Experiences of African Immigrant/Refugee Women with Prenatal and Maternal Health Care Services and Treatment Adherence in Winnipeg, Manitoba

by

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Abstract

In recent years, the number of immigrants who come to Canada seeking health care has increased. The study had three objectives: (1) describe how some African immigrant/refugee women living in Manitoba access perinatal and maternal health care services; (2) describe their interactions with health care providers and (3) describe how their experience impacts their treatment adherence. The study utilized principles of community-based participatory research in partnership with Sexuality Education Resources Centre Manitoba (SERC) representative leaders. Purposive and snowball sampling methods were used to recruit 16 women from SERC and local African community organizations. Data collection included in-depth interviews, and analysis was based on interpretative phenomenological analysis (IPA) and intersectionality from a black feminist tradition. IPA facilitated the description of meanings provided by the women of their experiences and intersectionality enabled to highlight issues such as how perceived racism can intersect with being immigrants/refugees facing unique challenges while accessing health care. The participants shared accessing these services through Mom and Me program, clinics, and family doctors. The women who arrived while pregnant or became pregnant within the first two years of their stay in Winnipeg experienced barriers such as language differences and lack of social support. Some of the main themes that emerged from the women's experiences with accessing care included: it was tough, trying to understand and left hanging. The women described positive and negative experiences with health care providers. The lack of understanding of the health care system led the women feeling unsure if their experience was due to racism/discrimination or to structural barriers. The women also shared not following some recommendations due to their traditional/cultural way of caring for a newborn. To our knowledge this is the first study that focused on African immigrant/refugee women's experience

with prenatal and maternal services in Manitoba. The findings from the study may help health care professionals to provide more holistic care. The study may also inform policy and advocacy actions to improve health services to this population.

Key words: African immigrant/refugee women, prenatal and maternal care, community-based participatory research (CBPR), interpretative phenomenological analysis (IPA) and intersectionality.

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Chapter 1: Introduction

In 2016, Canada welcomed 1, 212, 075 new immigrants; of these 13.4% were African immigrants (Statistics Canada, 2016). Manitoba welcomed approximately 19,000 new residents in 2019 - the highest annual immigration of its history (Manitoba Government, 2019).To date, only one study conducted in Winnipeg, Manitoba, examines the experiences of African immigrant families with the health care system (Woodgate et al., 2017). African immigrants come from a wide range of beliefs and ethnic backgrounds. Additionally, studies have found that perinatal and maternal health care services are primarily based on women that are born in Canada and are descendants from European origins and lack cultural sensitivity for immigrant women (Njue et al., 2022). African refugee women may also have specific needs because of their exposure to war, forcefully being removed from their home country and living in refugee camps (Willey et al., 2020). Before immigrating to Canada, some African immigrant/refugee women might have also experienced female genital cutting (FGC). Female genital cutting is a practice that involves the partial or complete cutting of external female genitalia that is practiced in different continents throughout the world (Berg et al., 2014). There are many reasons for this practice in different African countries, including preserving cultural traditions and beliefs (Proudman, 2022). As a result, the need for perinatal and maternal health care services that are flexible and culturally sensitive is important. When health care providers stigmatize African immigrant/refugee women who have experienced FGC, it can cause emotional, psychological, and physical problems (Lurie et al., 2020). Furthermore, not being proficient in English might make it difficult for some African immigrant/refugee women to develop a trusting relationship with providers (Pandey et al., 2021). How a physician communicates with a patient has also been shown to be influenced by factors such as patient's ethnicity and communication style

(Street et al., 2007) . Street and colleagues (2007) also found that physicians were more contentious with black patients. When health providers are not encouraging or have unhelpful or discriminatory attitudes, patients might not adhere to treatment plans, with potential long-term impacts on health.

Purpose of the Study

The primary purpose of the study was to highlight the lived experiences of African immigrant/refugee women as they accessed prenatal and maternal services and engaged with health care providers. The study explored the processes during and after their encounters with health care providers. Moreover, the study examined how African/refugee women responded to the care they received and their decision to follow or not follow maternal care guidelines. As a result, the study sought to provide information for African immigrant/refugee women and the health professionals they interact with to build relationships and work towards dismantling stigma of FGC and increase treatment adherence.

Research Questions

The following were the research questions that sought to uncover the experiences of African immigrant/refugee women living in Winnipeg, Manitoba with perinatal and maternal.

1. How do some African immigrant/refugee women access perinatal and maternal health care services in Winnipeg, Manitoba?
2. How do African immigrant/refugee women describe their experience specifically with their health care providers in Winnipeg, Manitoba?
3. How do their experiences with prenatal and maternal health services and health care providers in Winnipeg, Manitoba, impact their treatment adherence?

Significance of the Study

The topic is important because as immigration to Manitoba increases, understanding the healthcare needs of immigrants/refugees is critical. The study adds to the few studies that have focused on the experiences of Africa immigrant/refugee women with the Canadian health care system. The research findings may be useful for policymakers, health care providers and organizations that work with this population. The findings may highlight advocacy actions and increase healthcare provider awareness of the need for context sensitive and culturally appropriate care for African immigrant women. Cross study comparisons (e.g., in Europe) may help to define more promising maternal healthcare approaches for this population. Lastly, the study may help identify additional research needed in relation to African immigrant and refugee women and the health care system. In other words, researching their experience with prenatal and maternal care not only highlights their lived experience but also facilitates the opportunity for further inquiry on African immigrant/refugee and the health care system.

Identity and Positionality

As a master's student at the University of Manitoba, my social position in carrying out the study was that of a student. However, I was born in Ethiopia, immigrated to Kenya, and moved to Canada when I was 10 years old. My interest in this topic stemmed from my personal interactions with the Canadian healthcare system, including my primary care doctor visits, volunteering at the Children's Hospital at the Health Sciences Centre, and my employment as a COVID-19 screener at Cancer Care Manitoba. These experiences have given me several firsthand witnessing to the interactions between some healthcare professionals and patients who are racially, ethnically, and culturally different. The most striking instance occurred when I volunteered at the Children's Hospital and witnessed how a White Canadian resident doctor

interacted with an African immigrant mother. This east African mother objected to a resident doctor caring for her daughter, which infuriated the resident, who then retorted by saying, "I am better than the doctors in Africa," before departing. His actions and remark completely shocked me, and I was furious about it- especially since I am also an east African immigrant woman from Africa. I felt her frustrations. I had the assumption that being a physician meant you will always act professionally and treat others with sensitivity. Furthermore, this experience made me wonder if White Canadian physicians generally had the same mindset as the resident doctor. I wondered if they were taught this in medical school. While volunteering at Children's hospital, I was also disappointed at how it seemed like there were no interpreters available when needed. This led to my role to include interpreting whenever there was a Swahili or Amharic-speaking family. Although I was happy to help, I wondered, what if I had not been there, how long would it have taken for the doctors to communicate with the families? I strongly believe that hospitals and primary care clinics need to include or have access to professional interpreters who are bilingual and acquainted with both cultures.

My interest to learn more about how these interactions affect treatment compliance stems from hearing stories about my friends' family members who are from Ethiopia and have been given a diabetes diagnosis. These individuals described how their primary care physicians would attempt to coerce them into taking specific prescriptions or receiving insulin injections, disregarding their feelings towards these treatments. Their medical professionals frequently resorted to intimidation when patients refused to take these prescriptions. As a result, I was interested in hearing more from African immigrant women about their firsthand experiences with healthcare providers' recommendations-good and bad.

My identity indicates that I am a non-White settler who benefits from the theft of Indigenous peoples' lands. Although I have never used Winnipeg's prenatal and maternal health care services, I am African immigrant woman. I am aware that minority groups are denied access to certain opportunities or resources as a result of governments and academic institutions' tolerance of racism and discrimination against them, which negatively affects their socioeconomic status and mental health. I am also conscious that when we serve patients, both non-verbal and vocal behaviors can reveal implicit biases that we may not be aware of concerning other groups. Thus, when doing this research, I kept in mind that medical culture may also be seen in the communication styles used by healthcare professionals through verbal and non-verbal cues. I also considered the structural policies that create hurdles in the patient-doctor connection when I approached this research. My primary area of interest was integrating the lived experiences of African immigrants/refugees into the field of health services. Lastly, I was committed not to generalize the experiences of African immigrant/refugee women wrongly. To accomplish this and prevent my own assumptions from influencing this study, I exercised reflexivity during this study by writing a research memo.

Chapter 2: Review of Literature

Despite the limited number of studies that focused on the experiences of African immigrant/refugee women in Canada with prenatal and maternal care, there are some that focus on their interactions with the healthcare system. Similarly, research has been conducted on this population's encounters with healthcare systems in Europe. A comprehensive review of the available literature is essential to gain insights into topics relevant to this study. This section aims to present an overview of current literature covering various areas that relate to the study, including the experiences of African immigrant/refugee women in accessing prenatal and maternal services, the dynamics of the patient-doctor relationship with a focus on cultural sensitivity, the experiences of women who have undergone FGC, racism and discrimination within the healthcare system, and being racialized immigrant/refugee as well. In the Canadian context, perinatal and maternal care is provided at no direct cost by the provinces and territories under the Canadian Health Act of 1984 for Canadian citizens and permanent residents (Government of Canada, 1985). However, research indicates that there are a variety of obstacles to accessing these services for immigrants, including African refugee/immigrant women. To begin, adapting to a new country and understanding a new health care system can also be challenging.

In a meta-ethnographic review, Pangas and colleagues (2019) explored refugee women's experience with maternity services in high-income countries. The review found that while identical challenges do not impact all refugee women, many refugee women during the settlement period are disproportionally affected by challenges such as economic struggles, limited social connections and low or limited proficiency in English (Pangas et al., 2019). These contributed to their experiences when these women had access to perinatal and maternal health

services. However, the most consistent and significant barrier faced by African immigrant/refugee women to access maternity services identified in the literature is not sharing the same language as their provider (Bulma & McCourt, 2002; Due et al., 2022; Pangas et al., 2019). This is because other difficulties these women encountered could only be resolved after language was no longer an issue and they could have an understanding with their provider (Bulma & McCourt, 2002). In Bulma & McCourt's (2002) study, African immigrant women who did not have access to professional interpreters expressed that their physical and emotional needs could not be met. Participants who employed family interpreters or hired inexperienced interpreters reported being dissatisfied with the communications, feeling misunderstood, and unable to advocate for their care (Bulma & McCourt, 2002; Pangas et al., 2019). It is necessary to identify solutions to this problem since it affects other difficulties that African immigrants/refugees face and makes them reliant on the provider's ability to bridge the English language gap (Due et al., 2022). Not having access to professional interpreters is also significant because studies show that strong communication improves the chances of patient adherence to a course of treatment by 2.16 times (Zolnierek & Dimatteo, 2009) .

Other obstacles to accessing prenatal and maternity care that African immigrants/refugees reported include feeling disregarded by their caregivers and helpless to influence or change their circumstances (Due et al., 2022). As a result, these women believed that receiving prenatal care was more of a burden than a benefit, which left them with little understanding about prenatal care (Bulma & McCourt, 2002). Additionally, Due et al., (2022)'s study found that despite having children, providers did not consider the refugee women competent about their needs during pregnancy and labor. Furthermore, in Reitmanova & Gustafson's (2008) study, the Muslim women participants reported how maternal health care providers did not understand their

unique needs. For example, in Alzghoul et al., (2021)'s study conducted in Northwestern Ontario, Canadian Muslim women participants reported their providers did not understand why they were choosing to fast during Ramadan or preferred to have a female provider. All the aforementioned barriers lead these women to receive inferior perinatal and maternal care (Brämberg et al., 2010; Due et al., 2022). Due and colleagues (2022) have also found that these negative experiences impact African refugees' mental health and influence their desire to utilize healthcare services in the future.

Moreover, only a few studies have specifically examined African immigrant/refugee women's experience accessing maternal health care services such as midwifery care. Midwives are primary care providers who support pregnant women by ordering tests, prescribing maternal/newborn care medications, and attending births in various settings such as communities, homes or hospitals (Government of Manitoba, 2023). In Canada, midwifery services are regulated and funded at the provincial/territorial level, and a referral from a physician is not required (Canadian Association of Midwives, 2023; Government of Manitoba, 2023). However, existing studies not explicitly focused on African immigrant/refugee women have identified several barriers to accessing midwifery care, including a lack of knowledge about these services, the misconception that a family physician referral is necessary, and a lack of understanding of the role of midwives (Darling et al., 2019; Heaman et al., 2015). Furthermore, there is a higher demand for midwifery services in Manitoba than the current number of practicing midwives can accommodate (Thiessen et al., 2016). A study by Heaman et al., (2015), focusing on the experiences of women in Inner City Winnipeg accessing prenatal care, revealed that all available midwives were fully booked when these women attempted to access midwifery care.

Furthermore, there are limited studies focused on African immigrant/refugee women's access to maternal services after birth. This is significant since a Canadian study that examined depressive symptoms among pregnant women found that immigrants from African countries were among the groups with the highest rate of depression symptoms when compared to women who were born in Canada (Miszkurka et al., 2010). A study done in the United Kingdom of Nigerian mothers with postnatal depression found that these women were disappointed and felt neglected by their health care providers (Ling et al., 2023). This is because they hoped that medical professionals would prompt them to discuss depressive symptoms as they were battling cultural conventions to feel comfortable bringing up the subject of postpartum depression on their own (Ling et al., 2023). Those who were able to overcome cultural expectations of being strong and seeking help mentioned that their providers diagnosed them with postpartum depression quickly and began prescribing medications without listening to their preferences (Ling et al., 2023). Some of the participants described expecting to be referred to a specialist but were not, and others expressed cultural perceptions of mental health and medications (Ling et al., 2023). Additionally, they expressed that their providers did not explain the side effects of the medications (Ling et al., 2023). This resulted in the participants feeling defeated and deciding not to take the prescribed medications (Ling et al., 2023). A second study also found similar results of feeling let down by health care professionals (Gardner et al., 2014).

Patient-doctor Relationship and Culturally Appropriate Care

The relationship between a patient and physician is a significant relationship founded on vulnerability and trust (Chipidza et al., 2015). When participating in this relationship, the doctor pledges to adhere to a code of ethics, honor the patient's autonomy, safeguard confidentiality, obtain informed consent, and provide optimal care based on the existing evidence (Chipidza et

al., 2015). The patient is expected to be truthful, open in communication, and receptive to the physician's advice (College of Physicians and Surgeons of Saskatchewan, 2021). Thus, the patient-physician relationship involves mutual respect, an understanding of the patient's needs for positive health outcomes, trust, and collaborative efforts (Bajgain et al., 2020). However, there is evidence suggesting that immigrant patients often lack this kind of relationship with their primary care providers (Asanin & Wilson, 2008; Bajgain et al., 2020; Pollock et al., 2019).

Some challenges can arise during history taking or discussion of treatment that prevents patient-physician relationship building (Stewart, 1995). These challenges encompass communication issues, such as a lack of communication skills by either the physician or the patient (Stewart, 1995). When it comes to African immigrant/refugee women, the evidence suggests that they face several obstacles with their providers, including healthcare providers.These challenges include health care providers who do not speak their language and who do not involve them in the decision-making process (Due et al., 2022; Pangas et al., 2019; Lum, 2016). As mentioned above, language differences can impact access to quality care (Pandey et al., 2021). Language differences can also make it difficult for physicians and patients to get to know each other and build a trusting relationship.

Moreover, shared decision-making involves more than just the physician's willingness to involve the patient in the decision-making process; it also entails providing the patient with information about available programs and seeking the patient's understanding of their diagnosis (Evans et al., 1987; Kleinman et al., 1978). However, based on Bajgain and colleagues' (2020) review, many immigrant patients in Canada attributed their dissatisfaction with their interactions with healthcare services mainly to a lack of shared decision-making with their physicians. A separate study conducted in Sweden that focused on immigrant women patients' experience with

participation in their own care revealed that the interviewed women participated in their care when the physician listened to them with an open and caring attitude. For these women, shared participation in their care meant not only caregivers providing them an opportunity to express their needs and feeling free to make a request but also being taken seriously (Brämberg et al., 2010). An Australian study that focused on African refugee women accessing prenatal care suggested that women expressed a sense of not being sufficiently recognized during and pregnancy period (Due et al., 2022). Women emphasized the significance of having the ability to provide input and exert control over their pregnancy experiences (Due et al., 2022). Nevertheless, more studies are required that specifically examine shared decision-making from African immigrant/refugee's perspectives.

Cultural sensitivity includes awareness of one's assumptions, being familiar with African immigrant women's beliefs and norms, and understanding how to ask about issues these women are experiencing (Due et al., 2022; Pangas et al., 2019). Cultural sensitivity also includes being aware of the culture of biomedicine and how biomedicine can transmit stigma and maintenance of racial bias in institutions (Kleinman et al., 1978; Kleinman & Benson, 2006). Cultural humility, on the contrary, encompasses self-exploration and self-critique, addressing biases about other cultures while demonstrating a readiness to learn from others (Tervalon and Murray-García, 1998). Both cultural sensitivity and humility are fundamental concepts that contribute to providing culturally appropriate or informed care. However, in their review, Pangas et al., (2019), found that African immigrant/refugee women in high-income countries are regularly presented with care options that go against their cultural beliefs. This includes discussing technology and inductions contrasting these women's understanding of labour or giving birth (Pangas et al., 2019). Higginbottom and colleagues (2013) explored Sundanese women's

experience with maternity care in Alberta. The participants in the study described that they experienced a lack of respect for their cultural practices (Higginbottom et al., 2013). The lack of respect for these women's culture is significant because studies show that the lack of cultural humility and lack of knowledge of African immigrant/refugee women by providers can lead these women not to trust providers (Wojnar, 2015). One implication is that it reduces antenatal appointment attendance (Carolan & Cassar, 2010).

Female Genital Cutting

As mentioned above, FGC is a practice that involves the partial or complete cutting of external female genitalia (Berg et al., 2014). The World Health Organization (WHO) has classified FGC into four types based on severity (World Health Organization, 2023). Type I is the cutting of the prepuce and partial or complete cutting of the clitoral glands (World Health Organization, 2023). Type 2 is the partial or complete cutting of the clitoral glands and the labia minora, with or without the removal of labia majora (World Health Organization, 2023). Type 3 is infibulation, the narrowing of the vaginal opening, which is done through stitching with or without the removal of the clitoris (World Health Organization, 2023).Type 4 includes procedures such as incising, scraping, piercing and cauterization by burns of the clitoris and surrounding tissue (World Health Organization, 2023). In 2020, it was estimated that 200 million girls and women in 31 countries had experienced FGC (UNICEF, 2020). In 2011, it was estimated that more than 168,000 women in the United States had either undergone FGC or were at risk of FGC (Chibber et al., 2010). In Canada, although an amendment to the Criminal Code of Canada was passed prohibiting all forms of FGC, there is a lack of research focused on the prevalence and the number of girls who are at risk of FGC (Statistics Canada, 2023). However, there were a couple of qualitative studies conducted in Canada focused on FGC (Chalmers &

Hashi, 2000; Jacobson et al., 2022). The lack of research studying the prevalence of FGC in Canada is significant because there is evidence that women who have undergone FGC are more likely to have adverse obstetric and neonatal outcomes (WHO study group on female genital mutilation and obstetric outcome et al., 2006). A review study found that women who have undergone FGC had a higher rate of caesarean section, instrumental delivery, prolonged labour, and perineal tears (Lurie et al., 2020). A study by Chibber and colleagues (2010) study also revealed that women who had experienced FGC were twice as likely to have a cesarean section during delivery. Moreover, this information is also relevant to Canada because Canadian healthcare providers indicated they lack confidence in caring for women who have undergone FGC (Deane et al., 2022).

Furthermore, African immigrant/refugee women who have undergone FGC expressed that providers did not understand FGC, ridiculed them, and made hurtful comments (Bulma & McCourt, 2002; Chalmers & Hashi, 2000). For example, in Chalmers and Hashi's (2000) study, African immigrant/refugee women stated that when doctors discovered they had experienced FGC, health care providers displayed expressions of disgust and urged their colleagues to look without seeking the women's approval. Additionally, since FGC is illegal in Canada, some women reported being fearful of seeking prenatal care (Chalmers & Hashi, 2000). Instead, these women sought prenatal care from friends or family before consulting family doctors (Chalmers & Hashi, 2000; Wojnar, 2015). Thus, it is important that providers be aware of FGC, understand the cultural reasons and beliefs about FGC, and be sympathetic towards these women. In another study done in Sweden of African immigrant women who have experienced FGC experience with maternity services, the women expressed that they were happy and felt relieved when their providers were knowledgeable about FGC (Lundberg & Gerezgiher, 2008). Thus, the findings

from this study highlighted that negative experiences of African immigrant/refugee women with maternity services were associated with providers who lacked knowledge about FGC (Lundberg & Gerezgiher, 2008).

Discrimination and Racism Within the Health Care System

Discrimination is any action, judgement or practice that causes the exclusion of individuals and reinforces oppressive relations or conditions (Hyman, 2009; Karlsen & Nazroo, 2002; Krieger & Sidney, 1996). Discrimination against individuals or groups might occur due to language, culture, or religion (Carrasco et al., 2009). Racism is the idea that persons belonging to particular groups are less valuable than others because of the colour of their skin (Access Alliance, 2007). Prejudices, stereotypes, or beliefs can be used to illustrate racism (Paradies et al., 2015). Systemic racism refers to established customs, laws or practices that perpetuate racial inequities in society (Phillips-beck et al., 2020). In Canada, several studies have shown that racism exists within the health care system (Phillips-beck et al., 2020). Although much of the racism relates to Indigenous populations, there is also racism and discrimination against Black communities within the health care system (Dryden & Nnorom, 2021; Husbands et al., 2022). For example, in a study by Mahabir and colleagues (2021) that explored the impact of current healthcare policies and practices on racialized groups in Toronto, the participants indicated feeling disrespected or mistreated when receiving health care. This is significant because encounters with racism in healthcare settings can shape individuals' perceptions of the healthcare system, impact their interactions with healthcare providers, and play a role in determining whether individuals adhere to physicians' recommendations and their future utilization of healthcare services (Van Ryn et al., 2011; Williams & Mohammed, 2009).

Being an Immigrant/Refugee and Racialized in Canada

African immigrant/ refugee women, along with their immigrant/refugee status, also face racialization within the Canadian context. Racialization is how groups are categorized (Carrasco et al., 2009). This leads to them encountering multiple and intersecting forms of discrimination. Being an immigrant leads to experiences of systematic barriers or discrimination by the health care system, where the health care system does not consider the specific needs of immigrants/refugees (Pollock et al., 2019). Misinformation about the healthcare system and a lack of culturally appropriate mental health services are two other examples of systemic discrimination (Pollock et al., 2019). The lack of sharing information with this population about the different health care services available can also be a systemic barrier or discrimination. Pollock et al., (2019)'s study, which included interviews with health care providers and newcomer immigrants, they mentioned instances where health care providers did not accept new patients based on their ability to speak in English. The immigrant participants also described feeling like the doctors viewed them as overly time-consuming and burdensome (Pollock et al., 2019).

Systemic barriers can be compounded with encountering health care providers who have negative stereotypes about racial minorities. This includes being perceived as unintelligent and unable to comprehend information (Benkert & Peters, 2005). Overt racism against racial minorities can also occur, for example, when medical professionals treat them rudely with facial gestures (Cortis, 2000). Furthermore, systematic racism exacerbates health inequities among racialized populations in Canada. For example, this was reflected in the COVID-19 pandemic, where high COVID-19 mortality rates were seen among racialized populations who especially had low-income status in 2020 (Gupta & Aitken, 2022). Therefore, it is important to consider the

systemic discrimination encountered by African immigrant/refugee individuals because of their immigrant status and the racism experienced by this population due to racialization.

Chapter Summary

The review of the literature primarily identified barriers faced by African immigrant/refugee women when attempting to access health care services. These barriers encompass a lack of access to professional interpreters and culturally appropriate care. Additionally, there is evidence indicating that African immigrants encounter difficulties when engaging with healthcare providers. Although the prevalence of FGC in Canada is not known, there is evidence suggesting that physicians lack confidence in providing adequate care to women who have undergone FGC, leading these women to experience stigma. Furthermore, there is evidence of racism and discrimination within the healthcare system. Therefore, the study is advantageous for the health care system, healthcare providers, and African immigrant/refugee women as it contributes to a comprehensive understanding of their needs and aids in addressing them effectively.

Chapter 3: Methods

This chapter provides information regarding the study's methodology, theoretical perspective, recruitment, data collection and data analysis procedures.

Methodology

The study involved community representatives at Sexuality Education Resource Centre MB (SERC) and African immigrant/refugee women participants. Therefore, a community-based participatory research (CBPR) methodology served as the main guiding principle for this thesis project. This methodology allows researchers and communities to collaborate in the research process to conduct relevant research focused on community needs and capacity-building and enable the dissemination of results (O'Reilly & Kiyimba, 2015; Smith & Osborn, 2014). Thus, the topic was selected in collaboration with SERC representatives. CBPR enables the discussion of issues such as ethnicity, racism, and encourages cultural humility (Minkler et al., 2012). This methodology also includes common principles such as building on the strengths of the community and reciprocity (Minkler et al., 2012). Thus, a strength-based focus enabled us to look at the community from a position of strength instead of focusing on the deficits.

The reciprocity principle emphasizes the need for a mutually beneficial interaction between researchers and community members (Minkler et al., 2012). The research extends beyond being merely an academic pursuit for my degree; it is important to SERC due to the rising participation of African immigrant/refugee women in SERC's programs. SERC aims to highlight the lived experiences of these women. Furthermore, SERC conducts workshops for health care providers as part of their initiatives. The insights derived from this study could potentially be shared in these workshops to offer recommendations to health care providers on effectively working with this specific population.

Furthermore, Smith and colleagues (2015), engaged community members to develop specific CBPR principles for African American community members, such as ‘we are family’ and ‘it takes a village’, that might resonate better with African immigrant/refugee women (Smith et al., 2015). Ultimately, this methodology enabled me to work with SERC representatives and African immigrant/refugee women in Winnipeg to understand how current policies affect this community and what new policies are required to ensure that these women have increased access to perinatal and maternal care and culturally appropriate care. As community partners, SERC representatives acted as guest committee members. They provided an understanding of African newcomer women’s culture, identified issues and problems that can arise during research and provided guidance in language to describe this population. SERC representatives also helped recruit participants by sharing about the study, posting posters at their site, and providing feedback on the interview guide questions.

Second, interpretative phenomenological analysis (IPA) served as the conceptual framework to describe and explore the experiences of African immigrant/refugee women with health care providers. Phenomenological qualitative research concentrates on determining the core of a phenomenon or the individual’s experience through a rigorous purposive sampling of participants and interviews for data collection (Pranee, 2017). Interpretative phenomenological analysis (IPA) is a qualitative approach that enables us to closely examine individual lived experiences as an interpretative process rather than using pre-existing theoretical concepts (Smith & Osborn, 2014). The emphasis is on understanding and describing the meanings provided by those who have had the experience and how these meanings influence their decisions, enabling the researcher to differentiate the relevance of the phenomenon/experience through the analysis process (Pranee, 2017). Furthermore, this methodology has been

demonstrated to be particularly useful for researching issues that are both complex and emotionally intense (Smith & Osborn, 2014). For example, the pain and despair that African immigrants/refugee women may experience when trying to access perinatal and maternal services is a complex topic.

Theoretical Perspective

The study utilized intersectionality within the Black feminism tradition as a theoretical perspective. The concept of intersectionality began with black feminist activities in the 1960's and 1970's (Collins Hill & Bilge, 2016). This was a period of various social movements, and when African American women began to confront that black women's specific issues were not entirely addressed by these social movements such as anti-racism (Collins Hill & Bilge, 2016). However, the term "intersectionality," was first coined by scholar Kimberle Crenshaw in her 1991 article (Crenshaw, 1991). Crenshaw describes how an individual's various identities, such as their race and gender, intersect to shape their experience (Crenshaw, 1991). For instance, Crenshaw explains how, in the case of violence against women, these women's intersecting identities of race and class frequently influence the violence these women suffer (Crenshaw, 1991). Thus, intersectionality helped uncover how privilege or marginalization are brought about by several identities interacting.

Although there are studies focusing on marginalized populations, there is a lack of research utilizing intersectionality on African immigrant/refugee women (Hankivsky, 2012). The lack of research utilizing an intersectionality theoretical perspective is significant since Canada has a multicultural population, and it is crucial to discuss how experiences alter based on intersecting identities to avoid ignoring various vulnerabilities (Hankivsky, 2012). Thus, an

intersectionality theoretical perspective provided an insightful and critical framework for guiding the study (Bowleg, 2012).

Additionally, intersectionality broadened the exploration beyond individual or community-level cultural impacts on immigrant/refugee health. Specifically, it enabled the exploration of structural issues, such as the power dynamics of status hierarchies, and how these factors affect interactions with healthcare providers (Viruell-Fuentes et al., 2012). Consequently, it offered a comprehensive examination, highlighting the intricacies of the interplay between immigration, refugee status, and health (Viruell-Fuentes et al., 2012). Furthermore, an intersectionality theoretical perspective helped examine if African immigrant/refugee women encounter racism, discrimination, and ageism while seeking healthcare.

Participant Selection & Data Collection

Purposeful sampling was used to recruit participants for this study. The opportunity to contribute to the research was advertised among representatives SERC. SERC has several programs for African immigrant/refugee women. Thus, posters with information were posted at SERC, where sessions were delivered, and interested community members were invited to participate in the study. Posters were also posted at African Communities of Manitoba Inc (ACOMI), an organization that strives to serve African communities within Manitoba. Snowball sampling techniques were also used through the African community centre. The inclusion criteria included African immigrants/refugees, women aged 18-45, having lived in Winnipeg for at least 2 years, and having given birth in Winnipeg at least once. Data collection included individual in-depth interviews in their language of preference at a place of their choosing. These interviews took about an hour. Data-gathering techniques included conversation and open-ended questions with enough flexibility to respect oral traditions. Additionally, I reviewed the first two

interviews with the African immigrant/refugee women to determine whether the format of the interview questions was suitable.

Data Analysis

The interviews that were conducted in English were transcribed using Trint, a transcribing software. However, for the interviews that were conducted in Amharic, I transcribed them using Word while translating them to English. The transcripts were then uploaded to NVivo and analyzed following the principles of IPA and guidelines provided by Smith et al., (2009). The first step was reading and re-reading or "*Immersing oneself in some of the original data"* (Page 72). Since some women had accents, the software did not accurately transcribe the audio recordings. Consequently, a substantial amount of time was dedicated to correcting the transcriptions and ensuring their accuracy. This allowed me to immerse myself in the data by actively listening to the audio recordings and re-reading and carefully reviewing the transcripts. The second step is initial noting, during which I read the transcribes case by case and made a note of my initial thoughts, highlighting points that captured my interest (Smith et al., 2009) Thus, during this stage, I conducted an inductive analysis, a coding process that refrains from forcing the data into a pre-existing theoretical framework (Braun & Clarke, 2006). Proceeding the initial noting, I applied the principles of IPA to understand how the participants constructed meaning from their experiences—subsequently, theoretical analysis which is driven by my theoretical perspective (Braun & Clarke, 2006).

Following intersectionality analysis, the participants' numerous identities were analyzed to identify disparities between various identities (Hankivsky, 2012). As an analytic tool, intersectionality was also used to highlight any discrimination the women faced by medical providers and how these experiences impacted the women. Specifically, during analysis,

categories such as race, age, immigrant identity, and length of time in Canada were analyzed to determine which ones seemed to interact to impact the participants the most while seeking perinatal and maternal care. Moreover, how these women experienced power dynamics while interacting with health care professionals was examined. Moving on to the third step, I focused on developing emergent themes based on the codes, memos, and fieldnotes I had written (Smith et al., 2009). This involved gathering relevant data pertaining to each potential theme or category. The fourth step was searching for connections across emergent themes (Smith et al., 2009). Using my notebook, I created maps and used my research questions as a guide to search for connections across themes. Furthermore, a summary of the analysis was presented to SERC representatives, and their input was incorporated. Overall, the analytic process was an iterative process, entailing reading the transcripts multiple times, coding, and determining descriptive categories and potential themes.

Ethical Considerations and Mitigations

I attended to several ethical considerations. There was a recognition that the mechanism for recruiting participants through SERC representatives could lead to individuals feeling pressured to be part of the study. Thus, SERC representatives were informed to post the study poster and share information about the study but not to coerce women to join. Second, while obtaining consent, the participants who were not proficient in English were given options to access interpreters. I took steps to create rapport with participants by being respectful and considerate of them before, during, and after the research. I explained to participants they had the right to withdraw from the study at any time in the language of their preference. The informed consent form clearly outlined the research details in an understandable way to the participants.

The participants were also given enough time to consult with someone they trusted before deciding whether to participate in the study.

Third, there was the potential of characterizing African immigrant/refugee women participants within a deficit discourse. A deficit discourse is a failure and disempowering narrative that ignores these individuals' social and structural determinants of health (Mollard et al., 2020). Deficit discourses can be seen when blame is placed on participants, context is ignored, and the study encourages negative and implicit beliefs about the community (Mollard et al., 2020). This can negatively impact this population and how they perceive researchers and research. Deficit discourses can also cause health care providers and communities to view African immigrant/refugee women from a deficit perspective (Mollard et al.,2020). To avoid a deficit discourse, tools such as person-centered questions were asked with a strength-based approach (Mollard et al., 2020). Additionally, there was the potential risk of reaffirming stereotypes commonly associated with this population. Caution was taken to prevent this in collaboration with SERC representatives surrounding the choice of words while writing the thesis.

Fourth, the interviews were conducted where the participants felt most comfortable. Feedback on the interview guide questions was sought from my thesis advisor and SERC representatives to identify any questions that might lead to the women feeling judged or experiencing distress. In any such instance, they were changed or rephrased. Additionally, at the start of the interview, the participants were reminded that they could stop the interview at any time and choose not to answer particular questions. During the interview, I also considered the participants' emotional well-being by being aware of any indications of distress, such as visible frustrations, withdrawing or asking for the interview to end.

Fifth, to maintain confidentiality and privacy of the women's responses, the audio recording and notes written during the interview were kept in a safe area, and the data was saved on a password-protected computer. The audio recordings were deleted after the transcripts were written. Each participant was given a pseudonym to preserve their privacy and maintain anonymity. I stored the linked code and pseudonyms identifying individual participants on a secure computer. For women who have experienced FGC, their country of origin was not disclosed so as not to add to the stigma that FGC is only practiced in certain African countries.

Lastly, there is always a risk of inaccurately presenting the participants' responses. As a result, a summary of the analysis was presented to the SERC representatives to ensure that the ideas and lived experiences are appropriately characterized. The study obtained ethical approval from the University of Manitoba Health Research Ethics Board. All ethical guidelines were strictly adhered to. The participants were given $60 cash to compensate them for their time.

Chapter summary

Overall, community-based participatory methodology principles were applied when collaborating with SERC representatives. Participant recruitment included posters at both SERC and ACOMI, and SERC representatives also disseminated information about the study to African women participating in their programs. Data collection encompassed in-depth interviews conducted both in person and virtually via zoom. The subsequent data analysis followed the principles of IPA and the steps outlined by Smith et al., (2009). Additionally, a theoretical analysis was carried out using intersectionality from Black feminist tradition. Lastly, several ethical considerations were consistently addressed throughout the study.

Chapter 4: Findings

A total of 16 African immigrant/refugee women, who were expecting or had given birth in Winnipeg, took part in the study, with origins from various African countries. Some had left their countries and migrated to other African countries before coming to Winnipeg, Manitoba. Two of the participants were expecting at the time of the interview in addition to having given birth in the past in Winnipeg. Five participants had given birth within the last 1-2 years, while the rest had older children. Concerning their marital status, the women revealed their status at the time of their latest pregnancy to highlight the support they had while pregnant. Two participants revealed their status as asylum seekers when they initially arrived in Winnipeg, whereas the remaining participants mentioned their arrival as refugees/immigrants. Although the women identified the country they immigrated from, I have withheld reporting this information to mitigate any potential stigma associated with the cultural practice of FGC based on their country of birth. Table 1 provides details about the characteristics of these women.

Table 1. Participants characteristics

Characteristic	n
Age at the time of giving birth	
16-25	6
26-35	8
36>	2
Marital status at the time of last pregnancy	
Married/Common-law	14
Widowed/separated/divorced	0
Single mother	2
Number of children	
1-2	8
3-4	4
5-6	4
Level of Education	
High School completed	2
Completed or enrolled in adult high school	4
College/university completed	7
Post-secondary enrolled	2

Post-secondary completed	1
How long they have lived in Canada 2-5 years 5-10 years 10-20 years Did not say	 5 5 5 1
How they described their health Healthy Have to see their family doctor frequently	 16 0
Women who gave birth during COVID-19 pandemic	5
Type of pregnancy and past experience of miscarriage Normal pregnancy Complicated pregnancy Miscarriage	 15 1 5
The number of women who had a family doctor at the time of last pregnancy	10

Three overarching categories or sections, each encompassing major themes from descriptive categories, were identified from the data (see table 2). The first section, "Accessing and Understanding Care", centres on how women accessed care while simultaneously trying to understand the health care system of their new context, Manitoba. The second section, "Communication Barriers", sheds light on communication issues between these women and their health care providers. The third section, "Response to Recommendations", centres on the different ways the women responded to recommendations from health care providers. Nevertheless, the women's experiences do not fit neatly into distinct categories, and the sections and themes are closely intertwined. The last paragraph outlines recommendations made by the women about the health care system that could increase access to quality prenatal and maternal services.

Table 2. Categories/sections and themes that were identified from the transcripts.

Sections	Themes
Accessing and understanding care	It was tough Some are caring Left hanging
Communication barriers	You're rushing Trying to understand No one explains
Response to recommendations	No support Acceptance Faith and culture convictions

Accessing and Understanding Care

Most of the women shared their initial experiences of pregnancy while newcomers to Canada. Being new to Canada meant the women were unfamiliar with the health care system, and those who migrated while pregnant had to navigate where to receive care quickly. The women described the different ways they connected to a gynecologist. Most women who came as refugees or asylum seekers specifically shared that they lived at Welcome Place- the Manitoba Interfaith Immigration Council, a government-sponsored housing program for newcomers. The staff there connected them to a prenatal program called Mom and Me. Others were referred to this program through settlement agencies. The women shared their appreciation that the Mom and Me program is tailored to newcomers and had interpreters from various countries to ensure effective communication. The program focused on educating them about pregnancy, offering valuable resources, and providing information about prenatal healthcare services. This program played a pivotal role in guiding these women through the pregnancy process and assisting them in locating a suitable family doctor. For example, Kia, who arrived in Winnipeg as a pregnant asylum seeker and later obtained refugee status, shared her experience,

> The program was in English, but they had a translator which was good. We learn about things to eat, what to expect. We went to the program every Wednesday. The program is for until you give birth, or you can come for a year. Mom and Me connected me to Bridge Care clinical and they connected me to a doctor.

Adebola, who came to Winnipeg pregnant and was referred to the program by a settlement agency also described the program,

> So, the Mom and Me program was good. I loved it because we had so many sessions with nurses and they told us what to expect, what to eat, how to eat so that the babies were pretty well too. And then they would give us coupons for milk which is good.

The women also gained insights into the pain medication options available to pregnant women during labor. For example, Kia described how learning about pain medication prepared her for when she was asked if she wanted pain medication while in the hospital.

> When I used to attend the Mom and Me class, they mentioned that it was not good for those who are young and have strength to take pain medication specifically epidural. The reason is because the pain medications cause the baby to sleep. They said it was better to give it a try normal. Thus, when I heard that, I did not want to take a chance. I did not want anything to happen to the baby because of the pain medication I took. Also, it is not like we take pain medication back home. So, I just wanted to give birth naturally. I felt like Mom and Me prepared us well.

The women regarded the prenatal program as a welcoming place that provided emotional support and access to valuable resources. Kia shared that her only acquaintance at the time of pregnancy in Canada was a translator affiliated with the Mom and Me program, and they formed

a strong bond. When Kia was admitted to the hospital for childbirth, this translator provided her with crucial support. The women also shared that they received things such as pregnancy tests and prenatal vitamins. This was especially important for women who wanted prenatal vitamins in compliance with their cultural and religious norms (e.g., halal). *"*At Mom and Me program, they gave me halal prenatal vitamins. So that's when I had prenatal vitamins" (Amara). Amara also mentioned how she sought help from the program when things were not going well with her gynecologist. "I also talked to the staff at Mom and Me, and to the social service, I will not mention their names but yes, I got the resources I needed"

Thus, Mom and Me was where the women learned about pregnancy and met other moms while receiving support and resources. Others mentioned accessing maternal services through walk-in clinics or their family doctor. For example, one participant was connected to BridgeCare clinic by Welcome Place- the Manitoba Interfaith Immigration Council. BridgeCare clinic provides primary care for government-assisted refugees, including screening, immunizations and prenatal care. Those who did not have family physicians expressed that they went to the Manitoba Clinic. The women talked about different reasons for not having a family physician. For some, they were still new and did not have the chance to find a family doctor by the time they were pregnant. A couple of the women shared that they did not understand why the family doctors were the gateway to specialty services.They expressed that it creates a barrier to getting direct access to a gynecologist. Another participant mentioned it was easier for her to access walk-in clinic since there was one close to where she lived. Walk-in clinics were also convenient for the women because they did not have to make an appointment to see a physician. Another participant shared that she had a bad experience with her family physician, where he prescribed the wrong medication, and she decided to no longer go to him. The rest of the women had family

physicians who shared that they made an appointment to see their doctor, who confirmed their pregnancy and referred them to a gynecologist. Nearly all women who accessed a gynecologist through their family doctor had lived in Winnipeg for more than two years before pregnancy. These women described the importance of having a family doctor, and they were aware that they needed their family doctor to connect them to gynecology services.

Overall, the women accessed services through different means. For women who arrived pregnant or became pregnant within their first two years of living in Winnipeg, settlement agencies and Welcome Place were crucial. They connected the women to programs such as Mom and Me and BridgeCare. Additionally, a few women mentioned the convenience provided by walk-in clinics. This illustrates how geographical location influenced the choice between a family doctor and walk-in clinics. Specifically, since there were walk-in clinics near where the women lived, it was easier for some women to access care through these clinics. For a couple of women, their preference for walk-in clinics might have also been affected by a limited understanding of the Canadian healthcare system, including the roles of walk-in clinics and family doctors.

Moreover, only one woman discussed attempting to access midwifery services. Unfortunately, because she had a complex pregnancy, she was turned down. Some were unsure about midwifery services, and one participant shared a preference for just working with a gynecologist. Another woman mentioned thinking about getting a midwife but decided against it. She explained that since this was her first pregnancy, she wanted just to see a gynecologist.

The women’s experience accessing and understanding care can be categorized into three themes. The first theme, "it was tough," delves into the emotional difficulties that women encountered throughout the pregnancy and after childbirth. The second theme, "some are caring,"

highlights positive experiences with healthcare providers. The third theme, "left hanging," explores women's encounters at clinics, emergency departments, and hospitals.

It was Tough

Throughout this theme, the women shared the emotional challenges of navigating an unfamiliar environment, including the health care system. A few women notably used the phrase “it was tough” to describe their experiences of being new and pregnant as well as during postpartum. Several factors contributed to the emotional difficulties, with the primary causes being the separation from family and feelings of isolation. The women talked about the stress of figuring out everything and leaving their families behind. For example, Ruth came to Winnipeg when she was still in her teens, leaving her entire family back home. Although she has one family member here, she was left on her own to navigate the education system, and when learning she was pregnant had to seek care on her own. Ruth explained,

> Coming to a new country, you know, everything is totally different and all of that. So, it was really stressful, and I was a little bit like, I don’t know how to put it. Like it was a little bit depressing.

Adding to the distress, Ruth revealed that she had encountered significant abuse from her male gynecologist. To safeguard the participant's anonymity, additional information regarding the abuse will not be revealed. Ruth did find support from the one family member residing with her during that period. Nevertheless, these distressing encounters heightened Ruth's confusion and exacerbated the emotional challenges she was already facing. Adebola also explained that though she had in-law family members, they only helped her husband to connect them to their family physician and left them to navigate the health care system independently. It was up to her and her husband to determine where clinics were and how to get to places. She explained,

> She told us how to get our health card, how to get our SIN, how to get registered in Manitoba. Then that was it. So, every other thing we had to sort out by ourselves. But for the medical doctor, they did that, too.

Some women came with just their children. For example, Ameena came as a single mother with three children who were all under the age of five years of age. Her husband had been murdered in a refugee camp, leaving her completely heartbroken. She came to learn she was pregnant shortly after arriving in Winnipeg. She had no social support. To make matters worse, Ameena and her children came to Winnipeg during winter when the weather was cold. Coming from an African country with warm weather, experiencing winter for the first time was a huge shock. This made navigating their new life in Winnipeg difficult. Ameena explained,

> I did not know where to go and was so confused. The first time we came, I was scared. I have never seen winter. I did not know English or where to go. I cried and cried. My kids were small, they could not walk.

Due to language differences, it was also incredibly challenging for those who migrated from a non-English-speaking country such as Ameena. Nevertheless, many of the women shared that they were able to enroll in school to learn English and seek support. Each described that they got through the first year of being in Winnipeg by seeking support from programs and being determined to seek opportunities. Ameena explained,

> I cried. After that I asked why do I cry? People here, they work, they go to school, why do I cry? My kids need. So, some people helped me with finding a house at IRCOM on 95 Ellen. After one or two years, I started going to school close by and my kids began going to school. At school, I started learning English. After that I learned how to drive a car and I was happy.

Similar to the women sharing the emotional challenges they experienced while pregnant, the women also shared their postpartum experiences, with some expressing feelings of loneliness. The main support person identified by participants was their husband/partner. For the women who did not have a partner, and for those in traditional marriages where the male is the primary breadwinner and the wife fulfills the role of a stay-at-home mother responsible for cooking and cleaning, the postpartum period proved notably lonely and emotionally difficult. Adebola shared,

> I guess maybe because I wasn't home where my mom was and where my family was. Because when I had my children, my other children, my mom was always there. So, I didn't really feel alone or sad. But when I was sad, sometimes when she had to go, but because I knew she was always coming back. But this time around, because she wasn't here at all. And. Yeah. I felt so lonely and have so. I felt so depressed that, I would cry and sad sometimes and it is just start crying.

The women described how, back home, family members, friends and neighbors surrounded them. They talked about how it was challenging for them to understand that, in contrast to back home, they did not have a relationship with their neighbours and that it was not a feature of the culture here. Amani explained,

> But my family and friends, were not there so I would say it was a very difficult pregnancy because here, like, there's no one. You're just, you know, your kids. I mean, your family compared to like, if I want to have some aspect of food. Back home I could like maybe go to my neighbor's house or my mom's and just like, grab a plate to eat. But here I cannot just go to my neighbor's house to eat. So that was the emotional aspect. And I was always tired and my other two kids.

The participants also shared how when a woman gives birth back home, members of the community would support her by assisting her with cooking, cleaning and caring for her newborn. The lack of this kind of support, contributed to them to feeling isolated. However, despite many of the women describing the emotional difficulty they experienced after giving birth, none of the women saw their sadness as depression. This was owing to a variety of factors. For some women, it was due to a lack of understanding of what depression is, and the others, due to the taboo nature of mental health in their culture. Kendi described how she struggled emotionally after giving birth and felt as though she was "deteriorating both mentally and physically". However, when she was asked if she thought that was postpartum depression she explained,

> In our culture we do not view that as mental health. We do not say that it is a mental health thing, like for me, I just said that I was sad, or you just say that you're not feeling well and you get through it like that. So, because we do not see it from a mental health lens, like for us mental health we do not go for mental health services. For us. mental health would be like if someone was insane, then we would consider seeking a mental health service. So, there is a cultural difference.

A few women went through emotional difficulty as a result of their negative interactions with the healthcare system. One participant talked about how her encounter with the doctors and the way she felt pressured to decide to have a C-section made her feel sad afterward. When asked about postpartum depression, Nia shared,

> It's not only postpartum. You can be depressed when you're pregnant. It's just from pregnancy. And when you feel like your doctor are not welcoming. It's really hard. It's really hard because this continues on and on. This person who you mistreat them, it that

> hurts them. And they (women) take that as, you know, something forever in their heart and it's going to affect them.

Nia also experienced emotional challenges due to the perceived lack of support from her healthcare provider, which added to her struggles. In particular, Nia received a diagnosis of placenta previa, which restricted her from engaging in physical activity to avoid the risk of early delivery. However, a traumatic incident occurred when the apartment building's elevator malfunctioned and descended to the basement floor while she and her son were inside. Subsequently, she feared taking elevators and had to begin taking the staircases up to the 20th floor. Taking the staircase was contrary to her gynecologist's advice to refrain from physical activity. Additionally, since a one-year lease bound her family, she could not relocate. Faced with this dilemma, Nia approached her gynecologist, seeking a note explaining her condition and the need to avoid stairs, to give to her leasing manager and break her lease. Unfortunately, her gynecologist declined, leaving Nia feeling hurt and that her gynecologist did not prioritize her well-being. Nia's fear of using the elevator coupled with the not being able to take the stairs due to her diagnosis heightened her distress. She shared,

> So, what happened is I tried to explain to her, hey, this is what happened. If you can help me and you know, you can check what happened. And I'm experiencing a little bleed as well cause I have placenta previa as well. And I'm like, um, if you can, like, write me a doctor note because I don't want to take the elevator anymore. So anyways, see, I that she's like, she really didn't care what I was telling her because, you know, it's like she wanted me healthy, but when I needed her help me, it was emotional because that was the worst.

Nia was expecting her gynecologist to understand her circumstance and support her by writing a medical note. While it can be difficult to meet every patient's request, it appears the health care provider did not offer alternative solutions. Additionally, it is unclear if Nia's gynecologist clearly outlined reasons behind the decision to not write her a medical note. It also appears that the gynecologist did not acknowledged how Nia was feeling, which contributed to Nia feeling further frustration and hurt.

Moreover, the five women who gave birth during COVID-19, shared the increased isolation. Only one of the women indicated that she called the helpline number the nurse had provided when she felt sadness. Most participants said they kept their feelings to themselves because they did not have people to talk to. Others mentioned they did not want to tell their spouses they were having emotional difficulties. When asked why they refrained from sharing their emotional challenges with their husbands, they expressed uncertainty about the reasons. It is possible that they felt they had to navigate their difficulties independently or hold cultural beliefs where openly discussing feelings is not customary. However, despite the feelings of sadness and isolation that the participants experienced during the postpartum period, they persisted. Some managed to establish connections with one or two friends, while others sought solace in community programs they were involved in and their spiritual beliefs.

Some are Caring

African immigrant/refugee women described the positive experiences they had with some health care providers on the theme that "some are caring". The women explained that although not all health providers made them feel supported, welcomed and comforted while accessing services, some were nice. The majority of positive experiences the women shared were of their

interactions with the nurses in the hospital. They felt most of the nurses treated them with compassion and care while they were in the hospital. This is explained by Adebola,

"I felt cared for from the moment I entered to the time I collected my badge, they were all making me feel like okay you are having a baby and such"

Four participants mentioned positive interactions with their gynecologists or obstetricians who assisted them during delivery. Two participants who arrived in Winnipeg as asylum seekers and obtained their refugee status specifically highlighted their gynecologists as helpful and supportive. Kia, came to Winnipeg pregnant and had access to a gynecologist through BridgeCare Clinic. When discussing her interactions with her gynecologist, Kia explained,

> She was both compassionate and very encouraging. She would say things like "you've got this" and "You will be okay". I also had a translator, however, my doctor would also encourage me to try to speak in English to her as well. She was very encouraging. Also, I found out that something was wrong with my baby's right leg. I was very worried and I had no one else except for the doctor. I did not know that many people. At that time, this doctor gave me so much hope.

Kia found the positive encounters with her gynecologist to be particularly significant. This was not only because she had few friends in the city but also because she had received the unsettling news that her daughter might potentially be born with a physical disability. Thus, Kia needed emotional support, and her gynecologist played a key role in reassuring her that everything would be okay. Amani, another participant, described being happy that her gynecologist shared the same background as her. Amani's gynecologist was also an African immigrant. Amani explained that this facilitated their relationship *"*because she understands both the Canadian and my country of origin's health care system and culture". Sharing the same

background allowed her to have an understanding with her gynecologist and build a trusting relationship. She also shared that her gynecologist made bearing the isolation that came with COVID-19 easier and that she was there for her throughout the entire pregnancy process. She shared,

> She was a very good doctor. I mean, she knows what she's doing. With my experience, she made everything easy also because my first-time giving birth in Canada, so the experiences were really different. And because it was during COVID, Right. So those spouses weren't allowed to come to the clinic. It was just you. So that feels a little awkward and lonely cause my husband had to wait in the car. My gynecologist is a very good one and she did everything she could and she was there all there all through, she performed the surgery at delivery day and the baby came out and yeah, there was no challenges at all.

Other positive experiences mentioned include Mia and Sofia, who described their appreciation for how health care providers responded when complications arose. Mia, who had to have an emergency C- section due to experiencing high blood pressure, explained that she appreciated how quickly the physicians acted and collaborated to provide quality care. Sophia described that she appreciated how her gynecologist responded to the fact that her pregnancy was prolonged. She shared,

> I saw her, I didn't see any problem from her. She is just good. Because I feel like she kept caring about me because she said to me, I don't want to induce you. And that's why I was talking to you and also she said I'm worried a little bit because you have to have good feelings and because your first pregnancy was C-section and she said maybe Wednesday or tomorrow come so I can check the baby.

Sofia also explained that she appreciated that her gynecologist did not react to the fact that she is someone who has experienced FGC. In her previous pregnancy, she explained that her gynecologist had made faces when she discovered she experienced FGC. Her physician not reacting to this discovery was important to her because she did not want to feel different and insecure.

Overall, these positive experiences held considerable importance for the women and contributed to enhancing their well-being. The compassion and care exhibited by health care providers were integral to these positive experiences, fostering comfort and a sense of support.

Left Hanging

On the theme of left hanging, the women talked about their experiences at gynecologist clinics, emergency departments and the women's hospital. They talked about how these experiences left them hanging for answers and how having a miscarriage led them to see the gaps in the healthcare system. Specifically, a few women used the phrase "left hanging" to describe how health care providers not following up and the long wait times made them feel. Left hanging also explains how these experiences led them to wonder if their negative experiences were due to their racialized African immigrant status.

No follow-up. Some women described the lack of follow up after they had a miscarriage and others after giving birth. Two women who described the lack of follow up mentioned that it could be due to COVID-19. They talked about how they had expected a nurse to do a visit but understood why this was not available to them. Three other women shared their feelings of disappointment by the lack of follow up, particularly because they experienced a miscarriage. One of the participants described miscarrying while waiting to be seen by a physician at the emergency department. She then left because she was tired of waiting and needed to go home to

clean up. She had anticipated that a doctor or nurse would reach out to check on her, as she explained.

> But for those people, none of them ever even call me, they didn't call me to apologize or to say or how is she? Or if I if you come if you don't see the patient, then you are supposed to call, no? Why is the patient who they brought here this morning, it's oh she's left or their husband came by because I think you should address the person and call the person and oh, this is Doctor so and so, I'm so sorry for not attending to you, at time that we were having a patients that we were attending too. Thinks like that, you've gotta call, and apologize. But there was nothing like that from them. That was so, I was so disappointed at them. That is when I was like, you know what? I will never want to come to this hospital again, even when I'm sick. (Ruth)

Ruth felt the health care providers owed her an apology for not attending to her and ensuring she got appropriate care given she had a miscarriage in the waiting room. It appears, a follow up would have provided Ruth with the assurance that the health care providers have genuine concern for her well-being. Another participant, who had gone through a miscarriage, expressed her desire for the hospital and her gynecologist to initiate a follow-up conversation. She hoped to discuss the reasons behind her miscarriage and explore ways to prevent future miscarriages. She explained,

> No follow up at all. I have to call them to make a follow up. But I needed to make sure my hemoglobin was back. Right, Because I'm thinking of. Okay, I want to get pregnant again" (Sarah)

Given Sarah wanted to have more children in the future, understanding the factors that contributed to her miscarriage was imperative. This knowledge could potentially have alleviated

her concerns about experiencing miscarriages again, offering reassurance for future pregnancy. Moreover, Ameena, who went through several miscarriages, shared her experience of receiving pamphlets with information only for her first pregnancy. However, she did not receive any calls or follow-up after her other two miscarriages. She felt that healthcare providers assumed she knew where to seek care because of her previous miscarriage experiences. She explained,

> It is good service but some people who are newcomers do not know anything like where to go and such. So, tell me, especially because I had three miscarriage. Only the first time I had miscarriage they gave me papers after that nothing. They did not call me.

Experiencing a miscarriage can profoundly affect women, and each woman copes with it uniquely. Receiving follow-up care from hospitals or gynecologists could have provide substantial reassurance and a sense of support for these women. Sarah described that although the hospital had given her a phone number to contact for emotional health, she shared that they kept asking her if she was suicidal, which is not the kind of support she was looking for. She described,

> They were able to comfort me a little bit. But the image I saw when I saw the lush and the tissues, I couldn't get rid of that in my head really bothers me a lot. I didn't feel like doing anything and not even take care of your own. Right. It's really about like, it's so. But emotionally, I was so don't. I couldn't even eat to. To go back to normal. But the only people they like. Do you think Extreme? Are you suicidal? No, I am not that far. I just. I just can't help thinking about it.

It is possible that she was given a suicide crisis helpline instead of counselling and therapy resources. However, she expressed that she would have liked her gynecologists to follow up with her.

Overall, the women that expressed a desire for follow-up from healthcare providers, were primarily seeking emotional support and understanding. Although those who gave birth during the peak of the COVID-19 pandemic acknowledged the exceptional busyness of healthcare providers during that time, those who experienced a miscarriage were particularly disheartened. Beyond emotional support, the women sought closure and understanding, which a follow-up with their gynecologist could have offered.

Long wait times. Almost all the participants mentioned the prolonged wait times at gynecologist clinics, while a few discussed extended waits at emergency departments and during labor at the hospital. For example, this was explained by Kendi,

> The other thing is when we are in the clinic, it takes time. When they say come at 7:00 or but it's not 7:00 clock, maybe like at 10am, it takes like two hours or like one and half hours, you just keep waiting and waiting.

They described discomfort from sitting on chairs for a long period of time while pregnant. This was also especially frustrating for Kendi because it took two months for her to get a gynecologist after being referred by her family physician. Two participants shared their unpleasant experiences of waiting for extended periods in the emergency department. Ruth explained how she went to the emergency department because of blood spotting. She had expected to be taken into care immediately or the wait would not be for more than an hour. However, she explained that she waited from 10:00 in the morning to 11:45 at night. She shared,

> I sat on the chair I bleeding, but no nurse or doctors came to check up on me. None of them, they did not attend to me at all. I was just sitting down there, they brought me in there around 10 a.m. I had the cramp and then they had to rush me and so I was there by10am, yeah. But I was at the hospital until 11:45pm before a doctor came and check up

> on me. When he came to just to check up on it was just my pulse not to even to take me in the room to, to for me to you know flush everything because I sat there and everything came out by itself, I bleed right there and they had to send a housekeeper person to come there and clean out the blood and stuff on the floor.

Ruth explained that this experience disappointed her, and she never wants to receive care from that particular hospital ever again. She believed that the hospital's actions were racially biased, as they did not attend to her promptly, leading to her experiencing a miscarriage while waiting in the waiting area. While nurses eventually came to assess her vital signs, the fact that she was bleeding and had a miscarriage in the waiting room was not indicative of dignified care. Another participant, Sarah, was told by her gynecologist that her stomach was small and that she needed an ultrasound. However, she had to wait for weeks for an ultrasound appointment. Sarah explained,

> I was waiting for the ultrasound. Well, it was a month far too long. I had never heard from the gynecologist after that, usually the assistant. Yeah. So it was, um. She left me hanging there. It's a long time.

The long wait-time of ultrasound appointment made it incredibly difficult for Sarah, more so because she experienced a miscarriage while waiting for her appointment. She wondered how things would have changed had she had access to ultrasound earlier. These experiences also led to further anxiety about the next time she gets pregnant.

In general, the extended waiting periods proved to be challenging for African immigrant/ refugee women, as they did not anticipate such prolonged waits. It was also challenging due to the discomfort of being pregnant and having to sit in an uncomfortable chair for a long period of time. Their expectation was to receive immediate care. These encounters left the participants

with the perception that the Canadian healthcare system lacked personalized attention, and despite the existence of healthcare facilities, sufficient care was not being delivered. Kendi explained,

> One thing I have learned about the health care system here is that unlike back home's health care where there are not that many facilities, but if you have money, you are able to get everything you want/need. Here, there are facilities and such, but it takes such a long time to have access, it is not easy access. Nobody cares and that's not a good experience.

In essence, these encounters made it clear to the women that while Canada's publicly funded healthcare system allows them to access services without cost, there are delays for procedures like ultrasounds and appointments with gynecologists. However, specific challenges varied among women, depending on whether or not they had undergone a miscarriage.

Communication Barriers

Despite the positive experiences with healthcare providers mentioned earlier, African immigrant/refugee women experienced a number of communication challenges with health care providers. This presented a significant barrier for those seeking to access prenatal and maternal services. Communication barriers existed for several reasons, including gynecologists rushing through appointments, language differences, and the lack of physicians being transparent or providing information to the women. As a result, this section has three themes: "you're rushing," which describes how the women felt while interacting with their gynecologist, "trying to understand," which sheds light on the experiences of women who are not proficient in English and "nobody explains" which centres on the women's experience with a lack of communication

from health care providers. The impact of communication problems is evident in differential access to services, uninformed decision-making, and a lack of support.

You're Rushing

To begin, nearly all study participants talked about feeling rushed at their gynecology appointments and not having an opportunity to bring up concerns or questions. "you're rushing" was a statement made by two of the participants as they tried to explain how they felt during their gynecologist appointment. The women shared how their visits only consisted of blood work and required tests, with little guidance on the process/journey of pregnancy. This was disappointing and confusing for the women. This is explained by Kendi,

> They say things like of this is natural, they do not thoroughly explore how you are feeling. The time they give is less than 15 minute or 10 minutes, they rush. They are always rushing, You went to wait for 2 hours, or at times two and half hours and when you finally go in when you are exhausted and you only spend like 10 minutes or even sometimes 5 minutes.

The women who were pregnant for the first time, like Tamara, were especially disappointed because they not only wanted to know if they had a normal pregnancy but also to be educated on the process of pregnancy. They had questions and felt the rushed appointments did not allow them to ask their questions. This is explained by Tamara,

> She's very rushed. Like we going to her office and it's like, in. Like she wants you out of office in, like, 10 minutes, which for me sometimes feels like it's not enough time for me to address, like, questions that I have.

This also made some of the women feel neglected and not cared for. Tamara stated

> I just felt some kind of neglect in terms of like. She just took it like, oh, like, you know, your pregnancy is normal. But the fact that it was my first pregnancy, I had so many questions. It was more of just like being rushed, like she wasn't, you know, she didn't take her time, which sometimes made me feel like, uncomfortable and like, you do not want to, like, take up any more of the person's time.

However, they were unsure whether the haste was due to their gynecologist's personal practice or the healthcare system's structure. In other words, the women were uncertain whether the healthcare provider's haste was a result of a policy imposed by the healthcare system or if it stemmed from the physician's individual personality or approach to practice. This is explained by Tamara,

> I'm not sure if that's directly linked to the health care system or the person like the doctor herself, because that's it's hard to say. I'm not sure it's more of like a doctor thing or it's more like a health care or a health care thing that makes sense.

Some participants pondered whether these rushed appointments were influenced because they are African immigrant/refugee women. One participant observed that when white women visited the gynecologist, their appointments were longer, and they appeared to have lengthy conversations with the gynecologist. The participant explained,

> Well, I do wonder if the treatment I got is because I am an African Immigrant. Sometimes I feel like, when they or like when they treat white people, they usually give good treatment. They talk to them and even take a long time with them. But, when I enter, it is not the same, they do not give you much attention. (Kendi)

It is possible that the White gynecologist was more communicative with White women, or these specific women may have had medical reasons that warranted longer appointment durations.

Nevertheless, the question if their experience is due to racism or failures of the health care system was difficult for the women to answer. Some women explained that they struggled with this because of their lack of understanding about the health care system in Manitoba and previous experiences of racism. Some study participants wondered if they were treated in a certain way not only because they were African immigrants but also because they were not able to speak English proficiently. It is possible that these two identities- being racialized immigrants and English being a second language provided these women with unique treatment. Another participant also explained how her gynecologist's rushing made her feel like she was not important enough and that her gynecologist did not care about her. She explained,

> You 're rushing, because you don't care about this person's like, that's how I felt for me. Like, I'm not saying this is how she's doing it, but the way I felt, I felt like, okay, I wasn't important because I'm just one of the immigrant women. (Nia)

In addition, the women described they were also rushed when they were in the hospital. One participant described being rushed to receive medication, and another participant described being rushed to sign a consent form to have C-section. Nia, who felt rushed to sign the consent form described that the doctor had claimed that her baby's heart was changing even though, as a nurse, she could see that was not the case. After trying to convince the doctor that there was nothing going on medically, the physician insisted and said she was progressing slowly. When she got to the operating room, a resident was waiting for her, and the doctor announced that the student would be the one to do the C-section. This made Nia regret signing the consent form because she felt that the doctor had rushed her so the student could practice on her. She described this below,

> Then I get there, and she wants her student to practice on me. I was like, what the hell? So, I see. Like, I'm looking at them. Of course, I'm now sleepy. I'm looking just like, yeah, So I felt like, okay, you just want to do your own thing. You want to practice on me basically, this why you brought me here, because you didn't give me a good medical reason.

The physician may have hurried Nia to sign the consent form to allow the resident physicians to perform a C-section. Whether there was a valid medical reason for the urgency to get a C-section remains unclear. Nevertheless, Nia felt that she was not given the chance to provide informed consent and felt deceived into undergoing a C-section.

Overall, feeling rushed leads the women to feel disappointed, neglected and mistreated. They felt that the services prioritized efficiency over taking the necessary time to educate them and provide information about the pregnancy process. For certain individuals, the rushed nature of their appointments raised concerns about the health care system's structure and whether their experience was connected to racism or discrimination. Furthermore, feeling rushed in the hospital led to not providing proper informed consent. This is noteworthy for several reasons, as being well-informed ensures they have a comprehensive understanding of the procedure's risks and enables them to feel empowered to make informed decisions.

Trying to Understand

On the theme of trying to understand, some women talked about how not being proficient in English impacted their experience accessing services. "Trying to Understand" refers to how they tried to understand what was being communicated to them and how their husbands and friends helped with translating. Language differences posed a significant barrier, specifically for immigrant/ refugee women from African countries where English is not the main language.

These women struggled to understand information about healthcare services and communicate effectively with healthcare providers. The participants reported a lack of available translators in clinics and hospitals, leading to misunderstandings with healthcare professionals. Although the Winnipeg Regional Health (WRHA) offers translation services through the Language Access Program, only two participants mentioned having access to interpreters at the hospital. This participant mentioned it was limited to brief phone conversations.

Three participants mentioned relying on their husbands for translation, and two discussed attempting to understand the physician's message independently. However, the participants described not fully understanding the healthcare professionals' questions. For example, Kia described how, when she was in the delivery room, the obstetrician had asked her if students could be present during her delivery. Kia thought the doctor had asked if one or two students could come, but the physician was asking if more than two students could come. She mentioned even taking medication without fully understanding the question asked by a healthcare provider. Kia explained,

> I also did not have access to a translator, so this made it difficult. The experience I had after I gave birth was tough. This was exasperated by not being able to understand the language. For example, one of the nurses had asked if I had pooped. I had no clue what she was asking me but I ended up saying. After that she gave me medication and I just took it. So, communication was hard.

Kia expressed her gratitude that the medicine she agreed to take did not harm her. Her story highlights the misunderstanding that occurs when there is a language difference. It is not only a potential for conflict but also a safety concern. Language barriers were also a challenge for a French-speaking participant. Although she chose a bilingual gynecologist at the Manitoba Clinic,

she discovered that the gynecologist was not fluent in French. Furthermore, the French dialect spoken by the gynecologist differed from the participant's own. The participant described, "They don't really speak French. You know, also, the French they speak here and the French we were speaking in Africa, it's really different". (Grace)

In the hospital setting, Grace continued to face difficulties. Despite requesting a bilingual doctor, all the doctors she interacted with spoke to her in English, leaving her feeling frustrated and confused. She explained,

> I didn't see anyone who speak French. Every doctor who came to check me even. That day, I was. Have so many pain and go. No one speaks French. Yeah. They come with speaking English. They see that in my system, I speak French. But they send someone who speaks in English.

Those who relied on their husbands as interpreters explained this was not always ideal. One participant mentioned that bringing her husband as an interpreter meant bringing their children to appointments, which she would have preferred to avoid. Consequently, being dependent on their spouses was an additional burden on the family. Many lack the presence of other family members who can assist in caring for their remaining children. Another participant described her husband providing inaccurate translations, and she was uncomfortable with him accompanying her to all her appointments. This participant explained, "My husband translated since I did not understand. I don't like when he translated. I would have liked someone else*"*

(Nancy)

Furthermore, Nancy expressed the importance of fully understanding what was being communicated and having privacy at those meetings. Although this participant cared primarily to have an accurate translation, she also expressed a desire to maintain privacy. It is possible that

having a professional interpreter would enable the women to feel more comfortable discussing their concerns and have a more open communication with the health care provider. Most of the women come from cultures that support patriarchal beliefs, where men hold greater power, even within the family. This translates into expectations for women, even during pregnancy and post-partum to manage household responsibilities with limited time outside the home. Consequently, husbands accompanying women to their gynecology appointments to interpret might contribute to a further lack of autonomy. Thus, Nia's case highlights that women having a husband who can somewhat speak the language should not lead health care providers to expect he can provide translation or that the woman is comfortable with that. Access to a professional interpreter is crucial for ensuring accurate translation and allowing women to attend their appointments independently.

Nobody Explains

On the theme of nobody explains, the women talked about how health care providers did not explain the reasons for complications or the events during delivery. They shared how this made them feel and the power struggle they experienced while interacting with health care providers. As described above, Sarah explained how her gynecologist had told her that something was wrong after reviewing her ultrasound and that her stomach was too small for the stage of pregnancy she was at. This was the only thing Sarah's gynecologist had communicated with her. She described, "She mentioned she suspected something. Why she didn't want to tell me? or what she wanted to confirm. I don't know and she, also didn't rush to get the ultrasound done. She gave no explanation" Sarah was hoping her gynecologist would elaborate on what she suspected or the nature of the problem. The lack of explanation left Sarah with many questions and anxiety. She explained,

> I tried to be positive, so I tried to not think about it, but I couldn't hold on for long. It really, really bothered me. Why? Why is it my tummy is so small with the baby? What did she see? I was so disturbed.

Another participant, Mia, who had a complicated pregnancy due to her baby not growing at the expected rate while she was pregnant, shared her experience with the doctors. Mia mentioned that she and her partner had asked why their baby was not growing and what was wrong with Mia's placenta, but no explanation was given. Mia and her partner were also interested in finding out about additional treatment options beyond delivering early. However, the physicians did not provide an explanation about each treatment option, including the risks and advantages of the treatment options. She described,

> They're picking and choosing the information to provide us. I think that was the main thing and they were also not going in depth with treatment options. They were almost like pushing more towards early delivery, I kind of felt like that. They almost just wanted to get us out, like in a way. So, they were pushing for us to have the baby as soon as possible so they can do with other patients.

It is possible that the physicians did not thoroughly present information about other alternative treatment plans since they considered early delivery as the best option. Nevertheless, Mia and her husband needed comprehensive information about alternative treatment options to make an informed decision.

In addition, Mia shared that the medical staff had not provided detailed information about the intensive care unit (ICU) where their daughter would receive care in the event of an early delivery. She clarified that they had simply reassured her that everything would go smoothly in the ICU and, "in a way, made it sound more positive than it might be". It was not

until she had given birth and was at the ICU that she learned that things could get complicated at the ICU and that many moms lose their babies in the ICU. This led Mia to experience sadness and frustration at how the physicians did not explain what their life would be like with their baby in the ICU. Moreover, Mia shared that after giving birth, she learned from a nurse that baby aspirin can help with the formation of the placenta if taken early during the pregnancy. She expressed frustration that her gynecologist did not communicate this and that an ultrasound had not been done earlier.

Furthermore, Mia expressed her frustration that no further investigation was done on her placenta to learn what caused the malformation of the placenta. She had communicated to her doctors her desire to understand the cause and ensure she would not encounter the same problem, but there was no further discussion on the matter after she gave birth. This information would have helped Mia get closure about her case. Other women who experienced complications after giving birth also shared that their doctors did not explain what had happened. For instance, Grace developed high blood pressure after giving birth and was given medicine at the hospital. However, nobody explained the medication she was given or the intended purpose. When she began to experience pain in her leg, where the medication had been injected, she returned to the hospital to find out what had been given to her. However, she was not given any explanation. Grace explained,

> When I give birth, I start to have pain in my legs. And I go to the hospital so many times. But they told me or there's nothing going on. So, I said why it's after to give birth. that I started to have some pain in my leg. When I go to give birth, you inject me some stuff in my leg. Well, you didn't even tell me what you are Inject me with. So, what's going. What? What happened? They said, it's nothing and that they do that to every woman that

> comes to give birth, they inject. I asked what did you inject? I don't know why it's me who have this problem

The lack of medication explanation and information made Grace angry and frustrated. She shared that it felt like they were were holding back information. Another participant who had previously experienced FGC explained that after giving birth, she had extensive stitches. However, no one had explained why she had such extensive stitches. It was not until she went to see her family doctor and asked him to look at medical notes from her delivery that she came to learn that when she gave birth, she had experienced a third-degree tear. The participant shared,

> I could not even pee. And then nobody told me why and I did not know that I had a tear. I told everything to my family doctor. I had stitches, and they were so interwoven and then what was happening to. I came to learn that I had a tear. (Amara)

Furthermore, the participants who had experienced FGC were hoping the health care professionals would have a discussion with them about FGC and how it may impact their birth process. One woman described how the health care provider seemed unsure how she will be able to give birth but did have a conversation with her about it. While others were just expected to push as other women when they were contracting. Amara explained,

> They do not even ask when you are doing they checking, they can see and that should tell them that they need to do something medically because they baby will not be able to pass but they do not do that, they just tell you to push the baby.

The women were dissatisfied with the absence of transparent communication regarding how their experience with FGC might affect the delivery process. It appears this communication would have provided these women to reach an understanding with the physicians regarding the

potential impact on the childbirth experience and the physician's commitment to providing personalized and respectful care.

Overall, the lack of explanation or provision of detailed information by health care providers led to several negative impacts on the women. The women did not fully understand the complications or treatment options, which led to the women being confused and uncertain. The women also experienced increased anxiety and stress. Three of the participants who had experienced FGC also shared that they developed infections after giving birth. Ultimately, it impacted their ability to form a trusting relationship with health care providers and to make informed decisions. The women also shared feeling disappointed and unsure if it would have been better for them to immigrate to the United States due to the lack of interaction from medical professionals. Despite their support for universal health care, many said that after receiving poor care, they believed paying and getting better treatment could be preferable. Better treatment, in this instance, entailed increased communication and active engagement from healthcare providers with the women.

Response to Recommendations

This section is focused on the different ways the women responded to the recommendations they received from health care providers. Many of the women shared that their gynecologists did not provide them with many recommendations. While pregnant, many of them tried diligently to adhere to the advice they received, such as exercising and eating healthy foods. Those who had a diagnosis, including one participant who had placenta previa, another who had gestational diabetes, and another who had thyroid disease, shared that having a diagnosis increased their stress but motivated them to follow recommendations. Some received medical interventions, including early delivery and C-section. Others received the best available evidence

for taking care of an infant. However, some women revealed they had other children and knew what was best for them, while others had faith and cultural convictions. Most women also described the importance of having a female doctor. They shared that this is because of being more comfortable discussing childbirth and their bodies with a female doctor. In some cases, it was disclosed that the reason was due to cultural norms and religious beliefs. However, the women described understanding that this might not always be available to them.

No Support

On the theme of no support, a few African immigrant/refugee women expressed that they did not experience support from their gynecologist or health care professionals at the hospital while receiving recommendations. For example, a few of the women shared they had expressed their desire to have a natural birth without medications but were not supported. This is because some have heard from the prenatal program and family that giving natural birth is ideal, particularly if you are a young woman. At the same time, others described wanting to try without medications first. While some of the women aimed to avoid potential side effects associated with pain medications, others' decision was influenced by a desire to adhere to their family's guidance favoring natural childbirth. It is plausible that familial preferences stem from cultural norms, as some participants explained that natural childbirth is common in their home country. Another motivating factor could be the aspiration to showcase strength by enduring the natural pain of childbirth, given how some women expressed admiration for those who gave birth naturally back home. Additionally, the women who were in their early twenties, also expressed a desire to experience natural childbirth, because they believed that their bodies would be able to handle the pain of labor and delivery. However, the women shared that despite communicating their desire

to give birth without medications, they kept being offered medication by both the nurses and physicians repeatedly. Tamara explained,

> I just felt like I was being pushed to, like, use like medication, which for me was kind of like off putting because I was like, I came here and like, I made my intention clear and I would have liked a bit more support with that.

Another example was Mia, who as mentioned above, had a complicated pregnancy due to her baby not growing at the expected rate. As a result, Mia was redirected to the fetal assessment clinic by her gynecologist. The medical professionals at the fetal assessment clinic recommended an early delivery for Mia, citing concerns about the baby not growing at the expected rate and the potential for better care with an early delivery. Despite this advice, Mia and her husband chose to delay, wanting the "baby to be in the womb for as long as possible". They were only willing to deliver early if Mia's health was at risk. Mia clarified that the physicians had exerted pressure on them to opt for early delivery instead of respecting/supporting their choice to wait. She explained that after they communicated their decision, their physician set up a meeting with several physicians, including the head of the fetal assessment and doctors from the ICU to encourage them to choose early delivery. She explained:

> It was also with the head of like the high risk pretty much a high-risk doctor and knew the head of fetal assessment. So, we felt pressure like in that moment, like all these different doctors, you know, sitting and all of us. Like literally, like we just we've been telling you this whole time of the fact that, no, we were waiting because of ABCDE. As long as we don't see if and we're very clear as well, the fact that we're not holding back just for the sake of holding back, like if you know, if the heartbeat fluctuates, if the mother if

> something happens to me and I'm sick or anything like that, then we can go ahead, sign the papers for C-section and they can at that point do what they have to do.

It is possible that the physician arranged a meeting with fellow physicians and the head of fetal assessment to convey the gravity of not opting for early delivery. However, these interactions made Mia and her partner feel intimidated and lacking autonomy. They felt pressure from the significant power imbalance between Mia and the health care providers. The power imbalance can impact the dynamics of the patient-physician relationships and create an environment where the treatment options rest solely on the physician. Mia also mentioned that the physicians made broad statements about African newborns doing well in ICUs without referencing any studies conducted to validate these claims' accuracy. She felt they said this to persuade her to have an early delivery. Mia explained,

> The ICU doctors, something else that they said is, you know in ICU, African children do better. So that was also like pushing the agenda, of like I told you, you know because we are, African. So, the child will do better if we went ICU at 21 weeks.

Nevertheless, Mia shared that she told her health care providers that her body is hers and she has the right to make her own decision. She and her partner had gotten to the point where they had had enough with the health care providers pushing Mia to do early delivery. At the end, when Mia's life was at risk, Mia and her husband decided to follow the doctor's advice to do early delivery and she was able to do C-section. Moreover, some of the women discussed their disappointment that their gynecologist was not present at their labour and delivery in the hospital. They shared they would have appreciated a familiar face. Nevertheless, in Manitoba, a gynecologist is only present for a patient's delivery if they are on call. This seems to be information that the women were unaware of.

Acceptance

On the theme of acceptance, the women shared how they would accept the care and recommendation that they were receiving without questioning the health care providers. Although some women had questions, they decided not to ask, citing various reasons, including fear. For example, Kendi explained,“You don't talk, like you don’t try to bother to correct anything. You simply just accept. You just answer her questions including telling her your name again and she would respond by saying oh yes, I remember now” . When asked why the women did not try to correct the health care provider, ask questions, or clarify recommendations, some described not wanting to challenge health care providers. Some individuals expressed satisfaction with adhering to recommendations, yet there was also a sense of fear about the unknown consequences if they were to challenge healthcare providers. This is explained by Adebola,

> The major reason why I followed the doctor's recommendation was because I was new here, so I didn't know what was necessary to do. I just knew that they were telling me to do those things and which feels good to do. And none of them were really awkward to me. But of course, I had to do them because I'm in a land where I don't know if there's any consequence of not doing it or how it's going to turn out. If at the end of the day, I don't do it. And then they're like, Oh, it's your fault you killed the baby or something like that.

Fear of challenging health care providers may also come from stories that the interviewees may have heard from other African newcomers in Winnipeg. According to staff from the Sexuality Education Resource Centre MB (SERC), who work closely with some of these African communities, knowledge exchange with other community members is often among

the most reliable sources of information especially for recently arrived families. Community members many times perform informal roles as community resource people helping others learn how to access services and sharing their positive and negative experiences. This is further seen by how certain women described sharing their gynecologists' recommendations with friends or family members to seek confirmation on whether they should adhere to or disregard their doctor's advice. For instance, Amara, who her gynecologist advised to walk daily for weight loss, explained that she was uncertain why her gynecologist wanted her to lose weight, as she did not feel like she was over-weight. Instead of seeking clarification directly from the gynecologist, Amara, chose to seek understanding from her friends, who confirmed her concerns about not being underweight. She explained, “I had to talk to my friends to understand what was going on and they told me that I did not need to walk, because I was already under weight. It did not make sense for me to walk”. It's also possible that the women did not have a trusting relationship with their gynecologist, hindering open communication about their reluctance or uncertainty regarding the reasons behind the given recommendations.

Faith and Cultural Convictions

Other women shared that they did not adhere to recommendations because of their faith and traditional way of caring for a newborn. For instance, Mia as mentioned above was advised to do early delivery at 21 weeks due to complications by the physicians at the fetal assessment clinic. She explained that she did not feel comfortable following their recommendation because of her faith. She said she had prayed about her pregnancy and believed that God would assist them. When questioned about whether she and her husband had brought up religion with the doctors she explained that they waited a long time to tell them but eventually they did. She shared,

> After we told them about our faith, they kind of put that like they yeah, before. I don't think they really cared about our decisions like that. But once we talked to them about our faith, I think they kind of calmed down. I would say, just a little bit because even when we went to the actual delivery, even after we had this whole long conversation about our faith, the doctor was still pressuring us.

Thus, while Mia's physicians were somewhat understanding of the role of faith in her and her husband's decision to wait, the tension between Mia and the health care providers continued. Additionally, although physicians have an ethical responsibility to ensure they have conveyed the risks associated with not following recommendations to patients, it seemed that Mia's healthcare providers consistently emphasized to both her and her husband the potential consequences of not adhering to their advice. Mia and her husband interpreted this as not respecting their wish and attempting to instill fear. This is explained by Mia,

> So, there was some fear that was kind of put in of how, you know, like if you if you almost like if you don't take our recommendation, if you don't do what we want you to do, you may lose the baby. You know, your blood pressure might go high.

Two additional participants talked about how they did not follow recommendations given to them after giving birth due to their cultural understanding. For example, one participant described how she did not listen to the nurse's advice not to bath the baby until three days after birth because "this is not in align with how they care for babies in her home country". She further explained,

> So, I noticed they do not give them a bath until about three days later and that this will help their skin. But I couldn't do that because it was like smelling to me. I was just smelling on the blood and everything. So, what you do is just be just like take a wash

> clothes and wash the body that way but that was a no, for me. It. So immediately after I got home, I had to give the baby a bath. Even though it was not recommended. Back home they actually give special bath…They use a palm oil, and they use a native sponge to bath the newborn, they say it helps with body odor. So, I actually had an aunt come do that for me. Because I have always done that for the siblings, So, there was no way the newborn was not going to pass through that. And so even though it was not recommended in the hospital, I did that for the newborn. (Amani)

Another participant described how she was advised to let the baby sleep in the crib but that she reverted to their cultural way of letting the baby sleep with the mother. Amara explained,

> Usually, we let the baby sleep with us for attachment but here they say the baby has to sleep in a crib for safety reasons. I think they might roll over the baby, but. Stuff like that. But I have never used the cribs. Yeah, like in the daytime, I think I did but I used to sleep with baby next to me and nothing happened. I have two children and nothing happened. And that's what we used to do but the issues of putting the baby in a different crib, doesn't create an attachment. And that's why I'm very close to my kids.

While Amara, acknowledged the recommendation she was given is based on evidence, considering her cultural practice of having newborns sleep with the mother had not harmed her other children, she opted to let her newborn sleep with her. Additionally, it seems Amara was worried about the potential of not forming a strong attachment with her newborn if she had chosen to have the baby sleep in a crib.

Another participant shared trying to follow safe sleep recommendation for newborns provided by the nurse but decided against it afterwards, She explained, “it was all because I

wasn't used to that. And I tried. But some how I had to revert back to my cultural way of taking care of my baby, that that worked for me". (Adebola)

Adebola, further explained,

> For us when a baby's born, we believe that there might be some. I don't know what it's called, but that some tummy aches that the baby will have when he or she is born. And so in order to help, the baby relieve that we have to lay the baby on their tummies when they're sleeping. So, it helps to soothe that. But I was told that you have the baby has to lay on the back. Right. Yeah. So, most of the times when my baby is on the back is probably waking up before he has enough sleep and comfortable. But I find out when I leave him on he's tummy, he sleeps longer. So, I just switch back to my culture way of taking care of the baby so.

Nevertheless, even though both women deviated from the recommended safe sleeping practices for newborns and adhered to their cultural norms for newborn sleep, they were making choices they believed were in the best interest of their babies. Furthermore, some of the women also said that their mothers and aunts had taught them how to take care of a newborn and that they had learned how to take care of the infant by taking care of their siblings. They shared that medical professionals did not give them a chance to discuss their cultural approach to caring for babies and did not take into account the women's experience when making recommendations. A couple of the participants explained how they felt forced to conform to Canada's healthcare system culture. Sarah explained,"In my case, I think I was trying to be more in a place where I was trying to understand them more rather than them understanding me"

Thus, although the women recognized that healthcare providers were offering recommendations rooted in scientific knowledge, the absence of discussions about their cultural perspectives left some women feeling they were being compelled to adhere to Western medicine perspective.

Recommendations Made by the Women to the Health Care System

Towards the conclusion of their interviews, the women had a chance to offer recommendations for healthcare providers or the healthcare system as a whole based on their personal experiences. The different recommendations provided by study participants can be grouped into four key recommendations.

1. The women emphasized the significance of having access to skilled interpreters who are well-trained in conveying medical information.

They shared the need for the healthcare system to guarantee the presence of language interpreters in clinics and hospitals. Effective communication between African immigrants/refugee women and health care providers is crucial. This is emphasized by Ada,“A lot of translators because you don't understand English. if you do not know how to speak English, you don’t understand and there is confusion”

2. The women stated that health care professionals should be more engaging and inquire about the women’s cultures as well as for those who experienced FGC ensuring there is a birth plan. This is noted by one participant,

   I think they should consider apart from the background of the history of the babies or the children, they have had, their cultural background. So, it doesn't have to be anything in depth. But just to understand what their thinking is like in terms of having this baby so that if there's anything that they need in terms of resources or maybe even talking to someone who's from their background and is in the medical, you know, line maybe could

> help as well. So just trying to understand them culturally a little bit would be good. (Adebola)

This will also enable relationship building between African immigrant/refugee women and health care providers. Specifically, this will allow African immigrant/refugee women to perceive that healthcare providers are keen on understanding them and establishing a trusting relationship. This is explained by Adebola,

> Building a relationship is two way, where I could want to build a relationship with you as my doctor. But if you're not willing to take that step to make me welcome, then we're not building any relationships. Right. So, it has to be both. And I'm pretty sure we add that because we willing to pursue that relationship, it is just the other person. Are they willing to accept, I think, willing to open up an be a part of that person's journey.

3. The women mentioned that health care providers need to be transparent and communicate issues.

This is important for various reasons, such as allowing African immigrant/refugee women to understand the nature of the issue and it can alleviate concern. Moreover, transparent communication can empower African immigrant/refugee women by providing them with knowledge and understanding.

4. Some women recommended increasing the number of African immigrant or Black doctors.

The reason is, according to them, that it is easier to have an understanding with healthcare providers with whom they share a common cultural background. Thus, having African immigrant healthcare provider may help in providing more culturally appropriate care.

Chapter Summary

Overall, the women accessed services using various approaches, such as Mom and Me program, highlighting the significance of programs. Almost all of them expressed a sense of isolation during both the pregnancy and postpartum periods, primarily attributed to the absence of family members in Winnipeg and the prevailing individualistic culture in this context. Nevertheless, women residing in Winnipeg for over two years before pregnancy expressed a sense of being rushed by medical professionals, difficulty grasping the intricacies of the healthcare system, and challenges in building rapport with healthcare providers. Specifically, those who went through miscarriages highlighted the lack of emotional support and follow-up from health care providers. Additionally, individuals with a history of FGC emphasized the significance of having gynecologists who exhibit understanding upon learning about their history of FGC and stressed the importance of fostering an open dialogue about FGC before delivery. Furthermore, the women offered valuable recommendations to enhance the healthcare system, to improve access to quality prenatal and maternal care for African immigrant/refugee women. This includes having access to skilled interpreters, healthcare providers actively engaging and inquiring about their culture, fostering transparency and effective communication regarding health issues, and increasing the representation of African immigrant or Black doctors within the healthcare system.

Chapter 5: Discussion, Recommendations and Conclusion

This chapter is focused on summarizing the study's findings and the resulting conclusions. Specifically, it includes an overview of the study's findings, unexpected findings, their connection with existing literature, and an in-depth exploration of the key findings. Additionally, the chapter provides strategies aimed at addressing the limited understanding of the healthcare system among certain immigrant/refugee women, overcoming language and cultural differences and establishing meaningful connections with African immigrant/refugee women. The recommendations are applicable to health sector policymakers, healthcare providers, and programs targeting immigrants/refugees. Furthermore, the chapter discusses the implications of the study, suggests potential focus for future research and the strengths and limitations of the study.

Summary of Results

The study examined African immigrant/refugee women's experiences with prenatal and maternal health care services in Winnipeg. The findings showed how the women accessed prenatal care, their interactions with health care providers and their experiences with receiving recommendations. Facilitators of access to care for the participants who arrived while pregnant or in the first two years of being in Winnipeg included the support of settlement agencies, connecting with Mom and Me program, and walk-in clinics. The women also shared some positive experiences with health care providers. However, the findings highlight several barriers that African immigrant/refugee women experienced in accessing prenatal and maternal services. Some of the barriers mentioned by the women pertain to social determinants of health, such as the absence of social support.

Regarding isolation, the women shared the emotional challenges they encountered throughout their pregnancy and postpartum periods, primarily attributable to the absence of familial and community support. The women also experienced feelings of loneliness due to a lack of connections with their neighbors. Challenges in communication with healthcare providers resulted in some women feeling neglected, while others questioned whether their encounters were influenced by racism. Additionally, some women expressed that their limited understanding of the healthcare system made it challenging to grasp their overall experience. Women who experienced a miscarriage were even more likely to express their concerns about the health care system, especially because they had used emergency services and noted the absence of emotional support from healthcare providers. Lastly, while most of the women tried to follow recommendations made by health care providers, a few chose not to adhere to them. Some women discussed acceptance, meaning accepting recommendations when they did not want to challenge health care providers. The primary reason for simply accepting was the fear of not knowing what would happen if they did not follow physician recommendations. For those who did not follow them, they shared reasons such as faith and cultural beliefs. Finally, women shared their own recommendations about the healthcare system, such as health care providers being more transparent as a means of improving access to quality care for African immigrant and refugee women.

Unexpected Finding

The study sought to uncover the lived experiences of African immigrant/refugee women who had utilized prenatal and maternal services in Winnipeg, Manitoba. The identified themes emerged from the collected data, revealing an unexpected focus on the women's experiences of miscarriage. This encompassed their journey in seeking care and the emotional distress caused

by a lack of follow-up from health care professionals. As highlighted in the results section, these miscarriage experiences held considerable significance for the women. Consequently, the study also brought to light the women's discussions about their interactions with the emergency department. This also illustrated how access to any form of care can shape an individual's perception of the health care system. Furthermore, it shows the importance for researchers examining prenatal and maternal experiences to be attuned to a women's history of miscarriage and how it influences their perception of their normal pregnancy journey or the health care system.

Connection to Existing Literature

The absence of social support experienced by African immigrants and refugees upon migrating to Canada is congruent with the literature (Pangas et al., 2019; Woodgate et al., 2017). Specifically, the lack of family and community members during their perinatal period leading to feelings of loneliness is identified in numerous other studies (Carolan & Cassar, 2010; Kennedy & Murphy-Lawless, 2003). For immigrant/refugee women who arrive or become pregnant within their initial two years of residing in a new environment they experience accessing maternity care as a period that encompasses not just the transition to motherhood but also the process of resettlement (Pangas et al., 2019). These transitions are disruptive, and the absence of support networks requires women to cultivate individual resilience to navigate this period of their lives (Correa-Velez et al., 2010; van der Ham et al.,2015). Additionally, while there were signs that some of the women were grappling with post-partum depression, they expressed a reluctance to confide in their partners, family, friends, or health care providers due to cultural stigma and spiritual beliefs surrounding mental health. This aligns with existing literature that underscores how the stigma surrounding mental health, or a cultural perception of it as a taboo

subject, significantly influences the way refugee women perceive and cope with postpartum depression (Haque & Malebranche, 2020).

Regarding language differences, a substantial body of evidence shows that it represents a significant barrier to immigrant/refugee healthcare access (Pandey et al., 2021; Pangas et al., 2019; Woodgate et al., 2017). Language differences have been demonstrated to result in delayed access, hinder effective communication with health care providers, and elevate the use of more intensive services (Bowen, 2004; Pandey et al., 2021). Language differences have also been shown to negatively impact the ability of patients and health care providers to build a therapeutic relationship (Pandey et al., 2021). In Winnipeg, a report conducted on language barriers within the Winnipeg Regional Health Authority (WRHA) indicated that language barriers had impacted WRHA service utilization, including preventative services (Bowen, 2004). Other studies have also provided evidence that immigrants who utilized family interpreters or hired inexperienced interpreters reported were dissatisfied with the communication exchanges, feeling misunderstood and that they could not advocate properly for their care (Bulma & McCourt, 2002; Pangas et al., 2019)

Moreover, studies centered on this population and their experiences with the healthcare system have consistently shown that they face challenges in their interactions with healthcare providers (Bulma & McCourt, 2002; Pangas et al., 2019). The main challenges identified encompass communication issues, some of which stem from organizational or systematic barriers, such as the absence of professional interpreters, as discussed earlier (Pangas et al., 2019). Other challenges African immigrant/refugee women face with health care providers, such as feeling that health care providers are rushing appointments, are not transparent and do not inquire about their cultural understanding, are congruent with the literature (Due et al., 2022;

Lum et al., 2016). Additionally, a study on perceived discrimination in health care settings corroborates that this perception is significantly associated with reports of not having enough time with the physician (Benjamins & Middleton, 2019).

The lack of transparency and dialogue about FGC is consistent with another study that explored patient-provider communication surrounding FGC (Ameresekere et al., 2011; Lundberg et al.,2006). Study participants in Amereskere et al., (2011)'s study reported wanting physicians to discuss FGC and how it could affect their childbirth. The study showed women who underwent FGC, had postpartum infections and other studies also indicated higher rates of cesarean section, instrumental delivery, prolonged labor, and perineal tears in women with a history of FGC (Ameresekere et al., 2011; Lurie et al., 2020). Thus, initiating open and transparent dialogues about FGC with these women is imperative. Regarding cultural beliefs, other studies have also shown that when health care providers do not inquire about cultural understandings of health concepts or are not culturally sensitive, it results in frustrating experiences for immigrant/refugee patients (Woodgate et al., 2017; Due et al., 2022). The lack of cultural sensitivity by health care providers has also suggested that it leads African immigrant/refugee women to feel that their cultural practices are not important or valid (Pangas et al., 2019; Wojnar, 2015).

Lastly, in relation to African immigrant/refugee women's acceptance of care due to not wanting to challenge health care providers, Brämberg and colleagues (2010) also described that they accepted limiting participation in their care. However, the participants in Brämberg et al., (2010)'s study shared that it was because of knowing their health care providers had numerous other patients to attend to and did not want to inconvenience them. Cultural conviction as a reason to not follow health provider recommendations was also mentioned in other studies that

examined immigrant/refugee mothers, revealing that preserving their cultural beliefs from their home countries held great importance to them (Baird & Boyle, 2012; Briscoe & Lavender, 2013; Carolan & Cassar, 2010; Higginbottom et al., 2013).

An In-depth Exploration of the key Findings

Social Isolation

Community plays a particularly important role among people from many African countries, and the absence of social support can significantly impact African immigrants. Nearly all of the study participants discussed the lack of community, separation from family members and facing pregnancy to be emotionally challenging. The community especially plays a role during major transition periods such as giving birth. The women in the study talked about how, usually when a woman gives birth, all of her family members and neighbors come together, to not only celebrate but to provide help. This includes making meals for the new mother, helping with cleaning, and babysitting any children she may already have. Thus, the community is seen as a support system, providing both emotional and practical help. African mothers also rely on social/community networks for sharing information regarding birth and childcare (Simich et al., 2005). Canada, including Winnipeg, may be considered more of an individualistic culture where independence and personal autonomy are promoted (Evason, 2016). This can be a culture shock for African immigrant/refugee women and can impact their mental health. For example, Dennis and Ross's (2006) study focusing on the prenatal period showed that there is a relationship between lack of social support and depression among immigrant women. Although Canadian culture generally supports ethno-cultural bonds, exclusion can still exist for immigrants within their local community, workplace, and school (Ager & Strang, 2008). Additionally, prejudice and discrimination can also lead to separation between communities and newcomers (Ager &

Strang, 2008). Thus, programs and organizations, such as SERC, that collaborate with different communities are crucial and need to be supported. SERC empowers these communities to stay connected and provides a place for immigrants/refugees to meet, share their experiences and maintain a network. Furthermore, SERC promotes a strength-based discourse about African immigrants/refugee women. There is a tendency for the public and researchers to portray African immigrant/refugee women as lacking language capability and needy. However, African immigrant/refugee women are resilient and contribute to their host country in a significant way.

Organizational Barriers and Tension with Health Care Providers

Although the publicly funded healthcare system in Canada aims to provide services to all citizens, organizational barriers such as the limited number of professional interpreters and lack of cultural tailoring can lead to immigrants/refugee populations feeling marginalized, as shown above. The women who were not proficient in English were vulnerable to misunderstandings. Relying on family members for translation was a burden and added to a lack of privacy when seeking maternity services for the women. When it comes to women's culture, while physicians must provide clinical care based on current guidelines and standard procedures, engaging in dialogue with patients is crucial to understanding their cultural background, beliefs, and practices. This is especially important for individuals such as newcomers who may not be familiar with the healthcare system's standard procedures. The recommendation section will provide practical solutions that can be implemented to enhance cultural understanding.

Moreover, while high demand for services could cause long wait times and patients feeling rushed, the fee-for–service payment model may also be what led their gynecologists to rush appointments, an issue also identified by other scholars (Ikegami, 2015). As shown above, this led to the women not having the opportunity to ask questions or feeling that their needs were

not adequately met. This seems to suggest that services are focused on efficiency and do not encourage information sharing. It can render immigrant and refugee women lacking understanding about pregnancy, especially among those who are pregnant for the first time.

The findings also highlighted some tension between health care providers and the women when giving recommendations. While hospitals have established policies and procedures that health care providers must adhere to to ensure they communicate risks if a patient does not follow a recommendation, it is important to maintain rapport with patients. Health care providers must convey information in a manner that avoids instilling fear and doing it with humility while making it clear that their recommendations are based on the best available evidence. The request of a medical note by Nia was also an area of tension. Although physicians might have to say no to a request based on their practice guidelines, it would seem helpful to show compassion and maintain rapport even when a patient's request is not being fulfilled. This is especially true for newcomers who are encountering the health care system for the first time in their new context. A compassionate acknowledgement of their feelings can lead to a positive healthcare experience and encourage continuity of care. However, the lack of understanding of the structure of the healthcare system among some women may also explain why they have felt marginalized by services or encountered perceived discrimination.

Perception of Discrimination and Racism Within the Health Care System

Six women in the study experienced confusion as to whether their experience was racism, discrimination, or structural barriers in the health care system. This highlights the complexity of the health care experience for African immigrant/refugee women. While racism and discrimination may cause people to feel similar ways, different groups may view them or experience them differently. The experiences of racism or discrimination for African immigrants

or newcomers can also differ from those of Black individuals who are Canadian residents. In one study, refugee mothers in Hamilton, Ontario explained perceiving negative attitudes or long emergency room wait times as racism (Wahoush, 2009). This is similar to the experience of one of the study's participants, who attributed her lengthy wait time at the hospital's emergency department to racism. While this may indeed be the case, it could also be attributed to a lack of awareness about the structural barriers within the healthcare system. Put differently, it is common to experience prolonged wait times in emergency rooms, especially in Manitoba, where extended waiting periods in the emergency department have consistently been a prevalent concern (Greenslade, 2023).

Another experience that was questioned as to if it was racism was being rushed in their gynecologist appointments and lack of follow up. Similar to emergency long wait times, it is well known that there is a high demand for speciality services in Canada (Liddy et al., 2020). Knowing this could have helped prevent these instances from being interpreted as racist or discriminatory. Nonetheless, discerning whether instances of unfriendliness or rudeness by healthcare providers stem from their personal attributes or are driven by racism can pose a challenge. Subtle forms of discrimination, like being dismissed, can also be difficult to discern (Wahoush, 2009).

Moreover, the lack of physicians that represent the patient population, including African immigrants, means White Canadian physicians often treat African immigrant/refugees. This is important because there are studies that have shown Black patients in racially concordant physician relationships were more satisfied with the health care and rated their physician as engaging them more in decision-making (Cooper et al., 2003; Shen et al., 2018). In any case, whether the women perceived racism or discrimination or if their experiences genuinely were

that of racism or discrimination, both result in feelings of frustration and anger (Wahoush, 2009). There are studies that have demonstrated that experiences of racism and discrimination can negatively impact a group's health by causing heightened and prolonged activation of the body's physiological stress response (Hyman, 2009). Therefore, it is crucial to support African immigrant/ refugee women in understanding the healthcare system, to help them recognize their experiences, and to promote health care staff that represent the patient population.

Recommendations to the Health care System

This section will concentrate on my recommendations aimed at increasing African immigrant/refugee women's access to quality care prenatal and maternal services.

Health Education Program for Immigrant/Refugee Women

Given that some of the women in the study expressed uncertainty regarding the organization of the healthcare system, and additional research indicates that immigrants face challenges in acquiring information on accessing and navigating services, implementing an educational program tailored for immigrant/refugee women may prove to be effective (Kalich et al., 2016). Other studies have also proposed health education programs to assist immigrants in promptly accessing health services and effectively navigating the healthcare system (Fernandez-Gutierrez et al., 2019; Kalich et al., 2016). The education program could be delivered at one of the organizations that serve this population, such as SERC and the Immigrant and Refugee Community Organization of Manitoba (IRCOM). The program could be similar to Accessing Canadian Healthcare for Immigrants: Empowerment, Voice, and Enablement' (ACHIEVE) program (Ghahari et al., 2020). The ACHIVE program was created through collaboration with researchers, community organizations, and immigrants, including both the content and the delivery method (Ghahari et al., 2020). Moreover, ACHIVE aimed to assist immigrants in

enhancing their understanding of health care communication skills and self-advocacy, raising awareness about available resources, facilitating the ability to locate community resources, including social services, and ultimately promoting the community integration of immigrants (Ghahari et al., 2020). Furthermore, the program attempted to provide diverse cultural examples during class discussions around the differences between Western medicine and that of their country of origin (Ghahari et al., 2020). The pilot testing of ACHIEVE program found an increase in overall self-reported confidence in knowledge about the health care system and navigation among the immigrants who attended the program (Ghahari et al., 2020). Overall, a program similar to ACHIEVE in Manitoba could be beneficial and could also enable an increase in health literacy. Similar to the Mom and Me program mentioned in the study's results section, the health education program could include interpreters to ensure effective communication. The program could also serve as a space for pregnant African immigrant/refugee women to connect with fellow expectant mothers, fostering a sense of community.

Addressing Language Difference

To achieve accessible and good quality prenatal and maternal services for this population, language differences need to be addressed. The use of untrained interpreters (including family member or acquaintances of the patient) has been shown to not be effective. They do not have the medical knowledge to accurately interpret and tend to make errors such as substituting words and omitting information (Bowen, 2004; Woodgate et al., 2017). These mistakes have the potential for significant clinical repercussions. As well, immigrant patients often do not want family or friends to be their interpreters (Pandey et al., 2021; Pangas et al., 2019). Thus, while untrained interpreters may be convenient, they are not always effective. Using untrained interpreters also means that the health care system is leaving the responsibility of effective

communication to patients. Another strategy for addressing language differences has been the hiring of bilingual physicians. In Manitoba, this includes offering physicians who speak both French and English (Bowen, 2004). Having bilingual physicians has been demonstrated to increase patient satisfaction and comfort levels (Lopez Vera et al., 2023).

However, Manitoba is home to numerous small linguistic communities and ensuring that providers speak these languages is not feasible. Additionally, based on the available literature, there is a lack of evaluation studies regarding the effectiveness of bilingual health care providers in Winnipeg. A different strategy is to hire professional interpreters and ensure that they are available for all immigrants/refugees who are not proficient in English. A study in the United States found that when professional interpreters were introduced, the use of preventative services increased while the utilization of hospital emergency services decreased (Jacobs et al., 2001). Employing professional interpreters is linked to enhanced clinical care compared to relying on amateur interpreters. Although there are language services in WRHA, as mentioned above, the women described limited access to interpreters. Interpreter services also contribute to increased length of treatment visits and healthcare costs (Shamsi et al., 2020). A strategy that has increasingly been employed is the use of online translation tools such as Google Translate and MediBabble, as discussed by Albrecht and colleagues (2013). According to these researchers, the use of online translation tools in hospitals increased the satisfaction of both patients and medical providers (Albrecht et al., 2013).

The best strategy for African immigrant/refugee women must be determined through further assessment of needs in Winnipeg and evaluation of the current WRHA language access service. A combination of the above strategies is likely needed. Engaging with African immigrant communities is crucial to determine the best solution.

Addressing Cultural Difference

Kleinman and Benson, (2006) have outlined ways physicians can be sensitive to cultural differences and attempt to deal with issues related to culture. According to these authors, clinicians can utilize a mini- ethnographic approach which includes six steps titled revised cultural formulation when engaging with patients (Kleinman & Benson, 2006). For example, the first step includes asking patients their ethnic identity and determining whether this is an important part of the patient's sense of self (Kleinman & Benson, 2006). This approach aims to provide culturally informed care by understanding what matters to the patient (Kleinman & Benson, 2006). Moreover, Kleinman et al., (1978) have also developed eight questions to elicit the patient's explanatory model that helps to consider the patient's beliefs and customs.

Furthermore, a study focused on African refugee women's experience with prenatal care found that culturally appropriate care for this population also includes how to ask about FGC in a way that is responsive to cultural norms (Due et al., 2022). Thus, it would be highly useful for health-care providers to learn about FGC and the complications that could arise during and after childbirth. This could be incorporated as part of the medical school curriculum. Additionally, patient advocates who are specifically aware of the major African country origins of immigrants/refugees in Manitoba could be included in the women's hospital. These patient advocates would act as a representatives and help patients and health care providers have an understanding whenever an issue arises. Similarly, bilingual navigators could provide support to immigrants and refugees (Mistry et al., 2023). For example, Mistry et al., (2023) placed three bilingual community navigators (BCNs) recruited from the patient community within a general practice healthcare setting. They assessed the feasibility and acceptability of having BCNs in these settings and observed that patients and staff welcomed BCNs (Mistry et al., 2023). The

BCNs assisted with tasks such as referring to other services, identifying resources, and providing information about appointments (Mistry et al., 2023). Overall, these initiatives have the potential to improve culturally appropriate care and enhance patient satisfaction.

Engaging with African Immigrant/refugee Women and Fostering Trusting Relationship

Engaging patients in their care and fostering a trusting relationship is crucial for many reasons. This includes increasing patients' involvement in their care and reducing anxiety and distress (Dean & Street, 2014). It is also important for enhancing medication adherence (Dean & Street, 2014). According to Ashworth et al., (1992) patient's engagement or participation in their care is determined by factors such as a health care provider who adapts to the patient's circumstance and pays attention to the views of the patient's family members. For African immigrant/refugee women, health care providers adapting to their circumstances includes things such as being willing to ensure language differences are addressed, inquiring about possible trauma the women may have experienced and their cultural understanding of a health concept. Health care providers must be aware that African immigrant women are undergoing many life transitions, including becoming a mother and trying to navigate the unfamiliar environment at the same time. Moreover, other studies have showed that African women valued extended consultation and continuity of care (Byrskog et al., 2015; Higginbottom et al., 2013). Thus, it is important that appointments with African immigrant women not be rushed. Furthermore, engaging African immigrant women and building relationships includes having transparent conversations about issues that arise and discussing the impact of FGC on delivery for the women who have experienced FGC. Transparency includes providing information regarding suspicions of a problem and possible treatment options. Herrel et al., (2004)'s study showed that

Somali women wanted to know more about things such as the delivery room experience and pain medication.

Enhancing the Continuity of Care Through a Maternity Care Model

Given the fact that the women expressed that their gynecology appointments felt rushed, they desired more dedicated time with their gynecologists. One potential approach could involve implementing a specialized care model tailored to meet the needs of African immigrant/refugee women. In particular, the care model would embrace a comprehensive perspective, considering not only the medical requirements of women but also addressing their emotional and social needs. This approach would be grounded in evidence, employ a strength-based methodology, and be culturally sensitive across diverse African backgrounds. For example, Madeira and colleagues (2019) described a midwifery-led care model for East African immigrants who are low income living in midwestern U.S. urban location. The care included stress management, individualized and personal care and an educational program (Madeira et al., 2019). In addition to the health care providers, the model included medical assistants and women reproductive health care coordinators (Madeira et al., 2019). Overall, seventeen women participated, their self-reported satisfaction was high, and there was an increased knowledge of pregnancy, breastfeeding, what happens in the hospital and stress management (Madeira et al., 2019). The women also shared increased awareness of personal health and the value of building community (Madeira et al., 2019).

In another study conducted by (Owens et al., 2016), the authors described a community-based antenatal service specializing in maternity care for multicultural women and those not proficient in English in Perth, Western Australia. This service was led by midwives but also involves the collaboration of physicians, nurses, bicultural workers, and interpreters (Owens et

al., 2016). Women who utilized this service, as reported in Owens et al., (2016), found it beneficial in meeting their diverse needs. They highlighted advantages such as receiving information, having opportunities to ask questions, and obtaining assistance with issues beyond pregnancy-related concerns. The women also expressed gratitude for not having to repeat information to various healthcare professionals, and they particularly valued the postnatal care provided by the midwives. In general, literature emphasizing the adoption of midwife-led care highlights numerous advantages (Owens et al.,2016; Madeira et al.,2019). However, there is a lack of comprehensive evaluation of diverse maternal care models within high-income countries, particularly in relation to healthcare outcomes for African immigrant/refugee women (Njue et al., 2022). Moreover, implementing a midwifery care model may pose challenges in the Winnipeg context, considering the substantial demand for midwifery care as mentioned in the literature section.

Additionally, a study by Reiger & Lane, (2013) shows that some midwives described difficulties with the concept of midwife-led maternity care. Thus, evaluating the healthcare system and midwives' capacity is crucial in order to assess feasibility. A needs assessment would also have to be conducted in Winnipeg to identify primary priorities. This assessment will help identify the necessary clinical staff and other providers to address these women's medical, emotional, and physical needs. Additionally, African immigrant/refugee women should be involved in shared decision-making during the development of a care-model as an intervention to enhance maternity services. Ultimately, the care model should be responsive, striving to enhance continuity of care and improve maternal health outcomes for African immigrant/refugee women in Manitoba.

Implications

The findings of the study and previous research from European countries confirm the need for evaluating language interpretation services, prenatal and care models, policies and education to medical staff and students about African immigrant/refugees in Winnipeg. The policies that are currently in place for ensuring access to health care for this population should also be examined. The language services at WRHA need to develop clear instructions and guidelines in different languages for patients and physicians on how individuals can access their services. Additionally, as mentioned above, there needs to be a combination of methods to ensure immigrants/refugees have access to quality interpretation services. Different care models have been identified for this population that could possibly be replicated in Winnipeg (Njue et al., 2022) . The care models enable extended time with health care providers and increased support for this population. Moreover, based on the findings, follow-up requirements for women who have experienced miscarriage need to be evaluated. This includes how the women are supported emotionally to ensure they do not experience negative mental health impacts and that their trust in the health care system is not negatively impacted.

In regards to medical staff and students, there needs to be more education about this population and about things such as FGC, potential discrimination that African immigrant/refugee women experience, as well as cultural humility. They need to be trained to support this population to participate in their care and to be more knowledgeable about settlement challenges that African immigrant/refugee women face. In light of the findings regarding the women being confused about their experience was racism or structural barriers of the health care system, there needs to be adequate education about the health care system when the women are being taught about Canada by settlement agencies. Programs such as Mom and

Me can also incorporate Canadian health care system education. Education about the health care system should discuss some of the structural barriers and areas for improvement. This will enable African immigrants/refugee women to have realistic expectations and better identify if their experience is racism or structural/systemic barriers of the health care system and potential problems that may arise while they are seeking care. Health care staff should also receive anti-racism training and ensure they are adequately prepared to work with this population. Lastly, there needs to be an increase in African immigrant or Black physicians in the health care system to better serve this population.

Strengths and Limitations

The study's major strength is that it utilized principles of community-based research and engaged members from SERC. This enabled the study to focus on a relevant and important topic for African immigrant/refugee women. SERC representatives helped with further understanding of the findings, as representatives from SERC have worked with this population for a number of years and conducted research with this population. Moreover, SERC representatives played a key role in ensuring that the language used to describe this population avoided reinforcing stereotypes or stigma. Sharing background with the participants enabled me to gain trust and most of the women were comfortable sharing their experience. Some interviews were conducted in Amharic, based on the participants' preferences. This enabled these participants a chance to accurately describe their experiences. Furthermore, the use of principles of IPA for the analysis enabled me to concentrate on how their experiences made them feel and impacted their perspective of the health care system. Applying intersectionality as a theoretical perspective enabled me to examine how the duration of stay in Winnipeg, not being proficient in English,

previous experience of miscarriage, having an immigrant/refugee status and being a racialized person posed distinct barriers for some women.

The study has several limitations that should be considered. The women were from different African countries and various age groups and had different numbers of children. While diverse participants increase transferability, the lack of homogenous participants can negatively impact the interpretability of the findings. Additionally, sharing my background with the participants did not always positively impact the study. For instance, there were times during the data collection when the women assumed I could relate to their experiences and understand what they were saying. Moreover, research using IPA typically involves a small number of participants to thoroughly explore each individual's experience (Smith et al., 2009). Specifically, for masters students, Smith et al., (2009) suggest between three to six participants. Despite the effort to comprehensively examine each participant's experience, having 16 participants may be considered a relatively large sample size for an IPA study. Lastly, for the interviews conducted in Amharic, it is possible that some notions were lost in translation during transcription.

Future Directions

Future research should examine African/immigrant access to services, especially midwifery services and emergency department. There is also a need to examine further African/immigrant experiences of perceived discrimination in the health care system, including in primary health care and the emergency departments. How perceived discrimination impacts African immigrants/refugees in establishing relationships with health care providers should also be further explored. Maternal health outcomes of African immigrant women, including those who have experienced FGC, should be examined to determine if African immigrant/refugee women experience increased complications compared to immigrants from other parts of the

world. Additional research on the process of help-seeking and post-partum depression among African immigrant/refugee women should be explored. Lastly, the role of community support during prenatal and post childbirth in African immigrant/refugee women's depression symptoms and psychological well-being needs to be studied.

Conclusion

The study offered insights into the lived experiences of African immigrant/refugee women accessing prenatal and maternal health care services. The research elucidated the nuances of African immigrant/refugee women's experiences accessing prenatal and maternal care. Specifically, the study highlighted how immigrant/refugee and racialized status, coupled with a limited understanding of the healthcare system and the duration of residence in Winnipeg, influenced women's accessibility to these services. The role of programs such as Mom and Me and walk-in clinics as facilitators to access was evident. Apparent in the findings of the study is that the women who were pregnant and had to access health services during the first two years of living in Winnipeg experienced a number of challenges. Women living longer in Canada generally had fewer barriers to accessing prenatal and maternal services. The lack of connection to family and community support led to women feeling isolated. The study highlights the systemic barriers that can be interpreted as discrimination and racism by African immigrant/refugee women. Finally, the findings may inform future supports and resources for programs and organizations that are focused on immigrants/refugee women.

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Appendix

Interview Guide

Pre-screening Questions

Below are the probing questions for pre-screening once the individual has agreed to participate.

1. Can you please introduce yourself, and tell me how long you have lived in Canada?
2. Can you please tell me how old you are and your marital status?
3. Since relocating to Winnipeg, MB were you pregnant and received prenatal and maternal care?
4. Can you please tell me if you have a primary care doctor?
5. How many children do you currently have? How many of your children were born in Winnipeg, Manitoba?

Individual-Interview Guide

Below are the final probing questions for the individual interview.

6. Can you tell me your experiences accessing prenatal and maternal care services? Were you able to easily access care?
7. Can you describe your experiences interacting with health care providers? What was their attitude like towards you? Did you understand the treatment they recommended?
8. Did you feel like all of your needs were met by the health care provider? Was she or he sensitive to your cultural beliefs surrounding pregnancy and postpartum treatment?
9. If you have been through labour and delivery – what were some of your experiences with how health staff managed your labour and delivery?
10. Has your pregnancy involved an obstetrician or other specialist? What have been your experiences with those?
11. For those not through labour and delivery – thinking ahead to when you are in labour and going to deliver your baby, what are some of your expectations for how health staff will provide you care?
12. For those through labour and delivery- how would you describe the care you received after giving birth?
13. Can you tell me how these experiences made you feel? Were you able to follow your doctor's recommendation for a healthy pregnancy or after giving birth?
14. What impact do you think your experiences had on your decision to follow your doctor's recommendation or not?

15. What kinds of considerations do you think healthcare providers or the health system need to consider in caring for African immigrant/refugee women?
16. Based on your experiences, what you think would make these services more accessible for African immigrant/refugee women?