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Listening to the Voices of Syrian Refugee Women in Canada: an Ethnographic Insight into the Journey from Trauma to Adaptation

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Abstract
Syrian refugee women face many obstacles when accessing health services in host countries that are influenced by various cultural, structural, and practical factors. This paper is based on critical ethnographic research undertaken in Canada, to explore Syrian refugee women migration experiences. Also, we aim at critically examining how the intersection of gender, trauma, and violence, and the political and economic conditions of Syrian refugee women shapes their everyday lives and health. The study also investigates the strategies and practices by which Syrian refugee women are currently addressing their healthcare needs and the models of care that are suggested for meeting their physical and mental health needs. Findings show that these women experienced constant worries, hardship, vulnerability, and intrusion of dignity. These experiences and challenges were aggravated by the structure of the Canadian social and healthcare system. This study offers a better understanding of the impact of migration and trauma on Syrian refugee women's roles, responsibilities, gender dynamics, and interaction with Ontario's healthcare system to improve interaction and outcomes. Healthcare models should address these challenges among Syrian refugee families in Canada.

Keywords Syrian refugee women · Intersectionality · Critical ethnography · Migration · Trauma

Background

The Syrian civil war crisis has been described as the biggest humanitarian and refugee crisis of our time since the end of the World War II (United Nations High Commissioner for Refugees [UNHCR], 2018). About six million Syrians,

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three-quarters of whom are women and children, have been displaced around the world and create a significant impact on the socioeconomic and healthcare systems of the host countries. According to the UNHCR (2020), Canada admitted the largest number of refugees with a total of 21,745 privately sponsored Syrian refugees that have arrived, resettled, and gained citizenship in Canada. With these numbers, it is understandable that measures need to be put in place for the health needs of the migrant population. Thus, the UNHCR has called for urgent guidelines to address the healthcare for the Syrian refugee population due to their high medical needs. This call for healthcare guidelines makes intuitive sense for the need of different initiatives to support Syrian refugees. Health and social programs would potentially assist all Syrian refugees regardless of the current social, political, and structural challenges that they might be facing. Several systemic barriers impact the health of immigrants and refugees such as issues of language and availability of interpretation services, cultural competency, social isolation, poverty, and accessibility of healthcare and availability of services (McKeary & Newbold, 2010).

Research on refugee and immigrant families' experiences of accessing healthcare in Canada concluded that there should be a fit between the refugee's healthcare needs and healthcare system in terms of approachability, availability, affordability, and appropriateness so they can navigate the available services, reach out, and fulfill their healthcare needs (Woodgate et al., 2017). Moreover, refugee women faced many barriers to access healthcare services with an impact on their health outcomes due to the interactions between the uptake of health information and the availability of appropriate and culturally acceptable services in Canada (Khanlou et al, 2017). In general, Syrian refugees have faced catastrophic war crimes, human rights violations, poverty, forced migration, and repeated displacement, with potential physical and mental health implications (Acarturk et al., 2015; Drolet et al., 2017; El-Khani et al., 2017; Hansen et al., 2016). Specifically, Syrian refugee women may experience physical and mental health problems prompted by previous trauma, violence, and repeated displacement (Ahmed et al., 2017; Chung et al., 2017; El-Khani et al., 2017; Gaebel et al., 2016; Jefee-Bahloul et al., 2016), compounded by various stressors including unstable income and housing, loss of family, prolonged grief, settlement and integration challenges, language barriers, social isolation, discrimination, powerlessness, and uncertainty about the future (Acarturk et al., 2015; Agic et al., January 2016; El-Khani et al., 2017; Hadfield et al., 2017). Syrian refugee women, particularly those with children, are a highly vulnerable population in Canada (Cho et al., 2017), with severe implications for their health in terms of access to health services, better living conditions, and a higher quality of life. These refugees may be conceptualized as either victims lacking in capacity or victims of circumstances beyond their control (Cho et al., 2017; Myers, 2016), including adverse external forces, being a female with a different cultural background, and the structure of the social institutions and norms of the hosting country (Ahmed et al., 2017). In addition, Syrian refugee women's process of adaptation and acculturation appears to be diverse in terms of the process of adaptation itself, the level of difficulties and challenges, and to

some extent the eventual health outcomes of adaptation and acculturation (Berry, 1997). For instance, refugee women of different cultures and religions practice various means to cope and adapt to a new culture such as faith-based practices including prayers and meditation (Syed, 2013).

The points of view of Syrian refugee women are seldom incorporated in research, service provision, and policy design (Abu-rass, 2018), leading to an imbalance between what is provided and what is required. It is worth noting that striving to improve the health of Syrian refugee women is not just a one-way street and without rewards to the host country. Refugees participate in economic growth and bring considerable positive human and social capital that might benefit Canadian society (Drolet et al., 2017; Duncan, 2015; Hilado & Lundy, 2017). Exploring the experiences of these women in relation to migration and healthcare might influence their relationships with the host healthcare system and their physical and mental health, improving their ability to contribute to the development of their host country. Thus, understanding Syrian refugee women's experiences of trauma and migration in terms of their interaction with the Canadian healthcare system is of importance, as it is within these experiences that they will encounter positive or negative attitudes. The complexity of how quickly and how often these attitudes can change over time calls for the need to include the refugees' experiences within the health services scope of practice.

Although several studies currently address refugees' challenges in accessing and utilizing healthcare services in Canada (Cho et al., 2017; Guruge et al., 2018; Oda et al., 2017), there is a paucity of research on how the experiences of pre- and post-migration trauma impact their health and their navigation of the available health resources and services. Furthermore, research is needed to explore how the intersections of gender, trauma, culture, and political and economic conditions of the women shape their everyday lives and health, the strategies they are currently using to promote their own physical and mental health, as well as the availability and effectiveness of present and potential models of care in place for these women in Ontario. This study attempts to fill the gap in the existing understanding of Syrian refugee women's experiences of pre- and post-migration trauma and its connection to the healthcare system and their physical and mental health outcomes in Ontario. Furthermore, the study offers a better understanding of the impact of migration and trauma on Syrian refugee women's roles, responsibilities, gender dynamics, and their interaction with the Ontario healthcare system to improve both interaction and outcomes.

The purpose of this article is to explore and describe the pre- and post-migration experiences of Syrian refugee women in Ontario, Canada, and the impact on their physical and mental health. We aim to critically examine how the intersections of gender, trauma, and violence, political, and economic conditions of Syrian refugee women shape their everyday lives and health. The study also investigates the strategies and practices by which Syrian refugee women are currently addressing their healthcare needs and the models of care they suggest to meeting their physical and mental health needs.

Method

This study adopted a sound methodology based on critical ethnography with an intersectional analysis lens. Critical ethnography is a research methodology that is popular in sciences like anthropology and many other health and social disciplines. This research utilizes critical ethnography as a methodology to have a closer understanding of the perceptions of Syrian refugee women in elaborating a critical analysis designed to show how these perceptions relate to broader social structures of oppression. The selected methodology is informed by Carspecken's critical ethnography theory (Carspecken, 1996).

Critical ethnography applies ethnography to shared experiences within cultures or subcultures, in specific settings rather than throughout entire communities (Carspecken, 1996; Carspecken & Walford, 2001; Hammersley & Atkinson, 2007). This method helps the researcher to situate what is seen in the field in the broader political context, and to figure out the links between everyday interactions or experiences and wider cultural formations (Morse, 2016; Savage, 2000, 2006). Furthermore, it engages in cultural critique, allowing us to examine broader social, political, historical, and economic differences that, in this particular sense, influence the Syrian refugee women's situations and thus shape their trauma and migration experiences. Palmer and Caldas (2017) have argued that critical ethnography is a qualitative approach to critique hegemony, oppression, and unequal social power relations with the aim to achieve social change. Therefore, critical ethnography proved its potential and was particularly suited to this study since it is concerned with social inequities, and its ultimate goals are directed toward positive social change through legislative reform or policy formation. Critical ethnography helps us engage in cultural critique; it examines the broader social, political, historical, and economic differences that influence Syrian refugee women's situations and, thus, shapes their trauma and migration experiences and the impact of these experiences on their health and well-being.

This study uses intersectionality as a theoretical framework to promote the robustness of the study findings. Intersectionality is one of the promising approaches to analyze unequal social power structures and processes that produce unequal health outcomes (Bowleg, 2012; Collins, 2000; Crenshaw, 1989; Hankivsky et al., 2014). The central core of intersectionality is that it moves beyond examining individual factors such as gender and race to focus on the interactions and relationships between such factors across multiple levels of society (Collins, 2000; Crenshaw, 1989). For instance, Syrian refugee women from a lower socioeconomic group may find it more difficult to access healthcare than those from a higher class, even in a host country. In this case, the interactions explain how inequity and social power differential influence the Syrian refugee women's experiences of trauma, migration, and health. Indeed, an intersectionality-informed analysis allows examining various factors affecting Syrian refugee women's experiences of trauma and violence both systematically and simultaneously. Furthermore, it helps bring attention to the synergistic effects of multiple risk factors, vulnerabilities, and experiences. A blended approach of critical

ethnography with intersectionality can inform research that empower marginalized groups with a potential to call for social justice and change (Al-Hamad et al, 2022). Thus, Syrian refugee women's health is informed by the intersection of multiple levels of power structures and structures of discrimination in the host country.

Data Collection

This study was conducted in urban communities in Southern Ontario. The Syrian refugee women residing in the urban core of the selected cities were considered for the study if they met the inclusion criteria at the time of the study. Women would be able to participate if they were a Syrian refugee, able to speak English or Arabic, aged 18 years or more, had been in Canada for a minimum of 1 year, and were currently residing in Ontario. Participants were excluded from the study if they were non-Syrian refugees, unable to speak English or Arabic, and were not currently residing in Ontario. The setting consists of agency premises and sites in Southern Ontario, where settlement services have been provided to Syrian refugees. These areas show a higher proportion of Syrian refugees, as nearly half of the recent governmentally assisted Syrian refugees have resettled in Hamilton, Ontario (Cummings, 2016; Seto, 2016; Smith, 2015), and yet only a few studies have addressed refugees' experiences of pre- and post-migration trauma and access to healthcare in these areas. Recruitment flyers were posted at the main entrance of the organizations that provide health, settlement, and integration services for Syrian refugees to recruit women. These organizations include mosques, cross-cultural centers, refugee alliance centers, churches, community organizations, and city hall.

Purposive and snowball sampling techniques were utilized to recruit the study participants. A total of 25 Syrian refugee women participated in this study. Participants' age ranged from 21 to 60 years. Most of these women (19) were married, (3) were widows, (2) singles, and one was divorced. Of the 25 women, 23 were Muslims, and two were Christian. The number of children ranged from 0 to 8. On average, these women had stayed in the hotel when they initially arrived in Canada for around 30 days and had lived in Canada for 4 years. Regarding sponsorship type, 18 women came to Canada through governmentally assisted sponsorship, while 7 came through private sponsorship. All the women spoke the Arabic language at home and during the interview. More than half of these women (13) had high school level education, 4 had a diploma, and 8 women had a bachelor's degree. Out of the 25 women, 22 women were unemployed, and 3 women were employed part-time, and their primary income source was welfare or spouse income.

The study protocol was approved by the Western University Health Science Research Ethics Board (HSREB) (Project #114,519). After ethics approval, data collection was conducted by the first author over 6 months in 2020. Due to the challenges imposed by the COVID-19 pandemic, an immediate and effective action by governments to protect the health and basic human rights of everyone's life is required particularly refugees and migrants as they are potentially at increased risk (Lanzarone et al., 2021). Therefore, an online synchronous interviewing (OSI)

approach through a secure academic version of "Zoom platform" was utilized to conduct 25 individual, in-depth, open-ended semi-structured interviews in Arabic that lasted between 1 and 2 h to get an in-depth understanding of the cultural context. The semi-structured interview guide was revised and tested on two Syrian refugee women (voluntary), to ensure clarity and to promote credibility and dependability of this study.

An informed consent was sought from all participants. With their permission, all participants were interviewed individually and virtually in a private area based on their preferences such as their residences, backyards, and cars. Virtual observation of the participants' environment was included, such as observation of their homes, the meaning of their physical space, the people involved, and interactions occurring in this space with their children as well as any expressed emotions. Interviews were conducted in the Arabic language and recorded digitally. Field notes were taken after each interview to summarize observations and impressions about the interview. Such engagement assisted in gaining better insights into Syrian refugee women's lives to develop insights on how sociocultural processes emerge and change and how a specific social and cultural aspect relates to the broader processes and contexts. The informal dialogue was conducted with participants to obtain their perspectives on their experiences of migration and trauma. This data stimulate critical reflection through a dialogical process that is required to empower actors in social settings (Carspecken, 1996; Hammersley & Atkinson, 2007). Participants' recruitment continued until data saturation was reached, with no new themes being identified (Madison, 2019). The participant–observation stage involves reflection on the participants' responses, participants' ways of communication with their children, body language, eye contact, nonverbal communication, and interpretation of their voices to enrich the meaning.

The Researcher's Positionality

Throughout the research, I remained conscious and aware of my own positionality as a Muslim immigrant woman. The insider status derives from belonging to the Muslim community and being a woman who speaks the same language (Arabic), living in Canada for the past 6 years. On the other hand, the outsider status comes from having experienced different ways of being an immigrant woman and having lived mostly in different settings and circumstances from the participants.

Being an insider researcher enabled me to gain the participants' trust and also to interact with them, as well as to acquire some insights on the participants' backgrounds and feelings. Moreover, I had gained some insights about the study participants during my previous work with Syrian refugee women and their settlement in London, Ontario. In this manner, being an insider researcher helps in the construction of questions that could be effective in encouraging participants' responses during the interviews, especially since I speak their language. In fact, my insider status may also confer certain disadvantages, such as being influenced to make assumptions about participants, using my own personal characteristics and background as a yardstick for viewing participants.

My positionality also had a significant impact on my ability to interview Syrian refugee women about their experiences of trauma, migration, and Ontario's healthcare system. Given that I shared several identity markers with many participants, including skin color, gender, and religion, it was relatively easy to create a relationship of trust and rapport with the participants. Over the course of the research process, I have tried to minimize the power imbalance when I conducted the interviews with Syrian refugee women about their pre- and post-migration experiences. For instance, during the interview, I have directed the research agenda, considered myself as a "detached" researcher, and taken a back seat during the discussion. This detachment was not always easy to achieve, nor was it necessarily welcomed by the participants.

Data Analysis

The interviews were recorded, translated to the English language, transcribed verbatim, and analyzed using NVivo 12 software for qualitative data analysis. Each interview transcript was read in its entirety with good immersion in the data to get a sense of the whole text and dataset. Thematic analysis with an intersectional lens was used to understand the cultural norms and interlocking identities of the participants, such as language, gender, culture, ethnicity, and refugee status. The first author and three research team members coded the data independently. The analysis included the narrative data and observation field notes, and the meaning context was used as the unit of analysis for coding and description (Braun & Clarke, 2006; Terry et al., 2017). Exploring the multiple social identities of Syrian refugee women systematically and simultaneously allows for an understanding of the links that exist between gender, social and political processes, minority status, and social actions. Triangulation technique was used as it is a key in an ethnography study and it assists in producing another set of comparatives, dialogical data based on verbal interaction with participants (Carspecken & Walford, 2001; Hammersley & Atkinson, 2007).Two triangulation strategies were adopted in this study: first, data triangulation by using multiple data sources to validate conclusions such as interviewing women in time, space, homes, backyards, and cars; second, method triangulation by using multiple methods of data collection (e.g., interviews, participants, and context observation).

Analysis of the data began with a description of the cultural context or site where participants were interviewed, identifying their routines, roles, and power relations (Carspecken, 1996). Data analysis started during data collection, and continued with coding, leading to the development of analytic categories and ending with formulating major themes. During the initial phases of analysis, data were coded to develop categories. The meanings and relationships between concepts were explored, compiled, and reorganized multiple times to form tighter hierarchical schemes (Carspecken, 1996; Carspecken & Walford, 2001). This process of compiling and reorganizing raw codes was described by Carspecken (1996) as "pragmatic horizon analysis" and involves ranging codes from tacit to more explicit meanings (Carspecken, 1996). For instance, an informal dialogue was conducted with

participants to obtain the perspectives of their experiences of migration and trauma. The initial findings were compared with emerging codes in subsequent stages of data collection.

The emerging codes were reviewed in subsequent stages of data collection. A progressive comparison facilitates capturing cultural themes that might have meaning during interactions, such as interaction patterns, social practice, power relations, and roles (Carspecken, 1996). The last stage of data analysis was engaging in a dialogical approach to link the analyzed data to broader socio-political aspects. Based on the advice of the research team, decoding and further analysis were conducted to ensure that the analysis was in line with the cultural context and the selected theoretical framework. The major themes were labeled, and all the potential sub-themes, connections, and intersections that emerged from the data were listed together.

Various strategies were adopted in this study to enhance trustworthiness, rigor, and quality, as suggested by Lincoln and Guba (1985). For instance, member checking was conducted with some participants to verify that the analyses reflected participants' experiences. Furthermore, triangulating between data collection and analysis was considered to produce another set of comparative, dialogical data based on verbal interaction with participants (Carspecken, 1996; Hammersley & Atkinson, 2007). To ensure transferability, participants' languages, common concerns and views within their culture, were carefully transcribed verbatim with a thick and in-depth description of the study findings. The preliminary cultural themes with sub-themes were carefully interpreted to ensure their links to the context and content of the interview. Prolonged engagement with study participants was conducted to ensure that credibility was attained. Multiple self-reflection and audit trials with regular meetings between the researchers were performed to ensure conformability. Finally, pseudonyms have been used for the participants to ensure confidentiality. Utilizing these processes to address various dimensions of trustworthiness, the final cultural theme and subtheme were constructed. The study findings were disseminated thru conferences and shared with community organizations, the city mayor, settlement center directors, mosque imams, and Syrian refugee advisory group.

Results

A total of 25 Syrian refugee women participated in this study. This study included a diverse group of women of different ages, educational backgrounds, locations of initial migration, religion, and different types of sponsorship. The diversity of our sample enabled us to identify some of the common aspects shaping Syrian refugee women's experience with the Ontario healthcare system and to summarize commonalities in the views of our participants, through delving into their cultural experiences that shaped their perceptions about their migration to Canada. We also explore how various women's social identities such as their level of education, income, and type of sponsorship shaped their experiences with the current Ontario healthcare system and how their duration of staying in Canada may have shaped their perception and experiences. We also explore how the gender role critically plays in shaping these women's experiences given the frequently assigned role to familial responsibilities

and the role of the culture in strengthening these gender roles. Our nuanced analysis allowed us to explore the intersection between gender, culture, migration, and perception of healthcare system.

In this section of the article, we present the common findings that have been developed from the analysis. Figure 1 illustrates the key themes and the related subthemes that reflect Syrian refugee women's experiences for each time frame of their journey in a finding matrix developed for this study. The data analysis led to four major themes that cover different periods, including the civil war, premigration, migration, and post-migration. The emergent themes were as follows: compounded trauma and hardship, fear and worries, vulnerabilities, and intrusions of dignity and healthcare perception. Indeed, Syrian refugee women's narratives reflected the porous temporality of their experiences over different periods and showed how difficult it was to determine when to begin and move through the stages or whether they even had the choice to move. The key themes and subthemes regarding Syrian refugee women's experiences during different time frames are described next in a finding's matrix developed for this study.

Theme 1: Compounded Trauma and Hardship

Syrian refugee women's narratives revealed that the decision to leave their houses and move to another city in Syria or to another country for the sake of safety and security was an extremely traumatic experience for each of the women

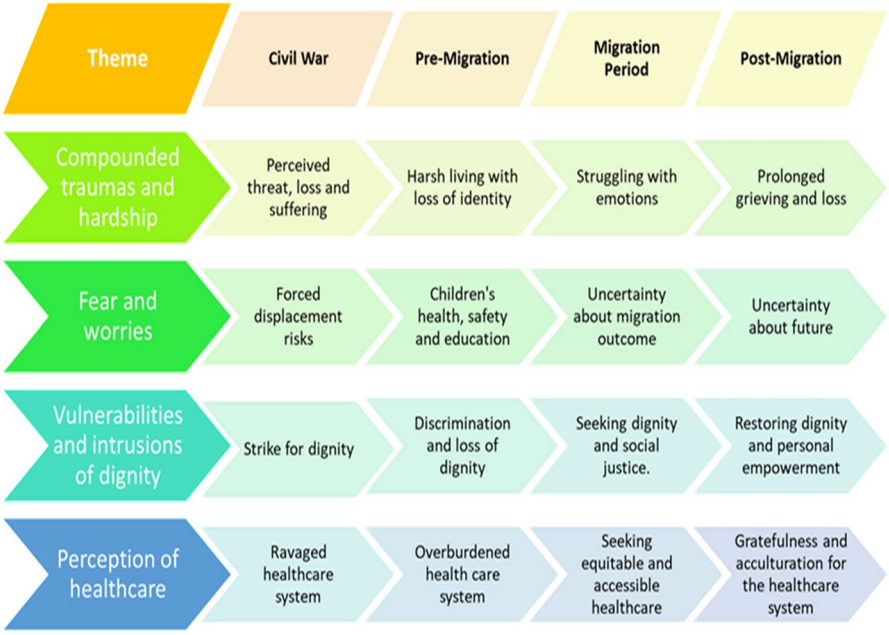

Fig. 1 The key themes and related sub-themes

interviewed. These data highlight a serious issue of trauma, threat, loss, and suffering and its impact on these women's health, particularly for those who were away from their families and thus did not have any family support. The majority of the women labeled the journeys they made to the borders as harsh, tormenting, dangerous, risky, unforgettable, and uncertain. For example, Khitam, a 23-year-old woman, said:

"It was scary and terrific times. It looks like a judgment day. We moved from one city to another inside Syria, but it was getting worse, and we could not tolerate it anymore, and it was hard and like a torment when we decided to go to another country." (Khitam, a 23-year-old woman).

The interviews show that Syrian refugee women who stayed in refugee camps have distinct experiences of suffering that illustrate the complex interaction of poverty, loss of home, food insecurity, and poor health outcomes. For instance, more negative physical, mental, and emotional health impacts were predominantly reported by women residing in the refugee camp than women residing in their homes. Bahia, a 25-year-old woman, explained how camp residency and weather challenges impacted their health and their children's health and food security.

"The life was expensive there. We stayed in the refugee camp, and it is hard, but I survive. The weather was hot in summer and during winter, it was freezing and muddy, and some kids, especially newborns, died from cold weather. It was a miserable experience in the refugee camp." (Bahia, a 25-year-old woman).

Most women also asserted that, while they were faced with difficult decisions about moving to another country, they endured their struggling with ambivalent emotions and constant worries as part of what made their experiences of trauma, migration, and suffering more harmful and problematic. The majority of the women explained the multiple difficulties, hardships, and challenges that they encountered regarding their initial migration. They also talked about how they had left their cities after losing their homes in the bombardments of their city. Loss of home, culture, and family consistently emerged across several sub-themes in this study; one such sub-theme concerned the impact of the loss of either home or family on women's mental health. However, the concern that was predominantly articulated invariably by all the participants was the financial constraints and burden that was worse with children's responsibilities and hardship. Indeed, the financial burden constantly shapes these women's daily life. It is worth noting that most of the women constantly expressed that they are still experiencing prolonged grieving and loss, even now in Canada. These experiences of grieving include the loss of their homes, families, culture, and the hardship of forced displacement with its related challenges, especially during the harsh winter or other challenging weather. Hiba, a 40-year-old woman, said:

"I struggled a lot because, at any time, you can find yourself in the street due to the crazy house rental. It is a struggle with raising children and paying house rental with no partner support; it is unfair, and a big struggle for me, and I know that this will have an impact on my health. You know I am still grieving, and I can't forget my loss." (Hiba, a 40-year-old woman).

Theme 2: Fear and Worries

One of the extremely disturbing aspects of the Syrian refugee women's narratives during the war was the constant worries and fear experienced by most of the women. Women talked about how they spend days and hours of each day in tears and worries about the safety of themselves or their families. Indeed, the majority of women touched upon the hardship of repeated displacement and moving from one city to another. Moreover, the participants consistently asserted the various impacts of their worries about their children's safety and future on their health and well-being, and the role that children-related worries play in relation to women's health in the context of civil war. For instance, women reported that the education system in the first migration countries seemed not well prepared to accommodate the influx of the Syrian refugee students. Some women reported that due to the financial burden and high cost of living and housing, some of their older children did not attend school and decided to work to assist their parents so they can cover the cost of living in the host countries. Indeed, the worries about children's safety, health, education, and future seemed to pose various challenges and health impacts such as stress, anxiety, and insomnia on Syrian refugee women during the pre-migration stage. Layla, a 35-year-old woman, reflects on this personal struggle.

"You know they forced Syrian refugee kids to go to afternoon schools. Their education was bad, and most of the students struggled, and definitely, that will affect their future. The teachers were already too exhausted to teach the Syrian refugees." (Layla, a 35-year-old woman).

The decision to leave for Canada came with a fear of the unknown and uncertainty about the migration outcomes and their future. All the women reported that they were initially hesitant to go to Canada. All participants shared their concerns about moving to a new country with different people, religions, and cultures. Moreover, most of the participants were worried about how to raise their children in a country that has different social norms, religious rituals, and culture and speaks a different language. Some women explicitly stated that they never heard about Canada before, and they perceived going to Canada as being the end of the world. Some of them expressed their worries about the ability to practice their religious rituals or cultural practices in a country with a different culture, language, and system. The women explained that although Canada was a secure and safe place and going could mitigate the effects of trauma and the migration hardship on their children, their feeling of uncertainty about their future and children's future intensifies their anxiety. On the other hand, some women perceived that going to Canada as escaping from the hill to heaven. For instance, Rania, a 22-year-old, and Amal, a 34-year-old, explained their feeling when it was the time to migrate to Canada:

"When we decided to go to Canada, I was scared, but I don't know why. You know I feel that I am far away in a different country, different in everything, their people, their weather, their culture. Then I agreed to go to Canada for my kid's future and opportunities, but I don't know if we really took the right decision for our children or not." (Rania, a 22-year-old woman).

"You know I was hesitant to go to Canada and, at the same time, happy to get a ride from the hardship in [the initial migration country]. We escaped from the hill to heaven, and I convinced myself that here (Canada)is the heaven." (Amal, a 34-year-old).

Theme 3: Vulnerabilities and Intrusions of Dignity

This theme illuminates the complexity and intersecting nature of these women's various experiences and how their life is being shaped by the predominant and interlocking structures of domination. Specifically, most of the participants repeatedly described feelings of discrimination, desperation, exclusion, and being different in the host countries. Indeed, the women's perception of vulnerability and marginalization arises from interlocking systems of oppression and various forms of social exclusion such as their gender, being a Syrian refugee with its related negative stereotyping, being perceived as a burden on the host countries, and poverty that hinders or prevent them from being effectively engaged and involved with the host countries. Zakia, 50-year-old, pointed out the people's perception of "Syrian refugee":

"We encountered some discrimination because we are Syrian refugees. Being a Syrian refugee woman was not a good thing. I don't like to be labeled as Syrian refugees not because of being refugees but due to the context and how people perceive it" (Zakia, 50-year-old).

It is worth noting that most women reiterated that they continually find themselves disadvantaged by various constraints imposed by their gender, refugee status, financial insecurities, place of residency, and socio-economic contexts of the countries of initial migration. The core narrative of disrespect, loss of dignity, and perception of being a burden in the host country imply that the women's pre-migration hardship was accompanied by multiple tensions arising from the detachment from their home country, which are associated with the women's multiple social identities and the intersections of various individual, social, cultural, and political dimensions. Samah, 28-year-old, reflected on her migration hardship and the loss of dignity and disrespect at the borders during her migration to the initial country prior arrival to Canada:

"They beat us on the borders like sheep. I know that every refugee is a victim that has been forced through various circumstances to leave his or her country. I decided to go back to Syria because the one who leaves his home will lose his identity, dignity, and value (proverb)" (Samah, 28-year-old).

All the study participants reported that they felt a strong sense of vulnerability and oppression in their life that was compounded by a sense of discrimination, feelings of contempt, and marginalization in the countries of initial migration but not in Canada. The majority of the participants perceived that their frequent displacement and migration-related struggles coupled with being Syrian refugee women actually made them stronger people and contributed to some personal growth such as learning new things and becoming a different and responsible person. In particular, they all reported that they were welcomed in Canada and described how residing in Canada contributes to their personal growth, and they have become strong women with a voice. For example, Fayza, 45-year-old, commented that residing in Canada empower her and gave her the freedom to reflect on her experience without discrimination compared to the previous country of migration:

"I was so sensitive, and now I become strong woman, and the previous emotions have changed, I have become stronger woman with a voice and opinion. I didn't feel any kind of discrimination here in Canada instead we have voices and freedom to speak." (Fayza, 45-year-old).

Theme 4: Perception of Healthcare

All the women shared various stressful circumstances and health-related challenges prior to arrival in Canada; these challenges include Syria's ravaged healthcare system, the overburdening of the initial migration countries' healthcare systems, and how they have been perceived as a burden on the host countries with different forms of discrimination. Syrian refugee women reported that seeking an equitable and accessible healthcare system was key to their decision to migrate to Canada. All women appreciate the free, advanced public healthcare system in Ontario and how the system is committed to providing follow up and screening with available and accessible services. In contrast, however, all the participants asserted that the healthcare system is too slow, with long wait times in the ER and to get an appointment with a specialist as well as expensive dental care. Rola, 39-year-old, commented on the advantages and disadvantages of the Ontario healthcare system and she constantly reported the issue lengthy waiting time to be able to see a specialist:

"The healthcare system here has advantages and disadvantages. You know everything here, is for free. This is good compared to my country. However, the issue here the waiting is lengthy you need to wait a long time I don't know why maybe lack of doctors. When it comes to the specialist appointment, it is too lengthy." (Rola, 39-year-old).

All the women shared some adaption strategies to overcome the current challenges in Canada such as going to schools for English as a second language to improve their English. Some women find that helping people or other refugees help give meaning to their own traumatic experience and transform it into a positive change. The majority of the women asserted that they rely on herbal medicines or over the counter medications to manage simple and easy health complaints rather than going to the emergency department (ER) and staying there for more than 6 h to be assessed by healthcare providers. One of the key strategies that the women employ to cope with the delay in the ER is to call the ambulance so they will be seen and examined by the doctors, without having to wait for long hours. Sumaia, 28-year-old, commented on the long waiting list when they go to ER, and she pointed out some of her strategies that they used to minimize the waiting time in ER such as calling the ambulance and pay 50 CAD bill. On the other hand, Haifa, 45-year-old, was grateful that she is receiving "good" healthcare for free:

"I used to have herbal tea, and we treat ourselves with herbal tea rather than going to ER and waiting there for long time. Sometimes, if it is an emergency, we used to call the ambulance and pay the bill of around 50 dollars rather than to stay in the ER. Most of the time, we stayed home rather than going and wait 6 h in the ER." (Sumaia, 28-year-old).

"The healthcare system in Canada is slow with long waiting, but we used to it. The good thing that we receive good care for free also. The health services here are adequate, available, accessible, but you can't say it is perfect but at least you don't worry about if you have money or not. In Syria, we used to sell our gold just to cover the cost of healthcare, and we don't have this stress here in Canada." (Haifa, 45-year-old).

Some women asserted the need for more trauma-informed and culturally appropriate healthcare services. For example, one participant was disappointed with the culturally inappropriate questions that she had encountered in the ER when she had an abortion: For instance, Maha, 30-year-old, stressed out the need for healthcare providers' cultural sensitivity training as she was "upset" from their unacceptable and inappropriate questions during her miscarriages:

"You know their questions like do you have multiple partners and with how many men did I slept with. When they asked me that question, I said [WHAT WHAT]. I am a Muslim lady why you asked me this question? I was annoyed by that question, and it is inappropriate to ask, but they said we should ask this question." (Maha, 30-year-old).

The participant highlights the needs for providing culturally sensitive care to women from different cultures in Canada, especially during miscarriage with severe psychological pain felt after miscarriage. This finding reveals that cultural awareness among healthcare providers in Canada is crucial when addressing the healthcare needs of Syrian refugee women who undergo similar physical or psychological losses in different cultures.

Discussion

The study findings reveal that Syrian refugee women, as a population, have gender-specific healthcare needs and experiences and require a multiplicity of health services. The findings also showed that Syrian refugee women have repeatedly reported trauma and suffering from constant worries, fear, and migration hardship prior to fleeing the country and coming to Canada. These findings are consistent with previous studies about Syrian refugee women (Cho et al., 2017; Myers, 2016). Moreover, this study showed that Syrian refugee women are an increasingly vulnerable population with histories of trauma, migration struggle and hardship, constant worries, and a growing sense of insecurity and marginalization, also consistent with the burgeoning literature on Syrian refugee women in terms of being a marginalized group, with negative experiences compounded with feelings of isolation and desperation, despair, and uncertainty about their future (Abu-rass, 2018; Cho et al., 2017; Myers, 2016).

The findings showed that Syrian refugee women have extant challenges in Canada that jeopardize almost every aspect of their life, including language barriers, housing challenges, lack of social ties, weather-related challenges, and healthcare-related challenges, in addition to highlighting various coping strategies that the women currently use to adapt to the new culture and healthcare system and promote their health and well-being. These findings are congruent with those of previous research aimed at improving and promoting the physical and mental health of Syrian refugees in their host countries (Agic et al., January 2016; Ahmed et al., 2017; Butler et al., 2011; Drolet et al., 2017).

In reflecting on the analysis undertaken for this study, we argue that the findings reveal the significance of utilizing intersectionality theory with its key assumptions, particularly the notion of the multiple interactions of various aspects of vulnerability among Syrian refugee women. Moreover, the study findings

support the rationale of adopting critical ethnography to capture Syrian refugee women's experiences of pre- and post-migration in different countries, which may be influenced not only by the sociopolitical contexts of a particular country but also by its cultural context. Nevertheless, the numerous healthcare-related challenges that Syrian refugee women continue to experience in Canada show that there is still a general lack of understanding about these women's experiences, challenges, and coping with the current Ontario healthcare system. The narratives of the women in this study provide a comprehensive contextual picture of the adaptation process and practices that Syrian refugee women, in general, are currently using in their daily life. Furthermore, the study findings offer a robust depiction of these women's strengths and the adaptation they make in response to residing in a new culture with a new healthcare system.

The findings showed that Syrian refugee women have extant challenges in Canada that jeopardize their well-being, including language barriers, housing challenges, lack of social ties, weather, and healthcare-related challenges. In addition, the findings highlight various coping strategies that the women currently use to adapt to the new culture and healthcare system and promote their health and well-being. These findings are congruent with those of previous research aimed at improving and promoting the physical and mental health of Syrian refugees in their host countries (Agic et al., January 2016; Ahmed et al., 2017; Butler et al., 2011; Drolet et al., 2017). The study findings are consistent with previous research in terms of the impact of the lack of social connections and lack of linguistically, culturally, and gender-appropriate services on Syrian refugee women's perception to health, access to, and use of healthcare services (Guruge et al., 2018).

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

The study findings reveal that Syrian refugee women face numerous barriers to access appropriate, culturally informed, and affordable healthcare services in Ontario, Canada. These barriers include language and literacy barriers, limited knowledge of Ontario healthcare system, limited social support systems, cultural beliefs, and unique family dynamics. In addition, Syrian refugee women face several intersecting structural barriers such as the precarious sponsorship status (i.e., privately sponsored vs. governmentally sponsored), non-eligibility for some health services due to sponsorship status, lower levels of education, and lower income due to unemployment due to the non-recognition of their qualifications obtained outside Canada. These women often face significant challenges during

pre-migration to Canada including uncertainty regarding immigration to Canada, stigma associated with mental health issues, and the misconceptions linked to their mental health healthcare needs. Integrating the issues of vulnerability, migration, and trauma and the impact of these issues on refugees' health and well-being into the nursing curriculum can have multiple benefits. First, it provides both educational nursing faculty and students as future service providers with the opportunity to create a support system that responds to refugee's healthcare needs and thus has a more positive impact on their lives. Second, it provides a common language and consistent platform of support to women who have experienced trauma and struggles including health, settlement and social services, and employment and housing services. Third, since previous experiences of trauma feed into cycles of vulnerability, uncertainty, prolonged grieving, and intergenerational conflict, a strong multi-sectoral response is required. Moreover, incorporating various teaching pedagogies and simulation scenarios that are based on refugees' lives and behaviors will create better opportunities for change and justice. Finally, embedding the principles of marginalization, oppression, social justice, empowerment, and culturally sensitive practices into nursing curriculums and programs creates a nursing care trend that minimizes harm and provides positive change for all people.

From a practical perspective, Syrian refugee women are often exposed to various forms of disadvantage. Service providers may assume that these women's culture substantially influences their experiences of trauma and violence and ultimately creates barriers to seeking care and support. With the current trend of moving the financial incentives for healthcare systems away from hospitalizations toward prevention and primary care (Machtinger et al., 2015), Canada's federal government has a responsibility to ensure the overall well-being of Syrian refugees. Developing and designing interventions and healthcare services for Syrian refugee women require a clear understanding of their history of trauma and migration-related struggles and hardship. This understanding can help healthcare professionals minimize further harm by preventing further trauma and offering supportive services tailored to these women's experiences. An understanding of the dynamic relationship between Syrian refugee women's experiences of trauma may be useful for exploring the health-seeking behaviors of these women and their coping with the current healthcare system. The findings imply that there is a need to promote the women's awareness about the available health services, which might, in turn, inform more widespread changes to the current practices pertaining to the Ontario healthcare system. These changes may inform some modifications to the current practices and policies about settlement and healthcare, such as those offering trauma and culturally informed care for Syrian refugee women.

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

healthcare practices might be unfamiliar to, or unaccommodating of, many refugee women and their needs.

Present refugee policies need to be continuously evaluated, and future policies need to be sensitive to the impact of refugee status on the mental health and well-being of Syrian refugee women. Also, there is a pressing need to transform health policies and practices based on an understanding of the impact of compounded trauma and migration hardship on Syrian refugee women's lives and behaviors. Moreover, the role of public policies needs to be further studied with an emphasis on the culture and circumstances in which healthcare is provided. This can include studying ways to promote timely access to primary care for newcomers. Furthermore, public policies that govern healthcare access and practices for Syrian refugee women need to pay close attention to these women's trauma experiences and prevent prolonged trauma-related stress and negative health impact. The narratives of the women in this study provide a comprehensive contextual picture of the adaptation process and practices that Syrian refugee women, in general, are currently using in their daily life. Furthermore, the study findings offer a robust depiction of these women's strengths and the adaptation they make in response to residing in a new culture with a new healthcare system.

Strengths and Limitations of the Study

This study has reflected a diversity of Syrian refugee women's viewpoints and experiences about their trauma, migration journeys, adaptation to a new culture, and their perceptions about the healthcare system and services in Canada. The findings from this study might be relevant to other Syrian refugee women who have been resettled in Canada and other countries that are accepting refugees. A key strength is that the first author is a qualified bilingual immigrant woman who shares a common ethnic heritage with the Syrian refugee participants; therefore, gaining entry to the group and building trust and rapport was quickly established. The interviews were also conducted separately from the men to ensure that the men's presence did not constrain the women's voices.

In terms of the findings' transferability, this study's findings specifically target Syrian refugee women residing in Canada and may not reflect the situation in Syrian or other refugee population groups in other countries. Moreover, conducting synchronous online interviewing due to the COVID-19 pandemic and the consequent social distancing precautions may limit capturing the physical space beyond the camera zoom. On the other hand, utilizing online interviewing offered a greater sense of control and voluntary participation for the participants, and they were able to terminate the conversation and leave at any time. The qualitative approach of our study mandates that the study findings would not be generalizable to the general population of Syrian refugee women in Canada. However, we believe that we shed some light on how these women's experiences regarding migration, resettlement, and health can be experienced by other refugee population in Canada or globally.

Conclusion

This study demonstrates how culture, repeated and forced migration, and various social identities of Syrian refugee woman are contributors to the complexities of gendered health equity and equality. Exploring the diverse journeys of Syrian refugee women has led to our conclusion that further work is needed to ensure quality health experiences in Canada. The voices of these uniquely marginalized women must be heard, and there is more that can be done for them than is currently offered. Syrian refugee women believe that they deserve to have culturally appropriate and trauma-informed healthcare and settlement services. By reflecting on these women's experiences of hardship, constant fear, and worries, desires to thrive and change, and how these experiences shape their everyday lives, this article highlights the intersectional nature of Syrian refugee women's experiences. Moving forward, listening to these women's voices can provide insight into some of the extant challenges and sociocultural needs of other women living in an unfamiliar place, and interacting with different cultural and social norms by immersing themselves in their new environment to adapt to the new life and healthcare system while waiting for the hope to return to their home.

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Declarations

Conflict of Interest The authors declare no competing interests.

Ethics Approval This study was conducted according to the guidelines laid down in the Declaration of Helsinki, and all procedures involving research study participants were approved by the Western University Health Science Research Ethics Board (HSREB) (Project #114519). Informed consent was obtained from all subjects.

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