ORIGINAL ARTICLE

Immigrant women cancer survivors' perceptions of healthcare services in Canada: A phenomenological study

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ABSTRACT

Middle Eastern immigrant women (MEIW) living in Canada have significantly increased. However, this group of women is under-represented in health research, and there is a gap in knowledge about their experiences when they access healthcare services for cancer care in Canada. This qualitative approach was conducted to uncover the meaning of the lived experiences of MEIW with healthcare services in Canada during their cancer survivorship (CS). Data were collected through unstructured interviews and one written description from three MEIW. Data were analyzed using a descriptive phenomenological approach developed by Giorgi. Four themes emerged to represent the essence (or meaning) of the participants' lived experiences. Their healthcare was accompanied with delays and unmet needs. Yet, they found it helpful when they were provided with knowledge and information. The ability to communicate in English was equal to empowerment for each of them, while they faced cultural stigmatization of mental health issues. Thus, healthcare professionals need to identify immigrant women's unmet support needs and psychosocial responses during their cancer survivorship. Language-specific and culturally competent cancer-care intervention programs must be developed within the Canadian healthcare system.

Key Words: Lived experience, Immigrant women, Qualitative approach, Cancer, Middle Eastern, Healthcare

1. INTRODUCTION

Within the last two decades, the number of immigrant women from Asia and the Middle East has significantly increased to more than 50% of Canada's total female immigrant population.[1] The frequency of healthcare providers interacting with immigrant women from the Middle East and Asia has increased and will continue to grow, along with the need for healthcare providers to have more knowledge about culturally competent healthcare services. A healthcare system comprised of culturally sensitive services is essential in Canada to improve health outcomes and quality of care. It can also contribute to eliminating racial and ethnic health disparities and achieving health equity.

Access to healthcare services, health promotion, and health prevention programs significantly impact cancer survivorship outcomes amongst women from different ethnic mi-

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norities. Access to health services is one of the significant challenges that many immigrant women face in Canada during their cancer care.[2–4] Low socioeconomic status, low levels of education, and language are the main reasons that complicate immigrant women's ability to access health services.[5] The availability of interpreters is also considered a barrier to access to health services.[2] Despite the presence of the universal healthcare system in Canada, access to health services is still a challenge for many immigrant women due to long wait times, lack of family physicians, and geographical barriers (i.e., patients who live in rural areas).[4, 6] Furthermore, other obstacles, such as sociocultural practice, socio-demographic characteristics, unemployment, and unfavourable social conditions, may influence overall accessibility to healthcare services.[6–8]

Several Canadian studies have shown that immigrant women from South Asia, new immigrants to Canada, and those considered in the family and refugee classifications have the lowest cancer screening rates leading to delays in cancer diagnosis and poor cancer survivorship outcomes.[9] Immigrant women from the Middle East and Africa have higher breast cancer incidence rates than other immigrant women in Canada.[10] However, little is known about their needs and experiences with the healthcare system during their cancer survivorship journey.

Furthermore, immigrant women experience challenges understanding Canadian culture, communicating in the English or French language, integrating into Canadian society, and finding employment.[11] This leads to immigrant women having challenges navigating the Canadian healthcare system and available programs for cancer patients, accessing culturally sensitive education programs and female healthcare professionals,[12] and finding cancer support groups for immigrant women who can communicate in the same language as them to understand their cultural needs. All of these challenges will have a significant impact on their cancer survivorship journeys and outcomes.

Weerasinghe and Mitchell (2007) found that immigrant women in Atlantic Canada experience culturally insensitive and unresponsive healthcare.[13] For example, healthcare providers sometimes misunderstand immigrant women's connection between their bodies, minds, and social health. This issue occurs in Canada and the United States of America, where ethnic minorities experience unmet informational, emotional, practical, and spiritual support from healthcare providers during their cancer care.[14] Consequently, many ethnic minority women prefer female healthcare providers or healthcare providers with the same ethnic and cultural beliefs.[12, 15] Patient-physician ethnic and linguistic semblance can improve patient health outcomes, health services satisfaction, quality of care, and continuous care.[16]

Unfortunately, many immigrant women mistrust the healthcare system and fear health research.[3] Others do not access health prevention programs because they fear stigma, shame, and other negative social consequences. Fear of cancer diagnosis, diagnosis technology, and treatment methods (e.g., chemotherapy and radiotherapy) have also been reported.[3, 15, 17] Therefore, physicians and nurses must play an essential role in educating these women about different health prevention and promotion programs, symptoms, available screening and treatment methods, and other healthcare services (e.g., sexual health information). Healthcare professionals also need to be knowledgeable about providing culturally competent care.

Middle Eastern immigrant women (MEIW) in Canada are underrepresented in health research, and very little is known about their cancer survivorship, accessing Canadian health services, and their needs. Therefore, this phenomenological study aimed to uncover the meaning of the lived experiences of MEIW with healthcare services in Canada during their cancer survivorship. The results of this study will enhance healthcare providers' understanding of MEIW's needs during their cancer survivorship. The voices, perceptions, and meaning of the experience of these women will help healthcare professionals to provide this cultural group of women with culturally appropriate and patient-centred care. From a health services perspective, where patients are partners in their care and treatment aims to empower persons, participatory non-patriarchal interventions based on knowledge emerging from cancer survivors will be more applicable to achieve this aim.

2. METHOD

2.1 Design

The lived experiences of MEIW, and their perspectives of health services during their cancer survivorship were explored using a qualitative descriptive phenomenological method developed by Amedeo Giorgi.[18] A phenomenological approach is the best design to understand a certain phenomenon from the perspectives of persons who have lived the experience. It allows the researcher to understand the meaning of the lived experiences based on persons' descriptions of the phenomenon.[19]

2.2 Recruitment

Social media support groups were the best method to reach out to the highest number of MEIW in Canada. Facebook support groups for MEIW communities living in Canada helped recruit two participants. WhatsApp support group for refugee women helped recruit one participant.

2.3 Sample

A purposive sample of MEIW cancer survivors in Canada participated. They were eligible to participate in this study if they met the following inclusion criteria: MEIW, diagnosed with cancer within the last five years, aged 20-65 years at the time of the interview, resided in Canada, and were able to speak English or Arabic.

Three women were interested and participated in this study. Giorgi has stated that a research study could be composed of one participant,[20] while Creswell and Poth (2017) stated that phenomenological studies could include 5 to 25 participants;[21] Russell and Aquino-Russell (2011) recommended using an average of 8 participants in descriptive phenomenological studies.[22] In this study, the stories of the three women were comprehensive to understand the complexity of the MEIW experiences, delving into the idiographic and generating vibrant data.

Table 1. Demographic information of research participants

Characteristics	Number
Age Range	41-47
Time lived in Canada	
Less than 5 years	2
Between 5 and 10 years	1
Education level	
No high school Diploma	1
College	1
Master's Degree	1
Employment	
Yes	1
No	2
Living area	
Urban	3
Rural	0
Have children	
Yes	2
No	1
Cancer history in the family	
Yes	3
No	0
Cancer treatment	
Surgery	3
Chemotherapy	3
Radiotherapy	3
Hormonotherapy	2
Immigration category	
Refuge	1
Economic	1
Family	1

The participants' average age was 44 years, with an age range of 41 to 47 years. Participants' demographic information included that they had been diagnosed with breast cancer between the ages of 37 to 43, with an average age at diagnoses of 40 years. They had a history of cancer in their families. All underwent similar cancer treatment, including surgery, chemotherapy, radiotherapy, and hormonal therapy (except for one participant who did not undergo hormonal therapy). Two participants were treated at hospitals, and one woman was treated at a cancer care center. See Table 1 for other demographic information.

The three participants lived in urban cities across Canada. Two participants resided in Canada for less than five years, while one participant lived for a period between 5 and 10 years at the time of the study. One participant was employed, and two were not employed outside the home. Education levels between the three participants differed- (university degree, college education, and no high school education). The participants were from three immigration classifications: economic, family, and refugee immigration status.

2.4 Data collection

Data descriptions were collected from two unstructured interviews, and one written description was submitted by email, as per the participant's choice. Email as a data collection method has been previously used by various researchers.[23,24] Giorgi's phenomenological method allows the researcher to have an in-depth one-to-one interview with the participants asking one open-ended question to let the participants' descriptions emerge in a natural setting with minimal interference from the researcher.[20] Participants were asked to respond to the open-ended statement: "As a Middle Eastern immigrant woman in Canada, please describe your lived experiences with healthcare services during your cancer survivorship." Further, whenever the participant started to generalize about the experience in the interview, questions were asked, such as: "Tell more about—?" and "What was it like?" These questions allowed the participants to express their experiences in their own ways and at their own pace. The participant who sent her description via email was sent a further email to elaborate on some descriptions in her story.

The three participants were Arabic-speaking women as their first language. Since the primary investigator is a Middle Eastern immigrant, bilingual in both English and Arabic languages, each interview was conducted in the participant's preferred language (Arabic) as it was easier for them to express their feelings and experiences in Arabic rather than in English. The interviews were recorded on a digital recorder. The primary investigator transcribed and translated the interviews/email description.

2.5 Data analysis

Data were analyzed and synthesized using Giorgi's five-steps of the descriptive phenomenological approach as the following:[19] The participants' transcripts were read freely and openly to gain an overall sense of the descriptions, assuming the attitude of the phenomenological scientific reduction, breaking down the description into smaller parts called meaning units (MU); transforming the MUs into scientific expressions to the researcher's / disciplinary language, which was the population health perspective. These were called focal meanings (FM). The FMs were joined together to become the meaning of the experience from each participant's perspective. This is known as the situated structural description (SSD). Finally, the meaning of the lived experience (or general structural description GSD) was synthesized from the SSDs of all participants.[20]

2.6 Ethical considerations

The Ethical Review Committee ethically approved the research project in the Faculty of Nursing at the University of New Brunswick and the main Research Ethics Board (REB) at the University of New Brunswick- Canada. This project was also ethically approved by the REB at the Horizon Health Network- New Brunswick, Canada.

3. RESULTS

The findings or the meaning of immigrant women cancer survivors' lived experiences were affected and shaped by the social determinants of health, including their ability to access healthcare services and also dependent on their immigration status and their ability to communicate in the English Language. A synthesis of the SSDs to the GSDs involves four essences: (1) Participants' quality care was accompanied with delays and unmet needs; (2) Healthcare professionals who spent time providing knowledge and information was beneficial for them; (3) Having knowledge of the English Language was equal to empowerment for each of them; and (4) Participants faced cultural stigmatization of mental health issues. Each essence is illustrated and supported below by direct quotations (meaning units) from the participants that uncover their experience during their cancer survivorship.

3.1 Participants' quality care was accompanied by delays and unmet needs

Concerning the participants' experiences with healthcare services, they received quality care from supportive, friendly, and professional healthcare providers during their cancer survivorship journey. The participants have never felt discriminated, and they perceived healthcare providers in Canada as approachable and supportive as Marwa (a pseudonym) stated: *I find doctors and nurses are very friendly to me; I never felt discriminated.* Nora also described her feelings whenever she made an effort to erase the painful memories of her mental and emotional experiences during the treatment stage. She would recall the support and empathy of the healthcare providers: *"If I decide to forget the psychological pressures, I can't forget the kindness of the medical staff. The nurses were compassionate and kind as well as the doctors."*

The participants were also amazed by the cancer care services and facilities provided for cancer patients: As Eman stated: *In the cancer agency, everyone was amazing there... It is an amazing place that has everything for cancer patients. I wish there were similar centers everywhere around the World.*

The participants of this study needed transportation to access healthcare facilities. The support services provided much-needed transportation to access health services. The participants appreciated these services as new immigrants to Canada. For example, participant Eman was transported from her house to the cancer care agency by a cancer care volunteer transportation service provided by the cancer care agency, as she stated: *The volunteer drivers who provided a ride for patients were merciful. Yeah, it was amazing... They [drivers] used to take me from my house to the cancer agency for the chemo and bring me back home. That was a big relief for me because we did not have a car. It was very helpful and comfortable for me.*

While another participant Marwa received this service from her Canadian volunteer sponsor or volunteer transportation services provided by the multicultural association, which also arranged and booked all her medical appointments to facilitate her cancer care process. She stated: *In the beginning, the multicultural association used to arrange all my appointments with family doctors and specialists. They also used to give me a ride to the clinic because we were newcomers. Sometimes, my Canadian sponsor would take me to my appointments.*

However, the participants experienced anxiety and stress-filled delays in acquiring health services due to healthcare system policies or poor communication between different healthcare facilities. The participants experienced extended wait times to receive a referral from a family doctor due to poor communication between the family doctors and other specialists. For example, Eman stated: *When the results came back, the doctor said there was something suspicious, and we had to do a biopsy for the right side [right breast] ... I expected them to call me after two weeks for the biopsy, but they were late. I called the clinic, but it seemed that the biopsy clinic did not receive any referral from the doctor at the family clinic. I waited for more than four weeks. Then I called the family clinic, asking them to send my mammogram report to the biopsy clinic. I was very stressed because, in 4 weeks, cancer would spread.*

As immigrant women, the participants lacked knowledge of the healthcare system in Canada, its policies, and how to navigate it in order to find the needed health services. The participants from different immigration categories had different experiences accessing the healthcare system. Eman, from the family immigration category, received help from her spouse navigating and accessing the healthcare system. Marwa, from the refugee immigration category, received support from the multicultural association. On the other hand, Nora, from the economic immigration category, struggled with accessing health services due to a lack of knowledge of the healthcare system policies in Canada. She could not access immediate healthcare because she did not have the provincial healthcare card. She stated: *After getting the immigration visa, I learned from the oncologist that I had cancer... I remember that when I landed in Canada and received my official documents, the weather was very cold, and we had no accommodation, so we stayed in a hotel. I went to a walk-in clinic, and the surprise was that I had to pay for health care out of my pocket. Then I told her [administrative assistant] that I am a permanent resident in Canada. Then she said: "it does not matter what your status in Canada; what we care about is the healthcare card." Then, I went to [the local] hospital, and they told me that they were sorry because they could not offer any services, and the system here is that I should have been transferred from a family doctor. I did not have a family doctor then. So, I decided to get a healthcare card, and they refused my request because I was staying in a hotel, and I did not have a permanent address. In addition to that, there was three months waiting time for the [provincial health] card to be issued. This woman experience delays and a decline in acquiring health services as a result of healthcare system policies.* When this participant needed to access health services, she was required to pay for health services because she did not have a Medicare card. Her request for a Medicare card was also declined because she did not meet the Canada Health Act requirements of time being a resident to become insured. This requirement is defined as "a resident of the province who has not completed such a minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services."[25]

As immigrant women, the participants had no family support to help with the children. Therefore, they were challenged in finding childcare services needed during medical appointments, treatment sessions, or visits to the emergency department. For example, Marwas' words: *One day, I had pills and got an allergic reaction. I had to go to the emergency department. Unfortunately, I could not find anybody to stay with my children.*

3.2 Having knowledge of the English language was equal to empowerment for each of them

This essence represents the participants' perception of their ability to communicate and understand the English Language. Research participants indicated how critical it was for immigrant women to speak English in order to access health services, communicate with healthcare providers, understand all the cancer care educational materials, and be part of support groups. One participant was able to communicate in English. She appreciated that because she was able to: understand all educational materials provided for cancer care, access various cancer care services, feel involved in the cancer care plan, and get the best health outcomes. Eman stated: *They [healthcare providers] also gave me books providing all the required information. They also showed me videos with all the expected outcomes and what to do. It was very informative. However, everything was in English (books, videos, and other resources). It was fine with me because I already speak English. However, if a woman does not speak English, it will be hard to go through all that material and information. They may need someone to help them translate the material. I am not sure if it is available in other languages. As a cancer patient, you feel that you are lost as you do not know what to expect if no one provides you with the right information. For me, it was good because I was able to read and write in English.*

Participant Marwa, who does not speak English, needed help whenever she wanted to access health services, as the multicultural association provided her with a volunteer interpreter. She also stated that she could not learn English well because she had no time to study as she was busy with her children. However, she realized that she must work harder to learn English in order to help her to access health services and improve communication with healthcare providers, stating *I am still struggling to learn the English language because I am busy with my children. I have no time to study at home. I do not have anybody to help me. And I hope to improve my English language skills to help improve my communication skills when I go to the hospital.*

The participants believed that the number of immigrant women from the Middle East is significantly increasing, and they have the right to have educational material in their first language, similar to other immigrant communities in Canada. They perceived that understanding the educational sessions and communicating with health care providers can significantly impact their cancer survivorship outcomes. For example, Eman stated: *If you do not speak English, you know, you will not understand all the information sessions (physiotherapist, nutritional information) and communication with doctors, nurses, counselling, and support groups.* The participants desired to have cancer educational materials in their mother language to help those immigrant women who could not speak English. Eman stated: *Many booklets and information sessions were in English, and I think they are available in Chinese and Panjabi because there are largely Chinese and Indian communities in [the province]. Recently, the Arab-speaking community has increased, but nothing is available in Arabic for this community.*

3.3 Healthcare professionals who provided knowledge and information were helpful to them

To increase the health literacy of cancer patients and their families about the cancer care process and expectations, cancer care centers and healthcare professionals provided participants with information and knowledge about every treatment stage, expected health outcomes, available programs, and how to take care of their health and well-being during this journey. Participants appreciated learning about their diagnosis, treatment, and expectations. The following are participants' words (meaning units) that depict the essence. Eman stated: *The informational sessions were very helpful, providing all expected outcomes from physical to psychological changes. My doctor also discussed different chemotherapy options with me, like four strong sessions than another mild session, and the expected changes and outcomes.* As well, Marwa stated: *I went to the hospital for chemotherapy. In my first appointment with the doctor, he explained everything to me before starting chemotherapy. . . . . He told me: "first, you need to take care of your mental health and be relaxed and stay away from negative people because they are going to increase your stress levels. . . .Second, you will be weak, and your appearance will change because you are going to lose your hair. . . you will not have an appetite for food...and your physical and psychological health will change."*

Participants desired more health promotion and prevention programs for immigrant women in their language. They also expressed a desire for education programs for their children to teach them about their parents' challenges during the cancer survivorship journey and how to adjust to changes in their social environment. Nora had experienced difficulties in communicating cancer information with her children and noticed changes in her children's emotions. Nora experienced conflicts with her partner and low social support from him. She became a single mother during her cancer survivorship journey describing, *"my husband decided to leave our two daughters and me."* Nora's children's adjustment to cancer and family separation was difficult and challenging. For example, Nora stated: *I wish there was health awareness from healthcare providers for cancer patients and their struggles. I wish the patients were supported to have more courage to* *continue their lives normally without overwhelming them with cancer care. I wish there was a place for me to enrol my children to learn more about my struggles.*

3.4 Participants faced cultural stigmatization of mental health issues

This essence presents participants' mental health perspectives and accessing mental health services. The participants declared that the cancer survivorship journey was arduous for them and their family members, which required psychotherapy because they experienced stress, depression, and anxiety. Eman, who accessed psychotherapy during the cancer survivorship journey, found it very obliging and beneficial. Eman stated: *You know there were things I could not say to my mom and my husband. However, when I went to the counselling session, I would say everything inside me. After every session, I felt very light and better. Many people refuse to go to a psychiatrist or counsellor because it is stigmatized in our culture. My family would say I am crazy to go there, yet, I found it very helpful to see a counsellor. It helps a lot as part of the cancer care plan.* On the other hand, others in their family refused to access mental health services because of the preconceived belief that psychotherapy is a disgrace and stigmatized in their culture. The participant, Nora, described her reaction as astonished with shock when her spouse outrightly rejected going to the psychotherapy. Nora described: *I was also surprised when the oncologist suggested that I must be referred to a psychiatrist, myself and my husband, but my husband refused categorically.*

Marwa realized the significant impact of cancer survivorship on her and her family's mental health, but she denied any need for mental health help. She perceived her experience as normal due to her illness because her oncologist informed her that her physical health was going in the right direction, but she denied mental health services. For example, Marwa stated: *Nowadays, everything makes me mentally tired. I get stressed out quickly, and I get angry and emotional very quickly. I get mad at my kids, the house, and my husband. I am very sensitive now. I go to the oncology clinic, and the doctor tells me everything looks fine, but I do not see any mental health specialist. My doctor tells me everything is fine. Alhamdulillah* [Praise to God].

4. DISCUSSION

4.1 Access to healthcare

Participants in this study received quality care with no discrimination during their cancer survivorship journey from supportive, friendly, and professional healthcare providers. The participants were satisfied with the quality of healthcare provided for them. They also described how healthcare professionals made a difference in their cancer survivorship experiences, and that they would not forget the sympathy of healthcare providers. They also described receiving exceptional and sympathetic social support from their healthcare providers and communities (i.e., cancer agency and multicultural association). Social support provided by healthcare providers assists in the development of a sense of emotional comfort and security among breast cancer patients.[26] In their study, Duffy and Aquino-Russell (2007) indicated that Canadian-born female cancer survivors had memorable connections with nurses who made a difference in their cancer journey.[27]

Although the participants received quality care and found volunteer services to access cancer centers, they experienced delays in accessing health services and had unmet needs that increased their anxiety during their cancer survivorship journey. These unmet needs and delays were attributed to current healthcare policies in Canada, poor communication between healthcare facilities, and a lack of support services for cancer patients and new immigrants. This finding was consistent with other Canadian studies, which indicated that some immigrant women (e.g., visible minorities) in Canada reported long waiting times to access health services and unmet healthcare needs.[28]

This study was unique because the participants were from three different immigration categories: refugee, family, and economic. These variations in immigration categories resulted in various experiences with the healthcare system in Canada. Participants from the refugee and family did not face challenges navigating and accessing health care because they found the support either from a family member (family class) or multicultural association and federal programs (refugee class). For example, refugee immigrants can access health services as soon as they arrive in Canada because the federal government insures them under the Interim Federal Health Program (IFHP).[29] Federal and provincial governments also support multicultural associations to support refugee newcomers and provide them with various settlement services in Canada. However, immigrant woman from the economic class faced a challenge in navigating the healthcare system without any local support or knowledge of Canadian healthcare policies. These factors elevated her stress because she required urgent healthcare but could not access it due to Canada's current public healthcare policies. These findings are in agreement with many previous studies that have indicated that recent Canadian immigrants experience inadequate access to health services due to a lack of knowledge of the healthcare system and navigating the system, financial barriers, and social isolation.[28,30]

The participants were challenged in finding childcare services whenever they needed to access health services (e.g., emergency department visits, appointments, and treatment sessions). This lack of childcare services for cancer patients increased their stress. Different provinces in Canada have various cancer patient support services, but not all provinces have childcare services for parents with cancer. For example, Nanny Angel Network: Child Care for Mothers with Cancer provides free childcare services for mothers with cancer during their treatments or any medical appointments in Ontario.[31] Kelly Shires Breast Cancer Foundation can provide financial assistance for breast cancer patients across Canada, which can be used for childcare services or other needed services.[32] This finding also indicates that the participants in this study had limited knowledge (or were not told) about the availability of these support services for cancer patients across Canada.

The participants were very distressed during the diagnosis stage of their cancer survivorship journey because they experienced a delay in accessing health services. This delay was attributed to poor communication between different healthcare facilities. Tudor Car et al. (2016) have identified that poor communication between primary and secondary care and health system regulations are the main problems causing delays in diagnosis.[33] Inefficient communication between healthcare professionals negatively impacts patient safety and continuity of care, leading to delayed diagnosis and treatment, decreased patient confidence and satisfaction, and increased unnecessary and avoidable costs.[34]

4.2 Education to face health literacy

The participants found the knowledge and information that were provided to them to be beneficial in improving their health literacy and empowering them. This is in line with many other studies which indicated that knowledge and information empower cancer survivors to make the best decisions concerning their health, to have the best health and well-being outcomes, to gain a sense of control over their situation, reduce anxiety, and formulate plans for the future.[27,35,36] Participants in this study desired more health promotion and prevention programs specifically for immigrant women in their language (Arabic). They also suggested that having the cancer informational sessions, videos, and readable material in Arabic would help them manage their fears and reduce the uncertainty during their cancer survivorship journey. This indicates that the women in this study showed positive attitudes towards improving their health literacy, health promotion and prevention programs, and staying healthy.

These results concur with previous studies conducted in Ontario, including Arab, African, South-Asian, and East-Asian immigrant women.[15,17] Many Canadian studies recommended the need to increase breast and cervical cancer awareness among immigrant women by providing health promotion and prevention programs that consider language barriers, cultural competency, and structural barriers to accessing health services.[12,17,37] Although there is a limited number of health intervention and promotion programs targeting immigrant women across Canada, a couple of programs were conducted in Ontario. These programs used culturally-tailored interventions, community-based care models, and innovative screening tools. These programs positively impacted immigrant women's knowledge of cancer screening programs and cancer care.[37] These empirical studies indicated the importance of providing culturally appropriate and language-specific cancer care intervention materials to help immigrant cancer patients and their families improve health literacy.

The participants would have liked to have been offered education programs for their children in order to teach them about their parents' challenges during the cancer survivorship journey and how to adjust to changes in their new social environment. Parental cancer leads to a disproportion in family life and their ability to handle the situation. Parents with cancer also notice fear and stress among their children.[38] It is essential to point out that parents newly diagnosed with cancer find communicating the news with their children difficult.[26,39] If children are not informed about their parents' cancer diagnoses, they can draw meaning from the changes in their family (i.e., physical and psychological health).[39] Previous studies have indicated that children of single mothers with cancer experience poor adjustment and more problems due to poor social support from their partner and family conflicts.[40] Previous studies have shown that providing children with appropriate information about cancer, quality communication, and the quality of the relationship with their parents can reduce children's anxiety and any long-term adverse consequences.[38,39] It is also recommended that healthcare professionals consider children's perspectives to develop appropriate interventions to support children and their parents. Parents who choose healthy coping mechanisms during cancer survivorship can enhance their children's coping abilities.[39] The ability to use available resources, find support groups for families with cancer, and ask for help from healthcare providers and the counsellor can also help the children and their parents cope successfully during the cancer survivorship journey.[38] The Canadian Cancer Society (n.d.) provides detailed information about how to find support and support groups to help family members cope with cancer and available resources for families.[41]

Research participants indicated how critical it was for immigrant women to communicate in the English language to help them access health services, communicate with healthcare providers, understand all the cancer care educational materials, and participate in support groups. This study showed the noteworthy difference between an immigrant woman who could communicate in English and one who could not. The participant who was able to communicate in English described her ability to communicate in English as empowerment for her to access various health services, understand various health educational materials, communicate with health services providers, join support groups, and reach out. However, the participant, who could not communicate in English, found it challenging to access various health services alone because she could not adequately communicate with healthcare providers. She would also always look for an interpreter to translate medical information. These findings are in agreement with various Canadian and international studies, which convey that poor English proficiency is one of the significant barriers for immigrant and refugee women to access health services.[2,17,37,42]

4.3 The stigma of mental health

The cancer survivorship journey was fear-inducing and anxiety-provoking for the women in this study, particularly during the treatment stage. All participants described how the chemotherapy treatment stage was the most stressful in this journey due to all the physiological and psychological health changes. This result agrees with many studies that declared that cancer survivors start experiencing psychological disorders as soon as they are diagnosed with cancer.[43] The chemotherapy treatment stage is the most challenging stage with the highest levels of distress.[44]

The participants declared that the cancer survivorship journey was arduous for them and their family members, which required psychotherapy because they experienced stress, depression, and anxiety. In Middle Eastern culture, the family is the dominant social unit, and women represent the backbone of the family. If a woman experiences any chronic illness (e.g., cancer) with psychological distress, it will impact the family. This is also common in various international publications, as the family is the primary source of social support and home caregivers during the cancer survivorship journey.[45,46] Further, cancer is considered an onerous experience for the family because it affects the family's stability, relationship, and ability to cope with considerable stress. The cancer survivorship journey also causes family members' burden, unwanted changes, distress, depression, and anxiety.[46] Consequently, accessing family psychotherapeutic interventions and services can have great potential for families to improve their communication, identify their needs, increase their role flexibility and coping, and enhance their adjustment to the new social, vocational, and financial realities.[47]

Educated participants in this study recognized the importance of psychotherapy for themselves and their family members during the cancer care process to enhance their health and well-being. This positive perception of mental health services indicated the acculturation of these women into the Canadian culture. On the other hand, other participants and/or their family members did not access psychotherapy services or counsellors because of their preconceived beliefs that psychotherapy is a disgrace and stigmatized in their culture. Sewilam et al. (2014), in their literature review about mental illness in the Middle East, have indicated that mental illnesses are highly stigmatized and faced with social rejection because they are viewed as a weakness, shameful, and disgraceful.[48] This cultural belief of mental illness in the Middle East leads to discrimination and social isolation because mental illness is associated with the terms "crazy," "mad," and "harmful." With the stigma of mental illness comes a devaluation of families with mentally ill individuals and diminished marital prospects.[48]

The participants faced anger and mental health struggles, but they reacted to this psychological distress with denial. This belief is likely due to mental health stigma or poor communication with healthcare providers about their mental health. Immigrant women and their families are less likely to discuss mental health issues with their healthcare providers.[37] Therefore, newcomers to Canada have lower mental health services attendance rates than longer-term immigrants.[49] Various studies have indicated that female immigrants and ethnic minority cancer survivors experience lower rates of emotional well-being, higher rates of fear of recurrence, low quality of life, and more symptoms of depression than nonminority women.[50–53] This is likely attributed to the fact that female immigrant cancer survivors are less likely to join individual or group psychotherapy programs,[54] lack of adherence to treatment sessions,[55] as well as other systematic barriers (i.e., cultural beliefs of mental health, or lack of English proficiency and communication skills, and lower socioeconomic status).[5]

The findings in this study can help healthcare providers to understand the lived experiences of MEIW during their cancer survivorship journey with health services in Canada and provide them with holistic care. Healthcare professionals must be aware of the multitude of factors and barriers that affect immigrant women's cancer survivorship outcomes. Communication in cancer care can help cancer survivors cope and improve their experiences.[56] Therefore, healthcare professionals are encouraged to communicate with immigrant women to identify their unmet support needs during their cancer survivorship journey. This particularly applies to women who manage their cancer survivorship journey without support from family or who can not speak the English language. Healthcare professionals can encourage immigrant women to communicate their feelings and concerns through interpreters if needed. Healthcare professionals can increase immigrant women's awareness that lack of communication and concealing their emotions and illness can reduce their ability to access various support resources that might help them improve their health and well-being.

4.4 Implications

Culturally appropriate and language-specific psychoeducational interventions are required for cancer patients and their families to help them learn how to cope and look for support in their community. They also need extra information and help identify possible support resources for them. The participants in this study also required health education programs for children of patients with cancer to help children learn more about cancer, adjust to the changes in the family, and learn the best coping strategies. Healthcare providers need education about providing culturally competent care and tools to learn more about their patients. This can be done by incorporating educational programs and courses into nursing, medicine, other health sciences, and health services programs. Continuing healthcare training on culturally competent care can be achieved through educational workshops and assessment tools.

To reduce disparities in healthcare services, the federal government should consider providing the Interim Federal Health Program (IFHP)[29] to all new immigrants from all immigration categories during the first three months of arrival to Canada. This program can provide limited and temporary coverage of healthcare benefits for all new immigrants until they receive the provincial healthcare cards that allow them to access various provincial healthcare services.

Some Canadian provinces, such as Nova Scotia, Quebec, and Ontario, have cancer care navigators to help cancer patients and their families.[57] This service can help new immigrants and Canadian residents navigate the healthcare system and find available health services, resources, facilities, and support programs. However, recent immigrants have had difficulties navigating the healthcare system. Therefore, the federal and provincial governments should fund programs to facilitate navigating cancer care programs and the whole healthcare system.

The federal and provincial governments should stress increasing, integrating, and providing culturally competent care within the Canadian healthcare system. This can be done by providing interpreters, workshops, and training for healthcare providers and recruiting minorities to work in the healthcare system. Federal and Provincial governments must also provide more resources for parents with cancer to help them find childcare services and any other necessary services for their children. Finally, for future studies, it is recommended to study the lived experience of new immigrant women separately from immigrant women who have already acculturated into the Canadian culture. The sample should include women from different ethnic groups who immigrated to Canada from the Middle East.

4.5 Limitations

Recruiting immigrant women in health research studies is still a challenge, and many health studies face this limitation. One of the most significant limitations of this study is that many of the participants' experiences overlapped with immigration to Canada experiences, such as the English language barriers, cultural stigmatization, and knowing the Canadian healthcare systems and available resources. This overlapping between the two experiences might influence the pure experiences of participants concerning cancer health services. Because all three participants were from the same ethnic group, the transferability of the results of this study to other contexts may be limited to only people from the same ethnic group, who have the same immigration status, and who live in similar circumstances to the study's participants. Although the small sample size (n = 3) can also be a limitation of this study and data can not be generalized, the results of this study are transferable, and the participants' stories were full and detailed enough to gain an understanding the phenomenon under investigation.

5. CONCLUSION

The findings from this study add to the knowledge of perceptions, reactions, the impact of various social determinants of health, and lived experiences of MEIW with cancer health services in Canada during their cancer survivorship journey. The experiences of healthcare services for Middle Eastern Immigrant women with cancer were both positive and negative. The positive experience encouraged cancer survivors to seek help and access cancer healthcare services; however, the negative experiences were very challenging, thus adding an extra burden on their shoulders to access appropriate healthcare services. Therefore, empowering, enlightening, and training healthcare professionals in meeting the challenges of MEIW cancer survivors may enhance the quality of care and the perceptions and experiences of cancer survivorship care by immigrant women. Healthcare professionals must identify immigrant women's unmet needs for support and psychosocial responses during their cancer survivorship. Language-specific and culturally competent cancer-care intervention programs need development within the Canadian healthcare system.

CONFLICTS OF INTEREST DISCLOSURE

The authors declare no conflicts of interest.

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