

Exploring Somali Refugee Women's Experiences Accessing Health Care Services in Manitoba

by

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A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

In partial fulfillment of the requirements for the degree of

MASTER OF NURSING

College of Nursing

Rady Faculty of Health Sciences

University of Manitoba

Winnipeg

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Abstract

In 2012, there were significant cuts to Canada's Interim Federal Health Program, an extended health insurance program for newcomer refugees. The cuts resulted in inequitable access to funding amongst government-assisted refugees, privately sponsored refugees, and refugee claimants. The funding was restored in 2016, back to pre-2012 levels; however, policies that differentiate access to health care based on refugee status continue to exist. This exploratory qualitative descriptive study recruited a purposive sample of Somali women who were government-assisted refugees (n=3), privately sponsored refugees (n=6), or refugee claimants (n=3) and were residing in Manitoba, Canada. The theory of Well-being in Refugee Women Experiencing Cultural Transition was used to guide the study. The principal investigator used a semi-structured interview guide to inquire about each woman's experiences accessing and utilizing health care services in Canada in individual, face-to-face, digitally recorded interviews. Five of the twelve interviews were conducted in English and were transcribed verbatim by a professional transcriptionist. The remaining seven interviews were conducted in Somali and were translated into English and then transcribed by the principal investigator. Qualitative content analysis was used to analyze the data. The principal investigator coded the transcripts by hand and then re-coded the transcripts using *Atlast.ti*, a qualitative data analysis software program. The codes were then organized into categories and sub-categories. The findings are presented in three sections: Accessing Health Care, Utilizing Health Care, and the Role of the Health Care Provider. The results of this study support the findings of previous research and problematize current refugee health care delivery in Manitoba. The refugee claimant women experienced the most significant challenges in accessing and utilizing health care. Two of the refugee claimant women reported experiencing discrimination when trying to access health care with their Interim

Federal Health Program coverage and before they had obtained a Manitoba Health Card. The privately sponsored refugees with limited English language proficiency experienced greater challenges utilizing health care services compared to the English speaking privately sponsored refugee women and the limited English language proficient government-assisted refugee women. This timely study has implications for health care providers, professional health program educators, and policymakers.

Acknowledgements

Thank you to my Thesis Advisor, Dr. Lynn Scruby, and my Internal Committee Member, Dr. Donna Martin, and External Committee Member, Dr. Shauna MacKinnon. I appreciate your support and feedback on my research project. Thank you to the Manitoba Centre for Nursing and Health Research (MCNHR), the Dr. Margaret R. Francis Award, and the Women's Health Research Foundation of Canada Part-Time Graduate Scholarship, for supporting this research. Thank you to S. R. who transcribed the English language interviews, H.F. who provided interpretation services for most of the Somali language interviews, and A.I. who reviewed my English translations of all the Somali language interviews. A final thank you to all 12 women who participated in this study and shared their experiences with me; this project would not have been possible without your participation.

Dedication

This work is dedicated to my family. Thank you for your continued support.

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List of Copyrighted Material

Figure 1: The Theory of Well-being in Refugee Women Experiencing Cultural Transition (Baird, 2012). 18

CHAPTER ONE: INTRODUCTION

The purpose of this chapter is to provide the context for this study. This chapter includes: (i) background information about the focus of this study and definition of key terms; (ii) the purpose, rationale, research question, and objectives of the study; (iii) background information about the population of interest; (iv) my personal experiences and observations; and (v) the underlying assumptions of this study.

Canada's Refugee Resettlement Programs

Canada's long tradition of accepting refugees dates back to 1969, when Canada signed the United Nations' Convention Relating to the Status of Refugees (Jackson & Bauder, 2014). To date, Canada uses the Convention's definition of a refugee which describes a refugee as an individual living outside his or her home country and who is unable to return due to fear of persecution based on religion, race, nationality, political opinion, or sexual orientation (Government of Canada, 2017c; Government of Canada, 2017d). The Office of the United Nations High Commissioner for Refugees (UNHCR) leads international efforts to resettle refugees in which countries, like Canada, participate (UNHCR, 2014). Resettlement is "the transfer of refugees from an asylum country to another State that has agreed to admit them and ultimately grant them permanent settlement" (UNHCR, 2014, para. 2). Refugee receiving countries have different policies regarding resettling refugees; thus, understanding Canada's policies is essential. This section serves as a brief introduction to Canada's refugee resettlement programs that are relevant to the proposed study.

Canada has two refugee resettlement programs (Government of Canada, 2017c). The first program, the Refugee and Humanitarian Resettlement Program, is for refugee applicants who are living outside Canada (Government of Canada, 2017c). Government-assisted refugees (GARs)

and privately sponsored refugees (PSRs), two of the three refugee statuses of interest in this study, arrive in Canada under this program (Government of Canada, 2017b). As the naming suggests, GARs differ from PSRs in that the government supports the former group for up to the first year of resettlement in Canada (Government of Canada, 2017c). GARs are Convention refugees referred for resettlement to Canada by a referral organization such as the UNHCR (Government of Canada, 2016a; Government of Canada, 2017c). On the other hand, PSRs are Convention refugees who are referred for resettlement to Canada by a private sponsor (Government of Canada, 2016b; Government of Canada, 2017c). Then the private sponsor becomes responsible for supporting the refugee during the first year of resettlement (Government of Canada, 2016b; Government of Canada, 2017c). There are further complexities within the private sponsorship program which leads to variation in whom (and how many people) can undertake the private sponsorship of a refugee or refugee family (Bramadat, 2014). There are also a small number of refugees who are jointly assisted by the government and private sponsors (Bramadat, 2014). Both of these designations are outside the scope of this study and are not explored further in this thesis.

Canada's second refugee program, the In-Canada Asylum Program, is for applicants who are already inside Canada and seeking asylum (Government of Canada, 2017c). Individuals arriving in Canada for the purpose of making an asylum claim under the In-Canada Asylum program are referred to as asylum seekers; however, once the individual makes a claim the individual is legally referred to as a refugee claimant (RC) (CCR, 2010; Government of Canada, 2017c). RCs are in a more precarious position in terms of their legal residency status, in comparison to PSRs and GARs, and their eligibility for support and services in Canada is limited (Jackson & Bauder, 2014; Newbold, Cho, & McKeary, 2013). RCs are considered temporary

residents of Canada until a decision is made on their refugee application by the Immigration and Refugee Board of Canada (Government of Canada, 2017b; WRHA, 2014). Only if the Immigration and Refugee Board approves an RC's application, is the individual allowed to stay in Canada and given the opportunity to apply for permanent resident status (Government of Canada, 2017b).

To sum up, GARs and PSRs: have had their refugee application accepted by Canadian government officials; have had their travel arrangements for arrival to Canada arranged by Canadian government officials; and are considered permanent residents of Canada upon arrival. In contrast, asylum seekers arrive in Canada first and then apply for permission to stay in Canada, by seeking protection as RCs. Only RCs who have had their claim approved can apply to become permanent residents of Canada.

Definition of Key Terms

This table summarizes the relationship between the refugee categories of interest in this study and the related definitions.

Table 1: Definition of Key Terms

Main Categories	Sub-Categories of Interest
Permanent Residents Individuals who are not Canadian citizens but have permission to reside in Canada permanently, such as immigrants and refugees (CCR, 2010; WRHA, 2014)	Government-Assisted Refugees (GARs) GARs are refugees living outside of Canada accepted for resettlement by the Canadian government. These refugees receive essential resettlement support through local settlement organizations, which are funded by the federal government, and they receive financial support through the federal Resettlement Assistance Program (Government of Canada, 2016a; WRHA, 2014).
	Privately Sponsored Refugees (PSRs) PSRs are refugees living outside of Canada who are referred to the Canadian government, for resettlement, by groups of individuals or organizations in Canada. These refugees are then accepted for resettlement by the

	Canadian government. Essential resettlement support and financial support is provided by the individuals or organizations that initiated the referral as private sponsors (Government of Canada, 2016b; WRHA, 2014).
Temporary Residents Individuals who have temporary permission to reside in Canada, such as international students, temporary foreign workers, visitors, and RCs (CCR, 2010; WRHA, 2014).	Refugee Claimants (RCs) RCs are individuals who have arrived in Canada and are now seeking legal protection as a refugee from the Canadian government (CCR, 2010; Government of Canada, 2017a; Government of Canada, 2017c; WRHA, 2014).

Statement of the Problem

There is an urgent need to conduct research on the health and well-being of Canada's refugee populations due to issues identified within the current health literature. Issues identified in the literature include the fact that the terms immigrant, refugee, and migrant are used incorrectly (Gushulak et al., 2011) and in a way that homogenizes newcomer groups (Edge & Newbold, 2013). Legal immigration or refugee status is acknowledged to result in different resettlement experiences (Aberman, 2014; Edge & Newbold, 2013); thus, there is a need to explore the different experiences across these legal statuses (Edge & Newbold, 2013; Guruge, Bipreet, & Samuels-Dennis, 2015). Also, many immigrants and refugees who resettle in Canada are known to face systemic barriers in accessing the health care system even though accessibility is one of the five principles of the Canada Health Act of 1985 (Asanin & Wilson, 2008). Across Canada, primary health care clinics are being created to address the barriers refugees are experiencing in accessing health care services; however, these clinics often limit their services to GARs (Dangerfield, 2010; McMurray, Breward, Breward, Alder, & Arya, 2014; Reception House, n.d.; WRHA, 2010a). Restricting access to specialized refugee health care services, to newly arrived GARs only, is a concerning policy that further strengthens the need to

acknowledge the health care experiences of all refugees. This policy also justifies the need to consider the impact of differences in legal status when exploring the health care experiences of refugees.

To combat the homogenization of refugees, there is a need to conduct research within specific cultural groups when exploring the experiences of refugees (Edge & Newbold, 2013). Somali refugees in Manitoba have arrived in Canada as RCs, GARs, and PSRs. This population's diversity in refugee status has significant implications on their access to services and support based on differences in their legal refugee status. This study will explore the health care experiences of Somali women in a city in Manitoba with sensitivity to the reality of this group's diversity in refugee status.

Research Question and Objectives

This study aims to answer the following research question: What are the experiences of Somali refugee women accessing health care in Canada? The objectives of this study are:

1. To describe Somali refugee women's experiences accessing health care services in Canada.
2. To explore factors that influence Somali refugee women's access to health care services in Canada.
3. To explore how refugee status influences Somali refugee women's access to health care services in Canada.

Theoretical Framework

Baird's (2012) theory of Well-being in Refugee Women Experiencing Cultural Transition was chosen as a theoretical framework to guide the study. Baird's research was influenced by post-colonial critical feminist theory and was based on research conducted with Sudanese refugee women resettled in the United States (2012). Baird's theory provides a holistic view of

how refugees undergo cultural transition during the resettlement process and the relationship between cultural transition and well-being (2012). The literature supports the need to use upstream, social determinants of health approaches (Castañeda et al., 2015; Hordyk, Hanley, & Richard, 2015; Wang, 2014) and a feminist lens (Guruge & Khanlou, 2004). Thus, using Baird's theory is an appropriate guiding framework for the proposed study. Baird's theory is described further in the next chapter of this thesis proposal.

Somalis in Canada

Of interest in this study is the experience of Somali refugee women resettled in Canada. Somalia, a country in eastern Africa, has been a refugee-producing nation since the early 1990s when the country's government collapsed due to civil war (CIA, 2016; Hopkins, 2010). Clan-based conflicts, renewed civil wars, droughts, and famines have resulted in over one million Somalis becoming internally displaced and another one million becoming externally displaced or resettled in countries such as: Kenya, Yemen, Sweden, Norway, Denmark, the United Kingdom, the United States, and Canada (Bokore, 2013; CIA, 2016; Sheikh & Healy, 2009; Stewart, Simich, Shizha, Makumbe, & Makwarimba, 2012). Unfortunately, the situation in Somalia continues to be grim due to the lack of a stable functioning government. This has resulted in Somalia being rated the most fragile state in the world during the years 2008 to 2013 (FFP, 2008; FFP, 2009; FFP, 2010; FFP, 2011; FFP, 2012; FFP, 2013; OCASI, 2016) and in 2016 (FFP, 2016), and the second most fragile state for the years of 2014, 2015, 2017, and 2018 (FFP, 2014; FFP, 2015; FFP, 2017; FFP, 2018; OCASI, 2016). This bleak current history explains some of the reasons why Somalia continues to be a refugee-producing country today and why Somali refugees continue to seek resettlement in countries like Canada.

Somalis have been seeking refuge in Canada since the mid-1980s (OCASI, 2016); yet, it is difficult to find accurate statistics about the Somali population in Canada (Bokore, 2013; Buchanan, 1996). For instance, in the 2006 Canadian census approximately 37,700 respondents reported Somali as their ethnicity (Bokore, 2013; Statistics Canada, 2010) and in the 2011 National Household Survey nearly 45,000 respondents report their ethnicity as Somali (Abdela, 2015; Statistics Canada, 2017a). More recently, the 2016 census reports that 62,550 respondents identify their ethnic origin as Somali (Statistics Canada, 2017b). Some sources suggest that Statistics Canada's numbers grossly underestimate the Somali population. For example, one source estimates that up to 70,000 Somalis arrived in Canada between the years 1988 and 1996 (OCASI, 2016) and another source reported that between 120,000 to 150,000 Somalis were living in Canada in 2006 (Abdela, 2015; Hiiraan Online, 2006).

The literature contains claims that Canada has treated Somali refugees inequitably when compared to other refugees (CCR, 2015). The fact that Somali refugees have never been the beneficiaries of a targeted Canadian government led refugee resettlement program, like that of the Chilean (Raska, 2016), Indochinese (OCASI, 2016; Raska, 2016), or Syrian refugees, is evidence used to support this claim. There is also evidence of government practices and policies that act as barriers to prevent Somali refugees from arriving in Canada through private sponsorship or family reunification (CCR, 2015). The lack of welcome and support towards Somali refugees is also attributed to local communities and not only the government (OCASI, 2016). The scholarly literature recognizes that racism (Aberman, 2014) or colour-coding (Spitzer, 2007) has historically affected Canada's refugee policies and both are suggested to have played a role in the inequitable treatment of Somali refugees (Spitzer, 2007).

In terms of numbers, it is difficult to find comparable data for the number of Somali refugees arriving in Canada under each refugee subcategory. The only year that nearly comparable data could be found was for 2014. A Canadian Broadcasting Corporation (CBC) article cites that there were 460 Somali GARs and 590 Somali PSRs arrivals in 2014 (Schwartz, 2015) and Canadian Council for Refugees indicates that 200 Somali RC cases were heard by the Immigration and Refugee Board that year (Rehaag, 2015). Unfortunately, the Canadian Council for Refugees figure is not exactly comparable to the CBC article's figures as the number of Somali RC cases heard in 2014 may not be the same as the number of Somali asylum seekers who entered Canada and made a refugee claim in 2014. This difference is due to the period of time that elapses between when one makes a refugee claim and when his or her case is adjudicated.

There is evidence that in 2011, Canada's then Conservative federal government made a decision to go against a UNHCR recommendation that supported the consideration of Somali refugees as a priority group for resettlement (Ahmed, Denetto, & DePape, 2015; CCR, 2015). Instead, the Conservatives cited a concern that Somalis are not integrating well in Canada, to support the government not considering Somalis for priority resettlement (Ahmed et al., 2015; CCR, 2015). This Conservative government policy stance has negative implications for Somali refugees because it marks this population as not deserving to come to Canada. This policy stance may also explain the decrease in the Immigration and Refugee Board's acceptance rates for Somali RCs after 2012, during the Conservative federal majority government (OCASI, 2016). For example, between 2008 and 2012 acceptance rates for Somali RCs were above 90% (Rehaag, 2009; Rehaag, 2010; Rehaag, 2011; Rehaag, 2012; Rehaag, 2013); however, the acceptance rates started steadily decreasing. This decline is evidenced by the following

subsequent rates: 79.6% in 2013 (Rehaag, 2014), 66.7% in 2014 (Rehaag, 2015), and 63% in 2015 (Rehaag, 2016). The acceptance rate in 2016 was 71.6% (Rehaag, 2017) which may be related to the change in the federal government to a Liberal majority after the 2015 fall election. In 2017, Rehaag's analysis shows that the acceptance rates for Somali refugee claimants differed based on which process was used to adjudicate the claim with 96.8% approval using the 'legacy' process and 62.9% using the new process (2018).

Somalis in Manitoba

Early figures of the Somali community in Manitoba is estimated to have been 90 individuals in 1996 (Buchanan, 1996). The 2006 Census found that 650 respondents in Manitoba reported their ethnic origin as Somali (Statistics Canada, 2010) and the 2011 National Household Survey revealed that 930 respondents in Manitoba reported their ethnicity as Somali (Statistics Canada, 2017b). The most recent population statistic, the 2016 census, reports that 1,740 respondents identified their ethnicity as Somali (Statistics Canada, 2017c). Given the number of recently arrived GARs, PSRs, and RCs to the province, the population of Somalis in Manitoba is expected to be even higher for 2019.

Since Manitoba Labour and Immigration publishes the number of new permanent residents arriving, it is difficult to infer exactly how many Somali refugees are arriving as GARs versus PSRs. Statistics about the number of new Somali permanent residents arriving in Manitoba prior to 2013 also could not be found. Presumably, because Manitoba Labour and Immigration only publishes the top ten most frequent countries of birth and languages spoken; thresholds that Somalis only began meeting in 2013. Per Manitoba Immigration Facts Statistical Report for 2014, 362 permanent residents arrived from Somalia in 2013, and 356 arrived in 2014 (Province of Manitoba, 2015). Comparatively, the number of Somali-speaking arrivals is slightly

higher with 379 arriving in Manitoba in 2013 and another 371 arriving in 2014 (Province of Manitoba, 2015). Numbers for Somali permanent resident arrivals were not published in the same fashion for 2015 since Somali arrivals were not part of the top ten most frequent countries of birth and languages spoken. However, in 2016 the report cites that there were 365 Somali citizens arriving in Manitoba as permanent residents and 380 permanent resident arrivals to Manitoba who reported their mother tongue as Somali (Province of Manitoba, 2017). The difference in the number of Somali speakers is higher once again implying that ethnic Somalis who were born outside of Somalia are resettling in Manitoba. An excellent example of this could be a child born to externally displaced Somali refugees, prior to arrival in Canada; thus, the child's country of birth would not be reported as Somalia.

Another problem with these statistical figures was noted in the Province of Manitoba's Immigration Facts Report for 2016. In 2016, the number of Manitoba's newly arrived permanent residents with Somali as their mother tongue was not published because it was no longer one of the top 10 languages (Province of Manitoba, 2017). Also in this 2016 report, the number of permanent resident arrivals in 2014 with Somalia as their country of citizenship, changed from 356 (Province of Manitoba, 2015) to 363 (Province of Manitoba, 2017). The reason for this change is unclear, but it emphasizes a problem with relying on secondary statistical data. A potential contributor maybe related to the federal government change in 2015, since the 2014 report cites utilizing data from 'CIC' referring to Citizenship and Immigration Canada (CIC); whereas, the 2017 report utilized data from 'IRCC' referring to Immigration, Refugees and Citizenship Canada (IRCC). Both of these federal departments are the same, just that the current Liberal government renamed CIC to IRCC (CIC News, 2016).

The Province of Manitoba's Immigration Facts Report for 2016 identified how many resettled refugees (GARs, PSRs, and blended visa office referred refugees) were Somali citizens (2017). This more well-defined statistic reports a total of 574 Somali refugees were resettled in Manitoba as permanent residents (Province of Manitoba, 2017). An improvement in the 2016 report is that it is very clear that these numbers exclude Somali RCs resettling in Manitoba who may gain permanent resident status soon after arrival (Province of Manitoba, 2017).

Somali refugee claimants in Manitoba. This research is particularly timely given that Manitoba is known to have a recent influx of Somali RCs who have walked into Canada through the Manitoba-North Dakota border (Grabish & Glowacki, 2017; Heppner, 2016; Huffman, 2017). Between 2011 and 2016, there were 365 asylum claimants processed in Manitoba; however, this number drastically increased with 1,090 and 620 asylum seekers being processed in Manitoba between January and December 2017 and 2018 respectively (Government of Canada, 2018a; Government of Canada, 2018b). This significant increase was linked to the inauguration of Donald Trump as the President of the United States in January 2017 and his proposed policies including a travel ban on Somalis and other Muslims (Malone, 2017).

Refugee Women

This research specifically focuses on the experiences of Somali refugee women because refugee women are considered to: be a vulnerable population (Baird, 2009; Brown-Bowers, McShane, Wilson-Mitchell, & Gurevich, 2015); be overrepresented in refugee communities; face significantly more challenges; and be at higher risk for oppression and violence than men (Tastsoglou, Abidi, Brigham, & Lange, 2014). Unfortunately, the vulnerability of refugee women continues into the post-migration or resettlement phase as they experience: isolation (Edge & Newbold, 2013), gender inequality (Baird, 2009; Brown-Bowers et al., 2015; Edge &

Newbold, 2013), sexual oppression (Edge & Newbold, 2013), and socioeconomic marginalization (Brown-Bowers et al., 2015; Edge & Newbold, 2013). Thus, there is a need for research to understand the experience of refugee women: socially, politically, and economically as forced migrants (Aberman, 2014; Brown-Bowers et al., 2015).

Somali Refugee Women in Canada

Somali refugee women resettling in Canada face additional challenges during the resettlement process (Bokore, 2013; Spitzer, 2007). Resettling in Canada with little to no English language skills and minimal formal education are significant challenges that are further compounded by oppression based on other categories of identity such as: religion, race, class, legal status, and gender (Bassel, 2010). This research study will endeavor to not homogenize the experiences of refugees in Canada by defining the population of interest as: women who self-identify as ethnically Somali, reside in a city in Manitoba, and have arrived in Canada as a GAR, PSR, or RC.

Framing Myself within Qualitative Research

This section serves to state my personal beliefs, perceptions, motivations, and experiences in order to illuminate my positionality and standpoint as the researcher. My interest in this area of research as a graduate student is not expert-driven, rather it stems from my personal lived experience as a Somali refugee who is now a Canadian citizen. I specifically chose to do a qualitative research study over a quantitative study because I want to give a platform for the voices of Somali refugee women to be heard by service providers. Qualitative description, as described by Sandelowski (2000, 2010), will be used in this study because it is an appropriate research design to explore a topic from the first-hand experiences of research participants (Neergaard, Olesen, Andersen, & Sondergaard, 2009).

My Personal Experience and Observations

I arrived in Canada as a resettled refugee prior to my third birthday and I attribute this young age of resettlement to much of my successes as a Somali-Canadian. Not only did my young age protect me from traumatic memories of: fleeing Mogadishu, Somalia; living in the Dadaab refugee camp in Kenya; and resettling in Canada. This young age also gave me the opportunity to start learning English as a four-year-old in a Canadian junior kindergarten classroom. I highly doubt that I would be a Registered Nurse pursuing graduate level education today if I had spent the last two decades living in the Dadaab refugee camp.

As a Registered Nurse, I am interested in using my scope of practice to promote the health and well-being of refugees resettling in Canada. I tailored my graduate course NURS 7360, Integrative Focus, to explore this area of interest. In this course, I was required to complete at least 156 hours of learning experience that I achieved through shadowing and conversing with: health care providers, professional medical interpreters, social workers, and immigration settlement workers, who work with immigrant and refugee populations. During this experience, I recognized how differences in legal immigration and refugee status could directly impact a refugee's determinants of health and well-being. I learned of the significance of legal refugee status and that differences in access to essential resources and supports existed between PSRs, GARs, and RCs. These are nuances that I was unaware of as a health care provider. Thus, I will use my master's thesis to explore the influence of legal refugee status on the health care experiences of Somali refugee women.

Assumptions Underlying the Study

Qualitative researchers acknowledge that they have their own personal assumptions and that the research paradigms they are using are also shaped by assumptions (Rossman & Rallis,

2017). In this section, I describe my personal assumptions that have influenced this research proposal; whereas, assumptions related to methodology are explored in chapter four of this proposal.

My first assumption is that differences in legal refugee status can affect the health care experiences of refugees. There is evidence in the literature to support this assumption as some researchers have found that legal immigration status differences can explain variation in post-migration health status (Gualdi-Russo et al, 2014; Moullan & Jusot, 2014; Pimentel & Eckardt, 2014) and other researchers have found that health care experiences differed among individuals with different legal immigration status (Campbell, Klei, Hodges, Fisman, & Kitto, 2014; Miklavcic, 2011; Woodgate et al, 2017). Based on this assumption, I have chosen to recruit Somali refugee women who have arrived in Canada as GARs, PSRs, and RCs, instead of narrowing my population to just one of these refugee subgroups or ignoring immigration status by viewing Somali refugee women as a homogeneous group. Since GARs have access to dedicated resettlement services, social services, and health care services, I anticipate that they may have more positive health care experiences to report than PSRs and RCs. Furthermore, based on the work of Campbell and colleagues (2014) and Woodgate and colleagues (2017), I anticipate that PSRs will have more positive health care experiences to report than RCs because PSRs have access to provincial health care insurance and social support from their sponsors; whereas, RCs lack both.

Secondly, I anticipate that length of time residing in Canada and fluency in the English language will both influence the health care experiences of Somali refugee women. There is significant support in the literature that length of residency can impact health status and that this should be considered as a demographic variable (Collins, Zimmerman, & Howard, 2011; Guruge

& Butt, 2015; Guruge et al., 2015; Hirani, Payne, Mutch, & Cherian, 2016; Moullan & Jusot, 2014; Ro, 2014; Sanou et al., 2014; Wang, 2014). Language proficiency is another known determinant of health among newcomers (Edge, Newbold, & McKeary, 2014; Guruge & Butt, 2015; Guruge et al., 2015; Moullan & Jusot, 2014) and language barriers are recognized to limit the usefulness of available health information (Gushulak et al., 2011). English language proficiency is recognized to improve with longer length of residency (Ro, 2014), this demonstrates a relationship between the length of residency and official language fluency. For the purposes of feasibility as a masters-level thesis, I did not specify length of residency in my inclusion criteria. Rather I recruited a convenience sample of women and collected information about their length of residency as demographic information. I then used this data to recognize the potential influence of length of residency and English language proficiency on my research findings.

Thirdly, I recognize that refugee women may be comparing their post-migration health care experiences to their pre-migration health care experiences, as other researchers have identified this was occurring in their studies (Bowen, 1999; Woodgate et al., 2017). This assumption supports the importance of understanding the pre-migration health care experiences of these women. However, in preference for minimizing potential harm and for reducing the risk of re-traumatizing the women, I did not ask any questions directly about the research participants' pre-migration experiences in this study. Nonetheless, if women voluntarily disclosed pre-migration experiences during the interview, this data was included in this study. Instead, I focused my questions to ask specifically about the women's early experiences of health care services in Canada and their expectations.

Summary

This chapter provides the reader with an introduction to this proposed study. The purpose, relevance, research question and objectives, and assumptions were presented. Definitions related to the refugee statuses of interest were also provided. The following chapter will introduce the conceptual framework guiding the proposed study.

CHAPTER TWO: THEORETICAL FRAMEWORK

In the last chapter, the proposed research and the chosen theoretical framework were introduced. In this chapter, the theoretical framework is described further. Chapter two includes: (i) an introduction to the theory of Well-being in Refugee Women Experiencing Cultural Transition; (ii) a description of the theory using Chinn and Kramer's (2011) guide; (iii) and an exploration of the fit between the theory and the proposed study.

The Theory of Well-being in Refugee Women Experiencing Cultural Transition

This researcher is interested in using the theory of Well-being in Refugee Women Experiencing Cultural Transition (RWCT) to guide an exploration of the health care experiences of Somali refugee women. Dr. Martha B. Baird first wrote about the theory of well-being in RWCT as part of her doctoral dissertation in 2009, and then published this theory in 2012. Baird developed this theory from the findings of two studies she conducted with refugee women from South Sudan who were living in the United States (2012). Baird set out to extend the theory of transitions to include cultural transition (2012). The theory organizes how cultural transition influences the well-being of refugee women in their host country (Baird, 2012). In her 2012 article, Baird includes a conceptualization of her theory. Baird's diagram is included below as Figure 1 in the print copy of this thesis and redacted for the electronic repository copy due to the limitations on the permission licence. No other published research which utilizes this theory or a critical review of it could be found, which is understandable given that this theory was first published eight years ago. Baird has given permission for her theory to be used and has confirmed that she is working with a Ph.D. student who is adapting the theory for use with parents who have a disabled child (personal communication, May 13, 2016).

Figure 1: The Theory of Well-being in Refugee Women Experiencing Cultural Transition (Baird, 2012). (Figure used with permission only in the print copy of the thesis. See Appendix A for permission license. The figure is excluded from the digital repository copy of the thesis, instead please find the diagram in Baird's (2012) original work.)

Describing the Theory

Chinn and Kramer's (2011) guide is utilized to describe the theory of well-being in RWCT. The purpose, concepts and definitions, and relationships and structure of Baird's theory are explored. The questions that Chinn and Kramer (2011) pose promoted the identification of the components of the theory. It is my interpretation of the theory that is presented below.

Purpose

Baird describes her theory as situation specific. Baird specifies that the theoretical purpose of the theory of well-being in RWCT is to extend the middle range theory of transition to include cultural transition (2012). The theory of well-being in RWCT also has clear applicability in nursing practice as identified by Baird. She intended for this theory to serve as a blueprint for nurses who are working with immigrants and refugees to promote well-being in this population during the resettlement period (Baird, 2012). Nurses can also use this theory to better understand the phenomenon of cultural transition among newcomer immigrants and refugees. More specifically, this theory enables health care professionals to understand how the Sudanese refugee women Baird interviewed achieved well-being during their transition to living in a new country with a different culture (2009, 2012). The end point of this theory is well-being among refugee women integrating into the culture of a new country.

Concepts and Definitions

Baird's description of the theory and the accompanying diagram clearly represent the concepts that make up the theory of well-being in RWCT. Some of the concepts are explicitly defined; whereas, other concepts are implicitly defined in the narrative of Baird's (2012) article. The organization of the concepts into major concepts, sub-concepts of major concepts, and minor concepts was gleaned from Baird's statement that the two "major theoretical constructs in the theory of RWCT are cultural transition and well-being" (2012, p. 255) and Baird's diagram of the theory.

The first major concept, cultural transition, is explicitly defined by Baird. Cultural transition is associated with three sub-concepts: separation, liminality, and integration. The second major concept, well-being, is also explicitly defined by Baird. Well-being is associated with two sub-concepts: enhanced well-being and diminished well-being. The remaining concepts are labeled minor concepts; this includes: culture of origin, facilitators (of cultural transition), inhibitors (of cultural transition), and nursing therapeutics. The definitions of these concepts are listed below in Table 2.

Table 2: Definitions of Concepts

Concept	Definition
Cultural Transition	Cultural transition is explicitly defined as "the process of moving from one culture to another and usually accompanies a geographic relocation" (Baird, 2012, p. 255). Baird also specifies that cultural transition "includes all of the variables within a culture such as language, food, social mores and behaviors, rules and laws, attitudes, and values" (Baird, 2012, p. 255).
Separation	Separation is explicitly defined as the "first phase of the cultural transition process" in which the refugee women experience "separation and displacement from their culture of origin and culture of identity" (Baird, 2012, p. 257).
Liminality	Liminality is explicitly defined as a phase of cultural transition that "occurs after a move to a new environment and culture" (Baird, 2012, p. 258) and that it is "during this phase that the reality of living in a new society becomes manifest as an individual begins to deal with the tedious activities of daily living..." (Baird, 2012, p. 258).

Integration	Baird includes a definition of integration by Phinney, Horenczyk, Liebkind, and Vedder (Baird, 2012).
Well-being	Well-being is explicitly defined as a “process measured over time in which one has adequate resources to meet basic physical, emotional, social, and spiritual needs” (Baird, 2012, p. 255). Baird also introduces other definitions of well-being before presenting the definition she is using for this theory.
Enhanced Well-being	Baird defines well-being as a fluctuating state that can be considered enhanced depending on certain factors or indicators such as: “connections with the ethnic group, mastery of new skills, and a sense of hope for the future evidenced by personal goals and a belief that these goals can be achieved” (Baird, 2012, p. 256).
Diminished Well-being	Baird defines well-being as a fluctuating state that can be considered diminished depending on certain factors or indicators such as: “isolation from one’s ethnic and social group, dependence on others, and a lack of hope” (Baird, 2012, p. 256).
Culture of Origin	Culture of origin is implicitly understood as the culture the women have before their geographic relocation and in which the women bring with them to the country of resettlement (Baird, 2012). Baird also includes a definition of culture by Marsella and Kameoka (Baird, 2012).
Facilitators	Facilitators of cultural transition is defined as “factors and conditions that can facilitate ... a healthy transition process” (Baird, 2012, p. 258).
Inhibitors	Inhibitors of cultural transition is defined as “factors and conditions that can ... inhibit a healthy transition process” (Baird, 2012, p. 258).
Nursing Therapeutics	“In the process of cultural transition, nursing therapeutics are those interventions or actions that can modify or influence the outcomes of a transition” (Baird, 2012, p. 259).

Relationships and Structure

Baird’s theory of well-being in RWCT cultural transition has a multi-directional structure as evidenced by her diagram. Her diagram begins with culture of origin, which is in its own box. This suggests that culture of origin is discrete. Culture of origin visually does not interact with the other concepts because it is the only portion of the diagram that does not have an arrow to demonstrate its relationship with the other concepts. However, the position of culture of origin on the far left suggests that this concept begins the phenomenon of interest in this theory which is cultural transition.

Next to culture of origin is cultural transition. This portion of the diagram demonstrates polarity and continuity between the sub-concepts of cultural transition which are: separation, liminality, and integration. Cultural transition is placed by Baird in the center of the diagram which signifies its place as the central phenomenon of interest in this theory. The first sub-concept, separation, is closer to culture of origin on the left; whereas, the third sub-concept, integration, is closer to well-being on the right and the second sub-concept, liminality, is in-between the two sub-concepts separation and integration. This portion of the diagram shows that cultural transition follows one path due to a horizontal arrow which points away from culture of origin on the left and towards well-being on the right. Positioning the sub-concepts on a linear plane shows the continuity and polarity of cultural transition's phases which begins with separation, is followed by liminality, and ends with integration.

To the right of cultural transition on the horizontal plane is well-being. The location of well-being on the far right demonstrates that well-being is the end point of this theory. Well-being is contained in its own box which represents this concept as discrete from cultural transition and culture of origin. Within the box of well-being are the two sub-concepts: enhanced well-being and diminished well-being. Enhanced well-being is placed above the major concept of well-being and indicators of enhanced well-being are listed between the two headings. The portion of the box above enhanced well-being is an arrow pointing upward on the vertical plane. This upward arrow shows polarity and matches the positive connotation of the word enhanced. The sub-concept diminished well-being, and the indicators of diminished well-being, are listed below the major concept well-being. The portion of the box outline below diminished well-being is an arrow pointing downward on the vertical plane. This downward pointing arrow illustrates diminished well-being's polarity as opposite of enhanced well-being. The downward pointing

arrow also implies the negative connotation associated with the word diminished. Furthermore, the organization of well-being's sub-concepts on the vertical plane and all within the same box demonstrates that there is continuity between the states of enhanced and diminished well-being.

The remaining concepts left to describe in the theory's diagram are located in the boxes above and below cultural transition. There are three of these boxes: facilitators of cultural transition and its indicators; inhibitors of cultural transition and its indicators; and nursing therapeutics. Facilitators and inhibitors are in separate boxes above cultural transition which implies they are discrete from each other. However, both these concepts have boxes which have similar arrows pointing downward which signifies that they are both related to cultural transition and are both simultaneously able to influence cultural transition. Since both arrows point downward toward cultural transition, the diagram does not adequately display the opposing influence that facilitators and inhibitors, as antonyms, can have on cultural transition. The last box to describe is nursing therapeutics which is below cultural transition. This box has examples of nursing therapeutics listed under the heading and is enclosed in a box which has an arrow which points upward toward cultural transition which signifies that nursing therapeutics can modify cultural transition.

Link between Theory and the Proposed Research

Although this theory focuses on well-being and the cultural transition of refugee women, it has theoretical relevance for exploring refugee women's experiences while accessing health care services. As a nursing discipline theory, there are many linkages between nurses assisting refugee women to improve their well-being and nurses assisting refugee women to access health care services. For example, Baird identifies: education, religion, English language skills, social support, isolation, informational support, autonomy, mastery of skills, and hope as factors which

influence cultural transition and well-being (2012). Many of the concepts, sub-concepts, factors, and indicators in the theory have also been identified in the Canadian literature on immigrant and refugee health and are discussed in the third, literature review, chapter of this proposal. However, other concepts such as autonomy, mastery of skills, and hope are not as prevalent in the Canadian refugee health literature. Thus, not only is the theory of well-being in RWCT well suited for this proposed research; this theory will also provide a novel lens to this study and the area of Canadian refugee health literature.

The theory of well-being in RWCT has influenced one of the objectives of this study. Since the theory identifies the concepts which inhibit and facilitate cultural transition and the concepts which enhance or diminish well-being, this study will aim to explore the factors which influence Somali refugee women to access and use the health care system. Some concepts from the theory, such as language, culture, and religion; have been integrated into the interview guide. Whereas, other concepts such as hope, autonomy, and mastery of skill will be considered during the analysis of the interview transcripts.

Another unifying aspect between Baird's work and theory and this proposed study is the focus on refugee women from African countries resettling in North America. Baird identifies postcolonial critical feminist theory as guiding her research which led to her creating the theory of well-being in RWCT (2012). I, as a woman conducting research about women, also recognize the influence of feminist theory on my work. I innately am more interested in exploring the health care experiences of refugee women more than refugee men due to the reality of gender inequality disadvantaging women. Affleck, Selvadurai, and Sikora (2018) also suggest that researchers are currently more likely to focus on refugee women instead of refugee men due to other factors such as the historical exclusion of refugee women as research participants and

fundings considering refugee women as a priority group. Receiving research funding for a project focused on women's health did reaffirm my personal decision to recruit refugee women only.

Summary

In this chapter, the theory of well-being in RWCT was introduced. The theory was described using Chinn and Kramer's (2011) guide and the purpose, concepts, definitions, structure, and relationships were explored. The link between the theory and the proposed research was also presented.

CHAPTER THREE: REVIEW OF THE LITERATURE

In the last chapter, the literature was briefly introduced to justify the fit between the chosen theoretical framework and the proposed research. In this chapter, I will present a review of the literature to establish the need for the proposed research. This chapter explores what is known about: (i) immigrant and refugee health; (ii) Somalis in Canada; (iii) access to the health care system including barriers and facilitators of access; (iv) experiences with the health care system; and (v) the negative outcomes of health care experiences.

Search Strategy

The databases PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Scopus, Google Scholar, and the University of Manitoba's MSpace were accessed to find the articles used in this focused literature review. Keywords used in these databases include: immigrant, refugee, government-assisted refugee (GAR), privately sponsored refugee (PSR), refugee claimant (RC), asylum seeker, migrant, newcomer, health, Canada, Winnipeg, and Manitoba. Articles which focused on: health, access, experiences with the health care system, Somalis, women, and legal refugee status, were included for a total of 117 articles of which 84 were primary empirical studies, 20 were review articles, and 13 were conceptual articles. The reference lists of articles were also scanned for additional articles which were relevant to this literature review. Since the focus of this research was on women, articles which only focused on men were excluded.

Immigrant and Refugee Health Literature

The immigrant and refugee health literature supports that a social determinant of health lens is needed (Castañeda et al., 2015; Hordyk et al., 2015; Wang, 2014) and that immigration status should be considered as a broad social determinant of health (Castañeda et al., 2015;

Gushulak et al., 2011). The literature maintains that immigrants, refugees, and asylum seekers need to be recognized as a heterogeneous group, due to their differences in history, context of migration, legal status, and socio-economic status (Campbell et al., 2014; Gushulak et al., 2011). The literature also supports that there is often a lack of clarity in the sub-population being studied and that the demographics of the study participants are not always included (Dassanayake, Gurrin, Payne, Sundararajan, & Dharmage, 2011; Guruge & Butt, 2015; MacDuff, Grodin, & Gardiner, 2011; Ro, 2014). Another common problem is that research on a specific immigrant group is often applied to all immigrants, despite the fact that demographic differences can influence the research findings (Ro, 2014). In Canada specifically, refugee sub-status is known to be directly related to differences in entitlement to support and services (Saberpor, 2016). Based on these criticisms, the Canadian health literature was examined to explore how immigrant and refugee terminology and legal status are used.

Immigrant and Refugee Terminology

Throughout the literature, it was noted that there is a lack of consistent and accurate use of terminology in the Canadian academic literature on immigrant and refugee health. The need for accurate labels has been identified by Canadian researchers, due to the fact that newcomers may have different rights, entitlements, and access to supports based on their legal status (Bronstein & Montgomery, 2011). The following describes the various terms being used and the complexity of immigrant and refugee terminology noted in the literature.

Newcomer. The term, newcomer, was utilized in many studies (Amin & Perez, 2012; Barnes, 2013; Bokore, 2013; Boli, 2016; Bowen, 1999; CHAC, 2008; Dastjerdi, Olson, & Ogilvie, 2012; Foster & McPherson, 2007; Hyndman, D'Addario, & Stevens, 2014; Larios, 2013; Lum, Swartz, & Kwan, 2016; Magoon, 2005; McKeary & Newbold, 2010; Nyman, 1992;

Pollock, Newbold, Lafrenière, & Edge, 2012; Poureslami, Rootman, Doyle-Waters, Nimmon, & FitzGerald, 2011; Reitmanova & Gustafson, 2008; Sadavoy, Meier, & Ong, 2004; Simich, Wu, & Nerad, 2007; Stewart et al., 2012; White, 2007; WRHA, 2010a; WRHA, 2014) in a manner which infers that the research participants were born outside of Canada and have immigrated to Canada recently. This definition of the term, newcomer, implies that it is inclusive of both immigrants and refugees (McKeary & Newbold, 2010; WRHA, 2010a). However, the inclusivity of the term, newcomer, can become problematic because it does not necessarily imply that the research participants are vulnerable or a visible minority (CHAC, 2008). This ambiguity serves as a strong argument to limit the use of the term newcomer to refer to recently arrived immigrants and refugees generally. More specific and accurate terminology is recommended when referring to specific subsets of newcomers. An example solution was noted in the articles that used the term, refugee newcomers, to emphasize a recent arrival to Canada while clearly excluding immigrants (Magoon, 2005; Pollock et al., 2012).

Ethnicity. Other terms noted to be used in the literature which allude to foreign-born status include: ethno-racial (MacDonnell, Dastjerdi, Bokore, & Khanlou, 2012; Pyke, Morris, Rabin, & Sabriye, 2001; Sadavoy et al., 2004), ethno-specific (Nyman, 1992; Pyke et al., 2001; Sadavoy et al., 2004; White, 2007), ethno-linguistic (Howard et al., 2009; Redwood-Campbell, Fowler, Laryea, Howard, & Kaczorowski, 2011; Simich, Maiter, Moorlag, & Ochocka, 2009), and ethno-cultural (Donnelly et al., 2011; Foster & McPherson, 2007; Howard et al., 2009; MacDonnell et al., 2012; Magoon, 2005; Nyman, 1992; Paisley et al., 2002; Poureslami et al., 2011; Stewart et al., 2012; Weerasinghe & Mitchell, 2007; White, 2007; WRHA, 2014). Bowen (1999) argues against using the term ethno-cultural because this term implies cohesion when in

fact research participants may not self-identify as belonging to a group made up of other individuals with whom they share the same ethnicity, culture, or country of origin.

Some researchers chose to focus on the ethnicity, race, culture, or primary language of their population of interest without clarifying the immigration status of their sample (Chalmers & Omer-Hashi, 2000; Chalmers & Omer-Hashi, 2002; Howard et al., 2009; Sadavoy et al., 2004; Simich et al., 2009). Other researchers used ethnic status to infer immigration status differences. For example, Anderson and colleagues (2010) reported recruiting Chinese individuals to represent an established immigrant group and Somali individuals to represent a less-established refugee group. Similarly, Sadavoy and colleagues (2004) recruited Chinese seniors to represent an established immigrant group and Tamil seniors to represent a newcomer refugee group. Conflating immigration status with ethnicity through generalizations can become problematic as evidenced by Merry, Gagnon, Kalim, and Bouris' (2011) research on RCs. In Merry and colleagues' (2011) study, the research participants came from many different countries including: China, Nigeria, Congo, India, and Mexico. Hyndman and colleagues (2014) also found that the top five source countries for RCs in Canada were: Columbia, Sri Lanka, Haiti, Mexico, and China. Both sources support the proposition that it is not safe to assume that all individuals arriving from countries, such as China, share the same legal immigration status.

Conflation between Immigrants and Refugees

Many researchers described their population of interest as immigrants despite the fact that the study was open to refugees as well (Amin & Perez, 2012; Dastjerdi et al., 2012; MacDonnell et al., 2012; Lum et al., 2016; MacDonnell et al., 2012). Other researchers subtly conflated immigrants and refugees by describing their research participants as immigrants, without specifically mentioning the inclusion or exclusion of refugees. For example, in a few articles the

authors described the sample as immigrants, even though the socio-demographic data suggests that some of the research participants arrived from known refugee-producing countries (Dahal, Qayyum, Ferreyra, Kassim, & Pottie, 2014; Howard et al., 2009; Redwood-Campbell et al., 2011). Furthermore, none of these articles adequately addressed how legal immigration status differences may have influenced the research findings. The conflation of immigrants and refugees can be problematic for consumers of research interested in refugee health who may incorrectly categorize research studies as not being applicable to their interests because the authors failed to mention that refugees were included in the study as well.

The issue of conflation between immigrants and refugees can also affect the work of researchers who accurately describe their research participants as immigrants without explicitly stating that they excluded refugees. For example, the inclusion or exclusion of refugees could not be determined for a number of reviewed studies because the researchers described their population of interest and sample as immigrants (Asanin & Wilson, 2008; Maticka-Tyndale, Shirpak, & Chinichian, 2007; Poureslami et al., 2011; Reitmanova & Gustafson, 2008; Simich et al., 2009; Weerasinghe & Mitchell, 2007). This lack of clarity raises the following question, are the researchers using the term immigrants as an umbrella term under which refugees are a subgroup of immigrant? This is how Hyndman and colleagues (2014), for example, define the term immigrant. Due to this ambiguity, all authors of immigrant health research articles need to be clear about whether refugees are excluded or included when they use the term immigrant to describe the sample population. Campbell and colleagues (2014) support the need to be more specific about the legal status of research participants by going beyond the umbrella term immigrant, as these researchers found different patterns of health care utilization among permanent residents, RCs, and undocumented immigrants.

Canadian Government's Immigrant and Refugee Sub-statuses

Legal immigration status has been found to explain differences in post-migration health status across newcomer groups (Gualdi-Russo et al., 2014; Moullan & Jusot, 2014; Pimentel & Eckardt, 2014). Post-migration experiences of fear, stress, discrimination, prejudice, and violence as well as access to resources, employment, and housing are also found to differ based on legal immigration status (Campbell et al., 2014; Castañeda et al., 2015; Edge et al., 2014). Based on these findings, the Canadian immigrant and refugee health literature was analyzed for use of Canada's immigrant and refugee sub-statuses.

Use of this terminology in the literature. Of the articles that specified legal status, some researchers were found to be using the government's specific terminology such as: Canadian citizen (Jorden, Matheson, & Anisman, 2009; Matheson, Jorden, & Anisman, 2008), permanent resident (Campbell et al., 2014), government-assisted refugee (GAR) (Larios, 2013; Lum et al., 2016; Woodgate et al., 2017), privately sponsored refugee (PSR) (Larios, 2013; Lum et al., 2016), refugee claimant (RC) (Campbell et al., 2014; Jorden et al., 2009; Matheson et al., 2008; Merry et al., 2011), family class immigrant (Lum et al., 2016; Woodgate et al., 2017), economic class immigrant (Woodgate et al., 2017), and undocumented immigrant (Campbell et al., 2014). One researcher was noted to use the terms government sponsored refugee and church sponsored refugee to differentiate between GARs and PSRs (Bowen, 1999). Other terms also found in the literature include: landed immigrant (Bowen, 1999; Goel, Bloch, & Caulford, 2013; Jorden et al., 2009; Matheson et al., 2008; White, 2007), sponsored immigrant (Larios, 2013), asylum seeker (Woodgate et al., 2017); irregular migrant (Simich et al., 2007), and migrant (Quintanilha, Mayan, Thompson, & Bell, 2016).

Changes in status. Another issue noted in the literature is the difference between legal immigration status on arrival and current legal immigration status because immigration status can change as immigrants and refugees live in Canada. Campbell and colleagues' (2014) study provides an interesting example of this issue because the authors categorized their sample as undocumented immigrants, permanent residents, and RCs. However, the researchers also acknowledged that there was further complexity with regards to these broad legal status categories (Campbell et al., 2014). The complexity becomes apparent when the researchers described that all of the women in the study were RCs at some point; however, at the time of the research data collection, some of the women had already had their refugee claim accepted making these women permanent residents; other women had their refugee claim rejected resulting in the women losing their legal status and becoming undocumented immigrants; and the remainder of the women were either waiting for their refugee claim case to be heard or were undergoing an appeal, allowing these women to remain in Canada legally as RCs (Campbell et al., 2014). Similarly, Simich and colleagues (2007) recruited individuals who the researchers categorized as irregular migrants; however, the article describes the sample including five individuals who came to Canada on visitor's visas, but at the time of the research their visas were expired, and six individuals who were RCs. Simich and colleagues further explained that of the five individuals with expired visas: two applied for family sponsorship, one applied for a visa extension, one was applying for residency based on Humanitarian and Compassionate grounds, and one had just received permanent status through the refugee claim process (2007). This finding supports Edge and colleagues (2014) proposition that researchers should consider both original and current legal status of their immigrant and refugee research participants.

The word limit restrictions of academic journals may explain the trend in lack of clarity about the inclusion or exclusion of immigrants and refugees. I found that a detailed review of Canada's immigration statuses was often located in the grey literature (Asaam, 2015; Boli, 2016; Hyndman et al., 2014; Magoon, 2005; WRHA, 2010a; WRHA, 2014). Another explanation may be that researchers are intending to respect the privacy of their research participants, for example, by not including legal status as a socio-demographic question (Quintanilha et al., 2016). In Asaam's (2015) thesis, the researcher clearly acknowledged the existence of different refugee categories in the background chapters of the thesis; however, Asaam failed to explicitly state which refugee category applied to the research participants. The decision for Asaam to not explicitly state the refugee status of the research participants is perplexing given that refugee sub-status can be inferred through the descriptions of participants (2015). For example, Asaam describes one participant as being sponsored by a group of churches and that another participant's financial and medical support came from the government (Asaam, 2015).

Differences between Immigrants and Refugees

A generalized difference between immigrants and refugees acknowledged in the literature is that the former group has made a voluntary and planned move (Anderson et al., 2010; Bowen, 1999); whereas, the latter group is fleeing their country of origin and seeking protection (Anderson et al., 2010; Bowen, 1999; Edge et al., 2014). This difference between immigrants and refugees also relates to the recognized differences in health needs in this population (Bowen, 1999). However, the literature also identifies the need to view immigrant or refugee status as one aspect of identity which is not prescriptive of an individual's experience or vulnerability (WRHA, 2010a). Weerasinghe and Mitchell (2007) support this view as they found that despite arriving from a third world country, some of the immigrant women in their study had high levels

of education and health literacy and that these women reported feeling offended when health care providers assumed that the women were ignorant and uneducated. Furthermore, despite recognized differences between immigrants and refugees, all newcomers are recognized as potentially being exposed to similar resettlement challenges and stressors such as language barriers, employment challenges, and social isolation (Anderson et al., 2010; Sadavoy et al., 2004; Simich et al., 2007). This is probably why some researchers, such as Woodgate and colleagues (2017), specifically chose to include both immigrants and refugees in their research.

The healthy immigrant effect is a term in the literature used to describe the phenomenon in which immigrants are found to arrive in Canada with better health status than their Canadian counterparts; however, the health status of these immigrants is also found to decline with prolonged residency in Canada (Asaam, 2015; Bowen, 1999; WRHA, 2010a). There is general consensus in the literature that the healthy immigrant effect may not apply to refugees as refugees may have poor health status on arrival due to pre-migration experiences (Asaam, 2015; WRHA, 2010a). However, at least one researcher found that the healthy immigrant effect may have applied to the refugee women in the study because the women reported being healthy upon arrival (Bowen, 1999). Bowen's (1999) finding supports that diversity exists in the vulnerability and health needs of newly arrived immigrants and refugees; thus, this cannot be assumed based on immigration status alone (WRHA, 2010a). The health status of immigrants and refugees is outside the scope of this thesis; and thus, not explored in the literature review.

Refugees are recognized as having a higher risk of exposure to trauma in the pre-migration period that resulted in these individuals fleeing their countries of origin (Asaam, 2015; Bokore, 2013). A less explored area in the research is the impact of Canada's refugee sub-categories and how differences in access and entitlement, to supports and services, impacts

refugee health (Campbell et al., 2014; Saberpor, 2016). For example, although PSRs and GARs often arrive from the same countries of origin (Hyndman et al., 2014), only GARs have access to the Refugee Assistance Program (Boli, 2016; Hyndman et al., 2014). The Refugee Assistance Program is described as being administered by the federal government, at rates similar to that of the provincial social assistance programs (Boli, 2016; Hyndman et al., 2014). There is also recognition in the literature that coverage under the Refugee Assistance Program generally lasts for up to the first year of resettlement in Canada for GARs; after which GARs can apply for provincial social assistance if needed (Hyndman et al., 2014).

Another difference between refugees identified in the literature includes that GARs and PSRs are more limited in where they can resettle in Canada, as compared to RCs (Aberman, 2014; Asaam, 2015; Dhital, 2015). GARs are reliant on government sponsorship; whereas, PSRs are reliant on private sponsors and RCs may not have anyone to rely on but themselves (Aberman, 2014; Asaam, 2015; Dhital, 2015). Despite the potential advantage RCs may have in actively planning their migration and resettlement, GARs and PSRs are given permanent residence status upon arrival to Canada that means their refugee status is secure; whereas, RCs are viewed as more vulnerable based on their temporary residence status (Hyndman et al., 2014; Miklavcic, 2011). Hyndman and colleagues (2014) explain that some of the similarity in resettlement experiences between GARs and PSRs relates to the shared experience these refugees may have based on living in exile or in refugee camps during the migration period. Hyndman and colleagues (2014) identify that this contributes to the physical and mental health issues and low literacy rates found among refugees who have spent long periods of time in refugee camps. This premise would support that length of time spent in a refugee camp is an indicator of vulnerability among refugees and should be considered.

The literature acknowledged that RCs may be detained upon arrival to Canada which is a practice that contributes to an increased risk for mental health issues (Cleveland & Rousseau, 2013; Hyndman et al., 2014). RCs know that there is a chance their refugee application may be rejected, which could result in deportation or becoming undocumented residents; a threat which is recognized as contributing to this group's risk for mental health issues (Campbell et al., 2014; Miklavcic, 2011; Simich et al., 2007). The need for a work permit further restricts RCs from pursuing employment and differentiates them from PSRs and GARs (Hyndman et al., 2014). However, RCs are recognized as having better access to health care services than undocumented immigrants who have had their refugee claims rejected, but decided to stay residing in Canada (Campbell et al., 2014).

Complexity of Refugee Health

There is evidence in the literature that Canadian health care providers are unwilling to take on refugees as patients due to perceptions that this newcomer group has: complex needs, communication barriers, and or complicated insurance coverage (Edge & Newbold, 2013). Although health care is a provincial or territorial mandate in Canada, refugee health care tends to be more complicated than immigrant health care due to the Interim Federal Health Program (IFHP). The IFHP is an additional source of health insurance for refugees, which is more expansive in coverage than the provincial and territorial health insurance programs (Asaam, 2015; Saberpor, 2016). The IFHP is described as more akin to the extended health insurance coverage given to individuals in Canada who are under social assistance (Barnes, 2013; Saberpor, 2016). The literature demonstrates that the IFHP can be inadequate in covering the complex needs of refugees (Campbell et al., 2014; Simich et al., 2007). The literature also

contains specific documentation of the negative impact that cuts to the IFHP has had on refugees (Barnes, 2013).

At the provincial level, both immigrants and refugees can be vulnerable to policies such as the three month wait for provincial health insurance (Asanin & Wilson, 2008). However, there is further complexity in the area of refugee health due to variations in policies at the provincial level (Saberpor, 2016). For example, not only does Manitoba not have a three month wait policy, the provincial government of Manitoba also openly challenged the cuts to the IFHP by the federal government by declaring that refugees would not be denied care (Barnes, 2013; Larios, 2013).

Municipal health policies are also identified as influencing refugee health care and barriers to access (Saberpor, 2016). The Winnipeg Regional Health Authority (WRHA) for example provides a medical interpreter service and a refugee health primary care clinic (2010b). Although the WRHA (2010b) document does not mention the restriction of their refugee health primary care clinic to GARs only, additional health care service provision for GARs, in an unnamed city in Manitoba, was raised as an issue in Woodgate and colleagues (2017) study. Similarly, McMurray and colleagues (2014) specifically studied the outcomes of a similar GARs only primary health care clinic in Kitchener, Ontario.

Location of Where Studies Were Conducted

Researchers have found that immigrants from the same country of origin who have resettled in different host countries have different morbidity, mortality, and health status (Dassanayake et al., 2011; Moullan & Jusot, 2014). While other researchers have found that immigrants from the same country of origin resettling in different areas of the same country also have differing health statuses (Guruge et al., 2015; Wang, 2014; Ro, 2014). These findings as

well as the differences in provincial health policies led to a need to explore which provinces and cities Canadian immigrant and refugee health research was conducted in. This review found that there is a lack of research on immigrants and refugees being published from certain provinces. Immigrant and refugee health research conducted in Manitoba specifically was noted to be missing from the academic literature during early searches for articles in the academic databases. This led to the need to include grey literature sources such as theses and unpublished research reports to gather findings relevant to immigrants and refugees residing in Manitoba. Other provinces missing from this list may also have unpublished research articles that would have been relevant but were not found in the search results due to the search terms used in this review. Some authors chose not to disclose the city or province in which the research took place to protect the anonymity of their research participants. Although it is understandable why researchers may choose not to disclose where the study was conducted, this lack of identifier inhibits an analysis of whether there is a gap in research being conducted in specific areas of Canada. The following Table 3 lists all the Canadian cities in which the research articles included in this review were conducted. Articles where the research was conducted in multiple cities are included more than once.

Table 3: Breakdown of Where the Canadian Studies Were Conducted

Province	City	Articles
Ontario	Toronto including the Greater Toronto Area	(Achon et al., 2006; Ahmad et al., 2004; Ahmad et al., 2005; Anderson et al., 2010; Bokore, 2013; Campbell et al., 2014; Chalmers & Omer-Hashi, 2000; Chalmers & Omer-Hashi, 2002; Gagnon et al., 2013; Goel et al., 2013; Guruge, Hunter, Barker, McNally, & Magalhaes, 2010; MacDonnell et al., 2012; McCleary, 1994; Merry

		et al., 2011; Paisley et al., 2002; Pathy, Mills, Gazeley, Ridgley, & Kiran, 2011; Pyke et al., 2001; Sadavoy et al., 2004; Simich et al., 2007; Simich et al., 2009; Steele, Lemieux-Charles, Clark, & Glazier, 2002; Wang, 2007; Wong & Tsang, 2004)
	Hamilton	(Howard et al., 2009; McKeary & Newbold, 2010; Milinkovic et al., 2018; Pollock et al., 2012; Redwood-Campbell et al., 2011)
	Ottawa	(Dahal et al., 2014; Jorden et al., 2009; Lagacé, Charmarkeh, & Grandena, 2012; Matheson et al., 2008)
	Mississauga	(Asanin & Wilson, 2008)
	Niagara region	(Lum et al., 2016)
	Waterloo	(Pollock et al., 2012; Simich et al., 2009)
	Guelph	(Pollock et al., 2012)
	Cambridge	(Pollock et al., 2012)
	Kitchener	(McMurray et al., 2014; Pollock et al., 2012)
British Columbia	Vancouver including the Greater Vancouver Area	(Anderson et al., 2010; Floyd & Sakellariou, 2017; Poureslami et al., 2011)
	Lower Mainland BC	(Elliott & Gillie, 1998)
Manitoba	Winnipeg	(Asaam, 2015; Benjumea-Bedoya, Bertram-Farough, & Plourde, 2017; Bowen, 1999; Foster & McPherson, 2007; Magoon, 2005; Nyman, 1992)
	Brandon	(Foster & McPherson, 2007)
	Undisclosed	(Woodgate et al., 2017)
Alberta	Edmonton	(Amin & Perez, 2012; Anderson et al., 2010; Quintanilha et al., 2016; Rennert-May et al., 2016)
	Calgary	(Ngwakongwi, Hemmelgarn, Musto, Quan, & King, 2012; Winn,

		Hetherington, & Tough, 2018)
	Undisclosed	(Salami, Salma, & Hegadoren, 2019)
Quebec	Montreal	(Gagnon et al., 2013; Merry et al., 2011; Miklavcic, 2011)
Newfound Land	St. Johns	(Reitmanova & Gustafson, 2008)
Nova Scotia	Halifax	(Weerasinge & Mitchell, 2007)
Undisclosed	Western Canada	(Dastjerdi et al., 2012; Donnelly, 2006; Donnelly et al., 2011; Kinch & Jakubec, 2004; Li & Browne, 2000; Yohani, & Okeke-Ihejirika, 2018)
	Seven Canadian cities	(Lai & Chau, 2007)
	Undisclosed	(Browne et al., 2018; Maticka-Tyndale et al., 2007)

Somalis

Some of the Canadian health research literature focused only on Somalis (Achon et al., 2006; Bokore, 2013; Chalmers & Omer-Hashi, 2000; Chalmers & Omer-Hashi, 2002; Jorden et al., 2009; Lagacé et al., 2012; Matheson et al., 2008; McCleary, 1994; Pyke et al., 2001); whereas, many more studies included Somalis as just one of multiple ethnic groups or research participants (Amin & Perez, 2012; Anderson et al., 2010; Asaam, 2015; Dahal et al., 2014; Edge et al., 2014; Gagnon et al., 2013; Howard et al., 2009; MacDonnell et al., 2012; Paisley et al., 2002; Pathy et al., 2011; Quintanilha et al., 2016; Redwood-Campbell et al., 2011; Simich et al., 2009). Some of the researchers specifically recruited Somali women because their study was focused on maternity care or motherhood (Amin & Perez, 2012; Bokore, 2013; Chalmers & Omer-Hashi, 2000; Chalmers & Omer-Hashi, 2002; Gagnon et al., 2013; McCleary, 1994; Quintanilha et al., 2016). Many of these articles considered Somalis as a refugee population (Anderson et al., 2010; Asaam, 2015; Bokore, 2013; Edge et al., 2014; Jorden et al., 2009;

Lagacé et al., 2012; Matheson et al., 2008; Pyke et al., 2001). However, it was noted that other researchers refer to Somalis as immigrants (Achon et al., 2006; Dahal et al., 2014; MacDonnell et al., 2012; McCleary, 1994; Redwood-Campbell et al., 2011) or chose to avoid focusing on legal immigration status (Amin & Perez, 2012; Chalmers & Omer-Hashi, 2000; Chalmers & Omer-Hashi, 2002; Howard et al., 2009; Paisley et al., 2002; Pathy et al., 2011; Quintanilha et al., 2016; Simich et al., 2009). For example, in Chalmers and Omer-Hashi's articles (2000, 2002), refugee status is noted only when the authors explain why some women chose not to participate in the study. Matheson and colleagues (2008) research found that Somali women report experiencing traumatic events more than Somali men and Bokore (2013) discussed that Somali refugee women are vulnerable to gender-based violence (Bokore, 2013).

Saberpor (2016) noted that much of the health literature on refugees and asylum seekers focused on mental health or pregnant women. In this review, of the articles that included Somalis as research participants, five were focused on pregnant and post-partum women (Chalmers & Omer-Hashi, 2000; Chalmers & Omer-Hashi, 2002; Gagnon et al., 2013; McCleary, 1994; Quintanilha et al., 2016) and six articles focused on mental health (Asaam, 2015; Jorden et al., 2009; MacDonnell et al., 2012; Matheson et al., 2008; Pyke et al., 2001; Simich et al., 2009). Three articles focused on access (Foster & McPherson, 2007; Howard et al., 2009; Pyke et al., 2001), and only the work of Chalmers and Omer-Hashi (2000, 2002) explored the maternity care experiences of post-partum Somali women. This finding supports that there is a need for research that examines the health care experiences of refugees (Saberpor, 2016) and the general health care experiences of Somali refugees.

Unique features of Somalis noted in the literature includes that it may take years for African refugees to learn how to navigate services in Canada (Stewart et al., 2012). Anderson

and colleagues reported specifically choosing Somali refugees as an ethnic group of interest for their study because this group is less-established and is known to be facing significant barriers to accessing services (2010). Jorden and colleagues (2009) similarly recognized the influence of ethnicity, religion, culture, and language differences as contributors to the challenges Somali refugees experience during resettlement. It was also noted that a fear of child protection services among Somalis was mentioned in multiple articles (Chalmers & Omer-Hashi, 2000; Chalmers & Omer-Hashi, 2002; Simich et al., 2009; Stewart et al., 2012). Simich and colleagues (2009) also identified that Somali women may have additional struggles accessing health care services due to the responsibility of caring for many children.

Although there is discussion on the history of Somali refugees struggling to gain secure legal status in Canada (Pyke et al., 2001), the majority of the health research articles in this review that focused on RCs recruited individuals from Latin America (Campbell et al., 2014; Merry et al., 2011; Morantz, Rousseau, & Heymann, 2012). A non-health research article comparing the housing experiences of GARs and RCs in Vancouver and Winnipeg identified that there was difficulty in identifying Mexican RCs in Winnipeg that led to the recruitment of Somali RCs in Winnipeg (Sherrell, 2010). Although Sherrell (2010) had not intended to recruit Somali RCs, her research experience supports that Somali RCs are accessible to researchers even though the voice of Somali RCs is missing from the health literature.

Defining Access and Accessibility

Nyman (1992), Saberpor (2016), and Woodgate and colleagues (2017) used Penchansky & Thomas' (1981) definition of access which measures the fit between the client's characteristics and expectations with that of health care services and providers. This definition of access considers the five following dimensions: accessibility, availability, affordability,

acceptability, and accommodation (Penchansky & Thomas, 1981). Ngwakongnwi and colleagues (2012) used Aday and Andersen's (1974) framework to study access to medical care. Aday and Andersen's (1974) framework focuses on four determinants: health policy, the characteristics of the population, the characteristics of the health care system, the utilization of health care services, and consumer satisfaction.

A few of the articles referred to accessibility as a principle under the Canada Health Act (Asanin & Wilson, 2008; Reitmanova & Gustafson, 2008; WRHA, 2010a). The Canada Health Act defines accessibility as: insured individuals having access to insured services without barriers such as additional charges or discrimination (Health Canada, 2016). Whereas, the WRHA (2014) proposes a more comprehensive definition of accessibility which is specific to newcomers by including the need for timely and equitable access to culturally appropriate and effective care and emphasizes the removal of educational, social, economic, physical, and cultural barriers. The Canada Health Act definition is used in this study.

Barriers to Accessing Health Care

Although this section includes a listing of many barriers that immigrants and refugees experience with accessing health care, it is important to note that barriers intersect and are not discrete (Saberpor, 2016). Barriers to access were grouped into socio-cultural, geographic, and economic barriers (Asanin & Wilson, 2008) and this categorical organization is also utilized in this review. However, since some barriers found in the literature are inherent to the organization of the Canadian health care system, these barriers are grouped together separately from the socio-cultural, economic, and geographic barriers.

Socio-cultural Barriers

Language. Language is a significant barrier to accessing health care services among newcomer immigrants and refugees. Language as a barrier is known to impact health outcomes, health status, and quality of care received (Campbell et al., 2014; Guruge et al., 2015; Gushulak et al., 2011; Pimentel & Eckardt, 2014; Subedi & Rosenberg, 2014). In the Canadian health literature reviewed, language barriers were cited as a barrier to health care services by nearly all of the studies (Asanin & Wilson, 2008; Campbell et al., 2014; Chalmers & Omer-Hashi, 2002; Dastjerdi et al., 2012; Donnelly et al., 2011; Guruge et al., 2010; Maticka-Tyndale et al., 2007; Ngwakongnwi et al., 2012; Lum et al., 2016; Merry et al., 2011; Poureslami et al., 2011; Redwood-Campbell et al., 2011; Reitmanova & Gustafson, 2008; Sadavoy et al., 2004; Simich et al., 2009; Simich et al., 2007; Weerasinghe & Mitchell, 2007; Woodgate et al., 2017). The issue of language as a barrier was even found among individuals who had sufficient English language skills (Asanin & Wilson, 2008; Maticka-Tyndale et al., 2007). Many of the research participants identified the need for a language concordant health care provider (Asanin & Wilson, 2008; Campbell et al., 2014; Dastjerdi et al., 2012; Lum et al., 2016; Maticka-Tyndale et al., 2007; Ngwakongnwi et al., 2012). Difficulty with low literacy and being unable to read in English were also identified (Dastjerdi et al., 2012). For some participants, there was lack of available professional interpreter services (Donnelly et al., 2011); whereas, for others the problem was lack of knowledge about available interpreter services (Ngwakongnwi et al., 2012) or lack of interpreters (Donnelly et al., 2011).

Culture. Cultural barriers were also cited frequently in the literature as a barrier to health care services (Asanin & Wilson, 2008; Chalmers & Omer-Hashi, 2002; Dastjerdi et al., 2012; Degni, Suominen, Essén, El Ansari, & Vehviläinen-Julkunen, 2012; Donnelly, 2006; Donnelly et

al., 2011; Guruge et al., 2010; Maticka-Tyndale et al., 2007; Poureslami et al., 2011; Quintanilha et al., 2016; Redwood-Campbell et al., 2011; Reitmanova & Gustafson, 2008; Sadavoy et al., 2004; Simich et al., 2009; Weerasinghe & Mitchell, 2007; Woodgate et al., 2017). The lack of culturally sensitive health care providers was also a prevalent issue (Chalmers & Omer-Hashi, 2002; Guruge et al., 2010; Poureslami et al., 2011; Reitmanova & Gustafson, 2008; Sadavoy et al., 2004; Simich et al., 2009; Weerasinghe & Mitchell, 2007). Reasons culture was cited as a barrier includes the fact that culture can dictate norms of asking for help and seeking services (Dastjerdi et al., 2012; Sadavoy et al., 2004; Simich et al., 2009), as well as expectations individuals can have of health care providers (Reitmanova & Gustafson, 2008). Some participants stated their preference for a language concordant care provider (Dastjerdi et al., 2012; Maticka-Tyndale et al., 2007; Simich et al., 2009); whereas, others just wanted a culturally sensitive health care provider (Dastjerdi et al., 2012; Donnelly et al., 2011; Weerasinghe & Mitchell, 2007). Perceptions of lack of confidentiality was also a barrier that was noted in the literature (Donnelly et al., 2011; Maticka-Tyndale et al., 2007; Sadavoy et al., 2004; Woodgate et al., 2017).

Family. In many of the articles the influence of coming from a collectivist society and subsequently ignoring one's own health needs to facilitate the needs of family after arrival to Canada was noted (Dastjerdi et al., 2012; Donnelly et al., 2011; Simich et al., 2009). For others, migration resulted in a loss of extended family support resulting in the need to adapt to an individualistic lifestyle (Quintanilha et al., 2016). Family's views and reactions to mental health was also noted to inhibit access to services (Sadavoy et al., 2004). In other studies, social positioning was noted to be a factor, such as in cases where women are socially vulnerable and dependent on the men in their lives (Donnelly et al., 2011), or seniors are financially and

emotionally dependent on family members (Sadavoy et al., 2004). In Woodgate and colleagues' study (2017), lack of childcare was associated with parents needing to take young children with them to appointments despite the cold weather and lack of appropriate winter gear. These examples suggest that women, both women with young children and senior women, may experience additional challenges accessing and utilizing health care given their role or positioning within a family unit.

Religion. Religion was included as a barrier in a few of the studies (Asanin & Wilson, 2008; Reitmanova & Gustafson, 2008). Religion and culture can both influence social etiquettes and whether one needs a gender concordant health care provider (Asanin & Wilson, 2008; Dastjerdi et al., 2012; Redwood-Campbell et al., 2011; Reitmanova & Gustafson, 2008) or gender exclusive health education programs such as prenatal classes for women only (Reitmanova & Gustafson, 2008).

Lack of trust. Mistrust of health care providers or the health care system was an important issue noted in the literature (Campbell et al., 2014; Dastjerdi et al., 2012; Donnelly et al., 2011; Simich et al., 2007). This mistrust can stem from newcomers' previous experiences with health care providers or the health care system in their home country (Dastjerdi et al., 2012). For some, the mistrust is more general and related to Western biomedicine (Dastjerdi et al., 2012; Donnelly et al., 2011). Whereas, for others mistrust stems from not trusting specific health care providers such as: nurses, non-physicians, or even non-specialist physicians (Poureslami et al., 2011). In research with individuals without secure legal status, mistrust was generalized to all non-family members (Simich et al., 2007).

Lack of knowledge or information. Considering the large numbers of immigrants and refugees Canada resettles annually, this problem is frequently described - lack of knowledge or

information about the Canadian health care system. What is perplexing to me is that limited interventions have been developed and tested to address it (Asanin & Wilson, 2008; Donnelly et al., 2011; Goel et al., 2013; Kinch & Jakubec, 2004; Lum et al., 2016; Maticka-Tyndale et al., 2007; Merry et al., 2011; Ngwakongnwi et al., 2012; Redwood-Campbell et al., 2011; Sadavoy et al., 2004; Simich et al., 2009). Specific issues included: low health literacy (Merry et al., 2011); not knowing where services are provided (Donnelly et al., 2011; Kinch & Jakubec, 2004; Maticka-Tyndale et al., 2007; Merry et al., 2011; Ngwakongnwi et al., 2012; Sadavoy et al., 2004); and not knowing that services exist (Kinch & Jakubec, 2004; Merry et al., 2011; Reitmanova & Gustafson, 2008). For example, Kinch and Jakubec found that the senior Ismaili immigrant women did not know that there was a public health nurse available within the subsidized apartment building in which the Ismaili women lived (2004). As Reitmanova and Gustafson (2008) noted, those who are unaware of what information they need are more disadvantaged because they will not think about seeking answers. The finding of lack of information as a common problem across the research articles supports the need to evaluate and ensure that immigrants and refugees are aware of resources available to them.

Lack of holistic care. The lack of holistic care being provided to immigrants and refugees was another common issue in the literature (Asanin & Wilson, 2008; Kinch & Jakubec, 2004; Maticka-Tyndale et al., 2007; Merry et al., 2011; Reitmanova & Gustafson, 2008; Weerasinghe & Mitchell, 2007). There was evidence of lack of psychosocial assessments, referrals, and support given to the research participants in these studies (Campbell et al., 2014; Kinch & Jakubec, 2004; Merry et al., 2011). For example, in one study the research nurses found that refugee claimant women who participated in their study were: experiencing abuse, skipping meals, and having symptoms of postpartum depression; yet, the research participants were not

receiving available health and social services (Merry et al., 2011). Maticka-Tyndale and colleagues (2007) found in their study that many of the men and women who participated in their study would like information on sexual health topics but were too embarrassed to bring up this topic with their health care provider or perceived that their health care provider would dismiss their questions and ask them to make another appointment for their new question.

Economic Barriers

Economic barriers were an issue identified in many of the studies (Asanin & Wilson, 2008; Campbell et al., 2014; Dastjerdi et al., 2012; Goel et al., 2013; Guruge et al., 2010; Kinch & Jakubec, 2004; Maticka-Tyndale et al., 2007; Merry et al., 2011; Reitmanova & Gustafson, 2008; Weerasinghe & Mitchell, 2007; Woodgate et al., 2017). Many of the research participants reported struggling with lack of financial resources (Asanin & Wilson, 2008; Campbell et al., 2014; Dastjerdi et al., 2012; Goel et al., 2013; Kinch & Jakubec, 2004; Maticka-Tyndale et al., 2007; Merry et al., 2011; Reitmanova & Gustafson, 2008). Some individuals were struggling to cover costs associated with food and housing which made paying for uncovered health care services not a priority (Campbell et al., 2014; Goel et al., 2013; Lum et al., 2016). Lack of financial means also made access to services not covered by the public universal health care system inaccessible for others (Asanin & Wilson, 2008; Maticka-Tyndale et al., 2007). Some individuals with precarious legal status and no provincial health insurance coverage reported a discrepancy between the fact that they were working and paying taxes; yet, they were still unable to get the same treatment at hospitals as individuals with provincial health cards (Simich et al., 2007). These articles support the need to assess finances as a contributing factor to access barriers and this population's experiences with receiving health care services.

In provinces with a three month wait period, newcomers reported delaying accessing services due to an inability to pay for private health insurance or services that would be covered under provincial health insurance in a few months (Asanin & Wilson, 2008; Goel et al., 2013; Lum et al., 2016). There were many examples in the literature of individuals having to pay out of pocket or being billed for services. Examples included: a \$12,000 bill for labour and delivery services received by an immigrant during the initial three-month wait period after resettling in Ontario (Goel et al., 2013); a \$600 bill for undisclosed health care services (Lum et al., 2016); and an \$8,000 bill for four days of hospitalization (Simich et al., 2007). Considering that many of the immigrants and refugees in the studies reported having limited financial resources (Asanin & Wilson, 2008; Campbell et al., 2014; Dastjerdi et al., 2012; Goel et al., 2013; Merry et al., 2011; Reitmanova & Gustafson, 2008), being billed for uninsured health care costs can become a significant financial stressor. These findings further provide evidence for the need to conduct studies across all Canadian provinces because not every province has a three-month waiting period in order for newcomers to be eligible for coverage under the provincial health plan.

Geographic Barriers

Geographic barriers were identified by multiple studies (Asanin & Wilson, 2008; Kinch & Jakubec, 2004; Lum et al., 2016; Ngwakongnwi et al., 2012; Sadavoy et al., 2004). Not only did some participants report a lack of physicians accepting new patients in their communities (Asanin & Wilson, 2008; Lum et al., 2016), others had an issue with culturally sensitive and specialized services only being available in certain areas of the city, such as only in the downtown area (Sadavoy et al., 2004). Transportation was another geographic barrier prevalent in the literature (Asanin & Wilson, 2008; Kinch & Jakubec, 2004; Lum et al., 2016; Ngwakongnwi et al., 2012; Woodgate et al., 2017). Given that Canadian cities vary in size,

climate, and affordability, the existence of geographic barriers supports the need for research to be conducted in all immigrant and refugee accepting cities.

Canadian Health Care System Barriers

Evident from the literature is that many barriers that newcomers face when accessing health care services are related to the Canadian health care system (Asanin & Wilson, 2008; Campbell et al., 2014; Lum et al., 2016; Maticka-Tyndale et al., 2007; Poureslami et al., 2011; Reitmanova & Gustafson, 2008). For example: the bio-medical model of health care (Asanin & Wilson, 2008; Lum et al., 2016; Weerasinghe & Mitchell, 2007); lack of family physicians (Asanin & Wilson, 2008; Lum et al., 2016; Reitmanova & Gustafson, 2008); lack of same gender health care provider (Asanin & Wilson, 2008; Guruge et al., 2010; Maticka-Tyndale et al., 2007; Weerasinghe & Mitchell, 2007); long waits to receive care (Asanin & Wilson, 2008; Campbell et al., 2014; Guruge et al., 2010; Maticka-Tyndale et al., 2007; Poureslami et al., 2011; Woodgate et al., 2017); limited time with health care provider (Donnelly et al., 2011; Guruge et al., 2010; Maticka-Tyndale et al., 2007; Poureslami et al., 2011; Reitmanova & Gustafson, 2008; Weerasinghe & Mitchell, 2007); one issue per visit policy (Campbell et al., 2014; Maticka-Tyndale et al., 2007); need for referral to access specialist (Dastjerdi et al., 2012; Guruge et al., 2010; Maticka-Tyndale et al., 2007; Poureslami et al., 2011; Sadavoy et al., 2004); lack of extended health insurance benefits (Asanin & Wilson, 2008; Campbell et al., 2014; Maticka-Tyndale et al., 2007; Woodgate et al., 2017); and the three month wait for coverage under universal health plans in some provinces (Asanin & Wilson, 2008; Goel et al., 2013; Lum et al., 2016; Poureslami et al., 2011). Across Canada, lack of access to provincial health insurance for RCs, undocumented immigrants, and irregular migrants is an issue (Campbell et al., 2014; Simich et al., 2007). Although RCs are covered under the IFHP (Campbell et al., 2014; Merry et

al., 2011) issues included: the program is limited and confusing (Antonipillai, Baumann, Hunter, Wahoush, & O'Shea, 2018; Merry et al., 2011), individuals can lose their coverage (Antonipillai et al., 2018; Campbell et al., 2014), and prescriptions may not be covered (Antonipillai et al., 2018; Campbell et al., 2014). Many of the Canadian health care system related barriers can affect Canadian citizens as well, which demonstrates the complexity newcomers may experience in trying to overcome the unique barriers they face in addition to the barriers to care that all Canadians can experience.

Experiences with Formal Health Care Services

There is overwhelming evidence of the negative experiences immigrants and refugees have with accessing formal health care services (Asanin & Wilson, 2008; Barnes, 2013; Bowen, 1999; Campbell et al., 2014; Chalmers & Omer-Hashi, 2000; Chalmers & Omer-Hashi, 2002; Dastjerdi et al., 2012; Donnelly et al., 2011; Goel et al., 2013; Kinch & Jakubec, 2004; Lum et al., 2016; Maticka-Tyndale et al., 2007; Merry et al., 2011; Ngwakongnwi et al., 2012; Pollock et al., 2012; Poureslami et al., 2011; Reitmanova & Gustafson, 2008; Simich et al., 2007; Weerasinghe & Mitchell, 2007). Newcomers report being: misunderstood (Campbell et al., 2014; Chalmers & Omer-Hashi, 2002; Dastjerdi et al., 2012; Maticka-Tyndale et al., 2007; Ngwakongnwi et al., 2012), stereotyped (Poureslami et al., 2011; Reitmanova & Gustafson, 2008; Weerasinghe & Mitchell, 2007), and discriminated against (Campbell et al., 2014; Chalmers & Omer-Hashi, 2002; Dastjerdi et al., 2012; Edge & Newbold, 2013; Pollock et al., 2012; Simich et al., 2007). There is evidence in the literature that health care experiences can be related to legal status. For example, in Campbell and colleagues' article (2014), permanent residents reported having better: access to health care services, access to a language concordant physician, and satisfactory experiences with seeking health care when compared to RCs and

undocumented immigrants. Also, in Woodgate and colleagues' study, a PSR described the difference in access to interpretation services between GARs and PSRs, with GARs receiving extra services (2017).

Negative Outcomes when Accessing Health Care Services

Examining barriers to health care access among immigrants and refugees is important because the literature contains evidence that this population experiences negative outcomes such as: declines in health status (Asanin & Wilson, 2008; Dastjerdi et al., 2012; Goel et al., 2013; Ngwakongnwi et al., 2012); delays in seeking health care (Asanin & Wilson, 2008; Campbell et al., 2014; Dastjerdi et al., 2012; Donnelly et al., 2011; Goel et al., 2013; Lum et al., 2016; Merry et al., 2011; Ngwakongnwi et al., 2012; Sadavoy et al., 2004), and or avoiding seeking health care (Asanin & Wilson, 2008; Campbell et al., 2014; Dastjerdi et al., 2012; Donnelly et al., 2011; Maticka-Tyndale et al., 2007; Sadavoy et al., 2004). Miscommunication was a significant outcome that lead to: medical errors (Campbell et al., 2014; Ngwakongnwi et al., 2012), missed appointments (Dastjerdi et al., 2012), and losing trust in health care services and providers (Dastjerdi et al., 2012; Poureslami et al., 2011). Emotional distress was a common theme in the articles reviewed. Research participants reported experiencing fear in many of the studies (Campbell et al., 2014; Chalmers & Omer-Hashi, 2002; Dastjerdi et al., 2012; Donnelly et al., 2011; Goel et al., 2013; Lum et al., 2016; Ngwakongnwi et al., 2012; Poureslami et al., 2011; Sadavoy et al., 2004; Simich et al., 2007). In some cases, the fear was related to language or communication barriers (Campbell et al., 2014; Lum et al., 2016; Ngwakongnwi et al., 2012; Reitmanova & Gustafson, 2008; Simich et al., 2009). Other reasons for fear included: fear of culturally incompetent health care providers (Simich et al., 2009); fear of discrimination and

stigmatization (Donnelly et al., 2011); fear of deportation (Campbell et al., 2014; Donnelly et al., 2011); and fear of financial harm due to lack of health insurance coverage (Goel et al., 2013).

Summary

This chapter included a review of the literature on the health care experiences of immigrants and refugees and the barriers to health care access that this population experiences. Many issues in the literature were explored such as the conflation between immigrants and refugees as research participants. The literature review strongly supports the need for researchers to consider the implications of refugee sub-status differences and gender. Most of the literature that includes Somali women focused on maternity and mental health. I was unable to locate research that included Somali RC women.

CHAPTER FOUR: PHILOSOPHY, METHODOLOGY AND METHODS

The review of the literature presented in the last chapter has influenced the research question: what are the experiences of Somali refugee women accessing health care in a city in Manitoba, Canada? In this chapter, the method and the methodology of the study will be presented. Included in this chapter is a discussion of the: a) ontology; b) epistemology; c) methodology including a discussion on qualitative description and qualitative content analysis; d) sampling approach including sample size and inclusion criteria; e) recruitment strategy; f) conducting the interview; g) writing field notes; h) maintaining a reflective journal; i) preparing the transcripts; j) choosing data for analysis; k) writing memos; l) data analysis; m) ethical considerations; n) data management and security; and o) enhancing trustworthiness of this study.

Philosophical Underpinnings

Qualitative description as described by Sandelowski (2000; 2010) will be used in this study because it is an appropriate research design for exploring a topic from the first-hand experiences of research participants (Neergaard et al., 2009). Philosophy is the study of abstract and general problems including the nature of reality and knowledge (McEwen & Willis, 2011). The philosophical underpinnings of this proposed study are explored in terms of ontology, epistemology, and methodology.

Ontology

Ontology is a branch of philosophy that is the study “of being, i.e., its nature or kinds of existence” (Powers & Knapp, 2011, p. 124). Ontology “embodies a certain way of understanding what is” (Powers & Knapp, 2011, p. 124). I am interested in exploring the health care experiences of Somali refugee women residing in a city in Manitoba. This interest stems from the fact that I view reality and truth as being influenced by context. This means that I

acknowledge that the experiences of Somali refugee women resettled in a city in Manitoba may be different than the health care experiences of Somali refugee women resettled in other areas of Canada, such as in Ontario, and in other countries. This belief of more than one reality existing lends itself to a relativistic ontology.

Relativism is defined as “the ontological assumption that there is nothing about human existence that is universally true” (Powers & Knapp, 2011, p. 157). Relativism recognizes that: history, culture, social environment, and politics influence reality (Powers & Knapp, 2011). The idea that multiple truths exist and that context needs to be considered is exemplified by noting the discrepancy between how the previous Conservative federal government and the current Liberal federal government approach refugee resettlement. Research that uses the relativism perspective acknowledges that the description or interpretation of a phenomenon is not a “mirror image” of the phenomenon, but rather how the phenomenon was viewed by the specific participants of the research (Powers & Knapp, 2011, p. 157). The constructivist paradigm assumes the position that there are multiple and subjective realities (Polit & Beck, 2014).

Epistemology

Epistemology, another branch of philosophy, is defined as “the study or a philosophy of knowledge that involves an understanding of its nature, origin and scope as well as justification of knowledge claims” (Powers & Knapp, 2011, p. 53). “Constructivism is a relativist epistemology” because it assumes that there is more than one reality (Powers & Knapp, 2011, p. 157). Constructivism also recognizes that knowledge is constructed through the interaction between the research participant and the researcher and in a specific context (Polit & Beck, 2014; Powers & Knapp, 2011). In this thesis, constructivism would support that the women are sharing their experiences which is based on their reality. This justifies the understanding why women

resettled in other Canadian provinces or other countries may have different health care experiences. Similarly, constructivism would support the view that Somali refugee women residing in a city in Manitoba with different demographic characteristics, such as legal status, can have different health care experiences.

Methodology

Methodology answers the question about how best to obtain evidence (Polit & Beck, 2014). Constructivism aligns with a naturalistic methodology (Powers & Knapp, 2011). Polit and Beck's list of methodological assumptions in the constructivist paradigm includes: emphasis is placed holistically on the whole phenomena, the focus is subjective, that the researcher is an integral part of the knowledge creation process, and that the research design is flexible and emergent (2014). Naturalistic inquiry involves studying the research participants in their natural environment and is a characteristic of qualitative research (Powers & Knapp, 2011). In this study, qualitative research, and more specifically, qualitative description and qualitative content analysis, was used to explore the health care experiences of Somali refugee women residing in a city in Manitoba.

Qualitative Research

Nursing, a human science, creates knowledge from the inside to the outside which is in contrast to the natural sciences which depends on exploring perspective from the outside to the inside (Munhall, 2012). This is why qualitative research methods are well suited to nursing inquiry (Munhall, 2012). Qualitative research endeavours to answer how, why, or what questions about human behaviours, perceptions, motives, and barriers (Neergaard et al., 2009). Qualitative research is also valued for giving voice to research participants (Munhall, 2012). Using qualitative research will allow me to explore the health care experiences of Somali refugee

women from their narrative. Not reducing these women's experiences to numbers was important to me because I wanted to use these women's actual words and their stories in knowledge translation activities. Using their actual words in knowledge translation activities will facilitate health care providers, health researchers, and health policymakers hearing the voices of these women. This is why qualitative research was best suited to answer the research question compared to quantitative research methods.

Qualitative Description

Qualitative researchers are called on to describe or interpret research findings (Munhall, 2012). Since I was interested in describing the experiences of Somali refugee women, I used qualitative description as described by Sandelowski (2000, 2010). Qualitative description is an appropriate research methodology for exploring a topic from the first-hand experiences of research participants (Neergaard et al., 2009).

Qualitative description is not limited by specific philosophical commitments (Sandelowski, 2000) and is known as one of the least theoretical qualitative approaches (Neergaard et al., 2009; Sandelowski, 2000). However, qualitative description is not atheoretical (Sandelowski, 2010). Neergaard and colleagues describe the philosophical underpinnings of qualitative research as a pragmatic approach (2010). The pragmatic approach refers to the preference for practicality and usefulness of theoretical knowledge (Munhall, 2012). In the pragmatic approach, truth: is arrived at inductively, can be modified as a result of new knowledge, and is relative to place and time (Munhall, 2012). The pragmatic approach acknowledges that knowledge development "is not value free and is historically contextualized" (Munhall, 2012, p. 229). The knowledge created with the pragmatic approach is judged based on its usefulness for influencing change (Munhall, 2012). Access to health insurance is recognized

to influence health care experiences of refugees in Canada (Campbell et al., 2014) and only as recently as April 2016, was the IFHP reinstated for all refugee subgroups in Canada (Zilio, 2016). There is a timely need for research given the recent policy change. Qualitative description is a well-suited methodology for this study because the knowledge created can be used to influence change.

Sandelowski (2000) describes qualitative description as a naturalistic inquiry; whereas, Polit and Beck (2014) attribute constructivist inquiry to qualitative descriptive research. These two terms are known to be used interchangeably, as Guba and Lincoln (1994) acknowledge that what they had previously called naturalistic inquiry, they now refer to as constructivism. As a naturalistic inquiry, qualitative description does not rely on any a priori commitments to a specific theoretical view. Although qualitative description does not require the pre-selection of variables to study or manipulate (Sandelowski, 2000), priority is given to areas where knowledge gaps exist or which intervention can produce change (Neergaard et al., 2009). In this study, I am pre-selecting legal refugee status as a variable of interest due to the urgent need identified in the literature to consider immigrant status as a determinant of health (Campbell et al., 2014; Castañeda et al., 2015). Thus, pre-selecting legal refugee status is justified for the purposes of this study and is compatible with qualitative description as a methodology.

Qualitative description is known to be useful in small research projects or when time or resources are limited (Neergaard et al., 2009). As a masters-level graduate student conducting her first qualitative research project with limited funding, qualitative description is the best choice for my project. The goal of qualitative descriptive research is to describe and to provide a summary of a phenomena while using the language of the research participants (Sandelowski, 2000). Thus, qualitative description entails less interpretation in favour of staying near to the data

(Powers & Knapp, 2011; Sandelowski, 2000). Less interpretation, instead of no interpretation, is a better descriptor of qualitative descriptive research since there is recognition that pure description may not be possible since the researcher's understanding and interests often influence the data collection and analysis process (Neergaard et al., 2009; Sandelowski, 2000).

Qualitative Content Analysis

Qualitative content analysis is identified as an appropriate data analysis method for use with qualitative description (Neergaard et al., 2009; Sandelowski, 2000). Similar to qualitative description, qualitative content analysis is also recognized as an atheoretical technique, in contrast to grounded theory or ethnographic methods of data analysis (Forman & Damschroder, 2008). Qualitative content analysis is often used by health researchers to answer practical questions (Forman & Damschroder, 2008; Hsieh & Shannon, 2005; Schreier, 2013). Elo and Kyngäs approach to qualitative content analysis which involves preparation, organizing, and reporting was used (Elo & Kyngäs, 2008; Vaismoradi, Turunen, & Bondas, 2013).

Distinctness from Other Qualitative Approaches

Qualitative description differs from other qualitative research approaches such as ethnography, phenomenology, and grounded theory (Neergaard et al., 2009). For example, ethnography generates thick descriptions, grounded theory results in theory development, and phenomenology produces interactive meaning of an experience (Neergaard et al., 2009). Whereas, the goal of qualitative description is a minimally interpreted description of the research participants' experience (Neergaard et al., 2009; Powers & Knapp, 2011) in which the final product uses similar language to the research participant's own language (Neergaard et al., 2009; Sandelowski, 2000).

Emic approach. Listening to the truth from the insider perspective of the research participants is considered an emic approach (Powers & Knapp, 2011; Munhall, 2012). Since I was interested in listening and sharing the stories of Somali refugee women and their health care experiences, I used an emic approach. The emic approach is consistent with qualitative research and is appropriate for this proposed study (Munhall, 2012).

Insider status. A researcher having an insider status with respect to their population is recognized as conferring some advantages, such as ease of gaining entry, as well as some disadvantages, for example, lack of disclosure if the research participants fear that their sensitive information may be leaked in the form of gossip (Lipson, 1991). Insider status is complex since it is difficult for researchers to claim either role of stranger or native when conducting research in their own community (Field, 1991). In reference to my skin colour and religion, I may be considered an insider of the Somali refugee community in Canada. However, other aspects which are not easily visible such as; my primary language being English, my professional career as a Registered Nurse, my graduate level academic preparation, and my young age of arrival to Canada, may result in me being considered an outsider of the Somali refugee community in Manitoba. Furthermore, growing up in Canada has allowed me to not view the Somali community without seeing subdivision based on the clan system, which is a world view that my research participants may potentially rely upon. This clan system is also another criterion a woman may use to evaluate my standing as an insider or outsider of her extended family and potentially whether to participate in this study or not. A few of the participants attempted to build rapport with me by asking who my parents were, which may be a subtle way for them to determine my social status within the Somali community. Only one woman overtly asked about

my clan but took back the question after she noticed that I was awkwardly struggling to come up with a response to her question.

Methods

The openness of qualitative description allows for a wide range of method designs to be possible, especially when variation in sampling, data collection, data analysis, and data presentation approaches are considered (Sandelowski, 2000). This wide range of potential methods necessitates researchers to describe the specific combination of approaches they use to design their study (Powers & Knapp, 2011; Sandelowski, 2010). This methods section describes the specific combination of approaches used.

Sampling Approach

According to Morse (1991), qualitative researchers should recruit informants who can best meet the needs of the study. Purposive sampling is a method of qualitative sampling in which participants are selected based on the need of the study and their knowledge of the study topic (Morse, 1991). In qualitative description, any purposive sampling method can be used; however, maximum variation sampling is specifically acknowledged for facilitating broad insight into the research topic (Neergaard et al., 2009; Sandelowski, 2000; Sandelowski, 2010).

Diversity among Somali women can be considered in terms of demographics such as: age, length of residency in Canada, education status, family status, and refugee status. Diversity may also exist in terms of experience with the health care system as well. Since this thesis is exploring refugee status as a determinant of access to health care services in Canada, I gave priority consideration to ensuring that my purposive sample included representation of Somali women who arrived to Canada as government-assisted refugees (GARs), privately sponsored refugees (PSRs), and refugee claimants (RCs).

Sample size. Since qualitative description is an emergent research design (Sandelowski, 2010), I planned to recruit at least nine women before assessing whether I reached data saturation. Nine women were chosen as a minimum benchmark because studies like Baird's (2009) were able to achieve data saturation with this sample size and data saturation is an appropriate approach for determining final sample size in qualitative research (Morse, 1991). In order to include equal representation of Somali women with each refugee status of interest, the proposed minimum sample size of nine women was to be composed of three GARs, three PSRs, and three RCs. However, there was more interest from PSRs to participate in the study and recruiting GARs and RCs took much longer. Thus, by the time that three GARs were recruited there were already six PSRs and three RCs interviewed, resulting in a total of 12 women participating in the study.

Inclusion criteria. There were four inclusion criteria for this study. Firstly, the research participant must be a woman. Secondly, she must be over the age of 17. Thirdly, she must self-identify as an ethnic Somali. Fourthly, she must have resettled in Canada as a GAR, PSR, or RC. Fifthly, she must live in a city in Manitoba. In the proposal stage there was the additional criteria of the woman speaking English as well but, as was anticipated in the proposal stage, this inclusion criterion was removed due to difficulty recruiting enough English-speaking Somali refugees. The inclusion criteria were chosen based on my research interests, feasibility of conducting this study, and the gap identified in the literature.

Recruitment and Eligibility Screening Procedure

After obtaining ethics approval I formally sought out permission to have my recruitment poster at agencies which serve Somali refugees. I approached staff of four different agencies by giving them a formal letter and a copy of the poster. I also personally explained my research

project to staff so if potential participants could not read English the staff member could explain the project. The letter and invitational poster are included as Appendix B and C, respectively.

Once a woman interested in the study called, the Oral Telephone Recruitment Script included in Appendix D was utilized to: establish if the inclusion criteria were met; provide information about the study to the potential participant; and arrange a date, time, and place for the face to face interview. I gave each woman the opportunity to choose the setting for her interview and choose a date and time that was mutually agreeable.

Initially I purposefully sought out only English-speaking participants. This meant that when women called willing to participate but spoke in Somali, I asked them sample interview questions in English to see if they could understand and answer back in English. Three Somali speaking women had called and were notified that I was only recruiting Somali women who could participate in an English only interview at this time but if it was okay for me to keep their contact information in case this changed. Recruitment was slow and when an English-speaking woman ended up only speaking mainly Somali during her interview, I decided to open up recruitment to Somali speaking women into the recruitment process. After making this decision, I called back the three women to see if they were still interested in participating. One of the numbers was no longer in service, thus, I was only able to contact two of the women. Both women were still interested and were recruited to participate.

Nine months after my first interview, I had recruited three RC women, six PSR women, and only one GAR woman. To facilitate recruiting GAR women specifically, I modified the recruitment poster to specify that I was recruiting GAR women and obtained ethical approval for my amended poster. I gave my new poster to staff at two agencies who were very helpful in my recruitment. This led to two GAR women being recruited.

The Interview

The primary method of data construction in this study was digitally recorded, face to face, semi-structured interviews. I chose to term this process data construction over data collection because the former better aligns with the constructivist paradigm in which the researcher and the research participants construct the data together (Olson, 2011). I chose individual interviews over focus groups, as a method of data construction, because I was not interested in the interaction between the women and the literature reviewed identified the need to establish trust and rapport as well as confidentiality (Olson, 2011). One potential research participant offered to host a focus group at her house by inviting some of her friends to also participate in the interview with her. This demonstrated that focus groups may be a potential way to construct the data needed for this study.

The interviews were digitally recorded in order to facilitate data analysis. The interviews were conducted face to face, instead of over the phone, because I wanted the opportunity to receive non-verbal data, such as facial expressions, in addition to the women's stories. However, due to time constraints, an ethics amendment was obtained so that any follow up interviews could be done over the phone and without being digitally recorded.

Giving an honorarium and obtaining consent. At the beginning of the interview, I provided each woman with a \$25 gift card to a local grocery store to thank her for participating in this study. Next, I went over the informed consent form and asked her to sign a copy to indicate voluntary written informed consent. The consent form gave each woman the option to receive a summary of the research findings via email. Participants were provided with one copy of the signed consent form.

Demographic survey. Then I asked each woman the questions on the demographic questionnaire, included in Appendix E. Morse (1991) argues that demographic characteristics have little significance in qualitative research. Morse (1991) instead favours descriptive methods of describing the research participants. Based on this opinion, and in consideration of maintaining the anonymity of my research participants, I chose not to publish specific demographic characteristics. Instead, I utilized descriptive methods to summarize the demographic features of the sample.

Beginning the interview. Next, I turned on the digital recorder and asked each woman to start by defining health. The goal of the interviews was to hear each woman describe her experiences accessing health care in Canada. I used the questions listed in the semi-structured face to face interview guide, also included in Appendix E, to ensure that I asked each woman similar questions during the interviews.

Semi-structured face to face interview guide. Semi-structured and open-ended interview questions are appropriate for qualitative description (Neergaard et al., 2009). I chose to utilize the semi-structured interview approach over an open-ended interview because it is more time consuming to compare across stories with the unstructured approach (Olson, 2011). In qualitative description health research, the interview guide questions are focused on areas where knowledge gaps exist or where intervention can produce change (Neergaard et al., 2009). The interview questions for this study are listed in Appendix E; however, since qualitative description is an emergent research design (Sandelowski, 2010) the questions may change as the study progresses. For example, earlier interviews may be guided more by the proposed interview questions and the informant; whereas, in subsequent interviews the questions may be influenced by the preliminary findings (May, 1991). Qualitative content analysis requires the interview

guide questions and all prompts to be open-ended questions so that the detail and depth of the informant's answers can be analyzed (Forman & Damschroder, 2008); thus, this criterion was integrated into the design of the questions and prompts.

Concluding the interview. To terminate the interview, I asked each woman if there was anything else she would like me to know about her experience that we have not discussed. Once the woman was finished answering this question, I thanked her for her participation and ended the recording. I then gave her some time to gather her thoughts and make any concluding comments.

Follow up interviews. Research participants who consented to being contacted for a second interview were contacted once all twelve transcripts from the first round of interviews were analyzed. Only one participant was interested in being re-interviewed. With ethical approval through an amendment, I had an over the phone conversation with this one woman and wrote a field note based on this conversation. A \$25 gift certificate was mailed to this woman to thank her for her time.

Field Notes

Immediately after each interview, I documented a field note entry to record the encounter with the research participant. I wrote: about my rapport with the woman, about the setting of the interview, and any discussion we had after the recorder was turned off. As Olson suggests, I used this time to reflect on: my impressions of the interview, what went well, what I could have done differently, and what I would like to have included in the interview (2011).

Reflective Journal

A reflective journal was maintained throughout this study to record my personal experiences during the data construction and analysis process. Reflective journals can include the

following: biases, ideas, fears, mistakes, confusions, breakthroughs, problems, reactions, feelings, hunches, impressions, prejudices, inadequacies, likes, and dislikes (Bogdan & Biklen, 2007; Tappen, 2016). Bogdan and Biklen suggest that reflections can be categorized as: reflections on analysis, reflections on method, reflections on ethical dilemmas and conflicts, and reflections on the observer's frame of mind (2007). The suggested practices of these authors were utilized to record my reflections throughout the study.

Writing Memos

Throughout the data analysis process, in addition to writing reflective journal entries, I wrote memos. Memos can be written about the methodology, emerging themes, or links between themes, and serve to encourage analytical thinking and reflection (Rossman & Rallis, 2017). The memos served to document the decision making throughout the data preparation and analysis process.

Preparing the Transcripts

The digitally recorded interviews were transcribed verbatim using a naturalized approach (Olson, 2011) by a professional transcriptionist who had signed an oath of confidentiality. Although I recognized that increased reflectivity and trustworthiness of the transcripts are benefits of transcribing the data myself (Olson, 2011), I outsourced this task to a professional transcriptionist since I had funding and this decision allowed me to dedicate my time towards preliminary data analysis and preparing for the next interview.

Once I began interviewing women in Somali, I took on the role of translating the audio into Somali and then transcribing my English translation. I then reviewed the audio and my translated transcripts with a bilingual Somali-English professional medical interpreter, who had signed an oath of confidentiality. There were words I did not know the translation meaning I

needed assistance in filling these gaps in my transcript. The Somali medical interpreter aided me in accurately completing the transcripts. In a few cases the Somali medical interpreter and I disagreed on a translation. In these areas we listened to the audio multiple times and discussed where the difference was. Since my English vocabulary was greater than the medical interpreter's, we mostly agreed that our difference of opinion was minor and that the meaning was not affected by staying with my translation, in which case I did not change the transcript. When the disagreement was based on how to interpret the Somali audio and the meaning would be affected, I differed to the medical interpreter's expertise and changed my transcript. This process enabled me to complete my transcripts and check the accuracy of my work.

Data Analysis

Preparation

Once the interview was prepared, I reviewed the accuracy of the transcript by reading the transcripts while simultaneously listening to the digital recording. I then reviewed each transcript to strip it of any identifying information, without changing any intended meaning. I spent time immersing myself in the data by listening to the digital recordings and writing reflective journal entries (Forman & Damschroder, 2008; Vaismoradi et al., 2013). Once the transcript was finalized, I read the transcript multiple times to familiarize myself with its contents.

Organizing

During the data reduction phase, I broke up the transcript data into smaller sets of data by coding, line by line, by hand, by writing in the margin of the transcript. I mainly used inductive coding, however, I also used deductive coding at times since I had a completed literature review and had chosen a conceptual framework when I proposed this study. I also used coding suggestions by Saldaña (2016) described in his book *The coding manual for qualitative*

researchers. I gave priority to creating descriptive and in vivo codes from the transcript data. I then categorized my codes by trying to group and organize the codes into parent codes and sub-codes. I used constant comparison to understand how refugee status was influencing each women's health care experiences and to be alert for any potential commonalities or differences in how they access or utilize health care services.

My thesis advisor and I independently coded the first three transcripts and then met twice to discuss our coding and my grouping of the codes. I then continued analyzing the transcripts as data collection continued. Since recruitment was a slow process, I found that I had a lot of time in between interviews; thus, I did not have to differentiate between the quality of the interviews in order to prioritize the order in which I was coding transcripts. I ended up analyzing the transcripts in the same order I interviewed the research participants.

Also, since I had lots of time in between interviews, I ended up coding my first ten transcripts multiple times. I then won a free subscription to Atlas.ti qualitative coding software at a conference, so I imported my transcripts into the software and electronically coded them as well. I found that the program helped me manage my data better, so I also hand coded and then electronically coded my last two interviews.

Reporting

Once I had all my transcripts coded, I had 1,055 codes, 76 memos, and 28 code groups. I then began writing the findings and fine-tuning code groupings. In discussion with my advisor, I regrouped my findings to focus on reporting the experiences of the women accessing and utilizing health care services as well as the role of the health care provider. This led to organizing the findings into three separate sections which were conceptually related because they told the story of the women's health care experiences.

Ethical Considerations

Ethical approval was obtained from the University of Manitoba Education/Nursing Research ethics board. A letter describing the research and the consent form is included in Appendix F. Participation in this research is thought to have had minimal potential of harm and minimal risk to the participants. Written informed consent was obtained from all research participants. All of the women were given a paper which identified local health care and resettlement supports in anticipation of the research participants having unmet physical or mental health care needs. A copy of the ethics protocol approval letter is included in Appendix G.

Data Management and Security

The research data included the reflective journals, field notes, memos, digital recordings, interview transcripts, demographic questionnaires, signed consent forms, and coded transcripts. The signed copies of the consent forms are the only documents which may have the participants name on them; thus, they will be kept in a locked cabinet in a secured place in my home separate from the rest of the research material for seven years. The remainder of the research material will be kept in a second locked cabinet in my home for seven years. Each research participant was given a code number and a pseudonym. One electronic file was maintained that lists which pseudonyms, used for the purposes of publishing the study findings, correspond to each code number.

The interview digital files, interview transcripts, and demographic surveys are saved electronically. All raw and hand coded data created during the data analysis process has been integrated into the electronically coded transcript files in Atlas.ti and the paper copies are stored in the second locked cabinet. All electronic data is saved on the researcher's password protected

laptop and a second copy of all the electronic data is saved on a flash drive which is kept in the second locked cabinet as well.

Enhancing Trustworthiness

Efforts to develop the trustworthiness of this study began during the proposal stage by using Lincoln and Guba's framework which includes the following four criteria: credibility, dependability, confirmability, and transferability (as cited in Polit & Beck, 2014).

Credibility

Credibility refers to the researcher endeavoring to ensure that the data and its interpretation is the truth of the participants (Polit & Beck, 2014). Lincoln and Guba specify two aspects of credibility: firstly, to conduct the study in a method that enhances the credibility of the findings, and secondly, to demonstrate credibility in the research reports (as cited in Polit & Beck, 2014). The credibility of the data was also enhanced by the principal investigator endeavoring to portray the perspective of the study participants (Neergaard et al., 2009) and reviewing codes and code groupings with the thesis advisor.

Dependability

Dependability refers to the stability and the replicability of the findings (Polit & Beck, 2014). In this study, the principal investigator practiced reflexivity by journaling about research decisions (Neegard et al., 2009). The credibility and the dependability of the findings was also established by digitally recording the interviews.

Confirmability

Confirmability refers to objectivity, specifically whether two independent researchers would come to equivalent conclusions about the accuracy, relevance, or meanings of the data in the study (Polit & Beck, 2014). Peer review or researcher triangulation is recommended to

minimize researcher bias and promote the integrity of the research findings as well as reflecting on researcher bias (Neegard et al., 2009). As the principal investigator, I maintained an awareness of the potential contribution of researcher bias. To minimize researcher bias, the thesis chair and the principal investigator individually analyzed the first few transcripts and discussed the coding together. The thesis chair also oversaw the data construction and data analysis of the entire project.

Transferability

Transferability refers to the ability to extrapolate the findings of this study to other groups or settings (Polit & Beck, 2014). Lincoln and Guba (as cited in Polit & Beck, 2014) support that the researcher's responsibility is to provide thick descriptions that consumers of research can use to evaluate the applicability of the findings to other groups and contexts. Thick descriptions are included in this thesis in order to meet the criteria of transferability.

Summary

In this chapter, the philosophical underpinnings of this study and the method for constructing and analysing the data were discussed. The data collection and data analysis procedures were described. Ethical considerations, the data management plan, and efforts to maintain trustworthiness was also presented.

CHAPTER FIVE: FINDINGS

This study used qualitative description to explore the health care experiences of Somali women with differing refugee status. In terms of organizing this chapter, first, the participants are introduced and then the themes and subthemes are presented in three sections: Accessing Health Care; Utilizing Health Care; and the Role of the Health Care Provider. The women's voices are shared as direct quotes within my context and interpretation as the researcher. Each of the major themes in each section is represented as a puzzle piece in figures to visually display the findings.

In this findings chapter, the terms, primary care provider or family primary care provider, are used to refer to primary care received from a physician or nurse practitioner in a walk-in clinic or family practice clinic setting respectively. This decision was made since five of the 12 women interviewed acknowledged receiving primary health care services from a nurse practitioner, despite only using the term doctor to describe their care provider during the interview.

The Participants

The 12 women who participated in the study are described in Table 4: Demographics, using relevant details obtained from the demographic survey and the semi-structured interviews. This study set out to recruit participants with the same gender and ethnic identity (Somali women) but differing refugee status on arrival to Canada (GAR, PSR, or RC) since gender and ethnicity are recognized to influence the experiences of refugees and a specific objective of this study was to explore the implications of differing refugee status. All 12 women also reported their religion as Islam and considered themselves Muslim. A fictional name is assigned to each participant. In an effort to protect the women's confidentiality, care and attention is used in

presenting additional details about them. For example, descriptive ranges are used to present ages and how long the women have lived in Canada.

Table 4: Demographics

Refugee Status	Government-Assisted Refugee (GAR)			Refugee Claimant (RC)			Privately Sponsored Refugee (PSR)					
Pseudonym	Gabriella	Gina	Gwen	Rae	Rosalie	Ruby	Paulina	Peggy	Phyllis	Pippa	Portia	Prudence
Age	young adult (18-35 years)	middle-aged adult (36-55 years)	middle-aged adult (36-55 years)	young adult (18-35 years)	young adult (18-35 years)	young adult (18-35 years)	young adult (18-35 years)	young adult (18-35 years)	young adult (18-35 years)	middle-aged adult (36-55 years)	middle-aged adult (36-55 years)	middle-aged adult (36-55 years)
Length of Time in Canada	5 years or less	5 years or less	6 to 10 years	5 years or less	5 years or less	5 years or less	5 years or less	5 years or less	5 years or less	5 years or less	6 to 10 years	6 to 10 years
Has Children	No	Yes	Yes	No	No	No	No	No	No	Yes	No	No
Highest Level of Education Obtained	English Language Training	Middle School	English Language Training	Some High School	Some High School	Some High School	Master's Degree	Some High School	Some High School	English Language Training	Middle School	English Language Training
Employed	No	No	No	No	No	No	Yes	No	No	No	Yes	No
Language Primarily Spoken by Participant During Interview	Somali	Somali	Somali	English	English	English	English	English	Somali	Somali	Somali	Somali
Somali Interpreter Used During Interview	Yes	Yes	No	N/A	N/A	N/A	N/A	N/A	No	Yes	Yes	Yes

Accessing Health Care

The major themes in section one, Accessing Health Care, are: Being New, The Importance of Social Support, and the Role of Technology. These themes present how the women access health care services.

Figure 2: Accessing Health Care



Being New

Being new to the country affected the experience the women had accessing health care services. Many times, the women made statements that referred to being new to Manitoba, Canada. For example, Gabriella said, “When I was new here, I didn’t know anything, I was confused”. Similarly, Rae said, “Yes, because you can’t know anything. You’re new to the country. You don’t know the system”. Prudence also remarked, “Yes, then I didn’t know anything”. When the women’s stories of being new were analyzed, time, language, and learning by trying, were noted to be three key aspects of this experience. These three key aspects are explored further individually.

Time. Whether a refugee is new or not can be defined by the length of time they have been living in Canada. The women interviewed for this study varied in how long they have been living in Canada, from as short as four months to as long as 10 years. Many times, the women

referred to how long they had been living in the country when they experienced difficulty. For example, Gina explained:

Back then, I was new to the country... I was here for a year in this country and understood a bit when [health crisis happened] ... But if I was even newer, and newer, and didn't know the emergency room, it would have been a bigger problem because, even though I was here for a year, I still experienced a lot of problems. (Gina)

Pippa who has been living in Canada for a similar length of time as Gina shared, "At this time, I didn't know anything. I was new. It was during the first year. My sister was helping me with everything". Gina and Pippa's experiences were slightly different from the refugee women interviewed who had recently arrived in Canada. For example, Paulina, the most recent arrival to Canada, responded, "No. I've only been here four months, so no", when asked if she had experienced any challenges during her resettlement experience. This finding suggests that the recently arrived women may not be reporting challenges accessing and utilizing health care because they have limited experiences in Canada overall.

As part of the demographic questionnaire, each woman was asked how long after arrival in Manitoba she received her Manitoba Health Card. Gabriella, Gina, Peggy, and Phyllis responded that they received their card within 24 hours of arriving in the province. Whereas, the remaining permanent residents, Gwen, Paulina, Pippa, Portia, and Prudence responded that they had received theirs within the first couple of days to weeks of living in Manitoba. In contrast, the non-permanent residents, i.e. the RC women who were interviewed, reported that they had received their Manitoba Health Card three to six months after resettling in Manitoba. The RC women reported being able to obtain their Manitoba Health Card only after securing a work permit first. The women's answers to this question highlighted that length of time living in the country influenced their experiences and there were subtle differences in their resettlement

experiences related to whether they were permanent residents or non-permanent residents upon arrival to Manitoba.

Language. All of the women who participated in this study spoke Somali. However, half of the research participants were also proficient in speaking and understanding the English language. Whereas, the other half were still learning English and had limited understanding and speaking skills in this language. Given that the English language is one of Canada's official languages and is the official language that is predominately used in Manitoba, it is understandable how language significantly impacted many of the women's experience of being new to Manitoba. Both Pippa and Prudence described being "like a deaf person" because of how significant the communication barrier was as non-English speakers in a predominately English-speaking society. Pippa explained, "I didn't even know how to say 'hi'. At this time, I did not know enough English. I would understand one word and then not understand one word". Both Portia and Gwen also described how newcomers miss out on a lot of information due to the language barrier. For example, Portia described it as:

The person is new in the country, there are a lot of things missing... Because when you are new to the country and do not understand the language, everything that is easy you think is very big. And the person when they are talking, if you don't understand anything, not even a word, it won't benefit you if you keep asking, 'what did he say', 'what did he say', 'what did he say'... (Portia)

Prudence described how challenging her experience as a newcomer was by saying, "I could never go out alone, I didn't know the language. I am forced to look for someone, to find someone, for them to take me out. Yes, it is difficult, I am not self-sufficient". Gwen also described the challenges of not knowing English as a newcomer but explained that over time, she began to understand English; "You are missing a lot, but when you're here for a while you learn a lot. When you understand English, you learn a lot. But when you are new, there is a lot of

difficulty you face”. Gwen’s statement suggests being new while not understanding the English language results in more significant challenges during the resettlement process.

Within the sample of Somali women with differing refugee status that were interviewed in this study, there was a baseline difference in English language proficiency on arrival to Canada. For example, all three of the RC women interviewed were proficient in the English language and spoke in English during their interviews. None of the three GAR women interviewed were fluent in English and all three spoke Somali during their interview. Of the six PSR women interviewed, the three young adult women were proficient in the English language and the three middle aged adult women were not. Two of the three young adult PSR women were interviewed in English. The third young adult PSR woman, Phyllis, automatically began answering in Somali despite the questions being posed to her in English and her consenting to participate in the interview using the English language. All three of the middle-aged adult PSR women spoke Somali in their interviews. Given the understanding that English language fluency may facilitate settlement in Canada, the RC women and the three young adult PSR may report experiencing less challenges than the three GAR women and the three middle aged adult PSR women. This potential difference would thus be unrelated to refugee status, and more related to baseline differences in English language fluency on arrival to Canada. The potential influence of English language proficiency was taken into account throughout the analysis of the interviews.

Despite being aware of the influence of English language fluency, an additional complexity was noted in the self-ratings of English language proficiency. As mentioned earlier, Phyllis’s interview was conducted in Somali despite her stating that she was comfortable participating using her English language skills. At one-point during the interview Phyllis said, “Sorry, I have been using Somali a lot because I am not good at English”; however, during other

times in the interview Phyllis was adamant that she was proficient in the English language. For example, when asked about communicating with her health care providers in English, Phyllis said, “Yes, it was easy to understand each other because it’s not the first time I am talking in the English language, so we understood each other well”. This finding supports that understanding English is a distinct proficiency which is easier than speaking English. This finding is also supported by one of Gabriella’s experiences. Gabriella said:

...I saw how difficult it was for her [health care provider at a walk-in clinic] to understand me and for me to understand her, when she responds to me, I understand some, but it is very hard for me to respond back to her in the way she wants. (Gabriella)

Unlike Phyllis, Gabriella was not able to understand my interview questions when asked in English. However, Gabriella’s statement supports Phyllis’s statement about the difference between English language comprehension skills and speaking skills. An interesting finding was that when asked about their highest educational attainment during the demographic questionnaire, a couple of the women responded with their English language scores. For example, Pippa reported her benchmark score as “3D” and Gabriella reported “43B”. The significant difference in score reported by the women may actually relate to two different kinds of English language tests being taken by the women. For example, Pippa may potentially have done the Canadian Language Benchmark (CLB) test and Gabriella may have done the Canadian Academic English Language (CAEL) test.

Learning by trying. The participants highlighted the importance of experiences, more specifically learning by trying. Despite living in the country for years, if one did not try things and learn through new experiences, it would be as if they were still new and did not know anything. Portia explained it this way:

It is very far apart when you are new, you don’t know anything... You don’t have friends; you only know the family that brought you... If you leave the house, you are worried you won’t be able to find your way back. You need to have someone accompany

you... Someone has to go with you to show you the bus, show you the school, show you the store. You have to go with someone. But if you stay home, you won't learn anything. (Portia)

After Gwen described how she became aware that she had misunderstood what having a joint bank account with her husband meant; she shared, "I know other women that have been here 8 or 9 years that still don't know how to use the [debit] card. So, when you are new you need to try to do things in Canada". Similarly, Pippa explained that she is learning about the health care system through her personal experiences. Pippa shared:

There is not any medication that I have been prescribed while I have been here. I haven't needed to fill a prescription. So, I wouldn't know anything about it. I would not even know where a pharmacy is. When someone needs, that is when they look for it. So, while I was sick, [I] haven't been prescribed anything by the doctor. (Pippa)

Similarly, Rae described how she learned where a walk-in clinic near her was after she had a health care need:

..for me like this place I was new to it, so I didn't know which one is like closer to a clinic. So, you had to find and ask like some of the people that I knew. And they told me you have to go this way and this way and that way. So, I went to this place. (Rae)

Rae's example shows that she was willing to try to find the walk-in clinic on her own and unlike Portia, she was familiar enough with her neighbourhood that she was not worried about not being able to find her way back home.

In terms of differences by refugee status, there were no overt differences noted, each woman learned through experiences by trying. One potential difference that was noted was with the middle-aged adult PSR women Portia and Prudence. Despite living in Canada for over five years, both of these women were still reliant on their social supports to access health care services; whereas, all the other women were nearly independent except for potentially requiring a medical interpreter. Both Portia and Prudence were single women without children which implies that they have not had as many experiences nor have had to try as hard to learn as the

other middle-aged women. Gina, Gwen, and Pippa are mothers who have had to parent and support their children during their resettlement process as well; thus, they potentially had more opportunities to learn by trying.

The Importance of Social Support

Social support was a significant aspect of the participant's resettlement experience. Social support came from: family, friends, settlement workers, social workers, school counsellors, and community members. There were three main types of social support provided to the women: financial support, navigational support, and interpretation support. Portia explained the link between social support and access to health care:

When you don't know the system or don't have friends or don't have a person who is a friend or don't have family... its hard. It can become a challenge because when you move to a new city while you are learning people and learning things, if you get sick it is hard to get connected with a doctor. (Portia)

Patterns in social support were noted in the data that were related to refugee status and are presented below.

Financial support. There were many health care related examples in which the women mentioned that they relied on their social support to help them financially as well. Pippa described an example in which she received financial support from her son to buy a new pair of glasses after hers got lost and she was told she could not get insurance coverage to replace them under the provincial Employment Income and Assistance program (EIA) for another three years:

She [staff at optometrist office] said 'do you work?'. I said, 'no'. I said, 'my son will buy it for me, he said he likes his mother's eyes and asked me to find out the cost'... I went with my son to Superstore and he purchased the glasses for me... for \$70. (Pippa)

In general, PSRs are supposed to be reliant on their private sponsor for up to their first year of living in Canada. It is only after this time in which a PSR may be eligible for financial support under EIA. The GARs have access to federal government funding through the

Resettlement Assistance Program (RAP) which is supposed to be similar to provincial EIA funding amounts. However, the RCs in Manitoba are known to have very limited access to EIA. In this study, income was not asked intentionally, to reduce the invasiveness of questions during the interview. By analyzing the women's stories, it is clear that this generalization is accurate.

For the GARs, Gabriella reported having access to dental insurance through EIA which implies she was receiving financial support and not completely reliant on her parents financially. Despite having access to EIA, when asked what she would have done if EIA did not cover the cost of her routine dental care; Gabriella said, "I would have waited until I was working, or my father would have to pay for me". After being asked if Gabriella paid for medications prescribed to her by a walk-in clinic, Gabriella said, "No I paid it, it was easy to afford, it was cheap" which further supports that she had access to her own financial resources and was not completely dependent on her social supports to assist her financially. This is different from the experience of Phyllis, who described her experience going back to a walk-in clinic to request a sick note because her teacher requested one:

So, when I went to the doctor, they said I had to pay money for the note. So, that was very surprising to me, that I had to pay money when I was visiting the doctor... I didn't pay, truthfully, even though I needed it so much I didn't. Firstly, I didn't have money and secondly, I couldn't bother my parents... (Phyllis)

Since this experience occurred during Phyllis's first year in Canada, she should have been relying financially on her private sponsor, an uncle. From Phyllis's statement, it is clear that not only did she not even think to ask her sponsor for help, she did not even want to burden her own parents. Furthermore, she may not have had any pocket money on her, to consider covering the cost herself. Similarly, Rae and Ruby, two of the three RC women interviewed, made it evident that they had limited financial resources. Both women were reliant on social supports to help them cover their health care costs. For example, Rae stated: "and [at] the pharmacy, I didn't have

insurance at that point... a friend of mine paid [for my prescription] for me". Similarly, Ruby shared, "No, I think they paid. At that time, I didn't have any health [insurance or] a Manitoba Health Card, but they paid I think, they [pharmacy] charge money to it [social supports] and yea. I think so". The women's experiences demonstrate how important social support networks are with assisting them to access health care services.

Navigational support. All of the GARs interviewed reported living at a settlement agency during their first few months in the country. All three GAR women described how their settlement worker and a resettlement agency provided navigational support during their first few months in the city. For example, Gabriella said, "whenever I had an appointment made for me, I needed an interpreter, and I also needed a staff member who was Somali who worked there and was responsible for me to take me to the appointment".

Nearly all of the PSRs reported receiving navigational support from their private sponsor. Paulina was the only PSR who did not report that her sponsor made an appointment for her with a family primary health care practitioner. Rather, her only health care visits were at a walk-in clinic which she found by asking her other social support, her roommate. Paulina said, "yea, the girl, I'm living with, told me about it. And she told me the direction and it was easy to find". Similarly, none of the RCs had anyone help them find a family primary care practitioner, but they did receive help navigating the health care system from their social support network. For example, Rae said:

There was a family, I stayed with them. That family helped me... They knew like how it goes and everything. They told me, like you have to get this one. When you get this one, you have to go to this place. And apply [for] it. They're the one who go with me and showed me everything... So, you need someone who's familiar with this system to kind of help you. Kind of navigate the way, like this. (Rae)

And Ruby said:

... before, I didn't get a health card. I went to the doctor and it was maybe stay two to three weeks in [name of city]. And then they ask me [for my] health card. So, my social worker tell them that I'm still new to the country, and I don't have the health card... (Ruby)

An unexpected source of navigational support mentioned by a few of the women came from counsellors at their English language training schools. Gina for example said, "my glasses got lost so I told my counsellor at school. So, he said I will make an appointment for you". Similarly, Portia explained the great lengths her school counsellor went to, to help her seek dental care for dental pain:

A man who works at the schools and helps immigrants, and isn't a teacher but comes to the students and asks 'what do you need'... I told him my tooth hurts and I want to be taken to a doctor. He said okay. He made an appointment. He said he would find someone for me. He asked me what language I speak, I said Somali. So, he said he will find a Somali speaking woman for me that isn't a teacher. He found a girl, made an appointment with her, he then came to me and took me to the appointment... (Portia)

Interpretation support. All of the RCs were proficient with the English language; thus, it is understandable why these three women did not mention needing social supports to function as interpretation supports. All of the GARs stated that their family primary care practitioner regularly provided them with a medical interpreter; however, at walk-in clinics or in the emergency department they often brought their own interpreter. Gabriella, for example, did not have an interpreter at her first walk-in clinic experience. Gabriella said, she and the doctor "forced ourselves to understand each other." Then Gabriella went on to explain the next time she went to this walk-in clinic, she had two family members interpreting between Somali and Arabic, since the doctor and her two family members could speak Arabic. Both Gina and Gwen also reported having their children available to help them with interpretation support.

Half the PSRs are young adult women with no children who are proficient in speaking English. Accordingly, none of these young adult PSR women reported needing any interpretation support. Alternatively, Peggy shared two examples in which she was the interpreter for her

mother during her mother's health care appointments. Peggy said, "My mother was the patient. So, I guess I just tag along as I say before, I was her translator, so I just tag along." The remaining half of the PSRs were middle aged adult women and all three of them reported relying on friends and family for interpretation support during their health care appointments.

The Role of Technology

A few of the participants interviewed early during the data collection process reported using technology to help them access and navigate health care services. This was an unexpected finding and this question was then added to the semi-structured interview protocol. Usage of technology ranged from using the search engine, Google, to using GPS or a local transit website or application for directions. An interesting finding was that some of the women appreciated using the phone to book health care appointments because it meant they did not have to leave the house and go to the health care practitioner's office just to request an appointment. Their experiences are presented below under the sub-headings: The Internet: Google, Smart Phones, and GPS; and Booking Appointments via the Phone.

The internet: Google, smart phones, and GPS. Peggy said, "You know in our generation we have what we call GPS, so we just Googled it and then went. And [the] GPS told [us] the directions and [we] went there." Ruby said, "I just Google it. I just go Google the nearest clinic, and then I went. So, it was easy." Paulina also wanted other women to know that they should "do research because nowadays, there is everything on the internet and Google. All you have to do is type [it] in so you can search." Gwen also wanted other women to know that they should do their own research on the internet, she said: "I would also tell her, that even if it is far from you, where your doctor is, you can go on the computer and in your area, you can look what doctors there are there".

Gwen did not arrive to Canada being technologically literate but developed this skill over the 10 years she has been living here with help from her children. Gwen said:

No, I didn't go on the internet. I didn't even know that, but now I do it. Anything I need, I go on the internet, or my kids do it for me, All Praise be to God, they can do that. But initially, I didn't know to go on the internet. I didn't know what to do with it, but they showed me. (Gwen)

Similarly, Gina also shared that her kids arrived in Canada comfortable with technology so they would help her. Gina explained how one day she had a prescription faxed to a pharmacy by her family primary care practitioner. When the pharmacy called her to say the prescription was ready for pickup, Gina realized she did not know where to go. She explained:

My kids put it into Google and said it is this one near us so we went and got it ... yes, everywhere we would go with this [smart phone]. We put the address in, look at what buses go there, and how much time does it take... how far it is... I went all over the city for doctors... I said send me the address, he [pharmacy staff] sent it to me and I put it in the GPS and then I went. So, we use to put it in here [the smart phone], the kids would do it. (Gina)

Peggy, a young adult woman, identified that being proficient in the English language facilitated her ability to use the GPS function on her phone to walk to health care appointments. Peggy said, "Like if you know the language, and you can understand the GPS lady. You're good to go." On the other hand, Phyllis, a young adult woman who self-reported as being proficient in the English language but spoke in Somali during the interview, responded differently. When asked about whether she used Google or the GPS function on her smart phone, Phyllis said:

Sometimes I use it but I don't have a car so I wouldn't be able to figure it out. Even if I Google it and I go in a car, I won't know how to drive. Usually my uncle helps me. (Phyllis)

So, having support from her uncle, her sponsor, meant that she did not need to do her own research or figure out directions. So, Phyllis had yet to see how she could use GPS technology to walk to her health care appointments on her own. Similarly, Rosalie, another young adult woman who is proficient in the English language and with using her smart phone did not realize that she

could use her smart phone or the internet to help her access health care services. To probe for more information, I told Rosalie that other women mentioned using the internet and looking up transit information on their phone to access health care services, Rosalie replied:

I didn't hear the app that you can use from your phone... the only thing that I know you can use [to access health care is] your health card. Um. Yea. I never heard the thing that you can use on your phone. (Rosalie)

Given that Rosalie had not had any health care visits in Canada beyond the immigration medical exam, her knowledge was limited to knowing that she needed her health card to access health care services. So, potentially until a refugee newcomer woman has a need and attempts to try to use the technology available to her, she may not see the value of technology in facilitating access to health care services.

Booking appointments over the phone. Through analyzing the women's experiences, there was a general understanding that many of them were accustomed to walk-in health care services back home and appreciated being able to seek medical attention for a symptom without making and waiting for a scheduled appointment. However, what was novel to some of the women was being able to phone for an appointment ahead of time with their family primary care practitioner. For example, Pippa said:

Yes, there are other things that can make it easy [to use health care services. For example,] while you are at your home, you can talk on the phone and make an appointment and you won't bug anyone or need to find someone. Appointment is a little thing a person can say, instead of taking someone or leaving and going to the doctor and saying I need an appointment. While you are at your home you can call. If you have their number you can call and tell them, [give them] your name and say I want an appointment and that is how you can get an appointment... (Pippa)

Similarly, Gabriella also reported being able to call ahead of time as something that made accessing health care experience easier. She would either try to do this on her own with her limited English language skills, like Pippa, or have an acquaintance who was also a medical interpreter make the call on her behalf. When asked if there was something that made it easier for

her to use health care services Gabriella said, “Yes, calling. Or even having someone interpret, I know a girl who does interpretation. I have her number. If I want, I call her and tell her this is my doctor make me an appointment”. This was a change for Gabriella because when she was new to Canada, she reported going in person to her family primary care practitioner without a pre-made appointment when she had a health care need.

Paulina, who did not have a family primary care practitioner, was frustrated with the long wait times at the walk-in clinic she was frequenting for a newly diagnosed health problem.

Paulina said:

Like waiting almost like an hour. Sometimes you already make the appointment. Then you have to go and wait sometimes two hours, an hour and a half, just sit. So, I asked myself, what’s the point of making [an] appointment [just] to have to wait. Why don’t you just call and walk in, see the doctor. (Paulina)

Paulina’s statement expresses that she wished she could have waited at home and used the phone to make a same day appointment, implying that having a same day appointment at the walk-in clinic would have provided her with a more accurate appointment time than the pre-booked appointment the walk-in clinic had made for her.

Utilizing Health Care

The major themes in section two, Utilizing Health Care, are: Services Utilized: Lack of Illness Prevention and Health Promotion; Pattern of Utilization: Seeking Out Health Care to Treat Symptoms; and the Importance of Health Literacy. These themes present how the women utilize health care services.

Figure 3: Utilizing Health Care



Services Utilized: Lack of Illness Prevention and Health Promotion

The women utilized a variety of different health care services, so their experiences are presented briefly based on the type of health care service. Since only two women shared their experiences with medical specialists, secondary care, these health care experiences are not presented as a subtheme. Instead the experiences the women had in primary care, tertiary care, and at the dentist, pharmacy, and optometrist are presented.

Primary care: Family practice and walk-in clinics. All of the GARs reported having their first appointment with a health care practitioner being with a family primary health care practitioner that was arranged for them by a settlement agency. All three of them remembered their first appointment being within the first month of living in Canada. None of the GAR women had needed to seek out any health care services for themselves prior to their first appointments. For example, Gwen said, “The family doctor, when I came to the country, at that time I was here for a month. [Settlement agency] made it for us. We went, they took us”. Gina, however, reported taking her daughter to a walk-in clinic for an acute symptom prior to their first appointment with their family primary care practitioner. Gina said:

The kids had allergies, she was sneezing... a lady who was living [here] for two months already, I asked her, ‘where you go to the doctor?’ She said, ‘there is a walk-in clinic... to just go’. I took the health card, we went to the place... they said wait, we waited until

it was our time. We went in... he prescribed her medication... They didn't charge us...
(Gina)

All of the RC women and one of the PSRs reported not having a family primary care practitioner. Of these four women, three had experienced acute symptoms that prompted health care visits. Rae for example, explained about her first health care visit as "one time I got sick, I was not eating, so I went to [a walk-in clinic]". Rosalie was the only woman who had not made any medical appointments in the year that she had been living in Canada. Relying on symptoms to prompt health care utilization also came up during her interview. Rosalie explained, "Because I didn't face anything that can, that you can say it's not health or any pain. So that's why I didn't go anywhere".

An interesting finding was that Rae and Ruby used walk-in clinics but did not complain about long wait times during all of their health care experiences. When asked specifically about this it turned out that they had help accessing health care services from publicly run, Nurse Practitioner led, walk-in clinics that pre-booked them for same day or next day appointments during their early health care experiences. This was important to them during this early stage because as RCs they did not have a Manitoba Health Card and would have experienced a lot of difficulty attempting to access privately run walk-in clinics. Once they had their Manitoba Health Card, they ended up using walk-in clinics in their neighbourhood that did not require pre-booking because they could access these clinics independently by walking to them.

However, both Rae and Ruby actually reported preferring their later health care experiences with the Manitoba Health Card because despite the longer waits, trying to access health care services without their Manitoba Health Card led to a lot of questions from receptionists. Ruby said of her health care experiences, first without and then with a Manitoba Health Card:

They show my refugee claim paper, but they say we, still want her health care, health card. And then they explained to her that I'm still new, I don't have other than this paper, and then that's when they started to help. And then now, when I went for last, one year ago, it was easy. I just went down; they ask me my health card. I give to them... So, it's pretty easy having Manitoba Health Card then. (Ruby)

And Rae said of her later experience with a Manitoba Health Card:

They told me you have to go this way and this way and that way. So, I went [walked] to this place. And it was like, yea, it was good. And it was not, it was not a lot of people there. So, it was for me. Like I had to wait like 30 minutes... So, it was easy, I just went there, and I told them my name and give them my health card. And they let me, [they] said you have to wait for at least a little bit and we'll call you... (Rae)

Both Rae and Ruby's experience demonstrates that the perception of being helped can be diminished when one has to take extra measures to advocate for themselves to receive the care that they are eligible for because staff may be unfamiliar with alternative health insurance coverage such as the Interim Federal Health Program (IFHP).

Paulina was the only PSR woman without a family primary care practitioner. Paulina described that she "wasn't feeling okay. So, I went there, and they told me my blood pressure was high and they need to follow investigation so make appointment to, you know, monitor again." The remaining five PSRs all reported having their private sponsor find a family primary care practitioner for them. Four of these five women reported that their first health care visit was within the first month of living in Canada. The exception was Peggy who reported it took 6 months to get her first appointment with her family primary care practitioner. Peggy said:

At first, it kind of seems like it's easier but we have to wait a long, long, like a long time... Like we had to wait 4 or 5 to 6 months. Like immediately we got the family doctor's name [but] we didn't get the contact and we have to wait until them to contact us. So, we came on [date of arrival to country], and our first meeting was on [a date 6 months later]. So, we had to wait long. (Peggy)

Four of the five PSR women who had a family primary care practitioner appointment made for them soon after arriving in Canada, reported their first appointment was with their family primary care practitioner. The exception was Phyllis who reported, "My first experience

going to a doctor here was a walk-in clinic doctor. At that time, at that time my head was hurting severely.”

Tertiary care: The emergency room. Five of the twelve women interviewed reported seeking urgent health care at an emergency department for themselves. Three of the twelve women interviewed were mothers and two of them reported seeking urgent care at an emergency department for their children. One of the women who did not have her own emergency care experience instead shared her experience helping her brother seek urgent care in an emergency department.

Of these five women with personal experiences seeking care in the emergency department, only one of the women’s experiences reflected a true medical emergency. Gina said, “I went to the emergency room. I waited 5 and a half hours while they didn’t do anything... When they casted it, they said after 15 days go to the doctor for the bones”. The other four women reported receiving a work up and then being told that they were okay. Phyllis said:

The emergency room, when I went, I said, ‘my heart hurts’, they said, ‘is this your first time coming here?’, so I said, ‘no this is my second time coming here’... they took from me blood and... an EKG... And when I told them [about] my chest pain, they sent me for a chest x-ray. So, I was waiting in the emergency close to... for 4 to 5 hours... I went at 11... I came back at 4:10, around there. (Phyllis)

Most of the women reported frustrations with the long wait in the emergency department. Gina was the only woman who reported a negative experience in the emergency room. Gina’s pain was so poorly controlled that she called a friend to bring her some Tylenol. Gina said:

I also asked a lady to bring me Tylenol and water, she brought it to me from her own house. She is my friend, I called her and said bring me Tylenol. They [health care providers] only gave me two pills and water, but it didn’t do anything for the pain, so I took another two. The ladies [health care providers] told me not to take any more pills or water because there is a chance that I will need surgery... So, I stopped. (Gina)

None of the RC women interviewed mentioned seeking out health care services in the emergency room and none of the women interviewed reported being hospitalized in Canada.

Pharmacy care. Nine out of the twelve women reported having an experience being prescribed medication and going to the pharmacy. Generally, the women were satisfied with their experiences at the pharmacy. A couple of the women reported using or trying to use their IFHP coverage at the pharmacy. Rae had tried to fill a prescription before she had a Manitoba Health Card and she said:

... they see that I'm a refugee and I don't have a health card. They ask me for my health card. I didn't have that paper. So, they said, uh, I'm not, we're not sure if the government's going to cover it... because your status of refugee right now. So, like we have to wait for a week. After I waited for a week, they said like, it's not going to be covered. (Rae)

Instead, Rae had a social support pay for her prescription.

Another common source of medication coverage came from EIA. Prudence said, for example, "Yes, I get prescriptions. When I go to them, I don't buy it. I am on welfare, so they pay for it". Similarly, Portia said:

Yes, many times, my doctor has prescribed me pills. He has prescribed me many times, he said go to any pharmacy. He doesn't tell you to go to a specific one, just that you want take this paper and go to the pharmacy. The pharmacy gives me the medication. They ask me questions like, 'do you work?' and 'who will cover the cost?'. Now I am working, I say, 'yes, I am working, and I will cover the cost'. Earlier when I wasn't working, I used the health card and tell them I am on welfare and they use this information. They didn't ask for more [information], they gave my medication. (Portia)

However, not everything is covered under the EIA medication coverage, for example Phyllis said:

The medication I just showed you, like this, when I get allergies, or in winter, they don't give it to me for free. Medications that are like \$20 that aren't covered they will say buy it or just leave it. It is not a big difficulty it is your choice. The government will only help you with what is dangerous. For example, these pills they just gave me [for free], but like this medication they don't cover it so I had to pay out of pocket. But the pills they gave me. They said take the medication when you feel pain and this other one is topical, and I apply the lotion. Things more than this I haven't taken... (Phyllis)

The women's experiences show that the pharmacy staff prompt them to disclose if they have additional insurance and that other than EIA or IFHP coverage, none of the women had additional insurance.

Dental care. Six of the 12 women interviewed reported receiving dental care in Canada. Five of these women sought out dental care as a result of pain. Gabriella was the only woman who began receiving routine dental care without an acute need prompting dental care. Gabriella reported:

My dad went there... Then he told me you can go there to get your teeth cleaned so you need to make an appointment for yourself... I went with my dad then they said bring papers from welfare and I took those papers to them and then they said welfare would pay the fee so we can clean your teeth and, Praise be to God, they made me an appointment. When I went to my appointment, I had to wait for about 10 minutes after that they cleaned my teeth. Praise be to God. My teeth were clean [after]. (Gabriella)

Gabriella's experience was very different from Ruby's experience. Ruby said, "It was a toothache and they say, if you want to take it out, you don't pay anything, it's free. It's covered. But if you want to clean it and fill it, you have to pay like almost a thousand". Similarly, Portia reported having her tooth pulled at no cost to her. Portia said, "I have gone to my dentist one or two times. At that time, I wasn't working, I was on welfare. I went to [name of location]. They pulled out my tooth." In contrast to Ruby and Portia's experience, two other women reported having teeth pulled and being given dentures at no cost and one woman reported having a filling at no cost. Prudence for example said:

...they did an assessment of the teeth that hurt. I left them that day and they made me another appointment. I went back to them and they took my teeth out. The process of appointments took four months. They gave me these teeth; it was paid for. Welfare paid for it. (Prudence)

This finding suggests that different dental practices provide different services and that some women may have received more care by going to low cost dental services instead of private dental clinics.

Optometry care. Six of the twelve women interviewed reported receiving optometry care in Canada. All three GAR women reported receiving help accessing an optometrist soon after arrival in Canada from their family primary care practitioner and or the settlement agency where they were living at that time. Gwen reported:

I have gone [to the optometrist] multiple times, when I was new [the settlement agency] took me. They prescribed me glasses. And then after, another one, close to me, they switched me to. And they paid the cost, I didn't pay, I didn't experience any other difficulty. (Gwen)

None of the RC women reported accessing an optometrist, so the three other women who reported having optometrist care in Canada were PSRs. None of these three PSR women had access to optometry care promptly after settling in Canada. Rather, both Portia and Prudence reported seeking out optometry care due to trouble with their vision at school. Prudence said:

I needed glasses because when I went to school. I could see the big writing on the board; I could see it, but small writing, like this [pointing at consent letter]. I was given a dictionary and its writing was small, I couldn't see it. I needed glasses. When I went to the appointment, he told me my eyes were good, but you have trouble seeing small writing. He made me glasses that I got and still have now. (Prudence)

Pippa reported that she was able to access optometry care after her first year of living in Canada, when she was no longer under the responsibility of her private sponsor and could access additional insurance through EIA. Pippa said, "When I first came and I was out of sponsorship, they gave me a check-up. They said you need the lowest level for reading, the government covered the cost".

Pattern of Utilization: Seeking Out Health Care to Treat Symptoms

From the participants' experiences, a common pattern of health care utilization was noted. Generally, the pattern would begin with a "Symptom Prompting a Health Care Visit", then "Deciding to Seek Care", they would attempt to arrange "Same Day Appointments".

Symptom prompting a health care visit. A common pattern that was noted was that the women primarily sought out health care after experiencing a symptom. Beyond first meeting appointments with a family primary health care practitioner, none of the women mentioned well woman health care visits. Rather, multiple times it was noted that women did not think they needed routine health care when they were not experiencing a problem. For example, Portia commented that she questioned her cousin about why she needed a first meeting with a primary health care practitioner when she was healthy. Portia said: “I also... told my cousin that when I was leaving [name of country], I had my health looked at and checked and that I am healthy... So why are we going to a doctor right away?” Portia also remarked that after she received glasses for the first time from an optometrist, she never went back for routine care. Portia said, the optometrist told her, “‘you can come any time if you experience any problems with your eyes or need a check-up’. I didn’t experience any problems with my eyes, so I haven’t returned for a second time.” Similarly, after receiving dental care for an acute problem Portia commented, “They pulled out my tooth. After my teeth were good so I didn’t need to go back”.

Peggy was an exception to this pattern. Since Peggy reported being healthy, her only health care visits thus far in Canada were for her first introductory meeting appointment with her family primary care practitioner and repeat visits for immunizations. Peggy also commented that there was something missing from the health care system. She said:

They should add a family fitness planner... And then it could be pretty good. You know from back home there is a different way. As in when it comes to [the] traditional and the food that you’re getting to eat and everything. Like here, everything is from industry right, but back home everything was organic. So even if you don’t have a family fitness doctor, how will you know... which food to eat at a certain time? You will grab any kind of food you want and then eventually will end up having a cancer or worse diseases because of it. (Peggy)

Peggy also commented that she had benefited from translating for her mother because she was gaining knowledge that she could apply in maintaining her own health. Peggy said,

“it’s good to be a translator somehow you will get more information that you didn’t know before... And that information, you’ll apply into your daily life. And it’s a good help for you to take care about your health”.

Deciding to seek care. Since symptoms were prompting the women to seek care, the women were also seeking treatment for their symptoms and wanted to be prescribed medication. In her advice to other newcomer Somali refugee women, Rae emphasized how it was important for women to seek care and not delay seeking care. Rae said, “because you’re sick. If you are home, you can’t get a cure. So, when you go to a doctor, the doctor will give you a treatment”. Phyllis experienced multiple health care visits due to chest pain. Despite her multiple visits, Phyllis was frustrated with all the work ups and a lack of treatment. Phyllis said about a recent health care visit:

I was very sick when I went. He took my blood [gave me a requisition to get my blood checked] but to this day I haven’t gotten my blood [drawn] because I know every doctor who takes my blood says you are healthy. So, it doesn’t make sense to keep going to the doctor and keep getting your blood taken. (Phyllis)

Similarly, Gina talked about being diagnosed with arthritis. Gina said:

She [family primary care practitioner] told me three places to call, she said go to physiotherapy, she said take Tylenol, and if it won’t do anything then come back. I still haven’t gone to the physiotherapist; I go to a gym instead. I take the pills and the pain is still there, but they said you can’t do anything once arthritis is in your back other than taking pain medication. (Gina)

However, after the interview Gina was candid about being dissatisfied with this response. She remarked that if she was still in the country she lived in as a refugee prior to being resettled in Canada, that she would have been offered a treatment or at least nutrient supplements. Although living in a different country prior to arrival in Canada, Phyllis also said something similar.

This is surprising because I came from one place to another place and there are a lot of things which I see are different. And it’s hard to get accustomed to what is going on here and what you came from. [In] the land we came from, when someone is sick, in a very

quick way the person is given medication or syrups. Here the doctor talks to you and says drink more or watch your stress or sleep more and then you leave. (Phyllis)

Phyllis had been living in a different country in a different continent than Gina prior to arrival in Canada; however, both women were in agreement about expecting treatment for their health concerns instead of being recommended lifestyle changes only.

In contrast, not all symptoms prompted health care visits. For example, the women mentioned embarrassing symptoms or being shy led to delays in seeking care. Gwen, for example said of her first few months of living in Canada:

It was difficult, because I was new. Everything I was afraid of. It was difficult for me to say where I was hurting. For example, I had an infection below. To say I have an infection below, I was very shy. It took me a few months, even though I had an interpreter. They were interpreting for me, yet, I was shy. I was shy. Okay. So, this was the greatest difficulty I encountered. (Gwen)

In their advice to newcomer Somali refugee women, both Rae and Phyllis also commented about the problem of hiding health concerns. Rae said, “if she has any problem, she doesn’t, she doesn’t need to hide it. She has to tell the doctors like I have this problem, I need help with it. And the doctor will help her.” And Phyllis said:

Truthfully, what I would advise her is every time to stay in touch with her doctor. The doctor back in our country and the doctors here are not the same. Not to hide anything from the doctor. If there are past illnesses, or treated illness, or new illnesses, to tell them. (Phyllis)

Same day appointments. Related to symptoms prompting health care visits and the women seeking treatment for their symptoms, the women interviewed wanted same day appointments. Phyllis, for example, was very clear why this was important to her. She said:

Today if you’re sick and they give you an appointment later, will you still be sick? Rather you will go to the appointment healthy saying ‘he, he, he’ [sound of fake laughter]. So, what will they help you with? ... They won’t help you with anything... But you want the doctor when you’re sick and to see the doctor right away. (Phyllis)

Phyllis also related this opinion to her experiences prior to coming to Canada, she said, “You don’t make an appointment. Only with the specialist you make an appointment. The others, if you’re sick, they will see you right away unless there are three, four, or six people are ahead of you already”. As a result of her thinking, Phyllis ended up going to the emergency room to seek urgent care because she could not get an appointment with her family primary care practitioner within a reasonable time frame. Phyllis said:

...in the recent past my heart was hurting and I called them... when I was making the appointment it was June 11 and they gave me an appointment on June 20. I didn’t have an appointment and my heart was hurting severely. I just went to the emergency. It was difficult that when you want an appointment you can’t get one and the one, they offer you, is far into the future. (Phyllis)

Pippa also remarked that she came to anticipate not being able to get an appointment with her family doctor when she had an acute need. Pippa said about a recent health care experience: “My shoulder was hurting... I went to them [a walk-in clinic]. Especially if I can’t get an appointment at my family doctor, like if I feel pain and its afterschool, I just go [to a walk-in clinic]”. The women were accustomed to not having a primary family care practitioner prior to coming to Canada. Having walk-in clinics available to meet acute needs maybe the reason why the three RC women and one PSR woman, who did not have a social support to find a family primary care practitioner for them, did not make it a priority to find their own family primary care practitioner.

The Importance of Health Literacy

While analyzing the transcripts, there were many times where it was clear that health literacy was an issue. An example is when Phyllis discussed being confused about why her health care provider was asking her about her family’s medical history. When I asked her if she had asked her health care provider this question, Phyllis responded:

I did ask. I said, ‘what does, what my grandmother has, have to do with me?’ and they said, ‘since families are related it is possible you might inherit an illness they have’. Yes, I have always heard this, but I would hear it from this country, I have never seen this in my country. (Phyllis)

Health literacy issues are explored further specifically in terms of Language Proficiency versus Understanding; and Lack of Access to Laboratory or Diagnostic Results.

Language proficiency versus understanding. There were multiple examples of health literacy being an issue where language proficiency may play a role. For example, Gwen who reported she had access to a medical interpreter during her primary health care visits described the tuberculin skin test in which Tuberculosis (TB) protein antigens were put under the top layer of her skin as “the place they took the blood swelled up”. This shows evidence that she did not truly understand the diagnostic testing and specifically that the health care provider had injected her with tuberculin at the site that swelled up instead of blood being taken from the site. Since Gwen reported having a medical interpreter available, another question is whether the medical interpreter understood the diagnostic test enough to accurately translate the description of the diagnostic test to Gwen. Since close to 10 years had passed since this health care experience, it could also be that this is how Gwen remembered the test. Gwen’s wording of this procedure made me aware of the need to be open to analyzing the word choices of the women who were interviewed.

Another example of word choice and the difference between language proficiency and understanding was found in the transcript of Ruby’s interview. After I asked Ruby if she had been to a pharmacy or had filled a prescription, Ruby responded, “I didn’t fill prescription, but I take medications from them, like drugs that the doctor say to eat”. This made me think she may have purchased an over the counter medication, and when I asked her if it was an over the counter medication, she replied “Yea”. However, when I asked her the price she paid, she

replied, “it was covered”, which implies it was not an over the counter medication. Additionally, when I asked how she knew to use her health insurance at the pharmacy she said:

Well they, when I went to the doctor, she say just give to her your health card and then she’s going to write the numbers, like this nine... digit number, and then the six one. And then she gave me the medication. It’s covered. (Ruby)

However, the only health card available to her at this time with nine and six-digit numbers is her Manitoba Health Card. Since Ruby had medication coverage through the IFHP and the Manitoba Health Card does not cover prescriptions, her answer made me question the accuracy of her response. Given that Ruby was proficient in speaking English and participated in the interview speaking in English, the importance of assessing for health literacy beyond just language skills is evident. If Ruby had gone to a pharmacy that was unfamiliar with IFHP coverage and tried to use her Manitoba Health Card only to get her medication covered, it is possible she may have been unsuccessful.

Another example of the difference between health literacy and understanding was noted in the transcript of Peggy’s interview. Peggy reported receiving immunizations from a nurse at her family primary care office and when asked if she received all the information, she needed about the immunizations she received, she said:

Yea. And in the different injections that we’re getting. So, they told us, like they kind of explain but if you don’t know how the system works you won’t understand what they are saying right? Although I’m not a doctor, so, um, you know, when they say like the, like a type of, uh, vaccine, you will know, right. So, they just wrote on a paper and then they say go research, I didn’t do my research yet. (Peggy)

Since Peggy was fluent in English and she was relied on as an interpreter for her mother by some health care providers, there are potential implications for informed consent if she did not truly understand the purpose of the vaccines to which she consented.

Lack of access to laboratory or diagnostic results. Another area related to health literacy was related to laboratory testing results. It was clear that for many of the women, they

were accustomed to receiving their results before arriving to Canada, but that this was not their experience in Canada. Paulina, for example, had already been waiting two weeks for blood results from a walk-in clinic she visited. During the interview, Paulina shared, “I thought like maybe, it’s only me, that I don’t get the copy of the result”. Similarly, Peggy wanted access to her results. Peggy said her health care provider told her when she was given the requisitions, “we usually call when we find out any sickness in your blood, so if you have nothing, you will not get a call from us.” When asked how she felt about this, Peggy responded:

Uncomfortable. Even though they take our blood sample, so we are, waiting for our result. Right, even if we are healthy, they should have called us and say, like your blood is clean and you don’t need any further treatments. You guys are OK. That would be good right? (Peggy)

Paulina, Phyllis, and Gabriella talked about how receiving their results was important to them, even if it meant needing to make a follow up appointment just to ask for their results. For example, Phyllis said, “they did not give me a response, so it turned out I had to make another appointment to find out my blood results”. Gabriella, on the other hand was successfully able to request that her health care provider call her with her results after one visit. Gabriella said:

So, the nurse, working for my doctor, I met with [her] and she took a sample from me. When I told her, I didn’t have an interpreter, I swear, but I forcibly made myself understand her. She was really good and understood me and she took a sample. Then she called me to tell me ‘you don’t have anything’. She called me using an interpreter. I had told her ‘I need an interpreter when you are giving me’... I told her, ‘answer’, I swear... She understood me. Result, this word I usually forget. (Gabriella)

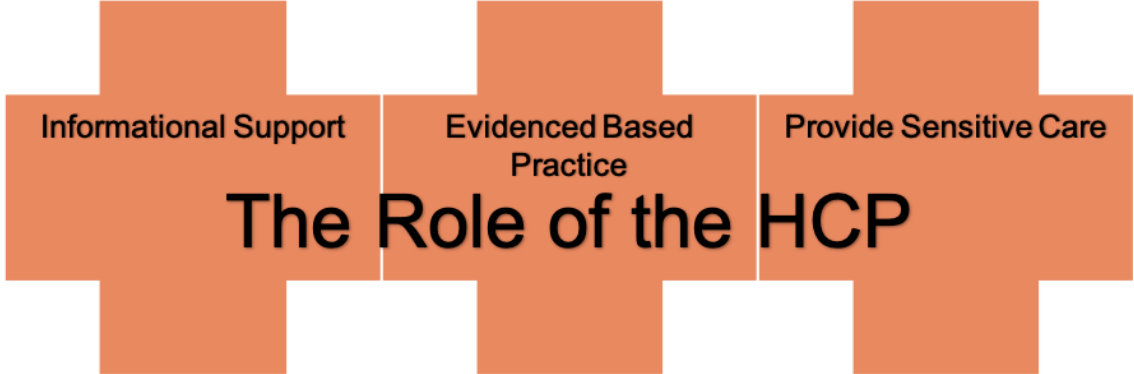
However, the remaining eight women who were interviewed all had experienced having blood work done in Manitoba (either during their immigration medical exam or during a primary health care visit) but did not mention having access to their results. For example, when asked what she thought about not receiving a copy of her diagnostic or laboratory testing results, Ruby responded “It’s okay. Because they say that it was negative, so everything was good”. Similarly, Rosalie replied, “It was okay. They didn’t see anything”. Both Ruby and Rosalie were

potentially conflating the fact their physical exam was unremarkable and that the panel physician conducting the exam had told them everything was good, so they are assuming that their diagnostic and laboratory testing results must have also been ‘negative’ or ‘good’. However, Ruby also reported multiple other health care visits to walk-in clinics during the first few months of living in Canada and being diagnosed with anemia. So, potentially everything was not ‘good’ in her immigration exam blood work as well.

The Role of the Health Care Provider

The major themes in section three, The Role of the Health Care Provider (HCP), are: Be an Informational Support; Utilize Evidenced Based Practice; and Provide Linguistically, Culturally, and Religiously Sensitive Care. These themes present how the health care providers contribute the women’s health care experiences.

Figure 4: The Role of the Health Care Provider



Be an Informational Support

An important finding of this study was the role that health care providers can play in providing newcomer refugees with informational support. Multiple times, the women identified that they did not know something but by obtaining information from their health care provider, they were better able to utilize health care services. For example, when Paulina described her first experience at a pharmacy, she said:

I told him like 'I'm a refugee'. So, he asked me, 'Do you have that paper?' I said, 'Yea'. So, he told me, 'If you bring that paper, then you will get your prescription free. You don't have to pay money.' So, I come back home, got that paper, then brought it to him and he give me the, uh, medicine. (Paulina)

This example demonstrates the role that pharmacists play in providing informational supports to refugees. However, if Paulina had gone to a pharmacy that was not familiar with IFHP coverage for refugees, it is most likely she would have been charged for the cost of her medication since it would have been assumed that she did not have any insurance. Thus, prescribers also have a role in providing refugee patients informational support. Ruby's experience reflects this fact. When asked how she knew her medication would be covered at the pharmacy, Ruby responded "when I went to the doctor, she said just give to her your health card and then she's going to write the numbers...".

Pippa described obtaining information at the optometrist office after going back when she lost her first pair of prescription glasses and not being eligible to replace them under EIA coverage. She said:

The doctor was good, and she said, 'These are expensive. If the government isn't helping you it's a few hundred. But I'll print out your prescription and you can buy it from anywhere...'. So, I said, 'Okay', and... I went with my son to Superstore and he purchased the glasses for me... for \$70. (Pippa)

Pippa then waited until she was eligible for coverage under EIA again to purchase a new pair of glasses. However, Pippa reported that at this time she paid for the eye exam in full but that the EIA insurance coverage paid part of the cost for the glasses because "They said the government will cover these narrow not good-looking glasses... but if you're buying another one that you see here, you then will have to pay the difference". When asked why she did not get her eye exam covered through EIA as well since she had access to this insurance, Pippa replied "No, I didn't ask, the teacher lady [school counsellor] said seeing they don't pay, so, I just paid". Pippa was implying that she was relying on her school counsellor for navigational support and since her

counsellor did not notify her that it could be covered through EIA she just paid the eye exam cost without asking anyone else, including the optometrist office, if it could be covered.

In her interview, Gina shared an experience in which a medical specialist would not give her informational or navigational support, despite requesting more information. Gina said:

He said, 'find a physiotherapist'. I said, 'I don't know where to go'. My younger son was with me translating for me. 'Where do I go?', I said. He said, 'I don't know, they are all over the city, every area has some. Go find one'... That man, that doctor, I don't remember his name but it's in the computer. The way I wanted, he didn't help me. (Gina)

As a GAR, Gina was only eligible for the refugee primary health care clinic for her first year of resettlement and had been recently transitioned to a new family primary care practitioner at a different clinic during this time. Still unsure of how to find a physiotherapist, Gina ended up making an appointment with her new family primary care practitioner. Gina said:

After, I went to my family doctor which I just got the day before and just met... I went to her and told her, 'they took off the cast, but my hand is like this now, what can I do?'. She said, 'I will send you to a doctor [physiotherapist] and make an appointment'. She told me to try to tolerate it in the meantime and to go buy a brace. I went to the drug store on [name of] street. I paid \$40 and put it on. Then, I went to the physiotherapist... (Gina)

Gina and Pippa's experiences demonstrate that health care providers need to be more cognizant about providing newcomer friendly care. By going to her family primary care practitioner, Gina was able to get an appointment with a public physiotherapy clinic, in a reasonable time and at no cost to her. Whereas, if she had followed her specialist's advice, and not sought out additional information like Pippa, Gina's experience may have been completely different as she may have been charged to be seen by a private practice physiotherapist.

Utilize Evidenced Based Practice

Analyzing the health care services that the women reported utilizing, it is clear that there is a disparity in access to evidenced based health care for refugees. For example, in terms of the GARs, both Gabriella and Gina reported having access to the same refugee specific primary

health care clinic during their first year of resettlement in Manitoba. From previous experiences observing health care provision at this clinic, I knew that this clinic uses evidenced based guidelines to provide health care to refugees. Gwen was the only GAR who denied that she had access to this clinic. Given the length of time that Gwen had been living in Canada, this is most likely accurate as the refugee specific primary health care clinic in Manitoba would not have existed when Gwen arrived in Manitoba. Despite not receiving care at the same refugee primary health care clinic, Gwen noted that the settlement agency made arrangements for her to get a family primary health care practitioner and that she was diagnosed with a Latent TB Infection (LTBI) after her first health care visit in Canada. Given that none of the other women reported being screened for an LTBI, and that the settlement agency made the arrangements, it is likely that Gwen had access to primary health care from a provider that was familiar with the health care needs of newcomer refugees.

Although Gabriella and Gina, the other two GARs, did not talk about being tested for TB, when asked if she had access to the results of her blood work from her first health care visit in Canada, Gabriella said: "Praise be to God. They said you are good, but they said there is a little infection in your blood". Then when asked if she had been given medication to treat the infection, she responded, "They said take this medication, but I said I can't take the medication because I know I will not consistently take the medication and it's not good to miss doses because that can make you sicker". Initially, based on taking Gabriella's response at face value, I assumed she had bacteremia and that her not complying with medical advice was alarming. However, after analyzing Gwen's experience my assumption changed. Specifically, that limited health literacy is evident in Gwen's statement, when she describes the tuberculin skin test as blood being taken and not something being administered under her skin. I realized that Gabriella

potentially did not have bacteremia and maybe was also referring to an LTBI, which was screened using laboratory testing of blood only, and not using the tuberculin skin test. Given that the treatment for an LTBI is long and commitment to adhering to the treatment is important, it is understandable that Gabriella was making an informed decision about refusing treatment for an LTBI instead of refusing treatment for a 'little blood infection'. Gabriella also shared that she was sent for an x-ray during her initial health assessment as well which supports that she was being worked up for TB.

When analyzing the health care experiences of the RC women, it was noted that all three RC women did receive an immigration medical exam after arrival in Canada. Thus, all three women would have been sent for chest x-rays in Manitoba. However, none of the RC women reported receiving their results; instead they seemed satisfied with the physician's feedback on their physical assessment. Furthermore, none of the RC women had access to a family primary health care practitioner; therefore, none of them had access to TB screening outside of the immigration medical exam setting. Considering that a chest x-ray would only show active TB in the lungs, these women would still require additional testing to screen for an LTBI.

Similarly, none of the PSR women reported being screened for TB in Manitoba. Paulina did not have a family primary care practitioner, so she did not have access to a generalized health screening. Peggy reported having blood work done after her first introductory meeting appointment with her family primary health care practitioner. She spoke English during the interview and described it as "so we have to go in there and take our blood types and, you know, [check] how healthy are we and what we need to improve, that kind of stuff". Peggy, however, did not mention any screening for TB or needing to go back to her primary care practitioner multiple times to have the site of a tuberculin skin test checked. Similarly, none of the other

privately sponsored women mentioned having a tuberculin skin test performed as part of their health assessment by their family primary care practitioner after they arrived in Manitoba.

However, two of the women, Phyllis and Portia, referred to their health assessment done prior to coming to Canada. Phyllis specifically made reference to her immigration medical exam and being screened for TB in her interview. She said:

Yes, in the beginning when someone is leaving their country and moving outside, immigrating, they check their pee, they check their blood, some people they take their sputum if they are suspicious that you have TB. Canada doesn't bring sick people; I don't know if you know that. If you have TB, they give you medication, or HIV. When your negative they bring you. When we were going to fly here some people were given pills and others needles, but Canada didn't give us pills or needles. (Phyllis)

Phyllis's understanding of TB seems limited to active TB, which can be screened for through x-rays which is done during the immigration health exam, or through sputum testing which she described as being done when the immigration medical exam physician was suspecting the refugee has TB. Thus, similar to the other women, Phyllis maybe unaware of LTBI and may instead have a false sense of reassurance that she does not have TB since she was not diagnosed with TB prior to coming to Canada.

Evidenced based refugee health screening includes assessing for other common chronic and infectious diseases as well. Given that the women were arriving to Canada from countries with different endemic diseases, their health screening requirements upon arrival would be different than a routine well woman exam. Prudence, for example, reported that during her first family primary health care visit in Canada, "they took our stool, they took our blood, and they weighed us on a scale". When asked if she had access to her results, Prudence responded affirmatively because her stool test result was positive, and she was prescribed medication to treat the infection. None of the other research participants specifically mentioned that they had to submit stool samples during their initial health screening appointments in Canada, and thus this

is an area that requires more data collection to explore further whether the women had access to this test.

Provide Linguistically, Culturally, and Religiously Sensitive Care

Of the twelve women interviewed, all 12 women were Somali, and they reported their religion as Islam; however, the women had varying degrees of English language understanding and speaking proficiency. These women's experiences supported the need to provide linguistically, culturally, and religiously sensitive care as a recommendation. Gina, for example, shared how she was left speechless in the emergency room when the nurse tried to assess her pain. Gina said:

...when I cried, the nurse said, 'this kid who is with you, did you give birth to this boy?' I said, 'yes'. She said, 'compared to when you were in labour, is the pain in your hand worse?' So, then I didn't talk to her. I didn't respond because it doesn't have a response... (Gina)

In this theme of Providing Linguistically, Culturally, and Religiously Sensitive Care, the subthemes are: Provide Medical Interpreters on a Need Basis, Assess the Need for a Female Provider, and Consider the Implications of Observing Ramadan.

Provide medical interpreters on a need basis. The need for linguistically appropriate care was also noted when analyzing the women's interviews. Gabriella, for example, after being asked if she could seek out health care on her own without an interpreter said:

No, I can go on my own. I can do it, but my body parts in English, yaa, I can't explain it because it's hard, it needs a lot of vocabulary right... There are also difficult questions, making sentences is hard, if someone doesn't know English well, it's too difficult to understand... (Gabriella)

When asked why Gabriella didn't request an interpreter, Gabriella said, "Oh, they don't do that. I don't think they can provide an interpreter for walk in clinic but for family doctor I think they provide this service." This response most likely refers to the difference between private practice and non-private practice health care providers. If Gabriella had known of this difference, she

may have been able to seek out a walk-in clinic service that could also provide interpretation support. Gabriella was not alone with this challenge as other women such as Prudence and Portia experienced this challenge.

At least as a GAR, Gabriella's family primary care practitioner was able to provide her with an interpreter. Some of the PSRs with limited English language proficiency did not have access to this service. Pippa, Portia, and Prudence reported being reliant on their private sponsor for interpretation support. Pippa's children mastered the English language quickly, so she had the support of her sons after she became independent from her private sponsor. However, recently Pippa has been going to appointments on her own. She said:

...my sons help me, but I can go on my own. I don't have to bring an interpreter. This has changed... I don't bring an interpreter when I go, some of the dialogue gives me difficulty, but overall, I understand. (Pippa)

Pippa's description supports Gabriella's description that understanding is easier than speaking. Pippa also described her experiences without an interpreter like this: "No, it wasn't easy. Some things your gesturing, like a deaf person and your trying to get them to understand... in the past I would not have even attempted this but now I just go. I try it." Pippa's attitude was opposite of Gabriella's, possibly because as a middle-aged single mother, Pippa may have a higher tolerance for difficulty and struggle compared to Gabriella, a young woman with no children.

Portia was not provided an interpreter for her medical visits. But she reported that this was important to her. She said, "I like to have an interpreter because health isn't easy. If you don't have someone, and don't know a word and understand it differently, you might take the medication differently." Despite her private sponsor finding her a family doctor, after a year of living in Canada, when Portia transitioned to being fully independent from her private sponsor, she stopped going to the family doctor. Instead, Portia began relying on a walk-in clinic to meet

her health care needs because the flexibility meant she could seek health care when she had a friend or family member available to interpret. Portia said:

...when you need a doctor, and don't know the language, and aren't able to go independently, it is hard to coordinate the doctor appointment with someone who can interpret for you. When you know the language it's not a problem. But when you don't, and you need an appointment, the [walk in clinic] doctor is always open. So, you just need to find a person to interpret for you. So, when you find someone, you don't need a specific timed appointment, you will just say come with me and interpret for me...
(Portia)

Prudence's English language was very limited, similar to Portia's level. Neither woman reported attempting to seek health care services without bringing their own interpreter. Prudence reported the language barrier as her greatest challenge; however, she has not experienced the difficulty of not being able to find an interpreter yet. Portia on the other hand has experienced the challenge of not being able to find her own interpreter. Portia said:

When I was here for a year and I was no longer the responsibility of my cousin. I had moved out on my own... I have a roommate who came to Canada after me and she doesn't know much. I told my roommate I am sick. While I was sick, I had no one who would interpret for me... I have only been here for one year, so I don't know a lot of people. The people I know mostly are from school, and the people from school there isn't anyone who would be able to interpret for me. There are a few which knew slightly more English than me or know as much as me, so there is no one who can interpret for me and that I can trust with my health... I didn't go to the school I was too sick. I looked for a girl I met who has lived in this country for a while. The girl came to me on the third or fourth day, I don't remember which day. At this point my high fever had broken and the pain was slightly less. I was slightly less sick. She took me to the doctor. So, it isn't easy.
(Portia)

It is unclear what Portia's relationship with her cousin, her private sponsor, was like. Potentially because they were not closely related Portia wanted to respect the fact her cousin was no longer her sponsor and did not ask him or her for help. It is also possible that Portia's cousin no longer lived in the same area or city as her. Regardless, Portia's experience clearly shows that relying on bringing your own interpreter can lead to delays in care. As Portia pointed out, she was "less sick" by the time she found an interpreter, so this problem can also lead to additional

dissatisfaction with health care services when one prefers to receive same day health care. Portia also made clear that her social circle consisted mainly of other limited English language proficient acquaintances at that time. So, she did not feel she could “trust” them to interpret for her since they did not know much more English than her. Since medical interpreters are bounded by Personal Health Information Act (PHIA), there are other elements of trust, such as confidentiality, that may be disregarded when women are desperate to find their own interpreter.

The experience of the English language proficient Somali women who participated in this study was different. Peggy’s experience and perceptions about her care re-enforces the need for patient centered health care delivery. Peggy, not only spoke English in the interview, she also reported being relied on by some health care providers to interpret for her mother. However, in her first health care visit with her family primary health care practitioner, Peggy was provided with a medical interpreter. She said:

My experience was like, they give us a translator. I was like, ‘we already know English. We don’t need a translator.’ And then they were like, ‘oh yea, how do you know English?’ We don’t live under a rock; we came from a country [where] we usually speak English. English was our second language. And they were like, they were shocked.
(Peggy)

When asked how she felt about this, Peggy said, “like offense, but first impression matters right.” Peggy’s statement implies that since this was her first encounter with her family primary care practitioner, this negative experience is additionally concerning. When asked what happened after notifying her family primary health care practitioner that the interpreter was not necessary, Peggy said:

They did insist that the translator will sit beside us, in case we run out of words. So, we just keep talking and talking and then hopefully [thankfully] the translator didn’t say anything about [beyond] her name and what she’s here for. (Peggy)

Despite her wishes not being respected, Peggy seemed to obtain some satisfaction by proving the health care provider wrong by not running out of words and not needing the medical interpreter.

Health care providers need to practice patient centered care and assess the patient's individual needs and wants, instead of assuming all newly arrived refugees require the same supports. Since Peggy was newly registered with her family primary care practitioner, it is possible that the medical interpreter was booked for Peggy's whole family. Peggy mentioned being an interpreter for her mother a couple of times so potentially her mother needed this support; whereas, Peggy did not. Peggy's experienced supports that health care providers should provide patient centered, linguistically appropriate, care for adult children within a family unit.

In her advice to other newcomer Somali refugee women, Rae said, "Sometimes people feel like, okay, you don't know the language enough. So, you feel sick and... stay home. And they keep on like pressuring themselves to stay home. So that's the problem... they have interpreters." Rae was interviewed before Peggy and thus only in a follow up interview was this explored further. When asked about this advice during the follow up interview, Rae explained that she was provided with an over the phone interpreter during her first health care experience in Manitoba. Given that Rae participated in the interview using the English language, I asked if she was offended by being provided with an interpreter. In contrast to Peggy, Rae responded that despite knowing English she recognized there is a chance she may miss something, so she was not offended by this additional support. Once again, this finding supports the need to practice patient centered care. Some newly arrived refugees may be okay with additional interpretation support despite their English proficiency; whereas, others may get offended.

Assess the need for a female provider. Only two research participants, Gwen and Pippa, explicitly mentioned that having female providers was important to them. As a PSR, Pippa had help from her private sponsor, her sister, to find a family primary care practitioner. Pippa said, "I told my sister, 'I want a Muslim female doctor, if possible'. She said 'on [name of street] there is

a Muslim female physician and a male [Muslim physician]. So, the female one I made my family doctor.” Pippa also commented about an experience in which she had to endure being embarrassed when her Muslim female health care provider requested a male health care provider to assess and give his diagnostic opinion. Pippa said:

Underneath my breast, I had some itchiness. They prescribed me a lotion in the past. The cream didn't help. They didn't know what it was. It came back... An Arabic speaking female doctor who wears the hijab, I showed her. She was confused about the small white spots, so she called over the head doctor. He said, 'can I see?'. While I was embarrassed, I showed him. Every time the women [health care providers] are preferred, but if it's a doctor, the Islamic law allows it. (Pippa)

Pippa's statement implies that she prefers a female health care provider but recognizes that her religion allows for male health care providers as well. Another of Pippa's health care experiences involved being embarrassed about having a male interpreter involved in her care. Pippa did not have routine access to a medical interpreter at her primary health care appointments and, thus, relied on her sister, who was also her private sponsor, for help with interpretation when she arrived in Canada. During an appointment with a medical specialist, however, Pippa, was provided with a male interpreter which became problematic for her. Pippa said:

The first time I had a male interpreter when I was getting checked up. He said to me, 'don't be embarrassed, this is a doctor, she is a female, I don't gossip, what I see I don't talk about'... a man who is asking you everything, talking about everything, asking how many kids you have given birth to, telling you they will assess you and they will look down there. My heart was racing, I felt embarrassed. But, I couldn't change anything or refuse, I didn't have a choice, and I didn't know the language. My sister was there, and she has been living here 20 something years and she knows English as well as [name of the interpreter], but they brought [name of the interpreter] because he is an employee. I felt shy that day. (Pippa)

Gwen was interviewed after Pippa, and after noting Gwen's satisfaction with having a female family primary care practitioner assigned to her through the resettlement agency, and a female medical interpreter at her family primary care appointments, I asked Gwen what she

thought about having a male medical interpreter, she said “initially I told them that I can’t be given a male interpreter... I would be more apprehensive about having a male because I am a woman. So, for a man to be my interpreter and to tell him my business I wouldn’t like.” Since, Gwen did not state that she was provided with a male interpreter initially, her statement suggests that she was given the opportunity to express her opinion about having a male interpreter (potentially after someone who anticipated a problem asked Gwen her opinion). Also, from Gwen’s experience, it is understood that there is an availability of female Somali medical interpreters.

Pippa’s experience demonstrates that despite feeling uncomfortable, it is not always easy for refugee women to make their opinions heard. Pippa’s medical interpreter sensed or anticipated Pippa’s discomfort because Pippa remembered him saying “don’t be embarrassed”. However, neither Pippa, nor the medical interpreter, nor Pippa’s English language proficient sister said anything to the health care provider to alleviate Pippa’s feelings of distress. This lack of action is even more problematic given that another finding from this study was that feeling shy or embarrassed led to delays in seeking care.

Not all of the women felt the same about the importance of having a female provider. Prudence for example, reported only the language barrier as the challenge she experienced with the health care system. When asked about her opinion on male or female health care providers as a probe, Prudence said, “I didn’t need a female doctor, I never looked for one. My dentist is male; my family doctor is a male... I haven’t experienced any challenges.” It is unclear if Prudence has ever required more invasive health assessments, such as a breast exam, and this may explain her answer.

Consider the implications of observing Ramadan. Two of the women interviewed had made comments about needing to do blood work while they were fasting during Ramadan. Phyllis explained to me, “I said to them, ‘during Ramadan taking my blood what is the benefit, if you don’t need it?’”. Phyllis did not find that her question was answered and reported that she took the requisition but did not get the blood work done. It is unclear if her health care provider understood that Phyllis was implying that she is fasting for 18 hours and she would have preferred not being sent for blood work if it was not necessary. However, given that Phyllis made the decision to not get her blood taken after taking the requisition, it is clear that her health care provider did not address her concern adequately. Similarly, Pippa experienced this situation; however, Pippa did not report discussing her fasting nearly 18 hours with the specialist who ordered her blood work. Rather, Pippa assumed this was necessary. She said:

One day, I was fasting, they took seven syringes of blood samples from me and I got dizzy. At this time my son was angry, and he said, ‘they are taking your healthy blood from you, leave this place’. He said, ‘...what is the benefit?’. I told him, ‘it’s important to know your health status’. (Pippa)

Pippa’s answer to her son suggests that she trusted her health care provider and willingly complied with getting her blood taken; however, Pippa’s explanation also suggests that she did not anticipate any side effects, such as feeling dizzy. If Pippa had discussed fasting to observe Ramadan with her doctor, there is a chance she could have explored whether this was urgent or routine blood work, and whether it could wait until after Ramadan was over or if she should have abstained from fasting that day.

Gwen was the last woman interviewed in this study, and the only one who was asked if it was important to her that her health care provider understood her culture and her religion. Gwen responded:

It’s not important. It is good that someone understands your culture, but your religion, it’s not important. You came here for medication and treatment; you didn’t come for

religion... If a person is a doctor for them to understand your religion isn't something that is mandatory. You went to the person for health care. I am Muslim and if I go to someone for care it is possible for some to know and for some to not know. But it's not mandatory for the doctor to know your religion, it's not mandatory. What is mandatory is for them to be a doctor and for them to understand your symptom. (Gwen)

Gwen was implying that since she covers her hair, she visibly looks Muslim, so it is possible for some health care providers to know automatically what her religion is. Gwen thought it was more valuable if the health care provider understands her culture but even this was not as important as receiving medication or treatment and having the reason for the health care visit addressed. All of the women interviewed for this study covered their hair and thus visibly looked like practicing Muslims. None of the women were asked about health care experiences in Ramadan specifically, and only Gwen was asked explicitly about her thoughts on religion, culture, and health care, so this is still an area which needs further exploration. For Somali refugee women to make informed choices about complying with medical advice such as taking medication or getting blood work done during Ramadan, health care providers need to provide linguistically appropriate and culturally and religiously sensitive care to this population.

Summary

This chapter presented the findings of this qualitative description study exploring the health care experiences of Somali refugee women in Manitoba. The findings were presented in three sections: Accessing Health Care; Utilizing Health Care; and The Role of the Health Care Provider, as these sections related to the objectives of the study. Each of the major themes was presented as a puzzle piece in the figures visually displaying the findings. The findings and the figures are discussed in the next chapter.

CHAPTER SIX: DISCUSSION

The aim of this study was to add to the literature on how refugee status differences influence access to and utilization of health care services in Manitoba, with a specific focus on comparing the health care experiences of women within one ethno-cultural group. To achieve this research aim, purposive sampling was used to recruit Somali refugee women who had arrived in Canada as government-assisted refugees (GARs), privately sponsored refugees (PSRs), and refugee claimants (RCs). As the final chapter of the thesis, the findings of this qualitative descriptive study are discussed in relation to the current evidence. Recommendations based on the findings are presented. The strengths and limitations of this study are addressed. My personal reflections are explored and then the study's findings are presented together holistically before the future directions of this research are considered.

Answering the Research Question

The findings of this study support that refugee status influences how women utilize and access health care services. The findings suggest that RCs experience more barriers to entering the health care system and in receiving family primary health care services than PSRs and GARs. This finding is congruent with the findings of other researchers such as Campbell and colleagues (2014) and Winn and colleagues (2018). The findings also suggest that PSRs experience more barriers than GARs and this finding is congruent with the work of other researchers such as Woodgate and colleagues (2017).

Despite barriers to accessing and utilizing health care, the findings of this study support that women are resourceful and resilient and can find creative means of accessing the health care that they need, when they need it. Similar to the findings of other researchers such as Floyd and Sakellariou (2017) and Woodgate and colleagues (2017), refugees work hard to meet their needs

despite intersecting barriers such as limited English language proficiency and refugee status. Baird's (2012) diagram, of her theory of Well-being in Refugee Women Experiencing Cultural Transition, visually demonstrates how autonomy and social supports enhance well-being; whereas, dependency diminishes well-being. From the participants' experiences, it was noted that these same factors correlated with whether the women were able to access and utilize health care services. For example, Portia, a PSR, struggled to find someone who could interpret for her when she had an acute need to seek out health care services. Based on this experience, Portia made additional efforts to increase her social support network and improve her English language fluency.

The fact that RCs, as temporary residents and not permanent residents like the PSRs and GARs, could obtain access to a Manitoba Health Card after securing a work permit was an unexpected finding. Another researcher also noted that this was possible for RCs in Prince Edward Island (PEI) and that in PEI it often took three months (Tastsoglou et al., 2014). Tastsoglou and colleagues (2014) suggest that coverage under the provincial health program may not be available to RCs in other provinces; however, this study found that Manitoba's policy is similar to PEI's policy.

Health care providers that serve refugees report that up to 75% of their job is advocacy (Winn et al., 2018). However, another problematic finding in this study was that RCs report challenges accessing health care, despite having advocates with them. This research was conducted post-2016, when the cuts to the Interim Federal Health Program (IFHP) were restored (Antonipillai et al., 2018). Therefore, it is troubling that in 2018, Rae and Ruby, as RCs, would report perceived discrimination from receptionists when trying to access health care with their IFHP coverage instead of a Manitoba Health Card. Given this finding, an additional benefit of

RCs being able to obtain a Manitoba Health Card is that it reduces potential discrimination based on refugee status. When an RC presents, a Manitoba Health Card, the receptionist or health care provider is more likely to assume that the RC is like any other refugee, immigrant, or Manitoba citizen. The findings of Winn and colleagues' (2018) supports that outside of refugee-specific health care settings, health care providers may not know that the patient or client is a refugee. This reality suggests that current health care policy is more in line with the U.S. military's 'Don't Ask, Don't Tell' policy (Bramadat, 2014; Miklavcic, 2011), in which RCs maybe treated differently based on whether he or she is identifiably an RC.

Recommendations

Recommendation for Health Care Provision

The research findings support that resettled refugee women need informational support. Although most of the GAR and PSR women reported access to some form of orientation, it was evident that they still lacked access to necessary information to make health care decisions such as which walk-in clinics provide interpreters or how to complain about dissatisfactory care. Providing women with access to a lay community health worker can potentially solve this problem.

Some of the women's health care experiences demonstrate that their health care providers were unintentionally insensitive or offensive. This finding supported the work of other researchers (Weerasinghe & Mitchell, 2007). As the women in this study identified, they may not know safe avenues of conveying their dissatisfaction and instead may fear retaliation. Health care providers need to know that silence may not mean that everything is okay. Research on African refugee women who have experienced gender-based violence suggests that silence may be used as a coping mechanism and serve to help the women to maintain a sense of dignity

(Yohani & Okeke-Ihejirika, 2018). Some of the women were very candid with me about their dissatisfactory health care experiences; however, unless the women's feedback is reported through official channels, there is little hope for change in the system. A lay community health worker is in a unique position to listen to the experiences of refugees and report concerns anonymously in order to protect the confidentiality of the refugees.

The women also conveyed their general disappointments with health care in Canada, including experiencing long waits or not being prescribed medication. Other researchers also noted that African immigrants and refugees experience disappointments due to unmet expectations (Woodgate et al., 2017; Salami et al., 2019). Integrating lay community health workers into the health care system can help newcomers to understand the Canadian health care system (Salami et al., 2019) and explore how to mitigate their disappointments or manage their expectations.

Most of the women interviewed in this study had been living in Canada for at least 12 months. This is an important distinction because before the one-year mark, GARs and PSRs are ineligible for provincial social assistance. However, after the year mark, GAR and PSR women may begin receiving social assistance that comes with additional health insurance which can help cover the costs of dental care, prescription medications, eye exams, and prescription eyeglasses. None of the RC women mentioned receiving funding from Employment and Income Assistance (EIA), Manitoba's provincial social assistance program; therefore, it is unclear if there was any potential for these women to access additional health insurance through EIA. However, all of the GAR women and most of the PSR women made references to receiving support from EIA to cover additional health care costs. However, the women's stories demonstrate that they may not have been taking full advantage of the EIA health care funding they were eligible for, which is a

finding supported by Amin and Perez's (2012) research with African immigrant and refugee mothers in Alberta. A lay community health worker could serve as an informed source of information when women are experiencing costs associated with health care and are trying to determine if they have access to funding to cover the costs. A lay community refugee health worker could also help the women make better use of their available coverage, such as receiving annual routine dental care instead of just one-time urgent dental care over a period of five to ten years of living in Canada.

Recommendations for Health Care Policy

The findings of this study support the need to provide evidenced-based refugee primary health care. There are refugee-specific primary health care clinics in Manitoba, Ontario, British Columbia, and Alberta. However, across the provinces, there is a lack of equitable access to this service for PSRs and RCs since many of the clinics specifically focus on GARs. Thus, there is a need to improve equitable access to evidenced-based refugee primary health care by providing refugee-specific primary health care to all refugees. For example, Winn and colleagues (2018) suggest that 90% of refugees settling in Calgary have access to a refugee-specific primary health care clinic; whereas, Benjumea-Bedoya and colleagues (2017) suggest that in 2015 less than 30% of Manitoba's refugees had access to a refugee-specific refugee primary health care clinic.

Inequitable access to refugee specific primary health care is problematic. For example, Milinkovic and colleagues (2018) support the need to screen all refugees with potential past exposure to Tuberculosis (TB) for Latent TB Infection (LTBI) in Canada. These researchers identified that not screening refugees for LTBI after arrival in Canada might potentially reinforce that LTBI is not a priority health issue (Milinkovic et al., 2018). In this study, only Gwen disclosed that she had tested positive for an LTBI and received treatment. Comparatively, Phyllis

suggested that since she was screened for TB during her Immigration Health Exam, prior to coming to Canada, TB was not a health concern for her. Currently in Manitoba, only newly arrived GARs over the age of 18 and residing in Winnipeg are currently screened for an LTBI (Benjumea-Bedoya et al., 2017). Rennert-May and colleagues (2016) suggests that Edmonton also had a similar strategy which offered LTBI screening to GARs.

This inequitable access to health care based on refugee status can primarily be addressed by opening access to refugee specific primary health care clinics for all refugees by funding these clinics to meet the current demand for this service. This policy change is needed so that refugees are not discriminated against based on the specific refugee program they arrived under. In addition to potentially receiving less refugee specific health screening, due to lack of access to refugee specific primary health care clinics, PSRs with limited English language proficiency are also less able to independently utilize primary health care services. This finding is also supported by another study which found that PSRs in Manitoba perceived and reported inequitable access to medical interpreters as compared to GARs (Woodgate et al., 2017). McKeary and Newbold (2010) suggest that inequitable access to medical interpreters across Ontario occurs because language services are not funded at the provincial level and that local services use their budgets creatively to provide this service. However, this thesis research findings suggest that inequitable access to medical interpreters within one city occurs because of policies at the local level. This thesis research found that although private sponsors are able to fulfill their role in assisting PSRs to find family primary care practitioners, the family primary care practitioners they are accessing maybe unable to provide medical interpreters despite the availability of a language access program at the local level. This finding is likely closely related to the fact that PSRs are ineligible for supports available from the refugee specific primary health care clinic, which

includes finding a long-term family primary care practitioner which is able to provide a medical interpreter. PSRs with limited English language fluency need access to this support as well, in order to gain independence in utilizing health care services without needing to find their own interpreter; thus, this inequity needs to be addressed. In terms of health care policy, this inequity can be addressed by providing PSRs with the same supports that GARs have access to at the refugee specific primary health care clinic. Or providing private sponsors with the information they need to make better informed decisions about choosing family primary care practitioners for PSRs with limited English language proficiency.

Recommendation for Training Health Care Professionals

One policy suggestion for training health care providers is to integrate refugee health care provision into current health care professional education programs. Refugees are accessing health care across the system and not just at refugee health care clinics. Winn and colleagues (2018) found that nurses do not receive education on different health care coverage types and thus were unaware that refugees could have additional health care funding.

This study findings also suggests that receptionists at health care facilities also need to be aware of alternative health care funding available to refugees since they may inadvertently refuse care to refugees who are eligible to receive care. Given that policies related to refugee health care change, there also needs to be opportunities for current health care providers to stay current with refugee health care provision. For example, as a health care provider with an interest in refugee health care, not knowing that RCs could obtain a Manitoba Health Card is problematic. I am more likely to give incorrect information to an RC woman based on my lack of knowledge about this opportunity.

A second policy suggestion would be to diversify the health care workforce by reducing barriers to accessing higher education for bilingual or multilingual students from ethno-cultural minority groups. The work of other researchers shows that some ethno-cultural groups have access to health care providers who are from the same ethno-cultural group which means that they can overcome language barriers, for example Chinese immigrants with access to Chinese health care providers (Wang, 2007) and Syrian refugees with access to Arabic speaking health care providers (Winn et al., 2018). Somali refugees are a unique population because they are often arriving from a third world country and experience barriers to accessing education pre-resettlement. Consequently, post-migration there would be fewer Somali's pursuing higher education and less Somali health care providers in Canada overall. When compared to the availability of Arabic speaking health care providers it is understandable why Syrian refugees may experience fewer challenges accessing and utilizing the health care system in Canada compared to Somali refugees (Winn et al., 2018). Resettlement trends and ethnic density would also play a role in this case because a newcomer Somali refugee settling in Winnipeg, Manitoba may have different experiences compared to a newcomer Somali refugee settling in Toronto, Ontario or Chinese immigrants resettling in urban cities across Canada (Anderson et al, 2010; Wang, 2007).

Strengths and Limitations

Strengths

As a Somali woman interviewing Somali refugee women, I had the unique ability to be able to understand the research participants' responses, even in the Somali-language interviews. I mostly used the interpreter to translate my semi-structured interview guide questions from English into Somali; whereas, I did not need the women's Somali responses translated back to

me from Somali to English. I am proficient in speaking Somali and near fluent in understanding Somali. I did not have any challenges with different dialects of Somali which suggests that the women participating in this study were not ethnic minorities within the Somali community, such as the Somali Bantu (Gurnah, Khoshnood, Bradley, & Yuan, 2011). I personally know that my Somali vocabulary is limited and that when interviewing Somali women who may not be able to understand English, there would potentially be limitations in finding alternative words to reach a mutual understanding which is very important for effective communication. Thus, I purposely had an interpreter available when I needed one. However, this is not to say that using an interpreter was without any problems. There were times in which I felt that the interpreter mistranslated my question. Other times, the interpreter stepped in to redirect the research participant when the woman misunderstood the research question or was responding to the question at a broader level. If I had not been able to understand Somali, I would not have been aware of these interactions in the moment. Being able to understand Somali meant that I was able to decide whether to let it go or intervene and tell the woman it was okay to go on. Generally, since I was interested in allowing the woman to keep going on her tangent, in case it may provide valuable insight, I was able to tell the woman, in the moment, that it was okay to finish her idea or anecdote.

Being a Somali woman also made me very comfortable in providing a culturally, linguistically, and religiously sensitive environment for the women. For example, interviews were strategically scheduled between prayer times so that women did not have to delay prayers to participate in this study. Also, I chose to utilize a female interpreter automatically and as my research participant Pippa identified, using a male interpreter may potentially have affected a woman's experience participating in this study (Floyd & Sakellariou, 2017).

Limitations

In terms of limitations, there were significant baseline differences in English language proficiency between the women. Due to difficulty recruiting enough research participants, I opened up the study to Somali refugee women with limited English language proficiency. Thus, I ended up with a convenience sample of three Somali-speaking GARs, two English-speaking PSRs, four Somali-speaking PSRs, and three English-speaking RCs. Since it took nearly one year to recruit these 12 participants, I chose to stop collecting data intentionally to complete my thesis in a timely manner. Given the significant influence that English language proficiency had on the women's ability to utilize health care services, the fact that there were no English language proficient GARs or limited English language proficient RCs recruited as research participants is a limitation of this study.

Another limitation of this purposive sample is that the women were generally healthy. None of the women were hospitalized in Canada, nor did any of the women report a significant physical illness, mental illness, or disability. Thus, as with most qualitative research, the findings of this study have limited generalizability outside the scope of this study.

Personal Reflections

Prior to conducting this study, I acknowledged my personal assumptions. I anticipated that refugee status, length of residency residing in Canada, and English language fluency would influence the women's health care experiences. I also acknowledged that pre-migration health care experiences might influence the women's expectations even though I purposely chose not to ask directly about their pre-migration experiences.

During the data collection and analysis phases of this study, I realized I had a hidden assumption about middle-aged Somali women. I came into this study expecting that the middle-

age Somali women who may participate in this study would be mothers. I realized my hidden assumption when two of the middle-aged PSR women, who participated in the study, were single women with no children. When I analyzed the health care experience of the two middle-aged women, I noticed that they seemed to be at a greater disadvantage compared to the middle-aged mothers and the single young adult women who participated in the study. Both of the middle-aged PSR women with no children reported they were dependent on others and could not access health care without bringing a bilingual Somali social support to serve as an interpreter. In contrast, the mothers could bring their English-speaking children and the other non-English proficient women had enough English language skills to attempt to access health care on their own. Baird (2012) identifies being single as an inhibitor to cultural transition and this fact could explain why the middle-aged single women were at a greater disadvantage than the middle-aged mothers and the young adult single women. In my research findings, age and relationship status intersect, and both contribute to whether the refugee women had easy access to a lay interpreter or could independently attempt to access health care services.

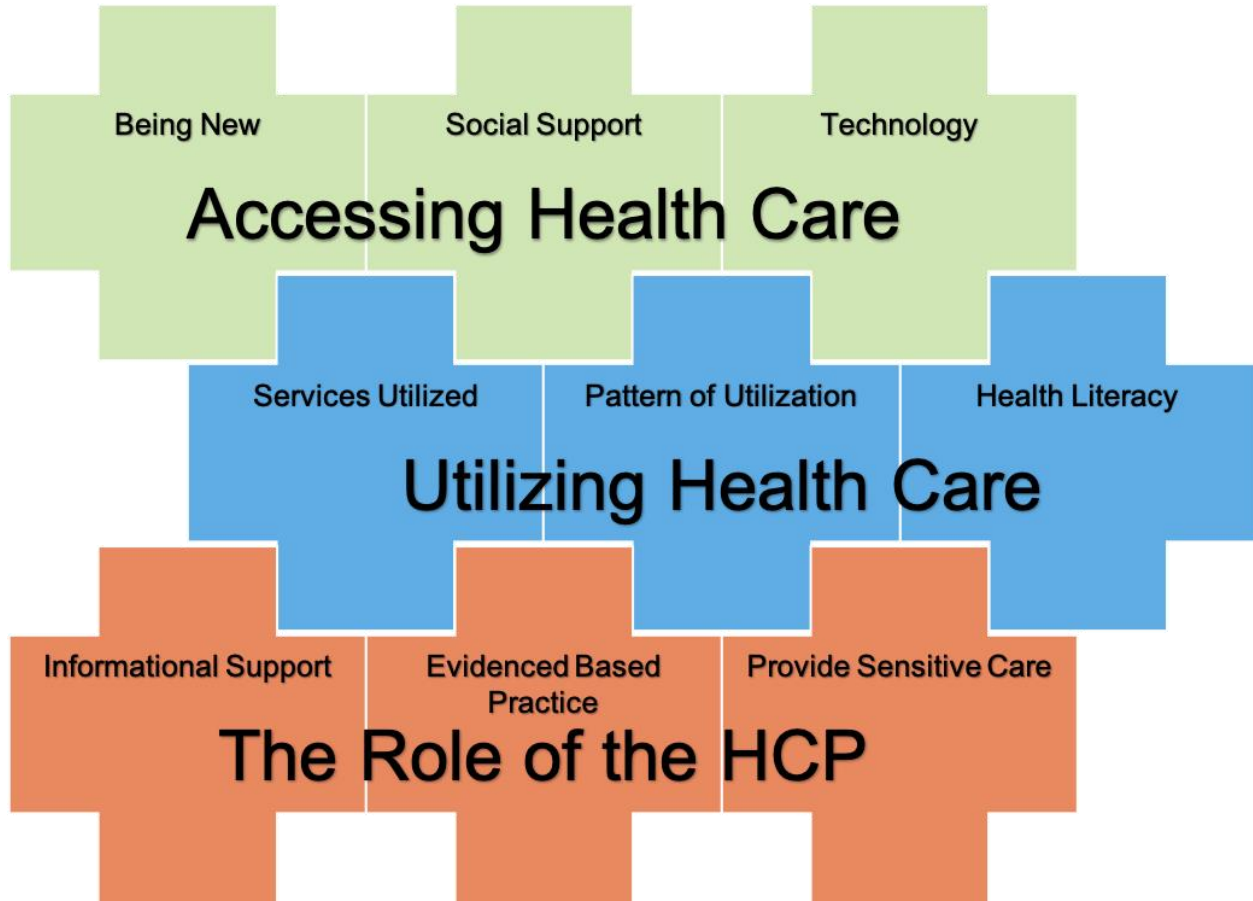
When analyzing the women's health care experiences, I found myself empathizing with the women and accepting their world view. However, in discussions with other health care providers about my findings, I came to understand how there is a need to include the voices of health care providers in understanding the health care experiences of this population. For example, Gina expressed her challenge in not receiving help in accessing a physiotherapist from a medical specialist. A comment posed to me by another health care provider made me realize that the medical specialist may have been aiming to be impartial or unbiased by not referring Gina to a specific physiotherapist. This diversity in possible interpretations of an experience relates to a relativistic ontology and is an example of how multiple truths co-exist. Including

health care providers as research participants can provide the context needed to understand the complexity and nuance of perception and how interpretation influences the study findings.

Putting it all Together

The image below, Figure 5, displays the findings because the women's stories provide information needed to understand their health care experiences in Manitoba. However, there are still missing elements of their experience needed to understand their experience fully. For example, interviewing the women more than once, or interviewing their social supports and their health care providers, would have provided me with a more holistic understanding of how the women access and utilize health care services in Manitoba. The three images presented in the findings chapter fit together to create one image. More research is needed to fill in gaps in the data collected to date.

Figure 5: Putting it All Together



Directions for Future Research

As suggested, the voices of the women's social supports and their health care providers are needed to fully understand the health care experiences of the women. Given the prevalence of refugee primary health care clinics across Canada that focuses on providing primary health care to GARs, there is a need for research to compare health outcomes between GARs, PSRs, and RCs. There is also a need for research that utilizes an intersectional framework, to explore how other factors such as age, family status, and education influence access to and utilization of health care services.

The women's experiences with nurses in Canada was limited to situations in which a Nurse Practitioner was their family primary care practitioner, or there were nurses employed at their family primary health care clinic, or they interacted with nurses who were employed in an Emergency Department. As Baird's (2012) theory proposes, nurses have a role to play in positively influencing the resettlement experiences of refugees. Future research could examine the outcome of implementing Baird's suggested nursing therapeutics for refugee women experiencing cultural transition (2012).

Summary

This chapter discussed the findings of this qualitative descriptive study exploring the health care experiences of Somali refugee women in Manitoba. The findings were discussed in the context of the literature. The recommendations, strengths and limitations, as well as my personal reflections, and the directions for future research were presented. This chapter concludes the thesis.

References

- Abdela, Y. H. (2015). *The lived experiences and sense of belonging among Somali adults and youth in Edmonton* (Unpublished doctoral dissertation). University of Alberta, Edmonton, Alberta.
- Aberman, T. (2014). Gendered perspectives on refugee determination in Canada. *Refuge, 30*(2), 57-66.
- Achonu, C., Jamieson, F., Behr, M., Lillebaek, T., Khan, K., & Gardam, M. (2006). Evidence for local transmission and reactivation of tuberculosis in the Toronto Somali community. *Scandinavian Journal of Infectious Diseases, 38*(9), 778-781.
- Aday, L. A., & Andersen, R. (1974). A framework for the study of access to medical care. *Health Services Research, 9*(3), 208–220.
- Affleck, W., Selvadurai, A., & Sikora, L. (2018). Underrepresentation of men in gender based humanitarian and refugee trauma research: A scoping review. *Intervention, 16*(1), 22–30. doi:10.1097/wtf.0000000000000157
- Ahmad, F., Shik, A., Vanza, R., Cheung, A., George, U., & Stewart, D. (2004). Popular health promotion strategies among Chinese and East Indian immigrant women. *Women & Health, 40*(1), 21-40.
- Ahmad, F., Shik, A., Vanza, R., Cheung, A., George, U., & Stewart, D. (2005). Voices of South Asian women: Immigration and mental health. *Women & Health, 40*(4), 113-130.
- Ahmed, A., Denetto, S., DePape, N. (2015). Deepening the divide: The negative impacts of Canadian immigration policy on the health and well-being of refugees in Manitoba. In L. Fernandez, S. MacKinnon, & J. Silver (Eds.), *The Social Determinants of Health in*

- Manitoba (2nd ed.)* (pp. 241-262). Winnipeg, Manitoba: Canadian Centre for Policy Alternatives Manitoba Office.
- Amin, M., & Perez, A. (2012). Is the wait-for-patient-to-come approach suitable for African newcomers to Alberta, Canada? *Community Dentistry and Oral Epidemiology*, *40*(6), 523-531. doi:10.1111/j.1600-0528.2012.00698.x
- Anderson, J. M., Reimer, J., Khan, K. B., Simich, L., Neufeld, A., Stewart, M., & Makwarimba, E. (2010). Narratives of "dissonance" and "repositioning" through the lens of critical humanism: Exploring the influences on immigrants' and refugees' health and well-being. *Advances in Nursing Science*, *33*(2), 101-112. doi:10.1097/ANS.0b013e3181dbc56b
- Antonipillai, V., Baumann, A., Hunter, A., Wahoush, O., & O'Shea, T. (2018). Health inequity and "Restoring Fairness" Through the Canadian refugee health policy reforms: A literature review. *Journal of Immigrant & Minority Health*, *20*(1), 203–213. <https://doi-org.uml.idm.oclc.org/10.1007/s10903-016-0486-z>
- Asaam, H. M. (2015). *Mental health and well-being of refugees to Canada: A brighter future*. (Unpublished master's thesis). University of Manitoba, Winnipeg, Manitoba.
- Asanin, J., & Wilson, K. (2008). "I spent nine years looking for a doctor": Exploring access to health care among immigrants in Mississauga, Ontario, Canada. *Social Science & Medicine*, *66*(6), 1271-1283. doi:10.1016/j.socscimed.2007.11.043
- Baird, M. B. (2009). *Resettlement transition experiences among Sudanese refugee women* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses.
- Baird, M. B. (2012). Well-being in refugee women experiencing cultural transition. *Advances in Nursing Science*, *35*(3), 249-263.

- Barnes, S. (2013). The real cost of cutting the Interim Federal Health Program. *Wellesley Institute*. Retrieved from <http://www.wellesleyinstitute.com/wp-content/uploads/2013/10/Actual-Health-Impacts-of-IFHP.pdf>
- Bassel, L. (2010). Intersectional politics at the boundaries of the nation state. *Ethnicities*, 10(2), 155-180. doi: 10.1177/1468796810361818
- Benjumea-Bedoya, D., Bertram-Farough, A., & Plourde, P. (2017). *Latent Tuberculosis Infection (LTBI) Management at BridgeCare Clinic: A case study of facilitators and barriers for treatment in a primary health care facility for refugees in Winnipeg, Manitoba*. Winnipeg, MB, CA: National Collaborating Centre for Infectious Diseases.
- Bogdan, R., & Biklen, S. K. (2007). *Qualitative research for education: An introduction to theories and methods* (5th ed.). Boston, Mass.: Pearson A & B.
- Bokore, N. (2013). Suffering in silence: A Canadian-Somali case study. *Journal of Social Work Practice*, 27(1), 95-113. doi:10.1080/02650533.2012.682979
- Boli, R. (2016). Refugee settlement services in Winnipeg: Approaches, programs, and organizations, presented at the Canadian Association for Forced Migration Studies Conference, Winnipeg, 2016. Retrieved from <http://carfms.org/wp-content/uploads/2015/05/Refugee-Settlement-Services-in-Winnipeg-final-version-october-24th-2016.pdf>
- Bowen, S. J. (1999). *Resilience and health: Salvadoran refugee women in Manitoba*. (Unpublished master's thesis). University of Manitoba, Winnipeg, Manitoba.
- Bramadat, P. (2014). Don't ask, don't tell: Refugee settlement and religion in British Columbia. *Journal of the American Academy of Religion*, 82(4), 907.

- Bronstein, I., & Montgomery, P. (2011). Psychological distress in refugee children: A systematic review. *Clinical Child and Family Psychology Review, 14*(1), 44-56.
- Brown-Bowers, A., McShane, K., Wilson-Mitchell, K., & Gurevich, M. (2015). Postpartum depression in refugee and asylum-seeking women in Canada: A critical health psychology perspective. *Health, 19*(3), 318-335.
- Browne, A. J., Varcoe, C., Ford-Gilboe, M., Wathen, C. N., Smye, V., Jackson, B. E., ... Blanchet Garneau, A. (2018). Disruption as opportunity: Impacts of an organizational health equity intervention in primary care clinics. *International Journal for Equity in Health, 17*(1), N.PAG. <https://doi-org.uml.idm.oclc.org/10.1186/s12939-018-0820-2>
- Buchanan, N. (1996). *The adaptation process of Somali refugees in Winnipeg: The role of adult education*. (Unpublished master's thesis). University of Manitoba, Winnipeg, Manitoba.
- Campbell, R., Klei, M., Hodges, A., Fisman, G., & Kitto, B. (2014). A comparison of health access between permanent residents, undocumented immigrants and refugee claimants in Toronto, Canada. *Journal of Immigrant and Minority Health, 16*(1), 165-176. doi: 10.1007/s10903-012-9740-1
- Canadian Council for Refugees (CCR). (2010). Refugees and immigrants: A glossary. <http://ccrweb.ca/en/glossary>
- Canadian Council for Refugees (CCR). (2015, February). Somalis and Canadian immigration policy. Retrieved from http://ccrweb.ca/sites/ccrweb.ca/files/somali_issues_in_canadian_immigration-2016.pdf
- Castañeda, H., Holmes, S. M., Madrigal, D. S., Young, M. D., Beyeler, N., & Quesada, J. (2015). Immigration as a social determinant of health. *Annual Review of Public Health, 36*, 375-392. doi: 10.1146/annurev-publhealth-32013-182419

- Central Intelligence Agency (CIA). (2016). *The world fact book: Somalia*. Retrieved from <https://www.cia.gov/library/publications/the-world-factbook/geos/so.html>
- Chalmers, B., & Omer-Hashi, K. (2000). 432 Somali women's birth experiences in Canada after earlier female genital mutilation. *Birth, 27*(4), 227-234.
- Chalmers, B., & Omer-Hashi, K. (2002). What Somali women say about giving birth in Canada. *Journal of Reproductive and Infant Psychology, 20*(4), 267-282.
- Chinn, P. L. & Kramer, M. K. (2011). Description and critical reflection of empiric theory. *Integrated theory and knowledge development in nursing*. St. Louis, MO: Mosby/Elsevier.
- CIC News. (2016, February 16). *Citizenship and Immigration Canada (CIC) rebrands as Immigration, Refugees and Citizenship Canada (IRCC)*. Retrieved from <https://www.cicnews.com/2016/02/citizenship-immigration-canada-cic-rebrands-immigration-refugees-citizenship-canada-ircc-027245.html>
- Cleveland, J., & Rousseau, C. (2013). Psychiatric symptoms associated with brief detention of adult asylum seekers in Canada. *The Canadian Journal of Psychiatry, 58*(7), 409-416.
- Collins, C., Zimmerman, H., & Howard, C. (2011). Refugee, asylum seeker, immigrant women and postnatal depression: Rates and risk factors. *Archives of Women's Mental Health, 14*(1), 3-11. doi: 10.1007/s00737-010-0198-7
- Community Health Advisory Councils (CHAC). (2008). *Issues that impact on the health of immigrants and refugees in the Winnipeg health region: Community perspectives*. Winnipeg: Winnipeg Regional Health Authority. Retrieved from http://www.wrha.mb.ca/about/engagement/lhig/files/CHAC_ImmigrantRefugee_Feb08.pdf

- Dahal, G., Qayyum, A., Ferreyra, M., Kassim, H., & Pottie, K. (2014). Immigrant community leaders identify four dimensions of trust for culturally appropriate diabetes education and care. *Journal of Immigrant and Minority Health, 16*(5), 978-984. doi:10.1007/s10903-013-9805-9
- Dangerfield, K. (2010, December 24). Manitoba newcomers can count on BridgeCare: Clinic caters to specific health needs of refugee. *Winnipeg Free Press*. Retrieved from <http://www.winnipegfreepress.com>
- Dassanayake, J., Gurrin, L., Payne, W., Sundararajan, V., & Dharmage, S. (2011). Cardiovascular disease risk in immigrants: What is the evidence and where are the gaps? *Asia-Pacific Journal Of Public Health, 23*(6), 882-895. doi: 10.1177/1010539509360572
- Dastjerdi, M., Olson, K., & Ogilvie, L. (2012). A study of Iranian immigrants' experiences of accessing Canadian health care services: A grounded theory. *International Journal for Equity in Health, 11*, 55-55. doi:10.1186/1475-9276-11-55
- Degni, F., Suominen, S., Essén, B., El Ansari, W., & Vehviläinen-Julkunen, K. (2012). Communication and cultural issues in providing reproductive health care to immigrant women: health care providers' experiences in meeting Somali women living in Finland. *Journal of Immigrant and Minority Health, 14*(2), 330-343.
- Dhital, D. (2015). *The economic outcomes of government assisted refugees, privately sponsored refugees, and asylum seekers in Canada*. (Unpublished major research paper). University of Ottawa, Ottawa, Ontario.
- Donnelly, T. (2006). The health-care practices of Vietnamese-Canadian women: Cultural influences on breast and cervical cancer screening. *The Canadian Journal of Nursing Research, 38*(1), 82-101.

- Donnelly, T. T., Hwang, J. J., Este, D., Ewashen, C., Adair, C., & Clinton, M. (2011). If I was going to kill myself, I wouldn't be calling you. I am asking for help: Challenges influencing immigrant and refugee women's mental health. *Issues in Mental Health Nursing, 32*(5), 279-290. doi:10.3109/01612840.2010.550383
- Edge, S., & Newbold, B. (2013). Discrimination and the health of immigrants and refugees: Exploring Canada's evidence base and directions for future research in newcomer receiving countries. *Journal of Immigrant and Minority Health, 15*(1), 141-148. doi: 10.1007/s10903-012-9640-4
- Edge, S., Newbold, K. B., & McKeary, M. (2014). Exploring socio-cultural factors that mediate, facilitate, & constrain the health and empowerment of refugee youth. *Social Science & Medicine, 117*, 34-41. doi:10.1016/j.socscimed.2014.07.025.
- Elliott, S. J., & Gillie, J. (1998). Moving experiences: A qualitative analysis of health and migration. *Health and Place, 4*(4), 327-339.
- Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 62*(1), 107-115. doi: 10.1111/j.1365-2648.2007.04569.x
- Field, P. A. (1991). Doing fieldwork in your own culture. In J. Morse, *Qualitative nursing research: A contemporary dialogue (Rev. ed., pp.91-104)*. Newbury Park, Calif.: Sage Publications.
- Floyd, A., & Sakellariou, D. (2017). Healthcare access for refugee women with limited literacy: Layers of disadvantage. *International Journal for Equity in Health, 16*. doi:http://dx.doi.org.u/ml.idm.oclc.org/10.1186/s12939-017-0694-8

- Forman, J., & Damschroder, L. (2008). Qualitative content analysis. In L. Jacoby & L. A. Siminoff (Eds.), *Empirical methods for bioethics: A primer (Advances in Bioethics Volume 11)* (pp. 39-62). Burlington: Emerald Group Publishing Limited.
- Foster, C., & McPherson, N. (2007). *Improving access to services for immigrant and refugee communities: Needs assessment*. Retrieved from https://www.serc.mb.ca/sites/default/files/resources/Improving_Access_Needs_Assessment_Report_Final_June_2007.pdf
- Gagnon, A. J., Dougherty, G., Wahoush, O., Saucier, J. F., Dennis, C. L., Stanger, E., . . . Stewart, D. E. (2013). International migration to Canada: The post-birth health of mothers and infants by immigration class. *Social Science & Medicine* (1982), 76(1), 197-207. doi: 10.1016/j.socscimed.2012.11.001
- Goel, R., Bloch, G., & Caulford, P. (2013). Waiting for care: Effects of Ontario's 3-month waiting period for OHIP on landed immigrants. *Canadian Family Physician*, 59(6), e269-75.
- Government of Canada. (2016a). Government-assisted refugees program. Retrieved from <http://www.cic.gc.ca/english/refugees/outside/gar/index.asp>
- Government of Canada. (2016b). Private sponsorship of refugees program – Information for refugees. Retrieved from <http://www.cic.gc.ca/english/refugees/outside/private.asp>
- Government of Canada. (2017a). Find out if you're eligible – Refugee status from inside Canada. Retrieved from <http://www.cic.gc.ca/english/refugees/inside/apply-who.asp>
- Government of Canada. (2017b). Find out what to do after you apply – Refugee status from inside Canada. Retrieved from <http://www.cic.gc.ca/english/refugees/inside/apply-after.asp>

- Government of Canada. (2017c). How Canada's refugee system works. Retrieved from <http://www.cic.gc.ca/ENGLISH/refugees/canada.asp>
- Government of Canada. (2017d). Resettlement from outside Canada. Retrieved from <http://www.cic.gc.ca/english/refugees/outside/index.asp>
- Government of Canada. (2018a). 2017 Asylum Claims. Retrieved from <https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/asylum-claims-2017.html>
- Government of Canada. (2018b). Asylum Claims. Retrieved from <https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/asylum-claims.html>
- Grabish, A., & Glowacki, L. (2017, January 9). New numbers show spike in asylum seekers crossing from U.S. to Manitoba. *CBC News*. Retrieved from <http://www.cbc.ca/news/canada/manitoba/refugees-manitoba-emerson-crossing-1.3926754>
- Gualdi-Russo, E., Toselli, S., Masotti, S., Marzouk, D., Sundquist, K., & Sundquist, J. (2014). Health, growth and psychosocial adaptation of immigrant children. *The European Journal of Public Health, 24*(Suppl1), 16-25. doi: 10.1093/eurpub/cku107
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). London: Sage.
- Gurnah, K., Khoshnood, K., Bradley, E., & Yuan, C. (2011). Lost in translation: Reproductive health care experiences of Somali Bantu women in Hartford, Connecticut. *Journal of*

- Midwifery & Women's Health*, 56(4), 340–346. <https://doi.org/10.1111/j.1542-2011.2011.00028.x>
- Guruge, S., Birpreet, B., & Samuels-Dennis, J. (2015). Health status and health determinants of older immigrant women in Canada: A scoping review. *Journal of Aging Research*, 2015, 12.
- Guruge, S., & Butt, H. (2015). A scoping review of mental health issues and concerns among immigrant and refugee youth in Canada: Looking back, moving forward. *Canadian Journal of Public Health*, 106(2), E72-8.
- Guruge, S., & Khanlou, N. (2004). Intersectionalities of influence: Researching the health of immigrant and refugee women. *Canadian Journal of Nursing Research*, 36(3), 33-47.
- Guruge, S., Hunter, J., Barker, K., McNally, M. J., & Magalhaes, L. (2010). Immigrant women's experiences of receiving care in a mobile health clinic. *Journal of Advanced Nursing*, 66(2), 350-359. doi:10.1111/j.1365-2648.2009.05182.x
- Gushulak, B. D., Pottie, K., Roberts, J. H., Torres, S., DesMeules, M., & Canadian Collaboration for Immigrant and Refugee Health. (2011). Migration and health in Canada: Health in the global village. *Canadian Medical Association Journal*, 183(12), E952-E958. doi:10.1503/cmaj.090287
- Health Canada. (2016). Canada Health Act annual report 2014-2015. *Health Canada*. Retrieved from <http://www.hc-sc.gc.ca/hcs-sss/pubs/cha-lcs/2015-cha-lcs-ar-ra/index-eng.php>
- Heppner, K. (2016, June 24). Somali refugees walking across Manitoba farm fields to become Canadians. *Real Agriculture*. Retrieved from <http://www.realagriculture.com>
- Hiiraan Online. (2006, November 10). Ontario municipal election: Somali Canadian perspective. Retrieved from <http://www.hiiraan.com>

- Hirani, K., Payne, D., Mutch, R., & Cherian, S. (2016). Health of adolescent refugees resettling in high-income countries. *Archives of Disease in Childhood*, 1-7. doi: 10.1136/archdischild-2014-307221
- Hopkins, G. (2010). A changing sense of Somaliness: Somali women in London and Toronto. *Gender, Place & Culture*, 17(4), 519-538.
- Hordyk, S. R., Hanley, J., & Richard, E. (2015). "Nature is there; its free": Urban greenspace and the social determinants of health of immigrant families. *Health and Place*, 34, 74-82. doi: 10.1016/j.healthplace.2015.03.016
- Howard, M., Lytwyn, A., Lohfeld, L., Redwood-Campbell, L., Fowler, N., & Karwalajtys, T. (2009). Barriers to acceptance of self-sampling for human papillomavirus across ethnolinguistic groups of women. *Canadian Journal of Public Health*, 100(5), 365-369.
- Hsieh, H., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15(9), 1277-1288.
- Huffman, A. (2017, March 13). Why refugees are choosing to cross over in Manitoba instead of Saskatchewan?. *Global News*. Retrieved from <http://globalnews.ca/news/3306357/why-refugees-are-choosing-to-cross-over-in-manitoba-instead-of-saskatchewan/>
- Hyndman, J., D'Addario, S., & Stevens, M. R. (2014). *Final report: Refugee research synthesis 2009-2013*. Toronto: Centre of Excellence for Research on Immigration and Settlement.
- Jackson, S., & Bauder, H. (2014). Neither temporary, nor permanent: The precarious employment experiences of refugee claimants in Canada. *Journal of Refugee Studies*, 27(3), 360-381. doi:10.1093/jrs/fet048
- Jorden, S., Matheson, K., & Anisman, H. (2009). Supportive and unsupportive social interactions in relation to cultural adaptation and psychological distress among Somali refugees

- exposed to collective or personal traumas. *Journal of Cross-Cultural Psychology*, 40(5), 853-874.
- Kinch, J. L., & Jakubec, S. (2004). Out of the multiple margins: Older women managing their health care. *Canadian Journal of Nursing Research*, 36(4), 90-108.
- Lagacé, M., Charmarkeh, H., & Grandena, F. (2012). Cultural perceptions of aging: The perspective of Somali Canadians in Ottawa. *Journal of Cross-Cultural Gerontology*, 27(4), 409-4
- Lai, D. W. L., & Chau, S. B. Y. (2007). Predictors of health service barriers for older Chinese immigrants in Canada. *Health & Social Work*, 32(1), 57-65. doi:10.1007/s10823-012-9180-3
- Larios, L. (2013). They have stood by me: Supporting refugee families in Winnipeg. *Canadian Centre for Policy Alternatives Manitoba*. Retrieved from https://www.policyalternatives.ca/sites/default/files/uploads/publications/Manitoba%20Office/2013/05/Refugee%20Supports%20in%20Wpg_0.pdf
- Li, H. Z., & Browne, A. J. (2000). Defining mental illness and accessing mental health services: Perspectives of Asian Canadians. *Canadian Journal of Community Mental Health*, 19(1), 143-159.
- Lipson, J. G. (1991). The use of self in ethnographic research. In J. Morse, *Qualitative nursing research: A contemporary dialogue* (Rev. ed., pp. 73-90). Newbury Park, Calif.: Sage Publications.
- Lum, I. D., Swartz, R. H., & Kwan, M. Y. W. (2016). Accessibility and use of primary healthcare for immigrants living in the Niagara region. *Social Science & Medicine*, 156, 73-79. doi:10.1016/j.socscimed.2016.03.024

- MacDonnell, J. A., Dastjerdi, M., Bokore, N., & Khanlou, N. (2012). Becoming resilient: Promoting the mental health and well-being of immigrant women in a Canadian context. *Nursing Research and Practice*, 2012. doi:10.1155/2012/576586
- MacDuff, S., Grodin, M., & Gardiner, A. (2011). The use of complementary and alternative medicine among refugees: A systematic review. *Journal of Immigrant and Minority Health*, 13(3), 585-599. doi: 10.1007/s10903-010-9318-8
- Magoon, J. (2005). *The health of refugees in Winnipeg*. Retrieved from <http://www.wrha.mb.ca/community/commdev/files/diversity-refugeehealth.pdf>
- Malone, K. (2017, February 22). Asylum seeker says husband, mother were killed on wedding day in Somalia. *CBC News*. Retrieved from <https://www.cbc.ca/news/canada/manitoba/surge-asylum-seekers-feb-22-1.3995188>
- Matheson, K., Jordan, S., & Anisman, H. (2008). Relations between trauma experiences and psychological, physical and neuroendocrine functioning among Somali refugees: Mediating role of coping with acculturation stressors. *Journal of Immigrant & Minority Health*, 10(4), 291-304. doi: 10.1007/s10909-007-9086-2
- Maticka-Tyndale, E., Shirpak, K., & Chinichian, M. (2007). Providing for the sexual health needs of Canadian immigrants: the experience of immigrants from Iran. *Canadian Journal of Public Health*, 98(3), 183-186.
- May, K. A. (1991). Interview techniques in qualitative research: Concerns and challenges. In J. Morse, *Qualitative nursing research: A contemporary dialogue* (Rev. ed., pp.188-201). Newbury Park, Calif.: Sage Publications.
- McCleary, P. (1994). Female genital mutilation and childbirth: A case report. *Birth Issues in Perinatal Care*, 21(4), 221-223.

- McEwen, M., & Wills, Evelyn M. (2011). *Theoretical basis for nursing* (3rd ed.). Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins.
- McKeary, M., & Newbold, B. (2010). Barriers to care: The challenges for Canadian refugees and their health care providers. *Journal of Refugee Studies*, 23(4), 523-545
- McMurray, J., Breward, K., Breward, M., Alder, R., & Arya, N. (2014). Integrated primary care improves access to healthcare for newly arrived refugees in Canada. *Journal of Immigrant & Minority Health*, 16(4), 576-585. doi:10.1007/s10903-013-9954-x
- Merry, L. A., Gagnon, A. J., Kalim, N., & Bouris, S. S. (2011). Refugee claimant women and barriers to health and social services post-birth. *Canadian Journal of Public Health*, 102(4), 286-290.
- Miklavcic, A. (2011). Canada's non-status immigrants: Negotiating access to health care and citizenship. *Medical Anthropology: Cross Cultural Studies in Health and Illness*, 30(5), 496-517. doi:10.1080/01459740.2011.579586
- Milinkovic, D. A., Birch, S., Scott, F., Newbold, K. B., Hopkins, J., & Essue, B. M. (2018). A cohort study of factors associated with LTBI treatment initiation and completion in Hamilton, Ontario, Canada. *Canadian Journal of Infection Control*, 33(2), 82–88.
- Retrieved from <http://uml.idm.oclc.org/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=130946028&site=ehost-live>
- Morantz, G., Rousseau, C., & Heymann, J. (2012). The divergent experiences of children and adults in the relocation process: perspectives of child and parent refugee claimants in Montreal. *Journal of Refugee Studies*, 25(1), 71-92.

- Morse, J. (1991). Strategies for sampling. In J. Morse, *Qualitative nursing research: A contemporary dialogue* (Rev. ed., pp.127-145). Newbury Park, Calif.: Sage Publications.
- Moullan, Y., & Jusot, F. (2014). Why is the 'healthy immigrant effect' different between European countries? *European Journal of Public Health, 24*, 80.
doi:10.1093/eurpub/cku11
- Munhall, P. L. (2012). *Nursing research: A qualitative perspective* (5th ed.). Sudbury, MA: Jones & Bartlett Learning.
- Neergaard, M. A., Olesen, F., Andersen, R. S., & Sondergaard, J. (2009). Qualitative description – the poor cousin of health research? *BMC Medical Research Methodology, 9*, 52-52.
doi:10.1186/1471-2288-9-52
- Newbold, K. B., Cho, J., & McKeary, M. (2013). Access to health care: The experiences of refugee and refugee claimant women in Hamilton, Ontario. *Journal of Immigrant and Refugee Studies, 11*(4), 431-449. doi:10.1080/15562948.2013.808390
- Ngwakongnwi, E., Hemmelgarn, B. R., Musto, R., Quan, H., & King, K. M. (2012). Experiences of French speaking immigrants and non-immigrants accessing health care services in a large Canadian city. *International Journal of Environmental Research and Public Health, 9*(9), 3755-3768. doi:10.3390/ijerph9103755
- Nyman, G. (1992). *Accessibility of mental health and social services by immigrants and refugees: A survey of providers*. (Unpublished master's thesis). University of Manitoba, Winnipeg, Manitoba.
- Olson, K. (2011). *Essentials of qualitative interviewing*. Walnut Creek, CA: Left Coast Press.
- Ontario Council of Agencies Serving Immigrants (OCASI). (2016). *Somali refugee resettlement in Canada*. Retrieved from

http://ocasi.org/sites/default/files/OCASI_Presentation_Somali_Resettlement_Metropolis_2016.pdf

- Paisley, J. A., Haines, J., Greenberg, M., Makarchuk, M., Vogelzang, S., & Lewicki, K. (2002). An examination of cancer risk beliefs among adults from Toronto's Somali, Chinese, Russian and Spanish-speaking communities. *Canadian Journal of Public Health, 93*(2), 138-141.
- Pathy, R., Mills, K. E., Gazeley, S., Ridgley, A., & Kiran, T. (2011). Health is a spiritual thing: Perspectives of health care professionals and female Somali and Bangladeshi women on the health impacts of fasting during Ramadan. *Ethnicity & Health, 16*(1), 43-56.
doi:10.1080/13557858.2010.523780
- Penchansky, R., & Thomas, J. (1981). The concept of access: Definition and relationship to consumer satisfaction. *Medical Care, 19*(2), 127-140.
- Pimentel, V. M., & Eckardt, M. J. (2014). More than interpreters needed: the specialized care of the immigrant pregnant patient. *Obstetrical & Gynecological Survey, 69*(8), 490-500.
- Polit, D. F., & Beck, C. T. (2014). *Essentials of nursing research: Appraising evidence for nursing practice* (8th ed.). Philadelphia: Wolters Kluwer/Lippincott/Williams & Wilkins Health.
- Pollock, G., Newbold, B., Lafrenière, G., & Edge, S. (2012). Discrimination in the doctor's office: Immigrants and refugee experiences. *Critical Social Work, 13*(2), 61-79.
- Poureslami, I., Rootman, I., Doyle-Waters, M., Nimmon, L., & FitzGerald, J. (2011). Health literacy, language, and ethnicity-related factors in newcomer asthma patients to Canada: A qualitative study. *Journal of Immigrant & Minority Health, 13*(2), 315-322.
doi:10.1007/s10903-010-9405-x

- Powers, B. A., & Knapp, T. R. (2011). *Dictionary of nursing theory and research* (4th ed.). New York, N.Y.: Springer Pub.
- Province of Manitoba. (2015). Manitoba immigration facts: 2014 Statistical Report. Retrieved from http://www.gov.mb.ca/labour/immigration/pdf/mb_imm_facts_rep_2014.pdf
- Province of Manitoba. (2017). Manitoba immigration facts report 2016. Retrieved from <https://www.immigratemanitoba.com/facts-report-2016/>
- Pyke, J., Morris, L., Rabin, K., & Sabriye, A. A. (2001). Improving accessibility: The experience of a Canadian mental health agency. *Psychiatric Rehabilitation Journal*, 25(2), 180-185.
- Quintanilha, M., Mayan, M. J., Thompson, J., & Bell, R. C. (2016). Contrasting "back home" and "here": How Northeast African migrant women perceive and experience health during pregnancy and postpartum in Canada. *International Journal for Equity in Health*, 15. doi:10.1186/s12939-016-0369-x
- Raska, J. (2016). Un/Wanted? Canada and the resettlement of Chilean, Indochinese and Somali refugees. Retrieved from <https://www.pier21.ca/blog/jan-raska-phd/unwanted-canada-and-the-resettlement-of-chilean-indochinese-and-somali-refugees>
- Reception House. (n.d.) A place for new beginnings. Retrieved from <http://receptionhouse.ca/>
- Redwood-Campbell, L., Fowler, N., Laryea, S., Howard, M., & Kaczorowski, J. (2011). 'Before you teach me, I cannot know': Immigrant women's barriers and enablers with regard to cervical cancer screening among different ethno linguistic groups in Canada. *Canadian Journal of Public Health*, 102(3), 230-234.
- Rehaag, S. (2009, March 4). 2008 refugee claim data and IRB member recognition rates. *Canadian Council for Refugees*. Retrieved from <http://ccrweb.ca/en/2011-updated-refugee-claim-data>

- Rehaag, S. (2010, March 29). 2009 refugee claim data and IRB member recognition rates. *Canadian Council for Refugees*. Retrieved from <http://ccrweb.ca/en/2011-updated-refugee-claim-data>
- Rehaag, S. (2011, March 1). 2010 refugee claim data and IRB member recognition rates. *Canadian Council for Refugees*. Retrieved from <http://ccrweb.ca/en/2011-updated-refugee-claim-data>
- Rehaag, S. (2012, August 6). Updated 2011 refugee claim data and IRB member recognition rates. *Canadian Council for Refugees*. Retrieved from <http://ccrweb.ca/en/2011-updated-refugee-claim-data>
- Rehaag, S. (2013, May 13). 2012 refugee claim data and IRB member recognition rates. *Canadian Council for Refugees*. Retrieved from <http://ccrweb.ca/en/2012-refugee-claim-data>
- Rehaag, S. (2014, April 14). 2013 refugee claim data and IRB member recognition rates. *Canadian Council for Refugees*. Retrieved from <http://ccrweb.ca/en/2013-refugee-claim-data>
- Rehaag, S. (2015, May 8). 2014 refugee claim data and IRB member recognition rates. *Canadian Council for Refugees*. Retrieved from <http://ccrweb.ca/en/2014-refugee-claim-data>
- Rehaag, S. (2016, March 30). 2015 refugee claim data and IRB member recognition rates. *Canadian Council for Refugees*. Retrieved from <http://ccrweb.ca/en/2015-refugee-claim-data>
- Rehaag, S. (2017, March 8). 2016 refugee claim data and IRB member recognition rates. *Canadian Council for Refugees*. Retrieved from <http://ccrweb.ca/en/2016-refugee-claim-data>

Rehaag, S. (2018, March 26). 2017 refugee claim data and IRB member recognition rates.

Canadian Council for Refugees. Retrieved from <https://ccrweb.ca/en/2017-refugee-claim-data>

Reitmanova, S., & Gustafson, D. L. (2008). 'They can't understand it': maternity health and care needs of immigrant Muslim women in St. John's, Newfoundland. *Maternal & Child Health Journal*, 12(1), 101-111.

Rennert-May, E., Hansen, E., Zadeh, T., Krinke, V., Houston, S., & Cooper, R. (2016). A step toward Tuberculosis elimination in a low-incidence country: Successful diagnosis and treatment of latent Tuberculosis infection in a refugee clinic. *Canadian Respiratory Journal*, 2016, 6. <https://doi.org/10.1155/2016/7980869>

Ro, A. (2014). The longer you stay, the worse your health? A critical review of the negative acculturation theory among Asian immigrants. *International Journal of Environmental Research and Public Health*, 11(8), 8038-57. doi: 10.3390/ijerph110808038

Rossman, G., & Rallis, S. F. (2017). *An introduction to qualitative research: Learning in the field* (4th ed.). Thousand Oaks, CA: Sage Publications.

Saberpor, T. (2016). Refugee and asylum seekers in Canada: Barriers to health care services. *Glendon Journal of International Studies*. Retrieved from

<http://gjis.journals.yorku.ca/index.php/gjis/article/view/40238>

Sadavoy, J., Meier, R., & Ong, A. (2004). Barriers to access to mental health services for ethnic seniors: The Toronto study. *Canadian Journal of Psychiatry*, 49(3), 192-199.

Salami, B., Salma, J., & Hegadoren, K. (2019). Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers. *International Journal of Mental Health Nursing*, 28(1), 152-161.

- Saldaña, J. (2016). *The coding manual for qualitative researchers* (3rd ed.). Los Angeles, CA: SAGE.
- Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, 23(4), 334-340.
- Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health*, 33(1), 77-84.
- Sanou, D., O'Reilly, E., Ngnie-Teta, I., Batal, M., Mondain, N., Andrew, C., Newbold, B., & Bourgeault, K. (2014). Acculturation and nutritional health of immigrants in Canada: A scoping review. *Journal of Immigrant and Minority Health*, 16(1), 24-34. doi: 10.1007/s10903-013-9823-7
- Schreier, M. (2013). Qualitative content analysis. In U. Flick, *The SAGE handbook of qualitative data analysis*. London: Sage Publications Ltd. doi: 10.4135/9781446282243
- Schwartz, D. (2015, October 4). Canada's refugees by the numbers: the data. *CBC News*. Retrieved from <http://www.cbc.ca/news/canada/canada-s-refugees-by-the-numbers-the-data-1.3240640#arrivals>
- Sheikh, H. & Healy, S. (2009). Somalia's missing million: The Somali diaspora and its role in development. Retrieved from http://www.undp.org/content/dam/somalia/docs/undp_report_onsomali_diaspora.pdf
- Sherrell, K. (2010). Legal status, place, or something else? The housing experiences of refugees in Winnipeg and Vancouver. *Canadian Issues*, 52-57.
- Simich, L., Maiter, S., Moorlag, E., & Ochocka, J. (2009). Taking culture seriously: Ethnolinguistic community perspectives on mental health. *Psychiatric Rehabilitation Journal*, 32(3), 208-214. doi:10.2975/32.3.2009.208.214

- Simich, L., Wu, F., & Nerad, S. (2007). Status and health security: An exploratory study of Irregular immigrants in Toronto. *Canadian Journal of Public Health, 98*(5), 369-373.
- Spitzer, D. L. (2007). Immigrant and refugee women: Recreating meaning in transnational context. *Anthropology in Action, 14*(1), 52-62. doi: 10.3167/aia.2007.14010206
- Statistics Canada. (2010). 2006 Census of Population, Statistics Canada catalogue no. 97-564-XCB2006007. Retrieved from <http://www12.statcan.gc.ca>
- Statistics Canada. (2017a). 2011 National Household Survey, Statistics Canada catalogue no. 99-010-X2011036. Retrieved from <http://www12.statcan.gc.ca>
- Statistics Canada. (2017b). Canada [Country] and Canada [Country] (table). Census Profile. 2016 Census. Statistics Canada Catalogue no. 98-316-X2016001. Retrieved from <https://www12.statcan.gc.ca>
- Statistics Canada. (2017c). Manitoba [Province] and Canada [Country] (table). Census Profile. 2016 Census. Statistics Canada Catalogue no. 98-316-X2016001. Retrieved from <https://www12.statcan.gc.ca>
- Steele, L., Lemieux-Charles, L., Clark, J., & Glazier, R. (2002). The impact of policy changes on the health of recent immigrants and refugees in the inner city: A qualitative study of service providers' perspectives. *Canadian Journal of Public Health, 93*(2), 118-122.
- Stewart, M., Simich, L., Shizha, E., Makumbe, K., & Makwarimba, E. (2012). Supporting African refugees in Canada: Insights from a support intervention. *Health and Social Care in the Community, 20*(5), 516-527. doi: 10.1111/j.1365-2524.2012.01069.x
- Subedi, R. P., & Rosenberg, M. W. (2014). Determinants of the variations in self-reported health status among recent and more established immigrants in Canada. *Social Science & Medicine, 115*, 103-110. doi: 10.1016/j.socscimed.2014.06.021

Tappen, R. (2016). *Advanced nursing research: From theory to practice* (2nd ed.). Sudbury, MA: Jones & Bartlett Learning.

Tastsoglou, E., Abidi, C. B., Brigham, S. M., & Lange, E. A. (2014). (En)gendering vulnerability: Immigrant service providers' perceptions of needs, policies, and practices related to gender and women refugee claimants in Atlantic Canada. *Refuge*, 30(2), 67-78.

The Fund for Peace (FFP). (2008). The failed states index 2008. Retrieved from <http://fsi.fundforpeace.org/rankings-2008-sortable>

The Fund for Peace (FFP). (2009). The failed states index 2009. Retrieved from <http://fsi.fundforpeace.org/rankings-2009-sortable>

The Fund for Peace (FFP). (2010). The failed states index 2010. Retrieved from <http://fsi.fundforpeace.org/rankings-2010-sortable>

The Fund for Peace (FFP). (2011). The failed states index 2011. Retrieved from <http://fsi.fundforpeace.org/rankings-2011-sortable>

The Fund for Peace (FFP). (2012). The failed states index 2012. Retrieved from <http://fsi.fundforpeace.org/rankings-2012-sortable>

The Fund for Peace (FFP). (2013). The failed states index 2013. Retrieved from <http://fsi.fundforpeace.org/rankings-2013-sortable>

The Fund for Peace (FFP). (2014). Fragile states index 2014. Retrieved from <http://fsi.fundforpeace.org/rankings-2014>

The Fund for Peace (FFP). (2015). Fragile states index 2015. Retrieved from <http://fsi.fundforpeace.org/rankings-2015>

The Fund for Peace (FFP). (2016). Fragile states index 2016. Retrieved from <http://fsi.fundforpeace.org/rankings-2016>

- The Fund for Peace (FFP). (2017). Fragile states index 2017. Retrieved from <http://fundforpeace.org/fsi/2017/05/14/fragile-states-index-2017-annual-report/951171705-fragile-states-index-annual-report-2017/>
- The Fund for Peace (FFP). (2018). Fragile states index 2018. Retrieved from <http://fundforpeace.org/fsi/wp-content/uploads/2018/04/951181805-Fragile-States-Index-Annual-Report-2018.pdf>
- The Office of the United Nations High Commissioner for Refugees (UNHCR). (2014). Resettlement. Retrieved from <http://www.unhcr.org/resettlement.html>
- Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences*, *15*(3), 398-405.
- Wang, L. (2007). Immigration, ethnicity, and accessibility to culturally diverse family physicians. *Health and Place*, *13*(3), 656-671. doi: 10.1016/j.healthplace.2006.10.001
- Wang, L. (2014). Immigrant health, socioeconomic factors and residential neighbourhood characteristics: A comparison of multiple ethnic groups in Canada. *Applied Geography*, *51*, 90-98. doi: 10.1016/j.apgeog.2014.03.010
- Weerasinghe, S., & Mitchell, T. (2007). Connection between the meaning of health and interaction with health professionals: Caring for immigrant women. *Health Care for Women International*, *28*(4), 309-328.
- White, J. (2007). *Enhancing and developing policies, models and practices to address the mental health needs of immigrant and refugee women in Saskatchewan*. (Unpublished doctoral dissertation). University of Manitoba, Winnipeg, Manitoba.

- Winn, A., Hetherington, E., & Tough, S. (2018). Caring for pregnant refugee women in a turbulent policy landscape: perspectives of health care professionals in Calgary, Alberta. *International Journal for Equity in Health*, 17(1). <https://doi-org.uml.idm.oclc.org/10.1186/s12939-018-0801-5>
- Winnipeg Regional Health Authority Research and Evaluation Unit (WRHA). (2010a). *The health of immigrants and refugees in the Winnipeg health region: A community health assessment resource for health services planning*. Retrieved from <http://www.wrha.mb.ca>
- Winnipeg Regional Health Authority Research and Evaluation Unit (WRHA). (2010b). *Part two: Develop and evidence-informed response*. Retrieved from <http://www.wrha.mb.ca>
- Winnipeg Regional Health Authority Research Immigrant & Refugee Working Group (WRHA). (2014). *Optimizing the mental health & emotional wellbeing of immigrants and refugees in Winnipeg: A conceptual framework*. Retrieved from www.immigratemanitoba.com
- Wong, Y., & Tsang, A. (2004). When Asian Immigrant women speak: From mental health to strategies of being. *American Journal of Orthopsychiatry*, 74(4), 456-466.
- Woodgate, R. L., Busolo, D. S., Crockett, M., Dean, R. A., Amaladas, M. R., & Plourde, P. J. (2017). A qualitative study on African immigrant and refugee families' experiences of accessing primary health care services in Manitoba, Canada: It's not easy! *International Journal for Equity in Health*, 16(5). doi: 10.1186/s12939-016-0510-x
- Yohani, S., & Okeke-Ihejirika, P. (2018). Pathways to help-seeking and mental health service provision for African female survivors of conflict-related sexualized gender-based violence. *Women & Therapy*, 41(3/4), 380–405. <https://doi-org.uml.idm.oclc.org/10.1080/02703149.2018.1434302>

Zilio, M. (2016, February 18). Liberals restore refugee health benefits cut by previous government. *The Globe and Mail*. Retrieved from <http://theglobeandmail.com>

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Winnipeg, Manitoba
Canada R3T 2N2
Telephone 204-474-7452
Fax 204-474-7682

Appendix B: Letter Seeking Consent from Potential Sites

To Whom It May Concern,

I, Anisa Isse, am a graduate student at the University of Manitoba conducting my Master's thesis research project as the Principal Investigator. I am sending you this letter to seek your consent and permission to post my poster, which is attached to this letter, at your site to advertise my study, titled Exploring Somali Refugee Women's Experiences Accessing Health Care Services in Canada, to potential research participants.

In this research study, I intend on conducting a qualitative study to explore the health care experiences of Somali refugee women resettled in Canada. This research project will involve recruiting and interviewing Somali refugee women, residing in Manitoba, who have arrived in Canada as government assisted refugees, privately sponsored refugees, and refugee claimants. Further information about the study such as the inclusion criteria and study requirements can be found on the attached poster.

For more information you can contact me over the phone at [REDACTED] or via email at umissea@myumanitoba.ca. You can also contact my thesis advisor and research supervisor, Dr. Lynn Scruby, over the phone at (204) 474-6659 or via email at lynn.scruby@umanitoba.ca.

Thank you for considering my request,
Anisa Isse RN BN
Master of Nursing Student
College of Nursing, Rady Faculty of Health Sciences
University of Manitoba

Appendix C: Invitational Poster

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UNIVERSITY OF MANITOBA | Rady Faculty of Health Sciences

Somali refugee women are needed for a study on their health care experiences in Canada.

To participate, participants must:

- identify as a woman
- be at least 18 years of age
- self-identify as Somali
- have migrated to Canada as a refugee (government assisted refugee, privately sponsored refugee, or refugee claimant)
- speak English
- and currently live in Manitoba

Other requirements to participate in this study include:

- Agree to participate in at least one interview that will be about 60 to 90 minutes in length.
- Be able and willing to provide information about your health care experiences in Canada.
- Be willing to meet the nurse researcher in your home (or another private place) for the interview(s).
- Allow the interview(s) to be audio taped.

If interested contact Anisa Isse, Master of Nursing Student at the University of Manitoba, Registered Nurse, and Principal Investigator, at [REDACTED]. **This research has been approved by the Education/Nursing Ethical Review Board at the University of Manitoba. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator (HEC) at 474-7122.**



Appendix D: Script for Replying to Expression of Interest

When a woman inquires information about the study, this script will be read to her by the principal investigator in English. If the principal researcher is unable to speak with the woman in conversational English, this individual will be excluded from consideration for the study.

“Hi, my name is Anisa Isse, and I am a registered nurse and a Master of Nursing student at the University of Manitoba. I am interested in learning about the health care experiences of recent Somali refugee women in Winnipeg. I am conducting a research project for my thesis in order to graduate. This research has been approved by the University of Manitoba Education/Nursing Research Ethics Board. I am looking to interview Somali women living in Winnipeg who: are at least 18 years of age; speak English; arrived as a government sponsored refugee, privately sponsored refugee, or refugee claimant, and live in Winnipeg.”

“Do you think you meet those criteria?”

“Can you tell me how you meet this criteria?” If not?

“Since you meet the criteria and are interested in participating in this study, I would like to give you some more information about my study before I ask to meet with you for a face to face interview. When we meet, I will first re-explain my study to you and ask you to sign a paper that states you understand the purpose of my study and are freely providing consent to participate. Next, I will turn on the audio recorder and start asking you specific questions about your health care experiences in Canada. During this meeting, I may also take notes about your answers to my questions. If you consent, I may contact you for a second audio recorded interview to ask follow up questions.”

“To protect your privacy and confidentiality, your name will not be on my notes, instead I will assign you a number only. I also want you to know that only my thesis advisor, a

professional transcriptionist, and if needed a professional medical interpreter, will hear your recorded voice or read all the answers you provide. When I publish or present my research findings, I will make sure to include your answers with the information all other women tell me in order to protect your anonymity. If someone reads or hears about my work, they will not be able to tell exactly which Somali women participated in my study.”

“It is believed that this study is important to help nurses and other health care professionals to understand the experiences of Somali refugee women in Canada. This study can help nurses and other health care professionals to better understand how to provide services to refugees who come to Canada. After my thesis is complete, I will present my findings at the University of Manitoba and at a couple of nursing or health conferences. Before presenting my findings publically, I can email or post mail you a brief summary of my findings. After I am finished this study, all the information that was collected during the study, including your consent form, the audio recordings, and transcripts of our conversations, will kept in a locked box for seven years and then destroyed in a confidential manner.”

“Do you have any questions about participating in this study? Do you need time to think over this information before you decide to participate? If yes, is it okay if I call you back in three days’ time? If you have any questions or are ready to book a date for the interview you can also call me back at any time. If no, what day and time would you like to meet for the interview? And where would you like to meet?”

Appendix E: Demographic Form and Interview Guide

The meeting will include the participant and myself. I will begin with introductions and a brief explanation of the purpose of the research and an overview of the study. The informed consent form will be reviewed and written informed consent will be obtained before starting the interview. The following demographic questions and interview questions will be asked.

Demographic Questions

What is your refugee status? _____

What is your age in years? _____

What was your age in years when you arrived to Canada? _____

How much formal education have you completed so far? _____

Are you currently working? Yes or No _____

What is your marital status? _____

Do you have any children? Yes or No _____

What is your religion? _____

How long did you live in Canada before getting a health card? _____

How long did you live in Canada before seeking health care services? _____

When was your most recent health care visit? _____

Do you have any health problems that you know about? Yes or No _____ If yes, please describe: _____

Interview Questions

1. What does health mean to you?
2. Can you tell me about your health today?
3. What are some health care services that you have used since moving to Canada? Can you tell me more about this?

Prompts/Probes:

- a. Have you been to a walk in clinic or quick care clinic? If yes, tell me about that experience.
- b. Have you been to an emergency room? If yes, tell me about that experience.
- c. Have you been hospitalized? If yes, tell me about that experience.
- d. Do you have a primary health care provider, for example a family doctor or nurse practitioner?
 - i. If yes, tell me about your experience getting a family doctor or nurse practitioner and your experiences receiving care with this person.
 - ii. If no, tell me what it is like not having a family doctor or nurse practitioner and how you manage your health care needs without one. Can you tell me more about this?
- e. For RCs: can you tell me about your experience with your immigration medical exam?
- f. Have you experienced filling a prescription in Canada? Can you tell me more about this?
- g. Have you gone to a dentist in Canada? Can you tell me more about this?
- h. Have you gone to an optometrist in Canada? Can you tell me more about this?

4. Can you tell me about any expectations you had about health care system in Canada before you came to this country?

Prompts/Probes:

- a. Is there anything that surprised you or made you disappointed with the health care system in Canada?
5. Can you tell me about a recent health care visit?
6. How did this recent health care visit differ from one of your first health care visits after moving to Canada?
7. What have been the biggest challenges you have experienced with the Canadian health care system? Can you tell me more about this?

Prompts/Probes:

- a. Are there things that make it more difficult for you to use health care services?
8. Is there anything that helps make it easier for you to use health care services? Can you tell me more about this?
9. If you were to give advice to a newcomer Somali refugee woman, what would you tell her about using the health care system in Winnipeg? Can you tell me more about this?
10. Can you tell me what you know about the Interim Federal Health Program and if you have used this health insurance?

After the interview is complete, I will thank each woman for participating in this study. I will debrief the data collection by reviewing what I have heard about her health care experiences in Canada. For the women that provided consent to be contacted at a later date if follow up questions arose, I will remind them that there is a chance I may need to contact them again for follow up questions. I will also reconfirm their consent for me to contact them again in the future for this purpose. For the women that do not consent to being contacted for follow up questions, I will conclude by stating that I will not be contacting them again with further questions. I will also review whether each woman would like to receive a summary of the research findings, once I have completed my thesis, and that the summary can be requested on the informed consent sheet.



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Appendix F: Letter of Research Study Information and Consent Form

Research Project Title

Exploring Somali Refugee Women's Experiences Accessing Health Care Services in Canada

Principal Investigator

Anisa Isse

umissea@myumanitoba.ca

Research Supervisor

Dr. Lynn Scruby

(204) 474-6659

lynn.scruby@umanitoba.ca

Sponsors

Funding was received in the form of awards from the following: Dr. Margaret R. Francis Award, Women's Health Research Foundation of Canada Part-Time Graduate Scholarship, and the Manitoba Centre for Nursing and Health Research Graduate Student Research Grant.

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of Study

The purpose of this study is to learn about the health care experiences of Somali refugee women residing in Winnipeg who arrived to Canada as government assisted refugees (GARs), privately sponsored refugees (PSRs), and refugee claimants (RCs).

Study Procedure

If you choose to participate in this study, Anisa Isse, Master of Nursing Student at the University of Manitoba and Principal Investigator, will meet with you once to ask you questions about your health care experiences in an audio recorded interview that may last 60 to 90 minutes. Anisa Isse will also record field notes immediately after the interview to document her experience conducting the interview. Anisa Isse will then send your audio recorded interview to a professional transcriptionist who will create a transcript of the interview. Although it is expected

that you only speak in English during the interview, if you end up using any Somali words during the interview, a PHIA certified Somali-English medical interpreter will be consulted to translate that portion of audio from Somali to English or back translate from English to Somali as needed. Only if you are willing to have Anisa Isse contact you again later, to ask follow up questions, will there be a chance that Anisa Isse may ask to meet with you once again for an audio recorded interview which may last up to 60 minutes. Also, Anisa Isse will send you a summary of the research findings by e-mail or post mail if you request one on the consent form. The total of your time involved in this study can range from one hour to two and a half hours.

Description of the Recording Device

This study will use a Digital Voice Recorder.

Benefits

By participating in this study, you can help health care providers better understand the health care experiences of Somali refugee women in Winnipeg. This can assist health care providers to deliver better care to refugees. You will also have the opportunity to share and reflect about your experiences with a nursing graduate student.

Possible Risks

Participating in this study is thought to have minimal risk. You do not have to share anything in the interview that you do not want to share. Anisa Isse will provide you with a list of health care and settlement organizations which you can seek any needed health care, counseling, information, or services from. (The list of resources is attached to the thesis proposal as Appendix D: Helping Resources.)

Confidentiality

Anisa Isse will maintain your confidentiality throughout the study. Anisa Isse will be the only person to know you participated in the study, unless you decide to share your participation with others. To protect your confidentiality, Anisa Isse will assign your interview a code number and code name to avoid including your name with your demographic information and interview transcript. Any document with your name, such as the consent forms will be kept secure in a locked box in Anisa Isse's home for a period of seven years after the study is completed. The remainder of the original hard copies and electronic copies of study documents will be kept in a separate locked box in Anisa Isse's home, also for a period of seven years. All of the saved material will be destroyed according to the University of Manitoba's policy about destruction of confidential material in May 2024. All hard copy material will be destroyed by shredding the paper.

Electronic, de-identified data will be stored on a University of Manitoba computer and Anisa Isse's laptop until the study is complete. Both will have firewalls to secure all information, and allow access to Anisa Isse only by authorized, password-protected user accounts and password-protected files. This will ensure all study information remains confidential and secure.

Information from this study may be published or presented at conferences or seminars, however your name and other identifying information will never be used or revealed. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed.

Anisa Isse and the transcriptionist will both have access your audio recorded interviews as well as the transcripts. Dr. Lynn Scruby may also listen to the audio recordings and read the transcripts as needed in her role as the Research Supervisor.

Cost for participation

There will be no added cost to you for taking part in this study.

Honorarium for participation

Anisa Isse will give you a \$25 gift card to The Real Canadian Superstore to thank you for your participation before she interviews you. If you consent to further contact for follow up questions and Anisa Isse contacts you for a second interview, she will provide you with another \$25 gift card to The Real Canadian Superstore to thank you for your participation again before she interviews you.

Voluntary Withdrawal from the Study

Your participation in this study is voluntary. You may withdraw your participation at any time before, during, and after the interview without any negative consequences. Your decision to withdraw from the study will not affect you in any way. You do not need to provide any reasons for withdrawing from the study. To withdraw from the study please contact the above named persons (Anisa Isse – Principal Investigator or Dr. Lynn Scruby – Research Supervisor). If you withdraw from the study before or during the interview, any data collected from you will not be included in the study and you will not be contacted by the researcher for a follow up interview. If you withdraw from the study within two weeks of the interview, the data collected from you will not be included in the study and the researcher will not contact you for a follow up interview. If you withdraw from the study 15 days after the interview is conducted, there may be a chance that your data was already anonymized, analyzed, and mixed in with the findings of interviews with other women and thus, there is no guarantee that any data collected from you will not be included in the study. However, if you withdraw from the study 15 days after the interview, the Principal Investigator will not contact you for a follow up interview.

Debriefing

Anisa Isse will debrief with you immediately after the interview is completed by reviewing what she has heard from you about your health care experiences.

Dissemination

The data collected from the women who participate in this study will be analyzed together and a brief one to three page summary of the results will be shared by email or post mail by December 2017, before the findings are shared publically. The results will then be published in peer-reviewed journals, and presented at conferences or in academic or health care settings so others can learn from this study.

Questions

You are free to ask any questions that you may have about your interview and your rights as a research participant. If any questions come up during or after the study, you can contact the above-named persons (Anisa Isse – Principal Investigator or Dr. Lynn Scruby – Research

Supervisor). Please do not sign this consent form unless you have had a chance to ask questions and have received satisfactory responses to all of your questions.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from documenting your reflections or you may prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the University of Manitoba Education/Nursing Research Ethics Board. If you have any concerns or complaints about this project, you may contact any of the above-named persons (Anisa Isse – Master of Nursing Student at the University of Manitoba and Principal Investigator at [REDACTED] or umissea@myumanitoba.ca or Dr. Lynn Scruby – Research Supervisor at (204) 474-6659 or lynn.scruby@umanitoba.ca) or the Human Ethics Coordinator (HEC) at 204-474-7122. A copy of this consent form has been given to you to keep for your records and reference.

Participant’s signature _____ Date _____

Researcher’s signature _____ Date _____

I agree to being contacted for a second interview if required.

yes or no

I am requesting a summary of the findings and any publications that come out of this research to be sent to me by e-mail or post mail approximately by December 2017.

Preferred contact information: _____

Appendix G: Ethics Protocol Approval Letters



TO: Anisa Isse
Principal Investigator

FROM: Todd Duhamel, Vice Chair
Education/Nursing Research Ethics Board (ENREB)

Re: Protocol #E2017:066 (HS20994)
"Exploring Somali Refugee Women's Experiences Accessing Health Care Services in Canada"

(Advisor: Lynn Scruby)

Effective: August 16, 2017

Expiry: August 16, 2018

Education/Nursing Research Ethics Board (ENREB) has reviewed and approved the above research. ENREB is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*.

This approval is subject to the following conditions:

1. Approval is granted only for the research and purposes described in the application.
2. Any modification to the research must be submitted to ENREB for approval before implementation.
3. Any deviations to the research or adverse events must be submitted to ENREB as soon as possible.
4. This approval is valid for one year only and a Renewal Request must be submitted and approved by the above expiry date.
5. A Study Closure form must be submitted to ENREB when the research is complete or terminated.
6. The University of Manitoba may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba *Ethics of Research Involving Humans*.

Funded Protocols:

- Please mail/e-mail a copy of this Approval, identifying the related UM Project Number, to the Research Grants Officer in ORS.



Human Ethics
 208-194 Dafoe Road
 Winnipeg, MB
 Canada R3T 2N2
 Phone +204-474-7122
 Email: humanethics@umanitoba.ca

AMENDMENT APPROVAL

September 13, 2018

TO: Anisa Isse (Advisor: Lynn Scruby)
 Principal Investigator

FROM: Joseph Gordon, Chair
 Education/Nursing Research Ethics Board (ENREB)

Re: Protocol #E2017:066 (HS20994)
 Exploring Somali Refugee Women's Experiences
 Accessing Health Care Services in Canada

Education/Nursing Research Ethics Board (ENREB) has reviewed and approved your Amendment Request received on **September 12, 2018** to the above-noted protocol. ENREB is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*.

This approval is subject to the following conditions:

1. Approval is given for this amendment only. Any further changes to the protocol must be reported to the Human Ethics Coordinator in advance of implementation.
2. Any deviations to the research or adverse events must be submitted to ENREB as soon as possible.
3. Amendment Approvals do not change the protocol expiry date. Please refer to the original Protocol Approval or subsequent Renewal Approvals for the protocol expiry date.