Shaping the care they deserve: Needs, expectations, and recommendations of healthcare provision at the New Canadians Health Centre for Afghan refugee women in Edmonton

by

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Abstract

This qualitative inquiry delved into the healthcare needs and experiences of Afghan refugee women resettled in Canada, addressing three primary research questions. Employing a community-based participatory research approach alongside qualitative narrative inquiry, the study explored the lived experiences of Afghan women refugees accessing healthcare services, at the New Canadians Health Centre (NCHC). Through focus groups with six NCHC staff and semi-structured interviews with three Afghan women clients, a nuanced understanding of their healthcare journeys emerged. The findings underscored the multifaceted nature of their experiences, tracing back to pre-migration challenges in Afghanistan, including societal constraints and disparities in healthcare access. Post-resettlement, the women navigated identity shifts, daily life adjustments, and interactions with the Canadian healthcare system, encountering both positive and challenging experiences. Access to medication and mental health support emerged as crucial post-resettlement needs, while reliance on community networks for health information persisted. Despite obstacles, Afghan refugee women demonstrated resilience and agency, advocating for their health equity. Their insights offered valuable recommendations for culturally sensitive service provision. Ultimately, this study highlighted the imperative of culturally safe healthcare practices and underscored the transformative role of community and empowerment in shaping the healthcare experiences of Afghan refugee women in Canada.

Preface

This thesis is an original work by Cristian Neves. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name “Shaping the care they deserve: Needs, expectations, and recommendations of healthcare provision at the New Canadian Health Centre for Afghan refugee women in Edmonton”, No. Pro00123961, on March 22, 2023.

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Glossary of Terms

For better understanding of this study, the following terms are operationally defined:

Agency: Human capability to influence one's functioning and the course of events by one's actions (Bandura, 1989).

Country of resettlement: Country that has agreed to admit refugees and ultimately grant them permanent residence within its borders (UNHCR, 2020)

Cultural competence: Refers to the ability of individuals or organizations within the healthcare system to effectively interact, communicate, and provide care to people from diverse cultural backgrounds. It involves understanding and respecting the cultural beliefs, values, practices, and needs of patients, and adapting healthcare delivery accordingly to ensure equitable and effective care (Lau & Rodgers, 2021).

Cultural safety: Is an approach to healthcare that goes beyond cultural competence, emphasizing power imbalances and systemic issues that affect marginalized groups. It requires healthcare providers to critically reflect on their own cultural biases and privilege, creating an environment where patients feel respected, valued, and empowered to express their cultural identities without fear of discrimination or marginalization (Canadian Institute for Health Information, 2021)

Empowerment: The promotion of the skills, knowledge, and confidence necessary to take greater control of one's life (APA, 2018)

Expectations: A state of emotional, cognitive and behavioral anticipation (APA, 2018)

Government Assisted Refugees (GARs): In a Canadian context, GARs are individuals who have been forced to flee their home countries due to persecution, conflict, or violence and are resettled in Canada with the assistance and support of the Canadian government. Upon arrival,

GARs receive financial, housing, and social support to aid in their resettlement and integration into Canadian society (Government of Canada, 2021).

Health: A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity (WHO, 1949). This study emphasizes the social, psychological, and spiritual dimensions of health, in addition to the biological/physical one.

Healthcare: Refers to the maintenance or improvement of an individual's physical, mental, or social well-being through the promotion of health, prevention of illness, diagnosis, treatment, and management of illness, injury, disease, and other physical and mental impairments. It encompasses a wide range of services, including medical, dental, nursing, pharmaceutical, social, psychological, spiritual, and allied health professions, as well as all facilities and institutions such as hospitals, clinics, nursing homes, community health centers, and individual stakeholders.

Person-centered care: Healthcare service delivery approach that prioritizes individual needs, preferences, and values, fostering collaboration and empowerment in decision-making. It respects the person as a unique individual, involving them and their families in care planning (Ekman et al., 2012)

Refugee: Involuntary immigrants who are unable or unwilling to return to their country of origin owing to a well-founded fear of persecution or harm due to race, religion, nationality, membership of a particular social group, or political opinion (UNHCR, 2011)

Chapter 1: Introduction

Healthcare plays a crucial role in shaping the journey of refugee resettlement and contributing to the overall well-being of refugees (Mangrio & Forss, 2017). While significant research has been conducted on refugees' health status and risk factors, limited attention has been given to understanding their preferences and perspectives regarding culturally safe healthcare services (Shen, 2015). This situation arises from the fact that patients' preferences are influenced by their cultural background, religion, personal values, and prior experiences with healthcare, making a one-size-fits-all approach ineffective. This issue becomes even more significant when considering marginalized and oppressed populations, particularly women (Human Rights Watch, 2021). It is well-established that women are at a higher risk of developing health problems when they receive ineffective care or face delays in addressing their health issues (Ahmad et al., 2021; Ezadi et al., 2021; Neyazi, 2022)

While delivering culturally safe care to all women remains significant, this imperative holds even greater significance for Afghan refugee women. Emerging from a society characterized by male-centric norms that have curtailed their rights and perpetuated a pattern of systematic oppression and violent actions against them, Afghan refugee women find themselves in a precarious position (Higgins-Steele et al., 2017; Najafizada et al., 2017). Consequently, healthcare systems within host countries must acknowledge and address these vulnerabilities, while at the same time, promoting women's agency to be a significant partner in their own care. In Alberta, Canada, the situation has become more pressing considering the substantial influx of Afghan refugees to Edmonton and Calgary (Government of Canada, 2023). Addressing their healthcare needs and aligning services with their expectations have become urgent priorities. By doing so, the aim is to enhance the quality of the healthcare services provided and increase the

likelihood of meeting their health requirements in a culturally safe manner. Therefore, this study explores the lived experiences of Afghan refugee women in Canada and aims to answer the following research questions: (i) What are the health care needs and expectations for Afghan refugee women? (ii) What are the lived experiences of Afghan refugee women accessing the NCHC? And (iii) What practices would support the NCHC in addressing the health needs of Afghan refugee women?

The neglected status of women's rights in Afghanistan for over 50 years has exacerbated a humanitarian crisis, as evidenced by deepening violations against women (Human Rights Watch, 2021; Mannell et al., 2021). Although existing literature predominantly focuses on maternal health, a comprehensive understanding necessitates exploration beyond childbirth, encompassing decision-making autonomy, socio-economic influences, and nuanced healthcare quality (Morgan et al., 2016). Structural and cultural factors, including barriers to accessing health services, male-dominated decision-making dynamics, and societal norms, contribute to poor health outcomes in women, with insecurity further impeding healthcare access (Ahmad et al., 2021; Ezadi et al., 2021; Najafizada et al., 2017).

Cultural norms, such as child marriage, hinder women's reproductive health decision-making and contribute to maternal mortality (Ahmad et al., 2021; Turner, 2006). Insufficient education, poor literacy rates, and the stigma around sexuality compound the challenges faced by Afghan women (Human Rights Watch, 2021; Neyazi et al., 2022). Mental health disparities, marked by higher rates of conditions like posttraumatic stress disorder (PTSD), depression, and anxiety among women, are influenced by societal norms, traditional gender roles, and experiences of domestic violence (Alemi et al., 2023; Coll et al., 2020; Kovess-Masfety et al., 2021; Shinwari et al., 2022). Women's constrained expression of emotions in public, shaped by

cultural constraints, contributes to the disparities in mental health between genders (Najafizada et al., 2017). The multifaceted landscape of Afghan women's health necessitates a comprehensive approach that addresses structural, cultural, and individual factors, transcending the prevailing maternal health focus.

The post-migration health challenges faced by Afghan women in Canada are rooted in historical barriers to healthcare access in Afghanistan, persisting through language difficulties, unfamiliarity with the Canadian healthcare system, and discrimination (Ezzadi et al., 2022; Neyazi et al., 2022; Nourpanah, 2014; Shoib et al., 2022). The trauma of displacement compounds existing health issues and introduces new challenges, aligning with the experiences of migrants and refugees in other high-income countries (Ahmad et al., 2020; Bradenberger et al., 2019; Patel et al., 2021). Studies conducted in Austria and Australia underscore the significance of unaddressed health needs among Afghan refugee women, revealing barriers such as scheduling conflicts, lengthy waiting lists, limited awareness of available doctors, and language obstacles (Kohlenberger et al., 2019; Riggs et al., 2019). Communication barriers, cultural unfamiliarity, and evolving concerns in the post-migration period emphasize the need for healthcare services to be attuned to the unique needs of Afghan refugees, necessitating trust-building, guidance, and community connections (Patel et al., 2021; Rosenberg et al., 2021). As approximately 51,000 Afghan refugee women and asylum seekers have resettled in Canada by 2021, the magnitude of the challenges in adapting to a new culture and accessing healthcare are accentuated (Hartog, 2020; UNHCR, 2021). Afghan women refugees in Canada represent a vulnerable population, requiring attention to their holistic health beliefs and experiences shaped by sociocultural elements and the ongoing war (Denov & Shevell, 2019; Nguyễn-Nalpas, 2023; Siddiq et al., 2023). Shifts in scholarly perspectives highlight the agency and resilience of

Afghan refugee women, moving beyond deficit-centric approaches to acknowledge their active roles in shaping their well-being narratives (Amin & Alizada, 2020; Nguyễn-Nalpas, 2023). This evolving discourse signifies a paradigmatic transition, contributing to a more empowering and nuanced narrative that captures the dynamic interplay between individual agency, societal expectations, and well-being in the context of forced migration (Dycke & Dossa, 2007).

The agency and empowerment of Afghan refugee women are examined through various resistance forms identified by Amin and Alizada (2020). Their analysis reveals three types of resistance: acts of submission, sacrifice, and situated agreements; open acts of defiance; and acts of negotiation. Resistance through nuanced actions, such as submission and situated agreements, highlights the intricate interplay of compliance and resistance within societal and familial constraints, emphasizing the multifaceted nature of women's agency. Open defiance, while less prevalent, showcases the determination of Afghan women to confront opposing forces directly. Acts of negotiation exemplify strategic and adaptive resistance, involving strategies like creating distance and accepting trade-offs to navigate challenges. Nguyễn-Nalpas (2023) further underscores negotiation's significance in redressing family imbalances and shaping transgenerational perspectives. While literature often depicts families as stressors, Kallio (2018) reveals their profound influence on the political dimensions of refugee agency. Understanding these nuanced forms of resistance is vital for healthcare services aiming to empower Afghan refugee women. A person-centered approach, integrating cultural safety, becomes imperative in providing effective and empowering healthcare, fostering an environment where refugee women actively participate in decisions regarding their health. As healthcare paradigms evolve, there is an opportunity not only to address immediate health concerns but also to contribute to the

broader empowerment and well-being of Afghan refugee women through responsive and culturally safe healthcare services.

Cultural safety, positioned as a systemic, person-centered approach, transcends individual care by addressing historical and institutional factors contributing to health disparities (Curtis et al., 2019). It actively works to dismantle discriminatory practices within healthcare systems, emphasizing an environment where patients feel respected, understood, and free from discrimination (Braucouspé & Waters, 2009). In healthcare settings, cultural safety goes beyond cultural competence, creating an inclusive space where individuals from diverse backgrounds feel safe, respected, and understood (Curtis et al., 2019). This approach acknowledges the impact of power dynamics, colonial histories, and institutional structures on healthcare experiences, focusing on person-centered care that aligns with cultural beliefs and values (Brauscoupé & Waters, 2009; Canadian Institute for Health Information, 2021; Curtis et al., 2019).

Responding to challenges in refugee healthcare, two paradigm-shifting approaches, patient-centered care and person-centered care, have emerged. Both emphasize the client's experiences, needs, and characteristics, departing from the traditional biomedical framework. While patient-centered care prioritizes a functional life, person-centered care views the individual holistically, striving to facilitate a meaningful life (Håkansson et al., 2018). Both the cultural safety paradigm and person-centered care are integral to understanding and addressing the complexities of refugee health, forming the foundational conceptual framework for this study (Dong & Gagliardi, 2023; Filler et al., 2020; Kwame & Petrucka, 2021; Santana et al., 2017).

This study aims to explore the healthcare needs and service expectations of Afghan refugee women at the New Canadians Health Centre (NCHC), a refugee healthcare center in Edmonton, Alberta. Furthermore, this study sought recommendations on how to effectively

approach healthcare provision for Afghan refugee women within a culturally safe and person-centered approach, with the intention of informing practices at the center and generating transferable knowledge applicable to other refugee centers and the broader health system.

A narrative inquiry qualitative design was employed to analyze the stories, experiences, and recommendations of three Afghan refugee women. Additionally, two focus groups were conducted with a total of six NCHC health providers directly involved in providing care to Afghan refugees (four participants in the first focus group and three participants in focus group two. One participant attended both focus groups). These focus groups provided insights into the complexities of delivering healthcare services to this community, offering background information to enrich the multiple perspectives sought in this study.

This study has empirical relevance, as it provides pivotal information about the needs and expectations of healthcare provision for Afghan refugee women from their own perspective. It also has social and ethical relevance, as it delves into the experiences of a historically neglected community and will contribute to public awareness by channelling their stories and bridging their expectations into possibilities for change and by promoting acting upon their own care from the perspective of women advocacy of Afghan women's healthcare needs, and measures from the healthcare system to improve Afghan refugee women care. Moreover, although three Afghan refugee women and staff from the centre contributed to the study, and more research is needed to fully represent the Afghan community as a whole, this study can be considered a first step in informing the NCHC practices regarding the Afghan community and lead to a more culturally safe service. Ultimately, this study will contribute to filling a knowledge gap regarding Afghan refugee women's experiences and expectations with healthcare in Edmonton, Alberta.

In the next chapter, I will delve into the literature pertaining to the health of Afghan women, offering a detailed overview of their health status both pre- and post-migration. Special emphasis will be placed on exploring the healthcare needs and experiences of Afghan women in Canada. Additionally, the chapter will elaborate on the adoption of a cultural safety and person-centered care approach as suitable frameworks for addressing the healthcare requirements of Afghan refugee women, aiming to foster their agency and empowerment. The introduction of the New Canadians Health Centre will provide essential context for the study's setting. The third chapter will comprehensively outline the methodologies employed, detailing the step-by-step processes of data collection and analysis. The fourth chapter will describe the study's findings, featuring illustrative quotes from participant transcripts. Chapter five will involve a more in-depth discussion of these findings, drawing comparisons with existing literature and identifying research and practice implications for leveraging or expanding upon the study's insights. This, chapter will conclude with a discuss of the study limitations and propose areas for further exploration.

Chapter 2: Literature Review

This chapter entails an exploration of the intricate interplay between forced migration, the Afghan conflict, and the consequential impacts on the health of Afghan women, both pre- and post-migration. This chapter begins by exploring the pre-migration health experiences of Afghan women, providing insights into the challenges faced in their home country. Subsequently, it transitions to the post-migration phase, focusing on the evolving health dynamics of Afghan women in their new context, with a specific focus on their experiences in Canada. Within this situation, the review also navigates the multifaceted aspects of Afghan women's agency and empowerment, acknowledging their resilience amidst challenging circumstances. After this will be a description of the paradigms of cultural safety and person-centered care, serving as foundational frameworks to understand and address the health needs and expectations of Afghan refugee women. There will also be a brief introduction to the NCHC, the refugee community health center where this study unfolds, offering a contextual backdrop. The chapter will end with an introduction to the guiding research questions that will navigate the subsequent chapters, setting the stage for a nuanced examination of the health experiences and expectations of service provision of Afghan refugee women within the Canadian healthcare system. Given the thesis's focus on learning from the experiences of Afghan refugee women, the exploration will commence with an elucidation of the concept of forced migration, considering it as one of the pivotal aspects intertwined with the sociopolitical background of these women.

Forced Migration

Forced migration refers to migratory movement. Although the motivations may be diverse, it involves force, compulsion, or coercion (International Organization for Migration [IOM], 2019). According to the United Nations High Commissioner for Refugees (UNHCR,

2022), until 2022, a total of 103 million people have been forcibly displaced, of which 54% were internally displaced, and 46% were forced to leave the country. This group is comprised of refugees and asylum seekers. Refugees are people who have been forced to leave their country of nationality due to persecution and violence for reasons of race, religion, nationality, political stance, or association with a particular group (UNHCR, 2023). They are also unable or unwilling, due to the loss of trust, to avail themselves of the protection of that country (UNHCR, 2023). Refugees account for one-third of forcibly displaced migration (UNHCR, 2022). Two-thirds of refugees come from five countries: Syria, Venezuela, Afghanistan, South Sudan, and Myanmar (UNHCR, 2022). Most refugees who flee their home countries do so because of war, persecution, and political instability, all of which require quick actions to avoid retaliation and ensure the individual's safety. For this reason, most refugees are hosted in neighbouring low-middle-income countries; however, the relevance of high-income countries as host countries for refugees has increased in recent years (Nguyen & Phu, 2021). Nevertheless, the pre-migration experiences of persecution and violence poses great health challenges to refugees, regardless of their arrival to low-middle-income countries or high-income countries.

Forced migration and mental health. Literature on refugee health shows that refugees frequently develop physical and mental health issues, such as PTSD, depression, and anxiety (Guruge & Butt, 2016; Mangrio & Forss, 2017; Satinsky et al., 2019). The prevalence of these disorders varies according to the phase of resettlement (pre-migration, migration, and post-migration) (Guruge & Butt, 2016; Kirmayer et al., 2011; Wilson et al., 2010) and the country of resettlement, where refugees resettling in high-income countries have better mental health outcomes compared to those arriving in low-middle-income countries (Donato & Ferris, 2020; Hartog, 2020). Additionally, lack of trust, language barriers and discrimination in the host or

transition country are common drivers of mental health related problems in refugees (King et al., 2016; Mangrio & Forss, 2017).

The Afghan Conflict

Afghanistan is a landlocked country in South Asia, bordered by Pakistan to the east and south, Iran to the west, Turkmenistan, Uzbekistan, Tajikistan to the north, and China to the northeast (WorldAtlas, 2023). The country has a long and complex history of conflict and political instability, spanning centuries of invasions, conflicts, and civil wars (Fazilat, 2020). In modern times, Afghanistan has experienced several major conflicts that have profoundly impacted the country and its people. One of the most significant conflicts was the Soviet-Afghan War from 1979 to 1989. During this time, Soviet forces supported the Afghan government against the Mujahideen, a coalition of anti-communist forces that included Islamic fundamentalists, nationalists, and tribal groups. The conflict resulted in the deaths of over a million Afghans and the displacement of millions more (Fazilat, 2020).

After the withdrawal of Soviet forces in 1989, Afghanistan descended into a period of civil war, with various factions vying for control of the country. In 1996, the Taliban, a fundamentalist Islamic group, seized power and established an extremist interpretation of Islamic law. The Taliban's regime was marked by extreme repression, including the oppression of women, restrictions on education and healthcare (Pherali & Sahar, 2018), and the destruction of ancient cultural artifacts (Fazilat, 2020).

In 2001, after the September 11 attacks on the United States, a U.S.-led coalition invaded Afghanistan and ousted the Taliban from power. The coalition supported the establishment of a new government; however, the conflict has continued for over two decades, with the Taliban regaining strength and control in recent years, after the withdraw of the US and coalition military

presence (Fazilat, 2020). Since then, the humanitarian, political and economic crises have deepened, and risk-reduction strategies aimed at mitigation of the hardships of the conflict have been difficult (Mena & Hilhorst, 2021).

Afghan Women's Health Pre-Migration

Women's rights have been neglected in Afghanistan for at least 50 years (Human Rights Watch, 2021; Mannell et al., 2021). Although some health indicators, such as the maternal mortality rate, have declined since the 2000s, the humanitarian crisis and the violation of women's rights have deepened. The Afghanistan Health Survey (KIT Royal Tropical Institute, 2018) showed that health services underserve maternal health, both, by neglecting the field with short staffing and poor training, and by inadequately addressing the maternal health needs of Afghan women. Despite advances made possible since 2002 by the joint action of the new government, in alliance with International Organizations, Non-Governmental Organizations, and private institutions, deep deficiencies remain among the poorest people and amongst women living in rural areas. Pre and postnatal care are inconsistent, with almost 80% of women attending only one prenatal visit and not being able to adhere to the four-visit gold standard recommended by the World Health Organization (WHO; 2016) (Najafizada et al., 2017; Turner, 2006). Furthermore, contraception is limited, with only 18.9% of women of reproductive age actively using any method of contraception, and about a third of the women not knowing or not being able to report any contraception method (KIT Royal Tropical Institute, 2018).

The predominant focus on maternal health in the existing literature pertaining to Afghan women's health is undoubtedly crucial, given the significant challenges faced in the context of childbirth and reproductive well-being. However, a comprehensive understanding of women's health requires an examination that extends beyond maternity. Broader dimensions such as

decision-making autonomy in healthcare, the circumstances influencing the distinction of health and illness, the material conditions determining the accessibility of healthcare services for women, and the nuanced quality of healthcare itself should be acknowledged (Morgan et al., 2016). Delving into the intricacies of decision-making processes allows for a more nuanced comprehension of the agency Afghan women exercise in shaping their health outcomes. Moreover, the socio-economic conditions and cultural factors influencing healthcare distinctions demand scrutiny, as they play pivotal roles in shaping women's overall well-being (Ezadi et al., 2021). The availability and quality of healthcare services, including potential biases within healthcare teams, must be explored to appreciate the entire spectrum of women's health experiences. Empowering women to actively participate in decisions regarding their treatment further contributes to a holistic understanding of the multifaceted landscape of Afghan women's health, transcending the current predominant focus on maternal health (Najafizada et al., 2017).

Several structural and cultural factors influence the disproportionately worsened health outcomes in women (Ezadi et al., 2021). Women deal with important barriers to accessing health services, especially in rural areas, where health institutions tend to be understaffed and have few or no female staff (Human Rights Watch, 2021). Moreover, since the Taliban regime regained power, women have been forbidden to play a public role and/or do professional labour (Mannel et al., 2021). This situation has directly impacted the rates of female staff in healthcare centres and has constituted a barrier to trust and the disclosure of health problems among female patients (Neyazi et al., 2022). Despite the concerted efforts of international organizations and donors to allocate resources for the provision of women's health services in various regions, the actual implementation often encounters significant barriers rooted in entrenched societal norms. In many instances, the decision-making dynamics within the communities targeted by these

initiatives are predominantly male-oriented. This translates into a systemic challenge where permission to provide health services to women is often contingent upon approval from male figures within the community. The emphasis on maternal health and childbearing exacerbates this situation, limiting the scope of healthcare interventions to women with reproductive concerns. Consequently, broader aspects of women's health, such as preventive care, non-reproductive medical needs, and mental health support, are often neglected or face substantial resistance (Najafizada et al., 2017). Lastly, insecurity is another structural barrier that has had an impact on women's access to health services (Ahmad et al., 2021). Afghanistan's armed conflict has resulted in attacks on health facilities, especially those that are government-based, and violence against healthcare workers has led to the closure of many rural health centres. In addition, retaliation and persecution against clinical staff working in government-supported facilities have created deficiencies in the quality of care and undermined the working conditions for health workers (Human Rights Watch, 2021).

Cultural norms exert influence over the structural barriers in healthcare (Metzl & Hansen, 2014). For example, child marriage, a common cultural practice, is linked to maternal mortality. In Afghanistan, 35% of girls marry before the age of 18, and 9% before the age of 15 (Ahmad et al., 2021). Women and girls do not have access to information regarding their health and development, so their capacity for decision-making regarding their reproductive health is undermined (Ahmad et al., 2021; Turner, 2006). The reluctance to openly discuss topics related to sexuality within Afghan society adds to the problem of women's reproductive health (Neyazi et al., 2022). Insufficient education and poor literacy rates among women and girls are other contributing factors (Human Rights Watch, 2021). The social stigma linked to sexuality among Afghan women persists in refugees after leaving Afghanistan (Hossain & Dawson, 2022).

In Afghanistan, the mental health issues of women is disproportionally high, marked by higher rates of conditions such as PTSD, depression, and anxiety when compared to regional averages (Coll et al., 2020). When comparing across gender in Afghanistan, women have a higher risk for PTSD and suicidal behaviors compared to men (Kovess-Masfety et al., 2021). While the ongoing war is a major contributor to the increased mental health challenges, the intricate interplay of societal norms further exacerbates the situation (Najafizada et al., 2017). The restrictions on women's autonomy, limited educational opportunities, and societal expectations place an immense psychological burden on them. The traditional gender roles, often reinforced by cultural norms, can contribute to feelings of powerlessness and isolation, intensifying the prevalence of mental health disorders (Alemi et al., 2023). Domestic violence is another prevalent issue in Afghanistan. Almost 50% of women report some type of violence from their husbands (Alemi et al., 2023; Shinwari et al., 2022). While the literature on violence perpetrators in Afghanistan is limited, a report by Echavez et al. (2016) emphasizes that Afghan men often deem it acceptable to physically punish women, although such actions may not be deemed suitable for other family members. The rationale behind resorting to violence against women, as articulated by these men, is linked to feelings of frustration stemming from an inability of men to meet societal expectations. Moreover, according to some authors (Alemi et al., 2023; Najafizada et al., 2017) Disparities in mental health between genders could be connected to the cultural constraints that limit the open expression of emotions in public. These constraints discourage women from revealing feelings of despair and men from displaying emotions like fear, grief, or doubt, as such expressions are perceived as potentially bringing shame to the family.

Afghan Women's Health Post-Migration

In Afghanistan, women have historically had limited access to healthcare due to cultural, social, and economic barriers (Ezzadi et al., 2022; Neyazi et al., 2022; Shoib et al., 2022). Some of these barriers persist among Afghan refugee women in Canada, where they face language barriers, lack of familiarity with the healthcare system, and discrimination (Nourpanah, 2014). Furthermore, the trauma and stress of displacement and resettlement can exacerbate health issues and create new health challenges for this community (Ahmad et al., 2020). These issues are common in the context of migrants and refugees resettling in other high-income countries (Bradenberger et al., 2019; Patel et al., 2021). In a study conducted by Kohlenberger et al. (2019), it was revealed that 40% of Afghan refugee women who were in the process of resettling in Austria encountered unaddressed health needs. The primary obstacles mentioned were scheduling conflicts, extended waiting lists, limited awareness about available doctors, and language barriers. While the expenses related to medical treatment were not frequently identified as hindrances, specialized medical services, often requiring patient co-payments, especially in dental care, were notably less utilized by refugees compared to the Austrian population.

In the context of pre- and post-natal health service provision to Afghan refugees, Riggs et al. (2019) revealed that interpreter services during labour were underutilized by refugees, as well as routine examinations, and educational programs, thereby compromising the effective exchange of crucial information. The provision of interpreter support in the appropriate language and dialect poses challenges for healthcare services and hinders women's comprehension of conveyed information. Both women and men participating in this study expressed unfamiliarity with the Australian healthcare system and a lack of clarity regarding the roles of health professionals. As discussed by Patel et al. (2021) in a study regarding communication in primary care with refugees, it is imperative for healthcare providers to invest time in building trust,

elucidating their roles, and gaining insight into individuals' past experiences and current contexts. This becomes especially crucial for facilitating conversations about aspects of antenatal and early childhood healthcare that families may not conventionally consider, such as support for individuals experiencing mental health issues. Expanding on this idea, Rosenberg et al. (2021), in a study focused on parental care among Afghan newly arrived refugees in the US, concluded that attention must be paid to parental concerns that gained priority shortly after their arrival in the United States. These encompass providing guidance for parents as their attention transitions from safety concerns to creating opportunities for their children to flourish in home and educational environments, and alleviating isolation to reduce acculturation stressors, possibly through facilitating connections between recently arrived refugee families and those who have been residing in the U.S. for over one year. These studies collectively emphasize the need for healthcare services to be cognizant of communication barriers, cultural unfamiliarity, and evolving concerns of refugee populations. Building trust, providing guidance that aligns with changing priorities, and fostering community connections are identified as essential attitudes and strategies for healthcare services to effectively address the healthcare needs of Afghan refugees.

Afghan Women's Health in Canada

According to the UNHCR (2021), as of 2021, approximately 51,000 Afghan refugees and asylum seekers have resettled in Canada. The majority of these refugees arrived after the fall of the Taliban regime in 2001. Since then, Canada has welcomed thousands of Afghan refugees through various resettlement programs, including the government-assisted refugee program and the private sponsorship program (Issraelyan, 2021). Despite drawbacks due to the COVID-19 pandemic (Edmonds & Flahault, 2021), since 2021, it is estimated that 30,455 (out of a total of 51,000) Afghan refugees have arrived in Canada (Government of Canada, 2023), and more

arrivals are expected, as Canada has made the commitment to welcome 40,000 new Afghan refugees by the end of 2023.

Afghan refugees in Canada face various challenges in adapting to a new culture and accessing essential services, including healthcare (Hartog, 2020). Many of these refugees have experienced traumatic events and may have complex physical and mental health needs that require specialized care (Ahmad et al., 2020; Ghahari et al., 2019; Lies et al., 2019). In addition, language and cultural barriers, and limited knowledge of the Canadian healthcare system can make it challenging for Afghan refugees to access appropriate and timely healthcare services (Hartog, 2020; Nourpanah, 2014).

Afghan women refugees in Canada represent a vulnerable population that requires special attention and understanding of their unique needs and experiences (Denov & Shevell, 2019; Nguyễn-Nalpas, 2023; Shoib et al., 2022). In a recent study conducted by Siddiq et al. (2023), Afghan refugee women of over 50 years old reported chronic physical and mental health issues as sources of stress and concern. The health and health behavior narratives provided by these women were shaped by sociocultural elements such as family involvement and religious beliefs. Afghan women commonly conceptualized health in relation to their overall well-being and their capacity to meet familial responsibilities. Additionally, their perceptions of health were influenced by experiences of displacement resulting from the ongoing war (Nguyễn-Nalpas, 2023; Siddiq et al., 2023). These holistic health beliefs align with existing research on health and disease perspectives within other Afghan communities, encompassing spiritual, physical, and psychosocial factors (Dyck & Dossa, 2007). Moreover, these women expressed that these health concerns and unmet needs, such as pain, disability, language and transportation issues hinder their ability to socialize outside their homes, leading to feelings of loneliness. However, there is

evidence focused on how Afghan women refugees actively contribute to addressing their health needs through daily practices (Amin & Alizada, 2020; DeSa et al., 2022; Dyck & Dossa, 2007). These practices encompass a range of activities, including the preparation of specific foods, utilizing, and enjoying the geographical features of their resettlement location, and engaging in prayer (Dyck & Dossa, 2007). Facilitators for mental health, according to refugee women also include the availability and awareness of mental health services, social support, and resilience.

Several organizations and initiatives across Canada are working to support Afghan refugees and improve their health outcomes. For example, the Canadian Red Cross provides healthcare services, including mental health support, to refugees and asylum seekers through its Health Equipment Loan Program (Canadian Red Cross, 2024). The Afghan Women's Organization (AWO) also provides support services to Afghan women and their families, including healthcare education and advocacy (AWO, 2024).

Continued efforts are needed to ensure these refugees have access to the necessary resources and support to rebuild their lives and integrate into Canadian society. Furthermore, refugees' involvement in these initiatives, and the promotion of women's agency is crucial for their success and is considered a facilitator for integration and well-being (Denov & Shevell, 2019; Kostiuk, 2019).

Within the scientific literature examining the health needs of Afghan refugee women, attention has historically been through a deficit perspective, emphasizing the challenges and vulnerabilities faced by this population. In the contemporary and emerging body of work, there is a noticeable shift towards amplifying narratives that emphasize the agency and empowerment of Afghan refugee women in shaping their own well-being (Amin & Alizada, 2020; Barakat & Wardell, 2002; Dyck & Dossa, 2007; Kallio, 2018; Nguyễn-Nalpas, 2023; Yükzel, 2020). This

growing discourse seeks to move beyond the conventional deficit-centric approach, acknowledging the resilience and self-determination exhibited by these women within the complex context of displacement.

In tandem with this shift, an expanding body of literature focuses on how Afghan refugee women actively rewrite their journeys and stories. This transformative process involves the re-negotiation of narratives, demonstrating a dynamic interaction between individual experiences and broader societal expectations (Free Women Writers, 2021; Hannah & Kargar, 2023; Nguyễn-Nalpas, 2023; Rahman, 2018). This nuanced exploration moves beyond the static portrayal of Afghan refugee women as mere recipients of aid and support, offering a more comprehensive understanding of their multifaceted roles as active agents in the construction of their own health narratives.

This evolution in research signifies a paradigmatic transition within the academic discourse surrounding Afghan refugee women, reflecting a deeper appreciation for their agency and resilience. By acknowledging and amplifying the voices of these women, current literature not only broadens the scope of understanding regarding their health needs but also contributes to a more empowering and nuanced narrative that captures the dynamic interplay between individual agency, societal expectations, and the negotiation of well-being in the context of forced migration.

Afghan Refugee Women's Agency and Empowerment

In an article by Amin and Alizada (2020), a variety of forms of resistance used by Afghan refugee women to overcome constrains were analyzed. They found that Afghan women use three types of resistance: (i) resistance in acts of submission; sacrifice and situated agreements; (ii) resistance in open acts of defiance; and (iii) resistance in acts of negotiation.

Resistance in acts of submission, sacrifice, and situated agreement refers to the ways in which Afghan women navigate and resist societal and familial constraints through subtle and nuanced actions. This form of resistance involves behaviors that may appear as agreement or submission on the surface but actually embed elements of resistance. The authors emphasize the importance of paying attention to whether action narratives reflect cognitive awareness and critique of power, and how each woman's experience can accommodate actions that reflect both "agreement" and "resistance." This framework acknowledges that resistance can be embedded within seemingly compliant behaviors, highlighting the complex and multifaceted nature of women's agency in the face of societal and familial expectations.

Resistance through open defiance denotes the overt and direct strategies employed by Afghan women to confront opposing forces and persist in pursuing their objectives. This form of resistance entails challenging the prevailing norms and opposing actors in a visible and confrontational manner. Amin and Alizada (2020) acknowledge that this type of resistance is less prevalent among the participants in their study. However, when utilized, women demonstrated the ability to find alternative resources to persist in their opposition. This manifestation of resistance underscores the determination and courage exhibited by Afghan women when confronted with societal and familial constraints.

In their pursuit of agency, Afghan women employ acts of negotiation as a form of resistance, encompassing strategies like creating distance, persuasion, compromises, and accepting trade-offs. These negotiation tactics reflect the strategic and adaptive nature of women's actions as they navigate societal and familial constraints. Amin and Alizada (2020) illustrate instances where women establish distance, such as attaining financial independence to fund their daughters' education or relocating away from extended family. This form of resistance

highlights the resourcefulness and resilience of Afghan women in effecting change and pursuing empowerment, emphasizing their ability to strategically navigate various challenges in their quest for agency and autonomy. This form of resistance is also present in a study conducted by Nguyễn-Nalpas (2023). In this research, Afghan refugee women identify negotiation as a strategy to redress imbalances in family dynamics. Moreover, they underscore the significance of this behavior as a model for their children. This emphasizes the transgenerational aspect of resistance, playing a crucial role in fostering critical awareness in the offspring of Afghan refugee mothers. The study highlights how the practice of negotiation not only serves as a mechanism for the women to navigate family relationships but also contributes to shaping the perspectives and behaviors of the succeeding generation within the Afghan refugee community.

While the literature often portrays families as a source of stress and mental health burden for Afghan refugee women, certain studies challenge this notion. In a qualitative investigation conducted by Kallio (2018), comprehensive interviews were conducted with refugees from the southeastern region, inclusive of Afghan women. The primary objective of the study was to examine the political dimensions of refugee agency. The findings elucidate that familial relationships wield a profound influence on the political dimensions of refugee agency through various mechanisms. These include the provision of essential resources, the shaping of intergenerational political agency, contributions to everyday micro-political activities, and the substantial impact on refugee subjectivities. The study underscores the intricate ways in which familial ties operate as a dynamic force shaping the political agency of refugees, thereby adding depth and nuance to the understanding of the multiple aspects of agency within the refugee experience.

The multifaceted nature of resistance strategies employed by Afghan refugee women calls for healthcare services to adopt a nuanced and culturally safe approach. Recognizing the complexity of agency, the varied forms of resistance, and the transgenerational aspects involved will contribute to the provision of more effective and empowering healthcare services for this population. By embracing a person-centered approach and integrating cultural safety into the core of healthcare models, the empowerment of Afghan refugee women may be advanced. Cultural safety, acknowledging the impact of cultural, historical, and gender-related factors, becomes imperative in fostering an environment where refugee women feel heard, respected, and actively involved in decisions regarding their health. As healthcare paradigms evolve to encompass the diverse and complex needs of refugee populations, there emerges an opportunity to not only address immediate health concerns but also to contribute to the broader empowerment and well-being of Afghan refugee women through responsive and culturally safe healthcare services.

From Cultural Competence to Cultural Safety in Healthcare

The continuum from cultural competence to cultural safety in healthcare represents a shift from a static, individual-focused approach to a dynamic and system-wide understanding of cultural responsiveness (Brauscoupé & Waters, 2009). At the initial end of the spectrum, cultural competence emphasizes individual healthcare providers acquiring knowledge, skills, and attitudes to effectively interact with diverse patients. This involves understanding cultural differences, respecting cultural beliefs, and adapting communication and practices accordingly (Curtis et al., 2019; Kirmayer & Jarvis, 2019).

The continuum represents a progression from individual-focused cultural competence to a more comprehensive and transformative approach encapsulated by cultural safety. The latter

emphasizes not only the ongoing development of individual competencies but also the restructuring of healthcare systems to ensure equity, inclusivity, and responsiveness to diverse cultural needs (Canadian Institute for Health Information, 2021). The continuum reflects an evolving understanding of cultural responsiveness, emphasizing the need for systemic change alongside individual growth in healthcare practices (Brascoupé & Waters, 2009; Canadian Institute for Health Information, 2021).

A concise overview of each end of the continuum of care will be provided, as both approaches are acknowledged in the literature as the gold standard for refugee care.

Cultural Competence

The idea of cultural competence has emerged as a response to the prevalent disparities in healthcare based on factors like culture, race, ethnicity, religion, gender, and sexual orientation (Kirmayer & Jarvis, 2019). This concept pertains to providing care that acknowledges patients' health beliefs regarding their illness and its origins. It involves viewing health concerns from a broader biopsychosocial perspective rather than just a biomedical one. Furthermore, cultural competence entails communicating in a language that patients can understand and involves patients in collaboratively creating a treatment plan that works for both parties (Lau & Rodgers, 2021; Saha et al., 2008).

Lau & Rodgers (2021) conducted a scoping review with the aim of examining the application of cultural competence in the context of refugee health. Through their study, the authors identified several practices that characterize the implementation of cultural competence in the provision of healthcare to refugees.

At the individual level, key practices encompassed self-awareness and the recognition of cultural diversity, a comprehensive understanding of refugee cultures, including their home

countries, histories, and experiences, as well as the respectful engagement of refugee clients. This often entailed seeking permission before posing questions, acknowledging sensitive subjects, and so forth (Lau & Rodgers, 2021; Yancu & Farmer, 2017).

On the organizational level, the commitment of healthcare organizations to both diversity and cultural competence was crucial in manifesting cultural competency. This commitment was evident through staff diversity. Additionally, active engagement and collaboration with refugee communities, the incorporation of language and cultural considerations into services, and the resolution of access barriers were pivotal aspects in achieving cultural competence (Lau & Rodgers, 2021; Stubb, 2020).

Various models and frameworks of cultural competence stress the importance of healthcare professionals being culturally competent. This essentially means that they should understand and respect cultural differences (Kirmayer & Jarvis, 2019; Lau & Rodgers, 2021; Stubb, 2020). However, these models often lack clear guidance on the practical approaches or steps needed to implement cultural competence effectively during patient care (Shen, 2015).

Critics have articulated several concerns regarding the concept of cultural competence in healthcare (Brascoupé & Waters, 2009; Curtis et al., 2019; Danso, 2016; Kirmayer & Jarvis, 2019; Kumagay & Lypson, 2009; Lekas et al., 2020; Li et al., 2023; Malat, 2013; Metzl & Hansen, 2014; Santana et al., 2017; Shen, 2015). Foremost among these is the tendency for cultural competence to essentialize diverse cultures, oversimplifying them into static and homogenous categories, thus perpetuating stereotypes and neglecting intra-cultural variations (Curtis et al., 2019; Danso, 2016; Kirmayer & Jarvis, 2019; Lekas et al., 2020). Additionally, there is a pervasive worry that efforts to achieve cultural competence might result in tokenistic gestures, where symbolic accommodations, such as incorporating cultural symbols or language

services, are prioritized over addressing deeper systemic issues (Danso, 2016; Kumagay & Lypson, 2009). This superficial approach may fail to challenge entrenched power imbalances and institutional biases within healthcare systems (Brauscoupé & Waters, 2009). The static and individualized nature of cultural competence is criticized for not adequately addressing the dynamic and systemic nature of cultural interactions within healthcare settings. Moreover, the lack of clear accountability measures and resistance to embracing deeper structural changes within healthcare systems raises doubts about the effectiveness of cultural competence initiatives in ameliorating health disparities (Brauscoupé & Waters, 2009; Shen, 2015). Critics also highlight the risk of cultural competence becoming a checklist of skills rather than an ongoing, reflective process, potentially resulting in a token acknowledgment of cultural considerations (Curtis et al., 2019; Danso, 2016). Finally, there are concerns that cultural competence often inadequately addresses intersectionality, neglecting the complex ways in which multiple social identities intersect and influence health outcomes (Shen, 2015). These critiques collectively emphasize the need for a more comprehensive and systemic approach that goes beyond individual competencies and addresses broader institutional and societal factors influencing health disparities (Curtis et al., 2019; Kirmayer & Jarvis, 2019; Kumagay & Lypson, 2009).

Moving along the continuum, cultural humility emerges as an intermediary concept (Danso, 2016; Lekas et al., 2020). This recognizes the limitations of cultural competence and encourages a lifelong commitment to self-reflection, learning, and open communication with patients (Lekas et al., 2020). Cultural humility acknowledges that healthcare providers may never be entirely “competent” in every aspect of every culture but can continually strive to enhance their understanding and responsiveness (Lekas et al., 2020; Yancu & Farmer, 2017). This attitudinal aspect of the healthcare provider's ontological, epistemological, and paradigmatic

stance is crucial to transitioning towards the other side of the continuum of care, which is represented by cultural safety (Curtis et al, 2019).

Cultural Safety

Cultural safety, positioned at the far end of the continuum, goes beyond the individual level, and emphasizes a systemic, person-centered approach (Canadian Institute for Health Information, 2021). It acknowledges historical and institutional factors contributing to health disparities and actively works to dismantle discriminatory practices within healthcare systems (Brauscoupé & Waters, 2009). Cultural safety involves creating an environment where patients feel respected and dignified. This approach recognizes the impact of power dynamics, colonial histories, and institutional structures on healthcare experiences and outcomes (Curtis et al, 2019; Kirmayer & Jarvis, 2019).

In the context of healthcare, cultural safety refers to an approach that goes beyond cultural competence and sensitivity (Brauscoupé & Waters, 2009). It involves creating an environment in healthcare settings where individuals from diverse cultural backgrounds feel safe, respected, and understood (Canadian Institute for Health Information, 2021). Originally developed in the context of Indigenous healthcare in New Zealand, the concept has been widely adopted to address cultural disparities in healthcare globally (Curtis et al., 2019). Cultural safety recognizes that healthcare is not just about acknowledging cultural differences but actively working to eliminate power imbalances, biases, and systemic issues that can contribute to inequitable care (Kirmayer & Jarvis, 2019). It emphasizes the importance of understanding the unique cultural and social contexts of individuals and communities to provide care that is truly person-centered, tolerant, and respectful for diversity (Curtis et al., 2019). Cultural safety aims to create a healthcare environment where everyone, regardless of their background, feels

comfortable, heard, and receives care that aligns with their cultural beliefs and values (Canadian Institute for Health Information, 2021).

Patient- and Person-centered care

Scholarly studies investigating healthcare service delivery to refugees from the standpoint of service providers have underscored various challenges and unmet requirements that hinder the provision of adequate care for refugees. Among these challenges are language barriers, time limitations, deficient knowledge and skills pertaining to awareness of available resources, cultural competence, and the healthcare system. Additionally, there exist system-related obstacles, including insufficient financial resources allocated to refugee support programs (Brandenberger et al., 2019; Filler et al., 2020; Kavukcu & Hakan, 2019).

In response to these pressures, a range of approaches have been formulated to address the needs, as viewed through the lens of service providers. Two paradigm-shifting approaches, namely patient-centered care and person-centered care have emerged (Kavukcu & Hakan, 2019). These approaches diverge from the traditional biomedical framework by emphasizing the client's experiences, needs, and characteristics, rather than solely adhering to the service provider's perspective (Filler et al., 2019; Ramlakhan et al., 2019; Santana et al., 2017).

While both approaches share common attributes such as demonstrating empathy towards clients, respecting their worldviews and preferences, fostering engagement, cultivating positive relationships, prioritizing effective communication, and advocating for shared decision-making, the person-centered approach places greater emphasis on viewing the individual holistically (Starfield, 2011). This approach sets its goal as facilitating a meaningful life for the client, whereas the patient-centered approach centers around achieving a functional life (Håkansson et al., 2018).

In a scoping review investigating barriers and facilitators of patient-centered care for immigrants and refugees, Filler et al. (2020) identified several obstacles reported by immigrant and refugee women concerning the quality of care within this approach. At the patient level, both women and clinicians observed that decision-making was predominantly influenced by family discretion rather than individual autonomy. Additionally, they found that obstacles such as limited access to services, financial constraints, and a lack of trust in the healthcare system impeded the provision of quality care. Clinicians highlighted patient-level barriers, including limited knowledge about disease processes, female anatomy, reproduction, or contraceptives. Clinicians also mentioned the influence of religion on pregnancy, contraceptive use, and abortion as a challenge to their practice. Furthermore, clinicians were cognizant that women feared familial reactions if contraceptives were used, or abortion was considered. While clinicians did not face barriers at the clinician level, immigrant and refugee women reported instances where their concerns were ignored or dismissed. Additionally, they noted a lack of information provided by clinicians regarding treatment outcomes and potential complications, coupled with instances of disrespectful behavior from healthcare providers.

At the organizational level, clinicians pointed out the absence of guidelines as a hindrance to providing care for immigrant and refugee women (Filler et al., 2020). Building upon this, in a literature review study on patient-nurse interactions, Kwame and Petrucka (2021) revealed that a shortage of nursing staff and high workloads constituted barriers to patient-centered care. Nurses also emphasized that the restricted amount of direct interaction time with clients impeded the quality of care and communication. Finally, another barrier related to institutions in achieving patient-centered care and communication is the healthcare system's prioritization of task-centered care. Healthcare providers concentrate more on accomplishing

care procedures rather than addressing the needs and preferences of patients and caregivers. According to some authors (Ekman et al., 2012; Håkansson et al., 2018; Saha et al., 2008; Santana et al., 2017; Starfield, 2011), this barrier stems from the epistemological assumption of the model, which perceives clients primarily as patients, guiding interactions with the client toward healthcare-oriented goals rather than fostering a more holistic and open relationship focused on the person as a whole. Regardless of these barriers, the patient-centered approach has evidence of its benefits in patient knowledge, satisfaction, well-being, self-care, and clinical outcomes (Ramlakhan et al., 2019).

Filler et al.'s study (2020) is one of the few that incorporated women's recommendations for healthcare service provision. The study highlighted that women recommended clinicians take the time to ask questions, adopt a non-judgmental tone or manner, and provide information to encourage active participation in decision-making.

The person-centered approach broadens the scope of the patient-centered approach by encompassing the entirety of the client's life (Ekman et al., 2012; Kwame & Petrucka, 2021; Santana et al., 2017). Recognizing the concept of an individual is crucial, advocating for a comprehensive care approach that considers various dimensions of overall well-being. This involves acknowledging a person's context, individual expression, preferences, and beliefs. Furthermore, it's important to note that person-centered care extends beyond the patient alone; it encompasses families, caregivers, individuals not experiencing illness, and also encompasses prevention and promotion activities (Ekman et al., 2012; Starfield, 2011; Santana et al., 2017).

While the person-centered approach has been increasingly studied since the 2000s (Lim et al., 2023), two seminal studies will be used to describe the foundations of the approach in healthcare. The importance of these studies includes their Canadian origin, the inclusion of

community members and non-clinical, non-staff individuals in the development of their framework, and a focus on women's health and participation in healthcare, all of which are contextual for this thesis.

The initial study, conducted by Santana et al. (2017), involved a narrative review of the literature on the person-centered approach. In this research, the authors developed a framework that synthesizes evidence, recommendations of best practices, and implementation case studies in Canada. Using Donabedian's domains for the analysis of quality in healthcare systems (1988), the authors propose several recommendations in the structure, process, and outcomes domains of the healthcare model to fit a person-centered approach.

In the structure domain, the authors recommend (i) creating a culture of person-centered care, (ii) co-designing the development and implementation of educational programs to support training for staff, (iii) co-creating and implement health promotion programs, through collaboration with diverse stakeholders, (iv) providing a supportive and accommodating person-centered care environment, (v) developing and integrating structures to support health information technology, and (vi) creating structures to measure and monitor person-centered care performance.

In the process domain, the authors recommend (i) cultivating communication by listening to patients, sharing information, and including patient into decision-making, (ii) have respectful and compassionate care by being responsive to preferences, needs and values, as well as providing supporting care, (iii) engaging patients in the management of their care and co-designing care plans with them, and (iv) integration of care alongside the care continuum.

Regarding the outcome domain, the authors recommend (i) improving access to care, by providing timely access to care, and being mindful of the financial burden for patients, and (ii) measuring patient outcomes through patient-reported outcomes, measures and experiences.

The second study, conducted by Dong and Gagliardi (2023), aimed to comprehend, from the perspective of women, what constitutes person-centered care and how it can be achieved. This research specifically focused on racialized women, including refugees. Employing a narrative review of foundational research and conducting interviews with multiple women and healthcare providers, the authors synthesized their recommendations into six domains to support a person-centered approach: (i) fostering a healing relationship, (ii) exchanging information, (iii) responding to emotions, (iv) managing uncertainty, (v) sharing decisions, and (vi) enabling self-management. Each of these domains includes specific actionable recommendations to ensure the proper alignment of service provision with the underlying concept of a person-centered approach.

These distinctive attributes underscore the relevance of both the person-centered approach and the cultural safety paradigm within the context of refugee health. These frameworks are deemed particularly pertinent, thus forming the foundational conceptual framework for this study.

Research Context: The New Canadians Health Centre

Alberta occupies the fourth position among Canadian provinces in terms of refugee reception (Government of Alberta, 2023). This has been a pressing concern for Edmonton to respond with responsive healthcare since the 2000, when Canada began welcoming a significant influx of newcomers (statistics Canada, 2018). Refugees in Canada often relied on mainstream healthcare systems and faith-based organizations like Catholic Social Services (CSS) for support.

Despite not being specifically tailored for refugees, these services played a critical role in ensuring refugees received comprehensive care that respected their cultural backgrounds and addressed social determinants of health. In 2016, the New Canadians Clinic opened with the aim of providing refugee-tailored care. However, it closed in 2018. Through extensive grassroots efforts, partnerships with diverse stakeholders in the healthcare system, and advocacy, the New Canadians Health Centre (NCHC) was established in 2021. The NCHC is the first community-driven refugee health centre in Edmonton, Alberta (Rutherford, 2022). The primary objective of the NCHC is offering comprehensive healthcare services specifically tailored to the requirements of government-assisted refugees (GARs) (New Canadians Health Centre, 2023).

At the NCHC, the ethos of person-centered care and culturally safe healthcare intertwine to create a welcoming and supportive environment for newcomers. This holistic approach recognizes the diverse backgrounds and experiences of individuals seeking care, ensuring that their unique needs and preferences are central to the healthcare experience. As the focal point of my study, the NCHC embodies these approaches to healthcare through their guiding principles by providing comprehensive services tailored to the specific health needs of GARs and other newcomers (New Canadians Health Centre, 2023). By offering culturally safe healthcare, the center acknowledges and respects the cultural, linguistic, and social factors that shape individuals' health experiences. The services provided by NCHC are grounded in five guiding principles: (1) Community-owned: This entails engaging communities in collaborative decision-making and offering opportunities for them to assume leadership roles. By doing so, NCHC aims to cultivate a sense of belonging and foster social inclusion within the larger Edmonton community. (2) Welcoming and inclusive: NCHC views refugees and communities as partners in the care process, ensuring that care and support align with their preferences. To achieve this,

NCHC promotes respectful interactions with clients. (3) Adopting a social model of health: Recognizing health as a fundamental human right, NCHC acknowledges the broader social determinants that impact health. Therefore, it takes a holistic approach to caring for individuals and families. (4) Acting collaboratively: NCHC establishes a principles-based support system grounded in collaborative decision-making. Support is coordinated among service providers, flexible, and responsive to diverse and emerging needs. (5) Creating a supportive learning environment: NCHC honors and respects multiple ways of knowing and worldviews on health and well-being. It provides opportunities for service providers to learn and reflect, thereby building capacity within the Centre and broader systems (New Canadians Health Centre, 2023). This is an innovative initiative aimed at addressing the challenges of the resettlement journey through the strengthening of community bonds and the provision of culturally appropriate health care.

Since the federal government's announcement of receiving 40,000 Afghans by 2023 (Government of Canada, 2023), the NCHC has welcomed a rising number of Afghan refugees (National Newcomer Navigation Network, 2021). The NCHC offers specialized healthcare services to Afghan refugees, however, the centre does not have information regarding their unique experiences, preferences, expectations and recommendations. This study aims to bridge that gap.

With the increasing number of Afghan refugees coming to Canada (Government of Canada, 2023; National Newcomer Navigation Network, 2021); it has become essential to address their healthcare needs and provide culturally safe care that aligns with their expectations of healthcare (National Newcomer Navigation Network, 2021). In this endeavor, it is crucial to engage with Afghan refugee women collaboratively to tailor healthcare services, fostering

agency, empowerment, and overall well-being. This approach seeks to facilitate their seamless integration into Canadian society. Few studies have examined Afghan refugee women's health needs using a culturally safe and person-centered approach, and even fewer have considered the expectations and recommendations of Afghan women regarding service provision. To bridge this knowledge gap, the purpose of this study is to explore the lived experiences of Afghan refugee women in Edmonton and gather insights regarding the following research questions: (i) What are the healthcare needs and expectations of Afghan refugee women? (ii) What are the lived experiences of Afghan refugee women accessing the NCHC?; and (iii) What practices would support the NCHC in addressing the healthcare needs of Afghan refugee women? Little is known about the health needs of Afghan refugee women in Canada and their expectations of healthcare service provision. Many studies often emphasize the challenges encountered during the resettlement process, such as physical and mental health issues, or the lack of support from public services (Zivot et al., 2020). Therefore, this study was conducted at the NCHC with the aim of providing insights that could help strengthen the centre's relationship with Afghan clients, while also generating knowledge that could be applied to other refugee centers and the broader healthcare system. Recognizing this gap in knowledge, the study adopted a community-engaged research approach, utilizing qualitative methodology and a narrative inquiry design. The objective was to explore the healthcare lived experiences, narratives and stories of diverse Afghan refugee women who are clients of the NCHC, as well as the perspectives of staff from the center who play a role in their resettlement journey.

Chapter 3: Methodology

This community-based participatory research study used qualitative narrative inquiry (NI) to understand the healthcare lived experiences and expectations of Afghan refugee women resettling in Canada, and the experiences of NCHC staff that are directly involved in providing care for these women. This study is guided by the following research questions: (1) What are the healthcare needs and expectations for Afghan refugee women? (2) What are the lived experiences of Afghan refugee women accessing the NCHC? And (3) What practices would support the NCHC in addressing the healthcare needs of Afghan refugee women? This study received ethics approval from the University of Alberta Board of Ethics on March 22, 2023, project ID Pro00123961.

This study aims to describe the lived experiences, stories, and narratives of Afghan refugee women by delving into their subjectivity as individuals. This is the focus of this study, as it relates to the understanding of the health experiences of Afghan refugee women from their own perspective. In this chapter, the epistemological and methodological framework guiding the study is outlined. First, social constructionism is discussed as the epistemological foundation of this study, and reflection on my subjective position in the research process is provided. Then, the approach of community-based participatory research (CBPR) is introduced, followed by an explanation of the narrative inquiry design employed. Furthermore, the data collection methods are described, including participant recruitment and demographics, and the data analysis processes are detailed. Finally, qualitative research rigour as applied to this study is described.

Epistemology

In this study, the research questions probing into the healthcare-related lived experiences of Afghan refugee women in Canada are approached through the lens of social constructionist

epistemology (Gergen, 2015a). This epistemological framework underscores the subjective and intersubjective nature of understanding human experience, emphasizing the role of language as a pivotal factor in sense-making and experience construction (Maturana, 2014). By adopting a social constructionist perspective, the study acknowledges that individuals' perceptions of reality are shaped by their unique subjective viewpoints, influenced by cultural, social, and personal contexts. Furthermore, this approach highlights the interactive process of meaning-making through social interactions, recognizing that individuals co-construct their realities through dialogue and shared linguistic practices (Flick, 2006; Gergen, 2015; Maturana, 2014). Thus, the research questions are framed within the context of how Afghan refugee women in Canada navigate and make sense of their healthcare encounters, considering the diverse sociocultural influences and linguistic dynamics at play in shaping their experiences.

Social constructionism is a philosophical stance established in the late 1960's with the seminal book, The Social Construction of Reality, published by Berger and Luckmann (2023). Social constructionism ideas were expanded during the 70's and 80's by several scholars coming from diverse disciplines (Bateson, 1972, Ibañez, 2000; Maturana & Varela, 1984; Maturana, 2014).

Social constructionism emerges from constructivism and builds upon the idea that reality is constructed by humans, and is not an objective, pre-conceived state of things that exists independently from human experience (Gergen, 2015a). However, it departs from constructivism by understanding language as a crucial factor in the creation of reality (Maturana, 2014). While constructivism has a biological, nervous system-based foundation (Maturana, 2006), social constructionism highlights reality construction as a social endeavor (Gergen, 1992, 2015a). By understanding language as a shared human activity, with rules and active feedback, social

constructionists shift from the constructivist's subjectivity as responsible for individual reality to intersubjectivity in the process of reality formation.

Aligned with social constructionism, an assumption of this study is that objectivity is not possible, although subjectivity and intersubjectivity are possible to discuss and comprehend through language (Maturana, 2006). According to Gergen (1992, 2015a), the understanding of the world is not based on objective facts but rather on individuals' subjective experiences and interpretations of the world, all of which are constructed in relationship to others. Furthermore, Maturana (2006) highlighted language as playing a crucial role in shaping the understanding of the world. He argued that language is not simply a tool used to communicate with others but rather a fundamental aspect of being-in-the-world. Language allows humans to articulate their experiences and interpretations of the world, and in doing so, shapes their understanding of the world. Hence, in this study, verbal production and participants stories will be considered as essential elements for approaching the lived experiences, and narratives of Afghan refugee women.

Furthermore, social constructionism emphasizes the importance of understanding the historical and cultural context in which a text was produced (Gergen, 2015a; Maturana, 2006). This means that in order to fully understand a text, it is necessary to understand the social, political, and cultural forces that shaped its production. This is especially important when making sense of the lived experiences of Afghan women regarding their health and their expectations of healthcare service. Although this study will avoid a generalization of the lived experiences or their clustering in a “refugee” category, attention will be paid to the nuances set by the political and cultural backgrounds of these women, which may or may not include their experience as refugees.

Derived from the epistemological grounds of social constructionism, and especially in its application through narrative inquiry, my positionality played an important role in all phases of the study as it contributed to the understanding of the experiences, stories and narratives of Afghan refugee women (Caine et al., 2019; De Haene et al., 2010; McQueen & Patterson, 2020).

Positionality

I am a learner on the topic of refugee health. Moreover, I am not of Afghan origin, I do not speak their language, nor do I share the cultural background of that community. Additionally, as a male, I understand that my gender might be associated, by Afghan women, as oppressive and violent, which may make some participants feel uncomfortable when sharing their experiences during the interviews. Similarly, the fear of being identified because of a history of persecution can hinder and put tension on the ethical aspects of the dissemination of results since they are related to the operation of the health centre that the participant attends. However, the involvement of experienced members of the NCHC research and evaluation committee, as well as practitioners at the centre, including health navigators and medical office assistants, helped me address these potential challenges during all phases of the research.

This project is rooted in a cultural safety framework and a person-centered approach, as a long process of learning, of centering others, of learning about them, with them, and about mitigating power imbalances. For example, though I was raised in a Latino family, I wouldn't know what it is to be Latino. I can never know because there is no one way of being Latino. People have different values and upbringings, and in this study, I felt the responsibility to create a safe environment for participants to express themselves and understand their subjectivity while being part of a larger social system that included me as a researcher.

Members of the Afghan community were included and consulted throughout this project.

Moreover, I worked closely with staff that have direct connections with Afghan women in order to better understand my position in relation to them and learn how I can engage in open dialogue with them in a culturally safe and respectful way.

In considering the positionality inherent in this study, it is essential to recognize the multifaceted perspective that I, as the researcher, bring to the research process. As an international student navigating the Canadian healthcare system while living with a life-threatening chronic illness, I embody a unique blend of insider and outsider perspectives. My personal experiences as a patient within the Canadian healthcare system provide me with firsthand insight into the complexities and nuances of accessing and navigating healthcare services in this context. Additionally, my academic background in Psychology, with both undergraduate and master's degrees specializing in Health Psychology and Clinical Psychology, equips me with a deep understanding of the psychological and social determinants of health. Moreover, my professional experience as a mental health professional working in healthcare settings further enriches my perspective, allowing me to comprehend the intricacies of the healthcare landscape from both a provider and patient standpoint. Furthermore, my ongoing pursuit of a master's degree in community engagement adds another layer to my positionality, underscoring my commitment to fostering collaborative relationships with communities and stakeholders, which is integral to the ethos of this study. It is through this intersection of personal, academic, professional, and community engagement experiences that I approach the study of Afghan refugee women's healthcare lived experiences in Canada, aiming to bring depth, empathy, and critical reflexivity to the research process. Finally, as a trained health psychologist and family therapist, I have clinical experience working with women in the field of cancer care and with adult women who were victims of sexual abuse during childhood. These experiences,

although gained in another culture, were crucial for keeping awareness of the nuances of dialoguing with women that have had painful experiences and trauma.

Community Engaged Research

Overall, this study is grounded in cultural safety as a paradigm for conducting community engaged research (Abe, 2019; Ross, 2010). Moreover, narrative inquiry, the study design used in this study, requires an attitude of respect and understanding for individual stories and narratives (McQueen & Patterson, 2020). Continuous attention was paid to the relational aspects of ethics during this study. In this line, the advisory committee played an important role in creating relational feedback and valuable input that ensured a culturally safe approach to the participants and their stories. In line with this, I used a qualitative community-engaged research approach with narrative inquiry methodology to understand the intricacies of the healthcare experiences, needs, expectations and recommendations of Afghan refugee women. Community-engaged research serves as a collaborative and participatory platform, fostering reciprocal relationships between researchers and the communities they study (Mercer & Cargo, 2008). Through active engagement with community members, this approach not only ensures the relevance and applicability of the research findings but also empowers participants as co-creators of knowledge (Attygale, 2020). By using community-engaged research and narrative inquiry, this study aims to not only elucidate the nuances of healthcare experiences and expectations of Afghan women, but also to advocate for transformative change grounded in the voices and experiences of the community.

Community engaged research is an umbrella approach to research that equitably involves partners in the conduct of research. There is a continuum of engagement from community-based to participatory and empowerment approaches to engaging participants and partners in research.

On that continuum, this study adopts a community based participatory research (CBPR) approach that emphasizes the value of local knowledge and honours the autonomy of communities (Holkup et al., 2004). This approach involves collaboration between researchers and community members to identify research questions, design and conduct research, and interpret and share findings in ways that are meaningful and beneficial to the community (Cargo & Mercer, 2008). Prioritizing the perspectives and experiences of the community allows CBPR to promote equity, social justice, and community empowerment (Attygale, 2020). Central to the successful implementation of CBPR is the establishment of collaborative partnerships with communities (Attygale, 2019, 2020).

In CBPR, academic and community-based partners contribute equally to all facets of the research endeavour (Holkup et al., 2004). This approach is particularly well-suited for studies involving marginalized groups as it allows the channeling of their voices and acknowledges the significance of their experiences and cultural/personal knowledge (Burklow & Mills, 2009; Holkup et al., 2004).

Recognizing the inherent power dynamics, CBPR acknowledges that trust cannot be assumed or bestowed merely by the presence of researchers; rather, it necessitates a deliberate negotiation process with communities to foster a sense of association that enables collaborative engagement and validation of research processes and outcomes (Jagosh et al., 2015). The bridges of trust that already exist between the NCHC and the Afghan community formed a foundation for me to build relationships with this community. Additionally, a key member of the Afghan community supported this project by providing language and logistical support. I have been engaged in learning about Afghan culture and practices since the beginning of this study.

Furthermore, I worked closely with stakeholders and was guided through every step of this study, ensuring that potential challenges were mitigated, or at least acknowledged.

Advisory Committee. To ensure cultural safety throughout the study phases and to include other voices in the design, an advisory committee was formed, as recommended by Newman et al. (2011). The advisory committee members for this thesis generously volunteered their time and expertise to support the research endeavor. Each member was personally approached by the researcher due to their strong connections to the Afghan community and their active involvement at the NCHC in various capacities. This committee was comprised of one female Afghan community leader, a non-Afghan health navigator, and an Afghan member of the NCHC research and evaluation committee. All committee members have extensive experience with refugee communities and were pivotal in identifying potential participants as well as providing invaluable advice on how to conduct this research in a respectful, inclusive, and non-threatening manner.

The advisory group provided feedback regarding the cultural safety and appropriateness of this study in two moments: (i) in the development of the interview questions, probes, and final guide; and (ii) for the development of a knowledge mobilization strategy. The collaboration with the advisory committee primarily took place via email, utilizing individual communication channels rather than group meetings. Through this method, committee members were able to provide feedback on various aspects of the research processes and materials using Google Forms templates tailored to solicit their insights and suggestions. This approach allowed for efficient and structured communication, ensuring that each member had the opportunity to contribute their expertise and perspectives on the research endeavor (Newman et al., 2011). Two out of three members of the advisory group responded to the Google Form.

Study Design

Instrumental to this study was narrative inquiry, as it offered a dynamic framework, enabling the exploration of individuals' lived experiences, perspectives, and identities through the lens of storytelling (Hernandez-Sampieri et al., 2015). By centering the voices of participants, this methodology facilitates a deep understanding of the complexities inherent in the phenomena under investigation (Harper et al., 2020).

Narrative Inquiry

In this methodology, the focus is on conducting inquiry that delves into the narratives of human lived experiences and generates data presented in narrative formats, such as stories, life stories, or biographies (Butina, 2015). The narrative inquiry approach goes beyond data collection; it involves immersing oneself in the rich and multifaceted stories of individuals to gain insights into their unique experiences, perspectives, and emotions (Finlay & de la Cruz, 2023; Lewis, 2018). Through narrative inquiry, researchers aim to capture the complexities of human life and to understand how individuals construct meaning and make sense of their world through storytelling (Butina, 2015; Finlay & de la Cruz, 2023; Flick, 2006; Harper et al., 2020). By exploring the intricacies of personal narratives, researchers can uncover underlying themes, patterns, and cultural influences that shape people's lives, offering a deeper understanding of the human condition (Flick, 2006; Hernandez-Sampieri et al., 2015).

This approach offers the advantage of presenting an alternative model for comprehending interactions at both the individual and group levels. Moreover, it elucidates how these interactions intertwine in the construction of meaning and sense, enabling a deeper understanding of the relationship between the individual and the narrative (Syed & McLean, 2023). Particularly suited to this study, this approach enables the exploration of Afghan refugee

women's individual perspectives on their healthcare needs and expectations. Simultaneously, it offers the opportunity to examine how the meaning attached to these experiences is influenced by societal norms and higher-level narratives, as well as material and special resources in the shaping of these women's stories (Caraganajah, 2021).

Narrative inquiry has been widely used in refugee research (e.g. Abkhezr et al, 2020; Abkhezr et al., 2018; De Haene et al, 2010; George & Selimos, 2018; Ghorashi, 2021; Kubota et al., 2022; Kumar & Triandafyllidou, 2023). Narrative inquiry is a suitable qualitative design for refugee research for several reasons. First, it captures lived experiences, which are often intricate and multifaceted due to factors such as displacement, trauma, resilience, and adaptation (Smith, 2018). Researchers can delve deeply into these experiences by eliciting personal stories and narratives directly from refugees, allowing for a nuanced understanding of their resettlement journeys (Beka, et al., 2023; Finlay & de la Cruz, 2023; Malloy, 2023). Second, narrative inquiry demonstrates respect for diversity among refugees, who hail from various cultural, linguistic, and socio-economic backgrounds (Kubota et al., 2022). By valuing the unique voices and perspectives of individual refugees, researchers can explore the cultural nuances, traditions, and beliefs that shape their identities and experiences (Josselson & Hammack, 2021). Third, engaging refugees in narrative inquiry empowers them to share their stories and reclaim their agency in the research process (Abkhezr et al., 2020; Ghorashi, 2021). This approach fosters a sense of empowerment, dignity, and validation, countering marginalizing narratives imposed on refugees by others. Additionally, narrative inquiry facilitates contextual understanding by allowing researchers to situate refugee experiences within broader social, political, and historical frameworks (Flick, 2006; Hernandez-Sampieri et al., 2015). Fourth, the rich qualitative data generated through narrative inquiry can inform policy and practice related to refugee

resettlement, integration, and support services (Pavlish, 2007). By amplifying the voices of refugees and highlighting their unique strengths, needs and challenges, narrative inquiry can contribute to the development of more responsive, culturally safe, and effective interventions and policies. All these distinctive features of narrative inquiry are instrumental to the aim of this study, and therefore, it was used throughout the research process.

Conducting narrative inquiry studies with refugees presents several ethical challenges (De Haene et al., 2010). Obtaining informed consent can be challenging due to language barriers, low literacy levels, and cultural differences in understanding research processes, necessitating thorough explanations of the study's purpose, risks, and benefits (Harper et al., 2020). In addition, researchers must approach participants with trauma sensitivity, considering the potential for re-traumatization and ensuring a safe environment for sharing stories voluntarily (De Haene et al., 2010; Harper et al., 2020). Furthermore, protecting the confidentiality and privacy of refugee participants is crucial, requiring measures to safeguard their personal information and identities (Abkhezr et al., 2020). Moreover, researchers must be mindful of power imbalances, cultural differences, and the need for equitable relationships with participants, respecting their autonomy and agency (Josselson & Hammack, 2021). Also, ensuring cultural sensitivity in communication and interpretation is essential to capture diverse perspectives respectfully (Josselson & Hammack, 2021). Finally, researchers have a responsibility to ensure reciprocity, providing benefits to participants and considering the long-term impact of the study on their well-being and community dynamics. Addressing these ethical challenges demands careful planning, ongoing reflexivity, and a commitment to upholding the rights and dignity of refugee participants throughout the research process. These relational and ethical challenges were mitigated by the use of a CBPR approach to research.

Data Collection Methods

The data collection phase of this study began with the exploration of insights from NCHC's staff and allied professionals, through focus groups, who provide healthcare services to the Afghan community. This was followed by interviews with Afghan refugee women.

Focus Groups

Two focus groups were conducted with a total of six participants (two medical office assistants and four health navigators) (see Table 1). The primary purpose of these focus groups was to obtain insights into their experiences with the Afghan community, with a specific focus on Afghan refugee women. According to Flick (2006) focus groups are well suited for gathering data from experts in a field and can be used as "Delphi groups" to elaborate guidelines and protocols. Therefore, a focus group guide was developed to delve into the experiences of NCHC and CSS staff in serving the Afghan community. Data from these focus groups informed the development of an interview guide to be used with Afghan participants. The questions in the focus group guide aimed to uncover the intricacies of working with this community, exploring the facilitators, challenges, and barriers in providing healthcare services, and understanding the relational dynamics of communication, particularly with Afghan refugee women. Ten open-ended questions were designed to achieve these objectives (see Appendix A). To ensure a comprehensive discussion within an approximately one-hour timeframe, and to cover all the questions, two separate focus groups were conducted—one with four participants and the other with three participants (one participants attended both focus groups). The insights gained from these focus groups were instrumental in formulating the semi-structured interview questions for use with Afghan participants. Additionally, insights were gathered on the cultural and relational dimensions of communication, particularly with Afghan refugee women.

Participant Selection and Recruitment. Potential participants for the focus group were invited during the NCHC non-clinical staff meeting in July 2023. An informational study sheet was distributed at the centre, and individuals interested in participating had the option to reach out or confirm their participation during team meetings. Each potential participant received a personalized invitation, emphasizing the importance of their insights and perspectives in shaping the research outcomes. No potential participant followed-up to the informational and invitation study sheet. In an effort to promote and facilitate their participation, the location for the focus group and the allocation of time in their schedules were coordinated with their respective coordinator at the NCHC. This strategy was successful, as all non-clinical staff were willing to participate. This collaborative effort ensured that logistical arrangements were seamless and convenient for the participants, minimizing any potential barriers to attendance. It's noteworthy that while participation was promoted by the NCHC, all individuals who participated in the focus group did so voluntarily, demonstrating their genuine interest and commitment to contributing to the research endeavor. In addition, two focus group participants from Catholic Social Services that work at the NCHC and have direct connections with the Afghan community were personally invited by me, ensuring a targeted and selective approach to recruitment. Focus group participants signed the informed consent in person on the day of the focus group. Prior to the session, issues and concerns related to confidentiality were discussed. A total of six NCHC/CSS staff members agreed to participate and provided informed consent. However, on the day of the focus group, only four participants were available, as three staff members reported being unwell and couldn't attend. The focus group had a duration of approximately 60 minutes and was conducted in a private space at the NCHC.

In addition to the focus group conducted with NCHC staff, a second separate focus group was conducted specifically with two health navigators from Catholic Social Services (CSS), who are stationed at the NCHC and play a vital role in assisting refugee clients with navigation through the healthcare system. This focus group was conducted in Spanish. One participant from the NCHC staff group attended the second focus group because she felt more fluent in Spanish, which enabled her to articulate her experiences with the Afghan community more effectively.

All focus group participants had different levels of engagement with the Afghan community at the NCHC, related to their position at the centre. The ages of the six participants ranged from 25 to 50 years old. All participants were migrants in Canada and provide healthcare services to the Afghan community on a regular basis. In addition to ensuring representation from various professional backgrounds within the NCHC, the focus group participants were selected to reflect the rich diversity present within the center's community. This diversity extended beyond cultural backgrounds to encompass differences in educational attainment, socioeconomic status, and lived experiences in Canada. Including participants with diverse educational backgrounds, ranging from health workers to medical office assistants in the focus groups captured a broad spectrum of perspectives and insights. Moreover, participants hailed from various socioeconomic backgrounds, reflecting the diverse socio-demographic composition of the Afghan community served by the NCHC. This deliberate inclusion of diverse voices enriched the discussions, allowing for a more comprehensive exploration of the challenges and opportunities encountered in providing healthcare services to Afghan refugees. Ensuring representation from across the spectrum of the center's community allowed the focus group discussions to unearth nuanced insights and perspectives that might otherwise have been overlooked.

Table 1

Focus Group Participants' role, organization, and language used in focus group

Participant	Role and Organization	Language used in focus group
Participant 1	Medical office assistant, NCHC	English
Participant 2	Medical office assistant, NCHC	English
Participant 3	Health navigator, NCHC	English
Participant 4	Health navigator, NCHC	English and Spanish
Participant 5	Health navigator, CSS	Spanish
Participant 6	Health navigator, CSS	Spanish

Note: participant 4 attended both focus groups

The focus group with NCHC staff participants was conducted in English, while the focus group with CSS health navigators and one NCHC staff member was conducted in Spanish, as it is the native language spoken by all participants.

To record the focus groups, a digital audio recording device was utilized, and data was downloaded to my personal computer, and later transcribed using Otter.ai software (Crumley, 2018). The focus group conducted in Spanish was transcribed directly from the audio device to a word document by me. Once the focus groups were completed, names and personal information were replaced by anonymized codes for each participant. Only the research team had access to the data and codes.

Preliminary Analysis of Focus Group Data. A preliminary thematic analysis following Braun and Clarke's (2021) technique was conducted using data from the focus groups. The purpose of this step was to begin to build the semi-structured interview guide that would be used when conducting interviews with Afghan refugee women. All data was transcribed verbatim from the audio recordings. Data from the Spanish focus group was initially analyzed in Spanish, then translated into English codes, alongside data from the English focus group. Following the steps outlined by Braun and Clarke (2021) several themes emerged from the data related to

staff's experiences serving the Afghan community. These included *domestic violence*, *women's health*, *male-centrism*, *mental health needs*, *adapting to a new culture* and *communication issues*. The development of the semi-structured interview guide and interview process is described below.

Development and Review of the Semi-Structured Interview Guide

Based on the themes identified through the data analysis of the focus groups, a semi-structured interview guide comprising 25 questions was created. These questions were formulated not only based on the themes derived from the focus groups but also from the research questions and existing literature. For example, from the theme *domestic violence*, questions, and probes such as *Have you ever experienced something in your home that made you feel uncomfortable or unsafe?* And *how do you manage those situations?* were constructed. This process was conducted iteratively with all themes, and research questions. Literature was consulted to formulate questions concerning mental health. According to Tahir et al. (2022), Afghans tend not to use terms like *depression* or *anxiety* when discussing their mental well-being. Instead, they may express such experiences as feelings of tiredness or worry. This insight guided the creation of the question: *How did you address emotional and mental well-being in Afghanistan? For example, when you felt sad, cried a lot, or tired?* To ensure cultural safety, these questions were shared and discussed via email, individually with each member of the advisory committee (Newman et al., 2011). A Google form, including the questions, a checkbox to indicate appropriateness, and an open space for feedback on any question if deemed necessary, was create. This Google form was distributed to each advisory committee member for their feedback. As a result of this process, five questions were eliminated from the original interview guide and an introduction to questions related to domestic violence and mental health were

added. For instance, in the question concerning domestic violence, a member of the advisory committee suggested incorporating an opening statement to introduce the question more smoothly. In this case, the statement *in some households, people might not always feel respected or safe* was used. Following the committee's feedback and approval, a final interview guide was formed, comprising 20 questions along with corresponding probes (see Appendix B). In addition to supporting the development of the interview guide, the focus group data contributed to addressing the research questions and is described in Chapter 4: Findings. Quotes obtained from the Spanish lead focus group were translated into English to be included in the findings chapter.

Semi-Structured Interviews

This study is grounded in qualitative narrative inquiry and focused on participants' lived experiences and stories. The quality of the stories and narratives is crucial for answering the research questions. In order to achieve this, a purposeful sampling technique with maximum variation (Hernandez-Sampieri et al., 2015) was used to select the most appropriate participants. Purposeful sampling included the selection of individuals who met the inclusion criteria and have lived experience as a refugee using healthcare services in Canada. In addition, a maximum variation sampling approach was employed as it permitted the documentation of narrative and individual variations. For the semi-structured interviews, participants were selected based on the following criteria: (i) Afghan refugee women that have been living in Canada for at least six months; (ii) current, or former clients at the NCHC; and (iii) adult participants (18+ years old).

Two separate semi-structured interviews (Hernandez-Sampieri et al., 2015) were conducted with each Afghan refugee participant of this study. The initial interview centered on post-migration healthcare experiences, while the second interview aimed to explore pre-migration experiences. These later interviews were crafted to elicit narratives and experiences

that could offer context for a more profound comprehension of the participants' current healthcare needs and expectations. Another reason for adopting this stepwise approach was to establish a trusting relationship with the participants, aiming to facilitate engagement during the second interview that focused on pre-migration experiences with healthcare. I assumed that discussions about participants' pre-migration experiences might be challenging, as they could bring forth potentially painful memories of violence or extreme situations. Consequently, building trust through an initial, non-threatening, present-focused interview was considered essential. This approach aimed to create a safer relational space for participants, enabling a more in-depth and past-focused conversation during the second interview.

Participant Recruitment and Interview Process. A study description and informed consent was shared with participants. This included a description of the study. their involvement, and information on the risks and benefits, and that they could withdraw at any time. The documents were available in English and Dari languages and were given to the participants at the time of the interview (see Appendix C). Potential participants were sought by the NCHC staff and allied professionals who were aware of this study. Staff and allied professionals had access to the study information sheets to be shared among the Afghan clients. Individuals who participated in the study provided their informed consent on the day the interview took place, whether in person or online.

Three Afghan refugee women, with different age, family configurations, social status in Afghanistan, education, and command of the English language were willing to share their stories in this study. A maximum variation sampling was chosen to ascertain the presence of common themes or patterns across this diversity (see Table 2).

Table 2

Participant Demographic Data

Pseudonym	Hasina	Masuada	Amina
Age	33	30	55
Marital Status	Married	Single	Married
Children	2	None	9
Education	Grade 7	Bachelor degree	No formal education
Family in Afghanistan	Yes	Yes	Yes
Transition countries before Canada	Iran and Turkey	None	Pakistan
Time in Canada	2 years	1.5 years	1 year
Illnesses or health concerns	Physical Chronic illness	No physical illnesses. Mental health concerns	Physical Chronic illness
Use of medication	Yes	Yes	Yes

Literature regarding narrative inquiry sampling and data saturation suggests including anywhere from 1 to 25 participants (Butina, 2015; Hernandez-Sampieri et al., 2015; Flick, 2006). This study engaged a total of three female Afghan participants, which is considered acceptable for qualitative narrative inquiry (Flick, 2006; Prasad, 2021).

The site of the interviews was selected according to the needs and desires of participants. Online and in-person interviews were used in this study. For one participant, pre- and post-migration interviews were conducted at the participants' home; for the other participants all interviews were held online, using the Google Meet platform. Participants received a 25 CAD gift card as recognition for their participation. For the in-person interview, the gift card was provided at the time of the interview, while for the online interviews, the gift cards were sent by mail to the participant's home address.

Data was collected in accordance with the specified modality. For the in-person session, a digital audio recording device was utilized. Online interviews were conducted and recorded through Google Meet's in-app video and audio recording feature. While participants interviewed online had the option to turn off their cameras, none chose to do so. Interviews conducted via

Google Meet were immediately downloaded directly to a secure folder on the computer, and the Google Meet cloud was not utilized. Data from interviews were downloaded to my personal computer, and later transcribed using Otter.ai software (Crumley, 2018). Once the interview process was completed, names and personal information was replaced by pseudonyms to identify participants. Only the research team had access to data and pseudonyms.

Translation Process.

As language forms a crucial foundation of the participants' lived experiences and a NI study design, adequately reporting the translation process in qualitative research is essential to ensure the presence of the participants' voices and the trustworthiness of the research (Yunus et al., 2020). All interviews were conducted in English by the researcher. However, two participants were not proficient in English, and I do not speak Dari (the participants' native language). Therefore, we utilized interpreters to conduct the interviews in Dari. The interpreters were two female Afghan individuals currently residing in Canada. One of them, mentioned in this study by the pseudonym Simone, arrived in Canada as a refugee and currently maintains a connection to the Afghan community through her involvement in providing healthcare navigation services at Catholic Social Services. I directly approached her, guided by a member of the advisory committee, to request her collaboration in the study. The second interpreter, mentioned in this study by the pseudonym of Margaret, currently a University of Alberta dentistry student, came to Canada as a student and later became a Canadian citizen. She reached out to offer assistance with the study after learning about it from the 2022 Women and Childrens Health Research Institute (WCHRI) annual report (WCHRI, 2022). Both interpreters are in their mid-twenties. The involvement of female interpreters was intended as a measure to forge trust and respect for the participants' cultural background.

Real-time conversation between myself and the participants was translated from English to Dari, and vice versa. For the first post-migration interview, no specific direction was given to the interpreters, nor were the interview questions shared before the interview. Both interpreters translated the participants' utterances verbatim at times, while at other times, they conveyed the main idea or a summary of what the participant said. This situation posed challenges in the preliminary data analysis, and therefore, a different approach was taken for the second interview. In this instance, the interview questions were shared with the interpreters beforehand, and they were instructed to provide verbatim translations of the participants' responses whenever possible. Additionally, a structured debriefing session was conducted after each interview to discuss the interpreters' impressions, particularly regarding the use of slang or uncommon phrases in English. Furthermore, we examined the linguistic structure of the responses from a narrative perspective, analyzing elements such as the main character, their role within a specific plot, connections between stories, and descriptions of settings. These debrief sessions were crucial in enhancing the richness of the pre-migration interviews, thereby contributing to a more comprehensive analysis, and understanding of the participants' voices.

Data Analysis for Focus Groups and Interviews Combined

Narrative inquiry involves analyzing interviews, focus groups, or written narratives to identify patterns and themes in participants' accounts of their experiences (Butina, 2015; Hernandez-Sampieri et al., 2015; Flick, 2006). The analysis is typically carried out in a recursive and iterative manner, where the researcher engages in a continuous process of revisiting the data, generating new insights, and refining the analysis (Flick, 2006; Josselson & Hammack, 2021). The goal of narrative inquiry is not to provide a definitive account of the participants' experiences but rather to develop a rich and nuanced understanding of how they make sense of

their experiences (Butina, 2015; Harper et al., 2020; Lewis, 2019). Data analysis using narrative inquiry also stresses that in order to understand the meaning of a text, it is necessary to understand its individual parts, or stories, but also how those parts fit together to create a larger whole, or narrative (Syed & McLean, 2021). It is at this point where narrative inquiry's idiographic approach merges with the hermeneutic interpretation of data, characteristic of a social constructionist view, as the analysis moves from the individual cases to search for connections between the cases (Josselson & Hammack, 2021).

Although there is no unique, consented guide to narrative inquiry data analysis (Lewis, 2018), when using narrative inquiry as a qualitative methodology, the forms of data analysis typically include thematic analysis (Abkhezr et al., 2020; Bengtsson & Andersen, 2020; Selimos et al., 2018), structural analysis (Bengtsson & Andersen, 2020; Syed & McLean, 2021), dialogical analysis (Abkhezr et al., 2018; Vähäsantanen & Arvaja, 2022), and performative analysis (Bengtsson & Andersen, 2020). For this study, I used thematic analysis given its suitability for delving into the healthcare lived experiences and expectations of Afghan refugee women, and because it seamlessly allows synthesizing their recommendations for healthcare provision in Canada. Although thematic analysis was used in this study, additional attention was paid to narrative elements sought in other forms of narrative analysis like tones and gestures, storytelling formats, narrative arc, character plot, and so on. All of these contributed to a fuller understanding of the participant's voices. Through thematic analysis, the study facilitated an in-depth exploration of the participants' narratives, enabling a comprehensive understanding of their stories. Moreover, this approach facilitated the comparison of various stories and narratives, paving the way for practical insights and recommendations to emerge from the data.

Thematic analysis in narrative inquiry involves a meticulous process of extracting, organizing, and interpreting themes from qualitative data, typically in the form of narratives or stories (Bengtsson & Andersen, 2020; Prasad, 2021). The initial phase of this analysis requires immersion in the narrative data, where researchers engage deeply with the text or audio recordings to develop a comprehensive understanding of the participants' experiences and perspectives (Butina, 2015; Lewis, 2018). Through repeated readings or listening, researchers identify meaningful segments of the narratives and assign descriptive codes to capture the essence of each segment (Flick, 2006; Josselson & Hammack, 2021). These initial codes serve as building blocks for the subsequent development of themes, allowing researchers to systematically organize and categorize the data based on commonalities, patterns, or recurring motifs (Hernandez-Sampieri et al., 2015; Flick, 2006).

Once a sufficient number of codes have been generated, researchers begin the process of theme generation, wherein they group related codes into overarching themes that encapsulate key ideas or concepts within the narratives (Josselson & Hammack, 2021). This iterative process involves reviewing, refining, and consolidating themes to ensure they accurately reflect the richness and complexity of the data (Lewis, 2028). Themes are defined and named in a way that captures their core meaning and relevance to the research question, with careful attention to coherence, consistency, and interpretability. Through mapping and interpreting the themes, researchers uncover the underlying structures and dynamics of the narratives, exploring the relationships between themes and their implications for understanding the research phenomenon (Josselson & Hammack, 2021). The findings of the thematic analysis are synthesized into a coherent narrative that highlights the identified themes and their significance, supported by illustrative quotes or excerpts from the narratives. Throughout this process, researchers maintain

transparency and rigor by documenting their decisions, reflections, and interpretations, thus ensuring the trustworthiness and credibility of the analysis (Prasad, 2021).

Following a meticulous examination of each individual case, a thorough understanding of the unique experiences, perspectives, and meanings attributed by the Afghan women refugees were attained. By delving deeply into the richness and complexity of each participant, the study aims to provide comprehensive and nuanced insights into their lived experiences.

Once the individual stories and narratives had been exhaustively analyzed, the focus shifted towards identifying connections, patterns, and themes that emerge across the participants (Josselson & Hammack, 2021; Lewis, 2028). Through a systematic comparison and exploration of commonalities, contrasts, and interrelationships, a comprehensive understanding of the broader experiences and shared themes among the participants was developed.

The utilization of Nvivo 14 software (Lumivero, 2023) served as a valuable tool in facilitating the data analysis process. This software provided a robust platform for organizing, coding, and analyzing qualitative data. By adopting the sequential approach of analyzing individual cases before establishing connections and employing the Nvivo 14 software (Lumivero, 2023) to aid in data analysis, this study adhered to the principles of rigour in qualitative inquiry. Through this methodological framework, the research aims to capture the depth and complexity of the Afghan women refugees' experiences while also facilitating the identification of overarching themes and relationships among their narratives.

Rigour

Rigour in qualitative inquiry entails the conscientious application of systematic and rigorous methods by researchers to ensure the trustworthiness, credibility, and reliability of their findings (Newman et al., 2011; Salgado, 2007). Adherence to established principles and practices

is essential to enhance the quality and validity of qualitative research (Hernandez-Sampieri et al., 2015; Flick, 2006). In the context of the study focused on Afghan women refugees, several key aspects of rigour in qualitative inquiry were pursued.

Credibility was fundamental to establishing confidence in the truth and accuracy of the findings (Hernandez-Sampieri et al., 2015; Flick, 2006). To ensure credibility, active engagement with the Afghan community was undertaken throughout the study. This engagement aimed to foster a deep understanding of their experiences and perspectives, which subsequently facilitated the analysis of data and the establishment of meaningful connections. Furthermore, the utilization of multiple sources of data, such as focus groups, interviews, and an advisory committee, enabled the corroboration and validation of the findings (Newman et al., 2011; Salgado, 2007). Preliminary results and interpretations of data were shared with two participants to ensure that the voices of the Afghan women refugees were faithfully represented.

Transferability, another crucial aspect of rigour, focused on the extent to which the findings could be applied or transferred to other contexts or settings (Salgado, 2007). To enhance transferability, comprehensive and rich descriptions of the research context, the characteristics of the Afghan women refugees, and the specific settings where the interviews took place were provided (Caraganajah, 2021). These detailed descriptions can enable readers to assess the applicability of the findings to diverse contexts. Moreover, the attainment of theoretical saturation was sought (Flick 2006), ensuring that a broad range of experiences and perspectives were captured, thus strengthening the transferability of the findings.

Dependability, emphasizing the stability and consistency of the findings, is integral to rigour (Flick, 2006; Salgado, 2017). The use of an audit trail was employed to enhance dependability throughout the research process (Hernandez-Sampieri et al., 2015; Flick, 2006).

This audit trail meticulously documented decisions made during data collection, analysis, and interpretation. By maintaining a detailed record, other researchers could assess the dependability and replicability of the study, promoting transparency and accountability (Hernandez-Sampieri et al., 2015).

Confirmability, the degree to which the findings are grounded in the data rather than influenced by researchers' biases or preconceptions, is a paramount consideration in rigour (Salgado, 2007). However, in congruence with social constructionism as the epistemological stance of this study, reflexivity was used as a means of creating awareness of my personal point of view, values, and beliefs when relating to the participants and data (McQueen & Patterson, 2020). To ensure reflexivity, a journal was consistently maintained as the study progressed. This reflexive journal facilitated self-reflection, allowing for the identification and acknowledgment of personal beliefs, assumptions, and potential influences on the research process (Flick, 2006). By documenting these reflections, transparency and confirmability within the study were enhanced (Hernandez-Sampieri et al., 2015; McQueen & Patterson, 2021). Additionally, the advisory committee served as an added voice, offering an enriched view of the data, analysis, and interpretations (Macqueen & Patterson, 2021). Their input served to triangulate the confirmability of the findings.

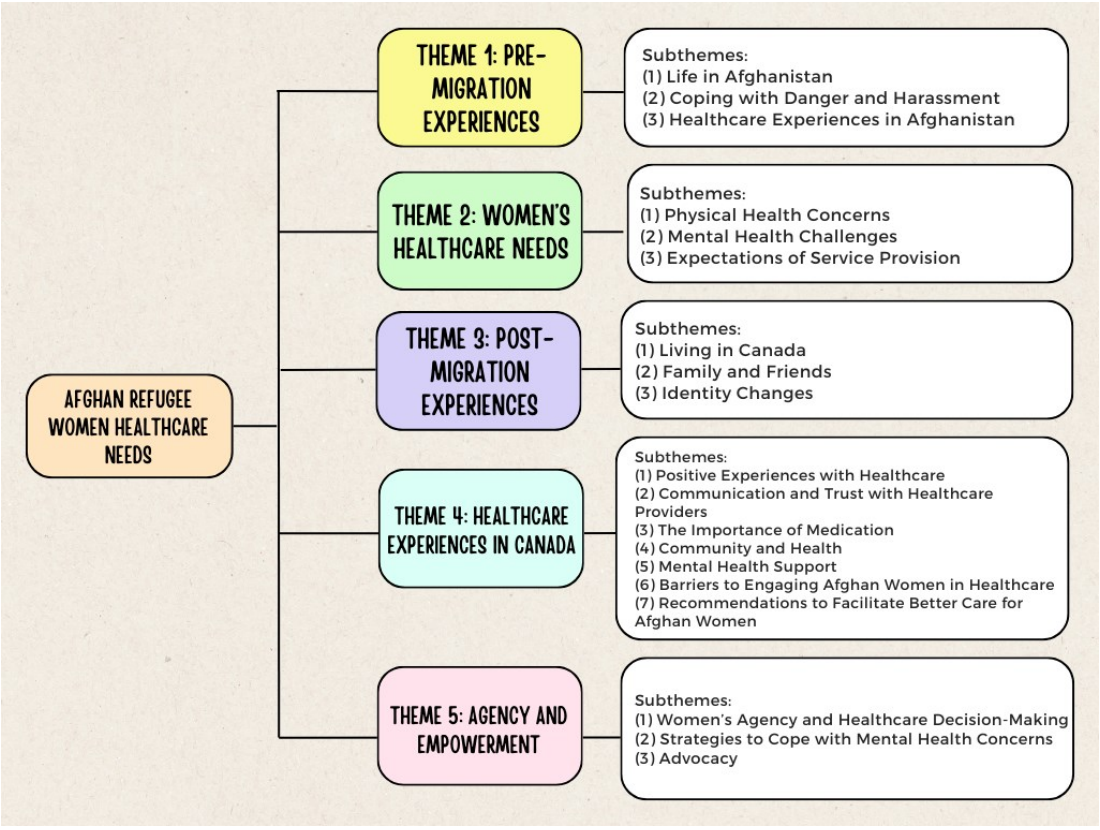
Through attentive consideration of credibility, transferability, dependability, and reflexivity, this study aimed to uphold rigour in qualitative inquiry, ensuring the reliability and trustworthiness of the research findings.

Chapter 4: Findings

The purpose of this CBPR study was to explore Afghan refugee women's lived experiences in healthcare, by exploring through interviews with three Afghan refugee women and two focus groups the questions: (1) What are the health care needs and expectations for Afghan refugee women? (2) What are the lived experiences of Afghan refugee women accessing the NCHC? and (3) What practices would support the NCHC in addressing the healthcare needs of Afghan refugee women? The results of this study yielded five themes and nineteen sub-themes. The findings are visually represented in figure 1.

Figure 1

Visual illustration of findings



The findings as visualized above show the interconnectedness of the themes and subthemes, which all contribute to an understanding of Afghan refugee women healthcare needs. This figure is divided into five main themes: pre-migration experiences, healthcare needs, post-migration experiences, healthcare experiences in Canada, and agency and empowerment.

In the *pre-migration experiences* theme, subthemes included *life in Afghanistan*, *coping with danger and harassment* and *healthcare experiences in Afghanistan*. The theme and subthemes directly influence Afghan refugee women participants' healthcare needs, presented in the figure as the second theme, which encompasses subthemes *physical health concerns*, *mental health challenges*, and *expectations of service provision*. The theme and subthemes highlight the significant impact of socio-political factors, cultural norms, and personal experiences that shape participants perceptions of healthcare and expectations of service provision upon resettlement in Canada.

Transitioning to the third theme, *post-migration experiences*, figure 1 shows the subthemes *living in Canada, family and friends,* and *identity changes*, related to how Afghan refugee women's identities evolve as new settlers in Canada.

Healthcare experiences in Canada, the fourth theme, is supported by subthemes *positive experiences with healthcare*, which illustrates good experiences with the Canadian healthcare system, including effective *communication and trust with healthcare providers*, mental *health support*, the subtheme *importance of medication*, and the influential role of community networks in their health outcomes in the subtheme *community and health*. The subtheme *barriers to engaging Afghan women in healthcare* highlighted the challenges women face in navigating the complexities of the Canadian healthcare system, such as language barriers, cultural differences,

and socioeconomic disparities. Finally, participants shared recommendations that would *facilitate better care for Afghan refugee women.*

The fifth theme highlights the central role of the *agency and empowerment* in shaping Afghan refugee women's healthcare experiences. By showcasing their resilience, resourcefulness, and capacity to advocate for their health needs, this theme underscores the importance of recognizing and supporting women's agency within healthcare contexts, through the subthemes *women's agency and healthcare decision-making*, and *strategies to cope with mental health concerns*. The final subtheme, *advocacy* shows active participation of women in this study in promoting social and cultural change. Overall, figure 1 aims to facilitate an understanding of the multifaceted nature of Afghan refugee women's healthcare needs and the factors influencing their experiences within the Canadian healthcare system.

In this chapter, each of the themes and subthemes of this study is described based on participants' lived experiences with healthcare and health in general and using their narrative quotes. Pseudonyms (see Table 4) are used for each participant when sharing their quotes to protect their identity. Since I required the assistance of interpreters to communicate with Dari-speaking participants, I use the descriptor "as interpreted by [interpreter's pseudonym]" for those participant quotes where an interpretation is provided from Dari to English. Interpretations are presented verbatim as the interpreters elaborated them. Sometimes they used a first-person style, and in other occasions, a third-person style and this is reflected in the quotes. It should also be noted that one of the focus groups was conducted in Spanish, and therefore the interpretations of participant's quotes were conducted by me. I followed the same descriptor at the end of the focus group quotations where I provided the interpretation.

Table 3

Role in this study, and pseudonyms as used in the findings chapter

Role in the study	Pseudonym
Participant	Hasina
Participant	Masuada
Participant	Amina
Interpreter	Margaret
Interpreter	Simone
Interpreter	Cristián Neves

Note: I participated as interpreter for the focus group conducted in Spanish, however, I did not use a pseudonym.

Pre-Migration Experiences

The first theme, *pre-migration experiences,* provided a context from which the healthcare lived experiences, needs, expectations, and recommendations of Afghan refugee women were shaped. This theme will be described through three subthemes: *life in Afghanistan, healthcare experiences in Afghanistan*, and *coping with danger and harassment*. These pre-migration contexts influenced the participants' expectations of healthcare and service provision in Canada.

Life in Afghanistan

The participants' depictions of life in Afghanistan reveal the complexities of daily existence amidst political turmoil and societal constraints. Their narratives paint a picture of a once-vibrant society overshadowed by strict regulations and the constant threat of conflict.

In their recollections, participants describe a pre-Taliban era characterized by relative freedom and opportunity. Two participants fondly reminisced about their professional pursuits, with one finding fulfillment as a teacher at an international school in Kabul and the other tending to household duties while her children grew. These experiences symbolize a time when aspirations and ambitions were within reach, albeit against the backdrop of uncertainty. As one participant stated:

> (...) like before the impartment of Taliban, everything was like, fantastic. I was really enjoying everything. Like my regular days, I was working. I was a teacher at one of the international schools in Kabul, I was teaching some Oxford subjects there. Beside it, I was studying IELTS [international English Language Testing System] because I wanted to apply for a student visa for UK. So, actually, it was fantastic. Until Taliban came, everything was just like, opposite of what it became. (Masuada)

Additionally, there is a sense of nostalgia for the freedom and ease of life before periods of conflict and political instability in Afghanistan. Women in this study reminisce about the sense of security and financial stability they once enjoyed, particularly when they were engaged in fulfilling careers or had access to quick and efficient healthcare services. As Masuada expressed:

> Actually, what I miss is that I was working, I had my own salary. And my father was a teacher too. So he was also earning some money. And that was like the financially we were, we were good. Like, we were fine. Because we could afford our own expenses. Also the hospitals were very, like, they had all the facilities for any kind of patients. And when they were working 24 hours, the emergency was like, very good. Like, I visited the emergency here and we waited for 10 hours. But there (in Afghanistan) we will not even wait for five minutes. And yes, so about Kabul That was fantastic. (Masuada)

However, the arrival of the Taliban marks a dramatic shift in their narratives, ushering in an era of repression and constraint. Afghan women in this study, found themselves subjected to stringent regulations governing their every move. From restrictions on education to limitations on mobility, their autonomy was severely curtailed, forcing them to navigate a world fraught with obstacles and limitations. According to Hasina:

> For girls completing grade six, it means that they are graduating. They are not allowed to go after grade six. And lots of other restrictions, like going outside, not being able to go and they were asking that if not with a man, like your brother, your father, or maybe your husband, you should not go by yourself outside. So for our generation, that was a very bad experience, because we grew up in a very full freedom life. (Hasina, as interpreted by Simone)

Despite these challenges, two participants recount moments of perseverance and adaptability in the face of adversity. Whether it be maintaining employment amidst political upheaval or managing household responsibilities amidst resource scarcity, their stories reflect a steadfast determination to carve out a semblance of normalcy amidst chaos. For example, Amina stated:

> I kept myself busy just doing regular housework. I was a housewife in Afghanistan. My job was to just wake up, tidy up the places, make breakfast for the kids, feed them and then clean up after them and then make lunch and then clean up after that and get ready for dinner. Like that was my duty. (Amina, as interpreted by Margaret)

Yet, amidst the turmoil, participants shared glimpses of community and camaraderie, which offered them solace. As one participant shared:

> (...) I also had a lot of friends back home. I would go on walks with them, go out on walks and socialize. So those were the things that we're able to do there most of the time. I truly miss that. (Amina, as interpreted by Margaret)

Supporting this idea, Masuada reflected:

> So I had lots of friends, my colleagues, my university class fellows, still I'm in contact with them. And most of the time, like on a daily basis, so what I what we were doing, like

> after our work, after four o'clock, we were getting off at four. So after four o'clock, most of the times we were going for, like for a tea for a coffee or like, you know, [to have] some Afghani foods that are like very popular. So we were going to some different kinds of restaurants and most of the times like I was spending my time with my friends and still we are in like in connection with each other. I think that is one of the reasons I was not depressed back home. (Masuada)

Ultimately, their narratives offer a poignant reflection on the lived realities of Afghan women, whose experiences are shaped by the intersection of personal resilience and societal upheaval. In their stories, echoes of struggle and strength, resilience and resistance are evident. For example, in recounting their experiences, participants recall instances where they took proactive steps to uplift and educate women, particularly those in more vulnerable or marginalized positions. One participant reminisces about her efforts to educate girls in her village during university breaks, highlighting her initiative to create a makeshift classroom and impart essential life skills and knowledge. Despite facing risks to her own safety due to the presence of Taliban forces, she persisted in her advocacy, demonstrating courage and determination in her mission to empower others. According to Masuada:

> When I was growing up as a girl, I found it very disheartening (how women in villages were more oppressed compared to those in Kabul, or other major cities). So what I did was, during my free time while I was at university and not working, mostly during my holidays, I would ask my dad to accompany me to the village where my uncle lived. There, I organized a class and taught them various subjects, starting from the very basics. I taught them about life, about girls, what they needed to do, and how to take care of themselves. This way, I was able to help them. However, most of the villages were under

> Taliban control, so my life was at risk whenever I went there. I couldn't go back as often as I wanted, but I did my best to teach them whenever I could. Sometimes I feel good about it, knowing that I tried my best to help them. (Masuada)

Coping with Danger and Harassment

Living in Afghanistan posed numerous challenges for Afghan refugee women, particularly in navigating danger and harassment in their daily lives. The societal landscape was fraught with corruption and insecurity, manifesting in various forms of harassment and threats to personal safety. This pervasive harassment created an environment of fear and mistrust, forcing her to adopt coping strategies to safeguard from harm. In the words of Masuada:

> I loved Academy places rather than money-driven, offices and organizations. Because even that time, the, the time was good. But there were like, some corruptions inside organizations that was not like unbearable. And sometimes it was not like very safe for young ladies or young girls. Sometimes we were, like, most of the times, we were asked for sexual activities, or for some other harassments. Like we were facing lots of sexual harassment, sexually in office spaces. That's why I prefer academy places. (Masuada)

To mitigate the risks associated with harassment and danger, women adopted a cautious approach to their daily activities. They strategically avoided certain locations and times of day deemed unsafe, opting instead for familiar and secure environments. Despite the limitations imposed by these safety measures, women continued to navigate public spaces with resilience and determination, albeit with heightened vigilance and awareness of potential risks. As stated by Hasina:

> In Afghanistan we have lots of beautiful places. But I knew that some places were not good for us (women). So I was avoiding those places. Like mostly we were going to

> places that were secure for us. And like we had some timings like okay, this time is safe. We have we can go in this time. But after mostly after evening, when it was getting dark, we will not be going outside by ourselves. Of course with family we were going till midnight, but not by ourselves. So yeah, we were like avoiding those things that we knew that they were not safe for us. (Hasina, as interpreted by Simone)

In instances where they encountered threatening situations, such as suspicious taxi rides or unfamiliar surroundings, women relied on assertiveness and quick thinking to protect themselves, often resorting to firm communication or seeking assistance from authorities. As recalled by Masuada:

> I just took a taxi; it was not like here to order a taxi online or to call a co-op. There you can ask taxi anywhere you can stop the taxi anywhere you want. So I just stopped the taxi. And it was like evening, late evening time. At that time, like the taxis were not very safe, because they didn't have specific license or anything. So anyone could do the taxi work. When I sit in the taxi, the taxi driver took me in different roads, like very unfamiliar roads for me, like, and then he stopped the taxi. And he wanted to pick two other ladies who had like the burqa on themselves. And when I saw I didn't feel safe, I knew something was like not very normal. So I asked the taxi driver look bro if you want to pick these ladies, I don't know them. And I took this taxi for myself, not for them. If you want to take or if you want to charge them, it's fine. I can give you that money. But don't take them (...) I become a bit rude to them. I became a bit serious. And then that's why I just took out my mobile and I said that I'm gonna call the police or something then he was scared say that, okay, I'm not gonna take this. (Masuada)

Despite the adversity they faced, Afghan refugee women exhibited remarkable resilience in coping with danger and harassment in Afghanistan. Their experiences underscored the pervasive nature of insecurity in their homeland, where navigating everyday life required constant vigilance and adaptability. As they continue to rebuild their lives in Canada, these women carry with them the lessons learned from their experiences, drawing strength from their ability to overcome adversity and forge paths towards a brighter future.

Healthcare Experiences in Afghanistan

In Afghanistan, healthcare experiences for women were shaped by a complex interplay of societal norms, economic challenges, and political instability. Participants recalled a time when access to healthcare services varied significantly depending on one's location and socioeconomic status. In urban areas like Kabul, hospitals boasted modern facilities and a diverse pool of foreign doctors, offering comprehensive care. However, the situation was starkly different in rural villages, where healthcare infrastructure was often lacking, leaving residents vulnerable to untreated illnesses and limited medical resources. As conveyed by Masuada:

> Oh, if I say from experience from Kabul, that was good. We never face any kind of healthcare problem in Kabul, we had very equipped hospitals, doctors, medicines, everything were very fine. We had lots of foreign doctors, like Indians, like Germans, Russians, from different countries. And the hospitals were very, like, they had all the facilities for any kind of patients. And when they were working 24 hours, the emergency was like, very good (...) The healthcare system was very nice. But, if I go to some villages, of course, they were facing lots of problems, because they didn't have hospitals, they didn't have enough doctors. And the medicines were actually not medicines. I don't

> know how they were making them. So they had problems. But in Kabul, it was very good. (Masuada)

Moreover, while one participant reminisced about well-equipped hospitals and prompt medical attention in urban areas like Kabul, other participant recalled the struggles of accessing basic healthcare services in more rural or underprivileged regions. The lack of accessibility to quality medication and timely medical interventions underscores the systemic challenges within Afghanistan's healthcare infrastructure. Regarding this, Amina recalled:

> The doctor prescribed some medications for my breathing problem, but they didn't help at all. I took these medications for months with no improvement. Additionally, they couldn't determine the cause of my shortness of breath. They attributed it to an allergy, but I knew it was more than that. They never tested me for cysts or cancer. (Amina, as interpreted by Margaret)

Moreover, the onset of conflict and the rise of the Taliban brought about additional barriers to healthcare access. Strict regulations imposed by the regime, including restrictions on women's mobility and education, compounded existing challenges, particularly for female patients seeking medical treatment. As healthcare facilities faced shortages of skilled professionals and essential supplies, many Afghan women found themselves grappling with unmet healthcare needs and limited avenues for seeking medical assistance. In regards to this, Hasina commented:

> She mentioned that back home in Afghanistan, everyone was very depressed, especially women. They faced numerous barriers, particularly regarding education and employment, especially after the Taliban took power. This led to a deep sense of depression among them. Additionally, poverty was a major issue, as they struggled to find employment.

> However, these challenges were not adequately addressed because women couldn't even visit a doctor, let alone a psychiatrist. (Hasina, as interpreted by Simone)

Despite these obstacles, participants expressed a deep-seated resilience and resourcefulness in navigating the healthcare landscape. They recounted instances of seeking care for themselves and their families, often relying on established relationships with trusted doctors or traveling to neighboring countries like Pakistan for specialized treatments unavailable in Afghanistan. However, the lack of confidentiality in medical consultations and the erosion of trust in healthcare providers was shared. As Masuada expressed:

> When it comes to confidentiality, it was not too high, because anybody can ask them [the doctors], and they would share all information. And some personal issues that we were having... we're not like, we couldn't share those with the doctors there. Even with lady doctors or men or whatever. But myself, like sometimes I was not able to discuss some very personal issues with doctors, because I could not trust them. (Masuada)

In addition, some participants recount challenges associated with medication efficacy in Afghanistan, particularly regarding the quality and effectiveness of medications received in local hospitals. One participant shares their mother's experience of ineffective medications prescribed after a brain stroke in Afghanistan. Despite multiple attempts to find suitable alternatives, including seeking medical care in Pakistan, the participant's mother continues to rely on the same medications initially prescribed in Afghanistan. This narrative highlights the enduring impact of ineffective medications and the challenges faced by individuals in navigating healthcare systems to find suitable alternatives. As Masuada recalled:

> (...) and especially with my mom, because she had a brain stroke there back home like eight years ago. And We admitted her in one of the hospitals. The doctor was Indian. And

> since that time, like still she's taking those medicines that they were given by the hospital in Kabul. We took her to Pakistan many times, but the medicines they the doctor gave her were not like effective for her and we restarted the medicines the doctor gave my mom in Afghanistan. And still now, in Canada, the doctors recommend those medicines for her. (Masuada)

Women's Healthcare Needs

The second theme, *healthcare needs*, describes the overall physical, mental, spiritual, economic, and social health concerns participants disclosed. These needs were connected to expectations during resettlement. They were included in the subthemes *physical health concerns*, *mental health challenges*, and *expectations*.

Physical Health Concerns

The experiences of Afghan refugee women regarding health concerns are multifaceted, reflecting both their struggles in Afghanistan and their challenges and hopes in Canada. In Afghanistan, access to healthcare was hindered by cultural barriers, limited resources, and societal norms. Participants in this study faced significant obstacles in discussing women's health issues, such as menstrual cycles, contraception, and reproductive health, due to prevailing taboos and stigmas surrounding these topics. These findings are consistent with observations made from focus groups participants regarding Afghan women's health in Afghanistan. As conveyed by a focus group participant:

> The primary health need is women's health. I can't imagine how a woman in Afghanistan can go to a doctor or nurse for a screening, a Pap smear, or a mammogram, or talk about her menstrual cycle or contraception. It's very difficult, even before the second Taliban crisis. During both Taliban crises, this situation persisted, and it might have already been

> ingrained in the culture. So, reaching the contraception aspect was very difficult, and when you see many families having many children frequently, that tells you something. When you see the ages, 4, 5, 3, 2, you can see... and it has happened that in some cases, women don't want to have more children, but I feel it's not much in their control. So, I believe that aspect is completely neglected. (Focus group participant 4, as interpreted by me)

The experiences shared by these women highlight the pervasive impact of health issues on their lives, both in Afghanistan and after resettling in Canada. One woman recounts her battle with breast cancer, undergoing biopsies and medical tests to monitor her health. Similarly, concerns about her daughter's heart condition and vision problems weigh heavily on her mind, underscoring the ongoing challenges of managing complex health conditions within the family. Hasina highlighted:

> She had breast cancer six years ago, plus, her daughter has Down syndrome, all of which was very difficult to treat in Afghanistan. There were no specialists available to treat her daughter's vision and heart condition, both typical complications of Down syndrome. Here, although there are available specialists, the waiting times are too long. (Hasina, as translated by Simone)

Transitioning to life in Canada has brought its own set of health-related challenges for these women. While access to healthcare may be more readily available, navigating the system and understanding unfamiliar diseases and treatments present new hurdles. Despite grappling with health issues like cancer, diabetes, pulmonary cysts, or surgery recovery, these women display resilience and determination in seeking medical attention and advocating for their health needs.

Mental Health Challenges

The interviews with Afghan refugee women living in Canada shed light on the profound mental health challenges they face, stemming from experiences both in Afghanistan and during resettlement. These women arrive in Canada carrying heavy burdens of psychological trauma, often compounded by the fear and uncertainty of starting anew in a foreign land. In the words of a focus group participant:

> There are women who arrive here alone and have psychological problems, with strong traumas. They arrive with a lot of fear. Many of them don't even want to talk because they're afraid of being sent back to Afghanistan. Often, it's difficult for them to come to appointments, and they tend to be very shy. I think it's mainly because of the psychological problems they bring with them. (Focus group participant 5, as interpreted by Cristian Neves)

For some, the specter of past traumas and ongoing struggles back home looms large, influencing their present existence. The constant fear for the safety and well-being of loved ones left behind in Afghanistan adds an additional layer of anxiety and anguish to their daily lives. Despite their efforts to maintain strength and resilience, the underlying trauma and uncertainty take a toll on their mental well-being. Regarding this, Amina expressed:

> I mean, we were just struggling with it, even though that we feared at times. I mean, every day that we were going out, we didn’t have a hope that we will come back alive. It was really bad. But we didn’t have a choice. So we were just living with it. And usually I’m very strict in my stress. reason is because my kids are in Afghanistan and one of them is incarcerated. My only stresses are my kids away from me and it is painful. (Amina, as interpreted by Margaret)

Yet, amidst these challenges, there is a resilience and determination to persevere. Despite the fear and uncertainty, these women display remarkable strength in confronting their struggles head-on and finding moments of happiness and comfort amidst the turmoil. The love and concern for their children serve as both a source of stress and a beacon of hope, anchoring them in their journey towards building a better life in Canada. For example, Hasina stated: "Everything I do now is for my kids. They bring meaning to my life, so I am strong for them" (Hasina, as translated by Simone)

Expectations of Service Provision

The participants in this study share their varied expectations and experiences with healthcare services, which has been shaped by their backgrounds in Afghanistan and their encounters with the Canadian healthcare system.

For many women, the transition from healthcare in Afghanistan to Canada brings about mixed feelings. Some express disappointment with the perceived shortcomings of healthcare in Canada compared to their expectations. They had hoped for more comprehensive and efficient care, particularly for their children. The contrast between their anticipations and the reality of healthcare services in Canada leaves them feeling disillusioned. As articulated by Hasina:

> Before coming to Canada, like when I was in Turkey, I was thinking like, maybe Turkey has like, the bad medical system. And I was expecting more from Canada when I arrived here, maybe my daughter will be like, treated well, but now I feel like I was wrong about this thing. (Hasina, as translated by Simone)

However, the other two participants in this study acknowledged the challenges of accessing healthcare in Canada but express appreciation for the quality of care they receive once they access it. They recognize the importance of open communication between patients and

healthcare providers, emphasizing the need for doctors to listen attentively to their concerns and address them thoroughly. They value the supportive and friendly demeanor of Canadian healthcare professionals but long for the quick and efficient services they were accustomed to in Afghanistan. Masuada shares:

> I would say [I miss] the quick services back home, I always miss those quick services, because we never we felt sick, we would go to the doctor, we would done our we would have done our test just in two days or one day, even the same day, we could do that one. And also, like, we had lots of hospitals there, like we had lots of emergencies, and everything. And I missed those things about health care, rather than that everything is fine. As I said before, I like the doctors here. They're very friendly kind. And also, the medicine here is very good. Because I was taking iron medications for three years back home, but it really didn't help me. But then here, I just took it for three months. And it really helped me. So yeah, just the quick services I miss, about the healthcare that I miss back home. (Masuada)

Post-Migration Experiences

The third theme, *post-migration experiences*, represents the changes and nuances of resettling in Canada and how that journey shaped participants' lives. The subthemes *living in Canada*, *family and friends*, and *identity changes* emerged as particularly important for all participants.

Living in Canada

The experiences of Afghan refugee women in Canada reveal a complex interplay of cultural adaptation, support services, and encounters with the Canadian healthcare and social systems.

Upon arrival in Canada, these women undergo comprehensive orientation sessions covering various aspects of life in their new country, including healthcare. They are informed about the confidentiality of medical consultations, reassuring them that their health information remains private. This knowledge empowers them to seek medical help without fear of privacy breaches, fostering trust in the healthcare system. This quote is interesting because it also highlights the connections between unmet needs, expectations and trust in the healthcare system. According to Masuada:

> As we arrived in Canada, we had a wide orientation about Canada. So it was a session for four weeks, and every week, we had to get some information regarding like, like housing, like, education, and everything. And one of those sessions was the health session. So in that orientation, I got that everything we share, or we say to the doctor is confidential. So from the first visit to the doctor, I was aware of the confidentiality. (Masuada)

Moreover, settlement counselors play a crucial role in facilitating access to healthcare and social support services. They act as bridges between Afghan refugee women and the Canadian systems, ensuring that newcomers receive the necessary assistance to navigate unfamiliar processes. However, challenges arise when cultural norms clash with Canadian policies, such as the separation of spouses in cases of domestic abuse. While difficult, these cultural adjustments underscore the importance of upholding Canadian laws and norms, even when they conflict with traditional practices. As a focus group participant remarked:

> Settlement counsellors provide much information about Canadian rules to the newcomers, which is very useful. However, sometimes settlement counsellor become aware of situations like domestic violence and, as usually they are Afghan (the settlement counsellor), they tend to oversee those situations, although, we have seen occasions

> where IRCC has been involved and took hands on the issue. (Focus group participant 5, as interpreted by Cristian Neves)

Despite these challenges, Afghan refugee women generally perceive Canada as a welcoming and equal society. They appreciate the absence of discrimination in accessing healthcare and other services, emphasizing that everyone receives equal treatment regardless of background. Regarding this, Amina highlighted:

> Everything is very equal here. Like, I never felt like I'm a newcomer to Canada or maybe I'm a like a refugee here. So I whenever I visited any doctor or any clinic, and never felt those kinds of racism or anything like that, so they were always very kind and very normal like they were all equal, like all people are the same. (Amina, as interpreted by Margaret)

However, isolated incidents of discrimination or harassment, such as the physical assault experienced by one participant, serve as stark reminders of the need for continued efforts to promote inclusivity and safety for all residents. As articulated by Masuada:

> I never felt discriminated or anything like that. But other than a very bad experience happened to me like last week. I was going to Superstore and a guy came. He just pushed me; He just pushed me, and he threw me on the floor is in front of the Superstore. I stand and I say What are you doing? Is that why you have a hijab on you? I said, it's not your problem. I've been doing this for two years. And nobody asked me that. Everybody's free here. Like it's like a very free country for everyone. That's why I love Canada. But he wanted like he wanted to assault me. And I said directly call 911 I say that, but he ran away. So that was a very scary experience for me. And a very bad experience because I got some scratches on my head as well. In my in my forehead. And after I was so scared

> when even when I came home, my whole body was shaking. That was a very bad experience for me. (Masuada)

Living in Canada also brings about practical conveniences that enhance daily life for Afghan refugee women. Access to modern amenities like laundry machines reduces the burden of household chores, allowing them to focus on other aspects of settlement. Moreover, the overall sense of peace and security in their neighborhoods contributes to their well-being and integration into Canadian society. As Amina shared:

> She says that she likes about Canada that she feels safe here, where she lives right now. There's peace and security. So she feels good. And, there's a lot of like, easier things. For example, you do things by machine, you do laundry and machine. I don't have to do a lot of things by work. So it's less work and it's easier. (Amina, as interpreted by Margaret)

Family and Friends

The experiences of Afghan refugee women in Canada are deeply intertwined with the support they receive from family and friends, both within and outside their immediate circles.

Upon arrival in Canada, the dynamics of family relationships undergo significant shifts. Some focus group participants noted instances where couples who arrived together eventually separate, speculating whether the newfound freedom in Canada contributes to this phenomenon. However, despite potential challenges, familial bonds remain strong for many Afghan refugee women. Regular gatherings for tea or dinner provide opportunities for connection and support, fostering a sense of belonging and solidarity within the family unit. When asked about her family life, Masuada recalled:

> Yes. Every night, we have like, a coffee time. Or I can say a teatime together. My brother and I work, so after that we all come home, like most of the times, we sit together with

> our parents and we make a tea, or sometimes we make dinner together. So yes, like on regular, everyday basis to meet each other. (Masuada)

Outside of familial relationships, forming friendships within the Afghan community and in the workplace becomes essential for social integration. These connections offer emotional support and practical assistance in navigating life in a new country. Moreover, these networks alleviate feelings of isolation and provide a sense of community and camaraderie, helping Afghan refugee women feel more at home in Canada. For example, Amina stated:

> I am a very social person, and I usually connect with the Afghan community here. I haven't been able to participate as much now, because of my surgery, but I'm usually busy visiting friends or meeting other people from the community. (Amina, as interpreted by Margaret)

Financial responsibilities often shift significantly for Afghan refugee women upon resettlement. For one participant, financial obligations were typically managed by other family members in Afghanistan, but in Canada, these responsibilities often fall on their shoulders. This adjustment can be daunting. Women in this study grapple with feelings of depression, anxiety, and overwhelming responsibility as they navigate the complexities of their new lives. The weight of caregiving falls heavily on their shoulders, as they find themselves thrust into roles of financial support and advocacy for their families. Balancing work, appointments, paperwork, and housing arrangements becomes a monumental task, exacerbating feelings of stress and hopelessness.

> But all those responsibilities are now like, they all came to me because I must attend appointments for my parents. Financially, I am responsible now, like I must work if I don't work, of course, I cannot afford it. I must support my family financially. And also,

> like for the official paperwork, I have to run everywhere I need, I have to go to different places for that. And also for housing. I'm thinking that I have to start searching for another apartment because it has stairs, and my mom is disabled on wheelchair. So stairs are not safe for her. So all these responsibilities have increased for me. (Masuada)

The contrast between family dynamics in Afghanistan and Canada is stark, with some participants highlighting the significant reduction in family size upon resettlement. Adjusting to smaller family units can be challenging, particularly for those accustomed to large, extended families. However, the resilience of Afghan refugee women shines through as they navigate these changes, drawing strength from the support of their loved ones. As Amina expressed:

> We used to have like 11 to 12 members of family in my family back in Afghanistan. Here we were three only and that makes me sad. Yeah, I just go by with it. My family and even my kids, they also keep telling me that I shouldn't be stressing out because I'm already sick, especially after the surgery. That helps a little. (Amina, as interpreted by Margaret)

Despite the participants facing health challenges and some undergoing surgeries, thy shared how they draw strength from their families and friends who provide encouragement and reassurance during difficult times. The emotional support they receive from their loved ones is invaluable in helping them cope with health issues and adapt to their new lives in Canada.

Identity Changes

The experiences of Afghan refugee women living in Canada reveal profound transformations in their identities and sense of self, influenced by their new environment, roles, and aspirations.

For two participants, the primary motivation for their endeavors is their children. They express a deep sense of purpose and responsibility, emphasizing that their actions and decisions

are driven by a desire to provide a better life for their children. Regarding this, Hasina expressed: "(...) she says that whatever I'm doing is because my kids, so I living I'm living for them, right." (Hasina, as interpreted by Simone)

Upon resettlement in Canada, these women experienced significant personal changes. They perceive themselves as different individuals from who they were back home in Afghanistan. The newfound sense of freedom and security empowers them to explore opportunities and assert their independence. They relish the freedom to choose where to work and engage in various activities without limitations, fostering a sense of agency and self-determination. As Masuada reflected:

> (...) here I feel like I'm a very different person from back home. Like I feel that that was another Masuada and this is someone else. I'm totally changed here according to my emotions, according to my character according to everything. Like, I feel like I become very like an old lady here. I think it has to do with all the responsibilities I have here, and the financial burden I'm take care of. However, I know that there is a bright future ahead. It is up to me now to pursue a better future. (Masuada)

Despite the challenges they encounter, such as health issues requiring surgery, two participants remain steadfast in their pursuit of personal and professional growth. They aspire to pursue further education and career advancement, reflecting their resilience and determination to build stable and fulfilling lives for themselves and their families in Canada. In this line, Masuada expressed:

> (...) for future like I'm thinking to, to start my studies back. And I want to go to a specific field here to study that one. And I want to work in a specific field, like a full time and to make my life like, I know, it would never be tension free life is never tension free. But at

> least like if I can make it like more stable for myself and my family, like financially if I became more stable. (Masuada)

While adapting to life in Canada, Afghan refugee women grapple with changes in their health and well-being. Some reminisce about their healthier days in Afghanistan, where community support and familiar surroundings contributed to their well-being. However, despite challenges they find solace in the peace and security of their current living environment, expressing gratitude for the accessibility of amenities and services that contribute to their overall sense of happiness and security. According to Amina's testimony:

> Yes, I mean, I was I was much better. I was healthier when I was in Afghanistan. I used to suffer from during winter more than summer, but in summer, I would get better because I was visited by my friends and neighbours. Here, I also like to go out but because of my surgery right now I can't do as much. Even in Norquest, where I'm studying English, I like to engage with other students, but now because of my symptoms, I'm not really finding it. I'm not feeling well enough to go now. The good thing about being here is that I feel safe here, where I live. There's peace and security. So I feel good. (Amina, as interpreted by Margaret)

In summary, the identity changes experienced by Afghan refugee women in Canada are multifaceted, encompassing shifts in roles, aspirations, and perceptions of self. Their narratives reflect resilience, determination, and a deep commitment to shaping their destinies and building fulfilling lives in Canada.

Healthcare Experiences in Canada

The fourth theme, *healthcare experiences in Canada*, describes participants' lived experiences while receiving healthcare services in Canada as refugees. These lived experiences

were approached through nine subthemes: *positive experiences with healthcare*, *communication with healthcare providers and trust*, *the importance of medication*, *community and health*, *mental health support*, *problems with healthcare services and barriers for engaging Afghan refugee women in healthcare*, and *recommendations of service provision*.

Positive experiences with healthcare

The accounts of Afghan refugee women living in Canada highlight several positive experiences with healthcare services, underscoring the quality of care and accessibility they have encountered.

One woman recounts her initial visit to the NCHC with satisfaction, describing a seamless process from consultation to receiving necessary tests and medications. This positive encounter influenced her subsequent interactions with healthcare providers, establishing a sense of trust and confidence in the Canadian healthcare system. As stated by Masuada:

> Yeah, it was a good experience for the first time I visited the clinic. I could briefly talk to my doctor after that I got some blood works and some X rays for my further appointments. So I did those. And after that, I went back to the doctor, and I had all my reports, and I needed some iron medications. So overall, it was good. (Masuada)

Another participant emphasized the efficiency and effectiveness of healthcare in Canada compared to her experiences back home in Afghanistan. She recalls a previous medical issue that remained unresolved due to limited access to appropriate care and medical advice. However, upon immigrating to Canada, she received prompt attention from healthcare professionals who addressed her concerns and provided necessary checkups, alleviating her uncertainties and ensuring her well-being. In her words:

> I had a problem back home. But I was never able to share that with a doctor. And once when I shared that to the doctor, they told me that that time, I was like around 24, 25 [years old], they say that you have to wait until you turn 30. And after that you can do those tests. So it was an issue for me, but I really didn't know what the problem was, really. But when I arrived here, I wasn't 30 years old. But as I met the doctor, the doctor gave me the checkups. I did the checkups, and everything was like normal. So those all those things were like, not very clear for me back home. But I got aware of all those kinds of things and issues here. I felt relieved. (Masuada)

Moreover, the women in this study expressed appreciation for the equality and inclusivity embedded within the Canadian healthcare system. They noted the absence of discrimination or differential treatment based on their refugee status, ethnicity, or background, highlighting the respectful and compassionate approach of healthcare providers in Canada. As conveyed by Amina:

> Yeah, she recalls the time when they took her to the x rays, she was very happy with it. She says she didn't feel like a stranger. The staff was very kind to her, and constantly ask her if she was comfortable and OK. According to her, it was a great experience. (Amina, as interpreted by Margaret)

Focus group participants highlighted that pregnant woman, in particular, receive specialized care and attention, reflecting the comprehensive nature of healthcare services tailored to meet specific needs and ensure optimal maternal and fetal health. This specialized care contributes to a sense of security and reassurance among expectant mothers, fostering positive healthcare experiences and outcomes. As a focus group participant highlighted:

> Pregnant Afghan women, who often lack adequate care in Afghanistan, receive thorough treatment here in Canada. Additionally, upon detection of pregnancy, these women are promptly referred to an obstetrician, typically a female practitioner. Furthermore, men tend to allow women to attend these appointments alone, which benefits the women as they have the opportunity to ask questions and gain more knowledge about their pregnancy. (Focus group participant 6, as interpreted by Cristian Neves)

Furthermore, according to focus groups participants, the accessibility of healthcare services is underscored by the convenience of proximity to medical facilities, allowing individuals to access care easily without the need for extensive travel or transportation arrangements. This accessibility is particularly beneficial for individuals with mobility limitations, such as those with disabilities or chronic health conditions, who rely on consistent access to medications and medical support. In regard to this, Hasina recalled:

> As much as I know most of the times the health services like the doctors, they're trying to find the closest areas to people's houses so that they don't need to take the buses, or they don't need to drive. They can even walk to the healthcare facilities (Hasina, as interpreted by Simone)

Overall, the positive experiences with healthcare services reported by Afghan refugee women in Canada highlight the overall effectiveness, inclusivity, and responsiveness of the Canadian healthcare system.

Communication and Trust with Healthcare Providers

The communication dynamics between Afghan refugee women and healthcare providers in both Afghanistan and Canada vary significantly, shaping their healthcare experiences and perceptions.

In Afghanistan, the participants recall challenges in communication with healthcare providers, primarily due to cultural norms and gender dynamics. The focus group participants shared that in Canada, there is a notable reliance on male family members to communicate health concerns, leading to potential miscommunication or discomfort for the women. However, there is also a recognition of gradual changes, with women becoming more open and comfortable over time as they interact with familiar faces within the healthcare system. The transformation from initial fear and apprehension to a more relaxed demeanor reflects the impact of consistent support and understanding from healthcare professionals. As a focus group participant recalled:

> Many times one looks at her [the Afghan woman], we tend to look at the woman and ask her, not through the husband, and many times the husband answers, and we look back, and the husband answers, and it's difficult to have an approach like that, because I can't tell the man, “Can you be quiet, sir?" [group laughs]. We would tell the women to be calm, that we were only women, and we respected their privacy. But let's say that here, the nice experience with the people is that those people we've seen arrive with too much fear and too much terror, over time they, seeing the same people always, and knowing that we are here to help and collaborate with them, they start to relax. (Focus group participant 6, as translated by Cristian Neves)

Conversely, the experiences of Afghan refugee women in Canada highlight positive shifts in communication dynamics within healthcare settings. Confidentiality and privacy are emphasized, by participants in this study, which provides them with a safe space to express their health concerns without fear of judgment or disclosure. The availability of female healthcare providers and the assurance of confidentiality contribute to a sense of comfort and empowerment

among the women, enabling them to openly discuss sensitive topics such as mental health issues or gynecological concerns. As conveyed by Masuada:

> Once I visited the doctor. And as I went there, the doctor just could recognize like, I was I was trying to hide something from him. And the doctor told me that I had to be very confident about everything. And that I can share everything. So the thing I had was like it was a kind of depression. I had an I didn't want to share that one. But the doctor asked me to share whatever it is because everything was confidential. And I was like, very, I was feeling very, very like good after sharing all those things, the depressions, the trauma I had, and it was like, it was very good experience for me. (Masuada)

Overall, as reflected by the participants in this study, the healthcare system in Canada is perceived as more patient-centered, with healthcare providers demonstrating attentiveness and empathy towards the women's needs and preferences. The emphasis on building trust and rapport fosters a sense of security and confidence in the healthcare process. Women in this study appreciate the opportunity to share their health concerns openly and receive comprehensive care tailored to their individual needs. Concerning this, a focus group participant added:

> (...) mostly what they do is like, they ask the women that, if you are comfortable, you can come inside. And most of the times their husbands don't even want to sit with a female doctor with their wives. So they can get a good chance, like, especially for the first time, if they have any kind of concerns, they can share those with the doctor. So that would be a good thing. (Focus group participant 2)

Moreover, according to focus group participants, the provision of interpretation services and cultural sensitivity training further enhances communication and understanding between healthcare providers and Afghan refugee women. Access to interpreters ensures that language

barriers do not hinder effective communication, allowing women to articulate their health concerns accurately and access appropriate care. This allowed some of the participants in this study to communicate with healthcare providers. In the words of Amina:

> Healthcare is good here; the doctors are really nice kind here. And they give enough time for everyone they with it. [And what happens if your daughter cannot go with you to translate, or if the doctor is saying something that you don't understand?] Yeah, if something like that happens, they usually get me a translator or interpreter. (Amina, as interpreted by Margaret)

Trust is critically important in how Afghan refugee experience healthcare and communicate with the healthcare providers. Across the narratives, trust is depicted as a multifaceted construct influenced by factors such as continuity of care, confidentiality, cultural competence, and perceived competence of healthcare professionals.

In Afghanistan, trust is portrayed as precarious and contingent on various factors. Participants express concerns about the lack of continuity in healthcare encounters, with frequent turnover leading to uncertainty and hesitancy in sharing personal health concerns. Additionally, there is a perception of low confidentiality, where the risk of information disclosure to others undermines the trust relationship between patients and healthcare providers. This lack of confidence in the confidentiality of medical information restricts the depth of communication and inhibits patients from disclosing sensitive health issues.

Conversely, in Canada, the narratives highlight positive experiences that contribute to the development of trust between Afghan refugee women and healthcare providers. Participants emphasize the importance of healthcare professionals providing sufficient time and attention during consultations, allowing them to express their health concerns openly and

comprehensively. This attentiveness and respect for patient autonomy foster a sense of trust and partnership in decision-making, enhancing the overall healthcare experience. Masuada fondly recalled:

> Yeah, actually, whenever I visited any doctor, or nurses, they always give enough time for us to explain whatever we want to share. We share everything, especially I'm the only one with my mom, always I take her to the doctors because she doesn't speak English. So I'm always with her. So whenever I take her to the doctor, I have the consent of her everything. So I'm always with her. And so whatever we bring to the consult, the doctor gives us enough time to speak about, or all the concerns that my mom has. They gave us enough time. They're kind, and they give us all the tests that need to be done. So those are the things that make us like, like optimist about the health services here. (Masuada)

Moreover, trust is bolstered by positive outcomes and perceived competence in medical care. Participants cite examples where their trust in healthcare providers is reinforced by successful treatment outcomes, such as effective management of chronic conditions like diabetes or responsive and personalized care for ongoing health issues. These positive experiences contribute to a sense of confidence and reliance on healthcare professionals, solidifying the trust relationship over time. Amina highlighted:

> The doctor would give me medication that was beneficial. So that was the reason we used to go back. We trust them. For example, my diabetes has been in control since I've been going to the doctor. So that's what makes us trust them. (Amina, as interpreted by Margaret)

Furthermore, trust is also influenced by external factors such as institutional reputation and peer recommendations. Participants recount instances where they sought medical care from

reputable clinics or hospitals, often based on recommendations from trusted sources within their community. The association of trust with reputable healthcare institutions underscores the importance of institutional credibility in shaping patient perceptions and healthcare-seeking behaviors.

> I had a kind of like, I cannot say that was a sickness, but I got a problem with my periods. Like I had them for two years, and they will not stop. So I went to doctors in Kabul, and they told me that I have no problem. And that I was totally fine, my hormones, and everything, they told me it was normal. I couldn't trust them, say, because I thought that there might be something causing my period not stopping. So somebody recommended me a doctor in Pakistan, so I went there, I did several tests, I went back to the doctor, and I got the same report, as I got from Kabul. They gave me the same report the same medicines, then I said, oh, well, then I should trust the doctors back home, too. So after that, I trusted them. (Masuada)

Overall, the narratives underscore the significance of communication and trust in shaping the healthcare experiences of Afghan refugee women in Canada. While trust may be fragile and context-dependent, it plays a pivotal role in facilitating effective communication, promoting patient engagement, and ultimately, improving health outcomes. As such, and according to the participants in this study, fostering trust in healthcare settings requires attention to factors such as continuity of care, confidentiality, cultural safety, and perceived competence of healthcare professionals, all of which are essential for building and maintaining trustful relationships between patients and providers.

The Importance of Medication

The importance of medication in the healthcare experiences of Afghan refugee women in Canada emerges as a significant topic, reflecting both positive and challenging aspects of medication access and efficacy.

For many participants, the availability and effectiveness of medications in Canada represent a notable improvement compared to their experiences in Afghanistan. One participant highlights the efficiency of medication provision at the New Canadians Health Centre, although noting a delay in receiving medications due to biopsy-related issues. Despite this delay, the participant's expectation and trust in accessing necessary medications illustrate the importance placed on medication for managing health conditions. As conveyed by Hasina:

> She said that she visited the New Canadians Health Centre for the medications, but she hasn't received it yet. So she's waiting because she had some problem with a biopsy. She says she is happy with the service, and she trust that she will receive the help she needs, but it is taking a lot more time that she expected to access the medication. (Hasina, as interpreted by Simone)

Another participant echoes this sentiment, expressing satisfaction with the quality and efficacy of medications in Canada compared to those in Afghanistan. They emphasize the shorter duration of medication regimens in Canada, contrasting with the prolonged courses often experienced back home. This observation underscores the perceived effectiveness of medications in Canada and their contribution to improved health outcomes. Amina added:

> The services are good here and the medication is better than back home. Here, you just need to take medications for three months, not four years as we had to take back home. So the medications are working better here. (Amina, as interpreted by Margaret)

Furthermore, participants emphasize the role of healthcare providers in facilitating access to beneficial medications. One participant mentions a doctor who provides beneficial medication, reinforcing the trust and confidence placed in healthcare professionals to prescribe suitable treatments. This highlights the importance of patient-provider relationships in medication management and the perceived impact of healthcare providers in enhancing medication efficacy and overall health outcomes. Regarding this, Amina expressed:

> She is taking painkillers for her backpain, and she also has diabetes, and she's taking medication for that as well. The doctor would give him medication that was beneficial. So that is the reason she goes back to that doctor. (Amina, as interpreted by Margaret)

Overall, the narratives reflect the multifaceted nature of medication experiences among Afghan refugee women in Canada, ranging from satisfaction with the availability and effectiveness of medications to challenges encountered in accessing suitable treatments. These narratives underscore the importance of medication in managing health conditions and highlight the role of healthcare providers in facilitating access to beneficial medications to support the health and well-being of Afghan refugee women and building trust in the healthcare providers and system.

Community and Health

The subtheme of *Community and Health* illuminates the vital role of community support in navigating healthcare systems, maintaining mental well-being, and fostering a sense of belonging in a new environment.

Participants emphasize the importance of community networks in facilitating access to healthcare services. They highlight how fellow Afghan women support each other by sharing experiences, offering advice, and encouraging one another to seek medical attention, particularly

from female doctors. This solidarity within the community enables individuals to overcome cultural barriers and access healthcare services with greater confidence and ease. As Hasina stated:

> So she says, from my experience, women can help each other. For example, she mentioned a friend who didn't want to go to the doctor because she preferred seeing a female doctor or didn't want to share everything. I encouraged her and told her she needed to take care of herself. So, in this way, all women should communicate with each other and be active in this aspect. (Hasina, as interpreted by Simone)

Moreover, participants underscore the instrumental role of established Afghan communities in Canada in assisting newcomers in navigating the healthcare landscape. They describe how these communities serve as valuable resources, connecting newcomers with healthcare providers, facilitating access to essential services, and offering practical support in adjusting to life in Canada. Through community organizations and social groups, newcomers receive guidance on accessing healthcare, engage in recreational activities, and forge meaningful connections with others, thereby enhancing their overall well-being. Masuada added:

> From my own experience, when we arrived here, our first encounter was with our own community, the Afghan community. They helped us connect with various groups, such as women's groups and larger community organizations. They also introduced us to different parts of Canada, including the city of Edmonton. Additionally, they facilitated connections with people who had been living here for many years. Also, certain agencies provided similar support to newcomers, organizing groups for women, individuals, and activities like hiking, visiting parks, attending parties, and cooking. So, overall, it's been a very positive experience for newcomers here. (Masuada)

Additionally, participants reflect on the impact of social support on mental health. They reminisce about the strong bonds and social activities they enjoyed in Afghanistan, which contributed to their emotional resilience and happiness. However, upon resettlement in Canada, some participants experience feelings of isolation and depression despite the newfound security and stability. They attribute these mental health challenges to the absence of familiar social networks and the disruption of their previous social routines. Nevertheless, participants express optimism about reconnecting with loved ones and maintaining ties with their community, which they believe will alleviate feelings of loneliness and contribute to their mental well-being. As fondly recalled by Amina:

> I was so happy with my relatives and neighbors because they would come visit me and they would pray for me, and they would just go to their place, and they would come to ours. It was a nice connection and networking. We I also had a lot of friends where I would go on walks with them, go out on walks and socialize. (Amina, as interpreted by Margaret)

In regard to this, Masuada added:

> I have a very high hope for my fiancé, if he comes, I'm sure my life will be totally changed because he's a person who can stand for me who can stand with me. Even from now he's like, always, I can feel like what the words he says or the conversation we have is like giving me a kind of hope that at least when he comes here, I will be a bit like 50% of my depressions or my tensions will go away from me, because I will have someone that I can rely on. (Masuada)

Overall, the narratives highlight the interconnectedness between community bonds, healthcare access, and mental health outcomes among Afghan refugee women in Canada. By

leveraging community resources, fostering social connections, and advocating for culturally safe healthcare services, Afghan women navigate the complexities of the healthcare system and cultivate a supportive environment conducive to their overall health and well-being.

Mental Health Support

The subtheme *mental health support* highlights Afghan refugee women's experiences of seeking and receiving support for mental well-being in Canada. Participants noted a significant improvement in their mental health compared to their experiences in Afghanistan. They describe engaging in counseling sessions and therapy provided by organizations like Catholic Social Services, highlighting the positive impact of these interventions on their overall well-being. Despite facing challenges such as language barriers and cultural differences, participants expressed gratitude for the availability of mental health resources in Canada and acknowledge the role of these services in their healing process. Hasina shared:

> She was taking some sessions like in Catholic Social Services with the counselor. So she says that whatever she told her to do, she did those things. And that kind of care is very good here. Here, she is improving because the situation in Afghanistan left her in a really bad shape mentally, so of course, things will improve here. (Hasina, as interpreted by Simone)

However, participants also express a desire for healthcare professionals to be more proactive in recognizing and addressing their mental health needs. They describe a sense of disappointment with the lack of attention given to their emotional well-being by healthcare professionals upon arrival in Canada. Despite their willingness to share their feelings and experiences, participants note that healthcare providers often fail to acknowledge or respond to their mental health concerns adequately. As conveyed by Masuada and Amina:

> I just thought that maybe because from my past experience, we would never share all those things with physicians back home, because that was not the right person to share those things with the physicians there. So that was the experience I had from back home that maybe this is not the right person to share all these things, but after visiting the doctor here, in Canada, after talking to him, then I felt good. And now I'm feeling like much better now. I am glad I talked about those things. (Masuada)
>
> When I used to tell the doctor about mental health problems, even if I did, they wouldn't really react much. They wouldn't really care much, because they would say that everybody in Afghanistan is suffering from this, like "it's a war and what do you expect?" Like this is normal. They wouldn't care that much. Here, I'm able to talk to my doctor about this, and he gives me advice. (Amina, as interpreted by Margaret)

Furthermore, participants acknowledged the complex interplay between social support, family dynamics, and mental health. Some expressed feelings of isolation and depression stemming from separation from family members and the challenges of adjusting to life in a new country. They highlighted the importance of having supportive relationships and express hope for the future, particularly in the context of anticipated reunions with loved ones. In words of Masuada:

> (...) Actually, for now, I'm sure that nobody can help me because it's myself. My father is 70 plus, and he has a language barriers so he's not able to do anything like that. My sister she's engaged, so she's living her life. My Mom is disabled so, I'm the one, Yeah, I will... I have a very high hope for my fiancé, if he comes, I'm sure my life will be totally changed because he's a person who can stand for me who can stand with me. (Masuada)

Overall, the narratives underscore the importance of culturally sensitive mental health support services and the need for healthcare professionals to recognize and respond effectively to the mental health needs of Afghan refugee women. For example, disclosing mental health concerns to healthcare professionals is not common among Afghan women. As discussed previously, past unsuccessful experiences with healthcare providers and the perception that mental health concerns should be dealt with alone pose barriers to addressing such issues. As Hasina recalled, regarding this:

> Yeah, because she says that, like, sometimes people when they're facing any kind of depression or stress, if doctors noticed that at the beginning, so of course, they would give them advice, or maybe they will advise them, and they can face those challenges. And they can maybe, like they can stand for those challenges. But if they don't say anything, or if they don't share with the doctors, so that will get worse and worse day by day. Sadly, this is very common for Afghans, especially for women. (Hasina as interpreted by Simone)

Barriers to Engaging Afghan Women in Healthcare

The subtheme *barriers to engaging Afghan women in healthcare* highlights various challenges and frustrations encountered while navigating the Canadian healthcare system.

Participants express dissatisfaction with the lengthy wait times for appointments, describing delays ranging from weeks to months. This prolonged wait for medical attention is particularly distressing for those with urgent health concerns or disabilities, such as vision problems or mobility issues, exacerbating their conditions and causing additional stress and discomfort. As Hasina recalled:

> So, she says that about the NCHC that, whenever she visited, she says that she didn't have a good experience from the clinic. Because she had to wait long days. Like wait for many, couple of weeks, sometimes months. The other thing like about her daughter is she says that she has vision problems. She had eight surgeries in Turkey. But here they are still waiting, like it has been five months already. They are waiting for the doctor to check her eyes, but still we didn't hear anything from them. (Hasina, as interpreted by Simone)

The same participant recounted instances where appointments are rescheduled last minute or canceled without prior notice, further prolonging their wait and causing frustration.

> I have experience of this that many times when they call me for the appointment, when I arrived there, they asked that we have to reschedule you, because the doctor is not here, or the doctor is sick or something like this, then she says that I have to wait again for another month, or maybe for a couple of weeks. (Hasina, as interpreted by Simone)

Moreover, this situation underscored lack of awareness and care for the patient's individual characteristics and healthcare needs, as Hasina noted,

> She says that, like I have experienced this many times, her daughter, she's not able to walk along the way. So she cannot walk like more than five minutes. She said that I went to the clinic many times. And as I got there, they told me that the doctor is not here, you have to come again. And she said that if this is happening, they should give me a call. Or maybe they can text me that same day that you don't need to come to your appointment, we will reschedule this appointment. So she says that when I go there, then they tell me that the doctor is not here. So she says that this happened to me like many times, and it was a bad experience for me because of my daughter. (Hasina, as interpreted by Simone)

Furthermore, participants express concerns about the fragmentation of healthcare services, noting the inconvenience of having to visit multiple locations for different aspects of their care, such as consultations, tests, and medication pickups. This disjointed approach contrasts with their experiences in Afghanistan, where healthcare services were often centralized, allowing for more streamlined and efficient care delivery.

> We used to access all healthcare services in one campus [in Afghanistan], we would see the doctor in one place, we would get the test the medication, everything, everything was like in one space. But here [in Canada] most of the people complain that we need to go to like to Dyna life for one thing, and then we have to do the X rays in another place, and then we need to get the medications in another place, and then we should see the doctor in another place. So these are a common concern in our community. (Amina, as interpreted by Margaret)

Financial barriers also pose significant challenges for Afghan refugee women accessing healthcare in Canada. Participants in this study recount instances where they faced exorbitant costs for medical procedures and treatments, causing financial strain and hardship, particularly for those with limited income and no access to health insurance. The inability to afford necessary healthcare services adds an additional layer of stress and worry for participants, further complicating their healthcare experiences. As stressed by Masuada:

> (...) And also, it's a bit expensive. Like for my mom, we did the surgery and I had to pay $1,300 for one eye, and $1,300 for the site. I paid almost $2,600 And they were not able to accept any kind of like health insurances in the clinic. So it was a very big challenge for me because as a newcomer, I don't work full time and just on casual. And my parents, they don't get enough money for the for their benefits. So it was very hard for me to

> manage that thing. And sometimes it's very expensive to like the dentist, the eyes. And these services are not free for the people. So it makes it a bit difficult for the people with low income here for the new arrivals here. (Masuada)

Language barriers emerge as another significant obstacle, with two participants struggling to communicate with healthcare providers due to limited English proficiency. The occasional absence of interpretation services in healthcare settings further exacerbates this challenge, hindering effective communication and understanding between patients and providers. This lack of linguistic support leaves many Afghan refugee women feeling marginalized and unable to fully access and engage with the healthcare system. Regarding this, Hasina said:

> I think most of the clinics don't have the language line. That makes difficult for the people, because most of the newcomers, even a single person doesn't speak English. And the agencies, they also cannot provide interpreters for them anytime they go to the doctors. So that's the thing that sometimes it makes it difficult for the patients. (Hasina, as interpreted by Simone)

Despite these challenges, some participants express gratitude for the quality of care received in Canada, particularly in terms of diagnostic accuracy and access to advanced medical technology. As Amina recalled:

> Yes, with my lungs, like the cysts that they found in Canada, no doctor was able to tell me what was wrong with me in Afghanistan. They couldn't find the cyst. But I found out about this in Canada, they told me what it was, what was causing my symptoms, like coughing and shortness of breath, so yes, here the system is good. (Amina, as interpreted by Margaret)

Furthermore, participants' narratives revealed a multitude of challenges faced by Afghan refugee women in Canada, hindering their ability to fully engage with and access healthcare services. These barriers stem from cultural norms, language barriers, gender dynamics within families, and personal preferences. For example, within Afghan households, there exists a prevalent patriarchal structure where men often hold decision-making power, particularly regarding healthcare matters. Women in these families tend to defer to their husbands for decision-making and often feel uncomfortable discussing health issues, especially in the presence of their spouses. The dominance of husbands in healthcare decision-making can result in women feeling silenced or overlooked during medical consultations, perpetuating a cycle where their health concerns go unaddressed. As conveyed by a focus group participant:

> Generally, it is the man who answers [the clinic intake questions], and we see that in other cultures as well, such as in Arab culture, and in others, but on this occasion, I saw it more pronounced [in the Afghan culture], and generally the woman is not sitting there, you have to call her, or maybe she is there, but she gets up and leave. Women don't get very involved when talking about their health, and it's very difficult for them to respond. The husband is always present, seen as a strong figure, so it's like everything goes through the husband, even the children. (Focus group participant 5, interpreted by Cristian Neves)

Moreover, the presence of husbands during medical appointments can create additional challenges, particularly when it comes to sensitive examinations or discussions. Afghan women may feel inhibited or embarrassed to discuss certain health issues in front of their husbands, leading to a lack of disclosure and potentially inadequate care. Masuada analyzed:

> So we have our medical survey with the newcomers, as they arrive here [in Canada] we have a medical survey with them, if they have any kind of health concerns, and I found most of the woman, they were not very comfortable to share their concerns, especially when they are with the family. (Masuada)

Additionally, cultural modesty norms may make it difficult for women to undergo certain medical procedures, especially in the presence of male healthcare providers or interpreters. As highlighted by a focus group participant:

> When I was working with them in the laboratory assistance area, it was a bit complicated for them because they are very modest, they don't like being watched, and in many cases, they had to undress for their samples and such to be taken. It's complicated because only the woman enters the laboratory, and the man stays alone with the children, and at first, the gentleman didn't like that, and the lady inside felt intimidated, like saying "let my husband come in" to see if he approves her uncovering herself and such. (Focus group participant 6, interpreted by Cristian Neves)

Language barriers mixed with emotions like fear and mistrust compound these challenges, further limiting Afghan refugee women's ability to communicate effectively with healthcare providers and access the care they need. This can exacerbate feelings of isolation and disempowerment among this population. As a focus group participant compelled:

> Language will always be a huge barrier for any client to navigate the system, of course, but so is the mental health concerns. In the beginning, when they have just arrived, I notice they are very afraid. There are clients who still think they can be sent back to their country, or that if they say something, something might happen to them. So, they remain very quiet. (Focus group participant 6, interpreted by Cristian Neves)

Furthermore, the responsibilities of childcare and household management often fall disproportionately on Afghan refugee women, leaving them with limited time and resources to prioritize their own health needs. As conveyed by a focus group participant:

> What I would also add is the number of children. They have many children. Many of those who arrive here have young children, so I think... many husbands come with a bit more English because they are connected through people who worked with Canada, in Afghanistan. Usually, the woman doesn't speak English and is in charge of many children. I don't know how that woman could study English because many have two, three, and four children at ages where they cannot enter school, and when they do enter at five years old, it's only for half a day. So, what does the woman do? I imagine the expectation is that the husband goes out and works. I believe this is one of the reasons why they struggle so much to integrate. (Focus group participant 7, as interpreted by me)

Despite these barriers, some Afghan refugee women express a desire to actively engage with healthcare services and prioritize their health. However, systemic and cultural factors often impede their ability to do so fully.

Recommendations to Facilitate Better Healthcare for Afghan Women

The subtheme *recommendations of healthcare provision* illuminate the perspectives of Afghan refugee women in Canada regarding improvements they believe could enhance the healthcare experience for themselves and others in their community. These recommendations touch upon various aspects of healthcare delivery, ranging from interpersonal interactions with healthcare providers to systemic changes within healthcare facilities.

One recurring recommendation was the importance of fostering a supportive and empathetic doctor-patient relationship. Afghan women emphasize the need for doctors to

demonstrate friendliness and approachability, as they believe that a warm demeanor encourages patients to share their health concerns more openly. They suggest that healthcare providers should strive to create a welcoming environment where patients feel comfortable expressing their needs and seeking guidance without fear of judgment. As conveyed by Hasina:

> So the first thing she wants to share is, she says that I believe that the doctor should be very friendly with their patients, because whenever somebody goes to the doctor ever, like, according to their behavior, if they're very friendly, they can share everything easily with them. (Hasina, as interpreted by Simone)

Furthermore, Participants in this study thought it was important that there is an increase in mental health support within healthcare settings. They highlight the prevalence of depression and trauma among newcomers and stress the importance of having psychiatrists or counselors available to address these mental health challenges. By integrating mental health services into primary care settings, Afghan women believe that patients experiencing psychological distress can receive timely support and intervention. Masuada added:

> I think by my point of view, I think that they must have like a psychiatrist there. So it might be easy for all those patients who are facing depressions because, from my own experience, people who arrive here newly, of course, they have some bad experiences back home, and maybe they have some family left there. So because of that, they have lots of depressions and lots of traumas. So I think, for the clinic, it's better to have a psychiatrist there. So the patients who have same situations, they can easily talk to the psychiatrist, or maybe they can get a good consultation from the psychiatrist. (Masuada)

In addition to mental health services, Afghan women emphasize the importance of comprehensive medical assessments tailored to their specific health needs. They recommend that

healthcare providers conduct thorough examinations and diagnostic tests to address any pre-existing health concerns carried over from their home country. As reflected by Masuada:

> The thing that they need to do here, there are like some specific testing that they really need to do here, because we didn't have those facilities back home. So all the woman who whoever comes here, I think they should talk to the doctor. And they can ask the doctor to give them all those checkups that they were concerned, like I had the concern back home. So like me, there are lots of girls and women who are concerned about some kind of issues that they cannot disclose her back home. So I think they can talk about those issues here with the doctor to get some checkups, and then they can do the ultrasounds or maybe the blood works, that might be very easy for them. (Masuada)

Moreover, Afghan refugee women recommend greater autonomy and privacy in their interactions with healthcare providers. They express discomfort with discussing sensitive health issues in the presence of family members, particularly husbands, and suggest that doctors allocate dedicated time for private consultations with female patients. By providing opportunities for women to speak candidly with their doctors without external influence, Afghan women believe that they can receive more personalized and effective care. Hasina explained:

> I think whenever they see a doctor, like what I experienced is, it's good. If they talk to the doctor personally, like without any family members, they will feel much better that way. Because I found most of the woman, especially the women who are married, they are not able to talk in front of their husband with the doctor very openly. And they have their husband must answer everything. (Hasina, as interpreted by Simone)

Lastly, Afghan refugee women propose practical solutions to address systemic challenges within healthcare facilities. They suggest increasing the number of healthcare professionals, such

as doctors and psychiatrists, to reduce waiting times and improve access to care. Additionally, they emphasize the importance of language accessibility in healthcare settings, advocating for the availability of language interpretation services to facilitate communication between patients and providers from diverse linguistic backgrounds.

> The only thing I can say is that back home, everything, including tests, was done very quickly. Here, the only thing I really don't like, as I mentioned before, is the waiting time. We have to wait for a long, long time for tests. Back home, if I went to the lab, I could ask them directly if I needed an X-ray. If I had fallen down or something, they would do the X-ray for me. But here, without a doctor's prescription or anything, it's good, but the waiting time is a bit longer. (Hasina, as interpreted by Simone)

Overall, the recommendations provided by Afghan refugee women underscore the importance of patient-centered care and the need for healthcare systems to adapt to the unique needs and preferences of culturally diverse populations. By incorporating these recommendations into healthcare policies and practices, healthcare providers can work towards delivering more equitable, inclusive, and effective care for Afghan refugee women and other marginalized communities.

Agency and Empowerment

The fifth and final theme, *agency and empowerment*, emerged as an attitude throughout the stories and narratives of these women, influencing their cognitive, emotional, and behavioural life both in Afghanistan and in Canada. Three subthemes highlight this aspect of the participants' lives: *women's agency and healthcare decision-making*, *strategies to cope with mental health issues*, and *advocacy*.

Women's Agency and Healthcare Decision-Making

The subtheme *women's agency and healthcare decision-making* sheds light on the evolving role of Afghan refugee women's agency and decision-making power in healthcare contexts. The narratives reveal a spectrum of experiences and perspectives, reflecting both traditional gender dynamics and shifting attitudes among different generations of Afghan women.

Across the narratives, there is a recognition of the traditionally dominant role of men in Afghan households, particularly in decision-making related to healthcare. Women describe observing a pattern where husbands often accompany their wives to medical appointments and are perceived as the primary decision-makers regarding their family's health. This observation aligns with broader cultural norms where women may defer to their husbands or male relatives for guidance on healthcare matters. As reflected by a focus group participant:

> The new generations have more say in the decision to have children because they know it will hinder their progress. So, what we've noticed is that young girls who already have children, at most, want to have two and no more. They come with a different mentality, not as dominated by their husbands, but rather with their own mindset. They already know what they want and where they're going. The new generations, because the older generations are much more traditional. (What do they mean by younger generations?) Women aged 18 to 20. But when they are ladies of 30 or more years, they come more dominated by their husbands. And besides, they already have a bunch of children. (Focus group participant 6, as interpreted by me)

However, amidst these traditional dynamics, there are glimpses of women exercising agency and taking proactive roles in managing their own and their family's healthcare needs. Some women recount instances where they independently sought medical care, shared their

health concerns with doctors, and advocated for necessary tests and treatments. These accounts illustrate a growing sense of empowerment and assertiveness among Afghan women, challenging conventional gender roles and asserting their right to make informed decisions about their health. Regarding this, Amina remarked that:

> If I had some health concerns, or whenever I feel like it, I sought medical help and shared everything with the doctors. I talked to the doctor. I know some women need permission from their husbands to do that, but not in my case. (Hasina, as interpreted by Simone)

Moreover, the narratives highlight the pivotal role that certain women play as caregivers and health advocates within their families. Despite facing barriers such as lack of education or language proficiency, these women take on significant responsibilities, including accompanying family members to medical appointments, managing medications, and facilitating communication with healthcare providers. Their stories underscore the resilience and resourcefulness of Afghan women in navigating complex healthcare systems and advocating for the well-being of their loved ones. As conveyed by Amina:

> She mentioned that she used to be the one to decide to take the kids to the doctor, and she was the one who actually did it because her husband had a very busy job and was frequently away from home. Despite not having any formal education, the doctors were very pleased with the care she provided for her children back in Afghanistan. (Amina, as interpreted by Margaret)

Overall, the narratives share a nuanced picture of Afghan refugee women's experiences with healthcare decision-making in Canada. While traditional gender roles and patriarchal norms continue to influence healthcare dynamics, there are signs of progress towards greater female agency, empowerment, and active participation in healthcare decision-making processes.

Strategies to Cope with Mental Health Concerns

The narratives within the subtheme *strategies to cope with mental health concerns* offer insights into the various coping mechanisms employed by Afghan refugee women to manage their mental well-being. These strategies encompass a range of activities aimed at alleviating symptoms of depression, stress, and sadness, reflecting the resilience and resourcefulness of these women in navigating challenging circumstances.

One prevalent coping strategy highlighted in the narratives is engaging in physical activities, particularly walking. Participants describe how going for walks serves as a therapeutic outlet, allowing them to temporarily escape from their worries and immerse themselves in the present moment. Walking not only provides a form of exercise but also offers a sense of peace and tranquility, enabling participants to clear their minds and gain perspective on their mental health challenges. Through this simple yet effective activity, individuals find solace and relief from the burdens of depression and stress. As recalled by Hasina:

> Like whenever I'm depressed, or whenever I have depression, so I go for a walk. And whenever I'm going for that it helps me to keep my depression or my problems or thinking I have to keep them like very low. And sometimes I even forget about all those problems by walking. (Hasina, as interpreted by Simone)

Additionally, socialization emerged as another essential coping mechanism among Afghan women. As articulated by Masuada:

> Most of my friends are people I've grown up with since my nursery school days, when I was only six or five years old. I still have those friendships. Whenever I feel down or sad, I naturally turn to my friends to talk about what's going on. When I do talk to them, I feel happy and uplifted. This has a positive impact on my health because I'm a sensitive

> person. While most things don't bother me, sometimes small issues upset me. When I'm upset, I tell myself that I need to talk to my friends, so I call or message them. This brings a sense of healing for me. (Masuada)

Participants reminisce about the social bonds and communal activities they enjoyed in Afghanistan, such as spending time with friends, engaging in farming practices, and caring for animals. These social connections served as sources of emotional support and companionship, buffering against feelings of loneliness and isolation. By fostering social interactions and maintaining connections with others, participants find comfort and solidarity in their shared experiences, strengthening their resilience in the face of adversity. In regard to this, Amina said:

> She mentioned that she would just think about herself, "what should I do?" And she would, for example, go make a cup of tea. That helped her to settle down. When she felt sad that said she would go with her friends and socialize, she would go on walks with them and such. It was her way of getting mental problems away from her. And she mentioned that she had her land, where they had farming practices that she misses because that was good too. The chicken farming and keeping cows and stuff kept her busy. (Amina, as interpreted by Margaret)

Furthermore, the narratives underscore the importance of familial support in coping with mental health concerns. Participants describe how their families, including spouses and children, play a pivotal role in providing encouragement, reassurance, and practical assistance during times of distress. Family members offer words of encouragement, remind individuals to prioritize self-care, and actively intervene to alleviate stressors in their lives. This familial support network serves as a crucial source of emotional and practical support, empowering individuals to navigate their mental health challenges with greater resilience and optimism. As

conveyed by Amina: “Also, my family is very supportive. Especially my children, who are always with me, visiting me, and telling me not to stress out. That helps too.” (Amina, as interpreted by Margaret)

Advocacy

The subtheme *advocacy* emerged from the narratives of Afghan refugee women and focus group participants, reflecting their commitment to empowering and supporting others within their community, both in Canada and back in Afghanistan. These women demonstrate a profound sense of agency and responsibility, utilizing their knowledge, skills, and resources to advocate for the well-being and empowerment of fellow women.

One participant shares her ongoing commitment to supporting newcomer women in Canada, many of whom lack access to education and basic knowledge about daily life. She describes how she dedicates her time to educating and assisting these women, whether it's through informal teaching sessions or practical guidance on navigating unfamiliar environments. From accompanying them to stores to demonstrate how to use different products to offering mentorship and support, she exemplifies the spirit of advocacy and solidarity within the refugee community. Regarding this, Masuada added:

> Oh, yes, here, actually, because with the newcomers, the people who have recently arrived, most of the women I see haven't ever attended school, and many of them lack basic knowledge. So I'm doing my best to assist them. Sometimes, I even take them out of my job to accompany them to stores and show them various products and how to use them, as they often lack familiarity with different items. I always strive to support them in any way I can. (Masuada)

Moreover, the narratives underscore the importance of creating safe and supportive environments for women to come together and share their experiences. Participants recall moments when they facilitated group discussions and gatherings, providing a space for women to feel comfortable, heard, and valued. These safe spaces foster connections, build solidarity, and empower women to speak up and advocate for their needs and rights collectively. As discussed in one of the focus groups:

> Like [Participant 7] mentioned, I remember at the beginning, the first large group that arrived, they were women, an intellectual elite from Afghanistan who came to Edmonton; therefore, they were much more empowered women. Many spoke English, had studied abroad, were activists, so they had a different approach. We had the opportunity to see them all together there because we had some meetings with a psychologist. I remember what they talked about. They felt really comfortable together, in a safe environment, but it has to be a safe environment where people listen to them. (Focus group participant 5, as interpreted by me)

Overall, the narratives illuminate the resilience, compassion, and agency of Afghan refugee women as they navigate complex socio-cultural contexts. Through their acts of advocacy, whether it's through education, mentorship, or community-building initiatives, these women embody a commitment to empowerment and solidarity, striving to create a brighter and more inclusive future for themselves and their communities, both in Canada and beyond.

Chapter 5: Discussion

This chapter discusses the findings of this community-based participatory qualitative study focused on Afghan refugee women's experiences with and recommendations for healthcare. The chapter first provides a summary of the findings, and then the findings are discussed in relation to the literature and the research questions that guided this study: (1) What are the health care needs and expectations for Afghan refugee women? (2) What are the lived experiences of Afghan refugee women accessing the NCHC? and (3) What practices would support the NCHC in addressing the health needs of Afghan refugee women?

Summary of Findings

The qualitative analysis of interviews with three Afghan refugee women and two focus groups with six participants yielded five interrelated themes that mirrored the trajectory of the participant's healthcare experiences. Because of the narrative inquiry approach to data collection, the themes naturally followed the journey of these women and their healthcare experiences including their pre-migration, description of their health needs, their post-migration experiences in Canada, specifically accessing healthcare in Canada, and finally their descriptions of agency and empowerment through these journeys.

The healthcare needs and expectations of Afghan refugee women are multifaceted, encompassing challenges rooted in cultural barriers, limited resources, and societal norms both in Afghanistan and during resettlement in Canada. Prior to settlement in Canada, Afghan refugee women encountered obstacles in accessing essential healthcare knowledge and services such as reproductive health and screenings due to taboos and stigmas. Transitioning to life in Canada introduces new challenges, including navigating the healthcare system and managing unfamiliar diseases. Mental health concerns, influenced by past traumas and ongoing struggles, add another

layer of complexity to their health experiences. Despite these challenges, a salient thread that was present across the narratives was the immense resilience and determination that Afghan refugee women possess in seeking medical attention and advocating for their health needs. Their expectations of healthcare services in Canada vary, with some expressing disappointment while others appreciate the quality of care. Ultimately, the study underscores the importance of culturally safe and accessible healthcare provision to meet the diverse needs of Afghan refugee women.

Regarding the lived experiences of Afghan refugee women accessing healthcare services at the NCHC, several key topics were discussed. First, positive experiences highlight the quality, accessibility, and inclusivity of Canadian healthcare, contrasting with experiences in Afghanistan. Communication dynamics and trust within healthcare settings were stressed as critically important by the participants in this study, especially the use of interpreter services in fostering openness and trust. The significance of medication in healthcare experiences was a surprising topic raised through the narratives, with satisfaction expressed regarding availability and effectiveness in Canada compared to challenges faced in Afghanistan. Another critical topic that was discussed centred around the role of community support as vital for facilitating healthcare access and mental well-being. While mental health support is deemed essential, there was a desire expressed for more proactive recognition and strategies for addressing mental health needs. Lastly, challenges and barriers to healthcare engagement, including waiting times, lack of accommodation, financial barriers, language barriers, and cultural norms hindering disclosure of mental health concerns. These barriers highlight the necessity for improvements in healthcare accessibility, affordability, and cultural sensitivity to better serve Afghan refugee women in Canada.

Several recommendations were put forth by the participants in this study in terms of how the NCHC could address Afghan refugee women's health needs. Participants emphasize the importance of fostering supportive and empathetic doctor-patient relationships, advocating for friendly and approachable healthcare providers who create a welcoming environment for open communication. They also suggested an increase and access to mental health support, comprehensive medical assessments tailored to specific health needs, greater autonomy, and privacy in interactions with healthcare providers.

Findings also highlight the themes of agency and empowerment among Afghan refugee women, depicting their nuanced path towards agency and empowerment in healthcare decision-making, coping with mental health concerns, and advocating within their communities. The narratives of this study participants showed various forms of resistance, including acts of submission, sacrifice, negotiation, and open defiance, showcasing the multifaceted journey of Afghan refugee women toward agency and empowerment in their resettlement experiences.

To follow is a discussion of the findings in relation to the literature in response to the research questions that guided this study.

RQ1: What are the healthcare needs and expectations of Afghan refugee women?

Healthcare Needs

The healthcare needs that Afghan refugee women shared through the interviews reveal significant challenges related to cultural barriers, limited resources, and societal norms in Afghanistan. Also, focus group participants highlighted the presence of taboos and stigmas surrounding women's health issues, such as menstruation, contraception, and reproductive health, which hindered access to essential healthcare services like screenings for PAP smears and mammograms. These findings are consistent with the literature on Afghan women refugees

(Human Rights Watch, 2021; KIT Royal Tropical Institute, 2018). For example, the Afghanistan Health Survey (AHS) revealed that 18.9% of Afghan women of reproductive age use contraception, with 32.0% unable to identify any contraceptive methods (KIT Royal Tropical Institute, 2018). Furthermore, in a study exploring family planning perspectives among Afghan women and men in Melbourne, 57 participants indicated a preference for two or three children and a willingness to consider modern contraception. However, challenges included adverse effects from hormone-based contraception and difficulties negotiating condom use, leading to inconsistent contraceptive practices and unintended pregnancies (Russo et al., 2020). Healthcare professionals were recognized as pivotal in addressing family planning needs (Russo et al., 2020). Another study by Ibrahimi and Stenberg (2022) investigated how spousal violence affects contraceptive use among Afghan women using data from 19,000 women in the 2015 Afghanistan Demographic and Health Survey. It found that women experiencing spousal violence were twice as likely to use contraception, particularly pills, injections, or the Lactation Amenorrhea Method. These findings advocate for policymakers to address violence against women and enhance accessibility to contraceptives under women's control. Overall, these studies reveal the intricate factors influencing reproductive health and family planning decisions among Afghan women, emphasizing challenges in access, awareness, and the significant impact of gender-based violence. They underscore the essential role of healthcare professionals and call for comprehensive policies focusing on improving awareness, expanding contraceptive options, addressing gender-based violence, and providing support services for women in need. Participants in the focus groups indicated that NCHC and CSS staff are aware of these issues, and strategies to address them have been implemented. These strategies include involving

Afghan women in conversations when their husbands assume a predominant role and encouraging one-on-one discussions with Afghan women whenever feasible.

In this study, all participants expressed a desire for access to more health information. According to Zivot et al. (2020), this need for information may be heightened by the loss of social bonds, such as family and friends, which are typically sources of health information in Afghanistan. Furthermore, research indicates that Afghan women encounter obstacles when accessing healthcare and are less inclined to seek medical assistance (Amiri et al., 2019). They face numerous challenges linked to patriarchal norms and cultural restrictions. Khattab et al.'s (1999) earlier study suggested that institutional and cultural barriers impede immigrant women's healthcare access as they enter reproductive age. Additionally, Amiri et al.'s (2019) research revealed that healthcare professionals encountered difficulties in delivering adequate care to Afghan women immigrants, with cultural, religious factors, and traditional patriarchal structures significantly affecting these women's health-seeking behaviours. Despite participants in this thesis study mentioning social networks as sources of information, they also exhibited agency by seeking out information independently, undeterred by cultural constraints. Nevertheless, participants in the focus groups of this study have highlighted unmet health-related informational needs within this community. One possible explanation for this inconsistency is that two out of three Afghan participants in this study come from more progressive family backgrounds, unlike many other women who were not part of this study but are served by the NCHC and CSS staff.

Transitioning to life in Canada brought new health-related needs, including navigating the healthcare system and understanding unfamiliar diseases and treatments. Despite these hurdles, Afghan refugee women in this study displayed determination in seeking medical attention and advocating for their health needs. Overall, their narratives highlight the intersection

of culture, access to healthcare, and socioeconomic factors in shaping their health experiences both in Afghanistan and in Canada.

The narratives of Afghan refugee women in Canada reveal mental health needs stemming from experiences in Afghanistan and during resettlement. Depression, anxiety, and overwhelming responsibility weigh heavily on them as they navigate new lives, balancing caregiving, financial support, and bureaucratic tasks. Past traumas and ongoing struggles back home cast a shadow on their present existence, with constant worry for loved ones left behind adding to their anxiety. This portrayal of mental health aligns with findings reported in the existing literature on Afghan refugee health (Coll et al., 2020; Human Rights Watch, 2021; Najafizada et al., 2017). However, it is noteworthy that this literature does not specifically address the factors driving how to overcome mental health concerns among Afghan refugee women. Instead, it discusses the prevalence of these mental health issues and highlights the lack of mental health literacy among Afghan refugees (Slewa-Younan et al., 2017). Additionally, in a systematic review of the literature on Afghan mental health, Alemi et al. (2014) concluded that further research is necessary to comprehend mental health patterns and help-seeking behaviours in this population. The participants in this thesis study disclosed that their families, and specifically their children, were important motivations towards improving their own mental well-being. It was consistent through participant stories their sense of responsibility towards their families and how these bring meaning to their lives. These findings align with those of Dyck and Dossa (2007) who investigated the healthcare practices of immigrant and refugee women living in the Lower Mainland of Vancouver, British Columbia, Canada. The study explored how the daily health-promoting and healing practices of these women contribute to the creation of a 'healthy space' within a culturally diverse urban environment. Participants were recruited through

settlement agencies, and individual semi-structured interviews were conducted with 10 South Asian women and 10 Afghan women. Among the Afghan participants, a strong emphasis was placed on their connection to their homeland and their aspirations for their children's future, especially considering challenges such as limited employment opportunities matching their qualifications, disrupted family structures, and displacement from their homes (Dyck & Dossa, 2007). In alignment with the experiences of participants in this study, these findings highlight the importance of families as a significant influence on the overall health of Afghan refugee women.

Expectations of Healthcare Service Provision

The narratives of Afghan refugee women in Canada reveal diverse expectations and experiences with Canadian healthcare services generally, influenced by their backgrounds in Afghanistan and encounters with the NCHC and the Canadian healthcare system generally. While some express disappointment with perceived shortcomings in Canadian healthcare compared to their expectations, others appreciate the quality of care once accessed. They miss the efficiency and convenience of healthcare in Afghanistan but value the supportive demeanor of Canadian healthcare professionals. Disparities in healthcare access within Afghanistan are highlighted, with some reminiscing about well-equipped hospitals in urban areas while others recall struggles in rural regions. These disparities are apparent in various reports on accessing healthcare in Afghanistan (Higgins-Steele et al., 2019; Human Rights Watch, 2021; Najafizada et al., 2019). Nostalgia for pre-conflict stability and financial security is evident, emphasizing the importance of culturally safe and accessible healthcare provision in Canada.

Overall, findings of this study suggest that Afghan refugee women anticipated improved access to healthcare services in Canada. Drawing on their experiences in Afghanistan and nearby countries, participants expressed expectations of reduced waiting times for doctor appointments,

transportation services available, and fewer financial barriers for certain non-covered services. These findings are similar to those reported by Omeri et al.'s study (2006), that explored the experiences of Afghan immigrants or refugees living in New South Wales, Australia, regarding access, use, and suitability of mental and physical health services. They conducted focus groups and semi-structured interviews with 13 key informants and 25 general informants, alongside healthcare agencies and resource-providing organizations. The study identified several concerns regarding meeting the expectations of Afghan refugees in terms of travel expenses, lengthy wait times, and the absence of health-related information in the Dari language. Moreover, in Chen et al.'s research (2015), certain participants expressed dissatisfaction with health professionals who failed to follow through on promised follow-up care. For instance, one woman recounted waiting two months for a counseling appointment, which she found exhausting and distressing. These expectations may be partially attributed to Afghan refugees' prior experiences with healthcare in Afghanistan. In this thesis, participants recounted positive experiences with healthcare in Kabul, where all services were provided within the same facility, and appointments could be obtained simply by walking in. However, further research is necessary to comprehend the expectations of Afghan refugee women and the processes by which they are shaped.

RQ2: What are the lived experiences of Afghan refugee women accessing healthcare services at the NCHC?

The lived experiences of Afghan refugee women accessing healthcare services at the NCHC revealed a spectrum of encounters, encompassing both positive and challenging experiences. Key themes emerged, highlighting the significance of effective communication in healthcare settings and the pivotal role of trust in shaping these interactions. Participants emphasized the importance of medication in managing their health conditions and navigating the

complexities of the healthcare system. Additionally, there was a pronounced need for mental health support among Afghan refugee women, acknowledging the significant impact of psychological well-being on overall health outcomes. However, alongside these positive aspects, participants also detailed various problems with healthcare delivery and identified barriers that impede their engagement with healthcare services, shedding light on systemic challenges that must be addressed to ensure equitable access to care.

Positive Experiences Accessing Healthcare Services at the NCHC

Participants' stories show several positive experiences with healthcare services. Their accounts underscore the quality of care, accessibility, and inclusivity they have encountered within the NCHC, and the Canadian healthcare system overall.

One participant described her initial visit to the NCHC with satisfaction, highlighting the seamless process from consultation to receiving necessary tests and medications. This positive encounter established, for the participant, a sense of trust and confidence in the Canadian healthcare system as a whole. Another participant emphasized the efficiency and effectiveness of healthcare in Canada compared to her experiences in Afghanistan, where unresolved medical issues were common due to limited access to appropriate care. However, upon immigrating to Canada, she received prompt attention from healthcare professionals at the NCHC, who addressed her concerns and provided necessary checkups, alleviating her uncertainties.

The absence of discrimination or differential treatment based on refugee status, ethnicity, or background is noted by these women, who appreciate the respectful and compassionate approach of healthcare providers at the NCHC, and in Canada generally. Focus group participants shared that, pregnant women, in particular, receive specialized care and attention, contributing to a sense of security and reassurance among expectant mothers. These positive

encounters with the healthcare system are consistent with the available literature (DeSa et al., 2022; Patel et al., 2022). For instance, in a systematic review examining barriers and facilitators to accessing mental health services among refugee women in high-income countries, DeSa et al. (2022) discovered that service availability facilitated access to mental health services. Participants expressed appreciation for receiving mental health care, which contributed to their positive healthcare experiences. Furthermore, Patel et al. (2022) conducted a study aimed to gain insight and understanding from Australian general practitioners (GPs) regarding their role in facilitating positive interactions with refugee and asylum seeking patients and assisting them in accessing healthcare. Semi-structured individual remote interviews were conducted with 12 GPs working in areas with high refugee and migrant populations. GPs recognized the importance of creating a culturally safe environment to minimize power imbalances and applied principles of trauma-informed care to address their patients' needs and social circumstances sensitively. GPs also advocated for their patients and played a crucial role in enhancing their health literacy. The study underscores the significant role GPs play in advocating for and engaging with refugee and asylum seeker patients, as well as assisting them in navigating the healthcare system. Providing sufficient time and applying principles of trauma-informed care and cultural safety may enable GPs to deliver the quality of care necessary to support patients from refugee and asylum seeker backgrounds (Patel et al., 2022). While these reports can provide background information to help understand the positive experiences of participants with the NCHC in this thesis study, it is also crucial to consider the uniqueness of the centre. The values and principles that underpin their service provision attitude may serve as a potential explanation for these positive experiences (New Canadians Health Centre, 2023). For instance, by embodying the principles of being welcoming and inclusive (principle 2), the NCHC acknowledges refugees as active participants

in their care journey. This approach cultivates respectful, non-judgmental relationships with refugees and ensures they are treated with dignity. Participants in this study echoed similar experiences at the NCHC, illustrating how this tailored refugee center can diverge from mainstream healthcare services, which typically lack specialized training in refugee care.

Additionally, focus group participants highlighted that the accessibility of healthcare services is sought by health navigators, with proximity to medical facilities allowing easy access without the need for extensive travel or transportation arrangements. However, these findings varied based on the perspectives of the participants. While participants in the focus groups expressed pride in providing health services close to their clients, Afghan participants in this study voiced complaints about the distances between services and the inconvenience of transportation to reach the centre. This is also evident in the literature; for instance, Reihani et al. (2021) utilized a transformative qualitative approach to explore the barriers and facilitators of healthcare access among Afghan refugees in the US. They conducted semi-structured interviews with ten Afghan refugee participants and ten key informants. Regarding healthcare navigation, participants highlighted transportation challenges arising from a lack of reliable vehicles or dependable public transport. Additionally, having large families was cited as a hindrance when using public transportation to reach healthcare facilities. In this thesis study, Afghan participants' homes were distant from the center, and there was limited public transportation available for them to safely and conveniently attend their appointments. However, many other Afghan families live nearby the center, with some even residing in the same building as the NCHC. This disparity in proximity could explain the differences in perspectives between the focus group participants and Afghan participants in this study. Further research is necessary to comprehensively understand the access needs of Afghan refugee women to the NCHC.

Communication and Trust at the NCHC

The narratives of Afghan refugee women resettling in Canada shed light on the communication dynamics and the theme of trust within the NCHC, revealing significant differences between their experiences in Afghanistan and Canada.

In Afghanistan, communication with healthcare providers was often hindered by cultural norms and gender dynamics, with women relying on male family members to convey health concerns. However, gradual changes were noted as women became more comfortable over time, suggesting the impact of consistent support from healthcare professionals. Conversely, in Canada at the NCHC, positive shifts in communication dynamics were observed, with emphasis placed on confidentiality, privacy, and patient-centered care. It is noteworthy that while some authors suggest that involving family members in healthcare discussions can enhance communication and trust with refugees (Patel et al., 2021; Tahir et al., 2022; Zivot et al., 2020), the Afghan and focus group participants in this study favored individual sessions in healthcare settings. According to the participants, this approach facilitates better communication with healthcare providers and encourages more openness about health issues and needs. This variance may stem from the demographic profile of the participants in this study, the majority of whom are relatively young and came from less conservative family backgrounds. In this study, the availability of female healthcare providers and interpretation services facilitated open discussions about sensitive health issues, fostering a sense of empowerment among these women. These findings are consistent with Branderberger et al. (2019), who, in a systematic literature review exploring healthcare delivery to migrants and refugees in high-income countries, identified three primary challenges in healthcare delivery: communication, continuity of care, and trust. These authors observed that establishing a collaborative environment between healthcare providers and

refugees resulted in enhanced confidence and trust, ultimately leading to improved inclusion and service quality. In the context of this thesis study, the NCHC carefully considers this gender-sensitive aspect of communication (New Canadians Health Centre, 2024), which serves as another example of their guiding principles in action and can explain these participants' positive experiences with the centre.

Trust emerged as a critical factor shaping healthcare experiences in both Afghanistan and Canada. In Afghanistan, trust was precarious due to concerns about continuity of care and confidentiality, whereas in Canada, positive interactions with healthcare professionals at the NCHC, sufficient time and attention during consultations, and successful treatment outcomes reinforced trust. Sufficient time and attention during consultation was also reported as a facilitator of access to healthcare by Patel et al. (2022). When questioned about the factors contributing to their trust in healthcare services overall, participants revealed that external factors such as institutional reputation and peer recommendations also played a significant role. This underscores the importance of credibility in healthcare institutions. These findings are consistent with those of Zivot et al. (2020). These authors conducted a scoping review of literature regarding gender-centered health research in the context of refugee resettlement in Canada. Through thematic analysis, they identified connections between gender roles, expectations, ideals, and health within family, community, and healthcare settings. Additionally, the report highlighted peer recommendations as a significant source of trust among Afghan refugees, influencing their health-seeking behavior. However, more research is needed to learn how this source of trust influences trust dynamics with healthcare providers at the NCHC.

Importance of Medication

The narratives of Afghan refugee women resettling in Canada highlight the significance of medication in their healthcare experiences at the NCHC, revealing both positive and challenging aspects of medication access and efficacy. In this study, participants express satisfaction with the availability and effectiveness of medications prescribed at the NCHC, and generally in Canada compared to their experiences in Afghanistan. They appreciate the efficiency of medication provision and the shorter duration of medication regimens, emphasizing the perceived effectiveness of medications in Canada and their contribution to improved health outcomes. While access to medication has been studied in the context of refugee health (Aljadeeah et al., 2022; Bellamy et al., 2015), further research is necessary to understand the significance of medication and its impact on trust dynamics in healthcare encounters with refugees. One notable exception is Shain et al.'s study (2020), which focused on analyzing the association of medication beliefs and adherence in Middle Eastern refugees and migrants resettling in Australia. The authors found that "necessity" and "concerns" mediated the relationship between immigration status and medication adherence. Refugees were likely to have less necessity and more concern beliefs than migrants and were also less likely to adhere to medications. Shain et al.'s study underscores the importance of medication beliefs for adherence, considered as a dimension of healthcare quality (Ehrenbrusthoff et al., 2022); however, more research is needed to fully grasp its importance in the trust dynamics between healthcare providers and refugees.

Participants also emphasize the crucial role of healthcare providers at the NCHC in facilitating access to beneficial medications, underscoring the significance of patient-provider relationships in medication management and the perceived impact of healthcare providers on enhancing medication efficacy and overall health outcomes. This facilitation in accessing

medication is particularly vital given the Canadian context, where reductions in publicly funded federal drug coverage for refugees and refugee claimants were implemented during the reforms of the Interim Federal Health Program from 2012 to 2016 (Antonipillai et al., 2017). Although the federal insurance program was reinstated in 2016 and now provides all refugees and refugee claimants with prescription drug coverage for up to one year (Government of Canada, 2019), individuals must explore alternative options after this period. They can either purchase private insurance or potentially qualify for drug coverage through provincial public insurance plans. However, individuals who cannot afford private insurance or are ineligible for provincial drug coverage, such as refugee claimants awaiting the processing of their asylum claims, encounter challenges in accessing prescription drugs and healthcare services overall (Goldring et al., 2009). Overall, participants' narratives in this thesis study illustrate the multifaceted nature of medication experiences among Afghan refugee women in Canada, emphasizing the importance of medication in managing health conditions and the role of healthcare providers, particularly at the NCHC in facilitating access to beneficial medications to support their health and well-being.

Mental Health Support

The experiences of Afghan refugee women resettling in Canada highlight the importance of mental health support in their overall well-being, both in Afghanistan and in their new country. Participants noted a significant improvement in their mental health upon accessing support services at the NCHC, such as counseling and therapy provided by allied health providers through organizations like Catholic Social Services. Despite initial challenges that included language barriers and cultural differences, they expressed gratitude for the availability of these resources and acknowledged how they positively contributed to their healing process.

However, participants also expressed a desire for healthcare professionals to be more proactive in recognizing and addressing their mental health needs. They describe disappointment with the lack of attention given to their emotional well-being by healthcare providers, both in Afghanistan and, to a lesser extent, upon arrival in Canada. This perceived lack of empathy underscores the need for greater awareness and sensitivity to the unique challenges faced by Afghan refugee women regarding mental health. This expectation, as noted by Tahir et al. (2022), may stem from cultural norms. According to these authors, some Afghan women struggle to address mental health issues, sometimes not recognizing them as such and instead interpreting them as feelings of fatigue or simply needing a break. Additionally, some Afghan women often rely on social connections to alleviate the burden of mental health issues (DeSa et al., 2022; Dyck & Dossa, 2007; Tahir et al., 2022) and may be skeptical of Western medical approaches (Tahir et al., 2022). This could be the case for one of the Afghan refugee participants in this study. Two participants, although they trust Western medical approaches, were initially hesitant to openly discuss mental health issues unless prompted by their doctors.

Issues to Engaging with the NCHC and extended Healthcare System

This study identified various issues and challenges that hinder the engagement of Afghan refugee women in healthcare services. Among these issues, long waiting times emerged as a significant problem, leading to frustration and loss of trust in the system. Additionally, unmet individual needs, such as specific healthcare requirements or preferences, posed challenges in delivering tailored and effective healthcare services to this population. Financial constraints also played a role, with limited resources impacting access to essential healthcare services. Language barriers further compounded the issue, making it difficult for Afghan refugee women to communicate their health concerns effectively or understand medical information provided to

them. Moreover, cultural norms and gender dynamics within the community influenced healthcare-seeking behaviors, potentially discouraging women from seeking necessary medical care. Collectively, addressing these multifaceted issues is essential to enhance the engagement of Afghan refugee women in healthcare and improve their overall health outcomes.

Lengthy Wait Times. Participants express dissatisfaction with lengthy waiting times for appointments, often waiting weeks to months, which exacerbates health issues and causes stress. Moreover, last-minute appointment rescheduling without prior notice further adds to their frustration. These findings are common in the refugee health literature (Davidson et al., 2022; Bhatia & Wallace, 2007; Murray et al., 2010; Razavi et al., 2011; Sharifian et al., 2019; Zivot et al., 2020), and are usually presented as a barrier towards trust in the system (Bhatia & Wallace, 2007; Patel et al., 2021; Tahir et al., 2022) For instance, in Razavi et al.'s (2011) study, participants expressed varying opinions regarding continuity of care, with some valuing it while others experienced a lack of consistency, being seen by different healthcare providers. This sentiment was similarly reflected in Murray et al.'s research (2010), where refugees voiced frustration over the fragmented nature of their healthcare. Bhatia and Wallace's study (2007) also underscored this issue, as some refugees expressed a desire for consistent care from the same general practitioner (GP) and interpreter to foster trust. In the present thesis study, while all participants shared concerns about prolonged waiting times at the NCHC, only one participant reported doctors cancelling appointments last minute. Furthermore, this participant expressed frustration about the lack of a designated primary physician overseeing her care and the rotation of different doctors at each NCHC appointment.

Accommodating Individual Needs. Concerns were raised about the lack of awareness and accommodation for individual needs, such as disabilities, with instances where appointments

were attended despite difficulties in mobility. Fragmentation of healthcare services when referring services from the NCHC to external partners, requiring visits to multiple locations for different aspects of care, is noted as inconvenient compared to the centralized approach in Afghanistan. Building on Branderberger et al.'s (2019) research, continuity of care emerges as a significant challenge for refugees resettling in high-income countries. The authors underscored that lack of information and knowledge about the healthcare system, difficulties in accessing facilities, and challenges in integrating medical appointments into refugees' personal schedules are common barriers to continuity of care. While these factors are reflected to some extent in the participants' narratives, the proximity and convenience of healthcare facilities emerged as a major issue hindering access to healthcare in this study.

Financial Constraints. Financial issues pose significant challenges, as some participants face high costs for medical procedures and treatments, especially in the absence of health insurance. Although these instances fall outside the scope of the NCHC healthcare delivery domain, participants in this study shared narratives about these issues, which affect their engagement with healthcare services overall. These findings are consistent with those of Brandenberger et al. (2019), who reported that the lack of continuous financial coverage for health expenses among refugees directly impeded the continuity of care they received. When it comes to accessing healthcare services in Canada, financial struggles are underscored by Saberpor (2016), who attributes this issue to policy changes enacted in 2012 to the Interim Federal Health Program by the federal government. These changes led to cuts in coverage, and many services previously covered by this program had to be covered differently. Consequently, many health issues not covered by provincial health plans are borne out-of-pocket by refugees, imposing a significant financial burden that results in worsening health outcomes (Branderberger

et al., 2019; Reihani et al., 2021; Saberpor, 2016). Although in an unprecedented turn of events, the government reversed this policy in 2016, many services were left uncovered and continue to pose a financial burden for refugees in Canada (Chen, 2017).

Language Barriers. Language barriers further impede effective communication with healthcare providers, especially when coupled with limited interpretation services, which diminishes agency and the ability to make informed decisions in healthcare settings (Saberpor, 2016). Additionally, in a study by Fang et al. (2015), language barriers were also mentioned, with many participants noting that interpreters were either not available or, if they were, there was a problem with confidentiality. This issue arose from the fact that the majority of the interpreters were from the same community as the refugees themselves, and therefore they were afraid of personal information being disclosed among the community. In this thesis study, two Afghan participants required interpretation assistance. While they expressed satisfaction with having family members and/or a health navigator or settlement counselor provide interpretation, they both agreed that accessing healthcare services would be much easier if they could communicate fluently with healthcare providers themselves. This desire for same-language encounters is reported by both healthcare providers and refugees. In a report prepared by Bowen (2001) for Health Canada, the author advocates for an increase in same-language interactions within the healthcare system as an ideal response to the challenges posed by language barriers and third-party interpretations. In addressing this issue, the NCHC is aware of these barriers and has staff members who are fluent in several languages, including many of the most commonly spoken languages by refugees at the centre.

Gendered Expectations. Afghan refugee women resettling in Canada encounter numerous obstacles related to cultural norms, language barriers, gender dynamics, and personal

preferences that hinder their engagement with healthcare services. According to observations made by focus groups participants in this study, in Afghan households, patriarchal structures often lead to husbands making healthcare decisions, leaving women feeling silenced or overlooked during medical consultations. As noted by these participants, the presence of husbands during appointments can inhibit women from discussing sensitive health issues, while cultural modesty norms may make certain medical procedures uncomfortable, especially with male healthcare providers or interpreters. This is widely recognized in Afghan health literature as a major barrier to accessing healthcare (Brandenberger et al., 2019; Patel et al., 2022; Zivot et al., 2020). However, due to the family structures and dynamics of the Afghan participants in this study, this did not emerge as a prevalent issue.

In this study, women often bear the disproportionate responsibility of childcare and household management, leaving little time to prioritize their own health needs. These findings are consistent with those by Zivot et al. (2020) and Dyck & Dossa (2007). In a scoping review, Zivot et al. (2020) examined published research on gender in relation to refugee health during resettlement in Canada. In this study, 34 articles published between 1988 and 2019 were included for in-depth analysis. These articles primarily focused on refugee women and covered various categories, including maternal health, social and emotional health, impacts of sexual and gender-based violence and torture on health, access to health and social services, decision-making and health-seeking behaviour, mental health, and sexual and reproductive health. Through thematic analysis these authors revealed connections between gender roles, expectations, ideals, and health within the family, community, and healthcare system. The review suggested that refugee women often encounter pervasive gender roles and expectations, along with gendered health systems and practices that can impact their health, particularly in

terms of mental health and access to services. However, in this thesis study, while two participants expressed feeling overwhelmed with family responsibilities and household duties, all participants demonstrated empowerment and agency by making significant efforts to learn English and allocate time for prayer, relaxation, and rest. These activities served as coping strategies to alleviate stress and mental health burdens, with a focus on their well-being, partially resonating with the findings of Zivot et al. (2020).

RQ3: What practices would support the NCHC in addressing the health needs of Afghan refugee women?

Participants offered insightful recommendations to enhance the healthcare experience for themselves and others in their community. They emphasized the importance of fostering supportive and empathetic doctor-patient relationships, advocating for friendly and approachable healthcare providers who create a welcoming environment for open communication. These findings are similar to those reported by Patel et al. (2021) in a review of communication experiences in primary care with refugees and asylum seekers. In this literature review, the authors found that open communication and compassionate care aspects of communication from healthcare providers are key to forging trust and comfort with refugees (Patel et al., 2021). In this thesis study, participants highlighted the importance of having enough time to discuss their health concerns with healthcare providers. Also, healthcare provider's friendly demeanor was a facilitator towards trust and disclosure of mental health concerns.

Afghan women in this thesis research stressed the need for increased access to mental health support within healthcare settings, proposing the integration and active involvement of psychiatrists or counselors to address prevalent depression and trauma among newcomers. Furthermore, Afghan refugee women in this study seek greater autonomy and privacy in their

interactions with healthcare providers, suggesting dedicated time for private consultations with female patients to discuss sensitive health issues without external influence. They also suggest practical solutions to tackle systemic challenges within healthcare facilities, such as increasing the number of healthcare professionals to reduce waiting times and enhancing language accessibility by scheduling interpretation services alongside medical appointments.

Overall, these recommendations underscore the importance of person-centered care and the need for the healthcare system as a whole to adapt to the unique needs and preferences of Afghan refugee women. According to the participants of this study, it is expected that by incorporating these recommendations, healthcare providers can work towards delivering more equitable, inclusive, and effective care. While recommendations drawn from the perspective of healthcare staff and extracted as conclusions of program and intervention research exist (Iqbal et al., 2021; Kanengoni-Nyatara et al., 2024; Oehri et al., 2023), research focused on refugees' recommendations from their own perspective to improve healthcare services in the host country is scarce. One notable example is Salinas et al. (2021) study, which described potential solutions to improve the health status of the Bhutanese refugee community based on their perspectives. This study utilized an explorative qualitative research approach, conducting four focus group discussions with 40 female participants to explore their healthcare experiences in Nepal (pre-resettlement) and the US (post-resettlement). Analysis of the focus group data revealed that Bhutanese refugees faced mistreatment and limited access to healthcare services in Nepal due to their refugee status (Salinas et al., 2021). Upon resettlement in the US, participants encountered challenges in the healthcare system, including cultural and linguistic barriers with medical interpreters and inadequate time during medical visits. Recommendations for improving their health focused on initiatives to develop leadership skills within the community and increase

access to external resources. These experiences differ from the Afghan women's experiences in this thesis research, possibly due to the unique nature of the NCHC as a principle-driven community health centre. However, the conclusions of Salinas et al. emphasize the significance of considering refugees' past experiences and current needs when developing culturally sensitive health programs and collaborative interventions to address their healthcare needs effectively. This resonates with the emphasis in this thesis study on refugees' past healthcare experiences as indicators of their expectations regarding healthcare services in the host country. Additionally, it underscores the significance of incorporating the refugees' perspectives, promoting a collaborative approach to care, through a bottom-up approach to healthcare service delivery.

Chapter 6: Implications, Limitations and Conclusion

In this chapter, I describe the implications, limitations, and conclusions drawn from this study. As a reflection on the rich stories and narratives shared by participants, I recognize the significance of these findings for informing healthcare practices, shaping public policies, and guiding future research endeavors. However, amidst these insights, it is essential to acknowledge the inherent limitations of this study, including constraints related to language interpretation and the number of participants involved. Despite these challenges, the conclusions drawn highlight the urgent need for culturally safe healthcare practices and underscore the resilience and agency of Afghan refugee women in navigating complex socio-cultural contexts and the healthcare system.

Implications

This study has implications for healthcare practice, informing culturally safe care delivery and empowering Afghan refugee women in their healthcare decision-making. Furthermore, it underscores the importance of public policy initiatives aimed at addressing the unique needs of refugee populations, particularly in the realm of healthcare access and mental health support. Additionally, this study highlights avenues for future research, emphasizing the importance of further exploration into the health outcomes, experiences, and resilience of Afghan refugee women to inform evidence-based interventions and policies. By examining the practice, policy, and research implications of Afghan refugee women's experiences, this study contributes to a deeper understanding of the challenges and opportunities in promoting health equity and well-being among refugee populations in Canada and beyond.

Implications for Practice

The information gathered from the experiences of Afghan refugee reinforce that healthcare practitioners need to be attentive to the cultural backgrounds and experiences of Afghan refugee women. Understanding the historical, political, and societal context of Afghanistan, including the impact of conflict and migration on women's lives, can inform more empathetic and responsive care (Curtis et al., 2019; Kirmayer & Jarvis, 2019). Additionally, healthcare providers play a crucial role in addressing mental health concerns, but it's essential to recognize that these issues are not universally understood or conceptualized (Tahir et al., 2022). Everyone brings a unique set of personal, cultural, and contextual factors that influence their perceptions and experiences of mental health. What may be considered a mental health concern for one person could be viewed differently by another based on their upbringing, cultural background, and life circumstances. Moreover, cultural norms and societal attitudes towards mental health can either facilitate or hinder open discussions about these issues (Tahir et al., 2022). Healthcare providers should therefore approach each patient with cultural safety, put in practice by acknowledging and respecting the diverse ways in which mental health is understood and expressed across different communities and individuals (Canadian Institute for Health Information, 2022; Curtis et al., 2019; Tahir et al., 2022).

Recognizing the traditional gender roles and dynamics within Afghan households is crucial for healthcare providers (Rosenberg et al., 2021). While men may often be perceived as decision-makers in healthcare matters, as suggested in this study, healthcare professionals should engage with women directly, respecting their autonomy and preferences in decision-making processes related to their health and well-being. However, while individual consultations with healthcare providers remain a critical healthcare need for women, as evidenced in this study, ensuring cultural safety in addressing this issue requires open discussions about the expectations

of healthcare services regarding client attitudes and behaviors (Santana et al., 2017). It is essential to openly discuss dominant societal norms in Canada, rather than implementing changes that may provoke resistance from clients or patients. Embracing a culturally safe approach involves acknowledging and respecting cultural differences and expectations, fostering a mutual understanding between healthcare providers and clients regarding their relationship (Filler et al., 2020).

Healthcare practitioners can play a role in facilitating the agency and empowerment of Afghan refugee women through active listening, or what Nguyễn-Nalpas (2023) terms "deep listening." This is essential for the emergence of stories and narratives depicting agency and empowerment. It is probable that all individuals possess experiences of agency and empowerment; thus, healthcare providers must be willing to listen to these experiences and utilize them to benefit the health and well-being of clients and communities (Filler et al., 2019; Nguyễn-Nalpas, 2023; Santana et al., 2017). Besides listening, healthcare providers can create the context for agency to emerge by providing Afghan women opportunities to voice their concerns, ask questions, and actively participate in their healthcare decisions (Filler et al., 2019). As found in this study, creating a safe and non-judgmental environment with enough time for women to feel comfortable expressing their needs and preferences is essential for fostering trust and further engagement. Furthermore, ensuring language access and effective communication is essential for delivering quality healthcare to Afghan refugee women (Brandenberger et al., 2019; DeSa et al., 2019; Kohlenberger et al., 2019; Patel et al., 2021; Siqqid et al., 2023). Healthcare providers should utilize interpreters and language assistance services whenever possible to overcome language barriers and facilitate clear and accurate communication with patients.

As found in this study, Afghan refugee women often take on significant caregiving responsibilities within their families, including accompanying family members to medical appointments and managing medications. Healthcare providers can offer support and resources to these caregivers, acknowledging their vital role in supporting the health and well-being of their families. To gain a comprehensive understanding of the needs of caregivers, implementing a caregiver needs assessment could be highly beneficial, both during the initial intake at the centre and after newcomers have settled and gained caregiving experience in Canada. Conducting assessments at these different stages allows healthcare providers to tailor support services and interventions to meet the evolving needs of caregivers (Canadian Institute for Health Information, 2022). During the intake process, such assessments can help identify immediate challenges and concerns, enabling timely provision of support and resources. Later assessments, conducted once caregivers have acclimated to their new environment and caregiving responsibilities, can offer insights into ongoing needs and areas where additional assistance may be required.

Given the prevalence of mental health challenges among Afghan refugee women (Kovess-Masfety et al., 2021; Najafizada et al., 2017), healthcare practices should prioritize screening, assessment, and intervention for mental health disorders such as depression, anxiety, and post-traumatic stress disorder (PTSD) (Tahir et al., 2022). However, it should be noted that research indicates that practices such as screening, assessment, and intervention can sometimes act as mechanisms of policing, exacerbating issues particularly for racialized communities (Faber et al., 2023; Arredondo, 2019; Williams, 2001). For this reason, it is essential to emphasize the importance of ensuring that these processes are culturally safe, to avoid worsening existing disparities. Integrating mental health services into primary care settings and offering culturally

safe interventions can help address the mental health needs of this population (DeSa et al., 2022). It is important to note that mental health is a collective responsibility that extends beyond mental health specialists. It encompasses everyone within a community. Creating friendly, non-judgmental environments and fostering trusting relationships are integral components of supporting mental well-being. Whether it's within families, workplaces, or social circles, each individual plays a crucial role in promoting mental wellness. Moreover, Afghan refugee women in this study have expressed benefiting from healthcare navigators or community supports, indicating a willingness to engage with healthcare systems. Yet, the absence of compatible services may hinder their engagement. Afghan women's understanding of their own mental health challenges, including grief, may differ from Western clinical models, and they may utilize personal coping strategies and seek support from biomedical professionals (Ramos, 2023; Tahir et al., 2022). The surge of Afghan arrivals presents an opportunity to reassess risk factors for mental illness and factors affecting resettled women's health-seeking behaviors, particularly as Afghan community's express eagerness for culturally adapted interventions and demonstrate trust in biomedical professionals.

Furthermore, adopting a trauma-informed approach to care is crucial when working with Afghan refugee women (DeSa et al., 2022; Siqqid et al., 2023; Tahir et al., 2022). As suggested in this study, healthcare practitioners should create safe and supportive environments, employ trauma-sensitive communication techniques, and offer trauma-informed interventions to address the complex needs of survivors of trauma. In light of numerous structural and ideological barriers, it is crucial for health systems to adapt to engage with individuals whose experiences may diverge from Western medical norms due to historical oppression. Additionally, psychiatric diagnostic labels, while convenient, may not universally apply across cultural contexts, as trauma

studies have shown. Ethnographic research offers valuable insights into cultural concepts of distress, facilitating a deeper understanding of suffering. Scholars advocate for medical ethnography and community-engaged scholarship to complement quantitative research, particularly in health professional education, given the scarcity of trained providers worldwide (Ramos, 2023; Tahir et al., 2022)

As found in this study, Afghan refugee women possess a collective understanding of health, which incorporates the community as one of its driving factors. Healthcare practices can facilitate community engagement and peer support initiatives to enhance social connections and resilience among Afghan refugee women (Brandenberger et al., 2019; Siqqid et al., 2023). Group-based interventions, peer-led support groups, and community health education programs can provide opportunities for women to share experiences, build social networks, and access resources for health promotion and disease prevention (Ahmed et al., 2022).

Implications for Policy

Several key public policies need consideration to effectively address the healthcare needs of Afghan refugee women resettling in Canada such as healthcare access and affordability (financial assistance, access to language interpretation, access to mental health services), cultural safety and communication training for healthcare providers, and community-level interventions to improve engagement and facilitate peer to peer learning.

Policies can mandate the provision of language interpretation and translation services in healthcare settings to facilitate communication between refugee women and healthcare providers (Ghahari et al., 2019). This includes ensuring access to qualified gender-sensitive interpreters, translated healthcare materials, and language assistance during medical consultations, thereby overcoming language barriers and improving the quality of care.

Public policies should prioritize the integration of mental health services into primary healthcare settings and community-based programs (Patel et al., 2021; Siddiq et al., 2023). This may involve allocating funding for mental health screenings, counseling services, and trauma-informed care tailored to the needs of refugee women. Additionally, policies can support the training of culturally safe mental health professionals to address the unique mental health challenges faced by this population (DeSa et al., 2022). Aligned with this, it is important to promote trauma-informed care practices within healthcare settings to address the complex needs of refugee women who may have experienced trauma, violence, or displacement (DeSa et al., 2022; Siqqid et al., 2023; Tahir et al., 2022). This involves training healthcare providers to recognize and respond sensitively to signs of trauma, provide trauma-focused interventions, and create safe and supportive environments for healing (Ahmad et al., 2020).

As found in this study, financial hardship is a major barrier for addressing the healthcare needs of Afghan refugee women. Public policies should prioritize initiatives that ensure equitable access to healthcare services for refugee women, including provisions for affordable healthcare coverage, regardless of immigration status (Ghahari et al., 2019; Kaida et al., 2019). This may involve expanding eligibility for government-funded healthcare programs, providing subsidies for health insurance premiums, and reducing out-of-pocket costs for essential health services. Moreover, Kaida et al. (2019) compared the employment and earning outcomes of Privately Sponsored Refugees (PSRs) and Government Assisted Refugees (GARs) in Canada from 1980 to 2009 using the Longitudinal Immigration Database. PSRs consistently outperform GARs in both employment probability and earnings over the first 15 years after landing, even after accounting for demographic and socioeconomic factors. This advantage is particularly pronounced for less educated PSRs, while well-educated PSR women do not maintain the same

economic advantage in the long run. PSRs with limited language skills do not exhibit a greater advantage in employment and earnings over time. The study highlights the economic benefits of private sponsorship for refugee resettlement and underscores the unique features of Canada's program compared to other countries. However, more research is needed to fully understand the financial impact of these modalities of refugee resettlement and how it impacts accessibility to healthcare services in Canada.

Furthermore, public policy can mandate and fund cultural safety and communication training for healthcare professionals to enhance their understanding of the cultural beliefs, norms, and preferences of Afghan refugee women. Alternatively, this training can be embedded within education and training programs directed at healthcare workers. By investing in training programs, policymakers can improve patient-provider communication, foster trust, and reduce disparities in healthcare delivery (Canadian Institute for Health Information, 2022).

Public policy can support community-based organizations in conducting outreach and education initiatives aimed at raising awareness of healthcare rights, services, and resources available to Afghan refugee women (Ahmed et al., 2022; Keylada et al., 2023). By investing in culturally tailored health promotion campaigns and workshops, policymakers can support women to advocate for their health needs, navigate the healthcare system, and make informed decisions about their well-being. Despite the historically oppressive sociopolitical environment in Afghanistan (Fazilat, 2020), and aligned with this study’s findings, it is important to recognize the ways in which women have sought empowerment, particularly in the face of challenges such as the loss of men's financial support. Evidence suggests that economic empowerment, such as through microfinance, may contribute to reducing instances of domestic violence (United Nations Development Programme, 2024). Enhancing women's economic power and providing

opportunities for employment or creative outlets can lead to greater financial stability and socialization within their communities. However, interventions involving work or education should carefully consider potential benefits and risks, including the possibility of escalating violence due to perceived imbalances in gender roles (Ramos, 2023)

Overall, public policies play a crucial role in shaping the healthcare landscape for Afghan refugee women in Canada. By addressing barriers to healthcare access, promoting cultural safety, integrating mental health services, and supporting community outreach, policymakers can advance health equity and promote the well-being of refugee women in their resettlement journey.

Implications for Research

The insights derived from this study offer some directions for research aimed at informing policies, interventions, and healthcare practices. Research can delve deeper into the healthcare needs and experiences of Afghan refugee women, exploring factors such as access to healthcare services, utilization patterns, barriers encountered, and satisfaction with care. Qualitative studies can capture the nuances of their experiences, shedding light on cultural beliefs, preferences, and challenges in navigating the healthcare system. Moreover, a focus on health disparities among Afghan refugee women, considering intersecting factors such as gender, ethnicity, language proficiency, socioeconomic status, and immigration status can be important to better understand the underlying social determinants and structural inequalities that contribute to disparities.

Studies can assess the impact of cultural safety training for healthcare providers on patient-provider communication, trust, and healthcare outcomes among Afghan refugee women.

Mixed-methods research can evaluate the effectiveness of interventions aimed at improving cross-cultural communication and addressing cultural barriers in healthcare delivery.

Research should explore the mental health needs and trauma experiences of Afghan refugee women, including the prevalence of mental health disorders, trauma exposure, coping mechanisms, and help-seeking behaviors. Longitudinal studies can examine the trajectory of mental health outcomes over time, identifying risk factors, protective factors, and effective interventions for addressing mental health challenges. Furthermore, mental health research from non-dominant paradigms and models of mental health are needed to fully capture the complexities of the lived experiences of Afghan refugee women (Ramos, 2023). While avoiding paternalism is crucial, integrating Afghan health professionals into participatory research while upholding high medical standards poses a challenge. Research by Mismahl et al. (2012) indicates inconsistencies in mental health provider training, with some professionals lacking essential skills. Psychosocial workers, in particular, may conflate giving advice with providing quality intervention due to limited specialized training. Given these gaps, research teams must be mindful of potential training deficiencies and the inclination toward directive approaches among Afghan health professionals (Ramos, 2023).

Research can investigate the role of social support networks, community resources, and peer-led interventions in promoting the health and well-being of Afghan refugee women (Ahmed et al., 2022). Participatory research methods can engage community members in co-designing and implementing culturally appropriate interventions that build social cohesion, resilience, and empowerment within refugee communities. Riggs et al (2015) conducted a participatory study to provide evidence about how women and men of refugee backgrounds experience healthcare services when having a baby. In this study, engagement of diverse stakeholders enhanced

collaboration, built trust, capacity, and laid a strong foundation for future endeavors. The authors recommend recognizing refugees' unique needs and perspectives to ensure effective participation of Afghan communities in research. Also, employing community researchers facilitated cultural understanding and ethical negotiation, enhancing the study's relevance and validity. The involvement of both male and female community researchers, along with their active role in data analysis, enriched the research process and outcomes. Moreover, the project's success underscores the value of community-based participatory methods in engaging typically hard-to-reach populations and bridging gaps between researchers, stakeholders, and communities. Drawing from Riggs et al (2015) and this study, future research with Afghan communities should prioritize inclusive and participatory approaches, recognizing the importance of building trust, understanding community expectations, and addressing power imbalances. These findings have broader implications for research with culturally diverse and vulnerable populations, emphasizing the need for inclusive strategies to address health inequalities effectively.

Studies can evaluate the impact of healthcare policies, programs, and service delivery models on health outcomes and access to care for Afghan refugee women (Ramos, 2023; Siddiq et al., 2023; Tahir et al., 2022). Health services research can assess the effectiveness of interventions such as language interpretation services, culturally tailored health education, and trauma-informed care in addressing the unique needs of refugee populations.

In addressing these research priorities, scholars can generate evidence to inform policy decisions, improve healthcare practices, and enhance the health and well-being of Afghan refugee women resettling in Canada. Additionally, research partnerships with community organizations, like the NCHC and refugee stakeholders can ensure that research findings are

culturally relevant, ethically sound, and effectively translated into actionable recommendations for policy and practice.

Limitations

While this study offers some transferable insights into the healthcare needs, expectations and recommendations of healthcare service provision for Afghan refugee women in Canada, it is important to acknowledge several limitations of the research process. These limitations are essential to consider when interpreting the results and implications of the study.

While the findings of this study provide valuable insights into the healthcare needs and expectations of Afghan refugee women resettling in Canada, it is essential to acknowledge certain limitations inherent to the research context. Conducted at the NCHC, a community-driven refugee health centre renowned for its cultural sensitivity and safety measures (The New Canadians health Centre, 2023), the study may have been influenced by the unique characteristics of this setting. The NCHC's multidisciplinary approach, integrating various experts and resources such as a language line to address the diverse needs of its clients, may have shaped the healthcare experiences and expectations of the Afghan participants in this study. Consequently, the findings may not fully capture the breadth of experiences of Afghan refugees enrolled in other refugee healthcare centres or organizations with different approaches or resources. Thus, while the insights garnered from this study offer valuable perspectives, they should be interpreted within the context of the NCHC's specific characteristics and may not be fully generalizable to other refugee healthcare settings. Future research endeavors should aim to explore the healthcare needs and expectations of Afghan refugee women across a diverse range of healthcare contexts to provide a more comprehensive understanding of their experiences.

Furthermore, the limited number of participants may lead to a narrower range of perspectives and experiences represented in the study findings (Flick, 2006; Hernandez-Sampieri et al., 2015). Each individual's experience is unique, shaped by various factors such as socio-economic status, education level, family dynamics, and personal resilience. Moreover, the voices of women who were unable or unwilling to participate in the study are notably absent. This exclusion may be due to various reasons, including language barriers, cultural sensitivities, or distrust of research institutions. These women may represent marginalized subgroups within the Afghan refugee community, whose perspectives are essential for understanding the full spectrum of healthcare needs and expectations. Their absence in this study results means that certain perspectives, challenges, and coping mechanisms remain unexplored, potentially leading to gaps in the understanding of effective healthcare service provision for this population. Without their input, healthcare practitioners and policymakers may overlook critical issues or misinterpret the priorities and preferences of Afghan refugee women when designing interventions or policies.

To address this limitation, future research efforts should aim to increase participant diversity by employing culturally safe recruitment strategies and building trust within the community (Siddiq et al., 2023). Engaging community leaders, cultural mediators, and peer networks can help reach women who may otherwise be hesitant to participate (Attygale, 2020; Mercer & Cargo, 2008). Additionally, employing qualitative methods such as focus groups or community-based participatory research approaches may facilitate broader participation and ensure that a more comprehensive range of voices is heard (Flick, 2006; Hernandez-Sampieri et al., 2015).

As a male researcher, it is crucial to acknowledge the potential limitations and challenges that may arise when conducting research with Afghan refugee women. In the context of Afghan

culture, gender roles are often deeply entrenched, delineating specific roles, behaviors, and responsibilities for men and women. Afghan women may adhere to traditional gender norms that prioritize modesty and privacy, particularly in interactions with male individuals outside their immediate family. Consequently, male researchers may encounter barriers in establishing trust and rapport with Afghan refugee women, as cultural norms may dictate limited interaction or discomfort in discussing sensitive topics related to women's health or personal experiences. Moreover, male researchers might unintentionally perpetuate power imbalances or uphold patriarchal norms, potentially hindering open communication during research interactions. Despite having the support of an advisory committee, female interpreters, and a trusted female member of the Afghan community, who all possess a deeper understanding of Afghan cultural norms and perspectives and helped mitigate these gender-based challenges, it remains challenging to fully grasp how gender dynamics influenced discussions about the participants' healthcare experiences in this study. This creates a potential gap that cannot be entirely addressed or bridged.

Furthermore, in this qualitative study, my own inability to communicate in Dari or Pashto, the native languages of the Afghan refugee women participants, posed a significant challenge in fully understanding the nuances and complexities of their narratives. As a Spanish native speaker, I had to rely on interpretation from Dari to English and then translate concepts back into Spanish before finally converting them to English for the study's write-up. This multilayered translation process introduced the potential for meaning to be lost or distorted along the way, creating a gap in comprehension that could impact the accuracy and depth of the study findings (Macqueen & Patterson, 2021).

Given that social constructionism served as the epistemological foundation of the study, recognizing meaning as a socially constructed endeavor, the absence of native language proficiency hindered the researcher's ability to conduct a comprehensive narrative analysis. Social constructionism emphasizes the importance of understanding individuals' lived experiences within their socio-cultural contexts, and language plays a central role in shaping these experiences. Without native knowledge of the Dari language and its pragmatic uses within Afghan culture, I may have missed subtle nuances, cultural references, or colloquial expressions that carry significant meaning for the participants.

Moreover, the reliance on interpretation introduced an additional layer of subjectivity into the research process. Interpretation involves the translator's interpretation of the participants' words and experiences, which may not always align perfectly with the intended meaning. As a result, the researcher may have inadvertently imposed their own interpretations or assumptions onto the data, leading to a distortion of the participants' voices and experiences (Macqueen & Patterson, 2021).

To mitigate these challenges and ensure a more authentic and nuanced understanding of the participants' narratives, future research endeavors should prioritize collaboration with bilingual and bicultural researchers who possess native proficiency in the language and cultural understanding of the study population. This would enable a more direct engagement with participants, allowing for richer and more accurate data collection and analysis.

Conclusion

This study offered insights into the experiences, challenges, and resilience of Afghan refugee women resettling in Canada, particularly concerning their healthcare needs, agency, and empowerment. Through community-engaged, narrative inquiry research, I have gained a

nuanced understanding of the healthcare needs, expectations of service provision and practice recommendations of Afghan refugee women. Despite facing great obstacles, including limited access to healthcare and pervasive societal norms dictating gender roles, Afghan refugee women exhibited remarkable resilience and resourcefulness in navigating complex healthcare systems and advocating for their well-being.

One of the key findings of this study is the importance of recognizing and addressing the intersecting factors that influence healthcare decision-making among Afghan refugee women. Traditional gender dynamics, cultural norms, and experiences of migration all play significant roles in shaping how these women perceive and engage with healthcare services. Understanding these factors is crucial for healthcare providers to deliver culturally safe and gender-sensitive care that meets the diverse needs of this population. Moreover, the study highlights the need for healthcare practices that prioritize inclusivity, respect, and dignity, fostering open communication and trust between providers and patients.

Furthermore, the study underscores the role of advocacy and community support in promoting the health and well-being of Afghan refugee women. All participants in the study demonstrated a commitment to empowering themselves and others through education, mentorship, and community-building initiatives. Through amplifying the voices of Afghan refugee women and recognizing their agency, healthcare providers and policymakers can work towards creating more equitable and accessible healthcare systems that address the unique needs and experiences of this population with them, for them.

In moving forward, it is essential to acknowledge the limitations of this study, including the need for greater representation of diverse voices and experiences within the Afghan refugee community. Future research should strive to engage with a broader spectrum of participants,

including those who may not have been able or willing to participate in this study. Additionally, a deeper exploration of the cultural and linguistic barriers to healthcare access and utilization is warranted to inform the development of targeted interventions and policies. Overall, by centering the voices and experiences of Afghan refugee women, we can work towards creating more inclusive, equitable, and responsive healthcare systems that promote the health and well-being of all individuals, regardless of their background or circumstances.

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Focus Group Guide

Consent Process

Thank you for agreeing to participate. We are very interested to hear your valuable opinion on how to provide refugee-specialized healthcare services.

- *The purpose of this study is to learn the needs, experiences, expectations and recommendations of Afghan refugee women regarding healthcare services provision in Afghanistan, transition countries and Canada. We hope to learn things that the NCHC and other institutions can use to tailor healthcare provision for Afghan women and newcomers in general.*
- *The information you give us is completely confidential, and we will not associate your name with anything you say in the focus group.*
- *We would like to tape the focus groups so that we can make sure to capture the thoughts, opinions, and ideas we hear from the group. No names will be attached to the focus groups and the tapes will be destroyed as soon as they are transcribed.*
- *You may refuse to answer any question or withdraw from the study at anytime.*
- *We understand how important it is that this information is kept private and confidential. We will ask participants to respect each other's confidentiality.*
- *If you have any questions now or after the focus group, you can always contact me at* [redacted]
- *Please sign to show you agree to participate in this focus group.*

[redacted] [redacted]

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Introduction:

Permission to record and start recording

Welcome and introductions: Begin the session by introducing myself and any co-facilitators. Also, ask the participants to introduce themselves briefly.

Purpose and context: Explain the purpose of the focus group, the significance of their participation, and how the information gathered will contribute to your research.

Icebreaker:

Icebreaker question (TBD): Position at the NCHC, where you were born, favorite hobby

Exploring experiences:

Experiences with Afghan refugee women:

1. Are there any unique aspects or cultural considerations you've encountered when providing healthcare to Afghan refugee women?
2. How do you perceive the level of trust between healthcare providers and Afghan refugee women? Can you provide any examples that highlight the factors influencing this trust?

Healthcare needs and expectations:

Understanding healthcare needs:

3. Based on your experience, what are the most common health issues or concerns that Afghan refugee women face?

Access to healthcare: Discuss the barriers Afghan refugee women face in accessing healthcare services and any strategies or initiatives that have been implemented to address these barriers.

4. In your opinion, what are the major barriers Afghan refugee women encounter when accessing healthcare services? Have you noticed any patterns or recurring challenges?

Expectations and preferences: Inquire about the expectations and preferences of Afghan refugee women regarding healthcare services. This can include topics such as language support, culturally sensitive care, availability of female healthcare providers, and other considerations.

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5. What initiatives or strategies have been implemented to address the healthcare needs of Afghan refugee women?

6. Can you share any specific examples of successful interventions or practices?

Communication and cultural sensitivity:

Communication challenges: Explore the communication challenges faced by health workers when interacting with Afghan refugee women. Discuss strategies that have been effective in overcoming these challenges:

7. What are the main communication challenges you face when interacting with Afghan refugee women? How do you navigate these challenges?

8. In your experience, what are some effective strategies for overcoming language and cultural barriers in healthcare interactions with Afghan refugee women?

Cultural sensitivity: Inquire about the importance of cultural sensitivity in healthcare delivery. Ask the participants to share their experiences and insights on how to provide culturally sensitive care to Afghan refugee women:

9. How important do you think cultural sensitivity is in providing healthcare to Afghan refugee women?

Supporting the healthcare workforce:

Training and resources: Discuss the training and resources available to healthcare workers for better understanding the healthcare needs of Afghan refugee women. Identify any gaps or areas where additional support may be needed:

10. What kind of training or resources have you received to better understand the healthcare needs of Afghan refugee women?

Prompt. Are there any gaps or areas where you feel additional support or training would be beneficial for healthcare workers serving this population?

Conclusion and closure:

Final thoughts: Give participants an opportunity to share any final thoughts or suggestions they may have regarding the healthcare needs and expectations of Afghan refugee women in Canada.

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Thank you and closure: Express your gratitude to the participants for their valuable insights and contributions. Provide any information on how they can stay informed about the research findings or follow-up steps.

Stop recording

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Interview Guide

Study Title: Shaping the care they deserve: needs, expectations and recommendations of healthcare provision at the New Canadians Health Centre for Afghan refugee women in Edmonton.

Healthcare needs

I have a set of questions that will help me better understand what health means to you and what is relevant when addressing your health needs in a healthcare setting. Some questions can be personal, so before I begin, do I have your permission to talk about these personal things with you? Remember, you can decide not to answer any question you want or contact me afterwards to withdraw any answer you want. Also, this conversation will be recorded. Do I have your permission to record it?

Sociodemographic

Name:

Age:

Marital status:

Education:

Children:

How long did you live in Afghanistan?

Do you have family in Afghanistan? Who?

Countries visited before Canada:

Length in Canada:

Diseases/illnesses:

Current health concerns:

Medications:

[redacted]

PRE-MIGRATION QUESTIONS

1. Daily life activities pre-migration:
    - Can you describe a typical day in your life in Afghanistan before you migrated to Canada?
    - What were your daily responsibilities and activities, especially in relation to your family and community?
2. Occupation and work:
    - What kind of work or occupation were you involved in before coming to Canada?
    - How has the change in occupation or work affected your sense of purpose and well-being since migrating?
3. Social connections and community involvement:
    - How were social connections and community ties a part of your daily life in Afghanistan, and have you been able to maintain or rebuild those connections in Canada?
    - In what ways did community involvement contribute to your overall well-being in Afghanistan?
    - In Afghanistan, how did your community support each other regarding health matters?
    - Can you share an experience where community connections positively influenced your health decisions or access to healthcare?
4. Leisure and recreational activities:
    - What leisure or recreational activities did you enjoy in Afghanistan?
    - Have you been able to continue or find similar activities in Canada?
    - How do these activities contribute to your overall sense of well-being and happiness?
5. Family dynamics and relationships:
    - Describe the role of family and relationships in your daily life in Afghanistan. How has this changed or remained the same since migrating to Canada?
    - Are there specific family traditions or practices that you've tried to maintain for the well-being of your family in the new environment?
    - In your family, how were decisions about health and well-being typically made in Afghanistan?
6. Access to healthcare in Afghanistan:

- Can you tell me about your experience with healthcare services in Afghanistan?
- How did you feel when accessing to healthcare in Afghanistan?
    - Did you have trust in the healthcare team?
    - Were you able to openly discuss all your health concerns?
- Were there specific healthcare practices or traditions that you found particularly beneficial to your well-being back home?
- Is there any health service that you needed that wasn't available in Afghanistan?
- How did you address your women's health concerns in Afghanistan?
- In Afghanistan, how did you participate in decisions about your family's health? Can you share a specific example?
- Did you ever need to advocate for specific health needs in Afghanistan? Can you share a situation where you had to speak up for yourself or others?

7. Emotional and mental well-being:
    - How did you address emotional and mental well-being in Afghanistan? For example when you were sad, or crying a lot, or tired.
    - How has this aspect of your life been affected by the migration?
    - Are there cultural practices or community support mechanisms that you miss from Afghanistan?
8. Sense of security and safety:
    - In Afghanistan, how did you perceive and ensure your safety and security?
    - How did you manage those security issues? For example, when you felt afraid, or threatened by something or someone.
    - How did you faced those things that made you uncomfortable, or that you didn't agree with? For example, rules that you didn't think were fair for you
    - Are there specific aspects of your daily life that contribute to your sense of security in your new environment?

POST MIGRATION QUESTIONS

1. Can you describe how you learned about the healthcare system in Canada?
    - Were there specific challenges or successes in navigating this system?
    - What resources or support have you found helpful in understanding and using healthcare services here?
2. Can you tell us about your experiences when you visit the doctor or the clinic in Edmonton?
3. Are there any barriers that make it hard for you to get healthcare here?
    - Transportation
    - Financial
    - Communication
    - Waiting times
    - Availability and access of services
4. When you see a doctor or nurse, what helps you feel comfortable?
    - What makes you trust a doctor?
5. Have you ever had a really good experience with a doctor or nurse?
    - What made it good?
6. What do you think the healthcare center or doctors can do better for people like you?
7. Do you feel that you can openly discuss your health concerns with doctors in Canada?
    - Why do you feel that way?
8. Are there things from your home country that you think could help you with your health here?
9. Do you ever have trouble understanding what the doctor or nurse is saying?
    - What would help you understand better?
    - Do you feel you have enough time to ask questions in a consult?
10. Do you feel in control of your health?
    - For example, do you decide when to seek medical help?
    - During the consult, can you make decisions regarding your treatment?
    - Is your family involved in your health? How?
    - Can you make decisions regarding your health, even if your family disagree? Can you share an example of that?

- How do you seek and gather information about health-related topics in your community, both in Afghanistan and Canada?
- Are there specific ways you prefer to receive information to make informed decisions about your health and well-being?

11. Sometimes, people feel worried, sad, or stressed.
    - Have you ever felt this way since coming to Canada?
    - Can you tell me about it?
    - What things make you feel better when feeling that way?
12. In Canada, what makes you feel uneasy or upset?
    - How do you deal with those things?
13. When you feel down or anxious, is there something that helps you feel better?
14. In some households, people might not always feel safe or respected.
    - Have you ever experienced anything at home that made you feel uncomfortable or unsafe? You don't have to share details, but please tell us if you've ever felt this way.
    - How do you manage those situations?
15. If someone you know was experiencing a difficult situation at home,
    - what advice or support would you give them?
    - What do you think could help them feel safer or better?
16. Are there specific health topics related to being a woman that you'd like to talk about or learn more about?
    - What kind of help or information would be good for you in these areas?
    - Have the doctors or nurses help you with your women's health concerns?
17. If you ever needed advice or help with something related to being a woman,
    - where would you feel most comfortable going?
    - Is there a place or person you trust for guidance?
18. If you could change something in the way doctors and nurses treat patients, what would you change?
19. what can the NCHC, or other health centre do to make it more familiar and welcoming to you?
20. How do you believe the Afghan community can be involved to make the health system better for them?
21. How would a perfect health system work for you?

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نامه اطلاعات مطالعه

عنوان مطالعه: شکل دادن به مراقبت وتوجح که زنان پناهنده افغان شایسته ان هستند: نیازها، انتظارات و توصیه های ارائه مراقبت های بهداشتی در مرکز بهداشتی کانادایی جدید برای زنان پناهنده افغان در ادمونتون.

سرپرست: [redacted]

پژوهشگر: [redacted]

این مطالعه پژوهشی در مورد چیست؟

از شما دعوت می شود تا در گفتگو در مورد تجربیات خود در زمینه مراقبت های بهداشتی در کشور خود، کشورهای در حال گذار و کانادا شرکت کنید. همکاری دارید. هدف از این تحقیق بررسی و (NCHC) از شما خواسته شده است که در این تحقیق شرکت کنید زیرا با مرکز سلامت کانادایی های جدید درک نیازهای بهداشتی شما، تجربیات شما در زمینه ارائه مراقبت های بهداشتی، و انتظارات و توصیه های شما از اقدامات به منظور دریافت مراقبت .های بهداشتی ایمن و مناسب فرهنگی در کانادا است
نتایج این مطالعه در حمایت از تحقیق پایان نامه من استفاده خواهد شد. قبل از اینکه تصمیم بگیرید، این فرم را با شما بررسی می کنم. اگر احساس .می کنید چیزی باید واضح‌تر شود، تشویق می‌شوید که سؤال بپرسید. یک کپی از این فرم برای سوابق به شما داده می شود

چرا این مطالعه را انجام می دهم؟

بیش از 1000 مهاجر جدید از سال 2021 از افغانستان به ادمونتون وارد شده اند. ارائه خدمات صحی مناسب گامی مهم برای رفاه و آسایش این مهاجرین در کانادا است. اطلاعات کمی در مورد تجارب زنان تازه وارد افغان در دسترسی و استفاده از سیستم مراقبت صحی وجود دارد. این تحقیق به بررسی نیازها و تجربیات زنان افغان تازه وارد در مراقبت های صحی در کانادا و انتظارات و توصیه های آنها از خدمات صحی, با هدف دستیابی به مراقبت ایمن و فرهنگی مناسب برای آنها می پردازد

چه کسی و چه چیزی دراین مطالعه دخیل است؟

زنان جوان تازه مهاجر افغان (سن بالای 18 سال) در یک مصاحبه یک نفره تقریباً 60 دقیقه ای شرکت خواهند کرد. مصاحبه ها را می توان شخصا، در انجام داد. برای مصاحبه تلفنی یا تماس تصویری، Zoom ،وبا از طریق تلفن، یا با تماس تصویری با استفاده از پلت فرمNCHC یک اتاق خصوصی در شرکت کنندگان به شکل شفاهی با پیوستن به مطالعه موافقت خواهند کرد

این مطالعه با دادن فرصتی برای به اشتراک گذاشتن تجربیات خود، و همچنین فرصتی برای آموزش و اطلاع رسانی به جوامع دانشگاهی، دولت و سیاست در مورد چگونگی پاسخگویی بهتر به نیازهای زنان پناهنده و تازه واردان افغان به طور کلی، برای شما مفید خواهد بود. همچنین این امکان وجود دارد که هیچ مزیتی برای شرکت کنندگان نداشته باشد. این مصاحبه ها ممکن است خاطراتی از تجربیات در افغانستان، کشورهای در حال گذار، یا کانادا را که دردناک یا آسیب زا هستند، به همراه داشته باشد. منابعی برای خدمات مشاوره در مصاحبه ها وجود خواهد داشت که در صورت نیاز می توان از آنها استفاده کرد
شرکت شما در مصاحبه کاملاً داوطلبانه است. حتی اگر قبول کردید که در مطالعه شرکت کنید، می توانید نظر خود را تغییر دهید و در هر زمان که بخواهید از آن کنار بکشید بدون اینکه عواقبی برای شما داشته باشد. اگر می خواهید مصاحبه فردی خود را از داده ها حذف کنید، می توانید این کار را در هر زمانی تا دو هفته پس از مصاحبه انجام دهید

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پاداش برای اشتراک کنندگان

یک کارت هدیه 25 دلاری به یک فروشگاه مواد غذایی و/یا قهوه/رستوران به همه شرکت کنندگان پس از تکمیل هر مصاحبه داده می شود تا از شما برای زمانی که در اختیارما قرار داده اید تشکر کنیم. در صورتی که با استفاده از پلتفرم زوم در مصاحبه شرکت کنید، کارت هدیه از طریق پست به آدرس منزل شما تحویل داده می شود. اگر هر زمان خواستید از مطالعه خارج شوید، بازهم کارت هدیه را دریافت خواهید کرد. نوشیدنی های سبک و تنقلات به شرکت کنندگانی که مصاحبه حضوری دارند ارائه می شود

محرمانه بودن و ناشناس بودن مطالعه

اطلاعاتی که شما ارائه می کنید کاملاء خصوصی خواهد ماند. هیچ نام یا سایر مشخصات هویتی به اطلاعات یا در هیچ گزارشی از مطالعه پیوست نخواهد شد. در طول مصاحبه شرکت کنندگان موظف به پاسخگویی به هیچ یک از سوالات نیستند. مصاحبه های حضوری در یک دستگاه ضبط صدا دیجیتال ضبط می شود تا از صحت اطلاعات اطمینان حاصل شود و همیشه ناشناس و محرمانه خواهد ماند. شرکت‌کنندگانی که مصاحبه را از طریق پلتفرم زوم تکمیل می‌کنند، این فرصت را خواهند داشت که کامره خود را خاموش کنند. علاوه بر این، آنها می توانند نام خود را تغییر دهند و به جای آن از یک نام مستعار در توضیحات برچسب نام پلت فرم استفاده کنند

اطلاعات مصاحبه‌ها در فولدر با رمز محافظت می‌شود و معلومات کاغذی در یک الماری قفل شده در دفتر من نگهداری می‌شود و فقط برای من و سرپرستم در دسترس خواهد بود. تمام معلومات ضبط شده در یک پوشه ایمن شده با رمز عبور در یک فولدر کامپوتر ذخیره می شود. فقط محقق اصلی و سرپرست او به ان دسترسی خواهند داشت. این معلومات به مدت 5 سال با رعایت پروتکل ایمنی و ذخیره سازی داده های دانشگاه آلبرتا نگهداری می شوند و پس از این مدت برای همیشه پاک می شوند

نتایج این مطالعه برای حمایت از رساله دکتری من مورد استفاده قرار خواهد گرفت. ممکنما نتایج کلی این مطالعه را در مجلات علمی منتشر کنیم و نتایج را در کنفرانس‌ها ارائه کنیم، با این حال، نظرات تک تک شرکت‌کنندگان قابل شناسایی نیستند. ما داتا ها را برای حداقل 5 سال نگه می داریم و سپس داتا ها با تضمین حفظ حریم خصوصی از بین می روند. در صورت استفاده از ان داتا برای مطالعات دیگر در آینده، تاییدیه از اداره اصول اخلاق اخذ خواهد شد

نتایج این مطالعه خلاصه می شود و با همه شرکت کنندگان و همچنین آژانس های اسکان و خدمت به پناهندگان در ادمونتون به اشتراک گذاشته می شود

معلومات درباره تماس باما

از توجه شما به این درخواست بسیار سپاسگزاریم. اگر سؤالی دیگری دارید یا اطلاعات بیشتری در مورد مطالعه می‌خواهید، لطفاً با محقق اصلی، کریستین نِوِس, یا استاد راهنما، دکتر ریکا گوکیرت، به ایمل آدرس های ذیل به تماس شوند

[redacted]

[redacted]

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Study Information Letter

Study Title: Shaping the care they deserve: needs, expectations and recommendations of healthcare provision at the New Canadians Health Centre for Afghan Refugee Women in Edmonton

Research Investigator: Supervisor:

[redacted]

What is the study about?

You are invited to take part in a conversation about your experiences with healthcare in your home country, transition countries, and Canada. You have been asked to participate in this research because of your involvement with the New Canadians health Centre (NCHC). The purpose of this research is to explore and understand your health needs, your experiences with healthcare provision, and your expectations and recommendations of practices in order to receive safe and culturally appropriate healthcare in Canada.
The results of this study will be used in support of my thesis research. Before you make a decision, I will review this form with you. You are encouraged to ask questions if you feel anything needs to be made clearer. You will be given a copy of this form for your records.

Why am I doing this study?

More than 1,000 newcomers have arrived in Edmonton from Afghanistan since 2021. Appropriate healthcare service delivery is a crucial step for newcomers' well-being and prosperity in Canada. Little is known about the experiences of Afghan women newcomers accessing and utilizing the healthcare system. This research will explore the needs and experiences of Afghan women newcomers with healthcare, and their expectations and recommendations of healthcare service with the goal of achieving safe and culturally appropriate care for them.

Who and what is involved?

Women Afghan newcomer adults (age 18+) will participate in one individual interview of approximately 60 minutes long. Interviews can be held in person, in a private room at the NCHC, by telephone, or by video call using Zoom platform. For telephone or video call interviews, participants will verbally agree to join the study.

The study will benefit you by giving you the opportunity to share your experiences, as well as the opportunity to teach and inform the academic, government, and policy communities about how to better meet the needs of Afghan women refugees and newcomers in general. It is also possible that there will not be any benefits to participants. The interviews may possibly bring up memories of experiences in Afghanistan, transition countries, or Canada that are painful or traumatic. There will be resources for counselling services at the interviews, which can be used if needed.

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Your participation in the interview is completely voluntary. Even if you agree to be in the study, you can change your mind and withdraw at any time with no consequences to you. If you wish to have your individual interview removed from the data, you are welcome to do this at any time until two weeks after the interview.

Compensation

A $25 gift card to a grocery store and/or coffee/restaurant will be given to all participants after each interview is completed to thank you for your time. If you choose to participate in the interview using Zoom platform, the gift card will be delivered to your home address by mail. If you choose to withdraw from the study at any time, you will still receive the gift card. Light refreshments and snacks will be offered to participants having an in-person interview.

Confidentiality & Anonymity

The information that you provide will be kept private. No names or other identifying details will be attached to the information or in any reports from the study. During the interviews, participants are not obligated to answer any of the questions. In-person interviews will be audio-recorded in a digital audio recording device to ensure accuracy of the information and will remain anonymized and confidential at all times. Participants completing the interview through Zoom platform will have the opportunity to proceed with their camera off. Additionally, they can change their name and use a pseudonym instead in the platform name tag description.

The data from the interviews will be kept on a password protected computer and hard copies will be kept in a locked filing cabinet in my office and will only be available to myself and my supervisor. All recorded data will be stored in a password-secured folder in a computer. Only the principal researcher and his supervisor will have access to the data. The data will be held for 5 years, following University of Alberta's data safety and storage protocol, and permanently erased after that period.

The results of this study will be used in support of my thesis research. We may publish the overall results from this study in scholarly journals and present results at conferences, however, individual participant comments will not be identifiable. We will keep the data for a minimum of 5 years and then the data will be destroyed in a way that ensures privacy and confidentiality. If the data are used for other studies in the future, ethics approval will be obtained.

The results from this study will be summarized and shared with all participants as well as settlement and refugee serving agencies in Edmonton.

Contact Information