


Impact of COVID-19 on Women Who Are Refugees and Mothering: A Critical Ethnographic Study

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Abstract

Refugee women often experience trauma and social disconnection in a new country and are at risk of experiencing reduced physical, mental, and emotional well-being. Globally, COVID-19 has affected the health and well-being of the population at large. This critical ethnographic study aimed to explore the effects of COVID-19 on women who are refugees and mothering in Saskatchewan, Canada. In-depth interviews were undertaken with 27 women who are refugees and mothering young children aged 2 years and under. This study suggests that during COVID-19, refugee women are at high risk of experiencing add-on stressors due to isolation, difficulty in accessing health care, COVID-19-related restrictions in hospitals, limited follow-up care, limited social support, financial difficulties, and compromised nutrition. During COVID-19, collaborative efforts by nurses, other health-care professionals, and governmental and non-governmental organizations are essential to provide need-based mental health support, skills-building programs, nutritional counseling, and follow-up care to this vulnerable group.

Keywords

refugee, COVID-19, pandemic, impact, mothering, women, ethnography, Canada

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As one of the most vulnerable groups, refugees are at risk of threats to all aspects of their health. Traumatic pre-migration events, including torture, witnessing the murder of loved ones, detention, kidnapping, and leaving family members or a child behind in a conflict zone (Brown-Bowers et al., 2015), generate prolonged grief disorders, post-traumatic stress disorders, and somatization (Jongedijk et al., 2020; Kokou-Kpolou et al., 2020). Migration, displacement, resettlement, and other necessary transitional changes often serve as major life stressors linked to sociocultural, economic, and environmental challenges in the host country (Hirani & Richter, 2019). In addition, post-migration refugee women have noteworthy stressors related to the difficulties of motherhood (Hirani & Richter, 2019; Porter & Haslam, 2005; Thomas & Thomas, 2004). Globally, women are impacted by postpartum mental health disorders, with 20% of women experiencing symptoms of depression and anxiety that have a significant impact on the health of the mother, child, and family (Howard et al., 2014; Stein et al., 2014). Women who experience migration and displacement encounter twice the incidence of postpartum depression as compared to native-born women (Falah-Hassani et al., 2015).

Refugee women settled in Western countries are at risk of reduced physical, mental, and emotional well-being, with the

incidence of post-traumatic stress disorder being 10 times greater than the incidence found in women within the general population (Fazel et al., 2005). This added risk experienced by refugee women tends to give rise to increased postpartum mental health emergency department visits that require hospitalization (Vigod et al., 2017). Refugee women often have a low educational and occupational status and experience the post-migration stressors of language barriers, social isolation, and difficulty using the health-care and social service systems (Qutranji et al., 2020). The Canadian Maternal Experiences Survey (Dennis et al., 2012) indicated a difference between recently immigrated women (including women who are refugees) and those who had been in Canada for greater than five years in the reporting of depressive symptoms and the frequency of contact with public health nurses (Vigod et al., 2017). Lenette (2013) recommended improved engagement with postpartum refugee women at an outpatient

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level to identify and treat postpartum symptoms, thus reducing acute hospital admissions.

COVID-19 has created many challenges in society and, more specifically, has impacted vulnerable women with young children. Worldwide, restrictions due to COVID-19 have led to various challenges for women with young children, especially in regions where COVID-19 lockdowns have been prevalent (Spinola et al., 2020). The COVID-19 pandemic has created many challenges for refugee families with young children due to substantial impacts on employment, the economic burden on families, food insecurities, marital issues, domestic violence, and the subsequent effects of parental distress on children's emotional and mental well-being (Brickhill-Atkinson & Hauck, 2021; Kluge et al., 2020; Pinzon-Espinosa et al., 2021; Rees & Fisher, 2020; Truelove et al., 2020; Vonen et al., 2021). COVID-19 restrictions were implemented in the early spring of 2020. During the initial phase of the COVID-19 pandemic, limited personal contact with health-care providers had a significant impact on this vulnerable population of women who are refugees and mothering young children aged 2 years and under due to the non-availability of breastfeeding counseling facilities or easy-to-understand user-friendly resources in their preferred languages (Hirani et al., 2021). In Canada, barriers to socioeconomic support, health care, education, and border crossing impediments were reported to affect the well-being and psychological health of the refugee population due to limited social support (both formal and informal sources of social support) during the first wave of the COVID-19 pandemic (Benjamin et al., 2021; Edmonds & Flahault, 2021; Clarke et al., 2021). Subsequent waves of COVID-19, in the Canadian context, suggest a significant gap in knowledge and empirical studies that focus on the impact of COVID-19 on the health and well-being of women who are refugees and mothering young children. Saskatchewan is one of the growing provinces in Canada that has a noticeable influx of refugee families with young children, mainly aged 2 years and under (Government of Saskatchewan, 2019). The number of refugee women settling in Saskatchewan increased by 10.4% per year from 2006 to 2011 (Saskatchewan Status of Women Office, 2016). Over 67% of these women settled in the larger urban centers of Regina and Saskatoon (Saskatchewan Status of Women's Office, 2016). Many refugee women who settled in Saskatchewan have young children aged 2 years and under (Government of Saskatchewan, 2019). From 2012 to 2014, statistics on immigrant children (including refugees) available through the Government of Saskatchewan indicated that 2,221 immigrant children aged 0 to 4 years settled with their parents in Saskatchewan, with 195 of these children classified as refugees (Ministry of the Economy Government of Saskatchewan, 2016). From 2015 to June 30, 2019, an additional 703 refugee children, aged 4 and under, migrated to the province of Saskatchewan with their parents (Ministry of Immigration and Career Training, 2019). Saskatchewan's

noticeable increase in the refugee population with young children aged 2 years and under, potential risks to the health of women who are refugees and mothering, and existing gaps in knowledge suggested a pressing need to explore the impact of COVID-19 on women who are refugees and mothering young children aged 2 years and under. This study aimed to explore the impact of COVID-19 on women who are refugees and mothering in Saskatchewan, Canada. During this global pandemic, it is essential to explore the experiences of this group of women to better respond to their challenges and initiate need-based interventions through partnerships with service providers and governmental/nongovernmental organizations.

Methods

Study Design

This study utilized a critical ethnographic study design using a critical realist lens (Banfield, 2019; Rees & Gatenby, 2014) and Carspecken's approach (Munhall, 2012) to explore the impact of COVID-19 on women who are refugees and mothering young children aged 2 and under in Saskatchewan, Canada. Critical ethnography as a qualitative research design facilitates researchers to explore the experiences of a vulnerable group in a specific cultural context, identify sources of vulnerability, and examine power relationships that are leading to vulnerability (Harrowing et al., 2010). This design facilitates critically examining the experiences of a vulnerable group facing struggles and vulnerability in a specific cultural context (Cook, 2005; Munhall, 2012), in this case, women who are refugees and mothering young children in the host country during the time of COVID-19 pandemic. The role of critical realist ontology is widely acknowledged in enhancing nursing knowledge, especially in the field of women's health (Clark et al., 2008). The ontological assumption of critical realism provided an opportunity to uncover the multiple realities of the impact of COVID-19 by gaining access to the experiences of women who are refugees and mothering young children in Saskatchewan, Canada. In this study, we utilized the approach proposed by Carspecken to maintain a trusting relationship with the study participants, engage in a meaningful dialogue, and generate meaning through the interaction process (Munhall, 2012). The researchers approached this critical ethnographic study as partial insiders and partial outsiders. The researchers were insiders to this research based on their lived experience of encountering the COVID-19 pandemic while living in Canada, prior experience in breastfeeding, and capability of conducting research with a vulnerable population, especially refugee women. The researchers were partial outsiders to this critical ethnographic study as they are Canadian citizens, employed, educated women, and nurses who had no prior experience of being displaced and living in a new country as a refugee. Our positionality being a partial insider and partial

outsider provided an opportunity to embrace new knowledge and perspectives during data collection. During this critical ethnographic study, the researchers were mindful of their positionality and power differences, practiced reflexivity through journaling, built trusting relationships with the study participants, involved refugee mothers and refugee organizations as collaborators in this research, maintained cultural sensitivity during in-depth interviews in accordance to their culture and religion (e.g., respected the religious obligation of some of the refugee women to wear a veil), and used multiple methods of data collection to explore the effects of COVID-19 on women who are refugees and mothering in Saskatchewan, Canada. This study received ethics approval from the University of Regina's Ethics Review Board (#2020-104).

Setting

This study was undertaken in Saskatchewan, Canada, a province that has experienced a noticeable increase in the refugee population with young children. In partnership with community-based service providers, women who are refugees and mothering were recruited from different cities in Saskatchewan.

Sample and Participant Recruitment

We used purposive and snowball sampling to recruit a sample of 27 women who were refugees, mothering young children aged 2 and under, and residing in Saskatchewan. Recruitment was supported by a collaboration with women who are refugees and mothering, and community-based service providers in Saskatchewan, Canada. Women who were refugees and mothering were initially invited to participate in this study through a recruitment poster and an invitation letter by the patient and community-based partners on this project (the consent to contact form was written in plain English). The invitations were sent to potential participants via word of mouth, mobile messages, social media announcements, and email communications by the patient and community-based partners. Refugee women who met inclusion criteria and accepted the invitation were contacted by the principal investigator who informed mothers about the purpose of the study, method of data collection, potential benefits and risks of the study, and their right to withdraw from the study without any penalty.

Data Collection

Multiple methods of data collection were used including field observations, review of media reports, and in-depth interviews with study participants. We uncovered multiple truths about the impact of COVID-19 on women who are refugees and mothering by gaining access to their experiences (empirical domain of reality) and triangulating those experiences with the facts gathered from field observations

and document analysis (actual and real domains of reality). Field observations were undertaken to identify potential structural, sociocultural, economic, and/or environmental barriers contributing to vulnerability and disparities among women who are refugees and mothering. During COVID-19, the principal investigator made observations on the availability of support services for refugee families, sources of informational support, accessibility to health care (distance and availability of transportation), follow-up care during the pandemic, affordable mental health supports in the community, access to helplines in different languages, job and learning opportunities for refugees, travel restrictions (provincial and federal), hospital practices during COVID-19, and services offered by settlement and refugee organizations during the pandemic. To supplement the field observations, we reviewed newspaper articles and media communications focusing on stressors of the refugee population in the Canadian context during COVID-19. We also undertook in-depth interviews of 40 to 60 minutes with study participants to understand the range of barriers, lack of control they may have over their daily lives due to racism and other societal barriers, and disparities increasing their stress during COVID-19. Following informed consent, in-depth interviews were undertaken with 27 women who were refugees (Syrian, Eritrean, and Somali women) and mothering young children of ages ranging from 1 day to 24 months. The interviews were conducted by the principal investigator and a trained research assistant in each woman's preferred language using a semi-structured interview guide. The questions in the interview guide of this critical ethnographic study intended to explore major barriers (sociocultural, environmental, and economic) and determinants causing stress and adding to the vulnerability of the women during the COVID-19 pandemic. The interview guide for the semi-structured interview evolved as the research unfolded during the fieldwork, hence the researchers added more probes and questions with progressive interviews. Researchers maintained field notes and reflexive journal entries throughout the process of data collection.

Due to the pandemic, all interviews were conducted virtually via Zoom. Almost all the participants accessed Zoom via their phones. During the in-depth interviews, the data gathered through observations and review of documents was verified with each participant. Out of 27 interviews, 24 were conducted in Arabic and the rest of the interviews were in English. All interviews were transcribed by a trained research assistant fluent in both Arabic and English. Interviews conducted in Arabic were initially transcribed in Arabic and then translated into English. Ten percent of all the interviews in Arabic that had been translated into English verbatim were then back-translated into Arabic by the trained research assistants to check the accuracy of the translated version.

Data Analysis

Data analysis during this critical ethnographic study was iterative and inductive (Fetterman, 2010; Hardcastle et al.,

2006). We used a critical lens, paid close attention to the context, and examined the data concerning the sociocultural, environmental, and economic determinants to present the impact of COVID-19 on vulnerable women who are refugees and mothering. Data gathered through observation, review of media communication, and in-depth interviews were analyzed manually. During data analysis, the study team contacted the participants by phone to seek verification of the interpretations drawn from the data. Several steps were followed to analyze the data. First, codes were extracted from the data gathered through multiple sources (in-depth interviews, media communications, and observations). As a next step, categories and themes were derived to present the impact of the COVID-19 pandemic on women who are refugees and mothering young children. To assure the trustworthiness of the data and rigor in the process of data analysis, independent coding was undertaken by two research assistants. The principal investigator, co-investigator, research assistants, and refugee women who are mothering actively participated in the process of derivation of themes. To assure anonymity and strict confidentiality of the participants, identification numbers were used instead of real names to report the study findings.

Findings

Description of Participants

Of the sample of 27 participants, 8 were 35 years of age or older and 12 were aged 30 to 34 years. Additionally, only four participants were between the ages of 26 and 29, one was between the ages of 21 and 25, and just two participants were under the age of 20. The oldest mother from the sample was 39 years old and the youngest mother was 17 years old. The average age of participants was 31 years old. About 22 of the 27 refugee women arrived in Canada within the last 5 years, 4 women arrived 6 years ago, and 1 arrived 7 years ago. The refugee women's average length of stay in Saskatchewan was 3.84 years. Education level was surveyed among the participants. Four participants had a university or college education, six had a grade 12 education, nine had some high school education with no diploma, and eight had a grade 8 education or less. The majority of participants, that is, 24 women, were from the Middle East, with the other 3 participants coming to Canada from Africa. Twenty-four participants spoke Arabic as their mother tongue, with one participant speaking Tigrinya, one speaking Somali, and one speaking Swahili.

All the participants were married. A majority of participants lived in households of five people ($n=9$), households of seven or more ($n=8$), or households of six people ($n=6$). A minority of participants lived in households with four people ($n=2$) or three people ($n=1$). Furthermore, most participants reported living in a nuclear household ($n=25$), with only 2 of 27 participants living in an extended household.

The majority of participants reported being Muslim ($n=25$), while two participants reported being Christian. A third of mothers ($n=9$) had three children, just less than a third ($n=8$) had five or more children, and six participants had four children. A minority of mothers ($n=2$) had two children, and two refugee women had only one child. The youngest child of over half of the women in this study was over a year old, while a third of the mothers had a child between the ages of seven to 12 months, and only four had an infant six months old or younger. None of the study participants was employed at the time of data collection. Most participants reported having no earning family members in the home ($n=17$) during the period of COVID-19, while seven refugee mothers reported having one earning family member, and only three participants reported two earning family members in their household.

Impact of COVID-19 on Women Who Are Refugees and Mothering

The women participating in this study spoke about the range of structural barriers (sociocultural, environmental, and economic) that contributed to add-on vulnerabilities, disparities, and stressors during COVID-19. Along with the COVID-19 restrictions, study participants were survivors of war, faced subsequent forced displacement, and were now living in the host country (Canada) where there is a new culture, language requirements, different regulations, unfamiliar health system, and in-demand skills/job requirements. The key themes derived from the data include isolation, maternal stress/depression, and frustration; somatic complaints; difficulty in accessing health care; hospital restrictions for visitors/caregivers; limited follow-up care; limited social support; financial difficulties; and compromised nutrition.

Isolation, stress, depression, and frustration. The women's descriptions of their experiences indicated that during COVID-19 they were feeling isolated, fearful, stressed, depressed, and frustrated. This was because no one knows when this pandemic will end and they will be able to reunite with their extended family members living abroad, get to know new people in this host country, and go outside their homes to make new friends, find jobs, and study in Canada. Participants shared that they often face power differences and racism in Canadian society due to their low-socioeconomic status, appearance, and educational background. This further aggravates their sense of loneliness in the new country, especially during the COVID-19 pandemic when they have no avenue to vent their feelings or make new friends. Participants revealed they are scared of COVID-19 and feel isolated due to the pandemic-related restrictions as there are limited avenues for them to meet with people who speak their language and share a common cultural context. While describing those feelings, a study participant shared:

COVID-19 has affected us badly. I have stayed home for four months [because I am] scared to go out or send my kids out and this made everyone bored and depressed. [We haven't gone to] playgrounds or swimming pools and the tension and stress have increased.

Another participant expressed:

COVID-19 affected many things in our lives. In my last month of pregnancy, I couldn't go for a walk, and when I [went] somewhere, I had to put on a mask which was suffocating. I stayed home most of the time.

While describing similar concerns, another participant verbalized, "COVID-19 affected me a lot. I was scared of anyone getting sick; I stayed home all the time with my kids and would [only] go [out] to get urgent things. COVID-19 restricted my freedom to go outside." Another participant shared, "I am tired, scared of COVID. I am also depressed since there is no socialization anymore." Our field observations and review of media communication also supported these findings as, during the COVID-19 pandemic, prayer halls and community centers were closed most of the time and all recreational events organized by the settlement organizations were cancelled. Moreover, most public places like public libraries, grocery stores, shopping centers, and theaters had COVID-19 restrictions in place such as the use of masks, a limit on the number of people, and social distancing.

Somatic complaints. Many women shared that COVID-19 negatively affected their psychological health and this resulted in them experiencing somatic complaints. They described juggling multiple stressors and vulnerabilities during COVID-19, including adjustment difficulties in the cultural context of the host country, financial difficulties due to job loss and/or limited job openings during the pandemic, a lack of adequate skills to find a job, limited opportunities to learn a new language, and a lack of social support. It was too intense and they experienced a variety of somatic complaints of unknown origin, such as body aches, fatigue, skin reactions, and reduced appetite. One of the participants shared:

I never called the helpline, but I went to the emergency [department] during the COVID-19 pandemic because of [an] allergic reaction I had. Whenever I become sad, I develop some skin condition. The doctor advised me to go outside and get some fresh air.

Another participant, who experienced anorexia during COVID-19, revealed that "COVID-19 affected [my] psychological state [and] my appetite has reduced." A review of media communications supported these findings and identified that, worldwide, COVID-19 has increased mental health issues among refugees, especially women who often face food insecurity, intimate partner violence, covert oppression

at family/societal levels, and adverse effects of post-traumatic stress disorder.

Difficulty in accessing health care. Participants spoke about the challenges of accessing health-care supports during COVID-19, which increased their vulnerability. They shared that during COVID-19 it was difficult to book doctor appointments as many health clinics were not accepting new patients, there were limited opportunities to have in-person appointments with doctors, the medical helpline was extremely busy and lacked services in their preferred language, community-based follow-up services and home visits were paused due to COVID-19 restrictions, and more importantly, there were limited avenues of interpretation services available during telephone doctor appointments. These findings are consistent with our field observations undertaken to assess restrictions in health-care settings during COVID-19. Electronic resources developed by the health authority during COVID-19 on health-related topics were often inaccessible to refugee families due to a lack of health and digital literacy, linguistic skills, internet access, and availability of a computer or smartphone. Also, a review of newspaper articles depicted that access to health-care services was an issue in general during the COVID-19 pandemic, especially for the vulnerable group of refugee families who often present with a language barrier and are not familiar with the health-care system of the host country. While sharing the challenges of accessing health-care services during COVID-19, one of the participants explained, "It is not easy to see a doctor during COVID-19. [When] I have to book an appointment, they give whatever available time they have." Another participant shared, "I think COVID-19, changed life itself, especially during the lockdown times. We are not able to see doctors as easily because of [a] fear of going to the hospital."

Hospital restrictions for visitors/caregivers and limited contact with a sick hospitalized child. Refugee women who gave birth to their children during the COVID-19 pandemic spoke about the difficulties experienced in the hospital due to COVID-19-related restrictions, including early discharge from the hospital after childbirth, a no-visitor policy during COVID-19, and mother-baby separation if the mother or child was sick or required hospitalization. Due to these new restrictions during COVID-19, many refugee women could not avail of need-based breastfeeding counseling and support from trained health-care professionals soon after their childbirth and post-childbirth while their infants were admitted to the neonatal care unit. Field observations and a review of hospital policies/reports support that all the health-care settings were expected to strictly follow no-visitor policies to assure social distancing and prevent the spread of COVID-19 in all health-care settings. During this initial phase of COVID-19, there were many discrepancies in the literature on the physical separation of mother and young child post

childbirth and the use of expressed breastmilk for sick and hospitalized children.

Study participants who had sick and hospitalized children faced tremendous stress from being away from their sick child, arranging transportation each time they visited their sick child in the hospital, following the new hospital regulations on visitation policies, and seeking regular updates on their child's progress from health-care professionals who had limited time. As interpretation services were not readily available in hospitals, refugee women who lacked linguistic skills faced add-on challenges and stress due to these COVID-19 restrictions. Mothers further shared that they were unsure if they were allowed to bring their expressed breastmilk for their sick and hospitalized infants. With great sadness, a participant shared during the in-depth interview, "It was such a frustrating time [visiting my sick child] during COVID-19. I would go back home crying. . .I was frustrated, tired, and depressed."

Another participant stated:

When the COVID-19 pandemic hit, they [health-care providers] gave us a certain time for visits, 2 hours in the morning to see the baby [sick and hospitalized child] and to meet the doctor and 2 hours in the night, and I was the only one allowed to visit.

Limited follow-up care. Study participants expressed that COVID-19-related restrictions have disconnected them from regular contact with health-care and service providers. They shared that COVID-19 has reduced the frequency of home visits and restricted mother-child follow-up care resulting in them being unable to access the health-care supports they had before the pandemic. While describing the challenge, a study participant shared, "Before COVID, nurses used to visit mothers with a baby at home to check both [the] baby and mother, however, with COVID, she [the nurse] came only once to ask me if I [needed] any help." Participants shared that regular community-based follow-up care was essential for them to seek informational health care and breastfeeding support, however, COVID-19-related restrictions have interrupted this essential source of health-care service. Field observations and a review of reports released by the health authorities suggested that many health-care settings had a shortage of health-care providers in response to the demand for care in emergency departments, intensive care units, and outpatient vaccination clinics during COVID-19. As a result, home-based follow-up care was put on hold. This shift in service provision during COVID-19 negatively affected refugee families who often lack transportation to the health-care settings, linguistic skills to book appointments, and familiarity with the health-care system.

Limited social support. The women participating in this study explained that before migrating to Canada they lived with their extended family members who offered them need-based support in child-rearing, management of household

responsibilities, and advice on child feeding. However, they were unable to unite with family members due to COVID-19 travel restrictions, political instability in their home country, and financial instability. As such, the lack of advice and support from close family members and relatives was acutely felt and was compounded by the limited support from health-care professionals and the reduced availability of guidance in their language during COVID-19. They perceived this lack of support to negatively affect their mental health, resilience, and coping during the pandemic in the cultural context of a new country they never visited before or even thought of coming to. In addition, because of COVID-19, they were restricted to their homes in a new country where they didn't know many people and had limited contact with other people in their neighborhood. As most of the participants were living in a nuclear family with their husbands and children during COVID-19, they had limited informal and informational support on breastfeeding and child-rearing from their extended family members living outside Canada and in other Canadian provinces. One of the participants shared, "The absence of my mom and my sisters [who are not in Saskatchewan, Canada] is hard, especially since my husband is busy [at work in Canada]." Our field observations supported that during COVID-19 the 24/7 helplines designed to offer mental health services not only were busy with wait times of more than 2 hours, but they had limited availability of health-care providers who could provide psychological counseling in multiple languages. Moreover, during COVID-19 there were limited avenues for refugee women to receive culturally sensitive care, health-care advice, and mental health services in their preferred languages during the prenatal and postnatal periods.

Financial difficulties and compromised nutrition. Data collected through multiple sources revealed that refugee women belonging to multiple cultural groups in Saskatchewan are facing add-on vulnerabilities due to financial difficulties. Field observations suggested that most of the women were residing in rental housing located far from health-care settings and had no nearby access to affordable public transportation. Study participants spoke about the financial difficulties and increased economic burden during COVID-19 due to which they were unable to secure decent housing, transportation of their own, and healthy food for their families. During COVID-19, many participants were unable to upgrade their language and technical skills (required to secure jobs) due to limited finances, child care responsibilities at home, limited social support, and interruptions in skill upgrade courses offered for refugee families by public libraries/settlement organizations. Most of the participants shared that their husbands are jobless as COVID-19 has resulted in the closure of many businesses and layoffs of staff. Mothers further shared that there are limited job openings during the pandemic that match their technical skills. A review of the Government of Canada's benefit information for low-income families

suggested that in Canada eligible families receive a tax-free monthly allowance from the Government of Canada to offset the cost of raising children under the age of 18 years. During in-depth interviews, study participants shared that although they received a child care support allowance (Canada Child Benefit) from the government, a major portion of this allowance and their salary went toward their rent and bills. Mothers further shared that financial difficulties after COVID-19 have affected their nutritional status as they cannot afford to buy culturally appropriate food items that are healthy and suitable to meet the ideal caloric intake requirement of a breastfeeding mother. While sharing these challenges, a study participant explained, “The salary we get is little and we put most of it [toward] rent and bills. Everything here [in Canada] is expensive.” Another participant shared, “If you don’t have enough money, you can’t buy the food you need to eat and breastfeed.”

Discussion

Before the COVID-19 pandemic, refugee women who had settled in Western countries were already documented as being at greater risk than the general population for prolonged grief and post-traumatic stress disorder related to traumatic pre-migration events (Brown-Bowers et al., 2015; Júnior et al., 2020) and post-migration stressors such as cultural bereavement or loss of the familiar (Jongedijk et al., 2020; Kokou-Kpolou et al., 2020). Although refugees were identified as being at risk for depression and mental health issues before the arrival of COVID 19 (Jongedijk et al., 2020; Kokou-Kpolou et al., 2020; Qutranji et al., 2020), our study suggests that COVID-19 has placed additional stressors and mental health risks upon the vulnerable population of women who are refugees and mothering young children in the cultural context of Saskatchewan, Canada. Previous studies undertaken in the Canadian context during the first wave of COVID-19 identified that the COVID-19 pandemic has negatively affected the health and well-being of refugee families due to barriers to socioeconomic support, health care, education, and border crossing impediments (Benjamin et al., 2021; Clarke et al., 2021; Edmonds & Flahault, 2021). Considering the growing number of refugee families with young children in Saskatchewan, Canada, and the increased vulnerability of refugee women during the COVID-19 pandemic, this critical ethnographic study highlighted add-on negative impacts of COVID-19 on the overall health and well-being of women who are refugees and mothering in Saskatchewan, Canada. It identified that women who are refugees and mothering faced multilayered vulnerabilities and disparities during COVID-19, including coping with the trauma of being displaced, migration, and integration into the cultural context of a new country; a lack of connectivity to their social network and extended family members; inaccessibility to informational, tangible, and emotional supports

due to COVID-19 restrictions; racism in health care and society at large; a lack cultural sensitivity in the health-care system; covert oppression due to their low socioeconomic status, appearance, and educational background; and inaccessibility to health-care and mental health services in their preferred language. This study suggested that during the COVID-19 pandemic, women who are refugees and mothering were facing add-on stressors and vulnerability due to isolation, depression, frustration, somatic complaints, difficulty in accessing health care, hospital restrictions for visitors/caregivers, limited contact with a sick hospitalized child, financial difficulties, compromised nutrition, and limited follow-up care and social support.

Isolation and Fear of COVID-19

Participants in this study emphasized that the limitations imposed by COVID-19 on their capacity to socialize with others and participate in community activities with their children, and on their freedom to leave their home, contributed to increased stress and frustration. Ensuring the safety of their families during the COVID-19 pandemic compelled these vulnerable women to remain quarantined, becoming further isolated and at risk for mental illnesses. Evidence supports that fear of COVID-19 for many refugee women has been one of the primary reasons to avoid large gatherings, handshaking, talking directly to people, and leaving the home for unnecessary reasons (Hamadneh et al., 2021). Literature from the global context further supports that among refugee women there is an increased fear of getting COVID-19 (Brickhill-Atkinson & Hauck, 2021; Lusambili et al., 2020). As a result, refugee women avoid accessing needed health-care services, such as by staying home to give birth rather than going to the hospital (Hamadneh et al., 2021; Lusambili et al., 2020).

Somatization of Stressful Experiences

In our study, women who are refugees and mothering also depicted the somatization of stressful experiences during the pandemic, describing the impact of the increase in physical complaints such as skin conditions and anorexia upon their psychological health. Similar findings are reported on the somatization of stressful experiences within this vulnerable population (Brickhill-Atkinson & Hauck, 2021; Jongedijk et al., 2020; Kokou-Kpolou et al., 2020). Integration into society is a fundamental step in the successful resettlement of refugees. During the onset of the pandemic, public health measure restrictions during COVID-19 limited social gatherings, social events, and attendance at community and religious centers (Edmonds & Flahault, 2021; Ullah et al., 2021). These restrictions prevented refugees from being able to build social and cultural connections in their country of resettlement and contributed to reported feelings of isolation

and mental health concerns (Brickhill-Atkinson & Hauck, 2021; Edmonds & Flahault, 2021). Results from a systematic review showed that, globally, restrictions set in place due to COVID-19 increased the prevalence of PTSD by 36%, anxiety by 44%, and depression by 44% within the refugee population (Júnior et al., 2020).

Inaccessibility to Health Care During COVID-19

In this study, women who are refugees and mothering young children reported inaccessibility to health-care services during COVID-19. The pandemic-related restrictions limiting follow-up personal contact between the vulnerable women and their health-care providers placed additional stressors upon them. The findings suggest that health care for the mental and physical health issues of our participants, aggravated by the isolation and stresses associated with the pandemic, was overlooked by the health system during COVID-19. Although in Canada remote health-care services began working with patients during the pandemic, this requires health literacy; internet access; availability of a computer; and digital, literacy, and linguistic skills that are often lacking for refugee families (Browne et al., 2021; Endale et al., 2020; Parajuli & Horey, 2020). Evidence supports that refugees who are able to access telehealth communication services often present with barriers surrounding limited privacy due to shared living conditions, hence many refugees avoid sharing sensitive information over the phone or video and are unable to access the care and attention they need (Mattar & Piwowarczyk, 2020).

Hospital Restrictions During COVID-19

Our study further suggested that refugee women with a sick hospitalized child were frustrated by COVID-19-related restrictions in hospitals. A study examining the experiences of parents who have been restricted in staying with their hospitalized preterm children due to COVID-19 identified four major themes that captured parents' experiences (Osorio Galeano & Salazar Maya, 2021). The first theme was an increased need for information to compensate for their ability to physically be close to their child and comfort them. The second was a heightened sense of emotional pain felt by the parents due to the limited interaction with their children. The third theme was increased fear about their child's condition, and the last was having limited social support for child care after the child has been discharged (Osorio Galeano & Salazar Maya, 2021). If these challenges are felt by individuals who are not refugees, it is essential to consider the add-on challenges of vulnerable refugee women who may already be facing mental health challenges due to past trauma, and often have add-on challenges such as language barriers, unfamiliarity with culture and health-care services, non-availability of transportation, and financial difficulties.

Limited Follow-Up Care

In our study, women who are refugees and mothering also described the reduced frequency of home visits and restricted mother-child follow-up care during COVID-19. This limited follow-up was associated with increased difficulties accessing health care supports. In a study conducted with Vietnamese refugee women in Australia, lack of follow-up care after childbirth had a negative effect on the maintenance of breastfeeding (Rossiter & Yam, 2000), while a study conducted with Black women in the US indicated that trusting relationships with health-care providers supported them to breastfeed (Cricco-Lizza, 2005). More recent research (Abbass-Dick et al., 2020; Puharić et al., 2020) demonstrated that follow-up after hospital discharge increased breastfeeding rates. However, despite these recommendations for follow-up after discharge from the hospital, follow-up care by health-care providers was reduced during COVID-19 for this sample of mothers.

Limited Social Support

Social support is crucial for the vulnerable population of women who are refugees and mothering, knowing they may already be carrying past trauma. In this study, the women portrayed an absence of social support, since COVID-19 restrictions prevented them from visiting their family members living abroad and having regular contact with health-care providers. They also shared the stress, anxiety, and tension they felt when they had a sick child in the hospital and were not permitted to stay with the child and while other family members were not permitted to visit the child or meet the doctor to discuss the child's condition. This eliminated an important source of support for the mother-child dyad. Evidence supports that the restrictions concerning social support create challenging situations for women who are refugees and mothering and consequently expose them to losses of the familiar, with them often ending up with prolonged grief disorder (Jongedijk et al., 2020; Kokou-Kpolou et al., 2020).

Financial Difficulties During COVID-19

Our study suggests that although refugee families were facing economic hardship due to COVID-19, the pandemic has exacerbated these financial difficulties. Refugee women often have a low educational and occupational status, contributing to a greater likelihood of experiencing language barriers, social isolation, and difficulty using the health-care and social service systems (Qutranji et al., 2020). These socioeconomic issues diminish their ability to find employment. COVID-19 restrictions created additional issues surrounding employment and have contributed to job loss, leading to financial difficulties for refugee families, especially for refugee women who are mothering. In this study,

increased financial difficulties resulted in it being too expensive for them to purchase good nutrition and culturally specific foods, which are linked to successful breastfeeding. Cultural practices, many of them centered around food, are known to play an important role in successful breastfeeding (Dozio et al., 2020).

Evidence supports that refugees often carry the responsibility of financially providing for their immediate family, whom they live with, in addition to their extended family members living in their home country. As a result, the overt economic hardships that they have faced during the pandemic are not only felt by their immediate family members but others living back home (Brickhill-Atkinson & Hauck, 2021). According to the Kovler Centre Child Trauma Program, an organization that assists refugee families in Chicago, many refugee families have lost their jobs during the pandemic and have not been able to access unemployment benefits (Endale et al., 2020). Ultimately, the pandemic forced some refugees to choose between their health and well-being or making a source of income to cover their basic needs.

Recommendations

It is essential to advocate for the overall health and well-being of women who are refugees and mothering as the literature shows that maternal distress and adverse child outcomes are linked (Rashid et al., 2020; Sangalang et al., 2017; Sim et al., 2018). This study suggests a range of challenges encountered by women who are refugees and mothering in Saskatchewan, Canada during COVID-19. Given the overall findings of our study, we recommend that it is essential for nurses and other health-care professionals to involve refugee women and their family members as partners, specifically involving them in designing innovative and need-based health-care programs, policies, and services that promote their physical, mental, social, and emotional health and well-being during COVID-19. Involving ‘patient as partner’ will facilitate the provision of need-based and culturally appropriate care; promote equity, diversity, and inclusion in the provision of care in their preferred language; assist in combating racism in health care and society at large; and reduce the disparities and vulnerabilities affecting the health and well-being of women who are refugees and mothering during COVID-19. We also recommend the use of social media, nurse-led helplines, and telehealth to provide mental health support, skills-building programs, nutritional counseling, and follow-up care in the preferred language of women who are refugees and mothering. Throughout the pandemic, partnerships and collaborative efforts by interdisciplinary professionals (nurses, doctors, psychologists, nutritionists, health economists, social workers, and public health workers) and governmental and nongovernmental organizations (refugee settlement organizations and health authorities) are also recommended to extend social support, facilitate resilience-building, promote mental

health, and build the capacity of women who are refugees and mothering.

Limitations

We recommend large-scale studies with women who are refugees and mothering in other provinces of Canada to explore a range of challenges and provide need-based care during this pandemic. Since this study was conducted during the COVID-19 pandemic, the researcher was unable to conduct face-to-face interviews. Interviews conducted over ZOOM may have influenced the participants’ communication with the researcher. Consequently, the researcher took action throughout the data collection to verify the information with participants and ensure that participants’ voices were heard.

Conclusion

Refugee women with young children—who often experience trauma, family separation, forced migration from one country to another, and social disconnection in a new country—are at risk of experiencing reduced physical, mental, and emotional well-being. This critical ethnographic study filled the knowledge gaps surrounding the impact of COVID-19 on women who are refugees and mothering in Saskatchewan, Canada, which has had a noticeable increase in the refugee population with young children aged 2 years and under. The findings suggest that during COVID-19, women who are refugees and mothering are at high risk of experiencing add-on stressors due to limited social support, difficulty accessing health care, and other COVID-19-related restrictions in their social environment. In this critical ethnographic study, women who are refugees and mothering identified negative effects on their mental health due to fear of getting sick, limited socialization, lack of social support, economic difficulties, limited follow-up community-based care, inability to access health-care settings, and restrictions on their ability to stay with their sick hospitalized child due to COVID-19 restrictions. The findings of this study are instrumental in better responding to the challenges encountered by refugee women with young children and initiating need-based interventions through partnerships with service providers, and governmental/nongovernmental organizations.

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