australia: A systematic review. *Sexual Health*. https://doi.org/10.1071/SH15235

Metusela, C., Ussher, J., Perz, J., Hawkey, A., Morrow, M., Narchal, R., Estoesta, J., & Monteiro, M. (2017). "In My Culture, We Don't Know Anything About That": Sexual and Reproductive Health of Migrant and Refugee Women. *International Journal of Behavioral Medicine*, *24*(6), 836–845. https://doi.org/10.1007/s12529-017-9662-3

Newbold, K. B., Cho, J., & McKeary, M. (2013). Access to Health Care: The Experiences of Refugee and Refugee Claimant Women in Hamilton, Ontario. *Journal of Immigrant & Refugee Studies*, *11*(4), 431–449. https://doi.org/10.1080/15562948.2013.808390

Newbold, K. B., & Willinsky, J. (2009). Providing family planning and reproductive healthcare to Canadian immigrants: Perceptions of healthcare providers. *Culture, Health & Sexuality*, *11*(4), 369–382. https://doi.org/10.1080/13691050802710642

Oda, A., Tuck, A., Agic, B., Hynie, M., Roche, B., & McKenzie, K. (2017). Health care needs and use of health care services among newly arrived Syrian refugees: A cross-sectional study. *CMAJ Open*, *5*(2), E354–E358. https://doi.org/10.9778/cmajo.20160170

Pottie, K., Greenaway, C., Feightner, J., Welch, V., Swinkels, H., Rashid, M., Narasiah, L., Kirmayer, L. J., Ueffing, E., MacDonald, N. E., Hassan, G., McNally, M., Khan, K.,

Buhrmann, R., Dunn, S., Dominic, A., McCarthy, A. E., Gagnon, A. J., Rousseau, C., & Tugwell, P. (2011). Evidence-based clinical guidelines for immigrants and refugees. *Canadian Medical Association Journal*, *183*(12), E824–E925. https://doi.org/10.1503/cmaj.090313

Pottie, Kevin, Gruner, D., & Magwood, O. (2018). Canada's response to refugees at the primary health care level. *Public Health Research & Practice*, *28*(1). https://doi.org/10.17061/phrp2811803

Redwood-Campbell, L., Thind, H., Howard, M., Koteles, J., Fowler, N., & Kaczorowski, J. (2008). Understanding the Health of Refugee Women in Host Countries: Lessons from the Kosovar Re-Settlement in Canada. *Prehospital and Disaster Medicine*, *23*(4), 322–327. https://doi.org/10.1017/S1049023X00005951

Saldaña, J. (2009). *The coding manual for qualitative researchers*. Sage.

Silverberg, S. L., Harding, L., Spitzer, R. F., & Rashid, M. (2018). The Who, What, Why and When of Gynaecological Referrals for Refugee Women. *Journal of Immigrant and Minority Health*, *20*(6), 1347–1354. https://doi.org/10.1007/s10903-018-0733-6

UNHCR, Government of Turkey. (2020). *Situation Syria Regional Refugee Response*. https://data2.unhcr.org/en/situations/syria

Urindwanayo, D. (2018). Immigrant Women's Mental Health in Canada in the Antenatal and Postpartum Period. *Canadian Journal of Nursing Research*, *50*(3), 155–162. https://doi.org/10.1177/0844562118784811

Veronis, L. (2019). Building intersectoral partnerships as place-based strategy for immigrant and refugee (re)settlement: The Ottawa Local Immigration Partnership. *The Canadian Geographer / Le Géographe Canadien*, *63*(3), 391–404. https://doi.org/10.1111/cag.12559

West, L., Isotta-Day, H., Ba-Break, M., & Morgan, R. (2017). Factors in use of family planning services by Syrian women in a refugee camp in Jordan. *Journal of Family Planning and Reproductive Health Care*, *43*(2), 96–102. https://doi.org/10.1136/jfprhc-2014-101026

Wiebe, E. (2013). Contraceptive practices and attitudes among immigrant and nonimmigrant women in Canada. *Canadian Family Physician*, *59*(10), e451–e455. Scopus.

Winn, A., Hetherington, E., & Tough, S. (2018). Caring for pregnant refugee women in a turbulent policy landscape: Perspectives of health care professionals in Calgary, Alberta. *International Journal for Equity in Health*, *17*(1). https://doi.org/10.1186/s12939-018-0801-5

Zivot, C., Dewey, C., Heasley, C., Srinivasan, S., & Little, M. (2020). Exploring the State of Gender-Centered Health Research in the Context of Refugee Resettlement in Canada: A Scoping Review. *International Journal of Environmental Research and Public Health*, *17*(20), 7511. https://doi.org/10.3390/ijerph17207511

Chapter 4: Article 2

I have drafted this manuscript as an original research article for submission to *Women's Health Issues*. The manuscript adheres to the structural, formatting, and length requirements of this peer-reviewed journal.

"I like it here, but there's so much pressure. You have to give up your life [for] your kids and forget yourself here": Exploring the maternal health of Syrian refugee mothers in Ottawa, Ontario

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Abstract

Background: The Syrian civil war has displaced more than 11 million people, 20% of whom are women between the ages of 18 and 59. Canada has welcomed 40,081 Syrian refugees since 2015. The majority of Syrian women that arrived were mothers. We explored Syrian women's experiences with and connections between maternal health, mental health, and motherhood since immigrating to Ottawa, Canada.

Methods: We conducted a multi-methods qualitative study that involved 17 in-depth interviews with Syrian refugee women and 12 key informants living in Ottawa, Ontario. The interviews explored Syrian women's sexual and reproductive health experiences, which included discussions on maternal health and motherhood as a newcomer. We analyzed our interviews for content and themes using inductive and deductive techniques.

Results: The Syrian women we interviewed reported that their maternal health was highly impacted by previous traumatic experiences of pregnancy and delivery in countries of displacement. They also found motherhood in Canada to be stressful due to social isolation, cultural differences, and heightened responsibilities. Our interviews with both Syrian women and key informants indicated that Syrian refugee women in Ottawa have unmet need for postpartum mental health support.

Conclusions: The maternal health experiences of Syrian refugee mothers show a clear need to prioritize this populations' mental health, mainly by increasing their social supports, especially from those within their community. It is also crucial that maternal health care providers understand the context that Syrian women have come from to guide their care in a trauma- and culturally-informed manner.

1. Introduction

The Syrian civil war displaced more than 11 million people; over 6 million now reside in countries outside of Syria in both refugee camps and urban and rural areas (UNHCR, Government of Turkey, 2020). Nearly 20% of Syrian refugees are women between the ages of 18 and 59 (UNHCR, Government of Turkey, 2020) and their sexual and reproductive health (SRH) has been highly affected by displacement and resettlement. Since November 4, 2015, Canada has welcomed 40,081 Syrian refugees and they have resettled in 36 cities across the country (Government of Canada, 2017a). Canada's capital, Ottawa, Ontario, has accepted 1,112 Syrian refugees and is well known for championing refugee resettlement initiatives (Carrière, 2016). The majority of Syrian women that arrived in Canada were already mothers (Government of Canada, 2017a) and many have gone on to have subsequent children.

Researchers interviewed Syrian women living in Aleppo just before the Syrian civil war began and they found that women perceived their communities and neighbourhoods to be crucial factors in their health and well-being (Ahmad et al., 2019). Another study conducted pre-conflict indicated that Arab women throughout the Middle East, including Syria, were experiencing high rates of postpartum depression which was associated with lack of support, experiences of violence, increased expectations of motherhood, and patriarchal kinship (Yount & Smith, 2012). This backdrop gives insight into the health challenges Syrian women may face in both displacement and resettling in a new country.

According the United Nation Population Fund (UNFPA), gender-based violence towards displaced Syrian women and girls is a major issue (Saadallah & Baker, 2016). Further, there is an emerging trend of obstetric violence which appears to disproportionately affect refugee women seeking care in neighboring countries (Heidari & Moreno, 2016). One study in Lebanon found that the majority of Syrian women (64.6%) who had experienced conflict related violence and non-partner sexual violence chose to not seek medical care for reproductive health issues (Masterson et al., 2014).

There have been two research studies conducted on Syrian women's experiences of maternal health care in Canada. One focused on health care professionals' barriers to providing maternal health services (Winn et al., 2018) and the other looked at Syrian refugee women's maternal depression (Ahmed et al., 2017). The latter found that half of the participants had depression and anxiety symptoms (Ahmed et al., 2017). More recently, Guruge and colleagues engaged with 58 Syrian women in multiple focus group discussions throughout the Greater Toronto Area looking at their access to health care. Their research highlighted that Syrian women faced many chronic health issues exacerbated by trauma from the conflict, faced significant language and system barriers, and had unmet expectations of health care in Canada; the researchers also briefly touched on the need for gender-appropriate services for reproductive health (Guruge et al., 2018).

Several studies in Canada comparing the maternal health of migrant women to Canadian-born women indicate that migrant women report higher levels of postpartum depression (PPD) and are at greater risk of having psychosocial issues missed by the health care system (Gagnon, Dougherty, et al., 2013; Kingston et al., 2011). Urindwanayo and colleagues identified that immigrant women in Canada face increased maternal mental health issues due to structural

barriers in the health care system, including the lack of culturally competent care/cultural humility, lack of social support, and poverty (Urindwanayo, 2018). A potential reason that PPD is so prevalent in refugee populations could lie in flawed psychiatric evaluations (Brown-Bowers et al., 2015). Brown-Bowers and colleagues (2015) investigated this within the Canadian context and propose:

> The sociopolitical location of refugee and asylum-seeking women during pre-migration and post-migration is central to their experience of birthing and motherhood. Our understanding of their postpartum distress depends upon the extent to which we consider this sociopolitical matrix. (p. 321)

A Canadian scoping review highlighted that there are no clinical guidelines on maternal health care for immigrant women in Canada (Khanlou et al., 2017). We conducted our study to explore Syrian refugee women's experiences of SRH services in Ottawa, Ontario. During the interviews and subsequent analysis, the connection between Syrian women's experiences of maternal health and their perceptions of motherhood and mental health as a newcomer to Canada emerged as a prominent and unexpected theme. In this article, we explore these important intersections and describe the three main themes we identified from the maternal health domain of this study.

2. Methods

In 2019, we conducted a multi-methods qualitative study that involved in-depth interviews with 17 Syrian refugee women and 12 key informants living in Ottawa, Ontario. To be eligible to participate self-identified Syrian refugee women between the ages of 15-45 needed to have immigrated to Canada on/after November 4, 2016, reside in Ottawa at the time of the interview, and received any form of SRH services in Ontario. All key informants had experience providing services to Syrian refugee women in the Ottawa area.

2.1 Recruitment

We used a community-based multi-modal recruitment strategy and posted ads on/in social media, health care clinics, refugee organizations, community housing for refugees, and religious institutions. We then utilized early participant referral and our key informants' connections to obtain more participants. We distributed all advertisements in English, French, and Arabic. To recruit key informants, we reached out to several key health centers and organizations in Ottawa that support refugees. We then sent formal email invitations to potential participants and after each interview asked them to connect us with colleagues they think would be appropriate to participant in this study. For all interested participants we confirmed eligibility, sent consent forms via email, and scheduled an interview for a mutually convenient time.

2.2 Data collection

We conducted the in-depth interviews with the Syrian women in English and/or Arabic; they lasted approximately 60 minutes. The study coordinator, LC, a master's student and registered nurse conducted all of the interviews for both study components. An Arabic-speaking member of our broader research group served as an interpreter for the Arabic-language interviews. AMF, a medical doctor and medical anthropologist with a doctorate in Middle Eastern Studies, provided guidance throughout the data collection and analysis process. We audio-recorded all interviews with participants' consent and took field notes throughout.

We used a semi-structured interview guide with open-ended questions for all interviews. For the Syrian women each interview began by obtaining background information and demographics, such as age, education level, family composition, and immigration journey. We then moved on to inquiries about their SRH histories. In the main component of the interview, we asked women to share and compare their experiences accessing and receiving SRH services in Syria, in displacement, and in Ontario. We focused on maternal health, contraception, abortion, and cervical cancer screening, but women could discuss any SRH experiences they thought relevant. Finally, we asked all participants how SRH services could be improved for Syrian refugee women living in Ottawa. Each participant received a CAD40 gift card to Shoppers Drug Mart.

The key informant interviews began with participants outlining their professional backgrounds and the services and/or care they provided to Syrian refugee women in Ottawa. Throughout the interviews we focused on facilitators and barriers to providing quality SRH care to Syrian women. We did not compensate key informants.

2.3 Data analysis

Data analysis began during data collection and was an iterative process. Formal memoing was a critical part of the analytic plan and occurred immediately after each interview to address positionality, identify and mitigate subjectivities, and begin identifying themes. Members of the research team, including LC, RH, and ZE transcribed each interview; RH and ZE translated Arabic-language interviews into English. The audio recordings, transcripts, memos, and field notes comprise the data for this study.

We created a codebook specifically for this study using *a priori* (pre-determined) codes based on a review of the literature and the interview guide. Throughout the analysis process, we identified several emergent codes, specifically around motherhood and mental health. We managed our data using ATLAS.ti software and LC led the analysis of interviews from both study components for content and themes (Clarke & Braun, 2012). For the in-depth interviews with Syrian refugee women, we suspected we had reached thematic saturation on our main research questions after 14 interviews; we conducted three additional interviews to confirm our findings. For key informants, we wanted to obtain a range of perspectives. However, common themes emerged early on in the data collection process. We initially analyzed the in-depth interviews and key informant interviews separately; in the final analytic phase we brought the two study components together with an eye toward identifying concordance and discordance.

2.4 Ethical considerations

The Social Sciences and Humanities Research Ethics Board of the University of Ottawa approved this study. We have removed or masked all personally identifying information of participants. We use pseudonyms for our in-depth interview participants.

3. Results

3.1 Participant characteristics

Over a four-month period in 2019, we conducted interviews with 17 self-identified Syrian refugee women; they ranged in age from 18 to 41. Most participants were government assisted refugees (n=12) and the remaining were privately sponsored refugees (n=5). The majority of our

participants after being displaced from Syria lived in Jordan (n=10), followed by Turkey (n=3), Lebanon (n=2), and Iraq (n=1). Overwhelmingly our participants were married or had been married (n=16), and around half were married before the age of 18 (n=9). Almost all our participants had children (n=15), with the majority (n=13) having three or more at the time of the interview. Our participants reflected a range of education and socioeconomic levels.

Our 12 key informants all worked closely with Syrian refugee women in their professional practices; given the focus of our study most worked in a health care setting. Our key informants comprised nurse practitioners (n=3), family physicians (n=2), registered nurses (n=2), a midwife, a dietician, a psychotherapist, a resettlement worker, and a health care administrator. The majority had expert knowledge of refugee health and were involved in community efforts to prepare for Syrian refugees in Ottawa.

3.2 Syrian women have experienced traumatic maternal health care due to conflict and displacement

Syrian women in our study who had accessed maternal health services in countries of refuge described experiences of discrimination and abuse that were deeply traumatizing. Almost all participants spoke about how unwelcomed their pregnancies were when they lived as refugees in displacement settings. Dalal, age 30, who fled her Syrian home in the night after it was bombed, ended up in Jordan and she explained what is was like being pregnant while living there: "They do not like Syrian women getting pregnant and delivering. Because they think we came as refugees meaning we're not allowed to get pregnant."

Not only did the women we interview face discrimination and verbal abuse while accessing maternal health services, several of them also faced physical abuse and neglect from health care professionals. Fatin, age 29, described her Cesarean section:

> In Turkey, especially those who give natural births, they hit them. They used to give women a really hard time during birth, they hate Syrians. The surgery was fine, but they wouldn't listen to me when I told them I was in pain. They would tell me I was fine.

When asked about giving birth in Syria, most of the women we spoke with described their pre-conflict experiences with nostalgia and fond memories. Several women gave birth in the midst of the conflict and faced extremely precarious and traumatizing situations. Yasmine, age 33, described her birth in Syria after the onset of the conflict:

> I gave birth in miserable conditions. There was shooting [at us] and the birthing began…My husband told [the border guard] that my wife is giving birth and I want to take her to the hospital. They said take her out but we're not responsible if someone shoots you. I remained in pain until 5 at dawn and my mother-in-law said she'd birth me. We had to sterilize the tools, boiling water on gas. I gave birth with a flashlight, [there wasn't] electricity.

Despite these maternal health experiences, several of the Syrian women in our study described a strong desire to have another child that they often referred to as a "Canadian baby". One of our

key informants, a nurse practitioner, conceptualized this observation in the context of the trauma Syrian women experienced. She explained:

> This one individual that we have, that we still see here, has gone through so much trauma. Has lost kids to war. Has had kids in the past that she had to abandon for whatever reason and so having a kid is therapeutic for her because… it's the guilt, she is recovering from that guilt. And it could be bringing her joy and helping her forget about the past.

When asked about their experiences with maternal health care in Canada, many Syrian women were just grateful that they were receiving care that was not abusive. However, several of our key informants felt that because Syrians were "easily pleased", providers were not delving into deeper issues. One family physician summed it up, "People are not doing culturally appropriate and trauma-informed reproductive health histories."

3.3 Syrian mothers experienced high levels of isolation and stress raising children in Ottawa

According to our participants, Syrian women are used to being surrounded by robust community and family support, especially when pregnant, in the postpartum period, and childrearing. When asked about their maternal health, the Syrian women we interviewed often talked about the challenges they faced raising their children in Canada and how the stress of this impacted their maternal health. Syrian women felt isolated in their homes in Ottawa without their communities and those feelings were especially heightened during the winter months.

Syrian women often had to be at home because they were the caregivers for their children and could not afford daycare. This resulted in missing out on many of the support programs offered by the government in the first year after arrival. Nadja, age 29 and a privately sponsored refugee, described her first year in Canada:

> In the beginning it was very hard to meet new people. They speak [a] different language and different life, and everything is different. I am alone with six children and everybody is young. It is hard in the beginning but I met my sponsors, my friends, and they helped me a lot to understand how the life is here. They teach me how to speak English because the first year I didn't go to school, because of my daughter. She is with me at home."

Strong female familial relationships were central to Syrian women's maternal health and conceptualization of motherhood, but many of the women we spoke to had to leave behind mothers, mother-in-laws, sisters, and women cousins. This amplified their sense of isolation and left them with no one to turn to for questions or guidance. Elham, age 41, was a widow as a result of her husband being kidnapped and killed in Syria. She fled Syria with her mother and young children, but Canada was unable to accept her mother for immigration. She was pregnant at the time of the interview and explained how challenging it was without her mother:

> So that's why being here, it's very nice, but very difficult because of my mom. I have a friend but it's not, it's not the…it's not like your family. With the one I'm pregnant with right now, it's a high-risk pregnancy. So having two kids at the age that they move and stuff. It's like you need somebody, but it's just difficult. It's hard.

Syrian women described high levels of stress with childrearing in Canada. Some of the stress was related to isolation and lack of support. However, the women we interviewed also explained that they felt child rearing in Canada came with an unreasonable amount of responsibility placed upon mothers by society. Wafaa, age 32, described her perception of the concept of motherhood in Canada as a Syrian refugee,

> Life is good here. But you feel it's sometimes hard...there's more responsibility here. You feel like [children] need more care and attention. In terms of school, studying, and the rules here. [In Syria], you don't feel these rules. You feel like life is easier there.

3.4 Postpartum mental health needs to be prioritized amongst Syrian refugee women

From the Syrian women we interviewed, two explicitly expressed that they were struggling with post-partum depression and an additional four women experienced general mental health issues. They attributed most of their mental health issues to the trauma experienced during the conflict and displacement, which was exacerbated by the isolation and stress of adjusting to life in Canada. Elham, age 41, said this when asked about her reproductive health:

> It's just being in Syria and problems, like I said, stress and anxiety, they are the worst. They will either make you good health if you have good experience and bad health if you have bad experience in your life. And me, a lot of bad experience from my husband passing away, from my mother-in-law not being here to help me, and by not having my family. By not knowing a lot of people, coming to a new country and place from what you are used to. That just brought my reproductive health down."

One participant very openly disclosed her struggles with postpartum depression after she gave birth in Canada. Dalal described in her own words what it felt like:

> I gave birth in October and the winter came with it. I was suffocated. I kept thinking I will be alone and stayed home without school. I was alone at home. I was tired.

She reached out to her family physician and they gave her a prescription for anti-depressants, but her husband picked up the prescription for her: "He went to the pharmacist [who] was also Arab. He told my husband that he does not recommend this medication because, 'she is fat and it will make her even fatter, and secondly, she will remain 15 days until she can get off it.'" After this interaction, Dalal's husband refused to get the medication.

Participants described living in communities with other Syrians in Ottawa as very supportive toward mental well-being. However, our participants still struggled with being separated from immediate family. Alya, age 33, had five young children and when asked about her social supports she said:

> I have my neighbors I love, the Syrians. We are all Syrians here and love each other, but some stuff you cannot talk about to your neighbor, or friend. It has to be with your sister. I can't say everything.

One of our key informants, a psychologist, echoed this concern in the context of postpartum depression she noticed in her patients. She explained, "I wouldn't call it postpartum depression because I think it's just the lack of support that they are used to having, because neighbours are not the same as having your whole family around you for 40 days [postpartum]."

Another key informant, a dietician, elucidated further on Syrian women during the perinatal period and why they may not be getting the support they need. She said, "So prenatally um, and postnatally, they are...I get a sense…it's not that I get a sense, I do see that the women will always put the needs of their family first, food wise and everything else."

4. Discussion

Syrian refugee women have come to Canada with experiences and expectations of socio-cultural norms that undoubtedly affect their maternal health, mental health, and role as mothers. A report by Immigration, Refugees and Citizenship Canada evaluated the first year after the Syrian refugee resettlement and noted that Syrian refugees, especially government assisted refugees, had significantly more complex health needs, specifically related to trauma, than anticipated and this had not been properly communicated to the organizations and health care professionals preparing for their arrival (Government of Canada, 2017b). Canada's lack of preparation to support Syrian's mental health, and the disproportional effect on Syrian mothers, is surprising because there is an abundance of research on the higher rates of maternal depression in migrant populations (Ahmed et al., 2017; Hynie, 2018; Khanlou et al., 2017). Additionally, two reports by the UNFPA looking at the needs of Syrian women and girls conceptualized the crucial relationship between violence, mental, and reproductive health, and called out the need to integrate these areas in any primary health care response (Baker, 2014; Saadallah & Baker, 2016).

To begin to understand how Syrian women prioritize their maternal well-being and experiences of motherhood in Canada, it is important to understand the judgements they faced before their arrival and while in displacement. One researcher who looked at the "restrained motherhood" of Syrian refugee women living in Lebanon described her observations:

> The state adopts and perpetuates a xenophobic and reductive narrative that paints a picture of reckless, negligent, promiscuous, immoral, uncalculating, and broken women, who have fallen too far from the virtue of motherhood, while actively neglecting and dismissing the sexual and reproductive health needs and conditions of Syrian refugee women. (Yasmine & Moughalian, 2016).

Studies from Jordan and Lebanon report high rates of PPD, upwards of 50%, amongst Syrian women and call out the immediate need to screen and better support childbearing Syrians (Mohammad et al., 2018; Stevenson et al., 2019). This evidence supports our findings and highlights again the need to prioritize Syrian women's maternal mental health. Indeed, if Syrian women were already having these challenges in displacement, it should have been anticipated that the rates of PPD would only increase when immigrating to a country that is not culturally similar to Syria and where Arabic is not an official language.

A Canadian critical review on refugees' mental health after resettlement challenges providers to not just focus on "pre-migration factors" such as the conflict and displacement, but recognize the important role of "post-migration factors" such as social isolation, language skills, and discrimination (Hynie, 2018). These "post-migration factors" fall in line with our Syrian mothers' stressors while living in Canada and should be addressed along with the trauma of their "pre-migration factors" to comprehensively manage their maternal mental health needs.

One review in the United Kingdom posited that up to 42% of migrant women face PPD, compared to 10-15% of native-born women, and propose that all migrant women should be considered high-risk for PPD (Collins et al., 2011). The common risk factors they outlined were similar to our findings: stressful life events, lack of social support, and cultural adjustment (Collins et al., 2011).

Finally, a book funded by the Canadian government to review the Syrian Refugee Resettlement project, has a chapter entitled "Stress in Refugee Resettlement: Syrian Mothers' Strains and Buffers during Early Integration" (Milkie et al., 2020). The authors explained that a chapter was dedicated to this topic because refugee mothers are often neglected in research and their well-being impacts entire families, especially children (Milkie et al., 2020). They found from their research, "A first-and-foremost stressor for Syrian mothers was the huge loss of a home, neighbourhood, extended family, and country that they felt fundamental to mothering." (p. 135)

4.1 Implications for policy and practice

Most Syrian refugees have lived in Canada for several years and their immediate health needs have largely been attended to. The Canadian health care system now needs to turn its attention to their less "obvious" needs and focus on the broader social struggles Syrian's are facing adjusting to life in Canada. Those working with Syrian refugees need to consider how important a strong community is to their well-being, and especially raising a family. Creating more opportunities for Syrian mothers to connect with each other is critical to them finding empathy and support from those who understand their journey; this falls in line with the recommendations from Milkie and colleagues on "buffers" to Syrian mothers' stressors (Milkie et al., 2020). Advocacy for prenatal and mother-baby support groups of individuals in "similar circumstances" is one potential avenue for support, although advertising campaigns would be critical because immigrant women are far less likely to attend these types of groups than Canadian-born women (Higginbottom et al., 2015).

From our research and other Canadian studies it is clear that there is a need for improved cultural competency/cultural humility training for maternal health care providers, especially in identifying different ways refugee women present with maternal mental health issues (Higginbottom et al., 2015). A review from the United Kingdom recommended that practitioners screen for isolation, social supports, and recent stress from a culturally sensitive lens to detect more cases of PPD in migrant women (Collins et al., 2011). Educational workshops for health care providers are needed to teach them about Syrian women's pre-migration stressors such as obstetrical violence, discrimination toward pregnancy, and the massive loss of family and community, as well as their post-migration stressors of social isolation, stigma, and language barriers. Finally, these educational and advocacy efforts need to highlight the complex

intersections that exist between mental health, motherhood, and maternal health for newcomers to Canada.

4.2 Limitations

This study is a starting off point for further research on Syrian refugee women's experiences with maternal health and motherhood in Canada. We conducted this small-scale qualitative study in Canada's capital city and it is not generalizable. However, we are confident that our findings would be transferable beyond Syrian refugee women living in Ottawa.

4.3 Conclusions

While trying to be a mother in Canada, Syrian women carry with them experiences of trauma, abuse, displacement, the absence of family, and unaddressed mental health issues. It is clear from our Syrian women participants and key informants that more attention needs to be paid to Syrian refugee women's maternal mental health and more needs to be done to support them to adjust to the stressors of motherhood in Canada. This support needs to be trauma-informed and culturally resonant. Syrian mothers have given up so much of themselves to put their families first, it is important that the health system prioritizes taking care of them.

References

Ahmad, B., Fouad, F. M., Zaman, S., & Phillimore, P. (2019). Women's health and well-being in low-income formal and informal neighbourhoods on the eve of the armed conflict in Aleppo. *International Journal of Public Health*, *64*(1), 75–82. https://doi.org/10.1007/s00038-018-1150-2

Ahmed, A., Bowen, A., & Feng, C. X. (2017). Maternal depression in Syrian refugee women recently moved to Canada: A preliminary study. *BMC Pregnancy and Childbirth*, *17*(1). https://doi.org/10.1186/s12884-017-1433-2

Baker, D. (2014). *Regional Situation Report for Syria Crisis* (No. 27). United Nations Population Fund (UNFPA). https://www.unfpa.org/sites/default/files/resource-pdf/UNFPA%20Regional%20SitRep%201%20-%2030%20November%202014%20%20%23%2027_0.pdf

Brown-Bowers, A., McShane, K., Wilson-Mitchell, K., & Gurevich, M. (2015). Postpartum depression in refugee and asylum-seeking women in Canada: A critical health psychology perspective. *Health*, *19*(3), 318–335. https://doi.org/10.1177/1363459314554315

Carrière, A. (2016). *History and Legacy of Refugee Resettlement In Ottawa: A Primer* (p. 32). Catholic Center for Immigrants. http://cciottawa.ca/wp-content/uploads/History-and-Legacy-of-Refugee-Resettlement-In-Ottawa_A-Primer.pdf

Clarke, V., & Braun, V. (2012). Thematic Analysis. In *APA handbook of research methods in psychology* (Vol. 2, pp. 57–71). America Psycholgical Association.

Collins, C. H., Zimmerman, C., & Howard, L. M. (2011). Refugee, asylum seeker, immigrant women and postnatal depression: Rates and risk factors. *Archives of Women's Mental Health*, *14*(1), 3–11. https://doi.org/10.1007/s00737-010-0198-7

Gagnon, A. J., Dougherty, G., Wahoush, O., Saucier, J.-F., Dennis, C.-L., Stanger, E., Palmer, B., Merry, L., & Stewart, D. E. (2013). International migration to Canada: The post-birth health of mothers and infants by immigration class. *Social Science & Medicine*, *76*, 197–207. https://doi.org/10.1016/j.socscimed.2012.11.001

Government of Canada. (2017a, January 29). *#WelcomeRefugees: Key figures*. https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/welcome-syrian-refugees/key-figures.html

Government of Canada. (2017b, April 20). *Syrian Refugee Resettlement Initiative – Looking to the Future*. https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/welcome-syrian-refugees/looking-future.html

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

Heidari, S., & Moreno, C. G. (2016). Gender-based violence: A barrier to sexual and reproductive health and rights. *Reproductive Health Matters*, *24*(47), 1–4. https://doi.org/10.1016/j.rhm.2016.07.001

Higginbottom, G. M., Morgan, M., Alexandre, M., Chiu, Y., Forgeron, J., Kocay, D., & Barolia, R. (2015). Immigrant women's experiences of maternity-care services in Canada: A systematic review using a narrative synthesis. *Systematic Reviews*, *4*(1), 13. https://doi.org/10.1186/2046-4053-4-13

Hynie, M. (2018). The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review. *The Canadian Journal of Psychiatry*, *63*(5), 297–303. https://doi.org/10.1177/0706743717746666

Khanlou, N., Haque, N., Skinner, A., Mantini, A., & Kurtz Landy, C. (2017). Scoping Review on Maternal Health among Immigrant and Refugee Women in Canada: Prenatal, Intrapartum, and Postnatal Care. *Journal of Pregnancy*, *2017*, 1–14. https://doi.org/10.1155/2017/8783294

Kingston, D., Heaman, M., Chalmers, B., Kaczorowski, J., O'Brien, B., Lee, L., Dzakpasu, S., & O'Campo, P. (2011). Comparison of Maternity Experiences of Canadian-Born and Recent and Non-Recent Immigrant Women: Findings From the Canadian Maternity Experiences Survey. *Journal of Obstetrics and Gynaecology Canada*, *33*(11), 1105–1115. https://doi.org/10.1016/S1701-2163(16)35078-2

Masterson, A., Usta, J., Gupta, J., & Ettinger, A. S. (2014). Assessment of reproductive health and violence against women among displaced Syrians in Lebanon. *BMC Women's Health*, *14*(1). https://doi.org/10.1186/1472-6874-14-25

Milkie, M. A., Maghbouleh, N., & Peng, I. (2020). Stress in Refugee Settlement: Syrian Mothers' Strains and Buffers during Early Integration. In *A National Project: Syrian Refugee Resettlement in Canada* (p. 34). McGill-Queen's University Press. https://search.ebscohost.com/login.aspx?direct=true&db=nlebk&AN=2579371&site=ehost-live

Mohammad, K. I., Abu Awad, D., Creedy, D. K., & Gamble, J. (2018). Postpartum depression symptoms among Syrian refugee women living in Jordan. *Research in Nursing & Health*, *41*(6), 519–524. https://doi.org/10.1002/nur.21919

Saadallah, S., & Baker, D. (2016). *Women and Girls in the Syria Crisis: UNFPA Reponse*. United Nations Population Fund (UNFPA). https://www.unfpa.org/sites/default/files/resource-pdf/UNFPA-FACTSANDFIGURES-5%5B4%5D.pdf

Stevenson, K., Alameddine, R., Rukbi, G., Chahrouri, M., Usta, J., Saab, B., Bennett, P., Glover, V., & Reynolds, R. M. (2019). High rates of maternal depression amongst Syrian refugees in Lebanon—A pilot study. *Scientific Reports*, *9*(1), 11849. https://doi.org/10.1038/s41598-019-48247-5

UNHCR, Government of Turkey. (2020). *Situation Syria Regional Refugee Response*. https://data2.unhcr.org/en/situations/syria

Urindwanayo, D. (2018). Immigrant Women's Mental Health in Canada in the Antenatal and Postpartum Period. *Canadian Journal of Nursing Research*, *50*(3), 155–162. https://doi.org/10.1177/0844562118784811

Winn, A., Hetherington, E., & Tough, S. (2018). Caring for pregnant refugee women in a turbulent policy landscape: Perspectives of health care professionals in Calgary, Alberta. *International Journal for Equity in Health*, *17*(1). https://doi.org/10.1186/s12939-018-0801-5

Yasmine, R., & Moughalian, C. (2016). Systemic violence against Syrian refugee women and the myth of effective intrapersonal interventions. *Reproductive Health Matters*, *24*(47), 27–35. https://doi.org/10.1016/j.rhm.2016.04.008

Yount, K. M., & Smith, S. M. (2012). Gender and postpartum depression in Arab Middle Eastern women. *Women's Studies International Forum*, *35*(4), 187–193. https://doi.org/10.1016/j.wsif.2012.03.017

Chapter 5: Discussion

There are clear themes that have emerged from this study indicating that Syrian refugee women living in the Ottawa area face complex challenges when it comes to their sexual and reproductive health and utilization of services. The in-depth interviews with Syrian women and interviews with key informants highlight that these factors stem from Syrian women's past experiences and cultural context, Canada's health care response to Syrian refugees, and Syrian mothers adjusting to the expectations of Canadian culture. This final chapter integrates the results of the two articles and explores broader themes. It will outline the priority issues for Syrian refugee women's SRH and suggest improvements to services and supports in Ottawa. Finally, the chapter will discuss future directions for research, limitations to this study, a reflection on the author's positionality, a statement of contribution, and a conclusion.

5.1 Integration of results

When comparing the two articles written for this study, one investigates pragmatic health system barriers and facilitators that Syrian women experienced when accessing SRH services as a newcomer to Ottawa. The second article takes a more in-depth look into how Syrian women perceive their own SRH, which ultimately most women described through their experiences of maternal health and motherhood. Although very different foci, the articles have some overarching themes that tie them together: SRH educational opportunities were not culturally sensitive to the baseline knowledge and needs of Syrian women; Syrian women desired to receive care, education, and support from/with other women in their community; and past experiences of trauma, gender-based violence, increased expectations of motherhood, and

leaving behind family have left Syrian women with many unaddressed maternal mental health issues.

5.1.1 *Gender-based violence and gaps in SRH knowledge*

Prior to arriving to Canada, when Syrian women were displaced from the conflict, gender-based violence was on the rise including early marriage, intimate partner violence, sexual assault, and obstetric violence, and it had detrimental effects on Syrian women's access to and knowledge of SRH care (Heidari & Moreno, 2016; Masterson et al., 2014; Saadallah & Baker, 2016). It was evident from this study that Syrian refugee women in Ottawa had gaps in their knowledge of SRH. Our participants were the first to admit these gaps existed, and expressed a desire to have more SRH knowledge for themselves and their children. Many of the women we interviewed identified that their lack of knowledge was the result of marriage at an early age, a lack of SRH education in Syrian schools, and SRH being a culturally taboo topic.

More than half (n=9) of our participants were married before the age of 18 and most participants disclosed that they had almost no knowledge of SRH before marriage. Although it has been a difficult statistic to evaluate, an article that combined all the available reports estimated approximately a 10% increase in early marriage – marriage under the age of 18 – and attributed it to the added stressors of the Syrian conflict (Sieverding et al., 2020). El Arab and Sagbakken indicate that the increase in early marriage after the Syrian conflict was a result of factors such as economics, protection and safety, honour, and tradition (El Arab & Sagbakken, 2019). They then go on to outline the repercussions of early marriage on reproductive health, such as minimal SRH knowledge, lack of access to education, and lack of agency, which resulted in young women having poor access to SRH services (El Arab & Sagbakken, 2019). Nearly half

of our participants (n=8) were very adamant that since they now live in Canada their daughters will not get married until they are at least 18, and they wanted them to have more SRH knowledge before marriage than they had. This is echoed in a qualitative study from Jordan where Syrian refugee women were generally against early marriage, but also understood the societal pressures that perpetuated it (Cherri et al., 2017). Early marriage and its consequences on SRH affected our participants' access to and knowledge of SRH services in Ottawa, and is an important factor for health care providers to consider when providing SRH counselling. Additionally, knowing that Syrian mothers want their daughters to have more SRH knowledge before marriage creates an ideal opportunity for the health care system to respond to this need.

In combination with early marriage, other forms of gender-based violence such as intimate partner violence (IPV) have increased for Syrian refugee women as a result of conflict and displacement (Usta & Masterson, 2012). After fleeing Syria, many women lived in precarious conditions and stayed in violent relationships because they were fearful that reporting or leaving would put them in even more dire circumstances (Heidari & Moreno, 2016). In Ottawa, Syrian women are still in those relationships and are now living in a new country where they do not speak the language or understand the systems, which further compels them to stay with their partners. Two of our participants spoke directly about physical violence they experienced within their marriages and many more recalled stories from friends and family who experienced IPV. Our key informants indicated that IPV was anecdotally more prevalent amongst their Syrian refugee patients. An observational study using the 2012 Jordan Population and Family Health Survey concluded that women who married as minors and experienced IPV had an 87% increased odds of unmet contraceptive needs (Clark et al., 2017). IPV prevents

women from seeking SRH knowledge and care (Heidari & Moreno, 2016), thereby exacerbating the SRH knowledge gap that already exists for this population.

There is an emerging global trend of obstetric violence that disproportionately affects refugee women seeking obstetrical care while living in another country (Heidari & Moreno, 2016). Several of the Syrian women in our study that had given birth while in displacement (n=6) described detailed stories of abuse, neglect, discriminatory remarks, and denial of analgesic during labour and delivery in hospital. Our participants expressed extreme fear of giving birth in their countries of displacement and some sought out unsafe abortions and/or contraception they could not afford to avoid a birth. Experiences of obstetric violence will undoubtedly have an effect on trust of SRH care providers, and a study in Lebanon found that the majority of Syrian women (64.6%) who had experienced conflict related violence and non-partner sexual violence chose to not seek medical care for reproductive health issues (Masterson et al., 2014).

Sexual and reproductive health education and preventing gender-based violence are intimately linked. UNFPA "believes that every Syrian woman and girl has the right to have access to affordable reproductive health care and be effectively protected from gender-based violence", and health care providers play a major role in accomplishing this goal (Saadallah & Baker, 2016, p. 2). In Ontario, health care providers need to be educated on the context of gender-based violence that Syrian refugee women experience and understand how this will impact their utilization of SRH care, ability to process SRH education, and reception of the care that is provided.

5.1.2 *Maternal mental health and trauma*

Outlined in Chapter 4 and from the research provided above, it is clear that Syrian refugee women have experienced multiple forms and layers of trauma in their lives. Our participants' experiences of trauma, which impacted many aspects of their SRH, are intimately linked to gender-based violence, conflict, displacement, and immigration. One area of SRH that our participants especially highlighted as being affected by trauma was their maternal mental health. In total six participants discussed explicitly how their mental health, especially in the context of motherhood, has suffered. Two of our participants were clinically diagnosed with postpartum depression (PPD). Studies from Jordan and Lebanon report high rates of PPD, upwards of 50%, amongst Syrian women and call out for the immediate need to screen and better support childbearing Syrians (Mohammad et al., 2018; Stevenson et al., 2019).

In the MENA region, mental health is relatively stigmatized and there is often low mental health literacy (Elyamani et al., 2021; Zolezzi et al., 2018). Our key informants spoke about the challenges of breaking through these barriers around mental health with their Syrian patients. Ahmed and colleagues conducted a qualitative study assessing maternal depression in Syrian refugee women from Saskatchewan and discovered that most Syrian women did not have the knowledge and vocabulary to describe their mental health symptoms and would often state they were bored or tired, rather than depressed (Ahmed et al., 2017). Our key informants similarly noticed that Syrian women would somaticize their depression and frequently present with vague complaints of chronic pain; only after several visits did providers realize that they were actually struggling with their mental health.

In Canada, when comparing the maternal mental health of migrant to Canadian-born women research indicates that migrant women report higher levels of PPD, yet they are at greater risk of having psychosocial issues missed by the health care system due to providers not

understanding different cultural presentations of mental distress (Gagnon, Dougherty, et al., 2013; Kingston et al., 2011). Urindwanayo and colleagues identified that immigrant women in Canada face increased maternal mental health issues due to structural barriers in the health care system such as lack of cultural competency, but the main contributing factors are usually social isolation and poverty (Urindwanayo, 2018). Additionally, Higginbottom and colleagues, from a systematic review, identified other potential causes of PPD for immigrant women such as, negative experiences with health care providers, increase in childcare demands, lack of opportunity to share feelings, and lack of recognition and diagnosis (Higginbottom et al., 2015).

Loss of home, family, and social supports were noted by our participants and are cited in the research as the main sources of grief for Syrian mothers in Canada, who felt they could not provide adequate "mothering" without these essential connections (Milkie et al., 2020; Zivot et al., 2020). A critical review conducted in Canada investigated refugees mental health after resettlement, and challenged providers to look beyond "pre-migration factors" such as trauma from conflict and displacement, but recognize the important role of "post-migration factors" such as social isolation, language skills, and discrimination (Hynie, 2018).

Finally, a critical health psychology perspective suggests that PPD is so prevalent in Canadian refugee populations because of misguided psychiatric evaluations (Brown-Bowers et al., 2015). They propose:

> The sociopolitical location of refugee and asylum-seeking women during pre-migration and post-migration is central to their experience of birthing and motherhood. Our understanding of their postpartum distress depends upon the extent to which we consider this sociopolitical matrix. (p. 321)

5.1.3 *Adjusting to a different health care system and SRH culture*

Accessing SRH care tends to be a vulnerable experience for most individuals, and being a newcomer from a country with a significantly different language and culture, would only make the experience more daunting. The Syrian women and key informants we interviewed identified many system and cultural challenges that impeded access to SRH care. Some of the barriers were more concrete such as wait times, increased volume of required appointments, and transportation/navigation difficulties. They also identified more abstract and psychosocial barriers such as adjusting to privacy/confidentially norms, expectations around maternal health, and a drastically different culture around SRH in general.

A health care system adjustment that our participants found immensely frustrating was the referral system. In Syria's health care system, to see a specialist provider it is not necessary to see a general practitioner for a referral, and one can just book an appointment directly with a specialist. In Canada, to see a specialized provider you have to see a general practitioner first, and then they decide if a referral to a specialized provider is necessary; one cannot self-refer. A Canadian study investigated Syrian refugees self-reported unmet health care needs, and among the top two most frequent unmet needs was seeing a specialist (39.3%) (Tuck et al., 2019). When it came to SRH care, our participants did not understand why they needed to see their general practitioner first before seeing an obstetrician gynecologist (OB/GYN). Two participants waited over a year to get an appointment with an OB/GYN to have an IUD/IUS inserted and then ended up getting pregnant during this time.

When it came to prenatal care, our participants described the Canadian health care system as very cumbersome, including volume of appointments, transportation to appointments, and lack of childcare. When comparing their perinatal experiences to living in Syria our participants

explained that there were far fewer appointments, their communities/neighbours would take care of their children, and they did not have to travel in cold weather. A large retrospective study in Sweden comparing refugee women's maternal health to Sweden-born women showed that refugee women were at higher risk of poor self-reported maternal health, gestational diabetes, still births, preterm delivery, and low birth weight (Liu et al., 2019). They explained that in Sweden refugees immediately have full rights to maternal health care, but concluded that equal rights were not sufficient to guarantee equal access (Liu et al., 2019). A Canadian literature review reported that immigrants face barriers to accessing maternal health care including lack of information and awareness of services, insufficient supports to access services, and 'discordant expectations' between patients and their service providers (Higginbottom et al., 2015). Discordant expectations were mentioned by several of our participants. Due to the two-tiered nature of the Syrian health care system, our participants who had accessed the private system were accustomed to requesting something of their health care provider and receiving it immediately without hesitation. This was not the case in their interactions with Canadian providers and Syrian women often left their appointments feeling very unsatisfied and unsure why the appointment was necessary.

Postnatal care was also problematic, our participants explained that in Syria women are used to staying at home and being cared for by their families and communities for several months after giving birth. In Canada you are expected to have frequent check-ups for both infant and mother starting the first week after giving birth. Prior to the conflict, the majority of Syrian women had prenatal care (71.9%), but the 2001 Syrian Family Survey indicated that only 29.9% of Syrian women received postnatal care (Bashour & Abdulsalam, 2005). The unfamiliarity with postnatal care could explain why our participants found Canada's extensive postnatal care

schedule to be overwhelming. Moreover, as newcomers to Canada there are many other factors that affect Syrian women's ability to prioritize postnatal care,

> [Postpartum immigrant women] are required to cope concurrently with migration stressors and new parenthood, both contributing to higher levels of loneliness and stress that is further exacerbated by time restrictions for financial support, prolonged family reunification processes, and uncoordinated government services that serve the postnatal period. (Khanlou et al., 2017, p.8)

The concept of confidentially and privacy was explored with our participants as a potential barrier to accessing SRH services. Our participants overall had high levels of trust in Canadian health care providers and believed they would adhere to Canada's strict privacy rules, especially when they compared it to their previous experiences in displacement and/or in Syria. This sentiment is echoed by a qualitative study on postpartum depression amongst Syrian refugees in Saskatchewan, in which some women expressed concern about people in their community discovering they were seeking help for a mental illness, but they felt strongly that privacy concerns were far less of an issue in Canada than in other MENA countries, and did not consider this to be a significant barrier to SRH care (Ahmed et al., 2017). Key informants provided a different perspective on confidentiality/privacy with this population. They often wanted to have private conversations with Syrian women, specifically around SRH, but struggled to do so because their husbands or children often interpreted for them and if they used an interpreter that was a man, their husband would insist on being in the room. A Syrian study indicated that 13% of Syrian women did not use contraception due to their husband's disapproval, and 27% of women stated their husband was the final decision maker for contraception use (Roudi-Fahimi et al., 2012). As discussed in Chapter 3, the importance of

having more Arabic speaking women healthcare providers cannot be understated when it comes to ensuring privacy for SRH care.

5.1.4 *Insufficient access to culturally and linguistically tailored SRH information and services*

Accessing culturally and linguistically tailored SRH information was noted by Syrian women and key informants in our study to be a significant challenge. Syrian women held many SRH misconceptions and sought out most of their SRH information through informal networks in own community, usually because this was the cultural norm, but also sometimes because they could not find other sources in Arabic. Barriers to accessing other sources of information were most commonly related to language, and further many participants felt that most SRH educational opportunities did not meet them at their baseline level of knowledge and did not address the beliefs they held about SRH.

As described in Chapter 3, most Syrian women had misconceptions about contraception and relied heavily on SRH information from familial matriarchal relationships. A qualitative study in Lebanon found that adolescent girls experienced anxiety and fear when they first menstruated due to inadequate SRH information (El Ayoubi et al., 2021). They also noted discordance between young women relying mainly on their mothers for SRH information yet mothers being very reluctant to speak about SRH to their daughters (El Ayoubi et al., 2021). This mirrors the experiences of many of our participants. A few of our participants disclosed that they were told very little from their mothers about what to expect on their wedding night and several believed their husband would kiss them and they would become pregnant. This can further explain why they felt that the available SRH educational opportunities in Ontario were above their baseline level of knowledge.

When further investigating misconceptions, many of our participants knew their SRH knowledge was incorrect, but still struggled to dispel long held cultural fears, specifically the fear that contraception could make you infertile. In Ontario, immigrants and refugees often express that there are gaps in their SRH knowledge and consequentially struggle to understand health teaching during appointments (Maticka-Tyndale et al., 2007; Newbold & Willinsky, 2009). These gaps in knowledge lead to fears and misconceptions, specifically around hormonal forms of contraception, which results in high levels of unmet contraceptive needs amongst newcomer populations in Canada (Wiebe, 2013). Most of the available SRH information for adults in Ontario often functions under the assumption that everyone had SRH education while in elementary and high school. Further, it would not specifically address certain misconceptions that Syrian women may hold because they are not common beliefs in Canadian culture. Having linguistically and culturally tailored SRH educational classes or resources was something our participants and key informants expressed a strong desire for.

Lastly, having a language barrier was mentioned most by our participants as one of the main barriers to accessing SRH information and services. In the primary health care setting, where most SRH care occurs, Pottie and colleagues found that increased interpretation services and communication support had the highest impact on improving care for refugees (Pottie et al., 2014). Interpretation services and language classes for Syrian refugees were available in their first year of arrival to Canada, but the Syrian Outcomes Report noted that many Syrian mothers were not able to take advantage of these services in the first year because of insufficient childcare and this resulted in husbands often being the only family member sent to the classes (Immigration, Refugees and Citizenship Canada, 2019). Refugee women's health is

disproportionately impacted by their language deficit, especially when it comes to SRH care. Zivot and colleagues explain:

> [W]omen are often required to take their children, partners, or family members along with them to medical appointments to act as translators. This practice may affect consent, confidentiality, and transparency, particularly when seeking services or information for issues that may be personal or stigmatized such as sexual and reproductive health, sexual or gender-based violence, or mental health (Zivot et al., 2020, p.13).

5.2 Suggestions for improving SRH services for Syrian women

Our study has identified several barriers that Syrian refugee women face when accessing and receiving SRH services in Ottawa, Ontario. These barriers are physical, psychosocial, and cultural, and all intersect to make SRH care inequitable for this vulnerable population. Inadequate access to interpretation services, especially after the first year in Canada, was the most significant barrier to SRH that our participants and key informants identified, and the evidence shows that Syrian women were disproportionately affected by the lack of language services and it is clear they needed interpretation support past the first year of resettlement (Immigration, Refugees and Citizenship Canada, 2019). Our key informants stressed that when it comes to healthcare, and specifically SRH care which requires a heightened level of confidentially, interpretation services should not have a time limit for funding and need to always be provided to make sure that information is understood fully without the need for familial interpreters.

Our key informants expressed a need for more cultural competency training for health care providers, especially in regards to SRH care for Syrian refugee women to understand better their beliefs, misconceptions, and origins of knowledge. Endler and colleagues, with support

from the International Federation of Gynecologists and Obstetricians (FIGO), wrote an article outlining how international guidelines and recommendations have a 'willful indifference' towards the SRH needs of refugee populations and have for the most part failed at the provision of care for this population (Endler et al., 2020). FIGO has created several initiatives to improve medical school curriculum and residency training for obstetrical gynecologists that include human rights and bioethics curriculum, as well to advocate that these programs be included in the international minimum requirements for OB/GYN education (Endler et al., 2020). When using a trauma-informed lens it is important to teach cultural humility, which moves beyond cultural competency and encourages health care providers to celebrate cultural identities without having to understand all aspects of a certain culture (Kimberg & Wheeler, 2019). It also asks the provider to recognize the power and privilege dynamics associated within cultures and then understand that culture will significantly affect how patients interact with the health care system (Kimberg & Wheeler, 2019). In our study, it was mainly nurse practitioners managing the SRH care of Syrian refugees in Ottawa because of their utilization within CHCs. Due to their prevalence as providers for newcomers, it would be very pertinent that nurse practitioner education include increased cultural competency/humility training, especially in relation to newcomer populations.

The intersections between maternal health, motherhood, and mental health for Syrian refugee women dominated the interview discussions in this study and ended up being a very strong emergent finding. It was clear from our participants that feeling supported in motherhood as a newcomer was essential to having optimal maternal health. Ahmed and colleagues found that a protective factor for Syrian refugees' maternal health in Saskatchewan was strong social supports with an emphasis on emotional support around the time of birth, and suggested

interventions such as gendered and culturally tailored support programs (Ahmed et al., 2017). The results of an ethnographic study in Canada recommended population interventions to improve migrant women's maternal-child health, and social inclusion interventions such as support groups with other newcomers were identified as major sources of resilience (Gagnon et al., 2013). Our participants also identified having Syrian neighbours as a critical part of their maternal health culture, and fortunately Ottawa did place the majority of GARs in neighbourhoods together.

When considering the importance of social support groups, our participants spoke about the desire to have SRH educational classes or prenatal classes with other Syrian women. Some of the more highly educated Syrian women we talked to said they were very interested in facilitating these groups and felt that traditional prenatal classes through local health units did not address the specific needs or beliefs of Syrian women. Torres and colleagues analyzed the use of independent "multicultural health brokers" for perinatal care of immigrants in Alberta (Torres et al., 2013). These health brokers, or essentially community health workers, were able to offer linguistically and culturally informed care, not available within the traditional health care system, and that was empathetic to the broader issues faced by newcomers (Torres et al., 2013). This is an idea that could be implemented in Ontario to provide more tailored and accessible maternal health care to Syrian women.

An overarching tenant of providing health care to any population is that it be trauma-informed, but this is specifically relevant to Syrian refugee women due to the inordinate amount of trauma they have faced. Trauma-informed care firstly recognizes the prevalence of trauma in any community and then uses a strength-based approach that prioritizes the feeling of safety for the patient and provider (Kimberg & Wheeler, 2019). The San Francisco department of public

health outlines the principles and competencies of trauma-informed care as "trauma understanding, cultural humility and responsiveness, safety and stability, compassion and dependability, collaboration and empowerment, resilience and recovery" (Loomis, 2014, p. 4). Providing this type of care to Syrian refugee women is especially critical when it comes to their SRH because many of them faced trauma when accessing this type of care in countries of displacement. Kimberg and Wheeler (2019) dedicated a chapter in their textbook to trauma-informed maternity care which explains the importance of being flexible and supportive of the mother's desires for her birth.

So far when looking at the initiatives to mitigate the barriers that Syrian refugee women face when accessing SRH care, it appears that they need to be community-based and involve Syrian refugees as central stakeholders. Veronis describes the successful work of Ottawa's Local Immigration Partnership (OLIP) which was an initiative by the federal government in 2008 (Veronis, 2019). Local immigration partnerships' mandate is "supporting and enhancing settlement service provision and coordination through a community-based, collaborative, and intersectoral approach" (Veronis, 2019, p. 393). OLIP was able to coordinate with CHC's and create the Ottawa Newcomer Health Center (ONHC) which was a key participant in our study and was accessed by many of the Syrian women we interviewed. The ONHC had a well-laid out plan for refugee's health assessment that always included a 'well woman visit', as assessment that specifically addresses SRH needs which are historically neglected upon resettlement. CHC's often have a wide variety of health care providers, creating more choice of practitioner, and their flexible funding allows for access to more services including interpretation services. This model of care is optimal for refugees, but unfortunately when talking with our key informants at the ONHC and other CHCs, every year it is a battle to maintain funding, especially for interpretation

services. The Ontario government needs to recognize the importance of and increase funding to community-based health care organizations which are critical for refugees to receive comprehensive and accessible health care that addresses all their needs, including SRH care.

5.3 Significance and future directions

This research represents the first primary data collection study in Ontario on the SRH needs of Syrian refugee women, and the first study in Canada that focuses on more than maternal health. This study is also unique in that it combined the voices of both Syrian women, often excluded in the current research, and key informants who provide SRH care to Syrian women in Ottawa. The findings for this study will help fill the gap in the literature and can act as a starting point to investigate the SRH needs of Syrian women living in other regions of Canada.

We have three main strategies to disseminate this research. The first is publishing both journal articles that comprise Chapter 3 and 4 of this manuscript in peer-reviewed journals. The second is by disseminating a report to health care providers using our key informants. This report will give a brief overview of the gaps in SRH care for Syrian women in Ottawa and suggestions for improvements to care. This dissemination step is critical because we know that frontline workers do not always engage in academic literature and need more accessible avenues. Finally, we will present this research at academic and practitioner conferences both locally and nationally. The content from Chapter 3 has already been presented at the Interdisciplinary Student Research Conference on Healthcare (ISRCH) at the University of Ottawa and accepted for an oral presentation at the Integrating Sex and Gender in Health Research Symposium at the University of Ottawa.

5.4 Limitations

There were several limitations to this study. Initially, during recruitment, we connected with very few Syrian women and as we predicted, establishing trust in their community was essential to our successful recruitment. We were able to prove our trustworthiness through the support of one of our key informants who was a midwife that almost exclusively catered to Syrian women in Ottawa. Once she connected us with a few Syrian women and they talked amongst their own networks they decided we could be trusted. After that we had no shortage of interest in study participation. We had a goal of 20 participants, but we reached thematic saturation after 14 interviews and already had 3 more interviews scheduled that we completed for a total of 17 interviews.

After our challenges of initial recruitment in Ottawa and issues with availability of an interpreter, we were not able to repeat this study in London, Ontario, as we had planned to. We were hoping to compare the results of Syrian women living in Ottawa to those living in London. This does impact the transferability of this research and the ability to triangulate results. It is recommended that future studies with more resources interview Syrian refugee women from various communities in Ontario to compare and contrast their experiences.

Another limitation was the level of heterogeneity of our participants. Fortunately, our participants' socioeconomic status and education levels relatively varied. We had participants with no education past Grade 8 to participants with graduate level education. We had a somewhat reasonable mix of GARs (12) to PSRs (5), although it would have been beneficial to have more PSR interviews. Our main drawback was that we conducted only one interview with an unmarried participant and therefore were not able to gain adequate insight on the challenges this subsection of Syrian women face when accessing SRH care in Ottawa. We were also unable

to recruit an obstetrician gynecologist from the Ottawa area for a key informant interview, which would have added more nuanced SRH insights.

This small-scale qualitative master's thesis study is able to give voice to Syrian refugee women's attitudes, behaviours, and experiences when accessing SRH care in Ottawa, but these results are not generalizable to other groups of refugees, and although experiences may be similar, they are not generalizable to Syrian refugees living in other Ontario communities. However, we are confident that the themes we identified are valuable and meaningful, and likely are somewhat transferable to other communities in Ontario.

5.5 Positionality and reflexivity

When conducting qualitative research, the experiences of the researcher can greatly affect the results. An important process in qualitative research is acknowledging and addressing one's positionality through reflexivity practices. Positionality is intersectional and shaped by our racial, ethnic, and gendered experiences, and additionally as a researcher, our position of power and privilege (Muhammad et al., 2015). These positionalities affect our decision-making in research, knowledge creation, and representation of participants voices (Muhammad et al., 2015). For a study such as this, when addressing researcher positionality in the context of race and culture, Milner recommends four practices for reflexivity: researching the self, researching the self in relation to others, engaging in reflection and representation, and shifting from self to system (Milner, 2007).

Throughout this research project I actively participated in reflexive memoing to engage with my intersectional positionalities. I worked personally on acknowledging my racial and cultural biases while reaching out to my Arab colleagues and supervisor for guidance to make

sure that I was understanding the cultural context of interviews and relaying it correctly through my writing. That being said, the heightened aptitudes that come with being an insider cannot be fully replicated, Muhammad and colleagues write, "Indigenous insiders may more easily hear hidden voices with their shared emotional connections, therefore being able to move beyond 'ventriloquy' to contextualize the research" (Muhammad et al., 2015, p. 14).

Although I engaged in many practices to acknowledge my positionality and bias, I found my positionality to be the most challenging aspect of this research. I am an Anglophone Caucasian woman of European descent and I do not ethnically, religiously, or linguistically identify with my participants. I learned an immense amount from the Syrian women I interviewed and my colleagues, but I truly feel that someone with a closer cultural connection to this population could have done more justice to this research. As a registered nurse, I do believe I brought a unique perspective to this study that is valuable, but I will never be able to fully empathize with my participants in a way that I believe would have been helpful for the interpretation of the results.

5.6 Statement of contribution

I completed this study under the supervision of Dr. Angel M. Foster. It was completed in partial fulfillment of the requirements for my Master of Interdisciplinary Health Science in the Faculty of Health Sciences at the University of Ottawa. I conceptualized and designed this study, created the study tools, conducted and transcribed – with interpretation and translation assistance – the interviews, and wrote both journal manuscripts.

Dr. Angel M. Foster oversaw and reviewed all steps in the research process. She helped me with the initial design of the project to make it feasible and culturally informed. She edited

my research proposal and assisted with the REB approval process. Dr. Foster reviewed my interview guide and codebook, as well as following along with interview data throughout data collection. We connected regularly to review emerging themes and discuss my memoing. Finally, she edited this document and helped me prepare both manuscripts for publication.

I prepared for this research project through my graduate courses, a qualitative research workshop conducted by Dr. Foster, that taught me how to use ATLAS.ti, code for themes, and interview skills. As part of our research team, we had weekly group meetings that explored the different elements of qualitative research design, we learned about SRH in a research context, and were exposed to other student's research projects and ideas. Additionally, as part of my directed study course, I was the Study Coordinator for a qualitative research study that investigated access to mental health services for women living in violence against women shelters. Personally, my experience as a registered nurse caring for Syrian refugee women's SRH needs in a primary health care setting was highly valuable.

5.7 Conclusion

Syrian refugees have lived in Canada in for over 5 years and although their most immediate health needs have been well attended to, Syrian women are still facing several complex barriers to accessing and receiving comprehensive SRH services. These challenges are intertwined with being a newcomer and the vulnerabilities associated with accessing and receiving SRH care. Understanding Syrian women's perceptions and experiences of the barriers they face is critical to creating SRH services that are equitable in the Ottawa area.

Syrian refugee women's experiences coupled with insights from key informants highlighted how Syrian women's experiences of trauma, gender-based violence, loss of family

and community, language barriers, and cultural preferences and traditions were all compounding factors that created barriers to them accessing SRH services and also achieving SRH wellness.

Within Ottawa's health system, there is a significant need for cultural competency training, an increased pool of Arabic speaking woman providers, permanent and stable funding for interpretation services, and culturally tailored SRH educational opportunities. Creating more community-based opportunities for Syrian women to connect, teach and learn with each other, and share their experiences of SRH is critical to them finding empathy, comfort, and support from those who understand their journey.

References

Abdulrahim, S., DeJong, J., Mourtada, R., & Zurayk, H. (2017). Estimates of early marriage among Syrian refugees in Lebanon in 2016 compared to Syria pre-2011. *European Journal of Public Health*, *27*(suppl_3). https://doi.org/10.1093/eurpub/ckx189.049

Ahmad, B., Fouad, F. M., Zaman, S., & Phillimore, P. (2019). Women's health and well-being in low-income formal and informal neighbourhoods on the eve of the armed conflict in Aleppo. *International Journal of Public Health*, *64*(1), 75–82. https://doi.org/10.1007/s00038-018-1150-2

Ahmed, A., Bowen, A., & Feng, C. X. (2017). Maternal depression in Syrian refugee women recently moved to Canada: A preliminary study. *BMC Pregnancy and Childbirth*, *17*(1). https://doi.org/10.1186/s12884-017-1433-2

Åkerman, E., Larsson, E. C., Essén, B., & Westerling, R. (2019). A missed opportunity? Lack of knowledge about sexual and reproductive health services among immigrant women in Sweden. *Sexual & Reproductive Healthcare*, *19*, 64–70. https://doi.org/10.1016/j.srhc.2018.12.005

Amiri, M., El-Mowafi, I. M., Chahien, T., Yousef, H., & Kobeissi, L. H. (2020). An overview of the sexual and reproductive health status and service delivery among Syrian refugees in Jordan, nine years since the crisis: A systematic literature review. *Reproductive Health*, *17*(1), 166. https://doi.org/10.1186/s12978-020-01005-7

Aptekman, M., Rashid, M., Wright, V., & Dunn, S. (2014). Unmet contraceptive needs among refugees: Crossroads clinic experience. *Canadian Family Physician*, *60*(12), e613–e619. Scopus.

Baker, D. (2014). *Regional Situation Report for Syria Crisis* (No. 27). United Nations Population Fund (UNFPA). https://www.unfpa.org/sites/default/files/resource-pdf/UNFPA%20Regional%20SitRep%201%20-%2030%20November%202014%20%20%23%2027_0.pdf

Bashour, H., & Abdulsalam, A. (2005). Syrian Women's Preferences for Birth Attendant and Birth Place. *Birth*, *32*(1), 20–26. https://doi.org/10.1111/j.0730-7659.2005.00333.x

Benage, M., Greenough, P., Vinck, P., Omeira, N., & Pham, P. (2015). An assessment of antenatal care among Syrian refugees in Lebanon. *Conflict and Health*, *9*(1), 8. https://doi.org/10.1186/s13031-015-0035-8

Bittles, A. H. (2013). Consanguineous marriages and congenital anomalies. *The Lancet*, *382*(9901), 1316–1317. https://doi.org/10.1016/S0140-6736(13)61503-2

Boerleider, A. W., Wiegers, T. A., Manniën, J., Francke, A. L., & Devillé, W. L. (2013). Factors affecting the use of prenatal care by non-western women in industrialized western countries: A systematic review. *BMC Pregnancy and Childbirth*, *13*(1), 81. https://doi.org/10.1186/1471-2393-13-81

Boonstra, H. (2001). Islam, Women and Family Planning: A Primer. *The Guttmacher Report on Public Policy*, 4–7.

Bowen, D. L. (1997). Abortion, Islam, and the 1994 Cairo Population Conference. *International Journal of Middle East Studies*, *29*(2), 161–184. https://doi.org/10.1017/S002074380006445X

Bradbury, H. (2017). *The SAGE Handbook of Action Research* (Third Edition). https://doi.org/10.4135/9781473921290

Brar, S., Tang, S., Drummond, N., Palacios-Derflingher, L., Clark, V., John, M., & Ross, S. (2009). Perinatal Care for South Asian Immigrant Women and Women Born in Canada: Telephone Survey of Users. *Journal of Obstetrics and Gynaecology Canada*, *31*(8), 708–716. https://doi.org/10.1016/S1701-2163(16)34274-8

Brown-Bowers, A., McShane, K., Wilson-Mitchell, K., & Gurevich, M. (2015). Postpartum depression in refugee and asylum-seeking women in Canada: A critical health psychology perspective. *Health*, *19*(3), 318–335. https://doi.org/10.1177/1363459314554315

Carrière, A. (2016). *History and Legacy of Refugee Resettlement In Ottawa: A Primer* (p. 32). Catholic Center for Immigrants. http://cciottawa.ca/wp-content/uploads/History-and-Legacy-of-Refugee-Resettlement-In-Ottawa_A-Primer.pdf

Chan, M., Johnston, C., & Bever, A. (2018). Exploring Health Service Underutilization: A Process Evaluation of the Newcomer Women's Health Clinic. *Journal of Immigrant and Minority Health*, *20*(4), 920–925. https://doi.org/10.1007/s10903-017-0616-2

Cherri, Z., Cuesta, J. G., Rodriguez-Llanes, J., & Guha-Sapir, D. (2017). Early Marriage and Barriers to Contraception among Syrian Refugee Women in Lebanon: A Qualitative Study. *International Journal of Environmental Research and Public Health*, *14*(8), 836. https://doi.org/DeJong

Clark, C. J., Spencer, R. A., Khalaf, I. A., Gilbert, L., El-Bassel, N., Silverman, J. G., & Raj, A. (2017). The influence of family violence and child marriage on unmet need for family planning in Jordan. *Journal of Family Planning and Reproductive Health Care*, *43*(2), 105–112. https://doi.org/10.1136/jfprhc-2014-101122

Clarke, V., & Braun, V. (2012). Thematic Analysis. In *APA handbook of research methods in psychology* (Vol. 2, pp. 57–71). America Psycholgical Association.

Çöl, M., Bilgili Aykut, N., Usturalı Mut, A. N., Koçak, C., Uzun, S. U., Akın, A., Say, L., & Kobeissi, L. (2020). Sexual and reproductive health of Syrian refugee women in Turkey: A scoping review within the framework of the MISP objectives. *Reproductive Health*, *17*(1), 99. https://doi.org/10.1186/s12978-020-00948-1

Colborne, M. (2015). Syrian refugees' mental health is top priority. *Canadian Medical Association Journal*, *187*(18), 1347–1347. https://doi.org/10.1503/cmaj.109-5183

Collins, C. H., Zimmerman, C., & Howard, L. M. (2011). Refugee, asylum seeker, immigrant women and postnatal depression: Rates and risk factors. *Archives of Women's Mental Health*, *14*(1), 3–11. https://doi.org/10.1007/s00737-010-0198-7

Darwish, W., & Muldoon, L. (2020). Acute primary health care needs of Syrian refugees immediately after arrival to Canada. *Canadian Family Physician*, *66*, 9.

DeJong, J., Jawad, R., Mortagy, I., & Shepard, B. (2005). The Sexual and Reproductive Health of Young People in the Arab Countries and Iran. *Reproductive Health Matters*, *13*(25), 49–59. https://doi.org/10.1016/S0968-8080(05)25181-9

Dikmen, H. A., Cankaya, S., & Yilmaz, S. D. (2018). The attitudes of refugee women in Turkey towards family planning. *Public Health Nursing*. https://doi.org/10.1111/phn.12553

du Prey, B., Talavlikar, R., Mangat, R., Freiheit, E. A., & Drummond, N. (2014). Induced abortion and contraception use: Among immigrant and Canadian-born women in Calgary, Alta. *Canadian Family Physician*, *60*(9), e455–e463. PMC.

El Arab, R., & Sagbakken, M. (2019). Child marriage of female Syrian refugees in Jordan and Lebanon: A literature review. *Global Health Action*, *12*(1), 1585709. https://doi.org/10.1080/16549716.2019.1585709

El Ayoubi, L. L., Abdulrahim, S., & Sieverding, M. (2021). Sexual and Reproductive Health Information and Experiences Among Syrian Refugee Adolescent Girls in Lebanon. *Qualitative Health Research*, *31*(5), 983–998. https://doi.org/10.1177/1049732321989685

Elyamani, R., Naja, S., Al-Dahshan, A., Hamoud, H., Bougmiza, M. I., & Alkubaisi, N. (2021). Mental health literacy in Arab states of the Gulf Cooperation Council: A systematic review. *PLOS ONE*, *16*(1), e0245156. https://doi.org/10.1371/journal.pone.0245156

Endler, M., Haidari, T. A., Chowdhury, S., Christilaw, J., Kak, F. E., Galimberti, D., Gutierrez, M., Ramirez-Negrin, A., Senanayake, H., Sohail, R., Temmerman, M., & Danielsson, K. G. (2020). Sexual and reproductive health and rights of refugee and migrant women: Gynecologists' and obstetricians' responsibilities. *International Journal of Gynecology & Obstetrics*, *149*(1), 113–119. https://doi.org/10.1002/ijgo.13111

Gagnon, A. J., Carnevale, F., Mehta, P., Rousseau, H., & Stewart, D. E. (2013). Developing population interventions with migrant women for maternal-child health: A focused ethnography. *BMC Public Health*, *13*(1), 471. https://doi.org/10.1186/1471-2458-13-471

Gagnon, A. J., Dougherty, G., Wahoush, O., Saucier, J.-F., Dennis, C.-L., Stanger, E., Palmer, B., Merry, L., & Stewart, D. E. (2013). International migration to Canada: The post-birth health of mothers and infants by immigration class. *Social Science & Medicine*, *76*, 197–207. https://doi.org/10.1016/j.socscimed.2012.11.001

Gagnon, A. J., & Redden, K. L. (2016). Reproductive health research of women migrants to Western countries: A systematic review for refining the clinical lens. *Best Practice & Research Clinical Obstetrics & Gynaecology*, *32*, 3–14. https://doi.org/10.1016/j.bpobgyn.2016.01.005

Government of Canada. (2017a, January 29). *#WelcomeRefugees: Key figures*. https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/welcome-syrian-refugees/key-figures.html

Government of Canada. (2017b, April 20). *Syrian Refugee Resettlement Initiative – Looking to the Future*. https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/welcome-syrian-refugees/looking-future.html

Government of Ontario. (2018, September 8). *Syrian refugees: How you can help*. https://www.ontario.ca/page/syrian-refugees-how-you-can-help

Gümüş Şekerci, Y., & Aydın Yıldırım, T. (2020). The knowledge, attitudes and behaviours of Syrian refugee women towards family planning: Sample of Hatay. *International Journal of Nursing Practice*, *26*(4). https://doi.org/10.1111/ijn.12844

Gürbüz, B., Großkreutz, C., Vortel, M., Borde, T., Rancourt, R. C., Stepan, H., Sauzet, O., Henrich, W., David, M., & Seidel, V. (2019). The influence of migration on women's satisfaction during pregnancy and birth: Results of a comparative prospective study with the Migrant Friendly Maternity Care Questionnaire (MFMCQ). *Archives of Gynecology and Obstetrics*, *300*(3), 555–567. https://doi.org/10.1007/s00404-019-05227-4

Guruge, S., Sidani, S., Illesinghe, V., Younes, R., Bukhari, H., Altenberg, J., Rashid, M., & Fredericks, S. (2018). Healthcare needs and health service utilization by Syrian refugee

women in Toronto. *Conflict and Health*, *12*(1). https://doi.org/10.1186/s13031-018-0181-x

Hansen, L., & Huston, P. (2016). Health considerations in the Syrian refugee resettlement process in Canada. *Canada Communicable Disease Report*, *42*(S2), S3–S7. https://doi.org/10.14745/ccdr.v42is2a02

Hansen, L., Maidment, L., & Ahmad, R. (2016). Early observations on the health of Syrian refugees in Canada. *Canada Communicable Disease Report*, *42*(S2), S8–S10. https://doi.org/Hessini

Heidari, S., & Moreno, C. G. (2016). Gender-based violence: A barrier to sexual and reproductive health and rights. *Reproductive Health Matters*, *24*(47), 1–4. https://doi.org/10.1016/j.rhm.2016.07.001

Hessini, L. (2007). Abortion and Islam: Policies and Practice in the Middle East and North Africa. *Reproductive Health Matters*, *15*(29), 75–84. https://doi.org/10.1016/S0968-8080(06)29279-6

Higginbottom, G. M., Morgan, M., Alexandre, M., Chiu, Y., Forgeron, J., Kocay, D., & Barolia, R. (2015). Immigrant women's experiences of maternity-care services in Canada: A systematic review using a narrative synthesis. *Systematic Reviews*, *4*(1), 13. https://doi.org/10.1186/2046-4053-4-13

Huster, K. M. J., Patterson, N., Schilperoord, M., & Spiegel, P. (2014). Cesarean Sections Among Syrian Refugees in Lebanon from December 2012/January 2013 to June 2013: Probable Causes and Recommendations. *Yale Journal of Biology and Medicine*, *87*, 269–288.

Hynie, M. (2018). The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review. *The Canadian Journal of Psychiatry*, *63*(5), 297–303. https://doi.org/10.1177/0706743717746666

IAWG. (2018). *Inter-agency field manual on reproductive health in humanitarian settings*. https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-English.pdf

Immigrant Women Services. (2020). https://www.immigrantwomenservices.com/

Immigration, Refugees and Citizenship Canada. (2016). *Rapid Impact Evaluation of the Syrian Refugee Initiative* (p. 4). https://www.canada.ca/content/dam/ircc/migration/ircc/english/resources/evaluation/pdf/e1-2016-execsum-en.pdf

Immigration, Refugees and Citizenship Canada. (2019). *Syrian outcomes report*. https://epe.lac-bac.gc.ca/100/201/301/weekly_acquisitions_list-ef/2020/20-22/publications.gc.ca/collections/collection_2020/ircc/Ci4-195-2019-eng.pdf

Inci, M. G., Kutschke, N., Nasser, S., Alavi, S., Abels, I., Kurmeyer, C., & Sehouli, J. (2020). Unmet family planning needs among female refugees and asylum seekers in Germany – is free access to family planning services enough? Results of a cross-sectional study. *Reproductive Health*, *17*(1), 115. https://doi.org/10.1186/s12978-020-00962-3

Jurdi, R. (2004). Caesarean section rates in the Arab region: A cross-national study. *Health Policy and Planning*, *19*(2), 101–110. https://doi.org/10.1093/heapol/czh012

Kabakian-Khasholian, T., Mourtada, R., Bashour, H., El Kak, F. E., & Zurayk, H. (2017). Perspectives of displaced Syrian women and service providers on fertility behaviour and available services in West Bekaa, Lebanon. *Reproductive Health Matters*, *25*(sup1), 75–86. https://doi.org/10.1080/09688080.2017.1378532

Khanlou, N., Haque, N., Skinner, A., Mantini, A., & Kurtz Landy, C. (2017). Scoping Review on Maternal Health among Immigrant and Refugee Women in Canada: Prenatal, Intrapartum, and Postnatal Care. *Journal of Pregnancy*, *2017*, 1–14. https://doi.org/10.1155/2017/8783294

Kimberg, L., & Wheeler, M. (2019). Trauma and Trauma-Informed Care. In M. R. Gerber (Ed.), *Trauma-Informed Healthcare Approaches* (pp. 25–56). Springer International Publishing. https://doi.org/10.1007/978-3-030-04342-1_2

Kingston, D., Heaman, M., Chalmers, B., Kaczorowski, J., O'Brien, B., Lee, L., Dzakpasu, S., & O'Campo, P. (2011). Comparison of Maternity Experiences of Canadian-Born and Recent and Non-Recent Immigrant Women: Findings From the Canadian Maternity Experiences Survey. *Journal of Obstetrics and Gynaecology Canada*, *33*(11), 1105–1115. https://doi.org/10.1016/S1701-2163(16)35078-2

Lewis-Beck, M., Bryman, A., & Futing Liao, T. (2004). *The SAGE Encyclopedia of Social Science Research Methods*. Sage Publications, Inc. https://doi.org/10.4135/9781412950589

Liu, C., Ahlberg, M., Hjern, A., & Stephansson, O. (2019). Perinatal health of refugee and asylum-seeking women in Sweden 2014–17: A register-based cohort study. *European Journal of Public Health*, *29*(6), 1048–1055. https://doi.org/10.1093/eurpub/ckz120

Loomis, B. (2014). *Trauma Informed Systems Initiative* (p. 40). https://www.leapsf.org/pdf/Trauma-Informed-Systems-Initative-2014.pdf

Masterson, A., Usta, J., Gupta, J., & Ettinger, A. S. (2014). Assessment of reproductive health and violence against women among displaced Syrians in Lebanon. *BMC Women's Health*, *14*(1). https://doi.org/10.1186/1472-6874-14-25

Maticka-Tyndale, E., Shirpak, K. R., & Chinichian, M. (2007). Providing for the Sexual Health Needs of Canadian Immigrants: The Experience of Immigrants from Iran. *Canadian Journal of Public Health/Revue Canadienne De Sante'e Publique*, *98*(3), 183–186.

Mengesha, Z., Dune, T., & Perz, J. (2016). Culturally and linguistically diverse women's views and experiences of accessing sexual and reproductive health care in Australia: A systematic review. *Sexual Health*. https://doi.org/10.1071/SH15235

Milkie, M. A., Maghbouleh, N., & Peng, I. (2020). Stress in Refugee Settlement: Syrian Mothers' Strains and Buffers during Early Integration. In *A National Project: Syrian Refugee Resettlement in Canada* (p. 34). McGill-Queen's University Press. https://search.ebscohost.com/login.aspx?direct=true&db=nlebk&AN=2579371&site=ehost-live

Milner, H. R. (2007). Race, Culture, and Researcher Positionality: Working Through Dangers Seen, Unseen, and Unforeseen. *Educational Researcher*, *36*(7), 388–400. https://doi.org/10.3102/0013189X07309471

Mohammad, K. I., Abu Awad, D., Creedy, D. K., & Gamble, J. (2018). Postpartum depression symptoms among Syrian refugee women living in Jordan. *Research in Nursing & Health*, *41*(6), 519–524. https://doi.org/10.1002/nur.21919

Muhammad, M., Wallerstein, N., Sussman, A. L., Avila, M., Belone, L., & Duran, B. (2015). Reflections on Researcher Identity and Power: The Impact of Positionality on Community Based Participatory Research (CBPR) Processes and Outcomes. *Critical Sociology*, *41*(7–8), 1045–1063. https://doi.org/10.1177/0896920513516025

Newbold, K. B., Cho, J., & McKeary, M. (2013). Access to Health Care: The Experiences of Refugee and Refugee Claimant Women in Hamilton, Ontario. *Journal of Immigrant & Refugee Studies*, *11*(4), 431–449. https://doi.org/10.1080/15562948.2013.808390

Newbold, K. B., & Willinsky, J. (2009). Providing family planning and reproductive healthcare to Canadian immigrants: Perceptions of healthcare providers. *Culture, Health & Sexuality*, *11*(4), 369–382. https://doi.org/10.1080/13691050802710642

Oda, A., Tuck, A., Agic, B., Hynie, M., Roche, B., & McKenzie, K. (2017). Health care needs and use of health care services among newly arrived Syrian refugees: A cross-sectional study. *CMAJ Open*, *5*(2), E354–E358. https://doi.org/10.9778/cmajo.20160170

Our Programs and Services | Somerset West. (2020). https://swchc.on.ca/our-programs

Pottie, K., Batista, R., Mayhew, M., Mota, L., & Grant, K. (2014). Improving delivery of primary care for vulnerable migrants. *Canadian Family Physician*, *60*(1), e32–e40.

Pottie, K., Greenaway, C., Feightner, J., Welch, V., Swinkels, H., Rashid, M., Narasiah, L., Kirmayer, L. J., Ueffing, E., MacDonald, N. E., Hassan, G., McNally, M., Khan, K., Buhrmann, R., Dunn, S., Dominic, A., McCarthy, A. E., Gagnon, A. J., Rousseau, C., & Tugwell, P. (2011). Evidence-based clinical guidelines for immigrants and refugees. *Canadian Medical Association Journal*, *183*(12), E824–E925. https://doi.org/10.1503/cmaj.090313

Pottie, K., Gruner, D., & Magwood, O. (2018). Canada's response to refugees at the primary health care level. *Public Health Research & Practice*, *28*(1). https://doi.org/10.17061/phrp2811803

Redwood-Campbell, L., Thind, H., Howard, M., Koteles, J., Fowler, N., & Kaczorowski, J. (2008). Understanding the Health of Refugee Women in Host Countries: Lessons from

the Kosovar Re-Settlement in Canada. *Prehospital and Disaster Medicine*, *23*(4), 322–327. https://doi.org/10.1017/S1049023X00005951

Roudi-Fahimi, F., & Moghadam, V. M. (2006). Empowering Women, Developing Society: Female Education in the Middle East and North Africa. *AL-Raida*, *23–24*(114–115), 4–11.

Roudi-Fahimi, F., Monem, A. A., Ashford, L., & El-Adawy, M. (2012). Women's Need for Family Planning in Arab Countries. *Population Reference Bureau*. http://www.who.int/evidence/resources/policy_briefs/UNFPAPBunmentneed2012.pdf

Saadallah, S., & Baker, D. (2016). *Women and Girls in the Syria Crisis: UNFPA Reponse*. United Nations Population Fund (UNFPA). https://www.unfpa.org/sites/default/files/resource-pdf/UNFPA-FACTSANDFIGURES-5%5B4%5D.pdf

Saldaña, J. (2009). *The coding manual for qualitative researchers*. Sage.

Sieverding, M., Krafft, C., Berri, N., & Keo, C. (2020). Persistence and Change in Marriage Practices among Syrian Refugees in Jordan. *Studies in Family Planning*, sifp.12134. https://doi.org/10.1111/sifp.12134

Silverberg, S. L., Harding, L., Spitzer, R. F., & Rashid, M. (2018). The Who, What, Why and When of Gynaecological Referrals for Refugee Women. *Journal of Immigrant and Minority Health*, *20*(6), 1347–1354. https://doi.org/10.1007/s10903-018-0733-6

Şimşek, Z., Yentur Doni, N., Gül Hilali, N., & Yildirimkaya, G. (2018). A community-based survey on Syrian refugee women's health and its predictors in Şanliurfa, Turkey. *Women & Health*, *58*(6), 617–631. https://doi.org/10.1080/03630242.2017.1321609

Stevenson, K., Alameddine, R., Rukbi, G., Chahrouri, M., Usta, J., Saab, B., Bennett, P., Glover, V., & Reynolds, R. M. (2019). High rates of maternal depression amongst Syrian refugees in Lebanon—A pilot study. *Scientific Reports*, *9*(1), 11849. https://doi.org/10.1038/s41598-019-48247-5

Torres, S., Spitzer, D. L., Labonté, R., Amaratunga, C., & Andrew, C. (2013). Community Health Workers in Canada: Innovative Approaches to Health Promotion Outreach and Community Development Among Immigrant and Refugee Populations. *Journal of Ambulatory Care Management*, *36*(4), 305–318. https://doi.org/10.1097/JAC.0b013e3182a5480f

Tuck, A., Oda, A., Hynie, M., Bennett-AbuAyyash, C., Roche, B., Agic, B., & McKenzie, K. (2019). Unmet Health Care Needs for Syrian Refugees in Canada: A Follow-up Study. *Journal of Immigrant and Minority Health*, *21*(6), 1306–1312. https://doi.org/10.1007/s10903-019-00856-y

UN. (2014). *Abortion policies and reproductive health around the world*. United Nations. https://doi.org/10.18356/3fc03b26-en

UNHCR. (2020). *UNHCR - Figures at a Glance*. The UN Refugee Agency. http://www.unhcr.org/figures-at-a-glance.html

UNHCR, Government of Turkey. (2020). *Situation Syria Regional Refugee Response*. https://data2.unhcr.org/en/situations/syria

UNICEF. (2013, December 31). *At a glance: Syrian Arab Republic*. UNICEF. https://www.unicef.org/infobycountry/syria_statistics.html#120

Urindwanayo, D. (2018). Immigrant Women's Mental Health in Canada in the Antenatal and Postpartum Period. *Canadian Journal of Nursing Research*, *50*(3), 155–162. https://doi.org/10.1177/0844562118784811

Usta, J., & Masterson, A. R. (2012). Assessment of Reproductive Health and Gender-Based Violence among Displaced Syrian Women in Lebanon. *UNFPA*, 3.

Veronis, L. (2019). Building intersectoral partnerships as place-based strategy for immigrant and refugee (re)settlement: The Ottawa Local Immigration Partnership. *The Canadian Geographer / Le Géographe Canadien*, *63*(3), 391–404. https://doi.org/10.1111/cag.12559

West, L., Isotta-Day, H., Ba-Break, M., & Morgan, R. (2017). Factors in use of family planning services by Syrian women in a refugee camp in Jordan. *Journal of Family Planning and Reproductive Health Care*, *43*(2), 96–102. https://doi.org/10.1136/jfprhc-2014-101026

WHO. (2015a). *Maternal mortality in 1990-2015—Syrian Arab Republic*. UNICEF, WHO, UNFPA, World Bank Group, and United Nations Population Division. http://www.who.int/gho/maternal_health/countries/syr.pdf?ua=1

WHO. (2015b). *WHO Statement on Caesarean Section Rates* (p. 8). World Health Organization. https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-statement/en/

Wiebe, E. (2013). Contraceptive practices and attitudes among immigrant and nonimmigrant women in Canada. *Canadian Family Physician*, *59*(10), e451–e455. Scopus.

Winn, A., Hetherington, E., & Tough, S. (2018). Caring for pregnant refugee women in a turbulent policy landscape: Perspectives of health care professionals in Calgary, Alberta.

International Journal for Equity in Health, *17*(1). https://doi.org/10.1186/s12939-018-0801-5

Yasmine, R., & Moughalian, C. (2016). Systemic violence against Syrian refugee women and the myth of effective intrapersonal interventions. *Reproductive Health Matters*, *24*(47), 27–35. https://doi.org/10.1016/j.rhm.2016.04.008

Yount, K. M., & Smith, S. M. (2012). Gender and postpartum depression in Arab Middle Eastern women. *Women's Studies International Forum*, *35*(4), 187–193. https://doi.org/10.1016/j.wsif.2012.03.017

Zivot, C., Dewey, C., Heasley, C., Srinivasan, S., & Little, M. (2020). Exploring the State of Gender-Centered Health Research in the Context of Refugee Resettlement in Canada: A Scoping Review. *International Journal of Environmental Research and Public Health*, *17*(20), 7511. https://doi.org/10.3390/ijerph17207511

Zolezzi, M., Alamri, M., Shaar, S., & Rainkie, D. (2018). Stigma associated with mental illness and its treatment in the Arab culture: A systematic review. *International Journal of Social Psychiatry*, *64*(6), 597–609. https://doi.org/10.1177/0020764018789200

Appendix A: Research Ethics Board (REB) approval certificate

04/05/2021

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	S-04-19-3906
Titre du projet / Project Title	Exploring Syrian refugee women's reproductive health experiences: A multi-methods qualitative study in Ontario
Type de projet / Project Type	Recherche de professeur / Professor's research project
Statut du projet / Project Status	Renouvelé / Renewed
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	03/06/2019
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	02/06/2022

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Angel FOSTER	École interdisciplinaire des sciences de la santé / Interdisciplinary School of Health Sciences	Chercheur Principal / Principal Investigator
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