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The postnatal experiences of resettled Syrian refugee women: Access to healthcare and social support in Nova Scotia, Canada ☆

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ABSTRACT

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

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

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

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

Conclusion: Resettled Syrian refugee women in Nova Scotia, Canada experience a range of barriers that limits their access to postnatal healthcare. Policy change, program development, and/or interventions are needed to improve access to postnatal services and supports for resettled Syrian women in Canada.

Introduction

The world is currently in the midst of the largest global refugee crisis ever recorded, with people being forcibly displaced at an exponential rate (UNHCR, 2020). A refugee refers to someone who has fled their home country due to persecution, conflict, or violence (United Nations General Assembly, 1951). One of the major crises that has contributed to this rise in statelessness has been the onset of the Syrian civil conflict, which began in early 2011 (UNHCR. Syria emergency. 2018). Syria has been the main country of origin for refugees globally since 2014 (UNHCR, 2020). To respond to the humanitarian crisis, the Canadian government announced the resettlement of 25,000 Syrian refugees in 2015 (Government of Canada, 2020). After which an additional 20,000 Syrian refugees have arrived in Canada (Government of, 2019).

The Canadian government prioritized the resettlement of young Syrian families, women, and children (Statistics Canada 2019). Most resettled Syrian refugee women in Canada are of reproductive age, and many are pregnant, postnatal, or have a young family and are in need of accessible reproductive healthcare (Ross, 2017, IRCC, 2021). During the postnatal period, mothers need access to health services and informal supports to help with a variety of psychosocial and physical health concerns (Brown and Lumley, 1998, Higginbottom et al., 2014). Yet access to postnatal healthcare and informal support remains a challenge for resettled refugee women in Canada (Khanlou et al., 2017, O'Mahony et al., 2012, Higginbottom et al., 2016). The postnatal period is a critical time when all mothers need access to maternal healthcare and informal supports (Aston et al., 2014,Thompson et al., 2002).

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Nearly 95% of all women report experiencing one or more maternal health concerns within the first six months of childbirth, including mastitis, caesarian site pain, postpartum depression, and social isolation (Brown and Lumley, 1998). Untreated health problems are directly related to a decrease in women's emotional wellbeing and functional abilities, including an inability to care for their infant or return to work (Webb et al., 2008). Timely and effective postpartum healthcare provided by formal healthcare professionals (e.g., family physicians, midwives, psychologists) can prevent or improve short- and long-term consequences of health morbidities (Haran et al., 2014). In addition to the availability of formal health services, informal supports provided by partners, family, friends, or community contribute to maternal self-efficacy and boosts emotional wellbeing in mothers (WHO, 2005, Xie et al., 2009, Leahy-Warren et al., 2012)

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

Disrupted access to healthcare and limited supports during the postpartum period contribute to health inequities among resettled refugee women, when compared to Canadian-born women. Resettled refugee women are more likely to have a poorer postpartum health status (Ganann et al., 2012) and a greater number of unmet physical and mental health concerns compared to Canadian-born women (Gagnon et al., 2013). Resettled refugee women with social networks containing fewer women, relatives, and people from their own ethnic background are more likely to experience high rates of depressive symptoms and postpartum depression (Zelkowitz et al., 2004). The accessibility of formal healthcare services and the availability of informal supports is crucial for supporting refugee mothers during the postnatal period. Impaired access to postpartum healthcare for resettled refugee women is an issue of reproductive justice—a fundamental human right that demands equitable access to reproductive care, regardless of one's immigration status, or ethnicity.

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

Methods

Methodology

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

Recruitment and procedure

Women were recruited through community centres, health clinics, and private sponsorship organizations within one urban area. Arabic and English versions of recruitment posters were distributed through the groups' social media, websites, email networks, and/or social media platforms. A designated research assistant who was fluent in Arabic was hired to assist with recruitment and interpretation. All recruitment and data collection materials were drafted and reviewed by two separate English- and Arabic-speaking research assistants to ensure an accurate translation. Interested participants contacted by a bilingual research assistant who confirmed eligibility. Participants selected whether they wanted to complete a telephone interview or a video call (Microsoft Teams), and then scheduled a time for the call. Women were eligible to take part in the study if they had a child within the last five years and were at least six-months postpartum. Women were emailed a copy of the consent form in advance of the interview in both Arabic and English. A recruitment goal of 10-15 women was set in line with recommendations suggested by Wuest et al. 2012 for a grounded theory study (Wuest, 2012). Before beginning the interview, the interpreter reviewed the consent form and verbal consent was recorded. This was done in lieu of signed consent to alleviate the burden on participants to print, sign, and scan, or electronically sign and email a consent form. Participants were then asked a series of demographic questions (e.g., marital status, number of children, years spent in Canada) before conducting the interview. The interview guide was comprised of a series of open-ended questions, that were guided by the literature and suggestions from community stakeholders (e.g., Did you use any health or wellness services (e.g., family doctor, counsellor, doula) the first year after giving birth? Did you have any friends or family to support you after birth? If yes, who? How did they support you?). Eleven women completed individual, audio-recorded interviews during the months of August and September 2020. Seven of the eleven women had given birth to a child before and during the COVID-19 pandemic. Only the pre-COVID experiences are reported here. The experiences of women who had a child or were postnatal during COVID-19 will be reported in a separate paper (Stirling Cameron et al., 2021).

Analysis

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

Table 1
Participant Demographics.

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

Results

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

The importance of social support

Familial separation and the availability of informal support. Every participant described feelings of homesickness and isolation, especially within the first few years of arriving in Canada. All women had been separated from members of their extended family through the process of international resettlement. Their absence was felt strongly during the postpartum period. One participant noted, "It was hard for me to give birth when I had none of my family around me… I haven't seen my family in 10 years." (Participant 1). Women described the ways in which their family (mothers, sisters) had supported them through previous births, by preparing meals, taking care of other children, cleaning, offering advice, and providing infant care: "In Syria it was better than here because I had my family, my mom to support and help me." (Participant 8). Women spoke at length about how valuable informal support from their family was and how difficult it was to care for their baby without them, "I am lonely, my family is not with me. I was in a lot of pain and I had no one to help me when the baby was crying." (Participant 2).

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

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

For several women, a lack of social support had an impact on their physical functioning after birth. One participant described an inability to prepare food which resulted in a decrease in milk production: "I found it very hard to prepare food. When I bought any meals, my milk would become scarce, it was really hard on me." (Participant 2). Several women who had given birth previously and had support felt that their recovery was delayed and impaired because they had to cook, care for their other children, etc. Two participants felt their caesarean site healed more slowly: "In Syria, I swear, after the fourth or fifth day after the cesarian I was able to get around. Here it took me two months and I was in a lot of pain." (Participant 2). Participant nine had a similar experience: "With my other kids, I would be fully functioning only one week after birth, but with this last baby it took me a month and I could still barely cook a small meal of rice." (Participant 9).

Access and quality of healthcare influenced by structural barriers

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

Interpretation was commonly provided in-person, but in some situations, was provided over the phone. Some women noted that although telephone interpretation was better than not having any service, in-person translation was preferable: "When the interpreter is there with me, she sees me, my facial expressions, if she feels that I am not doing well she notices and asks what is going on, but with the interpreter over the phone, they can't see me, they can't notice if I am distressed or tired." (Participant 5). Where interpreters were not provided, women relied on husbands, friends, or their own children to translate. Some women did not have access to any kind of interpreter and described these interactions as "traumatizing," "very hard" and "frightening." One participant was forced to labour and deliver without an interpreter, and in the end, did not receive any pain management as a result of the language barrier: "I desperately tried to tell them that I wanted an epidural. I tried to explain to the doctor and doula by pointing to my back, but they could not understand. They thought I wanted them to massage my back. I suffered a lot. I was in labour for eight hours… I just cried." (Participant 7). Women also reported finding it challenging to understand referrals and treatment instructions, prescription drug information, and had trouble booking and scheduling medical appointments over the phone.

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

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

Provider paternalism and women's decision-making autonomy

Multiple participants described negative interactions with their healthcare providers where they felt as if their decision-making autonomy was limited and the choices concerning their care were not recognized. These interactions often meant women felt disrespected, frustrated, and caused feelings of mistrust with providers. Participant nine described an encounter with her family physician where her appointment with a psychiatrist was cancelled without her consent:

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

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

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

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

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

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

Valued and missing services and supports

Valued services and supports. The majority of the participants in this study used a refugee-specific health clinic for the first few years after arriving in Canada Kohler et al., 2018. Given the current family physician shortage in Nova Scotia, (Health, January 2021) this was a critical service that helped bridge the gap while women waited to locate and transition to a long-term primary care provider in the community. Women reported that the clinic almost always provided interpreter services, and the care provided was culturally appropriate/sensitive. Participant three described her family physician at the clinic, "Honestly I wish I could stay with this doctor at the refugee clinic because she is excellent. [Doctor] is really famous and is an amazing doctor."

Doulas were also a critical support service for a number of participants. Many women were referred to a local volunteer doula program which assigns doulas to patients before delivery, at no cost. Doulas often met women in their homes before their due dates to build trust and rapport and offer support (e.g., health system navigation, emotional support). By providing interpretation services and home visits, the program by-passed structural barriers, such as finding transportation and childcare, and language differences. Often, the same doula continued to accompany women to their delivery and checked in after the birth. "I met the doula one month before I delivered... She didn't leave me when I

delivered my daughter. She stayed with me in the hospital. I was happy to have the doula because for me, I do have many friends, but I had no one to accompany me to the hospital." (Participant 5). Some women suggested it would be helpful for "the doula to come more frequently" (Participant 9) after birth, to provide informal support.

Several participants in this study arrived through Canada's private sponsorship program and found its approach beneficial. Private sponsorship organizations support resettled families for 12 months, providing financial, educational, and social supports (Refugee Sponsorship Training Program, 2021). As most private sponsorship groups are small, volunteer organizations, they are able to provide tailored, individualized care to families. Participants in this study who had arrived under this program stated that members of their sponsorship organizations helped fill part of the void caused by separation from family. Private organizations often provided a high level of informal support: cooking meals, providing childcare and transportation, and donating baby clothes and furniture: "They shopped for me, delivered groceries to our home. They booked appointments with doctors for me. They helped me with everything. I can't do things without them… They are my family here." (Participant 3)

Missing services and supports. Many participants were satisfied with healthcare services in Nova Scotia, and were grateful for the care available, particularly in contrast to their previous birthing experiences in Syria. Participant five said, "I gave birth to my second and third child during the war. My experience in Syria was hard beyond description… Medically, we had nothing there, no medications and no services. I couldn't feel the joy and the calmness that mothers feel after they delivered. The first thing we thought about was is how to get milk and diapers. But here, I didn't need to worry." None of the participants indicated that there were any services missing during their postpartum period. However, every participant stated that they were missing the support provided by their extended family. Participant seven said, "I wish I had someone from my family, my sister or any relative of mine. If something bad happens to me, I know that my kids would be safe with my brother or sister. We are happy here, but we are missing our families. Everyone here needs family."

Discussion

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

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

Language and communication challenges were significant drivers for negative healthcare experiences. Effective communication during labour and delivery is essential, and for many resettled refugee women, may only be achievable through an interpreter or interpreter services (Henry et al., 2020, Origlia Ikhilor et al., 2019). Failure to provide interpretation during labour and delivery led, for one woman in our study, to inadequate pain management, anxiety, and birthing-related trauma. Previous studies have highlighted similar traumatic experiences among perinatal women in resettlement countries (Henry et al., 2020, Origlia Ikhilor et al., 2019). Inadequate interpretation services contributes to high rates of miscommunication and undermines the fundamental concept of informed consent and patient-centred care (Henry et al., 2020, Origlia Ikhilor et al., 2019). Henry et al., 2020 posits that the healthcare system's failure to freely and consistently provide interpretation services should be seen as a form of institutional discrimination and should ultimately be viewed as structural violence. This systemic failure leaves newcomer women and their infants vulnerable to being misunderstood, improperly diagnosed, and their health mismanaged.

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

Obstetrics and reproductive healthcare have a long history of paternalism which has particularly impacted women of colour (Roberts, 1997). Women in this study described encounters within the healthcare system in which decisions were made about their care with which they did not agree, or where their medical autonomy was not recognized. Not only are refugee women at risk of encountering racial, religious, and gender-based discrimination, they may also experience prejudice related to their immigration status from healthcare providers. Providers may lack cultural competency, possess implicit or explicit biases, or perpetuate harmful stereotypes. Despite the presence of language barriers, providers must work to overcome their prejudices (whether they are cognisant of them or not) and support women to make their own informed choices. Few studies have examined reproductive liberty and healthcare decision-making among refugee women; future work is needed to better understand this important intersection (Ross, 2017).

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

offered informal support in similar ways, by cooking, offering emotional support and advice, and providing childcare.

Implications

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

Limitations

Several limitations of our study should be noted. First, recruitment for this research project was largely achieved through community and healthcare organizations. It is possible that women not connected with any of our recruitment groups/organizations were not interviewed. By advertising the study recruitment on social media (independent of organizations), the team hoped to reach individuals not formally connected to any recruitment groups. All analyses were conducted based on English translations of the interviews. It is possible that particular sentiments or experiences could not be accurately maintained through the translation. However, the translator worked closely with the first author to review parts of the interviews where the Arabic to English translation was not straight-forward. As data were collected during the COVID-19 pandemic, all interviews had to be completed virtually for the safety of the research team and the participants. It is possible that some women did not engage in the study because they did not have access to a telephone or computer or did not have a private space to complete the interview.

Conclusion

Reproductive justice is rooted in the belief that systemic inequities shape people's decision-making related to childbearing and parenting, particularly vulnerable women (Ross and Solinger, 2017). This study has laid bare the inequities that resettled refugee women experience while attempting to access postnatal healthcare in Canada—a critical reproductive justice issue. Women encountered a variety of structural barriers, such as irregular access to interpreter services, geographical and transportation challenges, and lack of childcare, all of which negatively impacted their medical care. Social support was seen to be extremely valuable during the postnatal period, but many women had less support, as they had been separated from their family during forced migration and resettlement. As access to reproductive healthcare remains a fundamental human right, it is crucial for researchers, clinicians, and policy makers to work collaboratively to support equitable care delivery and improve access to informal supports for resettled refugee women.

Declaration of Competing Interest

None.

CRediT authorship contribution statement

Emma Stirling Cameron: Conceptualization, Methodology, Formal analysis, Investigation, Resources, Data curation, Writing – original draft, Project administration, Funding acquisition. **Megan Aston:** Validation, Methodology, Formal analysis, Writing – review & editing. **Howard Ramos:** Validation, Methodology, Formal analysis, Writing – review & editing. **Marwa Kuri:** Data curation, Investigation, Resources, Writing – review & editing, Project administration. **Lois Jackson:** Supervision, Conceptualization, Validation, Methodology, Project administration, Funding acquisition, Writing – review & editing.

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Emma Stirling Cameron developed the project, wrote the project proposal, led data collection and analysis, and wrote the majority of this manuscript. This paper is contributing to a Master of Arts degree for this author.

Megan Aston contributed to the development of this project and provided expertise on postnatal care, and qualitative methodology. She was involved in editing the project's proposal, design, and edited this manuscript. She also provided comments on the preliminary codes for data analysis.

Howard Ramos contributed to the development of this project and provided expertise on refugee resettlement and health. He was involved in in editing the project's proposal, design, and edited this manuscript. He also provided comments on the preliminary codes for data analysis.

Marwa Kuri was the primary research assistant and cultural liaison for this project. She helped to draft recruitment materials and ensure their cultural appropriateness, recruited all participants, translated recruitment documents (consent forms, recruitment posters, interview guides) into Arabic, acted as translator for all interviews, translated and transcribed all interviews, and was involved in vetting the coding completed by the first author.

Lois Jackson was the supervising author on this paper. She was involved in the inception and development of this project, provided key oversight throughout, contributed to and approved all data collection documents and interview guides, oversaw the coding progress, and edited this manuscript.