MOTHERHOOD AND CHILDBIRTH EXPERIENCES AMONG NEWCOMER WOMEN IN CANADA: A CRITICAL ETHNOGRAPHIC STUDY

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ABSTRACT AND KEYWORDS

Statement of the Problem: Motherhood and childbirth are very sensitive experiences and have a strong impact on family functioning, social identity, and cohesiveness. Although motherhood and childbirth have been discussed extensively in the scholarly and popular literature, much of this work has been conducted from a North American perspective, with little attention to how motherhood and childbirth are experienced by newcomer women from diverse racial and cultural backgrounds.

Methodology and Theoretical Orientation: A critical ethnographic study using in-depth interviews with 16 newcomer women was utilized to explore newcomer women's experiences and understandings of motherhood and childbirth in the aftermath of migration to Canada. A critical feminist perspective was utilized to provide a reasonable explanation of the experience of newcomer women during motherhood and childbirth

Findings: Although the women in this study expressed different meanings of motherhood and childbirth experiences, most of them agreed that it was happy, unforgettable, and worth their sacrifices. They viewed motherhood as meeting the social and religious expectations from them as women despite their fears of childbirth process in a different environment and the difficulties of raising children in a new country. As well, the women identified some challenges they faced on becoming mothers. The lack of social and emotional support, parent- child conflict, and competing roles and economic distress were adding to women's hardship. Women also demonstrated strengths and employed a number of strategies to deal with the stress of the changes associated with becoming a mother in Canada. Among the strategies they used were preserving the good mother identity, using hope, patience and acceptance, adopting health promoting practices, using religion as catalyst for coping, and adjusting parenting style. Women expressed mixed opinions and experiences about the care they received from health care system in Canada. Although some of these stories were similar to many women without newcomer status, being in a different

health care environment for the first time and dealing with doctors and nurses who speak different language caused women an extra burden.

Although women identified different sources of support, with the absence of extended family support, this was not sufficient to meet their needs. Migration circumstances also influenced women's perspectives about the changes that occurred in their marital relationships. While most women described how their marital relationship became more intimate and close, some women reported the occurrence of conflict and stress inside their families.

Conclusion and Significance: Findings from this study provide insight to inform nursing practice, education, research, and policy making with regards to newcomer women's experiences during the process of childbirth, and as new mothers in a new land. This study provides information that enhances the ability of nurses to provide safe care.

Keywords: motherhood, childbirth, migration, ethnography, social support, intimate partner violence, immigrants and refugees, health promotion, postnatal health, interviews.

CO-AUTHORSHIP STATEMENT

The members of my dissertation advisory committee are coauthors on this dissertation. Through a process of ongoing feedback, they have each contributed to understanding of the subject, the development of the research question, the research design, and the description and interpretations of the findings as presented in this dissertation. My faculty advisor, Dr. Helene Berman, mentored me in analysing and coding the data and helped me the most in constructing the findings in a meaningful and clear manner. In this process, the coauthors were consulted when their expertise in some issues was needed. The chapters of this dissertation were my initial construction but each chapter was reviewed and edited by Dr. Helene Berman, and then by the other advisors, Drs. Marilyn Ford-Gilboe and Marilyn Evans. All coauthors have approved the content and the format of this dissertation.

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Chapter One

Introduction

Motherhood and childbirth are significant life events that have a strong impact on family functioning, social identity, and sense of cohesion. Although motherhood and childbirth have been discussed extensively in the scholarly and popular literature, much of this work has been conducted from a North American perspective, with little attention to how motherhood and childbirth are experienced by newcomer women from diverse racial and cultural backgrounds (Johnston & Swanson, 2003; Liamputtong & Naksook, 2003; Lupton, 2000). Implicit in this body of work is the assumption that all women experience motherhood and childbirth in the same way. While much has been written about the challenges faced by newcomer women, such as different role expectations and identity reorientation, cultural conflict and transformation, psychological adjustment, social isolation, differences in disciplinary practices, experiences of violence and past trauma, dealing with new heath care systems, difficulties in language, and economic problems (Dekel, 2004; Hyman, Guruge & Mason, 2008; Meleis, 2005; O'Heir, 2004; Parson, 2010; Raj & Sliverman, 2002), the particular challenges they encounter during pregnancy, childbirth, and mothering have largely been overlooked.

Intimate partner violence (IPV) is one contextual factor that has a serious impact on childbirth and may impact newcomer women's ability to carry out their mothering role (Barrett & St. Pierre, 2011; Kendall-Tackett, 2007; Wuest, Merritt-Gray & Ford-Gilboe, 2004). Although the rate of IPV among newcomer women is difficult to estimate, there is evidence that IPV is experienced by many newcomer women (Brownridge & Halli, 2002; Shirwadkar, 2004). More specifically, Barrett and St. Pierre (2011) estimated that based on the Canadian General Social Survey (1999), 14.4 % of women who experienced IPV in the past five years were born outside Canada. It is possible that changed gender roles and expectations, along with other stressors of migration, may increase the risk of IPV for newcomer women. However, there has been little research in this area. Although public health nurses, midwives and social workers are well positioned to offer prenatal

education and professional support for newcomer pregnant women, a deeper understanding of the factors that facilitate or inhibit a successful experience of motherhood and childbirth is needed in order to provide culturally safe care.

Various definitions have been used to describe who can be included under the category of 'newcomer woman'. For many agencies, the definition is determined by funding parameters. For example, federal funding agencies define a newcomer as someone who has been in Canada for less than three years, whereas provincial funding agencies have extended this period up to five years (Citizenship and Immigration Canada, 2006). For the purpose of this study, a newcomer woman is defined as a woman who has come to Canada as an immigrant or refugee during the last five years, and is learning to negotiate the health and social systems (CIC, 2006). Childbirth is defined as "a deeply physiologic, cognitive, cultural, social, and spiritual event." (Callister, Semenic & Foster, 1999. p. 280), and motherhood is defined as the processes and roles associated with becoming a mother (Shin & White-Traut, 2007).Cultural safety is defined as a method of carrying out nursing actions that moves beyond cultural awareness to understanding/challenging power differentials and addressing inequities (The Aboriginal Nurses Association of Canada, Canadian Association of Schools of Nursing & Canadian Nurses Association (2009). The purpose of cultural safety is to consider historically determined power relations between nurses and individuals, to bridge the differences that have evolved, and to find expression in caring spaces that are equality seeking and rights oriented.

Background, Significance and Purpose of the Study

Although motherhood and childbirth are experienced by women at an individual level, the meanings associated with these life events cannot be fully understood in isolation from wider social, historical, and cultural contexts. Consistent with this idea, motherhood is perceived differently across cultures, places, and times. For example, some women view motherhood as an experience of love, sacrifice, and moral duty (Liamputtong, Yimyam, Parisunyakul, Baosoung & Sansiriphun, 2004; Liamputtong, 2006), while others view

motherhood as a life stage that fulfills a basic need to keep the name and the legacy of the family (Liamputtong & Naksook, 2003). Some young mothers view motherhood as presenting risks their future (Smith Battle, 1995). Some authors have suggested that women from lower socioeconomic groups may view motherhood as a burden due to the high costs of caring for children (Shelton & Johnson, 2006; Weaver & Ussher, 1997). However, this is a highly contentious claim. Childbirth for some women is perceived as a joyful and happy event (Cheung, 2002), yet for some refugee women, it may be a disappointing, stressful, or even a traumatic process (O'Heir, 2004). The meanings presented by refugee women are shaped by the additional challenges as compared to immigrant women. Refugee women who have been exposed to rape or sexual assault in war-torn areas may face pregnancies which are unwanted, unplanned, and poorly spaced (O'Heir, 2004; United Nation High Commissioner for Refugees, 2003). Those who want to terminate their pregnancy and who lack access to safe abortion services may seek unsafe abortions and may need subsequent emergency treatment for obstetric complications. In addition, there is a potential to re-traumatize women during pregnancy, birth and postpartum with medical practices that trigger or re-enforce traumatic experiences (Lent, Morris &Rechner, 2000). Furthermore, their dislocation to unfamiliar surroundings in refugee camps and lack of infrastructure and access to basic survival needs for them and for their babies may heighten the difficulties they encounter (Eisenman, Keller & Kim, 2000; Gagnon et al., 2006; Krause, Jones & Purdin, 2000).Therefore, this study is designed to identify motherhood and childbirth meanings from the perspective of both immigrant and refugee women.

Upon arrival in Canada, newcomer women learn about Western values, and often attempt to integrate the old and the new cultural frameworks into their evolving ideas about motherhood and childbirth (Bakker, Van Oudenhoven &Van Der Zee, 2004). They also gain new knowledge that may influence their personal meanings of motherhood. Exploring how this re-conceptualization of motherhood and childbirth shapes newcomer women's experiences in the context of migration deserves more attention.

Becoming a new mother is a critical period in the life of a woman and her family. Despite efforts by health and social service professionals to improve newcomer women's living conditions, health and social disparities persist. For example, several researchers have shown that immigrant women experience higher rates of preterm birth, low birth weight, perinatal mortality, congenital malformation (Bollini, Pampallona, Wanner&Kupelnick, 2009; Urquia, Frank, Glazier, Moineddin, Matheson& Gagnon, 2009) and postpartum depression (Fung & Dennis, 2010; Stewart, Gagnon, Saucier, Wahoush &Dougherty, 2008). Possible contributing factors are: lack of social support, language barriers, and unfamiliarity with the Canadian health care system. In a randomized control trial of 501 mothers to examine the effect of peer support on postpartum depression, Dennis (2003) found a significant difference between mothers in the control (mean 12.1, SD 4.6) and experimental (mean 8.5, SD 3.7) groups (t [40] = 2.8,P = 0.008) when EPDS mean scores were assessed at four weeks. For newcomer women, research is needed to more fully understand the challenges faced by women and the type of programs and policies needed to promote their health and well-being.

The occurrence of IPV may be a particular concern for newcomer women during the perinatal period. However, little research has been conducted in this area. Hyman, Guruge, and Mason (2008) revealed that post-migration experiences and stress may result in marital conflict, which is a major risk factor for IPV. In a secondary analysis of data from the General Social Survey (1999) undertaken to determine the prevalence of IPV among recent and non-recent immigrant women in Canada, Hyman, Forte, Du Mont, Romans and Cohen (2006) found that IPV among recent immigrant women was estimated to be 17.4% as compared to 18.8% for non-recent immigrant women. It is possible that these rates are underestimated because of language difficulties and unwillingness to disclose information. A number of recent incidents across Canada have raised concern for immigrant and refugee women's safety and well-being. These incidents include the murders of Aqsa Parvez in Mississauga in 2007; the three Shafia sisters and their step-mother in 2009 in Kingston Mills; Khatera Sadiqi and Feroz Mangal in 2009 in Ottawa; AmandeepAtwal, killed by herfather near Cache Creek in 2003; and

Sunny Par, murdered by her husband in Victoria, in 2008 (Ending Violence Association of British Columbia, 2009; Ishaq, 2010). In Canada, little is known about the prevalence of IPV among newcomer women in general or more specifically during motherhood and pregnancy. For newcomer women, the mechanisms by which familial relationships continue to be abusive or become abusive during motherhood and childbirth in an unfamiliar context are not well understood. Considering gender as an explanatory construct, an exploration of contextual factors that contribute to newcomer women's experiences as mothers will strengthen theory and research regarding newcomer mothers.

The present research is designed to address some of these knowledge gaps, while also promoting personal and social change. Newcomer women will have a chance and the space to reflect on their motherhood and childbirth experiences in a positive environment which will encourage reflections on self and social understandings, thereby increasing their sense of agency and personal strength. Through the research process, their voices will be heard, they will have opportunities to name their realities, and they will indirectly help other women in similar conditions. It is also anticipated that the findings from this study will yield new knowledge that promotes social and structural change by increasing understanding of the transition to motherhood for newcomer women among nurses and other health care professionals, contributing to new policies and programs to support this population, and improving accessibility, cultural safety, and relevance of health and social services for these women and their families.

The critical ethnographic study which forms the basis of this dissertation was undertaken to explore newcomer women's experiences and understandings of motherhood and childbirth in the aftermath of migration to Canada. The challenges that newcomer women face in interacting with their families, and with the health care system and social networks were investigated. The main focus of this study was on motherhood and childbirth in the context of migration for newcomer women. The target group was any newcomer woman regardless of the country of origin, who gave birth in Canada but not necessarily to her first child. A

justification for giving specific attention to this population is that because of the new context, this group experiences cultural, social, and health challenges which may influence their motherhood and childbirth experiences.

Specific research questions. This research study was guided by four questions:

1) What is the nature of newcomer women's experiences during motherhood and childbirth?

2) What challenges do newcomer women face during motherhood and childbirth in the aftermath of migration?

3) What are the sources of strength and resilience among newcomer women during motherhood and childbirth?

4) How do the health care system and social networks support or hinder women's successful motherhood and childbirth?

Theoretical Underpinnings

This dissertation is informed by critical feminist perspectives and Intersectionality theory. Critical feminist perspectives offer the potential to provide a reasonable explanation of the experience of newcomer women during motherhood and childbirth, with a focus on strengths and capacities (Browne, 2000; Collins, 2000; Denzin, 2002). Critical feminist ideology supports a rethinking of prevailing gender roles, and encourages a critique of the social structures that shape, as well as challenge, newcomer women's experiences of motherhood and childbirth (Collins, 2000; Kincheloe & McLaren, 2003). Thus, it is a most appropriate framework for this research. In addition, an Intersectionality lens will be used to facilitate an understanding of how multiple identities and roles that newcomer women assume during migration, motherhood, and childbirth are socially and culturally constructed (Crenshaw, 1991; Fonow& Cook, 2005). Both of these theoretical perspectives are consistent with the use of critical ethnography which gives voice to newcomer women and has the potential to offer an in-depth understanding of their values, beliefs, and meanings about becoming a mother

(Madison, 2005). The use of a critical perspective is particularly relevant for this research as it problematizes motherhood and childbirth in terms of social structure, and directs attention away from a focus on an individualized analysis of motherhood and childbirth toward an analysis that takes into account the broader social, historical, and cultural realities that shape women's experiences. In essence, a critical lens encourages an understanding of motherhood and childbirth among newcomer women not as an individual or private problem, but as a public concern demanding social action. In the next section, a brief description of these theoretical perspectives and their compatibility with critical ethnography is provided.

Critical Feminist Perspectives

Critical feminist perspectives are means to frame enquiry with the aim of liberating women from constraints, either conscious or unconscious, that interfere with balanced participation in social interaction (Campbell & Wasco, 2000; Stanley & Wise, 2000). A main task of critical feminist research is social critique, whereby the restrictive and oppressive conditions of the status quo are brought to light (Kincheloe & McLaren, 2003). Critical feminist perspectives have made significant contributions to the advancement of qualitative and quantitative inquiries in the health and social sciences, including in Nursing (Berman, 2003; Berman, Ford-Gilboe & Campbell, 1998; Dyck& McLaren, 2004; Georges, 2005; Mason, Hyman, Berman, Guruge, Kanagaratnam & Manuel, 2008; Moony & Nolan, 2006; Wuest, Merritt-Gray & Ford-Gilboe, 2004). In addition, the tenets of critical feminist theory are grounded in an ethic of empowerment and social justice to individuals, including newcomer women (Fontana, 2004; Williams, 2002).

Ontologically, critical feminist scholars propose that there is no single truth that can be taken for granted, and that reality is socially constructed and influenced by one's context and the history (Campbell & Bunting, 1991). These perspectives require that researchers be clear about where they stand and how they view the struggles of disadvantaged individuals. Epistemologically, knowledge is not seen as "a pure fact" but is "value laden" and shaped by contextual factors such as history, economy, culture, gender, social and political

environments (Berman, Ford-Gilboe & Campbell, 1998; Guba& Lincoln, 1994). Critical feminist theorists argue that all that we know or do has a political nature and that some aspects of life can be understood in terms of gender equalities and inequalities (Brown, 2005; Dion & Dion, 2001). Gender, from this perspective, is a socially constructed system of values, identities, and activities that intersects with other identities to contribute to oppression (Collins, 2000; Whaley, 2001; Williams, 2002).

Critical feminist perspectives also include the idea that it is necessary to understand the lived experience of individuals in context and interpret acts and symbols of society in non-judgmental ways in order to understand how various social groups are oppressed (Cody, 2000; Denzin, 2002). In her book, "Black Feminist Thought", Collins (2000) wrote that "ideology refers to the body of ideas reflecting the interests of a group of people. Within U.S. culture, racist and sexist ideologies permeate the social structure to such a degree that they become hegemonic, namely, seen as natural, normal, and inevitable."(p.5). She describes how structural relations are embedded in ideology and how certain qualities that are associated with black women are used to justify oppression.

Feminists from the Middle East have adopted two feminist paradigms, the Islamic and the secular feminist movement. Islamic feminists advocate women's rights, gender equality, and social justice grounded in an Islamic framework, highlight the deeply rooted teachings of equality in the religion, and encourage a questioning of the patriarchal interpretation of Islamic teaching through the Qur'an (Abu Lughod, 2002). In contrast, secular feminists are constituted by multiple discourses including secular nationalist, Islamic modernist, humanitarian, and democratic (Badran, 2005). Because women in this study are from diverse cultural backgrounds, an understanding of how the religion shapes women's lives could help to understand women's conceptualizations of their roles as mothers and to explore the challenges women face and the strategies they use to overcome the stresses of motherhood.

By examining social conditions in order to uncover hidden structures with the implicit assumption that individuals are experts on their lives, this perspective is premised on the belief that knowledge is power (Browne, 2000; Denzin, 2002). This means that knowing and understanding the ways in which women are oppressed and increasing their self-awareness could lead to opposition to oppressive forces and challenge the status quo. Praxis is the key for liberation because it combines research with actions to produce change. Critical feminist researchers and participants engage in dialogic and didactic processes that lead to co-construction of social realities and knowledge (Carroll, 2004; Fontana, 2004; Reimer- Kirkham & Anderson, 2010). Liberation and emancipation from this perspective stem from the development of self-awareness and knowledge (Campbell & Wasco, 2000; Dow & McDonald, 2003; Freire, 1972). In this study, increased awareness on the part of newcomer women and health professionals regarding the impact of the contextual factors on motherhood and childbirth experiences may lead to enhanced quality of life and improvements in service delivery.

The experience of motherhood has been studied extensively using critical feminist perspectives (Liddell, 2005; Rodriguez, 2008). A review of the literature has revealed that there are two prevailing critical feminist perspectives regarding motherhood. In the first perspective, scholars reject motherhood for several reasons. Some of them have explored how current ideologies about motherhood sustain patriarchy and perpetuate the economic dependency of women (Caporale-Bizzini, 2006; Johnston & Swanson, 2003). Scholars from this perspective discuss that true power for women is in the employment field and if women choose to be mothers, motherhood should be paid work so that its social value is reinforced and women's economic dependence on men might decrease (Federici, 2004). On one hand, this perspective creates a conflict between being a mother and a worker because it implies that women must make a choice between motherhood and employment. On the other hand, assuming that the only way to power and agency is through employment seems to undervalue the less tangible rewards of motherhood. I argue that many women have succeeded in joining both experiences of employment and motherhood. The majority of Canadian mothers are employed and combining raising children

with their employment positions (Powell, 1997). Some scholars who have adopted that same perspective believe that motherhood hinders feminist goals by shifting the focus from women, their sexuality and identity, to that of the welfare of children (Bordo, 1995; O'Reilly, 2004). For example, Elvin- Nowak and Thomsson (2001) revealed that children's psychosocial well-being is dependent on the presence of mothers and that a happy mother is understood as the foundation for a happy child. According to these feminist scholars, experiences of motherhood are wholly child centered, emotionally involving, and both assume and reinforce the traditional gender- based division of labor; in this context, women's emancipation and personal fulfillment cannot be achieved (Allen, 2005; Gillespie, 2003).This perspective appears to have ignored the importance of motherhood experiences as a way of building and supporting women's agency and self-confidence.

The second perspective asserts that women can find opportunities within motherhood to explore and cultivate their own agency, to develop their relationships with others to foster social change, and that the emancipation of women would encourage, not undermine, their commitment to motherhood (Green, 2004; Kelly, 2009). Scholars from this perspective emphasize women's maternal superiority and agree that women's subordinate status and the status of women as mothers should be improved (Gillies, 2007; Thurer, 1994). In addition, this perspective deals with the personal benefits women gain from motherhood, such as the pride and achievement, satisfying maternal instincts, gaining pleasure in daily living and from the companionship of children, fulfilling the desire to have someone carrying on the family name, and having someone available to care for them when they become older (Brown & De Casanova, 2009; Brown, 2010; Elvin- Nowak &Thomsson, 2001). This perspective appears to acknowledge the essence of motherhood as an important role that honors women and does not undermine them. Although much of the early feminist work did not include women from diverse ethnic backgrounds and social groups, this work still has the potential to inform our understanding of how motherhood experiences might vary between western women and newcomer women.

Negative images of newcomer women have been found throughout the literature. There is some discussion about newcomer women as being passive, poor, and invisible (Dossa, 2001; Jiwani, 2001). Katrina Irving (2000) has identified racist images and myths about newcomers, which De Souza (2004) attributes, in part, to differences in cultural values and beliefs and the unavailability of social structures to support women's rituals and cultural practices. The rejection of the migration movement by the host society is another reason for the negative images because it proposed that newcomers and their reproduction are serious threats to the nation (Chavez, 2007). In addition, events such as September 11 created a political environment where newcomer women feel hesitant to engage in the new community and to share their stories about motherhood (Hewett, 2009). Furthermore, newcomer women have been conceptualized as "others" based on their skin color, beliefs and cultures (Ornelas, Perreira, Beeber & Maxwell, 2009). I argue that newcomer women may have some disadvantages that create extra challenges when they become mothers, but they still are also resilient and strong because they have been able to survive moving to a new context, and establishing new lives to support their families. On the other hand, using categories of "us or others" obscures the diversity that exists within groups by assuming homogeneity of motherhood experiences where it doesn't necessarily exist.

While this study is situated more within the critical paradigm, I acknowledge that I didn't use a specific critical feminist theory, but I reflected on the paradigmatic view in a general way and used some of the common elements. In this study, I argue that using a critical feminist perspective to examine newcomer women's experiences during motherhood and childbirth in the aftermath of migration is an appropriate and meaningful way to uncover issues of social disparities, barriers to healthy transition, and familial conflicts. Culture, language and participation are seen by critical feminists and ethnographers as issues related to power and amenable to critique, with the intent of challenging the status quo and moving toward social justice and equity (Madison, 2005). In addition, this perspective enables us to analyze the social structures and ideologies that contribute to vulnerability and oppression of these women. The critique of domination forms the basis for

dialogue and reflection and can transform health and social institutions and practices to better serve newcomer women. Furthermore, it has the potential to contribute new knowledge, fill the knowledge gap regarding this population, and provide a chance for newcomer women to negotiate gender hierarchies and identify social injustices. From a critical feminist perspective, creating a space where the voices of marginalized individuals can be heard, and where they can 'name' the realities of their lives, contributes to a social and political context conductive to social action, change, and emancipation.

Intersectionality Theory

Intersectionality is a theory that falls within the critical feminist perspective. The term, Intersectionality, was introduced by Kimberle Crenshaw (1989), when she discussed employment of black women in the U.S. Intersectionality theory holds that the classical models of oppression, such as those based on race/ethnicity, gender, religious affiliation, sexual orientation, class, language, country of origin, species or disability do not act independently of one another; instead, these forms of oppression interrelate, creating a system of oppression that reflects the "intersection" of multiple forms of discrimination (Anderson, 2002; Buitelaar, 2006; Crenshaw, 1991; Fonow& Cook, 2005; Guruge & Khanlou, 2004; Mahalingam, Balan &Haritatos, 2008). From this perspective, social justice is about redistributing economic resources, power, and respect to everyone (Brah & Phoenix, 2004; Hancock, 2007; Winker & Degele (2011). The focus is not only on the ways in which women are disadvantaged and oppressed, but also the ways in which some women are privileged compared to other women (Davis, 2008; Guruge & Collins, 2008). Collins (2000) describes Intersectionality as "matrices of domination" in which all identities based on social group membership interact with each other to create life situations that are qualitatively different depending on one's location in the matrix. Because this difference impacts on women's lives, choices, and socioeconomic status, women's lives must be viewed holistically.

There exist three key tenets of Intersectionality theory: (a) no social group is homogenous; (b) individuals must be located in terms of social structures that capture power relations implied by those structures;

(c) there are unique, non-additive effects of identifying the attributes of social groups (Cole, 2008; Dion, 2006; Ludvig, 2006; Nash, 2008; Stewart & McDermott, 2004; Warner, 2008). This formulation stands in contrast to the conceptualization of social identities as functioning independently and as added together to form experience. In addition, it argues for replacing additive models of oppression with interlocking ones that may create possibilities of change (Hankivsky &Christoffersen, 2008; Yuval-Davis, 2006). The challenge is how to name socially constructed identities without contributing to stereotypes and unwarranted generalizations. For newcomer women, this explanation sounds reasonable. Upon resettlement in Canada, newcomer women's everyday lives represent sites where power, ideology, gender, race, language, and social class intersect to shape their lives.

In summary, Intersectionality theory is a relevant framework for this critical ethnographic study for several reasons. First, it explains how gender intersects with other identities and how these intersections contribute to unique experiences of oppression and privilege among newcomer women. Intersectionality theory creates a space to explore the meanings of being a newcomer woman, at multiple sites of identity including being female, mother, worker, spouse, and pregnant in the new context. Third, it challenges the assumptions of homogeneity of newcomer women as a group and the normalization of motherhood and childbirth experiences among them. Fourth, it contributes to an understanding of the social locations in which newcomer women's identities are constructed, the fluidity and flexibility of their identities, and the salience of different identities in different social situations. Because intersecting identities create instances of opportunity and oppression, this research will examine the challenges faced by newcomer women as well as their strengths. With acknowledgment that newcomer women are differently disadvantaged, Intersectionality directs us to ask what is it about immigration, economics, political systems, and institutional structures that create challenges for newcomer women during motherhood and childbirth and what forces maintain them. Finally, it can be used to examine how the co-constructed systems of inequality are produced, resisted, and transformed over time.

This dissertation has been prepared in monograph format and contains five chapters, including this introduction in which I outline the significance of the study, research questions and the theoretical underpinnings. In Chapter Two, I present a review of literature published during the 1991 and 2011 focused on the main concepts of motherhood, childbirth, migration, interactions with the health system and social network, as well as how these concepts shape one another.

Chapter Three includes a description of the critical ethnographic methodology and methods used to guide this study. I also describe the research process, methods, sample, and setting of study. Strategies used for data analysis are described in this chapter, and the criteria for rigor are presented at the end of this chapter.

Chapter Four addresses the key findings, with a focus on the perspectives about motherhood; meanings of childbirth; the challenges to motherhood in the aftermath of migration; mobilizing strengths to overcome stresses of motherhood; the successes and challenges of negotiating the health care system; supportive relationships in the women's lives; and rethinking roles, motherhood and marital relationships.

Lastly, in Chapter 5, I summarize key findings of the study and examine how these findings add to our understanding of motherhood and childbirth experiences of newcomer women. In addition, I discuss the implications of the study findings for health care providers, social services providers, nursing research and education, and policy makers. Chapter Five ends with a discussion of strengths and limitations of the research, followed by concluding thoughts and reflections.

Declaration of Self

I am a newcomer woman who is a PhD student. I came from a Middle Eastern country where women are struggling to improve their status. Women in my country are expected to take care of their children above all others, to serve the family, and to have the freedom to study and work. However there is a movement toward greater gender equality and a challenging of the patriarchal division of gendered roles. I believe that women deserve to be equal to men, but through a systematic correction of the social, psychological, economic, and

political factors that create the difference. I am a mother of two children and I have experienced childbirth and motherhood in Canada with my second child. My personal perspective is that motherhood is a very significant identity for any woman; each woman experiences motherhood in a unique manner and it is shaped by pre- and post-migration contexts.

Searching and writing this thesis put me into conversation with myself and the women I interviewed. In conversation with myself, I revealed my vulnerability, conflicts, choices, and values. I took measure of my uncertainties, my mixed emotions, and the multiple layers of my experience as a newcomer woman and as a mother. I embrace critical feminist perspectives that value women and their roles and existence in this world. I value women not necessarily only because I am a woman, but also because I knew and experienced the spaces where women did multi-task jobs and tolerated high levels of stress with smiles, acceptance, and high capacities. As a newcomer woman, a mother, and a student, I value motherhood as a positive experience and a way for women to meet the social expectations in their communities. However, I know the amount of work needed to be "a good mother", therefore, I don't blame women who are not able or choose not to be mothers. Motherhood is also associated with great sacrifices and depletion of energy that not all women are ready to accept and provide. I am carrying the assumption that living in another culture requires me to learn new concepts, acquire new knowledge and attitudes, and change overtime. Because of the unavoidable interaction between what I learned and what I am learning in Canada and the different experiences, my understanding of culture has evolved and changed. I view culture as a fluid concept that carries negotiable meanings. This idea is reflected in the ways I interpreted women's accounts, in the ways I raise my children, and in the decisions I make.

I became interested in this study because I experienced some difficulties in meeting the competing roles I had while living in Canada. Having the stress associated with being a newcomer woman, a mother, a wife, a student, a researcher made me wonder about the meanings of motherhood among newcomers from other

women's perspectives. I wanted to know more about the challenges that faced newcomer women in dealing with the Canadian health system, the social networks, and the different strategies they used to overcome the difficulties they had. I was also interested in the changes in marital relationships and the occurrence of IPV among newcomers, so I framed my study in this way to comprehend this area of interest. I wanted other women and services providers to know about the struggles of newcomer women and to be in a position to offer different kinds of help.

Being an "insider" in this study provided me with an opportunity to better understand women's needs, their cultural practices, and the meanings they provided for their experiences. Being an "insider" also helped me to establish rapport with participants and to be engaged with participants in discussions with fewer limitations and greater comfort. However, my 'insider' status also may have led participants to be silenced in discussions pertaining to politically or culturally sensitive issues such as IPV. My familiarity with migration may have created a perceived risk that I know what women mean because I had similar experience, thereby assumptions made about the meaning of events without clarification being sought. More discussion on this issue is presented in the rigor section.

Chapter Two

Review of the Literature (1991-2011)

Motherhood and childbirth have been discussed extensively in the scholarly and popular literature. However, much of this work has been conducted from a North American perspective, with little attention paid to how motherhood and childbirth are experienced by newcomer women from diverse racial and cultural backgrounds (Johnston & Swanson, 2003; Liamputtong &Naksook, 2003). In this chapter, I present an integrated review of the literature that lays the basic foundation for this dissertation. In particular, I summarize and critique the literature related to motherhood and childbirth experiences, the challenges newcomer women face due to migration, and their interactions with health care systems and social networks. The knowledge that results from this review of the literature is created by defining each aspect of motherhood and childbirth experiences in a new context, reviewing the empirical and the theoretical knowledge that addresses our understanding of these aspects, and critically reviewing the social context in which these experiences evolved and been shaped by the multiple identities of newcomer women. This chapter ends with a summary of current knowledge and identification of gaps that should be taken into consideration in future studies.

Search Strategy

In this section, the gendered context of migration, acculturation and attachment, current research on newcomer women's experiences during motherhood and childbirth, challenges in navigating health care and social networks, intimate partner violence during motherhood, and newcomer women's strengths and resilience are discussed. A summary, including strengths and the gaps in the literature, is provided at the end of this review. Databases used in this review were PubMed, Criminology, Sociological Abstracts, Medline, Embase, and CINAHL. The emphasis was on recent literature. A search was conducted using the terms, "Motherhood Experience", " Childbirth Experiences among Immigrants", "Motherhood among Immigrants", "Newcomers' Health", "Maternal Health of Immigrants", "Social Support among Immigrants", "Reproductive Health of

Immigrants and Refugees", "Pregnancy Experience among Immigrants", "Motherhood across Cultures", "Family Relationships among Immigrants", "Gender Role among Immigrants", "Intimate Partner Violence among Newcomers", "Intimate Partner Violence among Immigrants", "Resilience among Newcomers", "Acculturation among Immigrants, "Attachment among Immigrants", "Feminism and Motherhood", "Critical Feminist Perspectives", "Critical Ethnography", "Identity and Intersectionality Theories", "Intersectionality", "and "Intimate Partner Violence during Pregnancy".

This review focuses on motherhood and childbirth experiences among newcomer women in Canada. However, as this search revealed, there is relatively little information about these experiences among newcomer populations as compared to the literature on motherhood among Canadian women. Thus, the nature and the meaning of childbirth and motherhood are not well understood as they pertain to newcomers. The review will lay the foundation for understanding the concepts included in this dissertation.

The Gendered Context of Migration

In 2008, Canada received an unprecedented 519,722 newcomers (Citizenship and Immigration Canada, 2008). This number includes over 247,000 permanent residents, 193,000 temporary foreign workers, and over 79,000 foreign students. Women represent128, 629 of this number, including 10,851 refugee women (CIC, 2008). Newcomers are considered a vulnerable population due to displacement, economic problems, under-employment, personal safety concerns, social isolation, and language difficulties (Crooks, Hynie, Killian, Giesbrecht &Castleden, 2009; Parson, 2010; Tummala-Narra, 2004; Wang, Rosenberg & Lo, 2008).Moreover, newcomer women are often vulnerable to the stress that comes from attempting to meet the basic needs of their families in a new country, learning about the new system, and homesickness that is often associated with leaving family and friends behind (Jiwani, 2005; Raj & Silverman, 2002).

Women migrate for several reasons. Some migrate to pursue advanced educational degrees either for themselves or for their family members (Raj & Silverman, 2002). Improved living conditions and income are

also strong reasons for migration (Kim, Conway-Turner, Trask &Woolfolk, 2006; Parson, 2010). According to the literature, some, particularly those who are seeking refugee status, migrate because of armed conflicts, natural catastrophes, or occupation (Abu- Duhou, 2003; Remennick, 2008). For women in this group, migration is not a choice. Rather, they are forced to leave their homes because of human rights abuses. For many refugees, adapting to a new life in Canada is complicated by the deep trauma that arises from the horrendous experiences they experienced before arriving in Canada (Jiwani, 2005). There is the additional challenge of raising a family in a new country and overcoming the psychological scars left by traumatic and violent experiences (Hyman et al., 2004). Added to this trauma may be the guilt of leaving family members behind to suffer through war or famine. For those without identity documents, restrictions on access to employment, secondary education, family reunification and mobility contribute to their vulnerability (Crawford, 2009; Rousseau et al., 2008).

Research supports the premise that newcomer women have preconceived expectations of the new country prior to leaving the country of origin. In a critical analysis based on data from a national study conducted in three Canadian cities with 60 Chinese immigrants and 60 Somali refugees, Anderson and colleagues (2010) introduced the concept of dissonance to illuminate the experience of starting over in a new country. The participants in this study revealed a sense of dissonance, or a 'disconnect', between what they believed Canada would have to offer them and the reality that they experienced. Other researchers have similarly described 'unmet' expectations including increased personal freedom, professional development, financial gains, and pursuing graduate studies (Dion & Dion, 2001; Raj & Silverman, 2002). When the new country fails to meet newcomer women's expectations, women may face stress and challenges in their coping with the new lives and managing their responsibilities as wives and mothers (Anderson et al., 2010; Chan, 2000).

For newcomer women, motherhood and childbirth may be more difficult than for Canadian-born women due to additional challenges related to post-migration factors. Low income (Boonzaier& De LA Rey, 2003;

Morash, Bui, Zhang & Holtfreter, 2007), underemployment (Bui & Morash, 2008; Hampton, Oliver & Maggarian, 2003), minority status (Dyck & McLaren, 2004), social isolation (Abraham, 2000), linguistic and legal barriers(Nilsson, Brown, Russell & Khamphadkdy-Brown, 2008; Anderson et al., 2010), difficulties accessing health services (Latta & Goodman, 2005), and residency status (Abu-Ras, 2007; Ingram et al., 2010) may increase women's vulnerability during pregnancy and after they become new mothers. While these studies have made important contributions in understanding the challenges faced by newcomer women as a result of migration, they focus on women's migration experiences in general and not necessarily during motherhood and childbirth periods.

Gender inequalities. There is continuous debate in the literature about gender inequalities and how women from various backgrounds and nationalities face gender inequality (Hadley, 2001; Jackson, 2004).Studies regarding how gender affects childhood and motherhood offer insights about specific challenges confronting newcomer women. Gender refers to "all duties, rights, and behaviours a culture considers appropriate for males and females" (Wade &Tavris,1999, p.16). Collins (2000) conceptualized gender as a social construction that exists within an integrated social system that also encompasses class, racial, and ethnic differences; these multiple differences affect women's experiences. Although circumstances determine the degree of influence each factor has, newcomer women in general suffer gender discrimination in both pre and post migration periods (Dion & Dion, 2001; Nilsson et al., 2008; Parrado &Flippen, 2005). For example, several researchers have suggested that socio-structural factors that might facilitate personal well-being and adaptation to the new environment may not always function in the same manner for male and female newcomers (Dion & Dion, 2001; Noh, Wu, Speechley &Kaspar, 1992). Newcomer women feel differently and less appreciated than men because of inequalities in the social structure based on race and ethnicity, inequities in income distribution, the structure of the welfare system, low-skilled jobs and the locations of these jobs (McLaren &Dyck, 2004; Parrado &Flippen, 2005; Sharma, 2006).

The division of roles based on gender in some traditional newcomer families may create power imbalances in partners' relationships. Studies have shown that male partners of newcomer women often have dominant roles, are the family's link to the external community, have more freedom in mobility, take care of legal issues related to residency status, and provide for the family (Abu-Ras, 2007; Latta & Goodman, 2005; Yick, 2001). Newcomer women, on the other hand, typically take care of children and do the housework (Abraham, 2000). Based on the socio-cultural definitions of appropriate roles in the culture of origin, newcomer women in Canada are often expected to comply and obey their partners, and if they are employed, their work is considered to be secondary to that of their partners (Kim et al., 2006). Little is known about the implications that such traditional gender hierarchies have on motherhood and childbirth among newcomer women.

The social value of being a newcomer wife and mother is affected by the ideology of patriarchy (Muftic & Bouffard, 2008). The role of mother is valued in the new context but differing views on mothering in the old and new context can be problematic. For example, a study conducted with 20 Mexican immigrants in North Carolina found that organizing daily life around traditional men's and women's roles was no longer workable following migration. More specifically, men described their new roles of caring for children with frustration and felt that they were no longer being given the respect that they had received when living in Mexico (Grzywacz et al., 2009). Morash, Bui, Zhang and Holtfreter (2007) found that newcomer women perceived their male partners to be accepting of them working and socializing outside the home, and for the economic benefits of their work, but that the subordination of women was the norm. Vietnamese women in this study were not allowed to socialize with members of the opposite sex. However, it was permissible for their partners to excessively drink and to have relationships with other women. Thus, there appeared to be a double standard regarding what was acceptable for men and women. Many researchers have described the dominance of men in the post migration context, with women having little or no say in such areas as how money is spent and whether they could work outside the home (Abu-Ras, 2007; Taylor, Magnussen&Amundson, 2001; Yick, 2000). It would appear from

these studies that patriarchal beliefs about roles and responsibilities of women and men significantly influence the dynamics of family and motherhood experiences post migration.

Employment stress. An important factor that affects the experience of motherhood and childbirth among newcomers is employment status. In the process of migration and resettlement, many newcomer women lose the status they had in the society they left behind (Sharma, 2006). While many women held well-respected positions in their countries of origin, because their credentials may not be recognized in the new country, they may be forced to work in menial, low-paying jobs (Anderson et al., 2010). Some women are unable to find any employment (Bui & Morash, 2008). Lack of recognition of foreign credentials or work experience, loss of investment income, inability to speak either official languages, and experiences of racism and discrimination further contribute to feelings of disillusionment and frustration after resettlement in Canada (Sharma, 2006; Young, Spitzer & Pang, 1999). According to the model of status inconsistency, a high level of stress among working newcomer women is derived from occupying social statuses which are unfamiliar and undesired (Janes &Pawson, 1986; Yick, 2001). This explanation seems reasonable because women with limited resources may perceive their status as inconsistent within social norms, resulting in increased vulnerability and decreased ability to adapt to the new country. In addition, decisions about work for newcomer women of childbearing age are not made in isolation from a wide range of social and personal factors. The availability of childcare, the option of flexible working hours, the attitudes and level of support provided by their partners, the presence of other sources of support from family or friends all play a role in influencing work-related decisions and options(Ryan, 2007). There is evidence that intensive work activities and stress during pregnancy have a negative impact on fetal health and are risk factors for low-birth weight among immigrant women (Hyman &Dussault, 2000).

The meaning of employment and its influence on mothering practices must be examined if one is to understand the lives of newcomer women and the choices they make in the context of their families.

Traditionally, Canadian norms have emphasized the man's role as the head of the family and the primary breadwinner, while women were expected to take care for children and serve the family (Zucker, 1999). Despite an official shift toward gender equality and neutrality in Canadian public policy, women in general continue to embrace traditional views of motherhood, family responsibilities, and employment (Kushner, 2005; McLaren &Dyck, 2004). A substantial body of literature has documented how stereotypical characteristics of a working mother are evaluated against the traditional role of a stay home mother (Johnston & Swanson, 2003). Newcomer women may enter the workforce because of financial necessity, not necessarily because of a belief in a larger principle of equality (Kim et al, 2006; McLaren &Dyck, 2004). Ryan (2007) conducted semi-structured interviews with 15 Irish nurses in Britain to examine how women access local ties after migration and during motherhood. She found that these nurses struggled to fulfill their motherhood roles while they were working. In the absence of support from family members and friends, most women experienced difficulties in organizing their shifts to share childcare with their husbands. Finding adequate childcare was an added stress for women in this study. When newcomer women perceive tension and opposition between employment and motherhood roles, they may neglect to care for themselves which has serious implications for their health and marital relationships (Perreira, 2008). For example, refugee women must carry the responsibilities of being employed mothers while simultaneously dealing with past trauma, uprootedness, and displacement. In addition, some newcomer women who leave their jobs to take care of their children may not perceive motherhood as a proper job that satisfies their personal growth and sense of self (Ryan, 2007). Based on these studies, it appears that newcomer women face extra difficulties when they are employed during motherhood, pregnancy, and after childbirth. It is not clear whether these difficulties are caused by the inability to fulfill their responsibilities as mothers and workers or because of their perceptions about the traditional role of mother as a career.

Acculturation and Attachment

Acculturation and attachment are concepts that influence newcomer women's adaptation to the new context and the ways in which they interact with their partners, children, friends, and service providers during pregnancy, childbirth, and motherhood. Acculturation is the process by which "groups of individuals having different cultures come into continuous first-hand contact with subsequent changes in the original culture pattern of either or both groups" (Ataca & Berry, 2002 p. 14). All newcomer women experience acculturation to some extent, and in some manner. Attachment is the process of socio-emotional adaptation and personality development of individuals (Blum, 2004; Thompson, 2000). It includes an affectional tie between individuals and a bond that involves a desire for regular contact. Acculturation and attachment styles could explain the challenges that newcomer women face during motherhood and childbirth. Among these challenges are marital conflicts, conflict with children, and maternal-fetal relationships. Flores, Tschann, Marin, and Pantoja (2004), for example, suggested that acculturation creates a source of stress that contributes to marital conflicts among Mexican couples. Migration researchers have also argued that when newcomer women are forced to choose between old and new ways of living, four different modes of adaptation result: 1) Assimilation, which is the relinquishing of cultural identity and movement into the larger society; 2) Integration, which is identified as a simultaneous adherence to traditional culture and adoption of some dominant societal values; 3) Separation, which is the self-imposed withdrawal from the dominant society while maintaining a traditional cultural identity; and 4) Marginalization, which is the alienation from the dominant society together with a loss of cultural identity (Berry, 1997). There is evidence that women who have experienced the integration mode of migration may experience less discrimination than women in other adaptation modes (Thurston &Vissandjee, 2005).

Attachment theory refers to the way individuals have been taught to approach others and how they behave in new situations (Blum, 2004). Bartholomew and Horowitz (1991) have distinguished four attachment styles based on the dimensions of self or other orientation: 1) The secure attachment style is characterized by a

working model of the self as positive and an expectation that others are trustworthy; 2) The preoccupied attachment style indicates a sense of unworthiness of the love of others, combined with a positive evaluation of others; 3) Individuals with a dismissing attachment style have a positive working model of the self and a negative disposition to others; 4) Fearful attachment indicates a working model of the self as unworthy combined with an expectation that others are rejecting.

There is a connection between the model of attachment styles and Berry's classification of acculturation attitudes (Van Oudenhoven& Hofstra, 2006). Only a few studies have explicitly investigated the relation between attachment styles and adjustment to a new culture among newcomer women and, more specifically, during motherhood and childbirth. In a correlational study of 847 first-generation Dutch immigrants in Canada, the USA, Europe, Australia, New Zealand, and several other countries, Bakker, Van Oudenhoven, and Van Der Zee (2004) found a positive relation between secure attachment and integration within the new culture, whereas the fearful, preoccupied, and dismissing styles were negatively associated with integration in the new culture. Based on this research, it is expected that newcomer women and their partners may have different levels of acculturation and varied attachment styles which could lead to different interests, stress, and marital conflict. In support of this argument, Thompson (2000) argued that migration experiences may lead to changes in attachment security. In other words, changes in family stress level and living conditions can lead to changes in family patterns of interaction, and consequently in attachment security. In a study conducted with 20 immigrant Mexican women and men in the US, Grzywacz, Rao, Gentry, Marin and Arcury (2009) found that immigrant Latino women tended to embrace an assimilation strategy for acculturation whereas men embraced a separation strategy. Therefore, women's decisions to seek employment following migration created several sources of intra-couple conflict because they challenged gender-based norms and behaviours surrounding the division of household labor, financial decisions, and how women and men interact within intimate relationships.

Ataca and Berry (2002) examined the acculturation and adaptation of 200 married Turkish couples in Toronto, Canada, using a self-report questionnaire. They revealed that male partners may have different acculturation attitudes that can influence their wives' cultural attitudes and that marital adaptation was mostly associated with marital stressors and marital support. This may especially be true in a context where the woman and her partner act as a unit and make decisions jointly, as often occurs in the context of migration, pregnancy and birth, child rearing, social and daily living activities. Flores and others (2004) similarly suggested that wives who are highly acculturated become verbally and physically more aggressive as they expect greater equality in the relationships with their partners.

Bonding and attachment with a new baby are important aspects of motherhood and childbirth in any culture and can be affected by many factors. Included among these are the mothers' own upbringing, socioeconomic conditions, psychological status, cultural beliefs and background, the relationship with their partners, as well as their experiences with present and past pregnancies (Huth-Bocks, Levendosky, Bogat&Von Eye, 2004; Kimbro, Lynch &Mclanahan, 2008). The migration experience could also affect maternal-infant attachment although this has not been well studied. Lack of family and social support may increase the potential for newcomer women to have difficulties in establishing and maintaining strong bonding and attachment relationships with their infants (Hyman &Dussault, 2000). There is evidence that mothers with low social support and families under stress are more likely to have insecure infants (Huth-Bocks, Levendosky, Bogat&Von Eye, 2004). Based on previous studies, exploring challenges that newcomer women face during motherhood and childbirth in an unfamiliar environment has the potential for deeper understandings of their attachment and acculturation experiences, addressing this gap in the literature, and creating new knowledge which has the potential to enhance mother-infant interactions and social interactions in general.

Current Research on Newcomer Women's Experiences during Motherhood and Childbirth

Motherhood and childbirth are challenging processes that entail physical, psychological and socio-cultural changes for all women. Meleis (2005) argued that safe womanhood would not be achievable without safe motherhood. In the context of migration, it is likely that the challenges associated with childbirth and mothering are heightened (Liamputttong, 2006). In this section, current knowledge regarding newcomer women's experiences during motherhood and childbirth after migration to new countries is discussed.

Motherhood and childbirth among native born women has been investigated by a number of researchers. Some of the general difficulties identified are: lack of preparation for the demands of infant care, fatigue, pain associated with child birth procedures, loss of personal time and space, workload demands, time management problems, sleep deprivation, and disturbances of body image (Choi, Henshaw, Baker & Tree, 2005; Cronin, 2003; Lupton, 2000; McVeigh, 1997, Warren, 2005). There has been little scholarly attention to newcomer women who become mothers following migration to a new country. Lack of social support (Liamputtong &Naksook, 2003), lack of knowledge in practical matters of self-care during pregnancy and infant care after delivery (Cheung, 2002), lack of prenatal and postnatal health services in refugee camps (O'Heir, 2004), undocumented status (Rousseau et al., 2008), PTSD (Tummala-Narra, 2004), maternal-infant attachment problems (Schwerdtfeger& Nelson Goff, 2007), and language problems(Raj & Silverman, 2002) constitute extra burdens for newcomer women. However, how these factors affect mothering in the context of migration has not been systematically studied.

In a qualitative study conducted with 30 Thai women in Northern Thailand, Liamputtong and her colleagues found that Thai women have different but positive meanings associated with motherhood experienced in their homeland. The societal expectations of Thai culture prepared women to perceive and practice motherhood with happiness and high satisfaction (Liamputtong et al, 2004). In another study with 30 Thai immigrant women in Australia, the Thai women who had migrated to Australia reported several concerns, including social isolation, differences in childrearing and child disciplinary practices, and a desire to preserve

their Thai culture. These women also reported that the presence of their partners played an important role in their ability to cope with motherhood and childrearing (Liamputtong &Naksook, 2003). While this study offers some important insights, the socio-political context of migration received little attention, and mothers were viewed as a homogeneous group with similar interests and concerns. In another study, Liamputttong (2006) explored the lived experience of motherhood among 91 Cambodian, Lao and Vietnamese immigrant women in Australia. Women in this study described motherhood as a moral transformation of self and noted that, when combined with migration, motherhood became a double burden primarily due to difficulty speaking English, financial problems, and lack of social support.

Tummala-Nara (2004) investigated newcomer women's experiences in the US based on the researcher's clinical observations as a psychotherapist and informal discussions with mothers. Tummala-Nara proposed that cultural displacement has an impact on motherhood through changing conceptions of gender role and attachment, bicultural conflicts, and changing family structures and networks. In another mixed methods study of 619 Mexican and migrant Hispanic women in North Carolina and Mexico, reconstruction of gender relations was found to be a dynamic process in which some elements brought from communities of origin are discarded, others are modified, and still others are reinforced (Parrado & Flippen, 2005). For example, Mexican migrants selectively incorporated some aspects of the American society such as demanding assistance from husbands in household while simultaneously reinforcing cultural traits and patterns of behaviours brought with them from their country of origin (Parrado & Flippen, 2005). Therefore, women may encounter tensions in their lives where they want to fit their own cultural practices into the new system. In an anthropological study of 356 Somali women who had migrated to Sweden, women's experiences and notions of childbirth brought from their country of origin resulted in revealing certain beliefs about pregnancy strategies and childbirth practices(such as avoiding C/S or not seeking perinatal care) which were not known to Swedish caregivers. These beliefs and practices combined with miscommunication, may have resulted in sub-optimal care and heightened risk of

perinatal mortality (Essen, 2001). In a qualitative study of 20 American newcomer women who gave birth in Japan, five interrelated issues emerged as important to them: a sense of isolation, the need for security, the need to regain control, the need for affirmation, and the need for cultural support (Sharts-Hopko, 1995).This study highlights important implications for service providers and adds to our understanding of newcomer women's experiences and needs.

Experiences of motherhood are understood differently across cultures. In a study exploring the predictors of parenting cognitions among 94 married immigrant Chinese couples in Canada, Costiganand Su (2008)found that a strong endorsement of Chinese cultural values by mothers was significantly related to strong endorsement of culturally-based parenting cognitions(interdependent childrearing goals, family obligation expectations and Chinese parent role beliefs). The results highlight how parenting is embedded in a cultural context and suggest that parents' ideas about child rearing may change after immigration only when core cultural values are modified. Similarly, Choi (1995) investigated the cultural differences in mothers' behaviours toward their infants in both the United States and Korea, and found that culture heavily influenced a mother's behaviour toward her infant and that some North American mothers typically encourage autonomous and independent behaviours from infants, whereas in the Korean culture, mothers tend to view infants as passive and dependent. Infants were perceived to fulfill the social role of parents, who have a marked status change among family members. Mothering in a North American context is, thus, individually fashioned and relies on the expertise of health care providers. Conversely, the Korean culture is highly ritualistic, following societal rules. North American mothers tend to rear their infants in a nuclear family setting, whereas Korean mothers rear their infants in an extended family or at least in a highly social environment. Therefore, there is a potential for conflict stemming from incongruence between the expectation of family life and actual family life for newcomer women and their families. More attention should be paid to the cultural meanings and styles of motherhood practices.

McMahon (1995) examined the social processes whereby women conceptualize themselves as mothers. Using symbolic interactionism, McMahon located meaning, identity and experiences of everyday life at the center of explanations about the social world. Because identity is upheld through interaction, newcomer women seek out those who can significantly validate their valued identities. The validators could be their partners, family members, and/or social and health system. Newcomer women and their partners engage in social interactions in order to seek validation of their valued identities. Each person tries to find a space between the culture that they want to preserve and the new culture. Because there are multiple and competing discourses of self-understanding of identities, women and their partners may not be in the same space. Oppositional values or misunderstanding could occur and affect marital relationships negatively. Consequently, newcomer women may not fulfill their expected roles as mothers. Alternatively, when newcomer women are not validated by the social and health system, their interaction with both systems could be altered, which may lead to social isolation and reluctance to use health and social services. For this reason, newcomer women need to continuously renegotiate their identities in their new social environment. Although McMahon provided a symbolic interactionist perspective to her analysis with non- immigrant mothers, her work has the potential to explain the impact of motherhood on newcomer women's identities as she located motherhood in the social context. In addition, this work could be used as a framework to explain how newcomer women's relationships with their partners evolve over time and might change to become abusive during motherhood and childbirth in the context of migration.

Maternal ambivalence is a concept describing coexistence of conflicting thoughts or feelings in the mother's relationship with her infant. Brown (2010) studied the feeling of maternal conflict among 1160 mothers from different ethnic and social backgrounds in the US. While mothers felt positively about themselves being mothers, a significant proportion of women experienced both negative and positive feelings. Four areas of ambivalence were identified: "a) identity ambivalence, which combines negative feelings of the "old self" with positive feelings of enjoying the presence of the baby; b) being a good mother ambivalence,

which combines negative emotions of being overwhelmed by motherhood responsibilities with the positive feelings based on mother's belief in her own ability to take care of the baby and enjoying parenting; c) attachment ambivalence, which combines feelings of uncertainty about bonding with the baby with their beliefs in the social expectations that mothers are the best providers of care for their babies; and, d) ambivalence about combining work and family in which mothers compare the cost and benefits of their work outside home for themselves and their families" (Brown, 2010, p.11). Ryan (2007) found a similar perspective about combining work ambivalence. In her study with Irish immigrant nurses, one of the participants who remained out of her work until her baby was well established described herself as "just a housewife" who didn't "do anything". This woman's account reflects her ambiguous position of motherhood, which is often idealized in society, but simultaneously dismissed, as not being a proper work to do. For newcomer women like this participant, this explanation is applicable because in the literature many newcomer women reported the conflict between a mother's enjoyment of her children and wanting to be with them and their feelings of restrictions, entrapment, and loss of identity because of motherhood responsibilities (Hewett 2009; Vincent et al., 2004).

Based on these studies, it appears that some aspects of motherhood and childbirth among newcomer women have received little attention, including issues of gender role conflict, social interactions, and cultural practices. The focus in the literature is primarily on the barriers that prevent healthy childbirth and motherhood. Social and cultural factors that determine how gender relations and familial relationships evolve during motherhood and childbirth in the aftermath of migration are not well understood. Little is known about the experiences of newcomer women who migrated to Canada compared to other countries.

Challenges in Navigating Health Care and Social Networks

Living in a new country may force newcomer women to examine their preconceptions about health and social issues and to adopt new social, health and economic roles in their transition to motherhood. Newcomer women must meet two different sets of cultural expectations in addressing their social and health concerns, that

of the Canadian culture and the culture of their country of origin. The following two sections discuss the challenges that newcomer women face in navigating the health care system, and in engaging in social interactions and obtaining support during motherhood and childbirth.

Health care system. When experiencing motherhood and childbirth in a new environment, newcomer women have to deal with a health care system that often works differently from the one in their country of origin. Newcomer women to Canada tend to be unfamiliar with the Canadian health care system in terms of accessing needed services and seeking health information (Zanchetta &Poureslami, 2006). With respect to maternal health issues, these women may prefer to receive care from a female health care provider in their own language, an option that is not always available (Tsianakas &Liamputtong, 2002). Although many women prefer medically managed hospital birth experiences, some newcomer women may prefer home births because this offers them more choice about the care they receive.

Many studies were found related to pregnant women's experiences with health care systems in host countries including Canada. Common themes identified by newcomer women were: insufficient maternal care (Small, Yelland, Lumley, Brown &Liamputtong, 2002; Wheatly, Kelley, Peacock & Delgado, 2008), racist attitudes by health care providers (Dousa, 2001; Sawyer, 1999), the need for culturally safe care during the perinatal period (Grewal, Bhagat, Balneaves, 2008), unaddressed health concerns (Gagnon, Dougherty, Platt, Wahoush, George, Stanger et al, 2007; Redwood-Campbell, Thind, Howard, Koteles, Fowler &Kaczorowski, 2008), lack of access to maternal care because of uninsured or undocumented status (O'Heir, 2004; Rousseau et al., 2008), and low literacy levels and language problems (Asanin & Wilson, 2008; Zanchetta &Poureslami, 2006). De Souza (2004) argued that the challenges immigrant women encounter in the health system are related to racism, assimilation, ethnocentrism and hegemony, which collectively result in newcomer women being stereotyped and pathologized, having their needs ignored and having limited or no input into services. She also criticized what she called "deficiency discourse" because it constructs newcomer women as weak, pathologized,

and homogeneous. In a cross sectional study of 1,250 women following vaginal delivery of a healthy infant; approximately 31% of women were born outside of Canada, immigrant women were significantly more likely than Canadian-born women to have low family incomes, low social support, poorer health, possible postpartum depression, learning needs that were unmet in hospital, and a need for financial assistance (Sword,Watt & Krueger, 2006).

There is strong evidence that newcomers face challenges in accessing mainstream services because of their inability to speak either official language (Abu-Ras, 2007; Liamputttong, 2006; Raj & Silverman, 2002). In a qualitative study conducted with 35 newcomer women in Toronto, the women revealed that adjusting to the mode of health care delivery in Canada was a difficult process for them because of language difficulties (Crooks et al, 2009). In a mixed-methods study conducted in Hamilton, Ontario, with 85 Kosovar refugee women, many women reported unmet health needs (Redwood et al., 2008). Preventive screening rates were also low. Only 5.3% had ever received a mammogram; 34.1% had never received a pap test, and 25.9% met the diagnostic criteria for PTSD (Redwood et al., 2008). In addition, it has been suggested that newcomer women may prefer to receive care from a health care provider who speaks their language, though this is often not available (Anderson et al., 2010;Wang, Rosenberg & Lo, 2008). Although health services use interpreters to communicate with newcomer women who don't speak English, reliance on interpreters may be seen by women as humiliating (Chan, 2000). Moreover, using family or community members as interpreters is not appropriate in discussing private and sensitive issues such as sexuality and maternal issues because it breaks privacy. As Oxman-Martinezand others (2000) note, the potential for misinterpretation is substantial. As a result, newcomer women's abilities to access and interpret health information and to make well informed decisions regarding health will be affected by their language abilities.

Social networks. Social networks play an important role in promoting and sustaining the health and well-being of newcomer women and their families. Little attention has been paid to how newcomer women may

engage with a variety of networks in different settings, such as the workplace, their neighbourhoods, and through their children's activities (Ryan, 2007). In many non-Western cultures, motherhood is viewed in the context of nuclear or two generation extended family structures (Hyman, Guruge & Mason, 2008). Family members not only support newcomer women during pregnancy, childbirth, and child rearing, but also allow newcomer women to continue their professional training, and keep their full time employment, which promotes greater gender equality (Moon, 2003; Ryan, 2007). A descriptive correlational study conducted with 165 immigrant women in Korea found that social support and prenatal-care practice were positively correlated, while stress was negatively correlated with both prenatal-care practice and social support (Kim, Choi &Ryu, 2010). There is also evidence that social support is associated with more positive maternal attitudes toward breastfeeding (De-Bocanegra, 1998). A study with 20 immigrant Vietnamese mothers living in a mid-size city, in Quebec, Canada, found that women who do not have family support may be unable to conduct postnatal traditional rituals, potentially jeopardizing mothers' perceived health and the perceived quality of their breast milk (Groleau, Souliere &Kirmayer, 2006). Low social support has been found to increase the risk of low-birth weight for the children of refugee mothers (Hyman &Dussault, 2000) and to result in higher rates of post-partum depression (PPD) among immigrant, asylum seeker, and refugee women in comparison to their Canadian born counterparts (Stewart et al., 2008).

Social interaction is influenced by the traditional culture of newcomer women and gender hierarchies. Newcomer women are often restricted in their social activities with males who are not relatives (Parrado &Flippen, 2005).Thus, conservative gender ideology of newcomer women's partners may contribute to their social isolation (Moon, 2003). Gender role conflict and imbalanced power relations may lead to social isolation among newcomer women (Koskela, 1999). There is a potential for family conflict when newcomer women ask their partners to take on responsibilities which may have been viewed as women's work in their country of origin in order to compensate for lack of support in fulfilling mothering roles in the new country.

At a community level, social services, including counselling, may be available to assist newcomer pregnant women and mothers during motherhood and childbirth, yet newcomer women are often unaware of the availability of social services within the community because of language difficulties and social isolation that act as barriers to accessing these services (Abraham, 2000). Furthermore, women may feel isolated within communities and are often afraid to ask for support or assistance from 'outsiders' such as health professionals and social workers (Parrado &Flippen, 2005). Little is known from these studies about the cultural differences and perceptions of social interaction with outsiders and regarding using community services.

Violence during Motherhood

Prevalence. Intimate partner violence (IPV) is very common. In a study of 292 Latina immigrant women in the U.S, it was found that 33.9% of women reported physical violence, 20.9% reported sexual coercion, and 82.5% reported psychological aggression at some time in their life (Hazen & Soriano, 2007). In Canada, little is known about the prevalence of during motherhood and pregnancy among newcomer women. Hyman, Forte, Du Mont, Romans and Cohen (2006) found that IPV among recent immigrant women to Canada was estimated to be 17.4% as compared to 18.8% for the non-recent immigrant women. Another study conducted in Canada with 7115 immigrant women based on data from Statistics Canada's cycle 13 of the General Social Survey (GSS), Brownridge and Halli (2002) concluded that women who immigrated from developing countries had the highest prevalence of violence in the 5 years preceding the survey. In a study conducted in Los Angeles with 210 Latina pregnant women, 44% (n = 92) of women had experienced IPV in their lifetime, and rates of depression in the perinatal period were highest (45.7%) for IPV-exposed women compared to those who had not experienced IPV(control group)(Rodríguez et al., 2010).

The questions shaping studies on immigrant women primarily address the barriers to leaving the abusive relationship and the use of domestic violence services such as legal justice systems and social services (Barrett &St. Pierre, 2011; Sharma, 2001; Shirwadkar, 2004). While a growing body of research exists regarding IPV

during pregnancy, little is known about the pattern of violence in this context, and whether violence actually begins, ends, or increases during pregnancy (Edin, Dahlgren, Lalos & Hogberg, 2010).Differences in the frequency, prevalence, and outcomes of violence in pregnancy have been reported (Bui &Morash, 2008; Kendall-Tackett, 2007; Lent, Morris &Rechner, 2000). These differences may reflect the lack of a standard definition of IPV, differences in the timing of the assault in relation to childbirth, and different populations studied. Little is also known about the impact of the IPV on childbirth process and whether childbirth triggers painful past memories of abuse, war or terror among newcomer women.

Migration and intimate partner violence. Motherhood and childbirth in an unfamiliar context create significant changes in marital relationships (Erez, Adelman & Gregory, 2009). Different factors related to migration experiences may increase newcomer women's risk of IPV. First, some newcomer women are economically dependent on their partners and, after migration, have lost or substantially reduced their family network and social interaction. As a result, newcomer women may be controlled by their partners and have nowhere to turn to get help when needed (Abraham, 2000; Bui &Morash, 2008; Kallivayalil, 2010; Wucker, 2004). Many researchers have described the dominance of men in the post migration context, with women having little or no say in such areas as how money is spent and whether they could work outside the home (Abu-Ras, 2007; Taylor, Magnussen&Amundson, 2001; Yick, 2000). Second, changes experienced by newcomer women's partners during pregnancy may result in frustration, increased feeling of insecurity and the need to enforce power and control, financial worries, fear of abandonment, doubts around paternity, jealousy, possessiveness, and feelings about unwanted pregnancy (Bui &Morash, 2008; Gelles, 1975). These factors may strain the couple's relationship and lead to IPV during pregnancy (Bacchus, Mezey & Bewley, 2006; Campbell, Pugh, Campbell &Visscher, 1995). Third, newcomer women may not be aware of their rights in the new country, as well as services and resources available to protect their rights (Erez, Adelman & Gregory, 2009; Ingram et al., 2010). Fourth, some newcomer women may have endured years of trauma in their country of

origin (Berman, Irias Giron &Marroquin, 2006; Jiwani, 2005; Muftic & Bouffard, 2008). They may have experienced torture, harassment, rape, or sexual and emotional abuse at the hands of individuals who were in a position of power over them (Cardozo, Talley, Burton &Crawford, 2004; Fisher, 2010; Oxman-Martinez, Abdool&Loiselle-Leonard, 2000). As a result, newcomer women may suffer insecurity, disturbed bonding, negative emotions, lack of affection, emotional distress, and post-traumatic stress disorder. Fifth, strong cultural and religious norms, language difficulties, as well as social and cultural isolation have the potential to negatively affect marital relationships (Anderson et al., 2010; Muftic & Bouffard, 2008; Ryan, 2007). In addition, the degree of integration and the extent to which newcomer women are influenced by family patterns that are commonly embraced within the 'new' country may contribute to increased demands for equality and equal rights in the family (Brownridge & Halli, 2002; Grzywacz et al., 2009). Sixth, the difficulty of securing employment that matches one's skills may be a significant source of conflict between newcomer women and their partners. Partner's dissatisfaction with their ability to find meaningful work can challenge their images of themselves as men and lead them to exert control over their wives (Erez, Adelman & Gregory, 2009).

Based on these studies, it appears that existing theories and explanations of how IPV occurs with newcomer women during motherhood and childbirth require further elaboration. We know little about the impact of migration on newcomer's marital relationships and motherhood experiences. The previous review on IPV revealed controversy with respect to the contexts that influence marital relationships. There is no consensus about the influence of women's economic dependency on gender relations in newcomer families. While some scholars have suggested that newcomer women's dependence may heighten their vulnerability (Parrado &Flippen, 2005; Shirwadkar, 2004), others have concluded that newcomer mothers who are contributing financially might be in a stronger position to alter gender relations. For the latter women, making critical decisions in their families may be resisted by their male partners (Grzywaczet al., 2009; Moon, 2003; Nilsson et al., 2008). Thus, it is unclear whether the migration experience improves or undermines newcomer women's

abilities to renegotiate hierarchical gender relations, or more importantly, how it impacts this process. For newcomer women, the mechanisms by which marital relationships become abusive during motherhood and childbirth in an unfamiliar context are not well understood. Considering gender as an explanatory construct, an exploration of contextual factors that contribute to newcomer women's experiences as mothers will strengthen theory and research on newcomer mothers. Exploring the challenges that newcomer women face during motherhood, pregnancy, and childbirth and the how these challenges shape newcomer women's lives is one of the objectives of this study and will help to fill this significant knowledge gap.

Newcomer Women's Strength and Resilience

Resilience is defined as "a dynamic process wherein individuals display positive adaptation despite experiences of significant adversity or trauma" (Luthar &Cicchetti, 2000, p. 858). Much of the research and writing on newcomer women's experiences during motherhood and childbirth have emphasized negative and pathological outcomes (Grewal, Bhagat, Balneaves, 2008; Kushner, 2005; Tummala-Narra, 2004). Little research has been conducted to explore newcomer women's resilience during motherhood and childbirth.

Although newcomer women face many challenges during motherhood and childbirth in an unfamiliar context, many adopt coping strategies and demonstrate personal strengths that enable them to grow and thrive in their new environment. In general, newcomers who are newly migrated are in better health, report fewer chronic conditions, and are less likely to be overweight than Canadian born citizens (Ali, McDermott & Gravel, 2004). Page (2004) conducted an integrated literature review of potential explanations for better than expected pregnancy outcomes in Mexican immigrants. The author found that focusing on socioeconomic status, social support, desirability of pregnancy, nutrition, substance use, religion, acculturation, and prenatal care may have played a role in improved outcomes. Despite having many of the risk factors for poor pregnancy outcomes, Mexican immigrants were found to have superior birth outcomes when compared to U.S.-born women. Social support, familism, a healthy diet, limited use of cigarettes and alcohol, and religion were found to play a role in

improved outcomes. Among Asian newcomer communities, strong familial ties, feelings of loyalty, reciprocity and solidarity toward family members were associated with social support and other positive health behaviours (Acedevo, 2000). Another strength of newcomer mothers is a positive attitude toward breastfeeding. In a cross-sectional survey of 962 foreign or Puerto Rican born women in New York, 68% of women indicated their intent to breast feed after delivery (De-Bocanegra, 1998). Maclean (1998) also found that newcomer women were more likely to breastfeed compared to non-immigrant women. When comparing prenatal health behaviours of American and foreign-born mothers, another study found that newcomer women had better birth outcomes because they reported less cigarette smoking and fewer mental health problems (Acedevo, 2000).

Newcomer women tend to cope by relying on their inner strength, resilience and ability to process and problem solve their dilemmas, and by turning to others in their environment and social contexts (Meleis, 2005; Ornelas, Perreira, Beeber& Maxwell, 2009). In a phenomenological study to examine the resilience strategies used by South Asian immigrant women in the US, Singh, Hays, Chung and Watson conducted five interviews and eight focus groups in (2010), which revealed five resilience strategies: use of silence, sense of hope, social support, social advocacy, and intentional self- care. Similar results have been documented in other studies. For example, newcomer women may receive formal support from the hosting community through access to health care, sponsoring local cultural events, and providing financial aids such as child tax benefits. Newcomer women may also access informal support from other newcomers or non-recent immigrants from their country of origin (Van Oudenhoven & Hofstra, 2006). Informal support was found to be one of the most critical factors in helping newcomer women to relieve stress and receive advice regarding the new environment, resources, and where to seek medical or social help (Usita &Blieszner, 2002). At the community level, some newcomer communities have resisted the systematic attempts of assimilation and identity removal and have provided social, cultural, and psychological resources for community members in alternative ways (Sonn& Fisher, 1998).

This study is designed to explore the sources of strength and resilience among newcomer women, with the potential to increase knowledge in this regard.

Critical Summary of the Literature

This literature review provides a critical assessment of relevant research on motherhood and childbirth experiences among newcomer women. Qualitative studies have highlighted the unique experience of motherhood experienced in different contexts (Liamputtong, 2006; Liamputtong&Naksook, 2003). The studies used different designs and samples with some using critical feminist perspectives, social, or acculturation theories to guide their understanding of research problem (De Souza 2004; McMahon,1995; Sharma, 2006). In addition, there is a growing body of literature that provides insights into newcomer mothers' needs. Findings have demonstrated some similarities and differences in the challenges newcomer women face during this period, highlighting the need for further research addressing the influence of migration on motherhood experience.

The body of literature examined in this review reveals that many contextual factors and dynamics, including marginalization, assimilation, economics, and social disparities, influence motherhood and childbirth among newcomer women. While these studies contribute to understanding the concept of motherhood among immigrants, more in-depth study of the women's experiences of mothering is needed. In general, studies concerning motherhood and childbirth among newcomer women have tended to focus on issues such as income and occupation (Cheung, 2002; Kim et al, 2006; Liamputtong , 2006), cultural differences of maternal practices during motherhood and childbirth (Cheung, 2002), linguistic and social barriers to interaction (Hyman &Dussault, 2000; Raj & Silverman, 2002), the demands of balancing motherhood with the need to work outside of the home (Kim et al, 2006), the presence or absence of social support, and coping strategies (Abboud&Liamputtong, 2005; Guendelman, Malin, Herr-Harthorn& Vargas, 2001). Little research was found on the meanings and conceptualization of motherhood experience among newcomer women in Canada.

The limited body of research suggests that a complex interweaving of cultural, environmental, and interpersonal factors contribute to the challenges that newcomer women face during motherhood and childbirth post migration. Overall, very little research was found regarding motherhood and childbirth among newcomers in relation to marital conflicts and intimate partner violence. It is not known whether migration experiences and acculturation styles heighten the potential for marital conflict and IPV among newcomers, or how migration experiences influence gendered relations. Even less is known specifically about newcomer women's motherhood experiences in Canada, in comparison to current research in Australia, USA, and the United Kingdom. In addition, most of the research included only women who spoke English. Therefore, the results do not reflect motherhood experiences for newcomer women who are not fluent in the English language. This study will address this gap by conducting research with newcomer women, offering them the option of participating in their language of origin.

Clearly newcomer women's experiences during motherhood and childbirth encompass a combination of many cultural, cognitive, social and behavioural dimensions, and contextual factors that require further clarification and understanding. These different dimensions of motherhood and childbirth experience are interrelated and associated with different types of outcomes. For example, studies found positive relationships between social support and breast feeding (De-Bocanegra, 1998). In addition, little attention has been paid to how newcomer women may engage with a variety of networks in different settings, such as work place, neighbourhood, and through their children's activities (Ryan, 2007). Rather, many of the studies examined isolated aspects of motherhood and childbirth and treated this population as a homogeneous group. Few studies looked at the interrelatedness and the intersectionality of physical, emotional, cultural, political, and historical factors in a holistic manner. De Souza (2004) discussed the need for multicultural methodologies to prevent the production of 'deficiency discourses' in studies that are focused on motherhood experiences. Much of the research has focused on aspects of education, language, employment, and social relations. Further research is

needed regarding the contextual factors that influence motherhood and childbirth in the aftermath of migration, including sources of resiliency and vulnerability. In addition, much of the research and writing on newcomer women's experiences during motherhood and childbirth have emphasized negative and pathological outcomes (see, as examples, Grewal, Bhagat, Balneaves, 2008; Kushner, 2005; Tummala-Narra, 2004). Little research has been conducted to explore newcomer women's resilience during motherhood and childbirth. Another limitation of many prior studies is that information about motherhood experiences in communities of origin is not available. Instead, such information is often inferred from newcomer women's recollection of their past experiences or is derived from findings of other studies that are not directly comparable. There is however, a small, but growing body of literature looking at the experience of motherhood and childbirth among newcomers (see, for example, Liamputtong, 2006; Liamputtong&Naksook, 2003; Sawyer, 1999; Tummala-Narra, 2004).

Chapter Three

Research Methodology and Methods

In this chapter, the methodology and methods used to guide this study are described. The study used critical ethnography methodology to gather data about motherhood and childbirth experiences among newcomer women in Canada. A critical feminist perspective and Intersectionality theory guided the methodology. I also describe the research sample, data collection methods, and setting of the study. Strategies that were used for the analysis of data are described. Finally, a discussion on how I addressed rigor is presented.

Research Methodology

This study drew on critical ethnographic approaches to develop an understanding of motherhood and childbirth experiences among newcomer women. Critical ethnography is a methodology that examines culture, knowledge, and action to aid social change (Thomas, 1993). Foley and Valenzuela (2005) defined critical ethnography as a subjective way of knowing in which the researcher-participant interaction mediates the production of an ethnographic account. The goal of critical ethnography is to restructure the research process in ways that promote an understanding of the views of individuals who are oppressed and marginalized (Hughes, 1992; Savage, 2000). *Critical* ethnography differs from descriptive or interpretive qualitative approaches, which historically adopted a description of a social phenomenon to critically examine the social conditions that limit choices, constrain meanings, and sustain the status quo. In recent decades, critical ethnography has flourished in various academic disciplines including social science (Richardson, 2000), nursing science (Borbasi, Jackson & Wilkes, 2005; Savage, 2006), history, and cultural studies (Stephenson, 2001;Tedlock, 2000; Warren &Fasset, 2002).

Critical ethnography prioritizes *culture* as its central focus. Thomas (1993) defined culture as "the material and symbolic artifacts of behavior such as belief systems, conceptual machinery for ordering social arrangements, and preexisting structural and material attributes"(p.12). Berman and Jiwani (2008) understood

culture as a "complex of values, lifestyles, behaviours, attitudes, and ways of being that are fluid and dynamic and that evolve in response to internal and external factors" (p. 150).Fetterman (1989) indicated the concept of culture helps the ethnographer to understand the characteristics of groups in a cohesive and logical pattern. However, this definition ignores that the culture is evolving and dynamic. Culture involves processes and practices constantly occurring within power-laden social contexts and locations to create fluid, contested, negotiable, ambiguous meanings (Stephenson, 2001). Spradley (1979) explains that individuals learn about their culture by observing and listening to others.

As these definitions reveal, there is no consensus in the literature as to what exactly culture is, what would constitute a cultural study or which methodological approaches would be most appropriate. However, for the purpose of this study, I used Browne's and Varcoe's (2009) definition of culture. They defined culture as "a relational aspect of ourselves that shifts and changes over time depending on our history, social context, past experiences, gender, professional identity, and so on" (p.36). Culture then is defined as a way of being and behaving in the world and includes processes and practices constantly occurring within the social contexts to create fluid and negotiable meanings. Becoming a mother in a new culture presents specific challenges in life transitions and identity formation for newcomer women (Limaputtong et al., 2004; Ryan, 2007). It is possible that the adaptation to the immigration process, changing conceptions of gender roles and attachment, and changing family structure and social networks may influence women's perceptions and experiences of motherhood. In this study, the focus is on culture as a site of identity formation. The cultural norms and traditions of newcomer women that are perceived to be different may be negatively valued by the dominant culture (Van Oudenhoven& Hofstra, 2006). Ideology, language, class, race, gender, and history which shape cultural modes of being and expression may situate newcomer women lower in the hierarchy of privilege. The new country may not appreciate the cultural differences of newcomers, not necessarily because of difference,

but from limited knowledge and the lack of social and political structures to support newcomers' cultural practices.

An underlying assumption in critical ethnography is that experience is intersubjective and embodied, social and open for critical reflections (Denzin, 2003; Madison, 2005). In addition, it explicitly assumes that individual cultures are positioned unequally in power relations. Critical ethnographic methodology rejects the idea of a universal truth and represents the culture in all its complexity, instability, and diversity (Savage, 2006; Smith & Gallo, 2007). This methodology does not assume homogeneity among individuals from different cultural backgrounds. Rather, it is recognized that there are varied and diverse languages, conceptual meanings, and understandings, ideas which are consistent with Intersectionality theory. When newcomer women talk about their experiences, they shape, construct, and perform their selves and realities. In this study, newcomer women's accounts are facilitated and constrained by a range of new social resources and circumstances. The content of newcomer women's accounts embodies their identities which develop and change over time.

Research Methods

Sample recruitment and location. Sixteen newcomer women from a Southwestern city in Ontario who experienced pregnancy, childbirth, and motherhood in the new context (Canada) were recruited using purposive sampling. Purposive sampling is a strategy used in qualitative research in which the researcher selects participants thought to be the most knowledgeable to discuss the research questions (Denzin & Lincoln, 2005). The rationale for using this method of sampling is that it represents varied perspectives and experiences of women who are differently located in the social system and allows the researcher to choose newcomer women who share the experience of pregnancy, childbirth, and motherhood in the aftermath of migration, and who are able to articulate their thoughts and feelings about their experiences. Sample size was flexible according to the criterion of saturation of the themes as suggested by Guba and Lincoln (1994). Saturation became apparent after

16 interviews were analysed and there was sufficient, deep, reasonable, appropriate, and adequate information about the phenomena of interest.

The women were recruited into the study through the use of several strategies. First, flyers (Appendix A) were distributed in a multi-cultural on-campus residence for married students where I was living. In addition, several conversations took place directly with women in the playground to explain the study. Informed consent was obtained from those who expressed an interest in participating (Appendix B). Two participants were recruited using this method. As a newcomer woman, I also used my personal connections and social networks to recruit more participants. My social network connected me with participants who were eligible to my study and agreed to participate. Five participants were ultimately recruited using this approach. Finally, snowball sampling was also used, whereby each woman who I interviewed was asked if she knew others who might be eligible to participate in the study. Three participants were ultimately recruited using this approach. I also met with staff from several community agencies (settlement workers, Cross Cultural Learner Center staff) that provide services to newcomers to provide information about the purpose of the study and to seek their assistance in recruitment (Appendix C). The staff contacted women by phone, gave them information about the study, and obtained women's acceptance to participate and consent to provide me their contact information. The staff subsequently provided names and phone numbers of refugee women who had expressed an interest in the research. I contacted them by phone and recruited six refugee women in this manner. All participants consented to participate in the study and signed a written consent form. For women who wanted to use their Arabic language, a translated copy of the consent form was provided to them.

Newcomer women were selected according to the following eligibility criteria: a) residents in Canada not more than five years and arrived in Canada as a refugee or immigrant; b) women between 6-12 months postpartum; c) newcomer women who were mentally, physically, and emotionally able to articulate their experiences of pregnancy, childbirth, and motherhood; and d) fluent in either English or Arabic. The time

selected for residency status is consistent with the province of Ontario definition of newcomers (Citizenship and Immigration Canada, 2006). Women were recruited after six months postpartum so that they would have some experience mothering and would have had time to reflect on their interactions with health care providers and members of their social network. Both multiparas and primiparas were invited to participate in this study to capture the variations in women's experiences. The rationale for restricting participation to Arabic and English speakers is that the researcher who conducted the interviews is fluent in English and Arabic. Newcomer women were recruited from varied educational and socio-economic backgrounds, and diverse ethno-cultural groups to ensure diversity within the study sample. Three newcomer women wanted to participate but didn't meet the criteria because the age of the baby exceeded 12 months. One newcomer woman initially agreed, but later changed her mind, explaining that she doesn't t like to talk with strangers about personal issues.

These strategies resulted in a sample of women who varied in age, country of origin, educational level, income, occupation, first language, and number of children. The 16 newcomer women ranged from 20-39 years of age. Six women were refugees and 10 were immigrants; they had lived in Canada from 8 months to 4.5 years. Seven of the women were Christians and nine were Muslims. All women described themselves as housewives, and two were doctoral students. With respect to the country of origin, four women were from Jordan, three from Colombia, three from Egypt, and one each from China, Ukraine, Bhutan, Iran, Venezuela, and Iraq. The first languages spoken by women were English, Arabic, Nepali, Azhari, Spanish, and Chinese. Their family income ranged from $12,000-36,000 annually. Eleven of the women had high school education, four have bachelor's degrees, and four have diplomas. One had a PhD degree, and another two were still working on their PhD degrees at the time of recruitment into the study. Twelve women had at least two children, while the remaining four women had given birth their first child. All of the women had been married for a period ranging from 7 months to 11 years.

Data Collection

Ethical approval was received from the Health Sciences Research Ethics Board at the University of Western Ontario (Appendix D). Most women were contacted by telephone to determine their eligibility and to set a time to be interviewed. The eligibility was determined by using a screening checklist that included the eligibility criteria and some demographical information (Appendix E). A detailed explanation of the research process was provided to each participant, and all questions were answered to their satisfaction prior to obtaining written informed consent. The letter of information included an introduction, the study procedure, risks and benefits of participation, confidentiality and voluntary nature of participation, and the researcher's contact information. The letter of information was provided in either English or Arabic, according to the participant's preference (Appendices C and I). All participants received a $20 honorarium in appreciation of their time.

Semi- structured interviews, lasting one and one-half to two hours, were conducted in a quiet, private location. Most interviews took place in participants' homes based on their request. Two women preferred that the interviews take place elsewhere. One of these took place in a private room at a community resource centre; the other was conducted at the researcher's office at the university. The interviews were flexible, dialogic, reflexive, and interactive in nature. In critical feminist research, interviews are conducted in an interactive manner in which the researcher and the participant can engage in a mutual self-reflection (Lather, 1991). Demographic information such as age, country of origin, length of time in Canada, religion, occupation, level of education, language spoken at home, weeks since delivery, number of pregnancies, number of living children, and marital status was collected at the end of the interview if it had not been obtained during the course of the interview. An interview guide was used to help the researcher to ask questions and to organize the interview content (appendix F). The main guiding questions pertained to the meanings of motherhood and childbirth in an unfamiliar context; the main challenges that newcomer women face; the quality of their interaction with the health care system and social networks; newcomer women's strengths; and the strategies they used to deal with the challenges they faced. Probing questions about newcomer relationships with their partners, marital conflicts,

and intimate partner violence (IPV) were also asked to gain more in-depth data. The purpose of these questions was to explore the broad context of motherhood and childbirth among newcomers. Open-ended questions were used to maximize discovery, description, and critique.

The data collection period lasted for nine months during which data were also analysed. Changes were made to the questions asked in the first interview including reframing some questions and adding more probing questions to obtain richer, more detailed accounts. All interviews were audiotaped and transcribed verbatim. The researcher conducted three interviews in Arabic and 13 interviews in English. The interviews conducted in Arabic were translated into English by the researcher who conducted the interviews. This process provided more appropriate cultural translation than using an interpreter because the researcher shared some of the cultural understandings of the motherhood experience as she is a newcomer too. Using a translator coming from the same culture will provide more appropriate presentations of the cultural meanings of women's accounts. The other 13 interviews were transcribed by a professional transcriptionist. Three interviews were difficult to transcribe due difficulties in women's language. The researcher listened to three audiotapes conducted in English and compared them with the content of the transcripts to ensure compatibility and to fill in gaps in the transcript due to difficulty understanding women's accents.

In critical ethnography, being an 'insider' may facilitate communication between the researcher and the participants (Kanuha, 2000; Meleis, 1996). To facilitate an open exchange in this study, I revealed that I am a newcomer woman and a mother, and that I had experienced some aspects of being a mother in an unfamiliar context. My presuppositions, feelings, thoughts, beliefs, and prior experiences about immigration and motherhood were noted in a journal and recorded as field notes. Consistent with the critical feminist nature of this study, these notes were discussed with participants during the interview using open discussion and critical reflection. I critically questioned my responses to women in order to reveal my personal biases. Participants who had difficulties with the English language were asked about the meanings presented by them during the

interview to ensure that I had accurately understood their intended meanings and the essence of their interviews. For Arabic participants who wanted to use their native language, I used an Arabic version of the interview guide (Appendix G), letter of information (Appendix I), and consent forms (Appendix H) to avoid doing "on the spot" translation. I also tried to be culturally sensitive to different meanings and different Arabic accents that women had. For example, an Iraqi participant used a word "thabeha" to explain one of the cultural traditions in Iraq of inviting people for a dinner made of fresh cooked meat after the delivery of a baby. Because of my accent, I used a different word, "akeka", for the same meaning so I asked the participant to make sure I understood what she meant.

Data Analysis

Prior to analysis, the audiotaped interviews were transcribed verbatim in English. To become immersed in the data, I started with manual coding of the first three interviews to develop an initial list of codes. The analysis started by carefully reading the transcripts to locate meanings pertaining to newcomer women's experiences during motherhood and childbirth. Nvivo 8 software was used to facilitate the sorting of the data. I also used a data analysis guide suggested by Lofland, Snow, Anderson, and Lofland (2005). I reviewed the transcripts line by line several times to attain deep a comprehensive understanding of the meaning units and the connection between them before coding in Nvivo. As suggested by Lofland et al., I conducted an initial coding, where the data were condensed and organized into categories, followed by focused coding, which builds on the initial codes by elaborating on a select few, and discarding those considered less descriptive or useful (Lofland et al.). The analysis was focused on structural and interpersonal factors. Although the analysis is described in phases, what happened in reality was quite fluid and flexible, moving back and forth between description, coding, and interpretations, with all analyses built on the previous ones. Notes were recorded in the margins of the transcripts in order to capture the main initial codes and connections between them. Memos that described the coding categories, interconnections, and the research experiences were written in order to assist with the

developing analysis. The process of analysis began directly after interviewing the first participant. This process was followed by continued deeper analysis of the codes and organization of codes into emerging themes. The final step consisted of describing and communicating in narrative form the verbal descriptions and the elements of the women's experiences.

Rigor

To maintain rigor in this ethnographic study, I used criteria from three different sources, namely catalytic validity (Lather, 1991), credibility, authenticity, and trustworthiness (Whittemore, Chase &Mandle, 2001), and contextuality, communication styles, awareness of identity & power differentials, and disclosure and empowerment (Meleis, 1996). I used these particular criteria because of their fit with the critical feminist nature of this study.

Catalytic validity is " the degree to which the research process re-orients, focuses and energizes participants toward knowing reality in order to transform it" (Lather, 1991, p. 68). Catalytic validity was demonstrated by being reflexive. Richardson (2000) defined reflexivity as the process of bringing to the consciousness some of the complex political ideological agendas hidden in our actions. I explicitly stated the assumptions underlying the study and reflected on my personal opinion and positionality in relation to issues that came up during the interviews. Examples include my perception about motherhood, the health care system, and discrimination. The processes of dialogue, reflection and critique allowed newcomer women to discuss and critique the challenges they face during motherhood and childbirth, thereby fostering new understanding and possibilities for action and change among the Canadian society.

Credibility and authenticity were addressed by providing descriptions and interpretations that I accurately represented participants' experiences as reported. Semi-structured interviews allowed newcomer women to name their experiences and tell their ethnographic account in their own words. Moss (2004) defined the provision of trustworthiness in critical methodology as "the researcher's commitment to include all points of

view as contrasted to the common points of view that emerge, protecting participants' well-being while putting their voices in the forefront as a model of authentic participation in educational research" (p.371). Trustworthiness was facilitated by conducting interviews in an open manner, and creating a space for personal reflections.

To meet the criteria suggested by Meleis (1996), the participants were not restricted to answering a set of questions in a limited time. To overcome the limitation of language and to capture the complexity and depth of experienced meanings, I paid careful attention to meanings of language and the need to demonstrate an ethical and cultural sensitivity to all forms of expression. I asked women about meanings to make sure that I interpreted data accurately. I also presented quotations from the women's stories in the presentation of the study findings in order to privilege newcomer women's voices. In addition, I accepted participants' felt meanings without being judgmental. I interacted with newcomer women respectfully especially when they refused to share some of their painful experiences. I listened carefully to their stories and asked their help in order for me to understand their experiences, which for them could be an opportunity for personal growth and empowerment. The study was supervised by a group of experts who provided guidance during the process. The diversity of the sample added to the rigor of this study as it presents different perspectives that enrich to the process of understanding and interpretation.

Ethical Considerations

Ethical approval was obtained from the Human Subjects Review Board at the University where the lead researcher is a doctoral student. The Tri-council guidelines, the nationally accepted Canadian guidelines for the ethical conduct of research, were followed throughout the study. Safety guidelines were used to ensure that the research process was safe for both the participants and the interviewer (Ford- Gilboe, 2005). These safety guidelines helped to deal with any event that could alter the safety of the research process and the people involved in it. Participation was voluntary, and the participants could withdraw at any time without

consequences. A letter of information with the researcher's contact information was given to the participants in their preferred language (English or Arabic). Informed consent was obtained from the participants prior to the conduct of the interview. The interviews were conducted in a safe and private setting. The anonymous transcripts and the audio taped materials were kept secured in a locked cabinet. Only the researcher and the supervisor have access to the data. Transcripts were coded with no identifiers attached. All documents will be shredded five years after the study has been completed. Women and their children were observed for signs of abuse. Women were told in the letter of information that if the researcher had reason to suspect abuse of a minor child, this would be reported to the Child Protection Services. The women who experienced IPV and chose not to report it were offered assistance and support. The women who reported signs of postpartum depression were offered information about the appropriate services to get the support needed.

To meet the criterion of ethical conduct of research with newcomer women in the postpartum period, participants were informed of possible risks and benefits to ensure safety. This information was provided verbally in the newcomer women's first language. During the interview process participants were observed for physical cues of distress, and breaks were taken when women needed them. Follow-up telephone calls were made to participants who demonstrated signs of emotional distress during or after the interview. At this time, offers were made to assist the women in obtaining support or counseling if they wished to do so.

As a summary, this chapter provided detailed information about the methodology and the methods used to explore newcomer women's experiences and understandings of motherhood and childbirth in the aftermath of migration to Canada. The study used critical ethnography methodology guided by critical feminist perspective and Intersectionality theory to gather data about motherhood and childbirth experiences among newcomer women in Canada. A detailed description of the research sample, setting, recruitment strategies, data collection methods, data analysis, and strategies to maintain rigor were described.

Chapter Four

Findings

The purpose of this critical ethnographic study was to explore newcomer women's experiences and understandings of motherhood and childbirth in the aftermath of migration to Canada. A secondary purpose was to identify challenges that newcomer women face in interacting with their families, the health care system and their social networks as mothers in a new context. Four research questions were associated with these purposes:

1) What is the nature of newcomer women's experiences during motherhood and childbirth?

2) What challenges do newcomer women face during motherhood and childbirth in the aftermath of migration?

3) What are the sources of strength and resilience among newcomer women during motherhood and childbirth?

4) How do the health care system and social networks support or hinder women's successful motherhood and childbirth?

In this critical ethnographic study, I used Browne's and Varcoe's (2009) definition of culture to inform this study. They defined culture as "a relational aspect of ourselves that shifts and changes over time depending on our history, social context, past experiences, gender, professional identity, and so on" (P.36). Although women in this study expressed different meanings of culture, the concept of culture was understood as a way of being and behaving in the world and includes processes and practices constantly occurring within the social contexts to create fluid and negotiable meanings.

Seven main themes were identified from the analysis of the data. These are: perspectives about motherhood; meanings of childbirth; challenges to motherhood in the aftermath of migration; mobilizing strengths to overcome stresses of motherhood; the successes and challenges of negotiating the health care system; supportive relationships in the women's lives; and rethinking roles, motherhood and the marital relationships. Eight subthemes were identified and are presented below. While it is recognized that there is overlap and intersections between and among these themes, they are discussed as distinct categories. All names

used throughout this section are pseudonyms. Some aspects of women's experiences are not unique to newcomer women, but the way the women expressed these themes was shaped by the unique intersection of their positions as newcomer women, who often spoke a different language and who were living on low incomes.

Perspectives about Motherhood

The women expressed three viewpoints on motherhood: motherhood as the epitome of happiness, motherhood as the fulfillment of social and religious expectations, and welcome sacrifices and endless worry. While some of the perspectives on motherhood may not be exclusive to newcomer women, they are particularly intense among newcomer women given their migration circumstances.

Motherhood as the epitome of happiness. Women in this study described motherhood as resulting in happiness and pride, and stated motherhood as being rewarding, transformative and valuable. Some appreciated the sense of attachment they have with their children, and others expressed it was a way to strengthen their marital relationships. Motherhood was referred to as 'a blessing', 'a process of self-transformation' and 'the best experience of my life'. As one 27-year-old woman from the Middle East explained:

> At the beginning of pregnancy, feeling attached to a baby is really nice experience. From the first day you know that you are pregnant you feel the attachment, you feel that there is a baby will come out of you. Taking care of the kid, being a mom, and seeing the kid growing up every day is a really enjoying experience. I feel that I am blessed to be a mom. Although sometimes you feel the stress and the burden, it is still an enjoyable experience.

For some women, the strong emotions associated with motherhood guided their definitions of this experience. They expressed that they loved their babies as they had never loved before and explained that they derived a deep sense of pride when they saw their children's faces or when children showed affection toward

them. Another refugee mother described her happiness about having a baby girl, and the love and intimacy she felt for her baby.

> She, Vivian, was my dream and now she's my life. I love her, oh my god. Every day I see her when she's sleeping and I put my hand on her to check if she's breathing. She's my life, she's part of my life. I have to take care of her and it's amazing, and it's beautiful; I can't explain to you how I feel.

Overall, the women in this study seemed satisfied and happy with their status as mothers. They were able to reflect upon the feelings and the rewarding aspects associated with becoming mothers.

Motherhood as the fulfillment of social and religious expectations. Becoming a mother from the women's viewpoint meant continuity of the family name, heritage, and someone to take care of them when they get older. As a newcomer woman explained:

> Having kids is hard work but you just look at these people that you're responsible for that you're bringing up and it's rewarding. And I guess it gives you meaning in life. Because what's the point of working, accumulating wealth or whatever, money you know, possessions who's going to have it? And then when you're old and there's no one, you don't have kids, what is that all for? What did you do? You live kind of like a selfish life if you don't have kids, and we're all selfish. I'm selfish; I want it to be about me, me, me. But you realize you need kids, you need someone to carry on after you. I don't know it's kind of like a philosophical thing. A lot of the time I think it's the traditional view of someone carrying a family name and it kind of sounds old fashioned but in a way you're continuing not necessarily the family name, but you're continuing the human kind.

This comment highlights different meanings of motherhood. From this woman's perspective, being a mother is a purpose in women's lives. Bringing up children for this woman represents a motive to work, share wealth, and live. The need to become a mother is clearly viewed as a means of achieving social expectations.

Unstated but implied by these comments is the idea that women who don't have children, either due to choice or circumstance, are not fulfilling their expected roles.

Religion also shaped the perceptions of women about motherhood. As one refugee woman from an Asian country explained:

> In my country, there is an expectation that the woman should have a baby as soon as possible after she gets married. If a woman doesn't have a baby, she will be considered bad, and people will not eat the food she prepares or serves. She is considered unholy by God.

This comment highlights how religion in some cultural contexts views mothers. From this woman's perspective, religious and cultural orientations put pressure on women to have children. This pressure is considerable, particularly for women who are not willing or able to have children. Judging women based on the presence of children ignores the value of them as humans and their capacities to work and to be effective persons in their communities.

Welcome sacrifices and endless worry. Many women mentioned the transformation in their lives and changes in their priorities that took place after they became mothers. The notion that 'children come first' was repeated by several women. Consistent with this idea was the view that sacrificing their own needs for the good of their children was welcomed and accepted, and they took this on willingly and happily. The women noted that motherhood is a 24-hour a day full-time job that gives them more responsibilities and less time for themselves. As a married, 26- year- old refugee woman explained:

> When you have babies or children you give up, like going to the disco for example. I used to smoke and now, when you have a baby, everything changes. I think everything revolves around your baby.

The comment provided by this woman was similar to the comments provided by many of the other women participants. The life changes associated with becoming a mother lead women to give up some of the personal freedom and practices that no longer fit their schedules and the new commitments.

Among the sacrifices women made were giving up work and educational opportunities. Most women in this study felt the need to improve their language skills. In order to do this, several women rearranged their schedules to attend English as a Second Language Schools (ESL). For many women, the significant time commitment forced them to give up school in order to manage their responsibilities as mothers and wives at home. One woman said:

> I went to school when my daughter Sarah was six months. At that time, I registered at school and I had to take my two daughters to the day-care to continue my study. I stayed at school for 2 months, then for one year. At the end of this year, I got pregnant with my son and my due date was in October, one month after school started. So, I decided to go to school after labour because daycares do not accept babies less than six months old, and I had to wait on the waiting list. Then I travelled, and during that time I found that I was pregnant again so it was impossible for me to go back to school.

Most women in this study had limited income and could not afford English courses and day-care for their children if they wanted to study and work. In the example above, the woman's income was about $24,000 annually. She was not in a position to study English because her husband was living in another city and she had five children of different ages (9 months – 10 years). With limited social support, she was the only person responsible in this family, so she had to give up even thinking about studying or working.

When the women discussed the demands of the caring process, particular concerns emerged. They described stress related to time management, being the "right mom", taking care of themselves, and providing equal and appropriate care for their children with different ages and needs. The location of women in a new context heightened their concerns about providing for their children. A 31-year- old woman explained the difficulties she had in raising her children while her husband was studying in another city:

> It is hard. Not only to be a mother but the right mother. Being the right mother is very difficult because you should be able to understand different age groups and meet their needs. Because the little ones are

more demanding than the older children, I find myself dedicating more time to them. The older children ask for more care and for me to spend time with them. I felt torn and lost between them; I didn't know what to do. For me sleeping is an issue too, because Nadia and Salem stay awake during the night. I felt disorganized, but now I feel that I am living for them; their care is the message we carry in this life.

Moving to a new country with limited social support, few financial resources, and limited ability to speak English or French appeared to intensify women's worries about the way they care for their children.

Meanings of Childbirth

The women shared diverse perspectives about childbirth experiences, which were multifaceted and shaped by the new context. These are described in the following section.

An Unforgettable moment. Childbirth was described by women as: 'a happy moment', 'an exciting event', 'a way to ease the pain of labour', 'a powerful experience', 'a reward from God', and 'an unforgettable moment'. Women loved meeting their babies after the pain of labour. As a 33-year-old newcomer mother described:

> You know, this time it was really, really nice. I will never forget when I had my baby boy. It was the first time they put the baby close to me when he came out. They opened my clothes and they made him lie down on my chest, and it was really very nice. I cried the first time.

The women described their dreams about their babies and recalled that the first time they saw their babies was very emotional. This moment was shaped by women's past history and socio-political context. A first-time refugee mother, who had a history of violence, described the happiness she felt after the birth of her daughter:

> I was dreaming about her - her hair, her face. I expected a girl. When she came out I felt very, very happy. Very, very happy. She was a very healthy baby because I tried to eat very healthy food when I was pregnant. I felt that the moment was from God; he gave me this moment because I don't have children.

The women's comments reflect a perspective shared by many women about childbirth. It is a valuable and exciting moment as it produces a newborn that shifts women's lives into different directions. Similar emotions are often shared by all women, regardless of newcomer status. However, it is possible that the intensity of childbirth for newcomer women reflects the marked contrast to other aspects of their lives which often included violence, pre-migration trauma, and the difficulties of resettlement.

Childbirth, fear, and unintended outcomes. Childbirth was described by some women as an uncomfortable experience because of the pain they felt, the uncertainty about the process, the emotional fluctuations surrounding the process, and their fear of complications. Although these concerns could be expressed by any woman, for newcomer women who were interacting with the health care system for the first time and were required to speak an unfamiliar language, these concerns were heightened. One 27-year-old woman was unable to obtain medical insurance. She therefore did not receive health care during her third trimester and lacked information about the progress of the pregnancy and the condition of the fetus. As she explained:

> When I had labor pain I did not know if the baby is in breech position or sitting position or in normal position. I didn't receive any medical care before labor because I was medically uninsured so I went to hospital as an emergency case. When I first arrived here to Canada, I was 26 gestational weeks, I have called many insurance companies, and all of them refused to cover me for birth. I went to the hospital with the labor pain and I was distressed because I did not know who to see and if I am going have a normal delivery or not. So the first thing I asked in the hospital- please make sure the baby is in the right position. Then I had another issue with the epidural. Because I did not have enough assessment in my third trimester, I was unable to plan my delivery and whether to take the epidural. So when they had done the assessment I was in the last stages of labor.

For this woman, the many unknowns increased her anxiety. Overall she felt that she had very little control over the pregnancy and childbirth, resulting in a greater sense of fear.

Some women believed that the complications associated with childbirth had changed their lives forever. They spoke about the persistence of emotional and physical problems throughout the postpartum period. One 39- year-old woman had bleeding, bladder trauma, and high blood pressure prior to and during childbirth. From her perspective, the problems were due, in part, to the failure of her physician to prescribe antihypertensive medication, despite her elevated blood pressure. She explained her status postpartum as:

> Till now, you know I have problems still, residuals from the whole process, yeah. I think I'm not the person as I am before this whole experience. I am, I think, I have a lot of, you know, bad feelings from this experience regarding the care, regarding the health system, a lot of things that is not hard to resolve easily.

This woman asserted that the complications shaped her evaluation of childbirth as a negative and unfortunate experience. She found herself rethinking and re-evaluating the decisions made and actions taken by her health care provider. She felt that she was neglected and mistreated and ultimately lost her ability to trust health services.

Challenges to Motherhood in the Aftermath of Migration

Many women in this study faced a variety of challenges associated with the experience of motherhood in a new country. Some of these challenges were related to being newcomers, and some were related to the nature of motherhood and parenting. Three major themes emerged concerning the lack of social and emotional support, parent-child conflict, and competing roles and economic distress.

Lack of social and emotional support. One of the most important challenges to being a mother in a new country was the absence of extended family support and social isolation. Most women interviewed spoke about the support they would have received from their families if they were in their home countries. Typically,

friends and family would help to care for the women, their partners, and their children. Feelings of isolation and loneliness were expressed by many women because of the geographic distance between them and their extended families, as well as the lack of social connections in Canada. One woman stated:

> Being alone and needing family support have made the experience harder. Although my husband helps me take care of my little ones, the presence of my mother would be different. If she were here I could rely on her to change diapers. Sometimes I feel sorry for myself. When I had Sana, I had no one to take care of me or bring me food because I didn't know anyone here. I felt so bad because I was in pain and couldn't stand in the kitchen and cook food for my family. My husband doesn't know how to cook and I needed someone to take care of me, prepare me special food. Therefore, I prepared some food before my due date and kept them in the fridge to feed my family... I thought, what I am I doing here? My family should be here with me! I felt scared for my children.

For women with limited access to extended family support or social networks in Canada, becoming a mother was associated with feelings of insecurity and loneliness. They felt emotionally conflicted as they sought to meet their own needs, while simultaneously attending to the care of their infant and other family members.

The social isolation also impacted negatively on the women's ability to provide appropriate socialization opportunities for their older children, resulting in feelings of guilt and emotional distress. The women identified low income, lack of time, and weather in Canada as compounding factors that heightened their social isolation. A 27-year-old woman stated that:

> Culturally, we are used to having a lot of visits to friends and relatives who have kids so that all kids will play with each other, interact, and feel more socially engaged. While here we don't have relatives and our friends are mostly students as well- so you have to find time and you will need to make a lot of arrangements before any visits. So it's limited, and as you know we need to have social interactions not

only for us but also for the kids. I feel sometimes that I should- for example- take the kids to a park or to a place where they can meet other kids and interact with them. I don't have enough time to do so except on the weekend and not all of the weekends. Here in Canada we have long winters and snow- and we don't have a car so it's difficult to take the kids to any place.

The absence of extended family networks impacted on their ability to find babysitters, or to obtain advice and information. One woman said:

> Yes, the biggest challenges are definitely loneliness and sometimes not knowing where to turn when you're having, you know those "I can't do this anymore I need some help" moments. I definitely turned to family. My first year when it was hardest for me, we actually lived with my uncle and his family and they provided a lot of moral support. So, if you don't have family here I don't know what you'd do because you need them, you need someone.

A refugee woman from the Middle East described the burden of caring for two children and a husband with a disability. Her husband has prosthetic arms due to an explosion. As a result, the woman was responsible for all family responsibilities. The desire for family and friends who could help was particularly evident in this woman's comment:

> I feel stressed because of the responsibilities that I have, especially when I need daily things like milk. It's painful and I am suffering. My husband can't help me. He can't grab a tomato or an apple and put it in the bag. It is too difficult. Life was easier before because taking care of two is more responsibility than one. When we were invited to dinner at our friend's house, I fed my husband and my children and then didn't have time to eat myself.

Although this woman seems to 'manage' despite the lack of support, her emotional and marital needs for support are substantial. Her story represents a good example of how health, socio-economic, and political factors intersect to create a life of considerable stress and sacrifice.

Parent-child conflict. Some women in this study encountered tension with their older children as they sought to impose their cultural beliefs and practices. This challenge is unique to newcomer women and their older children because they are exposed to a new set of beliefs, lifestyles, and cultural practices. Six women had older children ranging in age from four to 14 years. While their children embraced new ideas and life-styles, the mothers generally resisted these changes. The women generally shared the same viewpoints about childrearing as their partners, but they often found that they had conflicting views from their children with respect to food, clothing, the amount of time spent with friends, and social interactions. It appears that the mothers' resistance resulted from their perceptions about 'the new culture'. Most women presented culture as a set of values and beliefs that are static, taken-for- granted, and not questioned. This perspective ignores that cultural beliefs and norms can change and evolve with time. The women expressed uneasiness about the arguments between themselves and their children, and a desire to preserve the values and traditions of their native country. A woman said:

> One negative aspect is the differences in traditions. I need to raise my children in a culture different than mine. We are Muslims and I am struggling to make my children understand that we can't take so many things from Canadians and behave like them. It's a bit difficult but not impossible. My children ask for things that I can't do for them. For example, they ask to eat food that is not allowed or good for them. How could I teach Sana, my 4 year old daughter, that certain types of food are not allowed for us as Muslims to eat? She is not yet able to understand this. I don't want to generalize this for all Arabs, but for me, when my daughter tells me that she wants to have a sleepover at her friend's house, I can't accept this. The part of Canadian culture that says girls may have boyfriends is unacceptable for us. Therefore, I ask my daughter to bring her friend into our home, spend as much time as she wants with her, or go for lunch instead of her going there.

These comments reflect a 'disconnect' between practices and behaviours deemed unacceptable by the mother, but attractive to the daughter. The resulting tension was manifested in everyday parent-child interactions, permeating all aspects of the relationship.

The women expressed difficulties dealing with the requests of their children that were unacceptable to them. Their comments reflected a view of their children as dependent, passive, and unable to make the 'right decisions'. At the same time, they expressed concerns that the schools and the social system encourage autonomous and independent behaviors on the part of children. This dissonance created added tension, along with feelings of confusion and incompetency among the women. As one mother of three children described:

> Sometimes I have some difficulties explaining things. Once in a while my daughter will come up with something new to discuss and ask about... One time she told me: "Hey mom, you can't control my life". I told her, "I am not but, I provide you with information so you can be aware and more careful when you make decisions". So obviously, she heard words from outside and threw them in my face.

This mother's frustration was evident as she described this interaction, and she felt challenged to respond appropriately. The tension, thus, arose not only from mothers wanting their children to behave in certain ways, but also from children hearing and saying things that are not considered respectful.

Some women described being confused whether to raise their children in the manner they were raised or adopt new disciplinary approaches. Some mothers acknowledged the advantages of raising their children by learning new practices and information such as teaching them to express their concerns, being firm, and providing more freedom in making choices. However, in some areas, they preferred to use traditional ways of parenting. As an example, they tended to encourage their children to use their language of origin for communication and greetings. In addition, women expressed concerns about their children becoming independent too soon, having excessive freedoms, engaging in sexual activity, using English more than their

first language, disclosing private issues to their teachers, and lacking knowledge about their religion. A 39-year-old woman said:

> I think there are some things that I like about their [Canadian] way of raising their children and some things that I dislike. I like how they raise their kids to be very punctual and well behaved. In our culture we always give them a lot of care and spoil them because we love them very much; sometimes we are loose with them. You may see this as a good thing because your baby is receiving a lot of love and a lot of everything that he/she needs, but in the future this will not benefit them. I think the Canadian mothers are very, very restrictive in this issue. I think we are more emotional than Canadian people. Sometimes it is good for your kid to show a lot of emotion and sometimes it is not. They may take lead in some decisions but this can hurt them too if they were wrong. You have to be assertive sometimes and that's what I like about how they raise their children. They make them independent. The kids in our culture still depend on their parents until the age of marriage and sometimes after marriage too. Here the kids are independent in early, early life. They are independent and that's good for them.

For women who showed flexibility in learning about the new cultural context, their parenting style was challenged when they tried to integrate their children into the new system. Efforts to accept new ideas, acquire new practices, and understand different perspectives were an ongoing struggle for the women in this research.

Competing roles and economic distress. A significant dimension of the experience of motherhood among the newcomer women pertains to women's limited access to economic resources. This was reflected on women's housing, furniture, and wearing. Most women in this study had incomes that ranged from $12,000 to $36,000 annually. At the time of data collection, 11 of the women's partners were unemployed, despite efforts to find jobs. As a result, some of the women had to work outside of the home, leaving them with little time to care for themselves and their children. One international student said :

> The scholarship is not enough for me. My husband was searching for a job, but because his certificate is not from Canada, he can only work as a general labourer earning 10 dollars per hour when the job is available. In this case, I need to put my two kids in daycare and it's $4.50 per hour. So if he wanted to go to work and I am at school, we have to put our kids in daycare and what my husband gets from his work will be used to pay for daycare. What's the benefit of working then? It isn't worth it, so he stays at home and I work. I worked as teaching assistant and research assistant at the university. This job took up all my time. I didn't have time to myself to relax, so even the financial responsibilities are falling back on me. Also when I started my PhD program my child was 2 weeks old and I was a breast feeding woman. One of my challenges was to keep on breast feeding while studying. As you know I had to wake up many times during the night for breast feeding and in the morning I would have to go to school and do my courses. I took two courses in the same day from 9 to 12 then from 1 to 4. With two courses in the same day, I could not breastfeed unless I had my baby with me and it was difficult to bring him because other students might have felt uncomfortable and distracted in the class. I was worried and overwhelmed about this until finally, I had to compromise and drop one of the classes.

In some cases, it was necessary for the women's partners to study or live in a different city. These women were then further isolated and alone, worried about their ability to endure the difficult times, and to take care of and protect their children properly. A woman explained the difficulties she had in raising her children while her husband was studying in another city:

> I felt that I am having responsibilities. All they count on you. In my previous experiences, I had my extended family living near to me. They offered me support, so that my stress was less than here. In Canada, I am the only person in-charge; I am responsible for children care, preparing food, taking children out. It was huge responsibility. The number of children makes you feel very motherly. In the past, I didn't feel of motherhood as now.

Taking care of five children essentially on her own, with her partner away because of financial necessity, filling the space of the father, lack of support from extended family, social isolation, and the difficulties in language added to the hardship of this woman and shaped her perspective of motherhood. Compared to her motherhood experience in her home country, she felt that motherhood is an overwhelming burden with the absence of extended families.

Mobilizing Strengths to Overcome Stresses of Motherhood

The women described how they adjusted and coped with the challenges they faced during childbirth and motherhood, revealing many sources of strength and resilience. Despite the difficulties, they used effective strategies to manage their responsibilities. The strengths they possessed seemed to be rooted in strong familial ties, personality attributes, their love for their children, their religion that compelled them be good mothers and wives, and their determination to be "good mothers". Five strategies were identified from the women's narratives: preserving the good mother identity; using hope; patience and acceptance; adopting health promoting practices; using religion as a catalyst for coping; and adjusting parenting styles.

Preserving the "good mother" identity. Most women showed positive feelings about being mothers and were proud of the ways in which they were bringing up their children. They stated that motherhood provided access to a loving relationship, to social recognition and appreciation, and to a valued identity. One 35-year-old mother of two children said:

> Well as a mother maybe the strength that I have is that I really want to be a mother, a good mother, because I think that I have decided to have the baby and now I have the responsibility for the baby as it grows and then his success, everything. I tried my best to be a good mother and I really enjoy being a mother. I think that it's a good feeling because I don't think, "oh because of the baby I can't go out, because of the baby I can't work". I say "no, the baby didn't want to come, I wanted her to come so I

have the responsibility". I really want to be a good mother for her and to raise her in the best way that I can.

Using hope, patience and acceptance. Women shared that a sense of hope and optimism about the future supported their resilience. For instance, they reported holding onto the hope that their difficult times would end when their children were older. In addition, women said that being patient and accepting the difficulties in their lives helped them overcome the hardships they faced. Accepting the situation, working on it, and thinking positively were viewed as ways of coping. One mother commented:

> I use patience and acceptance. If we get upset, things will get worse. I advise women who don't have their extended families with them to be patient. Also to look at the future with hope that things will be better. Rely on God for a good future. I keep telling myself that "it's okay and I have to be strong. My youngest daughter will get older after 3 years, my life will be better, I will sleep and take a rest, I will study, and my husband will help me as I helped him to finish his studies.

Adopting health promoting practices. The women also showed positive attitudes towards health promotion practices during childbirth and motherhood. For example, they reported performing abdominal exercises postpartum, eating a healthy diet, encouraging their older children to adopt a healthy lifestyle, and breast feeding. Most women breastfed for 6-10 months. One mother of a 9-month-old baby stated that:

> At the beginning for maybe 4 days or 3 days there was no milk in my breast and I was very unhappy with this. My baby took formula for a few days, but after I came home there was milk in my breast and I fed her for 8 months. I like breastfeeding because it's useful for babies and useful for me as well because I return to my shape very quickly. I have plans to breastfeed my coming baby too.

Among other practices women used to promote their health were: sleeping, walking, crying, talking to friends, playing sports, retreating to a private space, sitting in silence, playing games, and reading. The women

stated that some of these practices strengthened their confidence in themselves, decreased their stress level, and improved their emotional status. As a 28-year-old woman explained:

> I have girl's night out with my friends and my husband looks after the kids and I go in the evening and we go out for coffee or whatever. And so that's nice, it's very nice. It's just maybe 3 hours or being with girls.

Using religion as catalyst for coping. Many women in this study relied on their religion for spiritual guidance and support. They attributed their desire to be merciful and respectful to their children to religion, and believed that religion shaped, in profound ways, their ideas about motherhood. One woman said:

> Well I've been a Christian all my life and a lot of people say they're Christian but they don't really go to church. They kind of believe in God and celebrate Christmas and that's about it. But yeah, I have a personal relationship with God, I pray and he helps. You know, it's difficult to explain but you know we asked for a job and it's impossible to find a teaching job now in Ontario but my husband and I prayed and we got a job, and we believe God gave him the job. And there have been financial situations. We were praying that UHIP would cover the birth and suddenly this OHIP situation came to be, and we were able to have it. And as Christians I believe that God is in control so when we ask, he does it, even if it's to change the law about OHIP, he did that. Whether it was for us only or for not only us, we don't know, but we take it as God helping us.

Adjusting parenting styles. To solve conflicts with older children on issues such as freedom, food, clothing, sleepovers, and social interactions, some women used a 'balanced way' as a compromise to avoid pushing their children to maintain the family's cultural beliefs and traditions . They believed that it was impossible for their children to totally preserve their own cultural practices and norms while living in Canada. They showed understanding and willingness to negotiate and described various strategies to encourage this. One woman described her flexibility experience with her son:

> Well, you know, I have to accept that even if I were in my country, there were some new technologies; new things that my child had wanted to do which were not acceptable for me. I really think just being a friend, letting him talk to me, and just not punishing him like that. You know, he has to believe me and I feel that we are his friends and we really like him to be a happy and successful person. I think if we talk like this he will accept what we say.

One of the strategies reported by some women to preserve their original cultural practices and beliefs was to spend more time with their children teaching them about the norms and beliefs in their home countries. They tried to involve their children with others from the same ethno-cultural group in order to practice their language of origin. They also tried to involve their children in certain traditions that they could do at home. For example, one woman reported that she made decorations for Ramadan 'the month in which Muslims fast" with her daughters and taught them about fasting.

The Successes and Challenges of Negotiating the Health Care System

All the women were asked about their experiences with health care, both in Canada and in their country of origin. Women expressed mixed opinions and experiences, and their accounts varied according to their health status and birth outcomes. Although some of these stories were similar to many women without newcomer status, being in an unfamiliar health care environment and interacting with doctors and nurses who spoke a different language caused women extra burden. As one woman said,

> The English language was difficult for me. When I was pregnant, I was worried where to leave my daughters when I am in labour, I didn't know anyone to help. I was alone and I didn't have information about the health system here, what to say for health professionals, and what to do. I was so scared, I don't go out alone, I was shameful when someone talked to me and I couldn't respond properly because of my poor language. The poor language has great negative impact on me

Many women considered the standard of care received in Canada was high. Refugee women in particular described their experiences positively when compared to their experiences in their home countries where the health services were either poor or unavailable. The women felt a sense of warmth, a high level of care and humanity as compared to the health services in their countries of origin. A 30-year-old refugee woman compared the health services in a refugee camp with the service she received in Canada:

> When I was pregnant in the refugee camp, I had to go for a check-up, and they provided me with an iron tablet for blood and some vitamins. They also provided some food but it was not sufficient for a pregnant woman. The prenatal care started after the first month. I wasn't seen by a midwife or an obstetrician. The care was just for doing blood tests like hemoglobin. If any pregnant woman got complications, there were some supplies to rescue her but not totally as needed. If my son was born in that country he would not be safe. Here it was better. I went for check-up for prenatal care and post-natal care in the hospital. When I was in labour, there was a doctor for my baby and for myself. Being here, we have medical facility, free treatment, and some free medication. Before delivery, nurses looked after me, measured my weight and vital signs, assessed my conditions monthly, weekly, and then after delivery. It was good care and I received the help that I requested. When I asked for help, they connected me to a social worker who provided me some clothing and a car seat. They were respectful, understanding and I am satisfied.

One 31-year old woman felt that the nurses respected her needs and preferences. She said:

> When I requested a female doctor, they understood and respected my desire without being angry. Also, when I refused to shake hands they understood. When I was in labour I put on my Hijab; no one asked me why, they were very respectful. Also, when they asked me to walk with the gown before delivery I refused because it was short, they accepted this without questioning. They were really respectful to my privacy.

Women also described how satisfied they were with the postpartum care and, more specifically, the public health nurse who visited their homes, the facilities that encourage breast feeding in public spaces, and the many other available resources. Some women used interpreters/translators when they were in the hospital. They found them helpful and felt they couldn't manage without them. Other aspects that women liked in their interactions with the health system in Canada were: the regularity of the care, the government-funded services, and the teaching materials for first-time mothers including information about vaccinations, baby care, and babies' growth and development.

Although most women stated that they were satisfied with the standards of care, some reported unsatisfactory experiences. In contrast to the previous comments, one woman spoke of insensitivity on the part of health care providers regarding patients' religious needs and lack of communication. This woman had to abort the pregnancy because the fetus had thalassemia. As a Muslim woman, she was required to have the abortion before 17 weeks of gestation. However, because of lack of communication with health care providers, inconsistencies between health care providers in calculating the gestational weeks, and the extended wait time, this woman was unable to undergo the abortion before 17 weeks and thus violated her religious commitments. She explained:

> My husband had a conflict with them because in our religion we have to do abortion within three months. Because of their delay the baby reached four months and we had to go to another hospital to do the abortion because the baby was big. We knew the real age of the baby after the abortion. Before I did the abortion I saw a psychiatrist there, but I couldn't talk with her because I was very depressed and shocked at the same time. I didn't want to see anyone because I had a lot of things going on in my head, and I didn't want to talk. After I had the abortion, the nurse asked me if I wanted to bury the baby. I told her no, because I thought that the baby was still three months, but she told me that he was 4.5 months. I was shocked, and I called my husband who argued with them that based on our calculations and

> ultrasound done at the clinic and in the hospital, the age of the baby was 3 months. The doctor said that I was almost in the fifth month. At that moment, we decided to bury him, so we asked the Imam how to do this. He said the body should stay at hospital until a representative from the Mosque came and picked it up. This process costs $2000. My husband was unemployed at that time and we were not prepared for this.

For this woman, the delay in having an abortion created frustration and anger as she felt ignored by health care providers. She also felt disrespected and discriminated against because of her religion, resulting in distrust of the Canadian healthcare system.

Another woman from the Middle East described what she perceived as inadequate care, lack of knowledge, and negligence of health care providers. This woman who is a doctoral student in nursing described her pregnancy and encounters with the health care system as disappointing. She had high blood pressure, edema, and carpal tunnel syndrome during pregnancy. From her perspective, her doctor did not provide the care she requested which caused her health to deteriorate, even after birth. When her blood pressure got dangerously high and her kidney functions were deteriorating, she was referred to the hospital by the midwife and not by the doctor, despite the fact that she knew that she needed the admission. She explained:

> If you have edema in your legs or your lower or upper limbs, it has to be checked to know the degree of edema, but my doctor didn't check it. So when I started to be worried about myself and my baby, I told her "I think I'm not gaining weight, my tummy is not getting bigger, I feel myself, I know my body very well". At this time, I felt that I was deteriorating, my blood pressure was going high, the edema was going worse, I had no sleep, severe pain, a lot of stressful issues because I am a hypertensive, pregnant mother who is a student and has a lot of stuff going on. So when I felt my tummy wasn't getting bigger, I told her that I felt my tummy was very small compared to the standard, so she told me "ok, I will send you to the ultrasound to check the baby and the amount of amniotic fluids or water". I have been

> checked and the water around the baby was diminished but she let me go home without any instructions or without any care, just saying "go and try to sleep". When I told her I can't sleep because of the pain she told me "try to sleep, try to make like a cold compresses or hot compresses, and try to sleep with your hand up high". I was complaining, complaining and no one heard me, no one listened. I felt mistreated, I felt humiliated because my voice was ignored. I wasn't pretending, I was very sick at this time with a lot of issues, a lot of troubles. And I am a mother and I have to study and do the housework. I have a lot of things I am responsible for and I was not able to do anything.

Although the complications that occurred with this woman may happen with any other woman, miscommunication and disrespect of women's requests were evident. She was denied an opportunity to participate as an equal partner in decisions affecting her health, leaving her dissatisfied, disempowered, and distrustful.

Several women complained about the difficulties accessing family doctors when they first arrived in Canada and, if the doctors are available, the time spent with doctors was insufficient to answer their questions and to get the information they needed. Also, many lacked information about OHIP and UHIP coverage and did not understand the referral system. In some instances, women were referred to doctors who could not take more patients. In their home countries, where health care was not publicized, they were able to choose the doctor; in Canada, they felt that they had no control from whom they would receive care.

Supportive Relationships in the Women's Lives

The presence of supportive relationships was identified as a significant facilitator for healthy childbirth and motherhood experiences. When the women left their families behind and moved to Canada, their partners were the main support available for them. Most women reported that their partners were helpful. As described by a woman from Asia:

> I think my husband is kind, and he helps me a lot. He makes lunch and dessert and sometimes he prepares food for me and my babies. When I'm blue, he makes me happy. He'll say some joke although he's very busy. He thinks and cares about me and does a lot of things for me. He's in my heart the best husband.

Women also mentioned the support they received from their partners in the labour and delivery room. Most women liked the presence of their partners and felt supported by the hospital policy that allowed this to happen. In some of their home countries, partners were not allowed to attend the birth. However, mothers were often allowed and this was culturally acceptable for them. A woman described the presence of her husband in the delivery room, stating that:

> I was glad that my husband was allowed to come to the surgery room and he was beside me when I had the cesarean surgery, it was very good. In my country they don't allow any people, any relatives or family members to come in the surgery room. You are just alone with the doctors and the nurses.

It appears the women's partners provided the support needed during delivery to fill the void created by absence of the extended family. Partners provided emotional and material support to their wives to help them manage the pain of childbirth and to help them when they would get distressed.

Most women maintained connections with their extended families in their home countries and tried to establish new relationships with friends in Canada. The social support they received from their families and friends facilitated coping with stress and provided access to information and advice. Some women relied on friends from the same ethno-cultural communities to compensate for the absence of extended families. Accompanying the women during birth, taking care of their other children, preparing food, and cleaning the house were activities offered from friends that the women found helpful. The mother of a 6-month-old baby stated that:

> If I need information, I search on the internet. If I need support, I talk to my friends here or in my country. I used to contact my friends and they are really supportive. I also contact my parents and my family. There is a lot of chatting and video conversation. We do video conversation through the internet so that we can express our concerns to each other. I used to feel very relaxed after any conversation with my friends or my parents or relatives.

Most of the women interacted primarily with others from the same ethnic and religious background and few had Canadian friends. They relied on friends for taking care of their children when they delivered. A 27 - year- old woman said:

> First I tried at this time to have a lot of friends from my same culture, like Arabic friends and they were very good support for me. I left my first child with a friend while I was in the hospital. To have a lot of friends from the same country or the same ethnic group is a lot of support for you because you share a lot of experiences with them. You know what problems they faced and you learn from them.

The women also acknowledged the social support and the financial assistance provided by the government and by community services. They compared the benefits of migrating to Canada with living in their countries of origin. Most women appreciated the financial assistance provided to them and their children by the Canadian government; in particular, they mentioned the child benefit tax, free education, safety precautions for babies, food banks, and free health services. One woman explained the support she received, and affirmed:

> This country is quite safe and secure. All people can afford living here. No one is extremely poor. There are no differences between people economically. All newcomers can afford living here. The government helps so the stress of affording family and the unhealthy social relationships is less than in our home countries. In relation to my children, they could happily live their childhood, have the space to increase their awareness and express themselves. I will not encourage them to carry heavy backpacks and worry about exams. As you know in our country, the child begins worrying about exams in grade one. I can't

> say that I left my home country and my family for nothing here. I think it is good here. There is no need for saving; when my children get older they can apply for OSAP to continue their higher education. In relation to health issues, we have insurance. When you are in financial crisis, the government helps. I hope that our countries will improve these aspects; the people there are dying of poverty!

Refugee women described the material and non-material support they received when they first arrived in Canada as helpful. They were satisfied with the financial aid they received from Ontario Works, and other aid from settlement organizations and social workers. Another woman described the support she received, saying:

> When we first arrived to Canada, we stayed 15 days in a center that helps immigrants. The staff were good; they provided breakfast, lunch, and dinner. I got my medical check-up there. And they provided us blankets and told us where to go for childcare. Generally it was good; they helped us. Also, the government of Canada provided us with money that helped to buy food and pay the rent. The living standard is higher in Canada than Nepal. I met a social worker in the hospital who gave me some clothing and a car seat for the baby.

Refugee women mentioned that they had fewer financial resources during settlement than immigrants. Although these women and their partners received financial assistance from the government, they felt that the amount of money provided was barely sufficient to cover their basic needs. A woman explained:

> I am receiving economic support from Ontario Works and it's excellent because I can pay my rent and I can get food and it's good. The health services are excellent too. The child benefit is in process. Really, it's not too much money monthly, we receive $1060 but we have to save some money and organize the expenses. It's difficult because sometimes I see a shirt, a blouse, and jeans I would like to buy but I can't because the money is only sufficient for the basic needs.

As these comments demonstrate, the women shared different perspectives about the financial assistance received from the government of Canada. Women who were grateful for income support and viewed it as sufficient to their needs tended to be members of small, middle-class families who had come from countries with low standards of living. In contrast, the women who complained that the financial assistance was inadequate came predominantly from countries where the standard of living is high.

Rethinking Roles, Motherhood and the Marital Relationship

All women in this study were asked about the nature of their relationships with their partners after the birth of their child. Women reported varied perspectives influenced by migration circumstances. While most women explained that their marital relationships became closer and more intimate, some women described conflict and stress inside their families.

Most women described their relationships with their partners as intimate and increasingly based on equality and respect, which they attributed to the experience of migration as well as the anticipation of having a child. They described feeling closer and more attached to their partners, and they received help from their partners with caring for their babies. They attributed this, in part, to the lack of extended family that caused them to rely on each other for support. Women and their partners shared the responsibility of making decisions related to their families. They also shared money equally and showed respect for each other. A 31-year-old housewife woman said:

> Our relationship becomes better and more intimate. When he was working in Saudi Arabia, he spent long time working at morning and afternoon that I can't see him. Also some of his time is going for friends. For me I was surrounded by my extended family and friends. Here, I can't go anywhere but home so I and my husband spend more time together. I am for him and he is for me, and both of us for our children. When he worked here, he still can afford time for us.

Women also explained that their partners behaved in a more mature and responsible manner after having a new baby in Canada. The birth of a new baby motivated them to work and act for the best of their families. Partners supported their wives throughout the pregnancy, childbirth, and postpartum, spent more time with their wives and children, shared decisions in child- rearing, and supported them emotionally and materially. One woman said:

> You know you do get so stuck in "baby, baby, baby", and I often say to my husband, "Can I just go grocery shopping without them?" And he's great because he will say, "you can go and let me take the kids". He will take them for a walk and I can have a sleep. So he does support me in that way. I have girl's night out with my friends and my husband looks after the kids and I go in the evening and we go out for coffee or whatever. And so that's nice, it's very nice. It's just maybe 3 hours of being with girls.

It appears from women's comments that a transformation happened in their marital relationships after giving birth and after migration. This shift could be attributed to the presence of babies who need love and care and to the changes that occurred in their daily routines and personal responsibilities. The coming of a new baby strengthened family ties and stabilized marital relationships as the focus of care and love is now shifted from parents to their babies. In addition, after the coming of a new baby, the women and their partners are working more to solve the conflicts to keep the family united and to have a healthy happy environment to raise children. The lack of extended family support also pushed partners to compensate their wives and children and spend more time with them.

The construct of gender was understood by newcomer women as a division of roles by which women and men are responsible for certain things. In the new context, women and their partners adopted family roles that were different from their traditional roles, and that sometimes contributed to conflict within the family. A 39-year-old woman provided an example:

> You know when we were in our home country; he was working all the time. He had work in the morning, afternoon, and at night. He was doing a lot and he was really satisfied with this. He was very busy with his work and he was feeling good about himself because he was doing what he likes to do. Here he's at home most of the time. He goes outside the home to do shopping, to see some friends, you know. He misses a big part of his life and his personality because he sees himself in his work. He was a very sociable person in our home country, back home. So here he can't find this kind of, you know, social life that he missed. Staying at home most of the time made him observant to anything inside the home. Sometimes he fights with me.

Some women reported that their partners resisted new roles of caring for children and helping with housework. They said that their partners expressed frustration and felt that they were no longer being given the respect they had received in their country of origin. This added to the women's responsibilities of taking care of their children and working outside the home and caused them more stress. One woman who is a student and works outside the home stated:

> Actually culturally the husband doesn't do housework and doesn't cook. So when we first came here he was carrying his thoughts and traditions with him so he was not supportive. Like even bathing the baby or changing diaper- he was not doing any of these things while I was home. He just did that when I was out sometimes. Now he's better in these issues, but sometimes he sticks with his traditions. I used to go home not finding anything to eat. So I had to go back home after the course to prepare food, take care of the kids, and doing my readings and homework.

The inability of partners to find jobs was also an important factor that influenced the marital relationship. According to the women, this caused their partners to question themselves, and led them to exert control over their wives. One 39-year-old mother of three children said:

> Sometimes I feel that he's distressed because he's not working, not studying, and not doing anything outside the home. And because he's not used to that situation, because he was working in my home country and doing his masters he always had something to do. While now he's just taking care of the kids and he's not considering that as the social normal role of the husband. So sometimes he becomes distressed, and this for sure will affect me, our relationship, my study, and my whole life.

Most women reported that they did not experience physical violence from their partners, but they acknowledged that their husbands would take out the stress they experienced on them. Intimate partner violence was not identified as a major issue through the course of this study but a few women reported receiving unfair treatment. Some of the women considered this acceptable to a degree. One refugee woman whose partner had a disability, however, reported intimate partner violence including, psychological and physical abuse. She described her experience of abuse, saying:

> Our relationship is almost the same but, he became more nervous after we migrated. I don't know, maybe because he is alone or under stress. Sometimes he shouts and yells at me for no reason. Sometimes when he yells at me without a reason I feel very bad. I don't like this because I do everything, taking care of the children, going to the bank to withdraw or deposit money, shopping (because he doesn't do it), housework, and he reflects his bad feelings on me. I don't want to talk about this with him because he will think that I am sick of him and that I don't want him anymore. Yes, I feel bored talking with him several times about this. When he gets very angry, he may beat me and yell at me. I am suffering. I feel bad. When he apologizes I forgive him because he was angry and I want to keep my family.

Women identified a number of factors that influenced the changes that occurred in their marital relationship. These factors included culturally-based perceptions of gender roles, lack of financial resources, health status, unemployment, and social isolation. Each factor influenced the women’s marital relationship

differently. For example, the woman in the previous example who reported that the violence heightened after migrating to Canada attributed this to increased stress levels, a health condition, and financial needs. When this woman was asked if she needed help, she refused it because she felt she could manage with her partner, and she wanted him to stay because he is the father of her children.

Summary

Although the women in this study embraced different meanings of motherhood and childbirth, most of them agreed that it was happy, unforgettable, and worth the many sacrifices. They viewed motherhood as a way to meet social and religious expectations, and welcomed this phase of life despite fears of childbirth in a different environment and the difficulties of raising children in a new country. As well, the women identified some challenges they faced in becoming mothers. The lack of social and emotional support, parent-child conflict, competing roles, and economic distress added to the women's hardship. The women in this study perceived culture as a set of clearly prescribed practices that they wanted their children to follow. In addition, their conceptions of 'right' and 'wrong' in raising children were influenced more by the desire to retain the cultural values and traditions and less by the fluid nature of culture.

The women also mobilized their strengths and employed a number of strategies to deal with the stress of the changes associated with becoming a mother in Canada. Among the strategies they used were preserving the good mother identity, using hope, patience and acceptance, adopting health promoting practices, using religion as catalyst for coping, and adjusting their parenting style. The women expressed mixed opinions and experiences about the care they received from the health care system in Canada. Their stories were varied according to their health statuses and birth outcomes. Although some of these stories were similar to those of women without newcomer status, being in a different health care environment for the first time and interacting with doctors and nurses who speak a different language caused women added stress.

Although the women identified different sources of support, with the absence of extended family support, this was not sufficient to meet their needs. In addition, they identified factors which hindered women from receiving needed social support. Becoming a mother in a new country influenced women's marital relationships. The findings indicated that most women and their partners accepted for the most part their new roles and responsibilities, and adapted accordingly. While most women described how their marital relationship became closer and more intimate, one woman reported the occurrence of conflict, violence, and stress inside her family.

Chapter Five

Discussion, Implications, and Conclusion

Discussion

This study focused on an examination of newcomer women's experiences during motherhood and childbirth, the challenges that newcomer women face during motherhood and childbirth, the sources of strength and resilience, and newcomer women's abilities to negotiate relationships with the health care system and social networks. In this chapter, the findings presented in Chapter 4 will be discussed. Throughout the chapter, findings will be discussed in relation to knowledge in the field, with particular attention to how this research extends current understandings and contributes to new knowledge. This discussion will be followed by a presentation of the implications of this research for nursing research, practice, education, and policy. Limitations of the study will be described and concluding reflections regarding this research will be shared.

Perspectives about Motherhood

Several perspectives concerning motherhood emerged from the stories of newcomer women. As Liamputtong and Naksook (2003) argue, the meanings of motherhood are multifaceted, and the women involved in this study had varying perspectives on what motherhood means. However, a common thread linking these diverse perspectives was the belief that motherhood is a source of happiness and joy. The women all considered motherhood as a fulfillment of their essence as women, and additionally derived great happiness from the time they were able to spend with their children. Meanings of motherhood suggested by the women are consistent with the feminist perspective that motherhood does not undermine women, but rather honours them (Brown & De Casanova, 2009; Brown, 2010). In addition, on a purely pragmatic basis, motherhood was seen as carrying a twofold advantage; in addition to ensuring the continuity of the family line and cultural heritage, the presence of offspring also suggests a means of financial and emotional security in old age. For all these reasons, the women claimed to see their children as divine blessings, and expressed the intention to raise their children to

be good and productive citizens. On the other hand, implicit in women's accounts is the idea that women who don't have children, either due to choice or circumstance, are not fulfilling their expected roles. While this impression might be adopted by many mothers, it could unjustly marginalize women who are not willing to have children or are facing infertility.

The religious connection to motherhood is not to be underestimated; if children are configured as gifts bestowed by God, then the proper upbringing of children becomes a spiritual necessity as well as an ethical responsibility. Another factor to be considered is the fact that every society and culture creates its own norms concerning maternity and the role of the mother. It is undeniable that the strong love most women feel for their children derives from a powerful biological instinct. However, it is equally beyond question that the way in which motherhood has traditionally been construed as a cornerstone of both the individual family unit and the more comprehensive structure of society means that the bond between woman and child is at least partially a learned feeling that results from a close relationship according to specific norms and values. The manner in which successful parenting is configured is equally a socialized phenomenon; aside from the natural and fundamental desire to provide for their children as best they could, the women also felt most successful and confident when they were able to conform to social expectations of their maternal roles.

Still, it should be understood that motherhood raises significant challenges for newcomer women. Some women expressed practical concerns that the entrance of children into their lives would lead to increased sacrifices both financial and emotional, and were consequently worried as well as excited about the prospect of becoming mothers. A great deal of psychological preparation is required for the advent of an addition to any family. Furthermore, there is an inevitable redefinition of one's relationship with both parents and partners once the decision to have a child is made. The negotiation and planning of child care and work responsibilities is also an essential consideration, necessitating thorough re-evaluation of one's own identity in light of the assumption of such significant changes to one's lifestyle, priorities, and even one's body. It should therefore be no surprise

that a small handful of women expressed the opinion that motherhood entails sacrificing one's own needs for the good of one's children. More interesting though is how the overwhelming majority of women acknowledged that while the sacrifices attendant to having children would be significant and often strenuous, the simple joy of being a mother rendered the unavoidable challenges worthwhile. McMahon (1995) provocatively suggests that women develop 'multiple identities' through the act of becoming a mother, and raising their children in a new country. McMahon's suggestion is supported by how the women in this study perceived themselves in a multitude of ways: as mothers, wives, newcomers, workers, students, and so forth. This understanding is informed by the theory of Intersectionality that has guided this study. After becoming mothers, women reported feeling dramatic shifts in their identities and priorities; this could be explained by the great surge of profound maternal love that caused the women to give priority to their children over themselves. The massive responsibilities of motherhood understandably lead to profound changes in an individual on various levels; motherhood takes precedence and other concerns are gradually pushed aside, or at least consigned to a position of lesser importance.

The actual process of migration to a new country has profound effects on women's perceptions of motherhood (Parrado & Flippen, 2005). Factors such as social support, sources of income, changes in social status, the demands of learning a new language, the circumstances unique to each specific instance of migration, the number of children present in a given family, and pre-migration experiences shaped each woman's personal narrative. The women most likely to perceive motherhood as a mode of self-sacrifice and endless worry tended to be students or housewives living with their children alone; the separation from their extended families resulted in heightened stress due to anxiety, and the intensified responsibilities related to raising children without the assistance of relatives and friends. The complex balancing act demanded of these women during periods of migration/ resettlement transition is essential to consider, and many of them endured grave

difficulties in their efforts to manage and balance their maternal responsibilities with their roles as wives, workers, and students.

The findings also suggest that some women felt deprived of certain economic and educational benefits as a result of the responsibilities and burdens attached to the raising of children. Consistent with findings presented by Hewett (2009) and Vincent and colleagues (2004), many newcomer women reported the conflict between a mother's enjoyment of her children and wanting to be with them and their feelings of restrictions, entrapment, and loss of identity because of motherhood responsibilities. Some women described motherhood as an impediment to their personal growth and self-agency, and worried that they would miss the opportunity to further their education and establish careers because of the demands of parenting. Women also reported that they were unable to improve their English by attending ESL classes simply due to the lack of time; with the responsibilities of raising children and running a household, something as necessary as educating oneself in the language of an adopted homeland came to be seen as a luxury.

Meanings of Childbirth

Women give birth within a socioeconomic context and political environments which varied widely, but for all women, giving birth was a powerful experience. They described their attitudes toward, perceptions of, and the meanings of childbirth, and spoke of childbirth as an unforgettable moment, a happy and rewarding experience. At the same time, they shared paradoxical feelings of immense love and the tremendous physical pain accompanying the birth of a child. There is also a strong sense of the spiritual dimensions of giving birth as filtered through religious and cultural contexts, similar to findings reported by Callister (2006) and Semenic, Callister and Feldman (2004). Giving birth was configured as a difficult yet empowering experience. Part of this can doubtless be explained by the necessity of mastering the immense pain of labour, which is in turn configured as an integral part of a self-actualizing experience. In addition, the experience of seeing the baby for the first time was consistently described as a very emotional event, the intensity of the experience being

augmented by the external reality of the fully formed child, previously seen as only a blurry image of a fetus from a sonogram.

Childbirth was described by some women as an uncomfortable experience because of the pain, the emotional fluctuations surrounding the process, and the fear of potential complications during labour. Literature indicated that mothers who are not newcomers reported the same concerns (Baker, Ferguson, Roach & Dawson, 2001; Jung Hee, 2010; Kartchner & Callister, 2003; Saisto & Halmesmäki, 2003). For example, in a cross-sectional descriptive survey of six hundred and fifty English-speaking nulliparous and multiparous women in British Columbia, between 35 and 39 weeks gestation, Hall and others (2009) found that twenty-five percent of women reported high levels of childbirth fear and 20.6% reported sleeping less than 6 hours per night. Childbirth fear, fatigue, sleep deprivation, and anxiety were positively correlated. Women with high childbirth fear were more likely to have more daily stressors, anxiety, and fatigue, as well as less help (Hall, Hauck, Carty, Hutton, Fenwick & Stoll, 2009). For newcomer women who were interacting with the Canadian health care system for the first time without a fluent grasp of the English language, these concerns were potentially heightened. Feelings of pain, fear, and powerlessness during childbirth led women to express uncomfortable feelings because of their worries about their babies and their health. The women who suffered complications during labour or in the postpartum phase described their experiences of childbirth as unsatisfactory, and different from their romanticized visions of the 'sacred' act of giving birth; this dissatisfaction was due primarily to the negative and sometimes permanent impact on their health as a result of inadequate medical care and possibly to their social isolation, limited finances, and limited English abilities.

The Challenges to Motherhood in the Aftermath of Migration

Women faced many challenges when they became mothers. Social support is identified in the literature as having an important effect on an individual's ability to cope with the stress that inevitably ensues from the profound lifestyle changes that arise from becoming a mother (Parrado & Flippen, 2005; Ryan, 2007). This is

consistent with what the study participants shared about the necessity of social support**.** The presence of family and friends assisted greatly with the demands of motherhood, and decreased the significant pressure the responsibilities of parenthood placed on the new mothers and their partners. In their native countries, the women described childrearing as a duty shared among members of an extensive social support network including extended family as well as friends and neighbours (Cheung, 2002; Liamputtong & Naksook, 2003). However, as recent and often isolated newcomers, the women in this study reported having to shoulder the burdens of motherhood almost single-handedly. Similar findings have been reported by other scholars (Kim, Choi & Ryu, 2010; Liamputtong & Naksook, 2003; Liamputttong, 2006). Although there is some evidence that social isolation and feelings of loneliness are also prevalent for women in Western societies (Choi, Henshaw, Baker & Tree, 2005; McDermott & Graham, 2005; Warren, 2005), the isolation suffered by newcomer women may be more intense due to the intersecting influences of an unfamiliar health care system, poverty, difficulty in language, and changing gender roles and expectations. Moreover, there is some evidence that many Canadians harbor negative attitudes toward newcomers and racialized persons of colour (Esses, Dovidio & Hodson, 2003). Social isolation was particularly evident if the women's partners had educational or employment obligations, or if they held the patriarchal view that the rearing of children is primarily a female responsibility. In Kim, Choi and Ryu's correlational study (2010) with 165 immigrant women in Korea, social support from family members and friends and prenatal-care practices were positively correlated, and stress was negatively correlated with the lack of both prenatal-care practices and social support. In other words, newcomer mothers' feelings of loneliness, stress, and isolation could effectively be reduced by appropriate support systems.

In order to understand the influence of social support on women's experiences of motherhood and childbirth, one must consider the socioeconomic context of women's lives as newcomers to a new culture. Women who lacked economic resources and friends in Canada (e.g. refugees) were unable to send their older children to day-cares during childbirth; therefore, they experienced labour and childbirth without their partners.

In addition, the high cost of day care, the limited number of openings, and the shortage of daycare centers for infants who are less than three months contributed negatively to women's perspectives. In addition, some women with health conditions, or with partners and children with health conditions, were unable to take the rest they deserved and needed postpartum because they had to take care of their dependents. In contrast, in their native countries, there is a vast network of family and friends to help lessen their burdens considerably, and allow the new mothers the luxury of sufficient time to recover from the emotional and physical strains of pregnancy and childbirth.

On the other hand, there are intersecting factors influencing the support the women received from community services in their new adopted homelands. Difficulties with the English language made it extremely challenging for women to perform their motherhood responsibilities properly. The need to communicate is crucial during pregnancy, childbirth, and the formative years of a child's life; lack of facility with the English language made it extremely difficult for many newcomer women to navigate the health, education, and social systems. Therefore, it is to be expected that they would try to establish relationships with friends fluent in the same languages.

Conflict associated with children has been described as one of the challenges newcomer women face. Women in this study had very strong feelings about preserving their own traditions and native languages. Despite this, some women were sufficiently pragmatic to acknowledge with some regret that such a goal might not be realistic after migration to Canada because of the unavoidable interaction that happens when placed in the context of a new culture. While the children of newcomers naturally adopted many ideas and lifestyle choices that conflicted with the cultural norms of their places of ethnic origin, the parents often vigorously resisted these changes. This highly charged opposition between first generation immigrants and their second generation offspring is consistently mentioned in the literature (Cheung, 2002; Liamputtong & Naksook, 2003; Parrado & Flippen, 2005) as a massive hurdle to the preservation of the norms and traditions treasured by the

former group. Many women reported a strong resistance on the part of their children regarding their attempts to educate them about their ethnic traditions, languages, beliefs and customs. The women expressed uneasiness about arguments over emerging cultural differences between themselves and their children. The difficulty could be explained by the women's perceptions of parenting, freedom of choice, and parent-children relationships as filtered through the lens of their native cultures. Some women in this study adopted authoritative parenting styles and viewed children as dependent, passive, and unable to make right decisions due to their youth, a stance which is different from that of some Canadian schools and media in the North American social system at large that encourages autonomous and independent behaviour from youth (Popadiuk&Arthur, 2004).

To understand women's perspectives in relation to parenting styles, one should understand how they perceived and defined the very notion of culture. From a critical cultural perspective, Browne and Varcoe (2009) understand culture as "a relational aspect of ourselves that shifts and changes over time depending on our history, social context, past experiences, gender, professional identity, and so on" (P.36). Most women in this study perceived culture as "static and rigid practices with boundary." This was evident in women's descriptions about "their own culture" and "the Canadian culture." Most women presented culture as a set of values and beliefs that are static, taken for granted, and not questionable. This perspective ignores that cultural beliefs and norms can change and evolve with time. Simply consider how many of the women in the study configured their homes as private areas in which to maintain and practice their native languages, customs, norms, habits, and religion. Women explained that they wanted their children to adopt some of these practices such as eating healthy foods and furthering their education, but that they did not want them to engage in what they perceived as 'Western' sexual freedom; the decision-making process related to the proper age and context for starting sexual activity and other important matters was seen by the women interviewed as a matter for parents to decide. Many women were confused about how to accomplish this goal, and how to respond to their children when the latter demanded rights and privileges that were not acceptable within their own moral codes

as shaped by their native cultures. Most women in this study felt stressed when they were asked challenging questions by their children that they couldn't answer, questions that frequently resulted from the clash between two vastly different cultures. As examples, some Muslim women described the challenge of explaining to their children the importance of wearing a hijab in contrast to the more casual dress of their non-Muslim Canadian friends, the refusal to celebrate Christmas and other traditional Western holidays, and the importance of refraining from the consumption of pork products.

The strong influence of the media was continually singled out as a factor that made the task of preserving the native culture doubly difficult; film, television, print media, popular music, advertising, and social networking all present captivating images calculated to generate consumerist fantasies of a glamorous North American lifestyle completely at odds with the cultures the women in the study were so determined to extend to their children. Women reported that it would be a less draining task if they were in their countries of origin where the vastly different cultural environment would render the majority of such questions and societal clashes null and void, and where the presence of an extensive social network comprised of sympathetic family and friends would be present to provide valuable assistance in answering any difficult questions that might be posed by children as they grow and deepen in thoughtfulness and curiosity. However, very few women interviewed managed to provide suggestions on ways to balance the tensions created by the different traditions and norms. As well, very few women acknowledged the potentially counter-productive results of their attempts to deal with the issues at hand by radically isolating their own cultural beliefs from prevalent Canadian traditions; in doing so, they essentially deny the shifting nature of culture, and thus create a tense cultural dialectic that never attempts to reach synthesis. This is a crucial area for service providers and settlement workers to consider when educating newcomer women about the challenges of adjustment to life in a new country, and potential ways to ease the progress for their children who must straddle two worlds by virtue of their status as second generation immigrants.

Ambivalence about embracing new cultural practices while remaining loyal to the previous set of beliefs and practices of the country of origin was evident in the narratives told by the women. Collins (1994) states that motherhood takes place within "specific historical contexts framed by interlocking structures of race, class, and gender" (p.56). According to the principles of Intersectionality theory, this means that not all mothers nurture, protect, discipline, or socialize their children in similar ways. Some women in this study demonstrated a greater need to balance the tension between preserving their norms and traditions and the desire to feel connected to Canadian life. On the other hand, disadvantaged women from countries with a low standard of living typically expressed the view that the life in Canada was better for their children despite the potential cultural cost. These women believed that to stay in their countries of origin would be a profound disadvantage to their children in terms of quality of education and hence future employment opportunities, and saw their sacrifices both monetary and cultural as the ultimate gesture of parental love. Moving to Canada was effectively seen as a means of giving their children the chance to start a life with a much higher standard of living, similar ideas found by immigrant women in Sharma (2006) and Shirwadkar (2004).

Having different roles, in conjunction with economic distress, also played a significant part in shaping the experience of motherhood for the women involved in the study. McMahon (1995) astutely notes that "individual women experience motherhood in terms of their own situated but interactive relationship with their social world" (p.29). The majority of women involved in this study were from low income households, and this negatively impacted their experience of motherhood. Women discussed the negative toll that financial stress had on their relationships with both their children and their partners; some of the study participants paid a personal price attempting to balance work, study, and the demands of running a household. They expressed physical and emotional frustration due to factors such as loss of sleep and the absence of leisure time, as well as the pressure of attempting to transition seamlessly from student or employee to a loving mother. Consistent with the findings of several studies of immigrant populations (Anderson et al., 2010; Perreira, 2008; Ryan, 2007),

many women needed to work to meet their families' financial needs especially if their partners happened to be either unemployed or employed as low-ranking labourers making an inadequate salary to support their families. Added to this is the resistance of changing gender roles among immigrants. Some refugee women were receiving financial assistance from Ontario Works that barely covered their basic needs, while others failed to find employment at all despite their best efforts. Labour market opportunities for women and their partners were extremely limited. According to Statistic Canada (2006), newcomers who have been in Canada five years or less have the most difficulty integrating into the labour market. In 2006, the national unemployment rate for these immigrants was 11.5%, more than double the rate of 4.9% for the Canadian-born population. Two women profiled in this study were graduate students who had additional responsibilities as lecturers and research assistants; they candidly discussed the difficulties they had in meeting the needs of their children while juggling academic duties, and the strain of undertaking so many diverse jobs without adequate postpartum rest. They also expressed guilt about being unable to devote sufficient time to breastfeeding and playing with their children as a result of their busy schedules.

From a critical feminist perspective (Collins, 2000; Denzin, 2002; Kincheloe & McLaren, 2003), the decision of many females to seek employment as new mothers is not a choice made in isolation, but rather is shaped by the intersection between a wide range of social and personal factors. The availability of childcare, the option of flexible working hours, the attitudes and level of support provided by their partners, the presence of other sources of financial support from family or friends are all essential factors to consider (Ryan, 2007). Some women in this study were unable financially to afford childcare for their children because of their low income, lacked much needed support from their partners and extended families, had difficulties in language, and had strict working hours that left little recreational time to spend with their families. These external issues led many women to feel personally responsible for their less than ideal family lives; many expressed a profound worry that they were inadequate wives and mothers.

Mobilizing Strengths to Overcome Stresses of Motherhood

Resilience is defined as "a dynamic process wherein individuals display positive adaptation despite experiences of significant adversity or trauma" (Luthar& Cicchetti, 2000, p. 858). This study's findings suggest that newcomer women view their life changes after becoming mothers positively, and are often able to identify personal strengths and use active coping strategies despite limited resources. In addition, the study findings support the premise that newcomer women demonstrate abilities to deal with motherhood responsibilities in the context of their relocation and migration. Unlike other studies that focus on newcomer women's weaknesses (Chavez, 2007; De Souza 2004), this study reported many strengths and evidence of great resilience in the lives of female newcomers. Preserving the 'good mother' identity, using hope, patience and acceptance, adopting health promoting practices, using religion as a catalyst for coping, and adjusting parenting style characterized women's resilience and their ability to deal with the responsibilities of new motherhood**.**

Many women in this study reported taking great pride in their ability to be good mothers despite the changes that occurred in their lives. Preserving the good mother identity may be a key feature of women's resilience. Findings from qualitative studies (Liamputtong, 2006; Marshall, Godfrey & Renfrew, 2007) suggest that women often view motherhood as an event that made their lives considerably more significant; the responsibility of caring for a young, helpless being granted them a strong sense of purpose. It appears that maternal experiences and decisions stem mainly from a desire on the part of women to provide the best possible lives for their children. As well, it is significant that feelings of love and intimacy towards their children made the women in this research feel socially valued and recognized for their strength of character and principle. It is therefore unsurprising that the women wished to sustain this image as a means to support their own self-confidence. As McMahon (1995) points out, motherhood is an identity that can confer self-validation and social approval. The consensus of the accounts given by so many different women from diverse cultures and various social backgrounds illustrates that far from being a source of perceived disempowerment, many females felt that

motherhood provided them with maturity and the stamp of social legitimization. In the context of migration and despite their frequently limited resources, the women nevertheless felt empowered by motherhood; their ability to achieve a degree of mastery over their lives despite such obstacles was a fact from which they derived a feeling of power and self-actualization.

The sense of hope, patience, and acceptance the women expressed is another mark of their essential resilience. These characteristics cannot be underestimated when considering the ability of the women who participated in this research to cope with and surmount the massive responsibilities of motherhood, and more generally to manage a wide variety of challenges attendant with settling in a new country. Benzein and Saveman (1998) discussed the critical attributes of hope. In their analysis they found that future-orientation, positive expectation, intentionality, activity, realism, goal-setting, and inter-connectedness are the main attributes of hope. It appears that the women in this study demonstrated many of these attributes to their personal benefit. They consistently articulated that thinking about positive expectations, being realistic, and setting achievable goals could help them to overcome any problems they encountered. They acknowledged that as they were responsible at least in part for the dual decisions of migration and having birthed children, they should therefore deal with the consequences of their choices with the care. As previously stated, their desire for having children was in part motivated by the hopes of providing their offspring with excellent educational and career opportunities not available in their countries of origin; to see this wish fulfilled would naturally imply a comfortable retirement and the funds to enjoy the latter part of their lives free from financial worries. This would act in large part as compensation for the sacrifices necessary to establish a new life in Canada. With the decision to become mothers, the women in this study are effectively positing their maternal duties as the importance of their existence, the reality around which all their efforts to better themselves in a socioeconomic sense revolve; it is reasonable for the women to accept this new life free from regret, and to focus on their maternal responsibilities with a positive and optimistic attitude rather than attempt to resist and change the

fundamental dynamics of the mother/child bond. This proactive stance further suggests that motherhood need not be denied within feminism, as a great deal of strength, courage, and self-determination are necessary to build a new life from scratch in a new land.

Adopting health promotion practices is a critical indicator of women's resilience. Women in this study demonstrated knowledge about how to safeguard their own and their families' health. In particular, the women reported practicing exercises specifically designed for the strengthening of the postpartum body in addition to the mutually beneficial act of breastfeeding their babies. Women with older children also mentioned encouraging their children to maintain a healthy diet and to avoid North American cuisine such as fast food that contain little to no nutritional value. Marshall, Godfrey and Renfrew (2007) indicated that breastfeeding one's infant is an attribute of being a good mother. Women expressed positive attitudes toward breastfeeding and stated that they were willing to breastfeed any future children should they choose to conceive again. This attitude stems from their comprehensive knowledge about the positive impact of breastfeeding on their babies' health and on their own bodies, the lack of financial resources to afford formula, and the cultural preference for breast feeding. Women also described using many health promotion strategies such as sleeping, low impact exercise, meditation, and reading to cope with stress and improve their emotional status. It appears that these strategies were used to release some of the negative feelings women confessed to possessing as a result of stress.

Through these simple strategies, the women found an efficient means of comforting themselves on both a physical and a spiritual level; a common thread expressed by the women in the study was the belief that health promotion practices were crucial as they allowed them to manage and provide for their families with greater energy and focus. Our findings also suggest that newcomer women benefited from their religion practices during periods of difficulty, transition, and stress. Religion has been found to enhance one's sense of competence; the belief in a higher power (god) provided motivation for the women to raise their children

properly with a strong moral core (Thomas, 2001). As well, religious faith sustained the women through challenging periods of their lives. Given the challenges that many women experienced, the women who identified themselves as devoutly religious may have been among the most motivated to improve their lives, a factor that likely contributed to shaping the motherhood experience. Still, this is a subject that has been insufficiently examined. Relatively few studies have investigated religion as a coping strategy among communities of newcomers coping with the experience of motherhood for the first time (Steele, 2011; Storey, 2000; Thomas, 2001).

The ability to adjust styles of parenting is another indicator of women's resilience. Women acknowledged the need to find a balanced way to discipline and raise their children as a compromise to avoid pushing their children to maintain the cultural beliefs and traditions of their respective ethnicities. As with many studies that have discussed the cultural clash and conflict between immigrants generations (Cheung, 2002; Liamputtong & Naksook, 2003; Parrado & Flippen, 2005), this study also provides suggestions on ways to balance the tensions created by the different traditions and norms. Many of the women believed that it was impossible for their children to totally preserve their own cultural practices and norms while living in Canada. In response, they attempted to better understand Canadian culture, showed increased willingness to negotiate with their children, asked for advice from schools and friends, and used strategies such as warmth, acceptance, and respect to encourage their children to express their ideas and wishes. The latter was especially important as it provided them with firsthand information about life in Canada as a youth straddling two highly different cultures, and allowed for an open dialogue to facilitate the growth and decision making of both parent and child.

The Successes and Challenges of Negotiating the Health Care System

Newcomer women's interaction with the health care system during pregnancy, childbirth, and the initial stages of motherhood were complex, with instances of great success and failures. Similar to the findings of Small et al (2002) and Tsianakas and Liamputtong (2002), some women saw healthcare and the quality of

nursing in Canada as being substantially better than the services available in their countries of origin, not only for themselves but also for their babies. Most of the participants reported that Canadian health care was safe, respectful, kind, and supportive. However, it must be noted that this highly positive assessment is most pronounced among poor refugee women who were formerly residents of nations with low standards of living. These women saw Canada as providing them with free high quality healthcare services which doubtless influenced their perspectives about the Canadian health system.

Women reported that nurses listened carefully to their concerns, explained issues in a detailed way, showed respect and understanding for their requests, and provided enough time for them to express their needs in less than fluent English. For instance, nurses showed understanding for women who requested to wear their Hijab in the labour room. Similar to the findings of a study conducted by Tsianakas and Liamputtong (2002), this study also revealed a female health care provider was offered to many women according to their requests. In addition, certain services women enjoyed in Canada were unavailable to them in their countries for origin. Examples include public health nurses who specialize in postpartum care, access to breast pumps, and the supportive environment for breastfeeding in malls and public places. Overall, the reasons for women's greater satisfaction with health care in Canada were attributed to the free services, the presence of translators, the quality of care, good communication, availability of high technology equipment, and the focus on education concerning breastfeeding, purple crying, vaccination, safety issues, and diet.

However, some women who came from countries with higher standards of living than Canada such as Dubai and Saudi Arabia and with the presence of private health services found numerous faults with the Canadian health care system, citing low quality of care, and insufficient attention to their needs by medical staff as their main criticisms, similarly to findings of previous research (Grewal, Bhagat &Balneaves, 2008; Wheatly et al, 2008). Women who suffered childbirth complications because of inappropriate and delayed care by health care providers were especially critical in their assessments of the Canadian healthcare system. Some women

viewed the health services as overly complicated and inferior in quality as compared to their home countries where they had the option of choosing their health care providers, and could change doctors when needed. The comparatively long waiting times for necessary procedures as well as the inability to receive care from medical professionals from the same culture were also factors that caused the women to negatively assess the Canadian healthcare system versus the systems of their respective countries of origin. Perceptions of Canadian physicians and nurses as unhelpful and emotionally indifferent played a major role in some women's dissatisfaction with their care in labour. Not feeling involved in decision-making and not knowing the physician prior to labour also significantly reduced women's overall satisfaction with their care. Although most of the stories shared about physicians were positive, there were some examples of miscommunication and disrespect. In one instance, a physician sent a woman home without any instruction or care despite the fact that the amniotic fluid surrounding her unborn child had diminished. Lack of knowledge and carelessness could explain this attitude by this physician. Our study findings also revealed that the Canadian health care system is not well prepared to deal with complicated cases. Lack of knowledge, experience, and staff shortage explain this result.

Obstacles in receiving appropriate care may be related to lack of communication between health care sectors, disrespect and ignorance for the women's cultural beliefs on the part of the healthcare providers, and lack of knowledge, negligence, and carelessness. Ahmad et al (2004), Fuller (2003), and Sword, Watt and Krueger (2006) shared similar results in their studies. Overall, the reasons for the low quality of women's care in this study were attributed to the lack of sufficient knowledge. Although physicians are not expected to know every detail about a case, they are still responsible for providing safe compassionate care for their patients. On principle, they should refer patients to a specialist when they are incapable of managing specific cases. The two women with complicated cases described their interaction with their doctors as unsatisfactory, and were concerned about the long-term impact of these interactions on their health. In a review of literature of 54 articles published 1990-2003 to explore the potential factors which may restrict ethnic minority patients from using

health services and receiving proper care, Scheppers, Dongen, Dekker, Geertzen, and Dekker(2006) found that the lack of skills of services providers, the authoritative communication style, stereotypical attitudes, lack of knowledge, and orientation focusing on the immediate complaint alone are factors that lead to dissatisfaction with health services. Our study findings support the results of this study.

Among other obstacles, women identified having no family physician during the process of settling into a new home in a new country, the lack of continuity of care by the same physician, difficulties in language, the long time in getting referrals, long waiting lists, short interaction times with physicians, and bad food services in hospitals as adding to the difficulties they faced in receiving care. Some women explained that their understandable lack of fluency with the English language made them feel as though healthcare providers viewed them as being inferior in status to their Canadian patients. Although women used interpreters, they believed that if they could speak English with ease their needs would be met more appropriately. Some of these obstacles resulted from the structure of health services such as the referral system. Another reason could be attributed to cultural differences in women's expectations of care in Canada, variation in experiences among the newcomer population, ignorance about foreign cultures on the part of healthcare practitioners, and the difficulties hospitals experience in acknowledging and accommodating the traditional cultural practices surrounding the needs of newcomer women.

It is important to note that there is a wide range of health practices between individuals and within cultural communities. Heath care providers may not be able to address all newcomer women's needs without support from local networks, the public health sector, and local cultural organizations. Women face systematic and individual barriers as they navigate many institutions and organizations in search of proper healthcare. While it is important to reinforce the positive aspects of the health care system, it is also necessary to mention that not all aspects of pregnancy, childbirth, and postpartum can be properly addressed by the health care system as it currently stands.

Supportive Relationships in the Women's Lives

The presence of supportive relationships was found to be an important factor in the transition to the changes involved in becoming a mother as a newcomer. Women's perceptions of social support depended greatly on their past experiences in their countries of origin. They tended to define social support broadly, encompassing informal and formal sources of assistance.

Women identified different sources of support as coping mechanisms. The first source of support in women's lives post migration was their partners. The partners contributed practical support by making meals and taking care of children; giving emotional support for their wives during labour and postpartum; and providing financial support for their families. Support from their partners was very important for the women, especially with the absence of an extended family network to assist with the running of the household. Women felt very positive about their partners attending labour with them, and viewed this gesture as an empowering one that provided evidence of their value and importance. Although there is a movement toward the idea that partners should be more involved with children's care (Hadlley, 2001), women in this study felt thankful and grateful to their partners for the help they provided during the months of pregnancy, and the rigours of labour. The points raised imply that women involved in the study are committed to the traditional gender roles in which females are configured as primary caregivers to children, and men function within the family unit mainly as breadwinners, a finding supported by Abu-Ras (2007), Grzywacz et al., (2009), Latta and Goodman (2005), and Muftic and Bouffard (2008). Although women appreciated help from their partners in the household or in taking care of children, they sustained an irregular division of labour because they wanted to maintain the "good mother" myth. Some women stated a belief that female self-fulfilment involves not only having children, but investing themselves completely in the care of their offspring.

The second source of support was extended families. Overall, maintaining regular contacts with friends and families was positively associated with women's strength and adaptation with stressors. Regular contacts

with family members and friends were identified by the women as a central resource enabling them to reduce isolation, receive emotional support and information about childcare, and as a means of providing them with greater control and autonomy within their relationships. The presence of family or close friends in Canada provides companionship and enables newcomers to overcome many challenges associated with settlement. The third source of support was identified as friends from the same ethnic group. The women expressed the need for social support to ease their integration into a new community, to facilitate employment opportunities, and to have friends with which to share their problems, worries, and joys; building these networks had an incalculable effect on reducing the sense of stress that is inevitable with relocation to a different country. On the other hand, women found it hard to establish friendships with Canadians because of differences in cultural perceptions and preferences. The women's satisfaction with the financial assistance provided by Ontario Works and Child Benefit Tax was influenced by their living expenses and the standard of living in their home countries. Women who came from low standard of living countries in which any service provided is paid by them found the financial assistance as sufficient and good for their needs, while women who came from a higher standard of living found the assistance provided as not sufficient to their families' needs.

Rethinking Roles, Motherhood, and the Marital Relationship

Women reported varied perspectives about the nature of their relationships with their partners after the coming of the new baby. Migration circumstances also influenced women's perspectives. While most women described how their marital relationship became more intimate and close, some women reported the occurrence of conflict and stress inside their families. The findings indicated that most women and their partners accepted for the most part their new roles and responsibilities, and adapted accordingly. Many of the women discussed how moving to Canada actually increased their feelings of intimacy with their partners. This is contrary to the findings of many studies in that the migration experience may heighten the exposure of women to marital conflict and intimate partner violence (Brownridge & Halli, 2002; Erez, Adelman & Gregory, 2009; Hyman et

al., 2006). According to Berry (1995), newcomer women and their partners adjust to the new culture by working actively to create a balance between old ways and new ways of living. Consistent with our findings, the lack of extended family caused women to rely more on their partners for support, thus strengthening the bond between two individuals both struggling to adapt to a new culture. Women also explained that their partners felt more mature and responsible with the advent of paternal duties. There are several explanations for these findings. Living in isolated circumstances far from their country of origin makes the male partner the main person responsible for the safety and the living expenses of the family. The lack of extended family support also forces the male partners to shoulder greater practical burdens, something that paradoxically increased their confidence in themselves as both providers and men, especially if they could fulfill their roles with adequate employment. As well, the new role of fatherhood encouraged the men to take more seriously their obligations to their wives and children.

According to Berry (1995), women who reported negative changes in their marital relationships consistently noted that their partners resisted the attempts to adapt to a new cultural context, and often became abusive as a result of their failure to establish themselves in Canada. Our results indicated that the woman's partner who is unemployed, had a health condition, and was emotionally distressed may be engaged in physical and verbal abuse against his wife. Underemployment, the negative psychological influences of his health condition, and low income may cause stress to this newcomer family. Another explanation for marital conflict is the location of the husband and the wife in a different understanding of gender roles. When the partner is strongly tied to the traditional division of gender roles, it is to be expected that the he will have a conflict with his wife. In the case where the woman was a victim of abuse by her partner, differing viewpoints stemming from the aforementioned gender constructs were commonly given as a primary trigger for debate, with the man frequently citing patriarchal models of behaviour as justification for both his abusive action and the position he assumed in the debate. This explanation is supported by the observation of Guruge, Khanlou and Gastaldo

(2010) that women's conceptualization of the production of intimate male partner violence in the post-migration context involved gender inequity in the marital institution, changes in social networks and supports, and changes in socioeconomic status and privilege. This issue was especially stressful for this woman who suffered from social isolation, low income, and was pursuing an education in English. Along with the difficulties attendant with both low income, family conflict, and settlement in a new country was an especially painful and unnecessary source of strain.

Summary of Discussion and Potential for Change

In this research study, there has been a critical examination of the underlying ideologies and social structures that contribute to the oppression of newcomer women who became mothers. The discussion in this chapter has highlighted a variety of social structures and processes that impact women's abilities to experience a successful transition to motherhood in a new context and to negotiate relationships with their families, health care system and social networks. In addition to describing some the meanings of motherhood and childbirth experiences, the discussion of the findings also has presented many challenges for women that shaped these meanings. In particular, the lack of social and emotional support, cultural differences and misunderstandings, parent-child conflict, and competing roles and economic distress have implications for service providers, nurses and settlement workers to consider when supporting and educating newcomer women about postpartum health, the challenges of adjustment to life in a new country, and potential ways to ease the process of parenting their children. In addition, women's experiences with the health care system challenge the prevailing assumption that postpartum women share the same needs regardless of their migration status. Moreover, these findings highlight the need to take into consideration the socio-political and economic context of women's lives when planning and providing care for this population. In addition, findings from a critical examination of the strategies women used to cope with the stress of motherhood challenge the stereotypes that depict newcomer women as weak and passive. Finally, the results also indicated that the birth of a new baby after migration to Canada often increased

women's feelings of intimacy with their partners. This is contrary to the findings of many studies that the migration experience heightens the exposure of women to marital conflict and intimate partner violence (Brownridge & Halli, 2002; Erez, Adelman & Gregory, 2009; Hyman et al., 2006).

In this study, I used an active dialogue with women to identify the socio-political processes and contextual factors that made women think and behave in particular ways. I paid extra attention to the underlying biases and assumptions. This helped me to be more conscious about the issues discussed without being judgmental and victim blaming. Initiating change is a primary aim of critical feminist research (Carroll, 2004; Fontana, 2004). The potential for emancipation and social change is ongoing and a long process. Therefore, the type of change that occurred in this study pertains to the way of thinking. Women had the opportunity and the space to reflect on their motherhood and childbirth experiences in a positive environment with some flexibility to use their first language. Richardson (2000) defined reflexivity as the process of bringing to the consciousness some of the complex political ideological agendas hidden in our actions. I explicitly stated the assumptions underlying the study and reflected on my personal opinions and positionality in relation to issues that came up during the interviews. I encouraged women to reflect on themselves and on their social understandings, they named their realities, thereby potentially increasing their sense of agency and personal strength as they indirectly had the opportunity to help other women in similar conditions. The processes of dialogue, reflection and critique allowed women to discuss and critique the challenges they face during motherhood and childbirth. By presenting and publishing the findings to settlement organizations, health care system, and policy makers we hope to foster new understanding and possibilities for action and change among the service providers.

Strengths and Limitations of the Study

Few studies have focused solely on motherhood and childbirth experiences of newcomer women. This study has contributed valuable findings that begin to address the gap in knowledge regarding newcomer women in Canada and enhance effective appropriate practice. In particular, the focus on what motherhood and

childbirth mean to newcomer women, the challenges women face, and their interactions with the health care system when becoming mothers provide important information for nurses, physicians, other health care providers, educators, policy makers, and researchers to provide sensitive and safe services, make appropriate policies, and develop theoretical understandings of the concepts of motherhood and childbirth regarding this population. One of the strengths of this study is the focus not only on weaknesses and challenges but also on women's strengths when becoming mothers in a new country. Findings from this study extend understanding of the changes within marital relationships after the arrival of a new baby in a new country. In addition, this study includes both immigrants and refugees from various cultural and social backgrounds which reflect different accounts and meanings thereby providing enrich data.

Another strength of this study is the use of a critical feminist perspectives and Intersectionality theory as a guide. Because these approaches acknowledge the underlying ideologies and socio-political processes and structures that contribute to the oppression of newcomer women, they allowed for a beginning identification of these factors and contributed to a deeper understanding of the intersection of these factors to create oppression. In addition, using semi structured interviews in a safe and private setting, and providing opportunity to use their mother language allowed for more flexibility for women to express themselves.

Another strength of this study stems from the fact that I am from the same culture as some women who participated in this study. Being an "insider" provided me with an opportunity to better understand women's needs, their cultural practices, and the meanings they provided for their experiences. Being an "insider" also helped me to establish rapport with participants and to be engaged with them in discussions with fewer limitations and greater comfort.

A limitation of this study is that it was conducted in only two languages (English and Arabic) in which I was fluent; therefore the findings cannot be conclusive for all newcomer women who spoke other languages. Including more women using their first language would strengthen women's accounts and provide more diverse

perspectives on motherhood and childbirth experiences. Furthermore, women who participated in the study by using English were not sufficiently fluent enough so there were several gaps in understanding, requiring the use of more simple or alternative words to facilitate communication. In addition, translating the three interviews conducted in Arabic into English was a challenging and time consuming process because I sought to choose the words that most accurately reflected women's meanings, paying close attention to the cultural understandings and differences. One of the challenges I faced in writing my findings is to address what is unique about newcomer women's experiences compared to other women without immigration status, especially that I did not interview women who had not migrated, so it was difficult to tease some of this out. As well, the women were from predominantly low income groups, which may shape their accounts about their motherhood experiences and the challenges they faced. Being an "insider" may have contributed to a silencing of participants in discussions pertaining to politically or culturally sensitive issues such as IPV. There were also some difficulties in recruiting refugee women. The connection was established thorough a settlement organization. It took a long time for the settlement workers to communicate with refugee women and get their approval to participate. Including more refugee women would strengthen the diversity of newcomer women's perspectives about motherhood and childbirth and enrich the data.

Implications

One of the important goals of this study was to generate findings that could be used to inform nursing practice, education, research, and policy making with regards to newcomer women's experiences during the process of childbirth, and as new mothers in a new land.

Nursing Practice

With the migration of women worldwide occurring at increasing rates (Citizenship and Immigration Canada, 2008), it is vital for nurses to understand the influence of migration on motherhood and childbirth. The purpose of this study was to explore newcomer women's experiences and understandings of motherhood and

childbirth in the aftermath of migration to Canada, and to inform nurses of the challenges presented to these women by their migration experiences within social, economic, political, and cultural contexts.

Everyday, nurses work with newcomer women from various cultural backgrounds. The concept of culture is important to the enhancement of nursing practice (Zoucha & Broom, 2008). According to Browne and Varcoe (2009), approaching cultural and social considerations in health assessment from a relational stance will enhance understanding and direct attention to the contexts that shape patterns of health and illness. Women can effectively communicate through telling stories, and create meaning as they articulate their feelings about life events such as pregnancy, childbirth and becoming a mother. The complexities of nursing practice in maternity care call for a more comprehensive level of care to meet the needs of newcomer women; the proliferation of diverse languages, ethnicities, and socioeconomic levels demands as much. This study provides information that enhances the ability of nurses to provide care using a relational approach that recognizes the significant impact of cultural values, beliefs, and behaviours as well as the power hierarchy often inherent in clinical interactions. Using simple language, non-judgmental and compassionate attitudes, and, above all, a respectful attitude will improve nurses' interactions with newcomer women who are new to the health system and who have language difficulties. Women should not be blamed for their difficulties in language, in contrast they should be appreciated. Moreover, programs should be implemented to support women at the system level to improve their language. For example, providing women free English courses upon arrival and daycare for their children would be helpful. Nursing interventions should ideally provide culturally safe care to facilitate therapeutic communication and dialogue. If newcomer women are made to feel comfortable, they are more likely to have more positive health outcomes. Knowing that newcomer women may face significant barriers accessing health services should prompt nurses to proactively assess what the barriers might be and when emotional support, information, and help navigating the system are needed.

In addition, nurses must recognize that newcomer women frequently experience challenges in their roles and relationships not only because of the burdens of motherhood, but because of their struggles to adapt to a new cultural context. These challenges can be a source of strain and could potentially transform what would otherwise be a healthy motherhood experience into a negative event fraught with stress. Midwives and public health nurses are in an ideal position to identify women who need additional care because of language barriers and an obvious lack of familial support, and to make suggestions or introduce interventions, such as connecting women with support groups, social workers, and community services to ease the patient's transition into motherhood. When nurses listen carefully to newcomer women's beliefs and practices in relation to prenatal and postnatal care, they will be better able to more effectively address their needs.

One example involves a study participant who had an abortion because her fetus was diagnosed with thalasemia. The feelings of discrimination, abandonment, and frustration this experience generated remained deeply entrenched in the memories of this woman and her closest family and friends, and deeply diminished the trust of her entire social network in the Canadian healthcare system. Nurses and other health care professionals including physicians need to acknowledge and try to address unknown cultural and religious values of the patients to provide more culturally safe care.

Assistance at every stage of pregnancy was something greatly valued and commented on by women in the study, as was the importance of seeing friendly, smiling faces at clinics and hospitals. During labour, it was small acts of kindness shown by nurses that meant the most to the women, little acts such as warm smiles, gentle affectionate touches, and especially sincere attempts to breach the distance imposed by the language barriers. The lives of newcomer women are fraught with conflict as they often struggle to identify their own needs and wants amid juggling diverse roles as mothers, wives, students, and workers, all in the difficult context of their status as newcomers unfamiliar with Canadian cultural norms. Nurses and social workers can and should help these women to explore the impact of these responsibilities. Examples include connecting women

to community services, paying attention to income and culture when designing interventions, and providing information and advice on issues of interest.

As newcomer women vary in their acculturation, many face cultural and linguistic challenges that require time to resolve. Nurses as advocates can express their sensitivity and empathy with their needs by ensuring sufficient time is made available for interaction, teaching, and counseling. In practice, nurses need to examine the broader socioeconomic and political context influencing clients. Often, newcomer women are poorly integrated into the system because of linguistic and social factors. This study provides useful information about the socioeconomic and political context of motherhood and childbirth experiences which will benefit and enhance nurses' understandings of their patients' circumstances. Nurses who attempt to develop a comprehensive understanding of different cultural values about motherhood and childbirth are valuable, and as caregivers they would have the ability to effectively assist in contributing to their patients' decision making processes. For example, understanding some of the cultural practices after birth would significantly improve the development and accessibility of support services for women. Nurses also could act to bridge the gap between these women and available community services by referring, advocating for better policy practice, knowledge exchange, and collaborating with other services.

The study findings also call on nurses to question the influence their own ethnicity and culture have on their practice as health care professionals. As cultural safety invites nurses to consider power relations and find expression in caring spaces that are equality seeking and rights oriented, nurses should be aware that fair treatment will not be possible without understanding factors that locate women lower in the power hierarchy, such as financial constraints and socioeconomic status. Moreover, nurses must familiarize themselves with their clients' ethno-cultural and faith perspectives to determine their specific requirements.

In prenatal classes, nurses should ensure that the curriculum is culturally oriented, patient-driven, and takes into consideration the women's perceptions about gender roles. Nurses could highlight Canadian

practices that may be different from those present in the native countries of their clients, and explain the purposes of these practices. During class, it is essential to ensure that clients are offered the opportunity to discuss their values and any rituals related to pregnancy, birth, and postpartum care, such as diet, bathing, and body care, and to ensure that all participants are non-judgemental and respectful of one another. Finally, nurses could work with settlement organizations to access the women with urgent needs, and consult with the latter about the curriculum of the prenatal classes and any especially sensitive and private matters, such as IPV and family problems.

Education

This study highlights the need to educate nurses particularly in the maternity field regarding the needs of newcomer women during pregnancy, childbirth, and postpartum recovery. In the past, the focus on the purely medical paradigm at the expense of social determinants of health was the primary influence on nursing programs. Currently, health promotion programs based on the social determinants of health and calls for health equity have focused more attention on the quality of care provided to members of marginalized populations including newcomers and refugees. To start addressing motherhood and childbirth among newcomer women in the nursing curricula, nursing educators should provide students with realistic experiences within the context of migration. Moreover, using the critical feminist perspectives to guide nursing curriculum provide an opportunity for students to question the assumptions and stereotypes about this population that present women as passive, weak, and with limited English skills. It also pushes the boundaries and challenges the systemic factors that lead women to sustain their status. Educating students about the concept of culture and how to use the relational approach suggested by Browne and Varcoe in their assessment and planning would enhance their understanding about theory and practice. Nursing students should be given the chance to be clinically placed in maternity units in hospitals and obstetrics and gynaecology clinics where they could both practice their basic skills and gain new knowledge about newcomer clients. More experience with this population will likely lead to

better care that meets more effectively their health needs according to their cultural differences. Greater emphasis needs to be placed by educators to ensure students are provided with a variety of cultural experiences of motherhood and childbirth.

The study findings highlight the necessity of placing key terminology regarding the various phases of pregnancy, birth, and postpartum care in the ESL curriculum. This could help women to communicate with and navigate health services. In addition, this study also gives some insights into the relationship between newcomer women and their children and how to respond to challenging questions by their children. Organizations that provide information to newcomer women could use the findings of this study to design programs that will more effectively help women to deal with the challenges of migration, potential parent- child conflict, language difficulties, and the lack of financial resources. The findings also could be used to better prepare women for what they can expect when they arrive in Canada. Furthermore, the findings could help the educational programs to focus on the key coping mechanisms used by newcomer women to deal with the challenges of settling in a new country, and in turn to refine these strategies to further benefit their target demographic. It is essential that these educational programs help empower the women by highlighting to them the strength and resilience necessary to undertake such a challenging life decision as relocation to Canada without the benefit of familiarity with Canadian culture, the English language, or, in many cases, even financial security.

Research

The study findings lay the ground work for future research on motherhood and childbirth experiences among newcomer populations in Canada. The findings have implications for the development of theories of motherhood, childbirth, and migration in newcomer communities. Most theories available on motherhood are based on non-immigrant populations, and of the studies that do deal with the matter of newcomer groups, the emphasis tends to be on negative factors that effectively posit the women as victims of the system rather than as survivors who demonstrate great resiliency in dealing with massive life changes (De Souza, 2004; Hewett,

2009). Many women in this study adapted positively to the challenges they faced and reported an increase in their confidence with their entry into motherhood. In addition, they reported an increased sense of hope regarding their future in Canada, and a greater sense of intimacy with their partners; the responsibilities of parenting served as a powerful force in uniting partners in the majority of cases.

This study reinforces the value and appropriateness of critical feminist perspectives and Intersectionality theory in studying complex phenomena of interest in nursing. Combined with ethnography, I found the critical ethnographic design (Madison, 2005) to be an excellent tool for understanding motherhood and childbirth experiences among newcomer women. Using this methodology, I put myself in the position of learning from participants about their lives. The critical feminist lens helped me to I questioned my understanding of the concept of culture and the social structures that support and weaken women. Intersectionality theory explained how gender intersects with other women's identities and how these intersections contributed to unique experiences of oppression among newcomer women.

The mutually reinforcing relationship between motherhood and economic status among newcomer women is an important aspect worthy of more in-depth study. Future longitudinal research would be wise to examine the impact of migration on specific aspects of motherhood experiences such as perceptions of maternity, the so-called "good mother" identity, and perceived self-agency. In particular, long-term research examining the slow process of identity formation among newcomer mothers is badly needed. There is a need to conduct interviews in the women's primary language and not simply in English, as this would bring greater understanding and lead to more precise descriptions of women's experiences. There is a need for quantitative research and mixed methods studies to explore some aspects of this research such as women's levels of satisfaction with health services during pre and postpartum care, interventions to solve parent-child conflict, effective parenting styles, and primary indicators of marital conflict among newcomer families. In addition a comparative study between newcomer and non-immigrant women could provide insights into the variation in

motherhood experiences and lead to a deeper understanding of the differences and similarities in order to better serve each population.

Policy Making

Newcomer women during motherhood and childbirth experiences are part of a system in which interaction with health, social, and legal services is a necessity. More fruitful approaches are needed to confront, question, and challenge negative images about newcomer women, and the systematic forms of power imbalances that perpetuate social injustices that impede institutional change. Being unable to focus on learning the English language because of motherhood responsibilities and being treated with lack of cultural safety on the part of health care providers are systemic issues that require systemic change. Reorienting the system into a coordinated collaborative approach of care and education holds promise for the future. From a public policy perspective, giving more attention to newcomer women on the part of the government is highly necessary, especially as lower-income immigrants may encounter more difficulties than other segments of the general population. This includes providing opportunities for newcomer women to share in decision making processes and implementation of policies directly related to them. Furthermore, programs should be put in place to help women connect with maternity care services and primary care providers (such as family physicians, nurse practitioners, public health nurse, or midwives) as soon as newcomer women arrive in Canada, particularly if the women in question are pregnant. Workshops that provide information about culturally safe care for both healthcare practitioners and newcomers would be very beneficial. In addition, it is imperative for the government to provide more facilities for women to learn about available community services, facilities that could also serve as forums to socialize and share their knowledge and support with other immigrants to ease their integration into a new cultural context. Settlement organizations could take on a greater role in connecting women with health and social services. For example, providing day-care for newcomer women who need to improve their English could help them to achieve this goal. It is necessary to revise and improve policies that

help newcomers to receive social support and health care after becoming mothers. Lastly, it is crucial to monitor practices that may situate newcomer women in discriminatory and judgmental environments that would prevent them from fully benefiting from the advantages that life in Canada has to offer, advantages that support their decision to leave a familiar country in favour of immigration to Canada in search of a better quality of life.

Conclusion

This study has begun to address the gap in knowledge related to motherhood and childbirth experiences among newcomer women in Canada, and the challenges they face during this critical phase. By using critical ethnography guided by feminist perspectives and Intersectionality theory, newcomer women were given the chance to describe their experiences of motherhood in a new cultural context, as well as the task of negotiating their relationships with their families, health care providers and extended social networks. This study used critical ethnography because it enabled us to analyze the social structures and ideologies that contribute to vulnerability and oppression of newcomer women. The critique of domination forms the basis for dialogue and reflection and can transform health and social institutions and practices to better serve newcomer women. Furthermore, this methodology provided women the chance to negotiate gender hierarchies and identify social injustices. From a health perspective, women negotiated the systemic barriers in the face of health care that was not always considered satisfactory by the women. Women also described the obstacles they faced as they tried to improve their statuses. In addition, this study allowed for exploring points of strength and resilience among newcomers and the influence of migration on their relationship with their partners. Most importantly, it located newcomer women's experiences of motherhood and childbirth within the appropriate socio-political context. This study provided insights into a newcomer population whose needs have long lacked attention by service providers, and serious studies as evidenced by the dearth of literature on this subject. In addition, this study has important implications for nursing practice, education, research, and policy makers to better serve this population.

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Appendix A

Flyer
Motherhood, Childbirth and Immigration

A research Study

Are you immigrant or refugee woman interested in talking about your experience of motherhood in Canada?

Do you speak English or Arabic?

Participation involves two interviews

You may be eligible if you are:

1) 18 years of age or older
2) Living in Canada as an immigrant or refugee for less than five years
3) Have given birth within the last 6 months. The age of the baby is (6-12) months.

For more information please call Fatmeh Alzoubi

Appendix B

Informed consent

Motherhood and Childbirth Experiences among Newcomer Women in Canada: A Critical Ethnographic Study

Principal Investigator: Dr Helene Berman

Co-investigator: Fatmeh Alzoubi

I have read the letter of information describing the study or have had it read to me, have had the nature of study explained to me, and I consent to participate in this study. I have received answers to questions asked.

Name _____ Signature _____

Date_____

Name of the person obtaining the consent _____

Signature _____ Date_____

Appendix C

Letter of Information for Participants

Motherhood and Childbirth Experiences among Newcomer Women in Canada: A Critical Ethnographic Study

Principal Investigator: Dr Helene Berman

Co-investigator: Fatmeh Alzoubi

Introduction

The purpose of this letter is to provide you with information about a research study that I am conducting to explore newcomer women's experiences and understandings of motherhood and childbirth experiences in Canada. A secondary purpose is to identify challenges that newcomer women face in interacting with their families, and with health care system and social network. I am a doctoral student in the School of Nursing at the University of Western Ontario and this study is part of my doctoral thesis. It is our hope that what we learn from you will help us to understand the challenges faced by newcomer women and perhaps assist in the development of programs and services for women in similar situations.

If you have lived in Canada less than five years, have a baby who is now(6-12) months, speak English or Arabic, are 18 years old or older, we would like to invite you to participate in this study.

Procedures

If you agree to be in this study, I would like to talk with you for one to two hours during which I will ask you questions about your experience of motherhood and childbirth here in Canada. This interview will be private and confidential. You will be asked open-ended questions about the challenges that you face during motherhood and childbirth. These challenges could be about your family, social support, and emotional changes that have occurred to you or your body as the result of pregnancy and childbirth. The interview will be audio taped and transcribed into written format. We will meet at time and place of your choice. You will be given a gift of $20 for your participation and to cover your transportation expenses. I will make a follow up call three days after the interview to make sure that everything is fine with you and to set a time for the second interview if you want.

Risks of Participation in the Study

It is possible that talking about your experiences may bring about some emotional distress. However, these are likely to be short-lasting and there are no known risks.

Benefits of Participation in the Study

There are several potential benefits to your participation. By talking about things that have happened to you, you may begin to understand them in a different way, make sense of what happened to you, and learn from your past experiences. As well, your participation in this research may help us to develop programs and services that would assist other newcomer women facing motherhood and childbirth in a new country.

If, after completion of the interview, you would like to discuss your experiences with a counselor or other support person, we will provide you with the names of appropriate persons.

Confidentiality

The audio- taped and the written records of this study will not be shared with anyone. Data going off site for analysis will be encrypted and password protected when sending electronically for transcribing. A paper master list with the identifier data will be saved in a hard copy in a separate place. All data will be kept in a locked file in my office, only my supervisor and I will have access to the tape recording and transcripts. One computer will be used to analyse data. If the research ends for any reason or you change your mind and decide you don't want to be in the study, all data and recordings will be destroyed. A summary of the study findings will be sent to you when the study is over.

Anything you share will be kept strictly confidential. If the results of the study are published, your name will not be used and no information that discloses your identity will be released or published. All information that you give us about yourselves will be kept confidential. However, if at any time you tell us about any child in your care who is being abused or is at risk of abuse, or if we have reason to suspect abuse of a child, we will report our concerns to the Children's Aid Society. If this occurs, I will talk with you about what will happen. If you are currently abused, the decision of mandatory reporting will be discussed with you as you have the option not to report the abuse. If you do not want to report the abuse, we will still offer to assist you to get the required support. If you are having any mental problems such as postpartum depression, and post traumatic stress syndrome, you will be referred to get the needed support.

Voluntary Nature of the Study

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time.

Contacts and Questions

The principal investigator conducting this study is Dr.Helene Berman, Associate Professor in the School of Nursing at the University of Western Ontario. The co-investigator conducting this study is Fatmeh Alzoubi .You may ask me any questions you have now. If you have questions later, you may contact me. If you have any questions about your rights as a research participant or the conduct of the study you may contact The Office of Research Ethics.

You will be given a copy of this form to keep for your records. Thank you for your interest.

Fatmeh Alzoubi

Doctoral Student

University of Western Ontario

Appendix D

Ethical Approval

Office of Research Ethics
The University of Western Ontario
Room 4180 Support Services Building, London, ON, Canada N6A 5C1
Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
Website: www.uwo.ca/research/ethics

Western

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. H. Berman
Review Number: 16980E **Review Level:** Expedited
Review Date: March 24, 2010 **Approved Local # of Participants:** 20
Protocol Title: Motherhood and Childbirth Experiences among Newcomer Women in Canada: A Critical Ethnographic Study
Department and Institution: Nursing, University of Western Ontario
Sponsor:
Ethics Approval Date: April 16, 2010 **Expiry Date:** December 31, 2010
Documents Reviewed and Approved: UWO Protocol, Letter of Information and consent, Posters, Advertisements, Flyers, Telephone Script (Follow-up 1), Telephone Script (Follow-up 2).
Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced study on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:

a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) all adverse and unexpected experiences or events that are both serious and unexpected;
c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. Joseph Gilbert
FDA Ref. #: IRB 00000940

Ethics Officer to Contact for Further Information

☐ Janice Sutherland (jsutherl@uwo.ca)	☐ Elizabeth Wambolt (ewambolt@uwo.ca)	☑ Grace Kelly (grace.kelly@uwo.ca)	☐ Denise Grafton (dgrafton@uwo.ca)

This is an official document. Please retain the original in your files.

cc: ORE File
LHRI

Appendix E

Demographics

1) What is your

   Name:

   Age:

   Country of origin:

   Religion:

   Educational level:

   Language spoken at home:

   Current occupation:

   Annual family income (optional):

   Telephone Number:

   Second contact:

2) How many weeks since you have given birth?

3) How long have you been here in Canada?

4) How long have you been married?

5) How many children do you have?

Consent received for follow up call:

Consent received for second interview:

Closure

A summary for the most important points will be shared. The second interview will be booked. Participant will be thanked.

Appendix F

Interview Guide

Motherhood and Childbirth Experiences among Newcomer Women in Canada: A Critical Ethnographic Study

Migration questions:

1) Tell me about your migration experience.

   What has this experience been like for you? What are the reasons for your migration? What aspects did you like here? What were you expectations of migration? In what ways was your experienceof migration similar to, or different from, your hopes, dreams and expectations?

2) What are your thoughts about being a newcomer in Canada?

   Are you happy and satisfied of living here? What are the reasons? Tell me about your thoughts and feelings of being newcomer to Canada?

3) What was the most challenging aspect of migration?
   How can you overcome these challenges? What actions have you taken to cope with the new context? What advice could you provide for women in your situation? Provide examples

Motherhood and Childbirth questions:

1) Perhaps you could tell me a bit about your experience of pregnancy and childbirth in a new country?

   How was your pregnancy? In what ways it is different from your previous pregnancies in your home country? Was there any difficulties? Tell me about it? How was your labour? What were you feeling at that moment? In what ways your labour is different from the ones in your home country? Tell me about the support you received during labour? Tell me about your feelings when you first saw the baby? Was it the way you expected? What preparations have you made to receive your baby? Tell me about your feelings in the few hours postpartum? Can you talk about strategies that you used to get what you needed (emotionally and materially) during your pregnancy and childbirth?

2) Tell me about your motherhood experience here in Canada?

   What has it been like for you to become a new mother? What are your feelings and thoughts of being a mother? What do you say about this experience? What does motherhood means to you?
   In what ways it is different from your previous experience of motherhood in your home country? In what ways were your experiences with pregnancy / childbirth & postpartum / during the 1st few months of your child's life similar to, or different from, your hopes, dreams and expectations? What are the challenges that face you in raising your children here in Canada? What have you learned about motherhood in Canada? What aspects do you like or dislike taking form Canadian community in relation to discipline your children? What are your thoughts about breast feeding?

3) In what ways is your experience of motherhood and childbirth influenced by your migration?

Was there any influence bad or good? Tell be about the negative and the positive aspects of this influence? Provide examples? What does it mean to you to be a newcomer and a mother at the same time?

4) In what ways is your caring for the baby and disciplinary practices influenced by your migration?

Health Care questions:

1) Tell me a bit about the care you received from health care providers during your pregnancy, the birth of your baby, and post partum?.
What was the care like? What was helpful? Not Helpful? Have you received the help you requested? Can you give me an example? What was the nature of your interaction with health care professionals? Does this interaction reflect mutual respect of authoritative or control? Tell me about your satisfaction with health services here in Canada? Did you feel understood and listened to by different health care providers in terms of your feelings, thoughts and behaviour as a newcomer who has different culture and health traditions? What could make health services better for newcomers who are dealing with childbirth and motherhood?

Social Support questions

1) Tell me about your support systems.

Who do you ask and where do you go when you need help (social, economic, emotional)? Do you think this was helpful? In what ways? What are kinds of support that you and other women in similar conditions would like to receive from your husbands, families, friends, and community? Based on your experiences, what have you learned that you think might be helpful to other women who are becoming new mothers here in Canada? How do you deal with stress? Can you talk about strategies that you used to get what you needed (emotionally and materially) after being a mother here in Canada? What are the most efficient coping mechanisms that other women could use? What are the positive aspects of being a mother? What are your personal strengths as a mother? What are you proud of about being a mother? What could help other newcomer women in your situation?

Marital Relationship and IPV questions:

1) Tell me about the nature of your relationship with your husband after immigration?

What was it like? Has it changed? How is it changed after migration and after the birth of the child? Is it a relationship that reflects equality and respect, or power and control? Who controls money in your house? Is money equally shared? How do you deal with marital conflict? How does that influence your children? How do you deal with things when you disagree? If you have any extended family here in Canada, do they interfere in your relationship with your husband? If your husband is not working, how is this affecting you? Does he make good things to help him to adjust to the new situation? In what ways do you think migration experiences are

influencing your relationship with your husband? How do you think these changes in your marital relationship may influence the experience of pregnancy, childbirth, and mothering?

2) Considering acculturation strategies? What is your strategy? What is your husband strategy? In what ways this could create conflict between you and your husband?

3) If there is any doubt that IPV is happening, what does intimate partner violence means to you? Have you ever experienced IPV? Tell me about this? What is the nature of the insult? When is this started, if this happened to you before migration, has there any change post-migration? What are the reasons for IPV? Frequencies? Would you like to receive help? What is the influence of IPV on your pregnancy, childbirth, motherhood, and children? How do you react to IPV? What is the influence of migration on IPV? How are you going to deal with IPV in the future? Do you know about certain services that help abused women? Would you like to have more information about these services?

   Closure

Appendix G

Interview Guide (Arabic Version)

تجربة الامومة و الولادة لدى القادمات الجدد الى كندا: دراسة اثنوغرافية

دليل المقابلة

اسئلة الهجرة :

- حدثيني حول تجربة الهجرة لديك؟

كيف كانت؟ما هي اسباب الهجرة؟ كيف وجدت البلد؟هل كانت ضمن التوقعات؟ ما هي الجوانب الايجابية و السلبية للهجرة؟ اعطي امثلة.

- كيف تقيمين نفسك كونك قادمة جديدة الى كندا؟

هل انت سعيدة او راضية عن هذه الخطوة؟ ما السبب؟ اذا كنت غير راضية ما السبب؟

- ما هي ابرز التحديات التي تواجه القادمات الجدد اثناء الهجرة؟

كيف يمكن مواجهة هذه التحديات؟ ماذا فعلت للتكيف مع الوضع الجديد؟ ماذا تقدمين من نصائح للسيدات اللواتي في وضعك؟ اعطي امثلة

اسئلة الامومة و الولادة :

- تكلمي عن تجربتك في الحمل و الولادة في بلد جديد عليك؟

كيف كان الحمل؟ بماذا يختلف حملك هنا في كندا عن حملك في بلدك الاصلي؟ هل كانت هناك اي مصاعب؟ حدثيني عنها؟ كيف كانت الولادة؟ بماذا تختلف الولادة هنا عن الولادة في بلدك الاصلي؟ ماذا شعرت عند الولادة؟ هل كا نت ضمن التوقعات؟ ما هي الاستعدادات التي قمت بها لاستقبال المولود الجديد؟

- حدثيني عن تجربة الامومة في كندا؟

ماذا تعني لك الامومة؟ ما رايك في كونك اصبحت اما؟ كيف تقيمين هذه التجربة؟ كيف تختلف تجربة الامومة هنا في كندا عن سابقاتها؟ ما هي التحديات التي تواجهك كام في تربية الاولاد هنا في كندا؟ ماذا تعلمت عن الامومة من الامهات الكنديات؟ ماذا تحبين و لا تحبين ان تكتسبيه من المجتمع الكندي في ما يتعلق بتربية الاولاد؟

- كيف تاثرت تجربة الولادة و الامومة بكونك مهاجرة؟

هل كان هناك اي تاثيرللهجرة ؟ حدثيني عن التاثير سواء كان سلبي ام ايجابي؟اعطي امثلة؟ ماذا يعني لك ان تكوني قادمة جديدة و ام في نفس الوقت؟

اسئلة التعامل مع القطاع الصحي في كندا

- حدثيني عن الرعاية الصحية التي تلقيتها خلال فترة الحمل, الولادة, وما بعد الولادة؟

كيف كانت الرعاية الصحية؟ ما طبيعتها؟ هل تلقيت المساعدة و المعلومات التي طلبتها؟ اعط امثلة؟ كيف كان تعامل الطاقم الصحي؟ ما طبيعة هذا التعامل؟ هل يعكس الاحترام المتبادل ام هي علاقة غير متكافئة؟ هل تمت تلبية و مراعاة احتياجاتك كونك مهاجرة لك ثقافة و عادات صحية مختلفة؟ حدثيني عن رضاك عن الخدمة الصحية بالنسبة للمهاجرين؟ ماذا يجعل هذه الخدمة افضل للسيدات المهاجرات في مرحلة الولادة و الامومة؟

اسئلة الدعم المعنوي

- حدثيني عن الدعم المعنوي لديك؟

من يقوم بدعمك معنويا, ماديا, واجتماعيا؟ كيف ساعدك هذا الدعم؟ ما هي انواع الدعم التي تتمنين وجودها للسيدات في مثل وضعك من الازواج, العائلة و الاصحاب, و من المجتمع الكندي بخدماته المختلفة؟ ما هي وسائل الدعم الفعالة التي تنصحين السيدات في مثل و ضعك باستخدامها؟

اسئلة العنف الاسري

- حدثيني عن طبيعة العلاقة مع زوجك قبل وما بعد الهجرة؟

هل العلاقة تعكس الاحترام و المساواة ام التسلط و التحكم؟ من يدير الامور المالية في البيت؟ هل القرارات مشتركة؟ كيف تتعاملين انت و زوجك مع الخلافات الزوجية؟ ماذا تفعلين اذا كنت لا توافقين زوجك الراي؟ كيف تؤثر هذه الخلافات على الاطفال؟ اذا كنت تعيشين مع عائلتك او عائلة زوجك, ما دور هذه العائلات في حل الخلاف؟ اذا كان زوجك لا يعمل او يعمل بشكل متقطع, كيف يؤثر هذا عليك و على العلاقة؟ ماذا فعل زوجك للتكيف مع الحياة الجديدة و مجيء المولود؟ هل تغيرت العلاقة بعد مجيء المولود الجديد؟ كيف اثرت الهجرة على علاقتك الزوجية سلبا او ايجابا؟ كيف اثر هذا التغيير في علاقتك الزوجية على الحمل, الولادة, و الامومة؟

- اذا كان هناك نوع من العنف الاسري؟

تكلمي عن نوع العنف الاسري؟ متى حدث؟ اذا كان يحدث قل الهجرة هل هناك تغيير بعد الهجرة؟ عدد المرات؟ ما هي الاسباب برايك؟ ممن طلبت المساعدة ؟ هل ترغبين بالمساعدة؟ ما تاثير هذه التجربة عليك خلال الحمل و الولادة و على الاولاد؟ ماذا تفعلين كردة فعل على الاساءة؟ ما تاثير ظروف الهجرة على حدوث العنف و الاساءة؟ كيف ستتعاملين مع هذا العنف لاحقا؟ هل تعلمين بوجود مؤسسات تساعد النساء في مثل و ضعك؟ هل ترغبين بمعرفة بعض المعلومات عن هذه المؤسسات؟

Appendix H

Consent Form (Arabic Version)

تجربة الامومة و الولادة لدى القادمات الجدد الى كندا: دراسة اثنوغرافية

اقرار بالموافقة على المشاركة بالدراسة

الباحثة الرئيسية: د هيلين بيرمان
الباحثة المشاركة: فاطمة الزعبي

لقد قرات موجز الرسالة التي تصف فيها الدراسة ,او تمت قرائتها لي, تم شرح طبيعة الدراسة و متطلباتها لي و انا اوافق على الاشتراك في الدراسة. لقد تمت الاجابة عن جميع اسئلتي.

اسم المشاركة:
التاريخ:
التوقيع:

اسم الشخص الذي حصل على موافقة المشاركة:
التاريخ:
التوقيع:

Appendix I

Letter of Information (Arabic Version)

تجربة الامومة و الولادة لدى القادمات الجدد الى كندا: دراسة اثنوغرافية

موجز عن الدراسة

الباحثة الرئيسية: د هيلين بيرمان
الباحثة المشاركة: فاطمة الزعبي

مقدمة

تهدف هذه الرسالة الى تزويدك بمعلومات عن دراسة بحثية للكشف عن تجربة القادمات الجدد الى كندا فيما يتعلق بالامومة و الولادة. و تهدف الدراسة ايضا الى معرفة الصعوبات التي تواجه القادمات الجدد عند التعامل مع عائلاتهم, النظام الصحي الكندي, و النظام الاجتماعي. انا الباحثة في هذه الدراسة طالبة دكتوراة في كلية التمريض في جامعة ويسترن اونتاريو و هذه الدراسة تمثل رسالتي للدكتوراة. نتمنى ان نستفيد من تجربتك و نتعلم المزيد عن الصعوبات التي تواجه القادمات الجدد لعل ذللك يساعد في تطوير البرامج و الخدمات التي تقدم الى هذه الفئة.

اذا عشت في كندا لمدة اقل من خمس سنوات, رزقت بمولود عمره 6-12 شهر, تتكلمين الانجليزية او العربية, عمرك 18 سنة وما فوق, نحن ندعوك للمشاركة بهذه الدراسة.

الاجراءات

اذا و افقت على المشاركة بهذه الدراسة, اود التكلم معك لساعه او ساعتين وخلال هذا الوقت سأسألك عن تجربة الامومه والولاده هنا في كندا. ستكون هذه المقابله خاصه وسريه. ستسألي اسئله توضيحيه عن التحديات التي واجهتكي خلال الامومه والولاده.هذه التحديات قد تكون عن عائلتك,الدعم الاجتماعي والتحديات العاطفيه التي حدثت لكي او لجسمك نتيجة الامومه والولاده.هذه المقابله ستكون مسجله صوتيا ومدونه كتابيا.سنلتقي في المكان والزمان الذي تحدديه.سأقوم باعطائك 20 دولار كندي كشكر لمشاركتك في الدراسة ولتغطيه مصاريف المواصلات.سأكلمكي بعد ثلاثة ايام من انتهاء المقابله للاطمئنان عليكي ولتحديد موعد للمقابله الثانيه اذا كنتي ترغبين بذلك!

مخاطر المشاركه في هذه الدراسه

قد يسبب الحديث عن تجربتك ضغط عاطفي.الا ان هذا الضغط على الارجح سيكون قصيرولا يوجد مخاطر معروفة ذات اهمية !

فوائد المشاركه في هذه الدراسه

هناك عدة فوائد محتمله اذا شاركت بالدراسة. بالحديث عن امور حدثت لكي في الماضي ربما يساعدك ذلك على فهم هذه الامور بطريقه مختلفه وتعي ما حصل معكي وتتعلمي من تجاربكي السابقه. كما ان المشاركه في هذه الدراسه ستساعدنا على تطوير برامج وخدمات تساعد القادمات الجدد على مواجهة الامومه والولاده في بلد جديد بطريقة افضل. اذا اردتي بعد تتمة المقابله مناقشة تجربتكي مع مرشد اجتماعي او اي متخصص لطلب المساعدة و المشورة سنزودكي باسماء الجهات المختصه.

الخصوصية و السريه

لن يطلع احد على الشريط المسجل والتقرير المكتوب عن مشاركتك .جميع المعلومات التي ستخرج خارج موقع الدراسه الكترونيا من اجل تدوينها و تحليلها ستكون محميه ومشفره برمز سري ولا يوجد فيها معلومات تعرف عن هوية المشاركة.ستكون هناك لائحه بالاسماء الحقيقية والمعلومات المعرفه ستحفظ في ملف خاص منفصل في مكان مستقل .جميع المعلومات ستكون محفوظه في ملف خاص في خزانة مغلقة في مكتبي, فقط انا والمشرفه علي سيكون بامكاننا الوصول لهذه المعلومات. لحماية المعلومات, سوف يتم استخدام جهاز حاسوب واحد فقط لتحليل المعلومات.اذا انتهت الدراسه لاي سبب او اذا قررتي الانسحاب من الدراسه في اي وقت كافة المعلومات الخاصه بك سيتم اتلافها.سارسل لك ملخص لنتائج الدراسه حالما تنتهي الدراسه.

اي معلومات ستشاركي بها ستكون في غاية السريه.اذا تم نشر الدراسه, لن يكون هناك اي معلومات تشير الى اسمك او هويتك. كافة المعلومات التي تعطيها لنا ستكون سريه لكن في اي وقت تخبرينا عن اي طفل تحت رعايتكي تعرض لاساءه او سيتعرض للاساءه سنقوم بابلاغ مؤسسة دعم الاطفال. اذا حدث هذا ساتحدث معك اولا عن الاجراءات. اذا انت حاليا تتعرضي للاساءه من زوجكي او شريك حياتك ساناقش الخيارات معك لكن يبقى لك القرار ان تخبري عن هذه الاساءه ام لا.اذا كنت بحاجة الى مساعدة او استشاره من مرشد اجتماعي لاي سبب سازودك باسماء الجهات المختصة.

طبيعة المشاركة في هذه الدراسه

المشاركه في الدراسه تطوعيه.بامكانك ان ترفضي المشاركه, او ان ترفضي الاجابه عن الاسئلة, او الانسحاب من الدراسه في اي وقت تشائين و بدون عواقب.

للاتصال والاستفسار

الباحثة الرئيسية التي تجري هذه الدراسه هي الدكتوره هيلين بيرمان, استاذ في كلية التمريض بجامعة وسترن اونتاريو. الباحثة المشاركة هي فاطمه الزعبي.

بامكانك ان تسأليني اي سؤال الان. اذا كانت لديك اسئله متعلقه بحقوقك كمشاركه في الدراسه بامكانكي الاتصال مع المكتب المسؤول عن اخلاقيات البحث العلمي

ساعطيك نسخه من هذا النموذج لتحتفظي بها.شكرا على الاهتمام .

فاطمه الزعبي

طالبة دكتوراه

جامعة وسترن اونتاريو

Curriculum Vitae
Fatmeh Ahmad Alzoubi

EDUCATION:

- Bachelor Degree in Nursing Science. Jordan University of Science and Technology. Irbid-Jordan (1997)

- Master Degree in Community Health Nursing. Jordan University of Science and Technology. Irbid-Jordan (2001)

- Current Nursing PhD student at the University of Western Ontario. London-Ontario-Canada (2006- now)

EXPERIENCE:

- **Staff Nurse** for 6 years period in different private and governmental hospitals:

1) Al- Khalidi Medical Center (Private Hospital) Medical/Surgical Ward, Amman –

Jordan. Jul 5, 1997 – Apr 30, 1999

2) Princes Basma Hospital (Governmental Hospital, MOH) Surgical Ward, Irbid –

Jordan. May 2, 1999 – Dec 24, 2001

3) King Abdullah University Hospital (Educational Hospital) Medical/Surgical Ward, Irbid – Jordan. Dec 4, 2001 – Oct 5, 2003

- **Clinical Trainer** at Nursing Faculty, Jordan University of Science and Technology.

Irbid – Jordan, Feb1, 2004 -Sep 20, 2006. I taught clinical courses of medical-surgical, fundamentals in nursing, physical examination, community health nursing, mental health nursing, pediatrics, and maternity.

- **Research Assistant** at the University of Western Ontario, Centre for Research and Education on Violence Against Women and Children, Jan, 2007 – until now.

Accomplishments:

1 - I am working as a research trainee in a Canadian Institutes of Health Research Grant (Title: Embodied trauma: the influence of past trauma on women during the transition to motherhood, 2008)

2 - I am working as a research assistant in The Canadian Observatory on the Justice System's Response to Intimate Partner Violence since 2008, and more specifically I conducted an annotated bibliography on "Justice System Responses to Intimate Partner Violence among Immigrants and Refugees".

3- I am a team member in an internal research award at Western / Social Sciences and Humanities Research Council (2008). Title: Violence in the lives of Muslim women and girls: developing a research agenda in the Canadian, Yemeni, and East African context.

4- I worked on a previous application of International Community-University Research Alliances (ICURA)—in Partnership with the International Development Research Centre (IDRC) in 2007.

5- I contributed in qualitative data analysis (coding) for several transcripts

6- I conducted an interview with abused traumatized women as a part of my research assistant duties in Nov 19, 2009.

7- I defended my thesis proposal on Jan 7, 2010.

- **Teaching Assistant** at the University of Western Ontario, Nursing Faculty

N254B Professional Development I: The Nursing Profession. Jan 2008 (10 hrs/week).

N4420 Focused Clinical Concepts. Sep 2008 (10 hrs/week).

N254B Professional Development I: The Nursing Profession. Jan 2009 (10 hrs/week).

N3319 Research Methodology in Nursing. Sep 2009 (10 hrs/week).

N254B Professional Development I: The Nursing Profession. Jan 2010 (10 hrs/week).

N2204 Nursing Professional Practice: Issues and Challenges. May 2010 (5hr/week)

N3331 Mental Health Care and Community Health Promotion. May 2010 (5hr/week)

N3318A Elementary Statistics. Sep 2010 (5hr/week)

N4420 Focused Clinical Concepts. Sep 2010 (5hr/week).

N2254B Professional Development I: The Nursing Profession. Jan 2011 (10 hrs/week)

N4420 Focused Clinical Concepts. May 2011(10 hrs/week).

N3319 Research Methodology in Nursing. Sep 2011 (10 hrs/week).

CONFERENCES and WORKSHOPS:

- I attended the 15th International Nursing Conference of the Nursing Network on Violence Against Women International: Complexities and Diversities: Creating Change in a Global Context. Oct 18-20, 2007 (held in Helton Hotel, London, Ontario, Canada)
- I attended The Summit Centre Introduction to Applied Behavior (ABA) training Workshop on **Autism.** Oct 4 & 5, 2008 (Held in Summit Center, Windsor, Ontario, Canada).
- I attended the Knowledge Translation in Health Care workshop. April 22, 2008 at The University of Western Ontario- School of Nursing. Presented by Dr Carol Estabrook.
- I attended the International Institute for Theory Based Intervention workshop, April 16, 2009 at The University of Western Ontario-Kresge Building Room 203. Presented by Drs J. Fleury & S. Sidani.

- I attended a workshop on enhancing interview skills with vulnerable population. March 6 and April 17, 2009. Presented by Gloria Mulckay and Jodi Hall at the Centre for Research and Education on Violence Against Women and Children.
- I attended NVIVO 8 workshop in April 30, 2009. Presented by Bengt M Edhlund in the Computer Based Learning Center (CBLC) located within the Schulich School of Medicine & Dentistry's Valberg Educational Resource Centre/ UWO.
- I attended the 16th International Conference of the Nursing Network on Violence Against Women International (NNVAWI). This conference was hosted by The University of Miami School of Nursing and Health Studies, Florida, The United States of America. This year's conference theme, "Trajectories for Change: Creating Culturally Meaningful Interventions to Prevent and Reduce Violence," The conference was held on October 1- 3, 2009, at the Westin Colonnade Hotel, 180 Aragon Avenue, Coral Gables, Florida.
- I attended an APA workshop on what the differences between the 5th and the 6th edition. Presented by Meagan Stanley and Nazi Torabi, Research and Instructional Librarians at Allyn & Betty Taylor Library, UWO. Held on Oct 6, 2009 in Dental Science Building Room 1002.
- I attended the Office of Research Ethics education session on how to complete the submission forms and how to write a letter of information. Organized by Grace Kelly and held in Nov 5, 2009 from 1:30-3pm in Support Services Building, Room 4220, UWO.
- I attended SPSS workshop, Nov 6, 2009. Presented by Peter H Fewster at the Social Sciences Center, UWO, 9am - 4pm, Room 1032.
- I attended a lecture about the "Hate Crimes". Organized by The Muslim Resource Centre for Social Support and Integration in London, Ontario. Held on Nov 21, 2009 at London Mosque, London, Ontario. Presented by Saleha Khan.
- I attended the Research Ethics Workshop. Organized by Janice Sutherland and held in March 5, 2010 at 9:30am to1pm in Room H4, Nursing School at UWO.
- I participated in a workgroup of reproductive health organized by Ontario Public Health Association in April 19, 2010. Teleconference.
- I attended a complimentary online demonstration of NVivo 8, presented by Brian Moriarty. Held on Friday, March 12, 9:00-10:00 a.m.
- I attended a qualitative analysis workshop, Nov, 3, 2010. Presented by the Faculty of Nursing School at the University of Western Ontario. 8:30- 4pm, Room H101.
- I presented a paper titled as "ENDING THE SILENCE: EMERGING RESEARCHERS, SENSITIVE TOPICS, AND NEGOTIATING ROLES AND PROCESSES"as a part of a symposium in a conference entitled "Innovations in Gender, Sex, and Health Research" being hosted by the Institute of Gender and Health, Canadian Institute of Health Research, at the Four Seasons Hotel in downtown Toronto on Monday, November, 22, 2010.
- I presented a paper tilted as "I don't feel I'm alone no more: Lessons learned conducting interviews with pregnant & parenting women survivors of trauma " in the program of the 28th Annual Qualitative Analysis Conference: Contemporary Issues in Qualitative Research, held at Wilfrid Laurier University, Brantford campus, in Brantford, Ontario, Canada from May 12-14, 2011.
- I coordinated a symposium titled "Violence in the lives of Muslim girls and women in Canada: Creating safe space for dialogue reflection and research". Hosted by the Canadian Institute of Health Research, held in Four Points Sheraton In London, Ontario on Sep 22-24, 2011.

SCHOLARSHIP, AWARDS, and BURSARIES

- I got a scholarship from Jordan University of Science and Technology to complete my PhD degree for four years. $32.000/year. Started fall 2006 and terminated fall 2010.
- I got the Faculty of Health Sciences Graduate Student Conference Travel Award in the amount of $400 in October 25, 2010 from the University of Western Ontario.
- I got the Graduate Thesis Research Award in the amount of $795.00 in Jan, 26, 2011 from the University of Western Ontario.

PUBLICATIONS

Berman, H., Gorlick, C., Csiernik, R., Ray, S.L., Forchuk, C., Jensen, E., &**Al Zoubi, F**. (2011). The changing face of diversity in the context of homelessness. In C. Forchuk, R. Csiernik, & E. Jensen (Eds.), Homelessness, housing, and mental health. Finding truths-creating change. (pp. 205-228). Toronto, ON: Canadian Scholars' Press Inc.

PERSONAL SKILLS

Windows 2010, XP Oriented.

Good Command in English.

NVIVO 8 software Oriented

SUMMARY:

- Several years experience working with patients and students

- Respect hospital policies, patients, supervisors, and colleges.

- Efficient time management with good ability to organize tasks

- Proven ability to be an active member of research teams and grants application.

- Registered Nurse in the Jordanian Nursing Council

- Registered Nurse at the College of Nurses of Ontario.

- I am a member in Sigma Theta Tau International, Iota Omicron Chapter at the University of Western Ontario.