

Exploring Mental Healthcare Needs and Challenges of Syrian Refugee Women in Winnipeg

by

Sanjida Newaz

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## Abstract

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### **Background:**

The UN Refugee Agency reports that 70.8 million people have been forcibly displaced at the end of 2018. Canada has a long history of accepting refugees and is the second largest resettlement country in the world. Approximately 700,000 refugees have resettled in Canada since 1959, with 2016 being a record year of welcoming 58,437 refugees. While refugees arrive to safety and protection in Canada, language, socio-economic barriers, and cultural differences contribute to struggles. Refugees have higher risk of developing mental illness like anxiety, depression and Post-Traumatic-Stress-Disorder as they flee from violence. The effects of war, family separation, displacement and long travel may pose more stresses on women, particularly when overlapping with pregnancy, childbirth, and caring for children. Adjusting to new life in Canada also becomes challenging for refugee women who have been separated from their spouse and need to take on new roles such as decision making, economic responsibilities, and accessing services. Therefore, the mental wellbeing of this vulnerable group needs to be assessed and monitored. Considering the recent influx of refugees, particularly from Syria, it is important to understand how Manitoba is addressing the mental health needs of Syrian refugee women.

### **Objectives:**

The objectives of this study were to 1) conduct a literature review on the mental healthcare needs and barriers in accessing services by refugee women in the Canadian context; 2) explore the perspectives of Syrian Refugee women on how they experience mental health and the healthcare system in Winnipeg; 3) explore the perspectives of service providers and decision-makers on how refugee women experience mental health and access healthcare services in Winnipeg; and 4) provide policy recommendations to improve mental healthcare services in

Manitoba based on the research findings.

### **Methods:**

Semi-structured interviews were conducted with Syrian refugee women and service providers/decision makers in Winnipeg. Interviews with refugee women focused on their lived experience and service accessibility issues. Interviews with decision makers focused on policy measures, exploring options for community-based and culturally appropriate healthcare. The data were analyzed using qualitative thematic analysis and coded for themes based on recurring issues aided by NVivo 12 qualitative software. The findings presented in two broad subject areas – (1) barriers in accessing mental healthcare services and (2) strategies to improve mental healthcare services for refugee women in Winnipeg.

### **Results and Conclusions:**

Both the service providers and refugee women provided their perspective on the existing challenges and what options can be considered for service improvements. Most cited barriers in accessing mental healthcare services by refugee women were language, weather, employment and income level, stigma and system navigation. The service providers mentioned stigma, and lack of resources to provide culturally competent care. Collaboration among agencies, leadership at all levels, and education for both refugee women and service providers were also mentioned. The refugee women were concerned about their financial struggles and were hopeful that employment for them or their spouse could improve their mental wellbeing. This study recommends that service providers use guidelines developed by UNHCR in providing culturally competent care, decision makers take leadership roles in implementing better collaboration among agencies, the employers be open in hiring refugees, and educational initiatives for the broader society to ensure that refugees feel welcomed and included.

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To my placement supervisors Lori Ulrich, Director, Crisis Response Center, WRHA and Dr. Natasha Howard, Assistant Professor, Department of Global Health and Development at the

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Finally, to my husband Shifullah Khaled for your patience, understanding, support and inspiration. I owe indefinitely to you Dear!

## **Dedication**

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*To All Refugees Around the World Who are Running for their Lives*

*I Pray for Your Safety*

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## **List of Abbreviations**

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CAMH	Centre for Addiction and Mental Health
CCR	Canadian Council for Refugees
CMHA	Canadian Mental Health Association
FRC	Family Rehabilitation Center
GSRs	Government Sponsored Refugees
IFHP	Interim Federal Health Program
IRCC	Immigration, Refugees and Citizenship Canada
MHCC	Mental Health Commission of Canada
MIIC	Manitoba Interfaith Immigration Council (Welcome Place)
MHSAL	Manitoba Health, Seniors and Active Living
PSRs	Privately Sponsored Refugees
PTSD	Post Traumatic Stress Disorder
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization
WRHA	Winnipeg Regional Health Authority
IRCC	Immigration, Refugees and Citizenship Canada
IRCOM	The Immigrant and Refugee Community Organization of Manitoba Inc.

## Chapter 1. Introduction

---

The number of people being displaced worldwide is currently at a record level. The United Nations (UN) Refugee Agency (UNHCR) estimates that 70.8 million people have been forcibly displaced at the end of 2018 as a result of persecution, conflict, violence or human rights violations (UNHCR, 2019). This is an increase of 2.3 million people over the previous year and 27.5 million since 2009. One person every two seconds is driven from their home and one in every 108 people globally is either an asylum-seeker, internally displaced, or a refugee (UNHCR, 2019).

The Civil war in Syria has disproportionately contributed to the refugee crisis recently. In 2018, the increase was driven particularly by internal displacement in Ethiopia and asylum-seekers fleeing Venezuela. However, at the end of 2018, Syrians still made up the largest proportion of forcibly displaced population, with 13.0 million people living in displacement, followed by Colombia (8.0 million), Democratic Republic of Congo (5.4 million), Afghanistan (5.1 million), South Sudan (4.2 million), Somalia (3.7 million), Ethiopia (2.8 million), Sudan (2.7 million), Nigeria (2.5 million), Iraq (2.4 million) and Yemen (2.2 million). Among the 70.8 million forcibly displaced people, 25.9 million are refugees, 3.5 million are asylum-seekers and 41.3 million are internally displaced people. Over two thirds of the world's refugees come from just five countries: Syria, Afghanistan, South Sudan, Myanmar and Somalia. According to UNHCR, "Women and girls make up 50 percent of any refugee, internally displaced, or stateless population" (UNHCR, 2018).

Canada has a long history of accepting refugees and is the second largest resettlement country in the world after the United States (UNHCR, 2016). Canada has resettled more than 700,000 refugees since 1959 with a record acceptance of 58,437 in 2016 (IRCC, 2017a; UNHCR

Canada, 2017). According to the UNHCR's annual global trends report, Canada took in 28,100 of the 92,400 refugees who were resettled in 25 countries during 2018, more than any other country in the world (UNHCR, 2019).

The mental healthcare of refugees remains a prime challenge as many have fled from war with traumatic experiences. The long term mental health problems of refugees fleeing from war are not limited to post traumatic stress disorder (PTSD), but also include prolonged grief, depression, substance-related disorders, explosive anger, and psychotic disorders (Bogic, Njoku, & Priebe, 2015). With the increasing duration of residency in Canada, the health status of the refugee population may further decline (Newbold, 2009). Research shows that newly arrived immigrants and refugees underutilize community resources and healthcare services compared to the general population (McKeary & Newbold, 2010).

Women refugees may have unique mental healthcare needs due to their vulnerability to gender-based violence and abuse during flight from war (Delara, 2010; Donnelly et al., 2011; Thomson, Chaze, George, & Guruge, 2015; Vasilevska, 2010). The effects of war, family separation, displacement and long travel may pose additional stresses on women, particularly when coinciding with pregnancy, childbirth, and caring for children (Cho, 2012; Donnelly et al., 2011; Sherzoi, 2017; Thomson et al., 2015). Adjusting to new life in Canada may become additionally challenging for refugee women who have been separated from their spouse and need to take on new roles such as decision making, economic responsibilities, and accessing services (Cho, 2012; Donnelly et al., 2011; Thomson et al., 2015). Moreover, social causes of mental illness – often referred to as social determinants such as gender (roles and identities), age, unemployment and income insecurity, substandard living arrangements, intergenerational struggles, isolation, racism, and discrimination can make the integration process challenging and

further affect the mental health condition of refugee women (McKeary & Newbold, 2010; Sherzoi, 2017; Sullivan, 2009). Barriers related to language, socio-economic status, religious beliefs, and reluctance to disclose mental illness, among others, may limit their access to healthcare (Asaam, 2015; Edge & Newbold, 2013; McKeary & Newbold, 2010; Saberpor, 2016; Sherzoi, 2017; Woodgate et al., 2017; WRHA, 2014). Women refugees may be disproportionately challenged by social exclusion and isolation as compared to men as they are less likely to speak the language of the new country and be employed outside home (Cho, 2012; Sullivan, 2009). They may not actively seek help and potentially put themselves and their children at risk of developing long term mental illness. Therefore, the mental wellbeing of this vulnerable group needs to be assessed and monitored.

Manitoba resettled record 3,730 refugees in 2016 (IRCC, 2017a). Considering the recent influx of refugees, it is important to understand how Manitoba is addressing the mental health needs of refugee women. In recent years, the healthcare services in Manitoba are experiencing major funding decreases and policy reforms, which may bring changes to how the mental healthcare services are offered in the province (Government of Manitoba, 2017a, 2017b; Kavanagh & Marcoux, 2017). While the mental healthcare needs for refugees, especially refugee women are significant, there is a lack of detailed research into the mental healthcare needs and access to services for refugee women in Manitoba and Canada. Reliable information on the shortfalls in the mental healthcare services is required to make important policy decisions and implement changes. The major research gaps in the subject area are summarized below:

- Very little mental health research specific to refugees in Canada is available, particularly refugee women. Most studies focus on immigrants which includes refugees. However, there is a clear distinction between the two groups – Immigrants are people who choose

to come to live permanently in a foreign country whereas refugees are forced to flee their country of origin to seek safety in another country. Therefore, the mental healthcare needs can not be generalized for all immigrants and refugees, especially when considering past lived experience.

- A study focused on mental healthcare needs of refugee women in Winnipeg or Manitoba does not exist. Importantly, health services are provincially and regionally managed.
- Although studies conducted in Winnipeg found evidence of mental health issues in many refugees and the challenges they face while accessing mental healthcare services (Asaam, 2015; Sherzoi, 2017; Woodgate et al., 2017), service providers and decision makers were not included to examine their perspectives on refugee mental healthcare issues.

## **1.1 Research Purpose & Objectives**

Considering the recent influx of Syrian refugees, it is important to understand how current healthcare services are meeting the gender specific mental health concerns and needs of Syrian refugee women living in Winnipeg.

The objectives of this study are:

- 1) To conduct a literature review on the mental healthcare needs and barriers in accessing services by refugee women in the Canadian context;
- 2) To explore the perspectives of Syrian Refugee women of how they experience mental health and the healthcare system in Winnipeg;
- 3) To explore the perspectives of service providers and decision-makers on how refugee women experience mental health and access healthcare services in Winnipeg; and



- 4) To provide policy recommendations to improve mental healthcare services in Manitoba based on the research findings.

In addition, presenting findings from the European response to the mental healthcare needs of insecure status women and applicable lessons learned for Canada constitutes another objective of this study. A short-term research internship conducted by the author at the London School of Hygiene and Tropical Medicine (UK) with funding from Mitacs Canada and University of Manitoba through Queen Elizabeth Diamond Jubilee Scholarship, is presented as Appendix E in this thesis.

## **1.2 Importance of Study**

According to 2013 – 2017 data from IRCC, Manitoba accepts the highest number of refugees among all Canadian provinces relative to provincial population. The percentage of visible minority group has increased by 7% in 10 years and now stands at 17% of the total population in the province (Manitoba Bureau of Statistics, 2016). Manitoba will see an increase in ethnocultural diversity, and the ratio will jump from just under 16% in 2011 to 22 or 32% in the next 20 to 25 years, according to Statistics Canada (CBC News, 2017). Manitoba also has the highest proportion of Indigenous people among all Canadian provinces and experience a disproportionately burden of depression, alcoholism, suicide, violence and other mental health issues (Boksa, Joober, & Kirmayer, 2015; Bond & Spence, 2017; Kirmayer, Brass, & Tait, 2000). Therefore, the Manitoba government has turned its focus towards mental healthcare. The provincial priority includes redesign of community care to support continuity of care and reduced health system utilization as well as performance management (efficiency and effectiveness) of policies (Doupe, 2017).

As refugees arrive to safety and protection in Canada, the story does not end there since

new challenges begin during their settlement and integration process (Awuah-mensah, 2016). Moreover, social causes of mental illness, often referred to social determinants such as gender (roles and identities), age, unemployment and income insecurity, substandard living places, intergenerational struggles, isolation, racism, and discrimination, can make the integration process very difficult and further affect the mental health condition of the refugees (McKeary & Newbold, 2010; Sherzoi, 2017; Sullivan, 2009). Language, cultural, socio-economic status, reluctance to disclose mental illness, religious and many other barriers may further limit their access to health care (Asaam, 2015; Edge & Newbold, 2013; McKeary & Newbold, 2010; Saberpor, 2016; Sherzoi, 2017; Woodgate et al., 2017; WRHA, 2014). While the number of refugees continues to increase in Manitoba, providing the much-needed mental healthcare support to the refugees while also addressing issues of addiction and substances abuse, particularly among the Indigenous population, remains a very challenging task for the Provincial Government.

The Government of Manitoba announced some major health care policy reforms in 2017 to streamline and concentrate resources based on the findings of Dr. David Peachey and KPMG LLP reports (Government of Manitoba, 2017b). Mental health care services have been shifted from 5 major sites to 3 sites. The government also instructed WRHA to shrink spending by \$83 million in 2017-18 budget year (Kavanagh & Marcoux, 2017). These major health care service reforms and funding cuts may impact how refugees in the province access mental health care services. Consolidating health care services can be problematic for the refugees who live outside of Manitoba's urban centre, Winnipeg. A study by the Rural Development Institute at the Brandon University examined the challenges of resettling refugees in rural communities (Cronkrite, Galatsanou, & Ashton, 2016). These small communities have limited resources and

experience with war-trauma or even working with an interpreter. Particularly, there are challenges is designing and organizing programs for refugees.

It is important that policy makers understand with other priorities and budget cuts the mental healthcare services for refugees are not being compromised. The proposed research will bring the voices of refugee women to the attention of policymakers, as to the kinds of services they need, the services available to them, and the ways they now access services. Results from this study may be used to identify existing gaps in services and inform ongoing development of services and support for refugees. The study will also provide important policy recommendations by reviewing the literature and examples from elsewhere in Canada, as well as Europe.

## **Chapter 2. Background and Literature Review**

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### **2.1 Refugee Migration**

UNHCR refers to refugees as people fleeing conflict and persecution. Refugees need protection from political or other forms of persecution after being forcibly displaced. The internationally recognized legal definition of refugees was set out in the United Nations Convention Relating to the Status of Refugees (the 1951 Geneva Convention) (UNHCR, 1992).

The definition of a refugee, as laid out in Section 1(A) of the convention, is:

*"A person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it."*

Often the terms “immigrant” and “refugee” are coupled but there is an important distinction between these two categories (WRHA, 2014). Immigrants are people who choose to come to live permanently in a foreign country whereas refugees are forced to flee their country of origin to seek safety in another country. This study is focused on refugees only. While planning healthcare services, these differences in migration experience should be considered. Many refugees may not have had any intention to leave their country of origin – they were forced to do so. Under the Immigration and Refugee Protection Act, Canada offers refugee protection to persons who are displaced, face prosecution in their home country or the country where they live or would face prosecution if they return to that country.

#### **2.1.1 Global Perspective**

At present we live in a world where nearly one person is forcibly displaced every two seconds as a result of conflict or persecution (UNHCR 2019). According to the 2018 UNHCR Global Trends report, the global population of forcibly displaced people grew substantially from

43.3 million in 2009 to 70.8 million in 2018. The rate of the world’s forcibly displaced population has outstripped global population growth. While the Syrian conflict has mostly contributed to this large number of displaced populations, a break in peace in South Sudan and conflicts in the Middle East – Iraq, Yemen as well as parts of sub-Saharan Africa such as the Democratic Republic of the Congo (DRC), resulted in millions of people having to flee for their lives. In 2017, over 610,000 Rohingya refugees have fled to Bangladesh escaping violence in Myanmar (UNHCR, 2017c).

The 2018 UNHCR report estimates that 13.6 million people were newly displaced, among which 10.8 million are internally displaced people (IDPs) and 2.8 million sought protection abroad (as new asylum-seekers or newly registered refugees). The 2018 rise in forced displacement was mainly due to internal displacement in Ethiopia and new asylum claims from people fleeing Venezuela. The following table summarizes the statistics presented in the UNHCR report:

**Table 2-1 : UNHCR Statistics on Worldwide Displaced Population**

<b>Overall situation at the end of 2018</b>	
<ul style="list-style-type: none"> <li>● <b>70.8 million forcibly displaced people worldwide</b></li> </ul>	<ul style="list-style-type: none"> <li>● 41.3 million internally displaced people</li> <li>● 3.5 million asylum-seekers</li> <li>● 25.9 million refugees</li> </ul>
<p><b>1 out of every 108 people is displaced</b></p>	<ul style="list-style-type: none"> <li>○ 20.4 million refugees under UNHCR’s mandate</li> <li>○ 5.5 million Palestine refugees under UNRWA’s mandate</li> </ul>
<p><b>Countries from where most displaced people are:</b></p> <ul style="list-style-type: none"> <li>● <b>Syria (13.0 million)</b></li> <li>● <b>Colombia (8.0 million)</b></li> <li>● <b>Democratic Republic of the Congo (5.4 million)</b></li> <li>● <b>Afghanistan (5.1 million),</b></li> </ul>	<p>67 % of all refugees worldwide came from just five countries:</p> <ul style="list-style-type: none"> <li>● Syria (6.7 million)</li> <li>● Afghanistan (2.7 million)</li> <li>● South Sudan (2.3 million)</li> <li>● Myanmar (1.1 million)</li> <li>● Somalia (0.9 million)</li> </ul>

- **South Sudan (4.2 million),**
- **Somalia (3.7 million),**
- **Ethiopia (2.8 million),**
- **Sudan (2.7 million),**
- **Nigeria (2.5 million),**
- **Iraq (2.4 million) and**
- **Yemen (2.2 million).**

The top 5 refugee host countries are:

- Turkey (3.7 million)
- Pakistan (1.4 million)
- Uganda (1.2 million)
- Sudan (1.1 million)
- Germany (1.1 million)

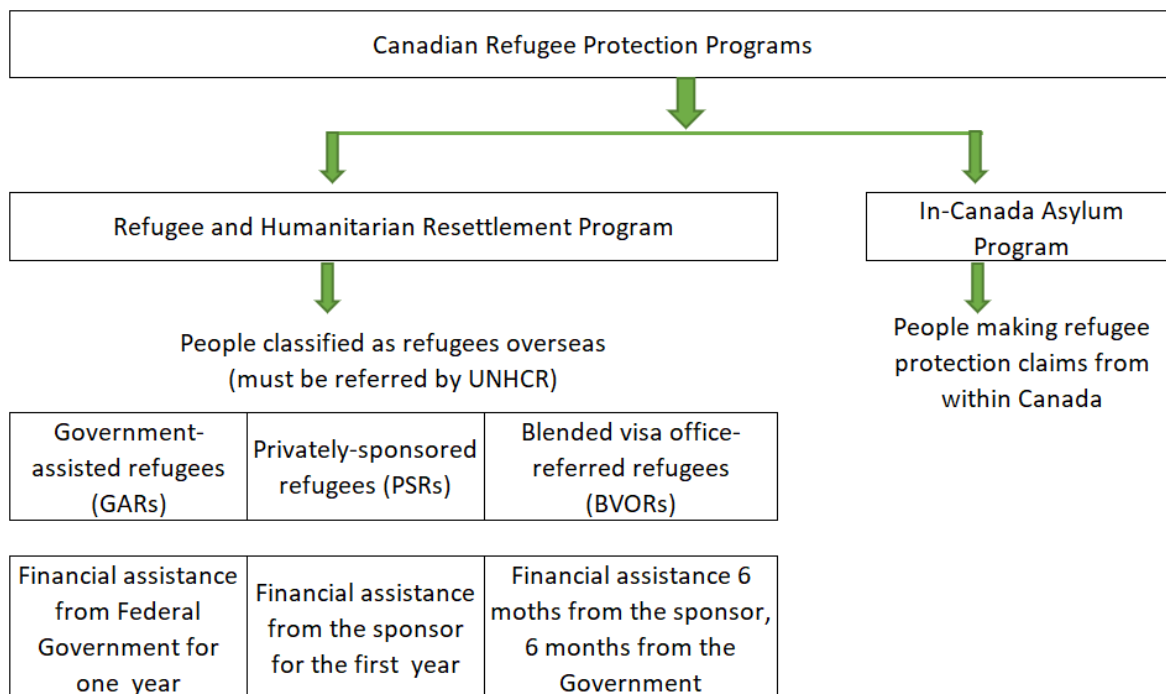
**In 2018**

- **13.6 million newly displaced**
- 10.8 million newly internally displaced
- 2.8 million new refugees and new asylum-seekers

Children below 18 years of age constituted about half of the refugee population in 2018.

**2.1.2 Refugee Resettlement Procedure in Canada**

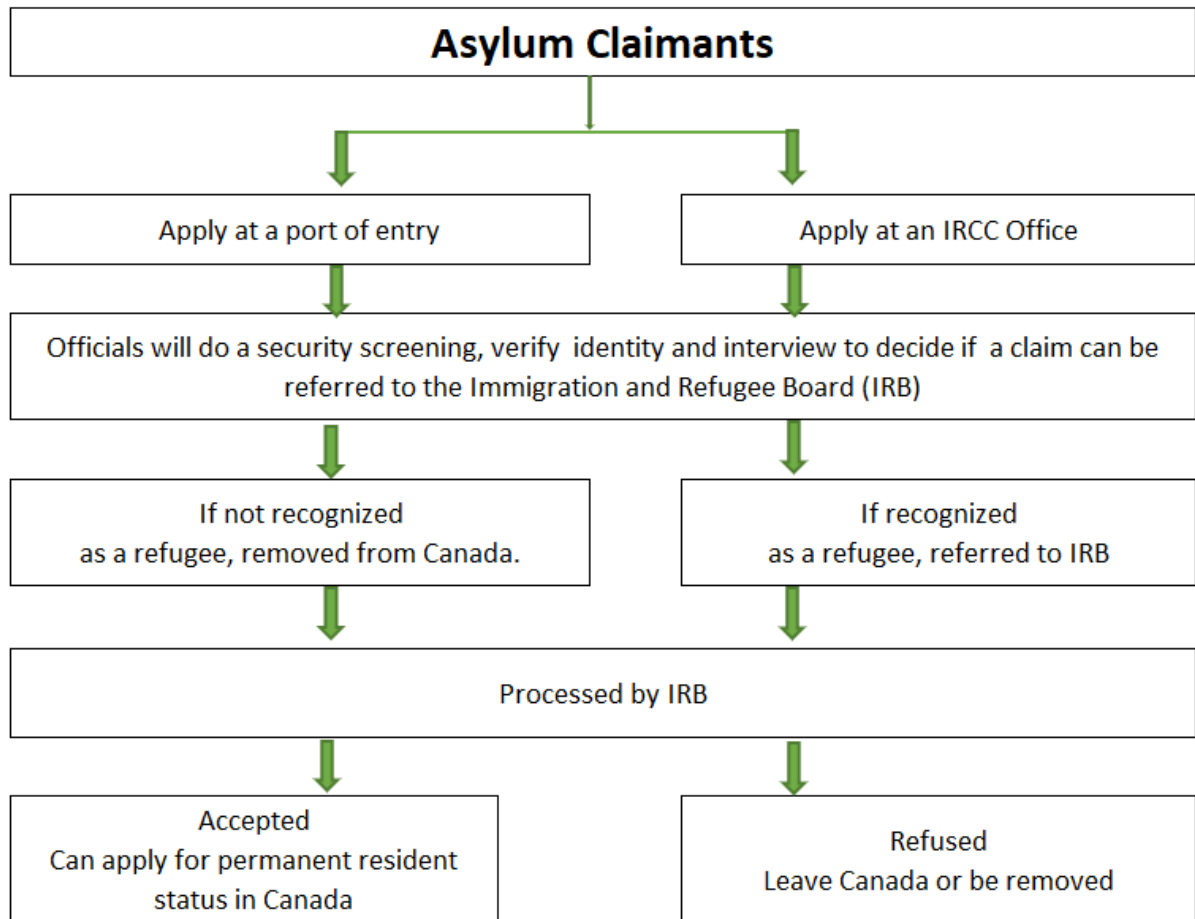
This section provides a description of Canada’s refugee resettlement program based on the information derived from Immigration, Refugees and Citizenship Canada (IRCC) website (IRCC, 2018a, 2019b). The program has two main parts as presented in Figure 1:



**Figure 2-1: IRCC’s Refugee Resettlement Program Overview**

- 1) Refugee and Humanitarian Resettlement Program (RHRP)– This program is for people who need protection outside Canada. Most refugees in Canada arrive through this program by applying from outside for permanent resident status as refugees. A person must be referred either by the UNHCR or by a private sponsorship group to come to Canada as refugee. After refugees are referred, Canadian Visa Officers screen them for potential medical, criminal and security concerns, and assess whether they are in need of resettlement (UNHCR Canada, 2019). Upon arrival, resettled refugees become Canadian permanent residents.
- 2) In-Canada Asylum Program (ICAP) – This program is for people making refugee protection claims from within Canada. Under this program a person can apply for refugee status either at a port of entry or at an IRCC office. Two divisions of the Immigration and Refugee Board (IRB) namely, Refugee Protection Division and Refugee Appeal Division make the decisions on refugee claims. For a legitimate concern that there was an error in the application of law by IRB, the Federal Court has the final say. Figure 2-2 provides a simplified overview of the details of the asylum claimants program in Canada based on the information available at the IRCC website. A detailed flow diagram of the program is available at the UNHCR Canada’s website (UNHCR Canada, 2019).

Under RHRP there are three pathways that offers resettlement of refugees through permanent resident status: Government-Assisted Refugee Program (GAR), Private Sponsorship of Refugee Program (PSR) and Blended Visa-Office Referred Program (BVOR). The Federal government is the sponsor for all GARs destined to all provinces and territories except Quebec. The Quebec government is responsible for the GARs destined to



**Figure 2-2 : Asylum Claimants Program Overview**  
(Source: IRCC)

that province. GARs receive initial resettlement support from the Government of Canada or the Province of Quebec. The private sponsors provide financial, social and emotional, housing, food, clothing and all other necessary support to the refugees they sponsor. Many of these sponsors represent Canadian citizens and permanent residents, cultural, humanitarian or faith-based organizations, community associations, or groups of five or more individuals and other settlement organizations. The support for both GARs and PSRs is available up to one year from the date of arrival in Canada or until the refugees can support themselves, whichever happens first. BVOR program is a combination of the first two programs. Refugees under BVOR program receive six months of assistance from the government and another six months from private



sponsors. In 2018, settlement programs used by IRCC was 67% PSRs, 29% GARs and 4% BVORs (UNHCR Canada, 2019).

More detailed descriptions about each program are available at the Refugee Sponsorship Training Program website (<http://www.rstp.ca/en/about-the-rstp/>), as well as Government of Canada's website (IRCC, 2019b). According to Canada's Immigration Plan for 2019–2021, the Government aims to welcome between 138,000 to 184,500 immigrants in the Refugees, Protected Persons, Humanitarian and Other category, of which 59,000 will be privately sponsored refugees and 30,700 will be government sponsored refugees (IRCC, 2019a). “Canada's Refugee Strategy – How It Can Be Improved” and “Evaluation of the Resettlement Programs (GAR, PSR, BVOR and RAP)” are two comprehensive reports on Canada's refugee sponsorship programs published by the University of Calgary School of Public Policy and IRCC respectively (IRCC, 2016; Vineberg, 2018). As far as the PSRs are concerned, it is a valid assumption that close relatives of refugees are also at risk in the most refugee-generating countries (Vineberg, 2018). Moreover, it is common knowledge that the presence of close relatives helps with the settlement process. According to the above-mentioned reports, budget allocations for the Resettlement Assistance Program (RAP) are insufficient for the current numbers of GARs and the increasing settlement challenges they face. On the other hand, the PSR program is very cost effective and by involving Canadians personally, helps maintain high levels of support for Canada's refugee programs (Vineberg, 2018). This program needs to be adequately resourced and supported.

While Government plans indicate that there will be more PSRs than GSRs in the coming years (overseas refugees only, not in-Canada asylum seekers), researchers have identified some gaps and areas of concern. Despite the PSR program being supported by positive public

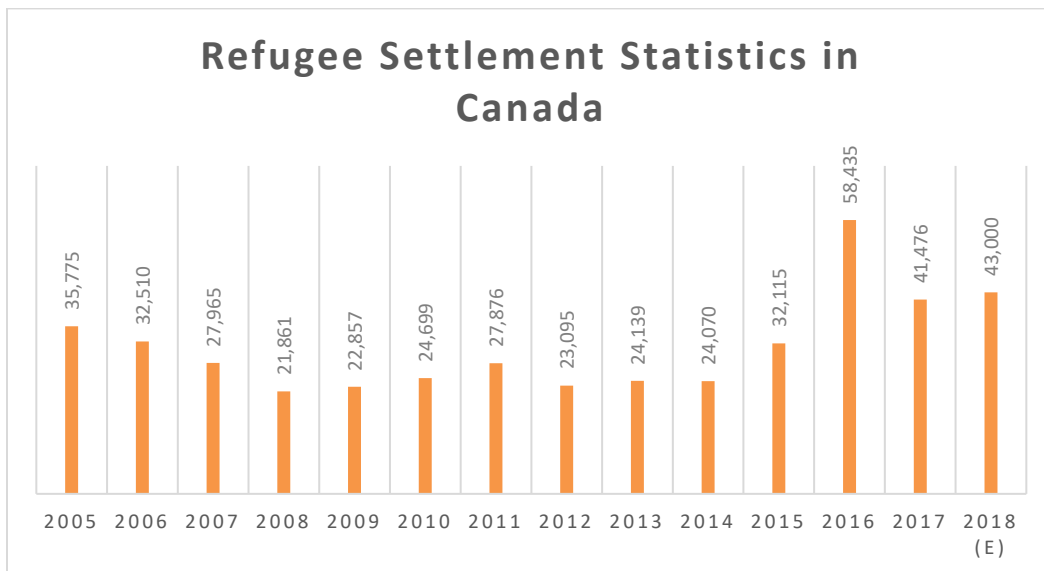
opinions, some have outlined negative impacts of policy changes that will increase PSR processing (Hyndman, Payne, & Jimenez, 2016; Labman, 2016). They have cautioned that civil society's involvement cannot be considered as substitution of the government's international obligations towards refugees or the privatization of costs. Private sponsorship was meant to be additional to government-assisted resettlement commitments, hence is supposed to be complementarity, not an alternative (Labman, 2016). However, over-reliance and dependence of the government on private sponsors to fulfil its international obligations can put this process at risk (Labman, 2016). A greater number of PSRs than GSRs can raise questions as to whether private sponsorship is beginning to privatize refugee resettlement in Canada (Hyndman et al., 2016). While the special circumstances of the Syrian Refugee Initiative must be considered, PSRs outnumbering GSRs were considered somewhat alarming by the researchers (Labman, 2016) and goes against the principle of additionality (Hyndman et al., 2016). However, there is a need for additional research regarding the private sponsorship of refugees and the policy implications, as it relates to health.

### **2.1.3 Refugee Resettlement Statistics in Canada and Manitoba**

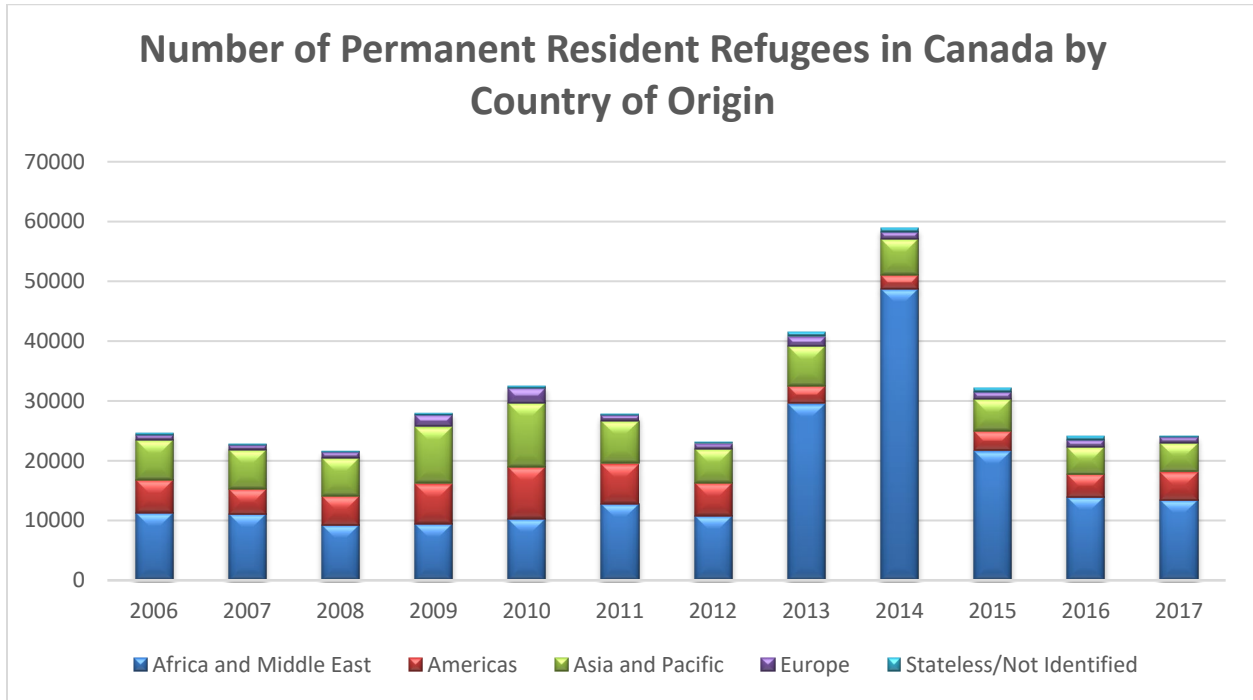
Canada accepted an average of 26,000 refugees annually in between 2006 to 2015, as shown in Figure 2-3. The Government responded to the humanitarian crisis in Syria by welcoming 25,000 refugees between November 4, 2015 and February 29, 2016 (IRCC, 2017b). Canada continued its commitment in resettling Syrian refugees in 2017 and has welcomed a total of 40,081 refugees as of January 29, 2017 (IRCC, 2017b). All together 2016 was a record year with welcoming 58,437 refugees (IRCC, 2017a).

The source countries of refugees to Canada usually varies. However, in recent years the majority of refugees to Canada came from the Middle East and Africa. Figure 2-4 shows the

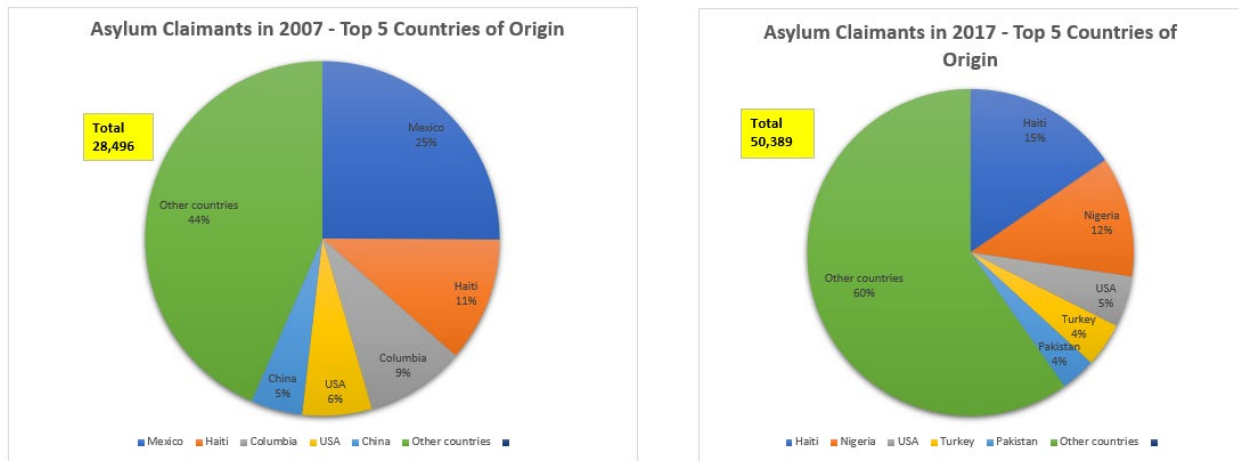
number of permanent refugees in Canada by origin area in between 2006 to 2015 (IRCC, 2017a; Statista, 2019). The number and source countries of asylum claimants in Canada have fluctuated over time, as shown in Figure 2-5. The number tripled since 2015, increasing from about 16,000 in 2015 to over 50,000 in 2017 (Statistics Canada, 2019). Figure 2-6 shows the top 10 countries of origin where asylum claimants were from in 2017. Asylum claims by irregular migrants (individuals entering Canada between ports of entry) as well as by those entering Canada regularly are on the rise.



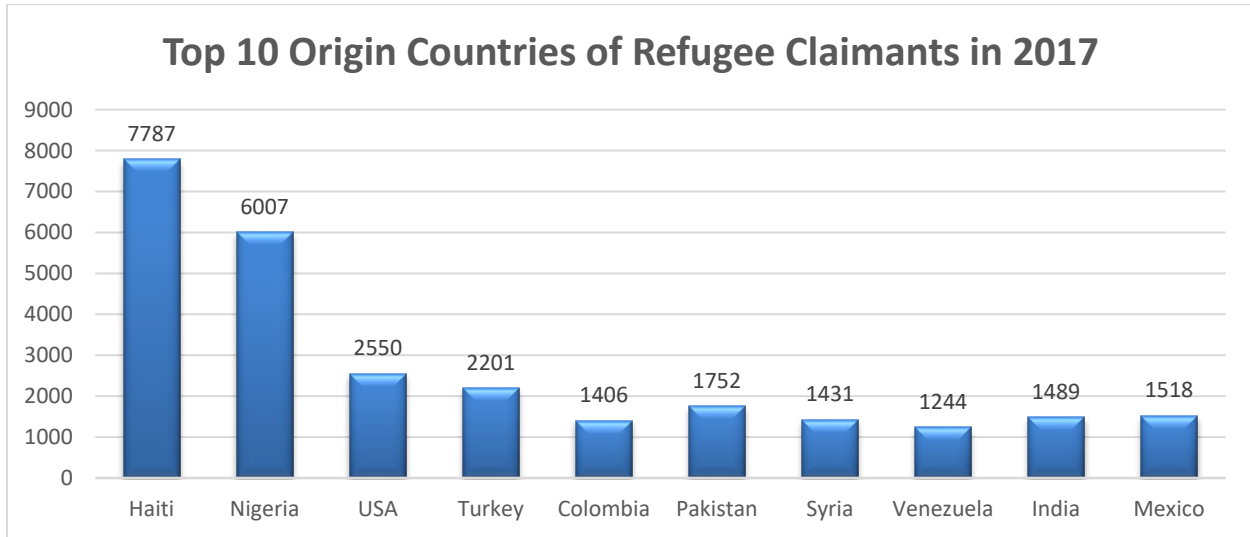
**Figure 2-3: Canadian Refugee (and Protected Persons) Resettlement Statistics**  
(Data Source: IRCC, statista.com)



**Figure 2-4: Refugee Statistics by Country of Origin**  
(Data Source: IRCC, statista.com)

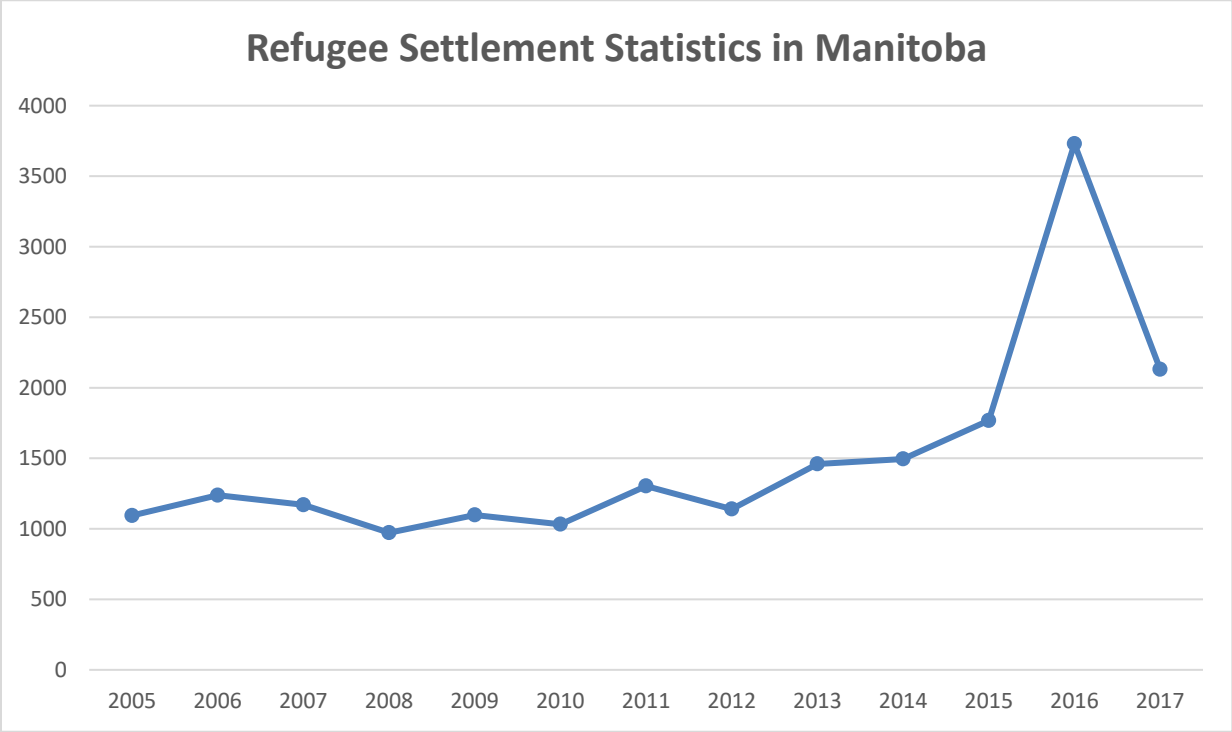


**Figure 2-5: Comparison of 2007 and 2017 Asylum Claimants Data**  
(Data Source: IRCC and statista.com)

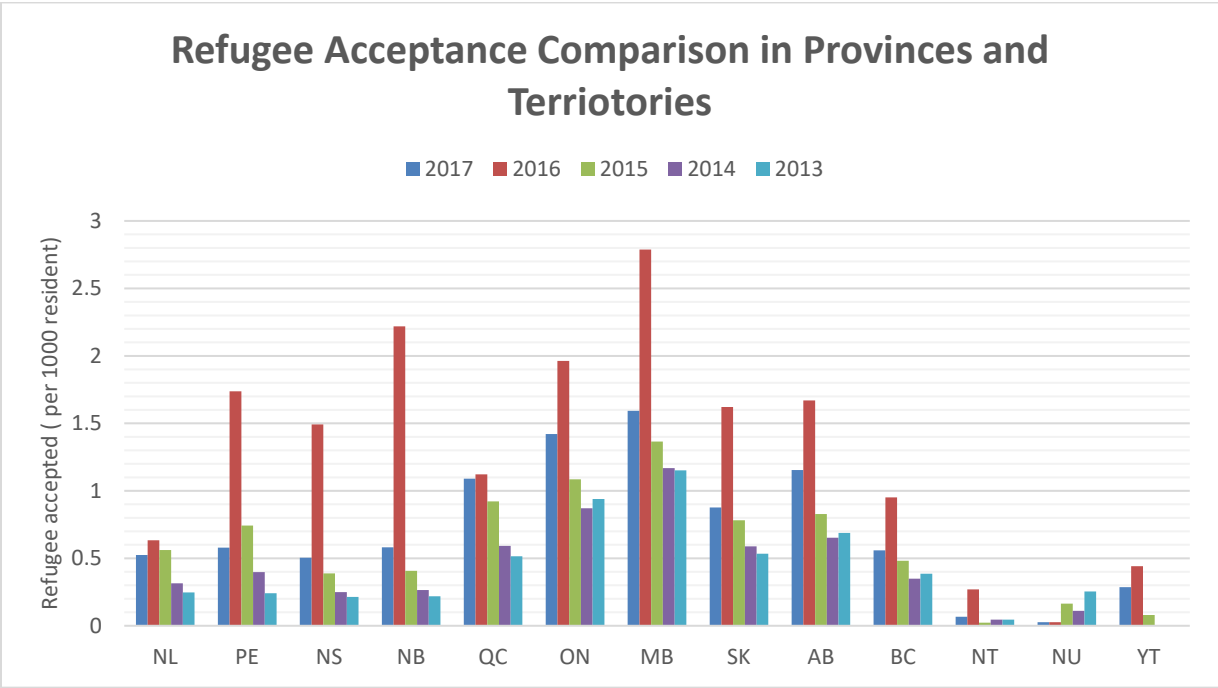


**Figure 2-6 : Asylum Claimants by the Country of Origin in 2017**  
(Data Source: IRCC and statista.com)

Manitoba has welcomed an average of 1250 refugees per year between 2006 to 2017, as shown in Figure 2-7 (IRCC, 2017a; WRHA, 2014). The province accepted a record 3,730 refugees in 2016, which makes the last 5 years average over 1900 refugees. In 2012, the number of refugees' arrival to the province decreased mainly due to the federal cap imposed on the Manitoba Provincial Nominee Program (MPNP) (WRHA, 2014). The increased processing times at IRCC was also a contributing factor. However, after 2012 the number of refugees in the province kept increasing. In fact, the 2013 – 2017 data from IRCC shows that Manitoba is accepting the highest number of refugees per capita than any Canadian province or territory (Figure 2-8). According to the last statistical report on immigration facts published by the Ministry of Labour and Immigration (Manitoba Labour and Immigration, 2015), Manitoba settled nearly 6 per cent of Canada's government-assisted refugees and 22 per cent of privately sponsored refugees in 2014. About 57 per cent of government-assisted refugees came to Manitoba from Somalia, Iraq, Democratic Republic of Congo, and Eritrea. About 92 per cent of privately sponsored refugees came from Eritrea, Somalia, Ethiopia and Democratic Republic of



**Figure 2-7: Refugee Resettlement Trend in Manitoba**  
(Source: IRCC)



**Figure 2-8 : Refugee Resettlement Comparisons (2013 – 2017 data)**  
(Source: IRCC and Statistics Canada)

Congo. In 2016, the majority of refugees to Manitoba came from Syria. Most refugees to Manitoba settle in Winnipeg, therefore the city is facing major challenges to meet the complex physical and emotional issues and needs of refugees (WRHA, 2014).

## **2.2 Mental Health**

### **2.2.1 Definition**

“Mental health” plays a key role in the overall wellbeing of a person. The World Health Organization (WHO) defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (para 1) (WHO, 2018). Health Canada has described mental health as the state of one’s psychological and emotional well-being, which is a necessary resource for living a healthy life and a main factor in overall health (Health Canada, 2018). It has differentiated between “mental health” and “mental illness” and mentioned that poor mental health can lead to mental and physical illness. Mental illness can extend over a prolonged period and hamper daily activities.

### **2.2.2 Mental Health Challenges of Refugees**

All three stages of migration (pre-migration, migration and post-migration settlement) may cause or contribute to different mental health care needs for refugees. In its conceptual framework document, WRHA has summarized the pre-migration, transit, and post-migration factors that influence mental health of refugees (WRHA, 2014). Leaving everything behind while fleeing from war and starting a new life in a completely different culture is stressful. Refugees may not show symptoms of mental illness immediately after arrival, but months and years after coming to Canada (Durbin, Moineddin, Lin, Steele, & Glazier, 2015; Kirmayer et al.,

2011a). Recent studies on Syrian refugees to Canada have reported the need for both acute and long-term mental health care (Ahmed, Bowen, & Feng, 2017; Oda et al., 2017).

Refugees have higher risk of developing mental illness like PTSD, depression, and somatic symptoms because of their exposure to violence and torture (Bogic et al., 2015; Durbin, Lin, Moineddin, Steele, & Glazier, 2014). Mental health of immigrants and refugees are influenced by several complex, interrelated and multifaceted factors where forced migration for the refugee group itself is a significant stressor (Woodgate et al., 2017). Research findings showed that psychosocial effects of trauma, direct and indirect effects of war and conflict, lack of access to healthcare prior to migration, time spent in refugee camps are all unique to the refugee population (Beiser, 2005; Gushulak, Pottie, Roberts, Torres, & DesMeules, 2011; Hyman, 2010; McKeary & Newbold, 2010; Rouhani, 2011; Vang, Sigouin, Flenon, & Gagnon, 2015). The pre-migration stressors, experiences in their home country and at the camps contribute to refugees higher risk of developing common mental health problems like anxiety and depression, as well as PTSD (Durbin et al., 2015; Islam, 2014; Kanagaratnam, Pain, McKenzie, Ratnalingam, & Toner, 2017b; Kirmayer et al., 2011a). Analysis from the Longitudinal Study on Immigrants to Canada (LSIC) also demonstrated that refugees have greater risk in developing mental health problems when compared to other immigrant groups (Quesnel-Vallee, Abrahamowicz, & Lynch, 2011). Other studies have found that racialized immigrant minorities have 2 times the risk of developing schizophrenia and psychological distress compared to the Canadian-born population (Anderson, Cheng, Susser, McKenzie, & Kurdyak, 2015; McKenzie, Hansson, Tuck, Lam, & Jackson, 2009). Moreover, the risk of depression increases with the number of years spent in the host country (Kirmayer et al., 2011a; Thomson et al., 2015). Recognizing the severity of the problem worldwide, UNHCR and WHO



have published mental healthcare guidelines for refugees. The Canadian Mental Health Association (CMHA), Mental Health Commission of Canada (MHCC) and Centre for Addiction and Mental Health (CAMH) all have published several documents outlining policies and providing recommendations to improve mental health care services for immigrants and refugees (Agić, McKenzie, Tuck, & Antwi, 2016; Bartram et al., 2012; Canadian Mental Health Association, 2017; Marianne et al., 2012; McKenzie, Agić, Tuck, & Antwi, 2016; McKenzie et al., 2009; Vasillevska, Madan, & Simich, 2010).

### **2.3 Syrian Demographics**

The ongoing civil war in Syria beginning in March 2011 has created a humanitarian crisis, probably the worst in our lifetime. Fatalities may have reached 400,000 (Aljazeera, 2016). As of September 18, 2017, UNHCR estimates about 5.22 million people have been registered as refugees, while 6.3 million have been internally displaced (UNHCR, 2017b). Most of the refugees have fled to 5 neighboring countries: Turkey, Lebanon, Jordan, Iraq and Egypt. Some fled to North Africa and Europe. The Government of Canada has responded to the humanitarian crisis in Syria by welcoming a total of 40,081 refugees as of January 29, 2017 (IRCC, 2017b). A portion of the recently arrived Syrian refugees have settled in Manitoba.

The Syrian population was estimated to be 23 million in 2011, then declined to 17.9 million in 2014 (Wikipedia, 2018). According to the head of the Syrian Commissioner for Family Affairs, the Syrian population was 28 million in 2017, including 7 million refugees (Wikipedia, 2018). However, the US Central Intelligence Agency (CIA) estimates the 2017 Syrian population as 18.03 million, of which 90.3% is Arab and the remaining 10.7% are Kurds, Armenian and others (CIA, 2018). According to the agency website, Arabic is the native language of 90 % of the population and is also the official language. Male to female ratio is 1.01

and the percentage of people over the age of 15 who can read and write is 86.4 %. According to the same website, approximately 87% are Muslim (Sunni – 74%, Shia, Alawi and Ismaili – 13%), approximately 10% are Christian (including Orthodox, Uniate, and Nestorian) and the remaining 3% are Druze.

The majority of families in Syria are quite extended including parents, children, grandparents, aunts, uncles, and cousins. Usually the oldest man is the head of the family and both the extended and immediate family member live together in a single dwelling (IRCC, 2015). A 2014 study conducted by the Agency for Technical Cooperation and Development (ACTED) on Syrian refugees in Lebanon found that majority of Syrians worked in the construction and agriculture sectors in Syria (ACTED, 2014).

Stigma around mental illness is one of the most commonly cited reasons for the under use of available psychiatric services in Syria and in the middle-east (G Hassan et al., 2015; G Hassan, Ventevogel, Jefee-Bahloul, Barkil-Oteo, & Kirmayer, 2016; IRCC, 2015; Sewilam et al., 2016; Stuart, Arboleda-Florez, & Sartorius, 2012; Tello, 2018) . Accessing formal services is associated with shame and embarrassment as people with mental illness were not able to find solutions of their problems through their faith, family/social support, or being more tolerant (Stuart et al., 2012). Seeking formal help is supposed to be considered as the last resource. However, the attitudes of Syrian people toward mental health are shifting (Cultural Orientation Resource Center, 2014). According to the Cultural Orientation Resource Center, before the crisis, receiving treatment for mental illness had a negative stigma and made people more reluctant to seek treatment or discuss issues. As large numbers of Syrian men, women and children are in psychological distress, now-a-days they are more open to receiving mental health support (Cultural Orientation Resource Center, 2014; IRCC, 2015).

## 2.4 Resettlement of Refugee Women and their Mental Health

### 2.4.1 Forced Migration from a Feminist Perspective

Globally, women make up half of displaced migrants due to war and conflict (UNHCR, 2018). Researchers have acknowledged the gendered nature of forced migration. Despite the particular needs and conditions of women in forced migration, gender-based guidelines are absent in global refugee legislations (Cho, 2012; Hopkins, 2006; Hyndman, 2010). For example, scholars have argued that the international human rights conventions like the Geneva Convention, have been written predominantly from male perspectives ignoring the situations and interests of women (Berman, Rosa, Girón, Marroquín, & Marroquín, 2009; Freedman, 2010). Therefore, it is important that we understand the challenges and issues of refugee women due to forced migration using feminist perspective. According to Ackerly & True (2010), feminism provides a *“critical perspective on social and political life that draws out attention to the ways in which social, political and economic norms, practices and structures create injustices that are experienced differently or uniquely by certain groups of women”*.

Feminist scholars have effectively challenged the existing beliefs on global politics to show that gender matters (Cohn, 2013; Hyndman & Giles, 2011; Tickner, 2006). The term ‘gender’ does not simply refer to biological differences, rather refers to a set of culturally shaped and defined characteristics associated with masculinity and femininity (Shinn, 2017). According to Hooper *“Gender is neither a thing nor a property of individual character. It is a property of collectives, institutions, and historical processes. It is also a linking concept, whereby biological difference is engaged with, and social practices are organized in terms of, or in relation to, reproductive divisions”* (Hooper, 2001). Wadley points out, *“ignoring gender means not recognizing the ways key actors are defined and differentiated by their relationship to norms of*

*masculinity and femininity*” (Wadley, 2009). Feminist scholar Shinn describes gender as a fundamental part of the construction of a state’s identity or the personhood of a state (Shinn, 2017). She also argued, the inequalities that women and girls experience before, during and after the migration journey due to war and conflict, should always be considered in context of social and cultural institutions. Mohanty, (1991) also discussed about “third world feminisms” and the political necessity of establishing strategic associations among western feminists, working class feminists and feminists of color around the world that means across the class, race, and national boundaries. She argues that the universal categorization of women from non-Western countries is mostly done through constructed monolithic terms and over-categorizing them without considering the class, ethnic, and racial contexts to which they belong to (Mohanty, 1991).

Interventions at the right time (e.g. through programs like women empowerment run by the Family Rehabilitation Center in Sri Lanka) can help women refugees or internally displaced persons to overcome mental health challenges (Miller & Rasco, 2004). The Family Rehabilitation Center viewed mental health and well-being as a number of interrelated factors like psychological, social, community functioning, cultural or spiritual belief and support systems, economic and sociopolitical factors. FRC assisted various war-affected groups by providing basic healthcare services (through running mobile/project based medical clinics and physiotherapy) as well as material assistance (through providing sewing machine or poultry to start small businesses) (Miller & Rasco, 2004).

The contribution of feminist theorists to bringing women refugees’ issues to the fore front to international agencies, UNHCR in particular, as well as major refugee receiving countries is significant (Edward, 2007). Following the UNHCR action in 1993 Canada became the first country to adopt formal guidelines for settlement of refugee claimants made by women by

broadening the definition of refugee thereby, including vulnerable women seeking asylum based on well-founded fear of gender-based persecution (Canadian Council for Refugees, 2001, 2016; Edward, 2007). However, in Canada's immigration policy women have tended to fall into dependent categories, which may have implications in accessing healthcare or social services (Bhuyan Rupaleem, Osborne Bethany, Zahraei Sajedeh, & Tarshis Sarah, 2014; Oxman-Martinez et al., 2005; Wahoush, 2009). Studies have documented a high number of postpartum health and social concerns among refugee claimant women that were not being addressed by the Canadian healthcare system (Merry, Gagnon, Kalim, & Bouris, 2011). Since men are overrepresented in primary applicant categories in Canada, the sponsored refugee women by spouses or families may be placed into marginal roles only and subject to further abuse (Hyndman, 2010, 2011). This may negatively impact refugee women's health during resettlement.

In October 2012, new regulations were introduced by the Federal Government that every spouse sponsored to live in Canada and obtain permanent resident status must be in a legitimate relationship with their spouse for at least two years after their permanent resident is granted. The Canadian Council for Refugees, along with many other organizations, expressed grave concerns about the regulation that *“making permanent residence conditional on staying in a relationship for two years traps people into staying in abusive relationships for fear of losing their status (Canadian Council for Refugees, 2017)”*. The organization further stated that *“conditional permanent residence has increased the vulnerability of many sponsored newcomers, particularly victims of domestic and sexual violence and abuse, who are often women. The measure has placed more power in the hands of abusive sponsors, and put sponsored partners at increased risk of abuse, increasing gender inequalities in cases where the sponsored person is a woman”*.

In April 2017 the Federal Government eliminated conditional permanent residence for sponsored spouses and partners citing the Government's commitment to family reunification and supports gender equality and combating gender violence (The Government of Canada, 2017). While the law has been changed now, not everyone may be aware of that.

Furthermore, the recent changes by the Canadian government to prevent asylum-seekers from making refugee claims in Canada if they have already made similar claims in other countries, including the United States, raises many concerns (Wright, 2019). In the United States gang and domestic violence will no longer be considered as grounds for asylum, according to the 2018 changes in the refugee policy (Korducki, 2019). Therefore, persons seeking asylum on such claims would be deported. As a result of these changes, a woman fleeing domestic violence will now be denied a full hearing in Canada, if her asylum claim in the U.S. has been rejected. An open letter to the Prime Minister of Canada, a group of 46 Canadian organizations, many of which help vulnerable women, called the new law "deeply harmful" to female refugees (Wright, 2019). While the government has said the new provisions are designed to prevent asylum seekers from "shopping" for asylum claims in multiple countries, the women advocacy group argues that women are not shopping for a better immigration deal, they are looking for protection (Wright, 2019).

#### **2.4.2 Challenges Faced by Refugee Women During Resettlement**

Physical and mental health disparities that refugee women experience, as compared to men, are often unaddressed during resettlement in host countries (Cho, 2012; Hyndman, D'Addario, & Stevens, 2014). Some refugee women may have been the victim of sexual harassment, domestic violence, rape, forced marriage, or forced pregnancy and abortion. Gender-specific violence and abuse may have led to mental illness such as depression, anxiety, PTSD,

suicide, and psychosis among refugee women (Asaam, 2015; Edge & Newbold, 2013; Saberpor, 2016; Woodgate et al., 2017). Therefore, women may be traumatized and afraid of the uncertainties in settling in a new country and culture. A study by Ahmed and colleagues found that refugee women were nearly five times more likely to develop postpartum depression than Canadian born women (Ahmed et al., 2017). Settling in a new country can be stressful with limited social networks and no financial capital. Refugee women face more challenges as their family roles begin to change, the traditional support system they had at home becomes non-existent and language, employment barriers, cultural differences become prevalent (Cho, 2012). Being isolated can have profound consequences on mental wellbeing of refugee women.

The underlying factors that contribute to a person's vulnerability to mental illness have been referred as social causes or social determinants in the literature as these are not direct causes of mental illness (Sherzoi, 2017). The Public Health Agency of Canada has listed 12 determinants of health that are applicable to the general population. Income and social status, social networks, education and literacy, employment and working conditions, gender and sexual orientation, social and physical environment, healthy child development, and racial discrimination are significant social determinants for refugees (Sherzoi, 2017).

### **2.4.3 Access to Mental Healthcare Services**

Accessing healthcare services is a challenge for all newcomers due to the lack of knowledge about Canadian healthcare system. Recently arrived Syrian refugees in the Greater Toronto Area (GTA) have reported unmet health care needs and mostly mentioned three reasons: long wait times, costs associated with services, and lack of time to seek healthcare services (Anderson et al., 2015). Long wait times to get healthcare services is a long-standing problem for Canada (Barua, 2017). Since primary care is the gateway to the healthcare system in Canada, a

referral by family physician is required to access specialist care such as psychiatrist, unless visiting a hospital. Furthermore, due to complex healthcare needs, communication barriers, and complicated insurance coverage that can delay payments for delivered services, some healthcare providers were unwilling to accept refugees as patients (Delara, 2010).

Even after accessing mental healthcare services, the barriers do not necessarily end there. Many refugee women have reported discrimination at doctor's office based on race, ethnicity, language, accent, religion, culture and other characteristics (Pollock, Newbold, Lafrenière, & Edge, 2012). According to Pollock et al. (2012), the documented discrimination in accessing healthcare services includes incidents of insensitive, unfriendly or ignorant treatment from providers to racial slurs, stereotyping, and receipt of inferior care. In many cases, the religious or cultural beliefs and needs of refugee women, such as preference for female providers or for privacy and remaining clothed were not adequately addressed (Reitmanova & Gustafson, 2008). Refugees have reported being judged too quickly based on their background or country of origin. Discrimination may be negatively associated with adverse health impacts both directly and indirectly, through its influence on access to health services.

Despite increased mental healthcare needs, refugee women face considerable barriers in accessing healthcare services, which subsequently leads to unmet healthcare needs. Studies conducted in Manitoba and other Canadian provinces provide evidence that both immigrants and refugees tend to underutilize the healthcare services available to them due to the challenges they face while accessing services (Asaam, 2015; Awuah-mensah, 2016; Edge & Newbold, 2013; McKeary & Newbold, 2010; Newbold, 2009; Sherzoi, 2017; Sullivan, 2009; Woodgate et al., 2017; WRHA, 2014). These studies further found that refugee women faced additional barriers such as language, transportation, scheduling appointments and follow-ups, cold weather, absence



of spouse, absence of childcare, preference to see female physicians, cultural and religious practices, improper referrals. In addition to the lack of the quality of care, many complained that the service providers did not always have time to fully communicate with their clients (Woodgate et al., 2017). The long wait time in getting appointments through referral system combined with the dissatisfaction of the quality of care and some negative experiences have led many refugee women to avoid seeking care (Donnelly et al., 2011; McKeary & Newbold, 2010; Pollock et al., 2012; Saberpor, 2016). Based on the findings from literature reviewed in this study, the barriers that refugee women face in accessing mental healthcare services were grouped into three categories and summarized in Table 2-2.

**Table 2-2 : Barriers in Accessing Mental Healthcare Services by Refugee Women**

<b>Category</b>	<b>Barriers faced</b>
Material	<ul style="list-style-type: none"> <li>• Income level</li> <li>• Housing</li> <li>• Employment</li> <li>• Transportation</li> </ul>
Structural and organizational	<ul style="list-style-type: none"> <li>• Communication with service providers (physicians lacking empathy with refugees’ mental health concern for being too busy)</li> <li>• Inadequate referral to specialized resources</li> <li>• Language and Interpretation</li> <li>• Health insurance/health care coverage</li> <li>• Lack of knowledge about services/unfamiliarity with new system</li> <li>• Long wait times and system complicity</li> <li>• Quality of service</li> <li>• Shortage of mental health care professionals</li> <li>• Lack of coordination among providers</li> </ul>
Social and cultural	<ul style="list-style-type: none"> <li>• Lack of awareness of mental health problems</li> <li>• Socio-cultural differences</li> <li>• Psychological (unfamiliarity with and mistrust of biomedical treatment, fear of deportation, being labeled as “mentally ill”)</li> <li>• Spirituality and religious faith as primary avenue to address mental issues</li> <li>• Lack of culturally competent care</li> </ul>

- 
- Inadequate social support, negative attitudes and behavior
  - Differences in expectations, trust issues
  - Stigma
  - Racism and discrimination
- 

#### **2.4.4 The Need for Culturally Competent Care**

Since most refugees to Canada often come from non-Western cultures, Western style “curative” medicine that focuses mostly on physical symptoms is not well-adapted for many refugees. This is a one-way relationship of providing service where the client seeks professional care and often there is no relationship between the client and health care provider other than diagnosis and treatment (McKeary & Newbold, 2010). Most likely, mental healthcare service providers are not aware of specific issues faced by refugees because of their experiences of persecution and forced migration. Service providers may not have experience in working with interpreters or do not know how to access them. Accessing services is not only about finding a provider but also a comfortable and understanding environment (Vasilevska, 2010). Culturally competent care includes the need for providers to know who they are caring for, the history of their clients, and awareness of difference(s) between refugee clients and others (Pollock et al., 2012; Thomson et al., 2015). For example, there are many terms used to describe mental health care, including therapy, counselling, psychology, psychiatry, etc. Refugees may have different understandings and awareness of the various terms and phrases. Healthcare providers need to be aware of cultural differences while providing services to refugees. Time commitment, communication and building trust are important factors to be considered by providers. Provider practices that focus on reducing stigma and providing hope and dignity should be encouraged.

Many refugees, particularly women, are victims of war and torture, and therefore the symptoms and outcomes may present differently. The Canadian Council for Refugees

recommended community-based preventative and healing measures. According to the study by Pollock et al. (2012) refugees have endorsed the benefits from family health teams, nurse practitioners, midwifery services, and community health centres in Ontario. The study also found that refugees felt the use of “preventative” and “holistic” approaches for addressing health care needs were more beneficial to them in contrast to the Western style “curative” medicine that focused mostly on physical symptoms. Since refugees have minimal to no knowledge about the Canadian health care system, applying one system that presumably fits everyone, regardless of faith, culture, upbringing, etc. would not be the best way to provide services to refugees. Unfortunately, nonmedical approaches such as counselling and art therapies, which may be more culturally appropriate, are often not covered by provincial or federal health care insurances. Medical practitioners and policy makers need to be flexible in program design. Alternative and more culturally appropriate approaches that includes the family, community and broader population, not only the individual as the sole unit of care, should be explored and made accessible to refugees.

## **2.5 Mental Healthcare Services for Refugee Women in Manitoba**

This section will cover what services are available for the refugee women in Manitoba, starting with the Federal program followed by the provincial and regional programs. Manitoba Health, Seniors and Active Living (MHSAL) has developed several resources for service providers on how to respond to mental health problems and where referrals can be made to access formal mental health and addiction services. MHSAL recommends that if a person is functioning and doing well, the service providers do not inquire about traumatic experiences but should be alert to signs and symptoms of post-traumatic symptoms and other mental health and addiction issues or illnesses.

### **2.5.1 Federal Refugee Healthcare Program**

The Interim Federal Health Program (IFHP) provides limited, temporary coverage of healthcare benefits to refugees and asylum seekers who are not eligible for provincial or territorial health insurance. Under IFHP the beneficiaries are covered for the following (IRCC, 2018a):

- **Basic coverage:** The same health care coverage provided by provincial/territorial insurance plans to Canadian and permanent residents.
- **Supplemental coverage:** Similar to the coverage provided by provincial and territorial governments to residents who are on social assistance. The coverage includes vision and urgent dental care, prescription drug coverage, and services from allied health professionals (including clinical psychologists).

Once refugees obtain provincial coverage, IFHP continues to provide supplemental services coverage until the end of Resettlement Assistance Program (up to a maximum of 12 months). Refugees can apply for provincial social assistance for supplemental coverage after IFHP support ends. IFHP coverage continues for refugee claimants until the refugee claim is accepted or if the refugee claim is rejected, until the date set for deportation.

Services for refugees who suffer from trauma are covered by IFHP, although the coverage is limited to licensed psychologists and psychiatrists. The 2012 cuts to IFHP by then Canadian Government had a significant impact on refugees' access to health care services as mentioned in the literature (Canadian Council for Refugees, 2016). Some provinces and organizations stepped in to help the uninsured refugee groups by offering a temporary health insurance. On April 1, 2016 the new government restored the IFHP to the pre- 2012 level. Due to the changes to the program and again reversal of the changes in different stages made it unclear

whether pre-2012 service levels are actually in effect or not. More investigations would be required to confirm who will be covered, what services will be covered, and whether health care service providers will offer services covered by IFHP.

The struggles of refugees when IFHP support is not available after one year have been reported. Refugee women often maintain their gender roles such as mothering, nurturing, and caring for family throughout the forced migration and resettlement stages (Adanu & Johnson, 2009; Berman et al., 2009). Single refugee women who have children become the primary caregivers for ensuring safety and well-being of their families (Cho, 2012). Unfortunately, a significant pay gap exists between women and men in Canada, whereby a full-time working woman earns 74 cents on average for every dollar earned by men (Canadian Women's Foundation, 2017). According to the Immigration department, most jobs obtained by recently arrived Syrian refugees in Canada are typically in the low-paying service and restaurant sector, or in construction (Douglas, 2017). With limited social networks, no prior work experience, and limited educational background, it is already difficult for refugee women to find a job in Canada. Moreover, the 'low pay in low-paying jobs' makes the situation even more difficult. Many refugees are struggling to pay for medicine, dental or mental healthcare if not covered by the employer insurance. Due to overwork to pay for living, the refugee women may be exhausted and are unable to find time to see a doctor for any mental health issues.

With the decline in commodity prices and the economy in a downturn, Canada is facing ongoing challenges in ensuring government and non-government funding for providing services to refugees. Maintaining a client-provider trust relationship based on socio-cultural elements is very difficult without funding for interpretation services and training for health care providers on culturally competent care. Manitoba has seen major cuts in healthcare recently. Nevertheless,

from a system perspective, accepting refugees must be simultaneously recognized within health care budgets (McKeary & Newbold, 2010).

### **2.5.2 Available Mental Healthcare Resources in Manitoba**

In Manitoba, mental healthcare services are provided through the local RHA's mental health program. The information on mental health crisis and non-crisis regional contacts for all 5 RHAs is available at MHSAL website (Manitoba Health Seniors and Active Living (MHSAL), 2018). The Bridge Care Primary Clinic in Winnipeg provides a single point of access for the initial health assessment and primary care services for newly arrived government-sponsored refugees (211 Manitoba, 2018; Bridge Care Primary Care Clinic, personal communication, April 4, 2018). The clinic also makes referrals for mental health services. There are several mental healthcare service providers in Winnipeg that includes Crisis Response Center, Willow Place, Crisis Stabilization Unit of WRHA, and Community Mental Health Service Programs/Clinics by WRHA. Mental healthcare services are available at Winnipeg's major hospitals and urgent care facilities. Some hospitals have psychiatric nurses on duty in emergency. Some clinics or programs that offer mental healthcare services specifically to refugees are: Aurora Family Therapy Centre, Immigrant Women's Counselling Service, KLINIC Community Health Centre, Mount Carmel Clinic – Multicultural Wellness Program, Nor-West Co-op/Community Health, and the Language Access Interpreter Services. Table 2-3 provides a list of settlement and mental healthcare service providing organizations in Winnipeg (CMHA Manitoba and Winnipeg, 2018).

Accessing health care services can be problematic for refugees who live outside of Manitoba's urban centre, Winnipeg. A study by the Rural Development Institute at the Brandon University examined the challenges of resettling refugees in rural communities (Cronkrite et al., 2016). These small communities have limited resources and service providers have minimal

experience with war-trauma or even working with an interpreter. Particularly, there are challenges in designing and organizing programs for refugees.

**Table 2-3 : Settlement and Mental Healthcare Services for Refugees in Winnipeg**

<b>Settlement Services</b>	
<b>Welcome Place (Manitoba Interfaith Immigration Council)</b>	Provides temporary accommodation and assistance with housing search, helps with settlement and life skills training.
<b>The Immigrant and Refugee Community Organization of Manitoba (IRCOM)</b>	Provides housing assistance, literacy classes, family support, employment skills training, after school programs, social and recreational supports.
<b>Neighbourhood Immigrant Settlement Workers (NISWs)</b>	Provides settlement information and orientation to newcomers, connects newcomers with programs and services, hosts special events for newcomers to meet their neighbours.
<b>Mosaic Newcomer Family Resource Network</b>	Helps newcomers to adjust to life in Canada so that they can become active members of their new community
<b>Newcomers Education and Employment Development Services (NEEDS Centre)</b>	Offers programs for newcomer such as employment skills training, introduction to Canadian education.
<b>Manitoba Housing</b>	Offers refugees accommodation under the Social Housing Rental Program or the Affordable Housing Rental Program.
<b>Mental Health Housing Programs and Services</b>	<ul style="list-style-type: none"> <li>• Canadian Mental Health Association Manitoba and Winnipeg – Rehabilitation and Recovery Service</li> <li>• Friends Housing Inc.</li> </ul> WRHA – Residential Care Facilities
<b>New Journey Housing</b>	Provides housing-related information, advice, support, and workshops.
<b>Employment and Income Assistance (EIA)</b>	Offers financial help to Manitobans who have no other way to support themselves or their families. The program also helps people get back to work by providing supports for employment
<b>Opportunities for Employment Service</b>	<ul style="list-style-type: none"> <li>• Helps people with job searches, skill development and making connections with employers</li> <li>• Presents workshops on Canadian Workplace Culture to help people learn about working in Canada successfully</li> </ul>

<b>Community Financial Counselling Services</b>	Offers refugees free help with financial problems, financial education and budgeting.
<b>Specialized Clinic for Refugees</b>	
<b>Bridge Care Primary Care Clinic</b>	Offers primary care services to refugees only. The clinic also makes referrals for mental health services. Refugees are required to be referred by welcome place to get service.
<b>Mental Health Care Service for All Manitoba Residents</b>	
<b>Crisis Response Centre (CRC)</b>	The Crisis Response Centre (CRC) offers crisis intervention options designed to meet the needs of individuals 18 years and older who are experiencing a crisis. Mobile Crisis Service is also available 24 hours a day, 7 days per week to provide on-site assistance with a mental health crisis.
<b>Other Crisis Services</b>	<ul style="list-style-type: none"> <li>• ‘Willow Place’ provides a safe and supportive environment for women and their children who are being abused by partner.</li> <li>• ‘Main Street Project’ provides 24-hour crisis services including shelter, detox and housing.</li> <li>• ‘KLINIC’ offers counselling service and crisis/suicide intervention.</li> </ul>
<b>Crisis Stabilization Unit (WRHA)</b>	Provides short-term intervention for adults experiencing mental health and/or psychosocial crisis.
<b>Hospitals/Emergency</b>	Mental health care services are available at Winnipeg’s major hospitals and urgent care facilities. Some hospitals have psychiatric nurses on duty in emergency.
<b>Community Mental Health Services at WRHA</b>	<ul style="list-style-type: none"> <li>• Adult Community Mental Health Services</li> <li>• Community Mental Health Program</li> <li>• WRHA Mental Health Housing Services</li> <li>• Program of Assertive Community Treatment (PACT)</li> <li>• Co-occurring Disorders Initiative (CODI)</li> <li>• Community Health Clinics (ACCESS centers, Women’s health clinic)</li> </ul>
<b>Mental Health Care Service Specific to Refugees and Newcomers</b>	
<b>Aurora Family Therapy Centre</b>	The Centre offers Support for people transitioning to new life in Canada and arranges Group sessions for women, cultural



	groups, and youth. Therapy Program for Refugees is free.
<b>Immigrant Women’s Counselling Service</b>	The Immigrant Women’s Counselling Service offers counselling for women who face violence or trauma. Group counselling is also available on healthy relationships, anger management, parenting, and self-esteem.
<b>KLINIC Community Health Centre</b>	The KLINIC community health centre offers Free community health, education, and counselling services
<b>The Language Access Interpreter Services</b>	Free interpreter services offered by WRHA.
<b>Mount Carmel Clinic – Multicultural Wellness Program</b>	Offers counselling for newcomers, support during cultural adaptation and low-cost dental program.
<b>Nor-West Co-op/Community Health</b>	Provides medical care and counselling.

While there are many programs and services available in Winnipeg, how effective these initiatives are remains unanswered. The supporting services may have been stretched to their limits and facing staffing shortage challenges due to the recent record number of refugee influx in the province. Literature findings suggest that many refugees are unaware of what services are available to them. A program or initiative can be considered effective if refugees are receiving the service and reporting benefits. Therefore, the evaluation of current programs is important in understanding their effectiveness. Literature suggests that how refugees perceive the available mental healthcare services and how healthcare providers offer such services should be examined to understand refugee mental health needs and services (Asaam, 2015; Silove, Ventevogel, & Rees, 2017; Vasilevska, 2010). In this study important information regarding the knowledge and accessibility of mental health services among refugee women in Winnipeg was obtained by interviewing refugee women, service providers and decision makers in Winnipeg.

## 2.6 Theoretical Perspectives in Integrations

Culture plays an important role in the refugee women’s re-settlement process and mental health. It is important to understand the interplay between long-term psychological

consequences of the process of acculturation and mental health. Living one's entire life in one culture and then attempting to re-establish lives in another one may be very challenging for refugee women. Berry outlined a conceptual framework within which acculturation and adaptation can be investigated (Berry, 1997), including four acculturation strategies:

- Assimilation – Individuals do not wish to maintain their cultural identity and seek daily interaction with other cultures.
- Separation – Individuals hold on to their original culture, and at the same time avoid interaction with others.
- Integration – Interest in both the individual and the host country's society maintaining one's original culture, while in daily interactions.
- Marginalization: Little possibility or interest in cultural maintenance (often for reasons of enforced cultural loss), and little interest in having relations with others (often for reasons of exclusion or discrimination).

No doubt that 'integration' would be the best option during the re-settlement process of refugee woman, in terms of mental health, and 'separation' may be likely to lead to mental healthcare avoidance. In integration some degree of cultural integrity is maintained, while seeking to participate as an integral part of the larger social network at the same time (Berry, 1997). However, Berry also argued that the integration strategy can only be pursued in societies that are explicitly multicultural, which the Canadian societies are, as Canada includes immigrants from all over the world. During the interviews special attention was given in exploring the acculturation process of the Syrian refugee women and the consequence on their mental health. Recommendations were provided accordingly.

## **Chapter 3. Research Methodology**

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### **3.1 Research Design**

I employed a qualitative research design to explore what the health system can do to better address the mental health needs of refugee women in Winnipeg. Semi-structured interviews were conducted with Syrian refugee women and service providers/decision makers living/working in Winnipeg. Interviews with refugee women focused on their lived experience and service accessibility issues. Interviews with decision makers focused on policy measures, exploring options for community-based and culturally appropriate healthcare.

The qualitative approach of this proposed study is supported by literature. In the literature, qualitative study has been described as the systematic inquiry into social phenomenon in natural settings that includes how people behave, experience different aspects of their lives, how organizations function, and how interactions play a role in building relationships (Teherani, Martimianakis, Stenfors-hayes, Wadhwa, & Varpio, 2015). The researcher is the main data collection instrument in applying a qualitative research design (Sofaer, 2002; Teherani et al., 2015). Furthermore, literature suggests that qualitative research begins with the intention to explore a particular area, includes the collection of data through observations and interviews, and generates ideas from these data (Greenhalgh et al., 1997). Therefore, a qualitative approach was best suited for the proposed study, which included data collection through semi-structured interviews to explore the mental health status and use of mental healthcare services of refugee women living in Winnipeg. Interviews with the Syrian refugee women provided their perspective on mental wellbeing, health care needs, and barriers in accessing mental health services.

### **3.2 Ethical Considerations**

Research ethics approval was obtained from the authorities:

- Health Research Ethics Board (HREB), University of Manitoba. Ethics # HS22244 (H2018:406)
  - Full Board Review Approval: November 15, 2018
  - Amendment Approval: February 14, 2019
  - Annual Approval: October 14, 2019 (Valid till October 22, 2020)
- Research Access and Approval Committee, Winnipeg Regional Health Authority (WRHA). Reference # RAAC 2019-004

The purpose of the research, data collection and analysis methods, confidentiality, research implications and all other aspects of the research were shared with participants before obtaining verbal and written consent. The Syrian refugee women were informed about the research and if they were okay to answer a series of questions about their mental health and care experiences. They were not required to answer any questions that they were not comfortable with and could discontinue at any time they wanted. It was disclosed that the identity of all participants and the shared information will be kept confidential. An interpreter confidentiality agreement was in place where interpreters were required. The interview guides ([Appendix A](#)), consent forms ([Appendix B](#)), interpreter confidentiality agreement form ([Appendix C](#)) and recruitment materials ([Appendix D](#)) were prepared in collaboration with refugee serving organizations (settlement agencies, clinics etc.), who also subsequently helped in interview participant recruitment. The demographic questionnaire in [Appendix B](#) served as the additional data collection instrument.

Health professionals suggested that pushing for disclosure of traumatic events who survived through torture, sexual and gender-based violence can potentially increase the risk of inducing trauma and raise issues of stigma (Banks et al., 2014; Pottie, Greenaway, Hassan, Hui,

& Kirmayer, 2016). Therefore, systematic screening for PTSD or any other diseases were avoided as suggested by health professionals as well as there was no push to disclose any information. During the interviews useful information about services that are available to the refugee women were communicated.

### **3.3 Sample and Recruitment**

#### **3.3.1 Syrian Refugee Women**

Nine Syrian refugee women were recruited for semi-structured interviews to explore their mental wellbeing and potential accessibility issues related to mental healthcare services. Eligibility criteria included Syrian refugee women who have settled in Winnipeg within the last 1 to 5 years and are between 18 – 45 years old.

The Syrian refugee women were recruited for interview using a mix of convenience and snowball sampling approach. Searching for refugee women and sending invitations were done with the help of settlement agencies and clinics who welcome and serve refugees in Winnipeg. Briefly, settlement organizations are Immigrant serving agencies which are non-profit, community-based agencies that provide settlement, integration and adaptation services to immigrants (including refugees) with the goal of facilitating adjustment to life in Canada (Salami, Salma, & Hegadoren, 2019). Specialized refugee clinics such as BridgeCare Primary Care Clinic in Winnipeg, provides a single point of access for the initial health assessment and primary care services for newly arrived, government sponsored refugees.

- First, a list of refugee settlement organizations and specialized refugee primary care clinics in Winnipeg was prepared through online search.
- Second, representatives of these organizations were contacted via sending email invitations followed by in-person visit. Refugee support service organizations were

requested to coordinate and facilitate the recruitment of their Syrian clients (convenience sampling).

- Third, at the end of each interview, the refugee women were asked to recommend other potential participants for this study (snowball sampling).

### **3.3.2 Service Providers and Decision Makers**

Representatives from organizations were contacted to help with recruiting Syrian refugee women were also requested for interviews as service providers either by themselves or referring to their coworkers. In addition, personal communication and references were used to recruit potential interview participants. Manitoba Health, Seniors and Active Living (MHSAL) was contacted to take part as decision maker. Five service providers and one decision maker agreed to give interviews.

### **3.4 Data Collection**

Since the refugee women were sharing their personal experiences, confidentiality, trust, and their comfort levels were very important. The refugee women were offered one-on-one interviews at a time and a place of their convenience. One-on-one interviews were given preference over focus group interviews considering the fact that the refugee women may be uncomfortable in sharing sensitive information related to past experience, trauma, sexual abuse and mental illness in front of others. Moreover, one-on-one interviews provided the option of doing the interview with a partner or family member if the participant preferred. Only two out of nine Syrian refugee women were able to communicate in English. The help of two professional interpreters was required for the remaining seven interviews. Both interpreters were women and working at refugee serving organizations but not from Syria. Since the consent form was written

in English, the interpreters interpreted the form to the refugee women in front of me and explained the contents (study purpose, procedures, risks, benefits, confidentiality, permission to quote, withdrawal from the interview etc.) of the form in detail. After explaining all in detail, signatures from the refugee women were obtained in the consent forms before starting the interviews. With respect to the interpreter confidentiality agreement, the agreement was signed only once with each interpreter, before taking the first interview. Then the agreement was applied to the remaining interviews.

Service providers and decision makers were offered one-on-one interviews as well. Based on the location and convenience, they were given options to participate in person, via teleconference, or email. The consent forms were provided to the Service providers and decision makers for review and signature before the interviews were conducted.

### **3.5 Interview Process**

The interviews started by introducing myself and explaining the purpose and procedure of the interview to obtain informed consent for interviewing. I was able to build a good rapport with the participants by introducing myself at the beginning, then with regular eye contact, smiling, appropriate nodding, being an active listener, and other cues to indicate my interest in their stories throughout the interview. Most of the interviews with refugee women were conducted at the refugee serving organizations, which may have further enhanced their comfort since they are familiar with the space and environment. The interviews were conducted in a closed room with round table setting where the participant, interpreter and I were present. All interviews followed a semi-structured format with the aid of an interview guide. However, I started with small talk and general ice-breaker questions before I launched into the specific questions. This helped to establish rapport. Separate interview guides were prepared for the

refugee women and the service providers/decision makers. The interviews were planned such that both the providers and refugee women's interviews were conducted concurrently. The interview guides were piloted first and then were updated as necessary. Initial analyses and interviews also informed subsequent interviews so that it was possible to build on and further explore emerging themes.

All interviews were audio recorded with permission and transcribed verbatim. Only the English conversations (and the interpreted portions) of the interviews were transcribed by me and included for analysis. [Appendix B](#) provides the consent forms for the refugee women and service providers/decision makers. All interviews were completed by me. Detailed field notes on context and nonverbal cues were taken during the interviews as well.

Others (Choi, Kushner, Mill, & Lai, 2012) have cautioned that the comprehension and interpretation of the meaning of data is central in cross-cultural qualitative analysis. Translation from a different language provides an additional challenge in cross-cultural research. Therefore, careful attention was given during the interpretation and transcribing process. According to Temple & Edwards (2002), *“to conduct meaningful research with people who speak little or no English, English speaking researchers need to talk to the interpreters and translators they are working with about their perspectives on the issues being discussed.”* Having that in mind, I explained the purpose of the research in detail to the interpreters to make sure that I also understood their perspectives on the subject matter, to further inform an accurate interpretation. Temple & Edwards (2002) wrote, *“rather than there being an exact match, word for word, in different languages, the translator is faced with a dazzling array of possible word combinations that could be used to convey meaning”*. With this challenge in mind, and to further add to the trustworthiness of study, I had one audio recording re-interpreted and transcribed by a native



Arabic speaker to analyse the interpreter's interpretation of my explanations and questions.

### **3.6 Roles of Principal and Co-Investigator**

I, as the Principal Investigator, developed the concept for the study, conducted all interviews by myself, completed all transcriptions, and conducted the data analysis. My supervisor, in the role of Co-Investigator, provided support and advice as required. I discussed the analysis and my findings from time to time with my supervisor during the interviews, as well as while writing the thesis. Importantly, this topic area is outside the co-investigator's research area, which also served to minimize hierarchies in our relationship. Though outside the scope of this thesis, we acknowledge that our relationship, in addition to my own positionality, described below, also shaped the study and its interpretation. In the context of feminist research, this is an area that has been reflected on by others (Yost & Chmielewski, 2013).

### **3.7 Analysis**

The data were analyzed using qualitative analysis and coded for themes based on recurring issues aided by NVivo 12 qualitative software. Qualitative thematic analysis – which is a method for identifying, analyzing, organizing, describing, and reporting themes found within a data set (Braun & Clarke, 2006; Vaismoradi, Turunen, & Bondas, 2013) is best suited for this study. Braun and Clarke (2006) presented thematic analysis as a linear, six-phased method. However, Nowell and colleagues (2017) argued that it is actually an iterative and reflective process that develops over time and involves constantly moving back and forth between phases. They outlined a practical and effective procedure of conducting thematic analysis by combining Lincoln & Guba's (1985) trustworthiness criteria with Braun and Clarke's (2006) six-phased method. How trustworthiness was obtained for the entire study has been described separately in

Section 3.7 based on Lincoln and Guba's (1985) trustworthiness criteria. The phased approach of thematic analysis conducted for the present study is described in detail below:

- Phase 1 – Familiarizing with Data: Braun & Clarke (2006) had emphasized on familiarizing and understanding the depth and breadth of the data, which can be achieved by the repetitive readings of the data. Searching for meaning, common pattern, and linkage are good approaches to follow while reading the data actively. I transcribed the audio recordings of all interviews, which allowed me to familiarize myself with the data. Following transcription, reading the transcripts several times provided an in-depth understanding of the participant's experience.
- Phase 2 – Generating Initial Codes: The next step is the coding phase where patterns and linkage in the data and labeled paragraphs are identified. Combining the text into small pieces of information (i.e., words and phrases) that seems interesting and reflects the overall research goal are suggested by researchers to develop codes (Braun & Clarke, 2006; Creswell & Poth, 2017). The initial codes are then reviewed and examined, and re-organized where necessary to match with the specific objectives of the study, as described by other scholars (Nkulu Kalengayi, Hurtig, Ahlm, & Ahlberg, 2012; Rouhani, 2011). I followed this procedure in generating codes, which was further informed by my discussions of preliminary results with the co-investigator and feedback from other researchers when presenting preliminary results.
- Phase 3 – Searching for Themes: Braun & Clarke (2006) had described this phase as re-focusing the analysis at the broader level of themes, rather than codes. This phase involves sorting the different codes into potential themes and collating all the relevant

coded data extracts within the identified themes. In brief, this step means analysing codes and combining different codes to form an overarching theme. The researchers suggested that, aid of visual representations such as mind-maps, or other techniques such as tables, writing down the codes in a separate piece of paper with description and sorting/ organising them into theme-piles can help to sort the different codes into themes, which may result in codes falling under more than one theme. In the present study, I used both mind-maps and tables to organize codes and emerging themes.

- Phase 4 – Reviewing Themes: This phase involves refinement of candidate themes. According to Braun & Clarke (2006), during this phase it becomes evident that some candidate themes are not really themes (e.g., if there are not enough data to support them, or the data are too diverse), while others might collapse into each other (e.g., two apparently separate themes might form one theme). Again, the reviewing and refinement of themes occurred with ongoing engagement with the data, the literature, and in discussions with my supervisor and those who responded to my preliminary presentation of results at various conferences.
- Phase 5 – Defining and Naming Themes: “Define and refine” means identifying the essence of what each theme is about (as well as the themes overall) and determining what aspect of the data each theme captures, as Braun & Clarke (2006) mentioned. Attention was given so that a theme does not seem covering too much ground or becomes too diverse and complex.
- Phase 6 – Producing the Report: The final step is writing the report. Braun & Clarke (2006) suggested that the analysis and write-up, should provide a concise, coherent,

logical, non-repetitive, and interesting account of the story the data tell – within and across themes.

Although widely used in qualitative research, thematic analysis has been poorly branded and rarely appreciated in the same way as grounded theory, ethnography, or phenomenology, as examined by Braun & Clarke (2014). The researchers further argue that as thematic analysis provides core skills for conducting many other forms of qualitative analysis, it should be a foundational method for qualitative analysis. Boyatzis (1998) has described thematic analysis as a ‘translator’ for those speaking the languages of qualitative and quantitative analysis, enabling researchers who use different research methods to communicate with each other.

### **3.8 Rationale Behind Selecting Thematic Analysis**

Qualitative thematic analysis – which is a method for identifying, analyzing, organizing, describing, and reporting themes found within a data set (Braun & Clarke, 2006; Vaismoradi et al., 2013) is best suited for this study. Although being widely used in qualitative research, thematic analysis has been poorly branded and rarely appreciated in the same way as grounded theory, ethnography, or phenomenology, as examined by Braun & Clarke (2014). The researchers further argue that as thematic analysis provides core skills for conducting many other forms of qualitative analysis, it should be a foundational method for qualitative analysis. Boyatzis (1998) has described thematic analysis as a ‘translator’ for those speaking the languages of qualitative and quantitative analysis, enabling researchers who use different research methods to communicate with each other.

While discussing the application of thematic analysis in health services research Braun & Clarke (2014) wrote “*TA offers a really useful qualitative approach for those doing more applied research, which some health research is, or when doing research that steps outside of academia,*

*such as into the policy or practice arenas. TA offers a toolkit for researchers who want to do robust and even sophisticated analyses of qualitative data, but yet focus and present them in a way which is readily accessible to those who aren't part of academic communities”.*

Below are some advantages of thematic analysis described in the literature:

- By means of theoretical freedom, thematic analysis provides a highly flexible approach that can be modified for the needs of many studies, providing a rich and detailed, yet complex account of data (Braun & Clarke, 2006).
- Thematic analysis is a useful method for examining the perspectives of different research participants, highlighting similarities/differences and generating unanticipated insights (Braun & Clarke, 2006; King, 2004).
- Thematic analysis is useful for summarizing key features of a large data set, as it forces the researcher to take a well-structured approach to handling data, helping to produce a clear and organized final report (King, 2004).
- A rigorous thematic analysis can produce trustworthy and insightful findings (Braun and Clarke, 2006).

### **3.9 Establishing Trustworthiness**

Lincoln and Guba (1985) define trustworthiness as a way researcher can persuade themselves and readers that their research findings are worthy of attention. They further refined the concept of trustworthiness by introducing five criteria – credibility, transferability, dependability, confirmability and audit trails. Nowell and colleagues (2017) elaborated on criteria of trustworthiness for qualitative research by reviewing the literature. Below each criterion is described in further detail based on literature and how they were applied in the present analysis for this thesis.

- **Credibility:** Lincoln and Guba (1985) suggested a number of techniques to address credibility such as prolonged engagement, persistent observation, data collection triangulation, researcher triangulation and peer debriefing. I, also the principal investigator, performed the tasks of participant recruitment and taking interviews, transcribing and analyzing data. Therefore, I believe that in participating in that many steps, I had prolonged engagement and persistent observation of the data. A randomly selected interview audio file was translated by a second interpreter; thus, a quality control check was also performed. I have discussed data collection progress and analysis with the co-investigator in detail, which confirmed the researcher triangulation task. I also had presented findings at different stages of the research (i.e., at the end of literature review, after data collection and analysis) in various conferences. Interaction and feedback from experts were obtained, and thus, peer debriefing task was also completed.
- **Transferability:** Transferability refers to the generalizability of inquiry. According to Lincoln & Guba (1985), it is not possible for the researcher to know beforehand what organizations or individuals may wish to transfer the findings; however, the researcher is responsible for providing thick descriptions, so that those who seek to transfer the findings to their own site can judge transferability (Lincoln & Guba, 1985). To meet this criterion, I included a description of the study sample and setting, and presented the research findings in detailed description, as well through simplified visual means (mind maps). Mind maps are an excellent visual thinking tool that aid in structuring information and for a more rigorous analysis. I used Edraw software to create the mind maps and organize my ideas. This structured, visual data presentation

- will help in knowledge translation by individuals or organizations for various use.
- **Dependability:** By ensuring that the research process is logical, traceable, and clearly documented, dependability can be achieved (Tobin & Begley, 2004). When readers are able to examine the research process, they are better able to judge the dependability of the research (Lincoln & Guba, 1985). As discussed in the credibility section, research findings were presented at various conferences. The feedback from conference participants including examination of the research process and judgement on findings were later incorporated into the research. The author's thesis supervisor and research co-investigator had the opportunity to examine the research process and judge the dependability throughout the research program and at the end during reviewing the manuscript.
  - **Confirmability:** According to Guba & Lincoln (1989), confirmability is established when credibility, transferability, and dependability are all achieved. Tobin & Begley (2004) emphasized that the researcher's interpretations and findings are clearly derived from the data, requiring the researcher to demonstrate how conclusions and interpretations have been reached. This process has been well documented in data analysis.
  - **Audit trail:** With the same data, perspective, and situation if another researcher could arrive at the same or comparable, but not contradictory, conclusions then the research can be considered as auditable, as argued by Koch (1994). According to Sandelowski (1986), a study and its findings are auditable when another researcher can clearly follow the decision trail. This step again was verified by the positive feedback and agreement by peers at research conferences, the literature, by author's research

supervisor, and thesis review committee.

### 3.10 Positionality and Reflexivity

Positionality and reflexivity are critical to any research, and therefore require attention. According to Patton, “*Reflexivity has entered the qualitative lexicon as a way of emphasizing the importance of self-awareness, political/cultural consciousness, and ownership of one’s perspective*” (Patton, 2002). The researcher attempts to be neutral by making rational and logical interpretations and assume a ‘null hypothesis’ in a traditional positivist research paradigm (Bourke, 2014). However, we are human beings with our own morals, beliefs and values that can impact our perceptions or the ways we see the world. Willingness to consider how the researcher’s background, personal values, and experiences can affect what the individual is able to observe and analyze is important and required by reflexive research (D ’silva et al., 2016). Researchers’ socioeconomic status, education, training, ethnicity, or whether one is an “insider” or “outsider,” all can influence the research outcome and interpretations (D ’silva et al., 2016).

I am a fairly new immigrant to Canada and an adult woman. It is important to note that immigrating as an adult is very different than immigrating as a child or teenager. The child or teenagers are more likely to adapt with the new culture, environment, making friends and learn the new language more quickly. The refugee women arrived as adults, like me. My own background and values may have influenced this study right from choosing this topic, to the interpretation of the findings, and representation of the results (what information was deemed important and presented and what was omitted). I acknowledge that I might have my own biases and opinions, which is a limitation to this study, but also a strength. Therefore, I took into consideration the influence of my background on emerging data and to record immediate thoughts during data collection.



Being a physician (International Medical Graduate), I interpret mental health issues from a clinical, biomedical perspective, which added value to the research given the pragmatic focus on the healthcare systems. For example, when the participants talked about not being able to sleep or not feeling hungry, my biomedical perspective immediately led me to correlate these as symptoms of depression. At the same time, my biomedical perspective potentially limited my ability to look beyond that perspective or to see a different perspective.

It was anticipated that the power dynamics would come into play considering the immigration status, gender, economic status, war experience, language challenges etc. I believe my ethnicity and gender acted as a bridge between me and the refugee women participants. Moreover, similarities in my and refugee women participant's background as being from developing countries also brought a sense of familiarity and made them more comfortable during the interview. Being from same religious belief (Islam), it was easy for me to understand what the refugee women meant when they referred to prayer and reading the Holy Quran as options to cope with stress. While Arabic is not my first language, I learned to read Arabic in my childhood, like many Muslims, as the Holy Quran is written in Arabic. Therefore, I was able to pickup on some Arabic words during the interviews, for example, 'Alhamdulillah' means 'praise be to God' or 'thank God'.

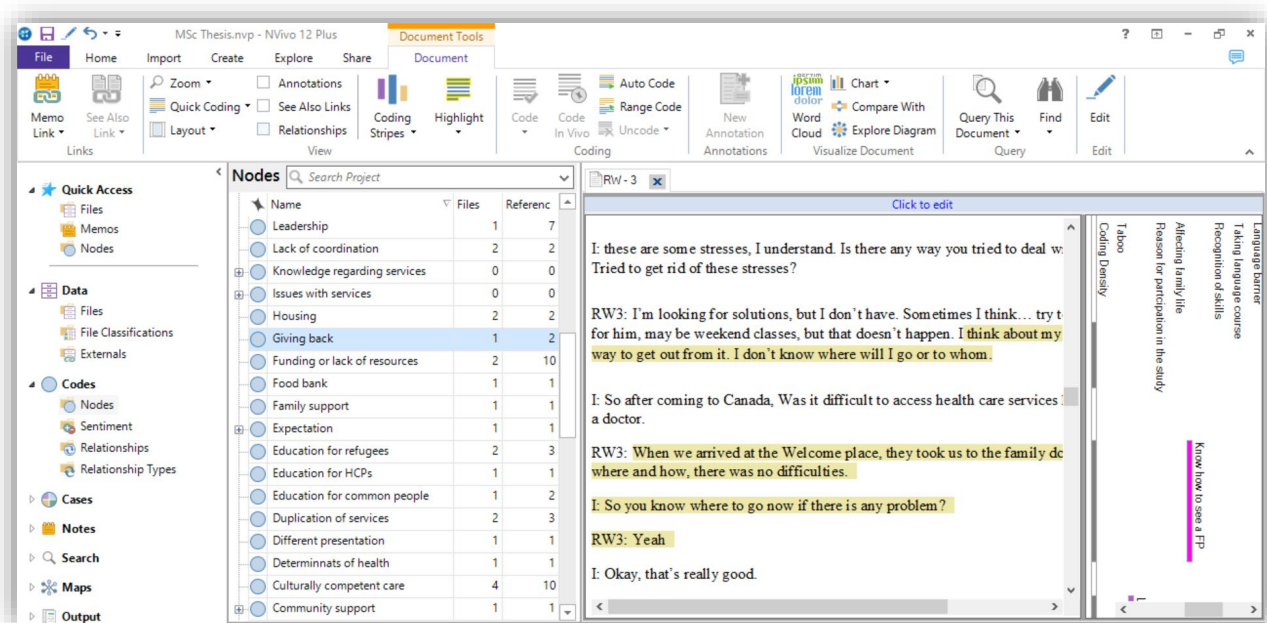
## Chapter 4. Analysis and Results

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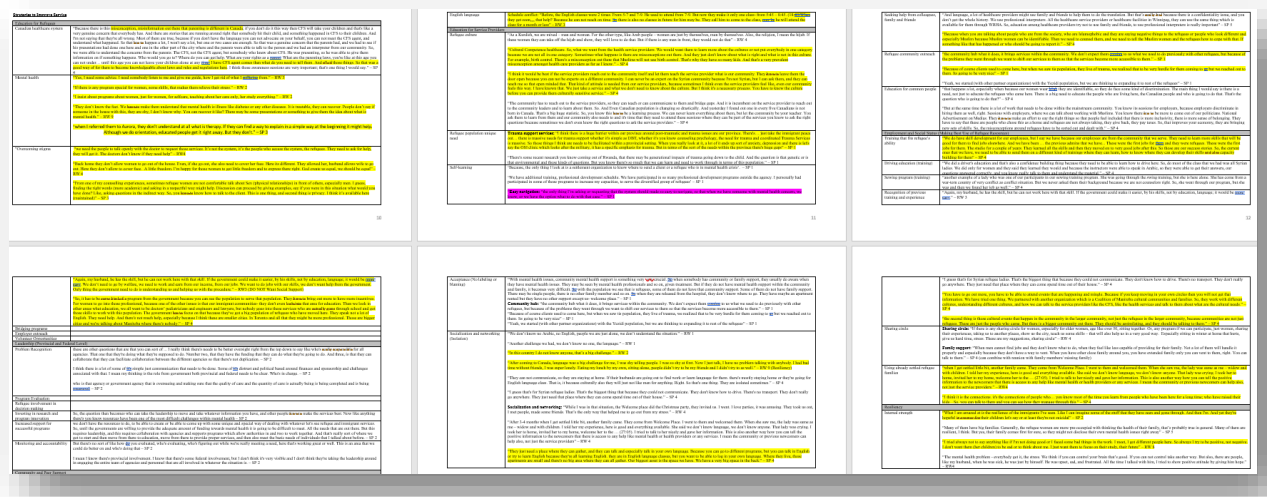
A total of nine refugee women and six service providers/decision makers were interviewed. The interviews for both refugee women and service providers were analyzed simultaneously. In summary, the analysis process included reading the transcripts over and over to familiarize with data. Then a list of primary codes was developed inductively. The codes were further refined, expanded and combined to form overarching themes. While reviewing defining and naming themes, sub-themes were assigned within themes where similarities among codes were found. This step has helped with better data representation. For the final analysis step, patterns were identified within and across the themes, which led to presenting the entire analysis in two broad subject areas – (1) *barriers in accessing mental healthcare services* and (2) *strategies to improve mental healthcare services for refugee women in Winnipeg*. In addition to the analysis software NVivo, suggestions from Braun and Clarke (2006) such as visual representations (mind-maps), and other techniques (tables, writing down the codes in a separate piece of paper and sorting the piles of developed themes etc.) were implemented during the analysis. Figure 4-1 provides a snapshot of the thematic analysis with NVivo and Figure 4-2 provides a snapshot of using tables for analysis, respectively. Separate Mind maps were developed for both subject areas – barriers and strategies, then revised numerous times throughout the analysis process. The final Mind-maps at the completion of analysis are presented at the beginning of each section for each of the two subject areas listed previously.

### 4.1 Participant Characteristics

Table 4-1 provides an overview of the participant characteristics. Among nine refugee women, six were married, two were widowed and one was single. The education level among the refugee women participants varied. One refugee woman had a bachelor's degree from Syria and



**Figure 4-1: Thematic Analysis Coding with NVivo**



**Figure 4-2: Organizing Transcripts in Tabular Forms to Develop Codes**

working at part-time or in a temporary position in Winnipeg. One refugee woman was attending a post-secondary institution. The remaining seven participants had education level in between elementary to Grade 9 and the majority mentioned attending English as an Additional Language (EAL) programs in Winnipeg. One refugee woman was employed, and another engaged in

casual work. The majority of the participants had to rely on social assistance for living. The interviews ranged in length between 40-90 minutes. Two participants were PSRs and remaining seven were GSRs. By reaching a sample size of nine, a wide range of participant characteristics were covered – such as, PSRs and GSRs, employed and unemployed, single/widowed refugee women and refugee women having spouse, large and small families, varying education background etc. Therefore, the sample size of nine, which was in the range of my proposed sample size, seemed adequate. In my last two interviews, I felt that most information was repetitive of previous interviews and would not result in developing any new themes. This has helped me to conclude that by interviewing more women I did not anticipate any new information; thus, the data saturation had been reached.

**Table 4-1: Interview Participants**

Category	Participant Number	Participant Details
<b>Syrian Refugee Women (RW)</b>	9	<ul style="list-style-type: none"> <li>• 2 Privately sponsored and 7 Government sponsored</li> <li>• 2 were able to communicate in English and 7 participated through interpreters</li> </ul>
<b>Service Providers and Decision Makers (SP)</b>	6	Professionals who directly or indirectly serve refugees such as Psychiatrist, Family Physician, Settlement Worker, Decision Maker

## 4.2 Feasibility Challenges

Recruiting Syrian refugee women to participate in the interview was a challenge. Only two out of nine participants were able to communicate in English, therefore the interpreter service was used. As a measure to meet the trustworthiness criteria in data collection, one interview that required interpretation service was rechecked by a second interpreter. However, still the possibility exists that through translation meanings may not have been interpreted as they were intended. Some participants may not have chosen to disclose traumatic experiences,

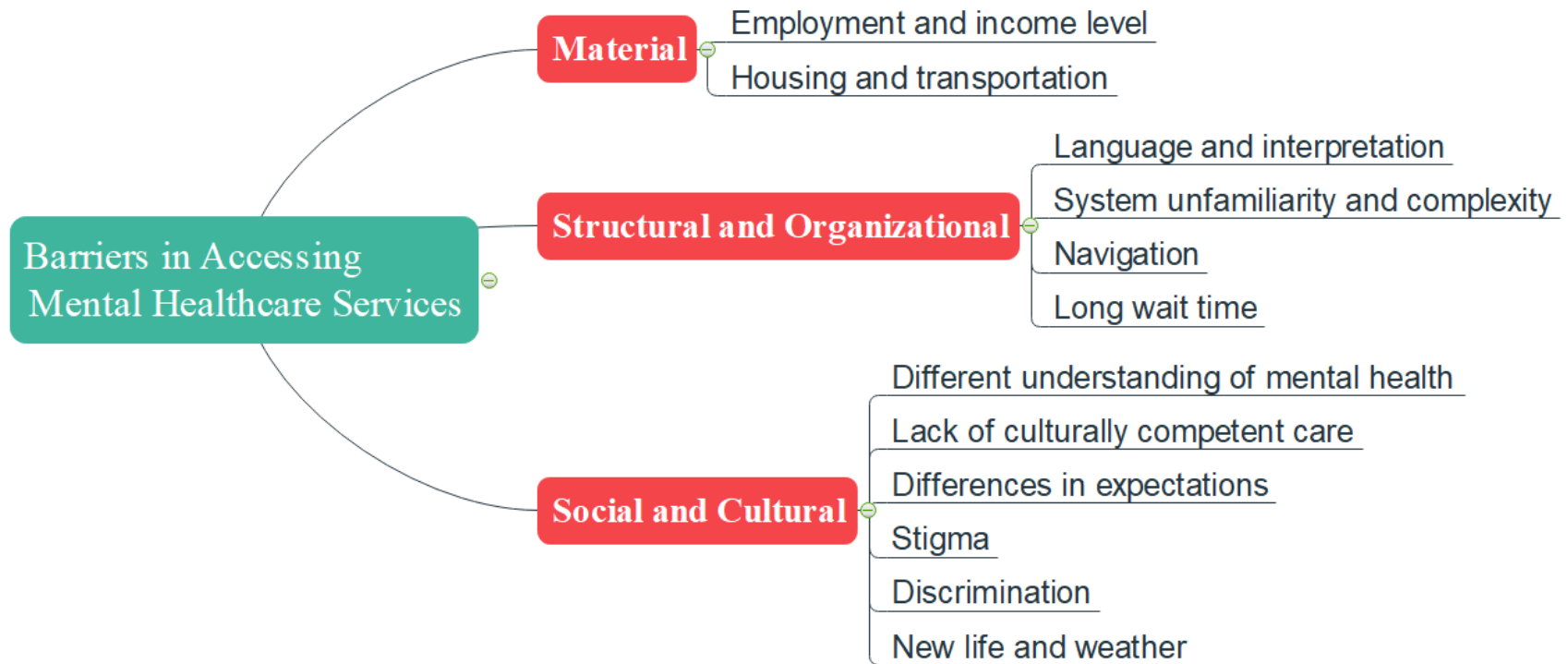
histories of sexual violence, or lack of autonomy in domestic spheres, as examples. As another example, one woman was reluctant to speak when the recorder was on. She only shared issues regarding her daughter's marriage when the recorder was off.

#### **4.3 Mental Healthcare Needs of Refugee Women and Sources of Stress**

The mental health issues that the Syrian refugee women talked about during the interviews were lack of overall mental wellbeing, anxiety, frustration, stress, and persistent sadness. Additional mental health concerns that the service providers identified among refugee women are trauma, mood issues, sleep problems, PTSD and grief. It was difficult for the service providers to identify mental health issues specific to Syrian refugee women. However, service providers mentioned that they have seen the same mental health problems among refugee women who had experienced war and violence.

The most common sources of stress identified among refugee participants were not speaking the English language, unemployment, health issues of family members, difficulties in terms of relationships with children, fear of negative repercussions (such as losing custody of children to Child and Family Services), struggles of settling in a new country, weather, bullying, the feeling of being unwelcomed, and family members left behind. Service providers were concerned about the mental health issues of their refugee clients and settlement workers seem to waste no time in getting their health checked. One interview participant, who is a settlement worker had summarized the initial settlement and health screening process of GSRs:

“After I pick them up (from airport), we give them allowances for 10 days. Then they meet IRCC and we start from there. Housing department will find a house for them and for me, I refer them to BridgeCare family clinic to find a family doctor, to the dentist and to the eye doctor. Then to Aurora right away, as required. Then I arrange for documentation and other necessary registration for adults and kids. Aurora will refer them to family dynamic if they have any Psychiatric problem and those things.” (SP 3)



**Figure 4-3 : Mind Map of Barriers Faced by Refugee Women in Accessing Mental Healthcare Services**

## **4.4 Barriers in Accessing Mental Healthcare Services**

The barriers in accessing mental healthcare services were grouped into three themes as illustrated in Figure 4-3: material, structural and organizational, and social and cultural. Each theme is described in detail below. Importantly, there were also inter-relationships between some themes, which are also highlighted below. Lastly, what were described as barriers to accessing mental health services were, in many cases, simultaneously sources of stress, which potentially contributed to poorer mental health.

### **4.4.1 Material**

#### **4.4.1.1 Employment and Income Level**

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The majority of the refugee women interviewed did not have a job and were relying on social assistance for their living. Refugee women who are widowed and/or have children to take care of, face more challenges as their family roles begin to change, and the traditional support system they had at home becomes non-existent. With increased family responsibilities some work in multiple jobs and do not have any time to take care of themselves.

“The life is very hard over there, I mean the financial, I had to take care of everything. And, because I’m by myself, the responsibility is too big” (RW 5)

#### **4.4.1.2 Housing and Transportation**

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Immigrant & Refugee Community Organization of Manitoba (IRCOM) helps the refugee women to find affordable housing, which was usually centrally located in Winnipeg. Being located close to downtown, the participants described having better access to services while living in these houses. However, they need to move out after certain period (usually 2-3 years). Several refugee women mentioned moving to the south side of the city and facing barriers in accessing services like transportation, distance to the facilities etc.

Both the refugee women and service providers also discussed the challenging weather conditions. The cold weather during winter makes it even more difficult to take the public transit if they want to visit a doctor or therapy/counselling service provider.

“I think we have to look at a couple things one is as simple as housing is sometimes a concern as it can really impact mental health” (SP 2)

“.....Among other barriers the cold, the winter is really bad for mobility. Especially we have lot of people who have challenges, like physical challenges, wheelchair dependent. Some have hard time to connect to handi-transit, which always takes time. So, mobility is a big thing” (SP 5)

Since the Health Science Center (HSC) and majority of the service providing organizations are located near downtown area, participants talked about the lack of service facilities in other parts of the city, such as in the south end. Carrying disabled children to doctor’s offices is another major challenge that a participant pointed out.

“For me it was challenge to take my children by myself, especially my two children, their physical disability – they can not walk” (RW 2)

Sometimes the housing issue keeps the women so occupied that they are less likely to think about their own mental health problems or to see a doctor. Financial inability limits the refugee women’s access to better housing, in terms of both renting and purchasing, and hence was also a source of mental stress.

“The rent is very expensive and compare to our country, everything over there was very cheap, and here it is very expensive. We cannot afford it.” (RW 6)

“We are thinking about the house, for example. It's very difficult to buy. Now I work all the time. I work more than one job, but all of them casual. So, I think to get loan from the bank for example and buy a house, because my work is not permanent, this is one of the difficulties or make us all of us stressed.” (RW 8)

## **4.4.2 Structural and Organizational**

### **4.4.2.1 Language, Interpretation, and Communication**

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Language barrier is one of the major challenges in accessing any healthcare services that



was repeatedly mentioned – in the literature, by the service providers, and the refugee women themselves.

“First issue is language. Somebody is talking to you and you cannot respond to them. You don’t understand anything. It is not easy.” (RW 6)

The service providers discussed this issue. This is also not easy for the refugee women to learn a new language so that they can communicate with the service providers. Moreover, as discussed in the literature, being women makes it even more difficult to learn English, which the services providers found to be true.

“Language issue is a problem, especially in lot of cultures women are not educated, they don’t speak English, they have a hard time learning English because they are illiterate. Especially if they are single women with children and if there is no male figure around, it’s harder for them to learn the language, navigation, as they try to make the appointments or going to the specialist appointment can be very difficult and challenging.” (SP 5)

“The challenge is not mental health, but challenges are because of language. They can not communicate, so they are staying at home. If their husbands are going out to find work or learn language for them. They are mostly staying home or they're going for English language class.” (SP 4)

Due to the lack of English language fluency many refugee women need the help of interpreter to communicate with mental health professionals. Needing the help of an interpreter means that someone else has to go with the refugee women to translate, and the availability or wait times for that individual also adds to the wait time to see a psychiatrist or psychologist.

“The bigger issue we have here is language, it’s a barrier. We always need somebody to be with us to translate” – (RW 7)

Since professional interpretation service is not always available options like using family members including kids, friends, personnel from same community or culture, telephone interpretation services etc. have been explored by service providing organizations. They all have disadvantages, as the service providers have pointed out.

“Sometimes we use telephone interpreters, which then could be from anywhere in North America. It's much more anonymous but it may not be as effective because you don't have the person in the room to read the facial expressions and know what's going on”. (SP 2)

The service providers have noticed that many of their clients didn't like using telephone and felt that therapy was enhanced by having a real live interpreter in the room. Many refugee women were not comfortable sharing their mental health issues or past experiences in front of an interpreter who is from their same community. This also applies to using friends or family members. Therefore, in many occasions the refugee women have searched for service providers who speak the same language.

“Sometimes the women or even men who are from this particular language, they want to talk to a counselor who is from that language, so they can understand. They can go to counseling but if it's through interpretation; obviously there's so much information that's lost, because the interpreter is from their own community. They don't want to be opening up in front of that person. So that plays a role. Second thing that we see is that sometimes they want to go to somebody outside the community because they don't want their own community to know what is going on with them. They want to be private.” (SP 4)

#### 4.4.2.2 System Unfamiliarity and Complicacy

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The lack of knowledge about the Canadian healthcare system in general is a challenge for refugees. To see a specialist, for example a Psychiatrist, involves many steps like seeing a Family Physician or a Primary Care Physician first, then getting referred, making appointments etc. The service providers have recognized that the system is complex for the refugee women and very different than what they have been used to, therefore, many struggles with going through the entire process.

“The system is different here. I think a lot of refugees are kind of lost about how the system works here. We try to tell them and explain them in their first visit what is the emergency for, when should you go to the family doctor. But I think it's very challenging for them to get used to that, to learn the system. I guess the system also has some problems –they might go to emergency and then find another doctor, I don't know if they have a family doctor. So, we need more communication, collaboration. Healthcare

system is for sure one barrier.” (SP 5)

#### 4.4.2.3 Navigation

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System navigation is particularly challenging for refugee women, especially those who does not have a male figure around them. The refugee women recognized that there are services available for them, but they do not know how to get there, especially using public transit. Many depend on their husband to take them for appointments as they cannot navigate by themselves.

“I can not find my way easily by using buses or knowing the addresses. The language is a big problem. Even there may be services out there, but I don’t know how to reach to those services. I just go to school or come here at CMWI. I don’t know any other places.” (RW 1)

#### 4.4.2.4 Long Wait Time

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Long wait time is a major problem for the overall healthcare system in Canada. Both the refugee women and services providers discussed this particular issue. The long wait time is a significant barrier as it demotivates the refugee women to seek help. There is long queue in getting a specialist appointment or even at hospitals.

“The waiting hours in the emergencies, that is not good. When I fell or get unconscious, they took me to the hospital. I wait 2 hours, 3 hours until I saw the doctor. This is the only thing that is not good in the system.” (RW 4)

“In Middle East they don't have appointments. When you are sick, you go, and you wait over there in the reception for example, until your turn is coming. So, they don’t like a long waiting.” (SP 3)

### 4.4.3 Social and Cultural

#### 4.4.3.1 Different Understandings of Mental Health

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When asked about what mental health and wellbeing means to them, the majority of the refugee women could not express their knowledge very well. Sensing a lack of overall well-being or being stressed were not viewed as mental health problems by the clients. Several

refugee women who were interviewed did not use any word consistently to express mental health issues, such as, they did not know what stress or depression means.

“I don’t understand what the mental health care issues or mental health issues. I have not fully understood what mental health is. And where is the services.” (RW1)

“I actually don't read about it or know a lot. Just I know, if like somebody has these mental issues, maybe he'll go to a specialist. I think psychiatrist. But it's a little bit, not too much.” (RW 8)

Interviewing refugee women revealed their understanding of mental illness was more consistent with specific types of mental health issues, rather than how western medicine describes mental health. For example, refugee women described mental illness as ‘nothing can be done as God has created people like this’, or ‘as acts of aggression’, or ‘acting crazy’.

“For mental illness, they have no brain, they are out (brain out). But for psychologic, they can think, sometimes they control their behaviour, still they need to sit by themselves, sometimes they cry, they talk with themselves. It is different.” (RW 4)

“I like to say something, in back home when people see someone suffer from mental health issue, they know this is something that we have no control on it. And, God create those people like that. And they shouldn’t make fun of them. And also, regarding the stress that I have, because I get stress from those things, I don’t know what to do sometimes, I don’t know.” (RW 6)

Service providers corroborated the differences in understanding mental health as being a barrier to accessing services. Notably, this barrier was also partially attributed to limited educational background of refugees rather than solely a cultural difference.

“At the beginning our client when they come, they' don’t understand anything about that one (therapy sessions). For example, if I tell them, okay I will refer you to the therapists, even in the language they don't understand. Especially when we are dealing with a people with the educational background is zero, they understand nothing. So, I have to tell them in a very simple way that, this is something related to the mental health illnesses. Then they will go.” (SP 3)

Mental illness is seen as western concept by many refugees. It is a common practice in their culture to seek help from family, friends or spiritual leaders first instead of seeing a medical

professional. The refugee women mentioned that back home people with mental illness are being labeled as crazy, kept in isolation. Therefore, many are not even willing to express any kind of mental health issue. The service providers had recognized the differences in understanding and expressing mental illness between Western and Middle Eastern culture.

“I guess, it’s also has to do with the culture. In western culture we are more focused on our own mental health. Probably for their culture, if your family is doing well that means you are doing well. They might have underlying mental health issue, but their mental health would be more focused on their family’s mental health. And, I think that’s cultural.” (SP 5)

Gender also figured prominently in this theme of socio-cultural differences as a barrier to accessing services. The Syrian women are used to being dependent on their husband back home. They had traditional family support from parents or relatives as well. The dependency on husband in combination with language challenges makes it much more difficult for refugee women to access services by themselves in Canada.

“Back home, I depend on my husband for everything; even when I go to doctor, or shopping, anywhere, he takes me there. Or if he is not there my mom goes with me. Here little bit different; by myself with my family, even my husband is busy. That’s a challenge how I’ll go by myself. This is one. The other one is language. Also, that is hard for me. If I want to know how to go out and communicate with people, I have no idea. That’s more challenge. Still even after 3 years we are learning little bit about communication, still I’m dependent on my husband somehow.” – (RW3)

Preference for female physician by refugee women is very common, which is related to their religious beliefs and Middle Eastern culture. During the interviews it was mentioned by both refugee women and service providers that seeking permission from husband was required to see a male physician. In some instances, unavailability of a female physician can result in restrictions or cancellations of appointments.

“.....to make referral for a woman to see a male doctor, with male psychiatrist/psychologist this woman, in some instances, has to have permission from their husband..... Or they may even decline the appointment because they are scared what

the community may say about. But its obvious we have been making effort to make sure that female clients are seen by female doctors or female health professionals.” (SP 1)

However, many of the participants reported that the situation is changing after spending some time in Canada and the refugee women are willing to see male physicians without any restrictions from family members. They had recognized the cultural differences and learning is the way of living here. Moreover, the healthcare service providing organizations including clinics and hospitals have many female service providers working there anyways. Therefore, some systematic adjustments in accommodating requests can help to a great extent.

“Here in Canada it’s different than back home. Here everything for men and women. So, at least men allow their women go out, go to school at least, because that is not their choices. Back home they don’t allow them to go anywhere, just sitting home. But now in Canada they are going to school, try to go and participate in another program. So, a little different.” (RW 4)

“Yes, a lot of Syrians like to see female physicians. So, for mental health issues they do not have problems to see a male physician. It’s more like gynecological issues when they prefer female physician. And, we have a lot of women working here, the counselor is a woman. But our Psychiatrist is a male, and people don’t have any problem to see him. But yes, for physical exam probably they don’t like to be in front of a male person, but for history taking usually they are okay.” (SP 5)

#### 4.4.3.2 Lack of Culturally Competent Care

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The lack of culturally competent care is a significant barrier in accessing mental healthcare services by refugee women. The refugee women have limited understanding on ‘Western’ method of mental illness treatment. Similarly, many service providers may also be unable to recognize or understand the way refugee clients express their mental illness. It could be difficult for a physician to read the body language or the role of culture in treating mental illness not being familiar with that culture.

“So, we got to be also careful how much do we ask about their past and their trauma. So, we've got to be sensitive to that. I mean not that such a cultural, but that maybe in sense of how much we actually ask about, what the base to be able to make a diagnosis right. So how do we engage people in a respectful manner without re-traumatizing them all

over again. And that's one of the challenges. One of the things that we did is that we had a bunch of Syrian women come together and started quilting together. So, they started knitting, quilting or whatever. They were doing quilting and we have provided some therapists that would be associated with that.” (SP 2)

The service providers have talked about the importance of teamwork. ‘One size fit all’ type of care may not work for these refugee women and will further limit their access to mental healthcare.

“You can’t put them all in one bag, each culture is different, each refugee is different, they have different backgrounds. I think, you just have to tailor to that individual, family or need.” (SP 5)

“The refugees are not all the same. So, tailoring to each culture, each individual – using interpreters being culturally sensitive as far as male or female kind of physicians. I think a teamwork, with this kind of population you cannot provide an effective care if you are just alone, you have to have a team – the outreach work counsellor. So, working in a team with this population is important.” (SP 5)

Related to culturally competent care and differences in expectations, not being heard or having a feeling of neglect has resulted in trust issues among the refugee women about the healthcare services in general. When asked during the interview about seeking help, several refugee women said they do not think that there is anyone who will listen to them, therefore, they do not feel like sharing their problems.

“I don’t complain. I don’t know where I go to seek help. I don’t know who will listen to me.” (RW 1)

“If I come here (CMWI) they understand me because of the language or the attitude. But for the doctor, he never asks me, I never told him anything. Just that what I complained. He never asked me about my feeling or how do I feel.” (RW 1)

“I need something to get rid of my stress. If I go to a doctor or psychologist will they guide me somehow? Do you think they will help me?.....I never think there is people to listen.” (RW 3)

#### 4.4.3.3 Differences in Expectations

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The refugee women had talked about their frustrations with the service providers. In

some instances, the Family Physician did not take enough history or engaged conversation with the refugee women, which gave the patient a feel of neglecting. Again, the need for culturally competent care be related here. The physicians need to spend more time with these patients, considering the fact that they will not be able to express their problems like the Canadian born patients. In some instances, the refugee women felt that they could not open up to the physicians, therefore, a referral to a specialist was not made. During the interview one refugee women talked about her dissatisfaction that when she visited a clinic, she was given a physical checkup but was not asked any questions about her mental wellbeing or stresses of her life.

“If we go to physio/ family physician and there is anyone to check, they do check up the body. Why they don’t check up our mental health, if we have some mental stress or situation, talk with us to know what we are suffering from?” (RW 2)

“Last time when I was very sick, my blood pressure went up, we went to the doctor. The doctor asked why your blood pressure is high? Then I give him little details about my situation, he was not like continue to ask me or refer me to anyone. That’s it. He just changed the medication. Because he didn’t continue or ask about my situation, that affected me negatively, so I just kept quiet.” (RW 3)

#### 4.4.3.4 Stigma

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Stigma is a major access barrier that has been mentioned repeatedly – in the literature, by the refugee women, and healthcare service providers. In many instances, although the refugee women had suffered significant mental health issues, they decided to manage their life stresses by themselves, and keep going or deal with it. Much of this stigma came from the negative attitude that the refugee women had faced or seen around mental illness in their country and culture.

“In my culture, for example, we don’t talk about mental health. No one will say they have diagnosis of depression. Otherwise they will be understood as crazy.” (RW 5)

“Back home, it’s like taboo. No one talk about this. By chance if you know a person who has problems or suffering from mental illness, no one tell. The family doesn’t tell. Even if they go to the doctor, no one tell that they have a problem, or they complained.” (RW3)



Although these Syrian refugee women have moved to Canada, yet the stigma around mental illness is there, therefore many are suffering in silence and unwilling to seek any help. Even, if they visit a Psychiatrist, they are not willing to take any medication.

“Stigma plays a significant role, I think, in individuals. Either one is not wanting to be on medication or what that means seeing a psychiatrist could be very stigmatizing.” (SP 2)

“Yeah, because of the background, all Middle East people have the same opinion right away. They think it's crazy (talking about mental illness) and you don't want to affect your job..... and they don't want to go (see a doctor). And even if they go, they try to keep it secret. They don't like to mention this to anybody.” (SP 3)

“I have clients, they have mental health issues, but they don't want me to refer them to another organization. Specially when they hear about mental health issue, they don't want to go there. Because, they are afraid how the society will look at them.” (SP 3)

The service providers have identified that it is very difficult for a refugee woman to talk about histories of sexual assault, she is afraid and cannot trust anyone. Sexual violence carries its own stigma, in addition to mental illness. In this way, the theme of stigma is very much related to the theme of trust.

“For example, if I'd been sexually assaulted, I won't trust them (service providers) to tell this, because maybe that person will go to the community and talk about that. I cannot trust my husband, maybe he will divorce me. I cannot trust my family, there is stigma. .... (now talking about herself) but when I went to get therapy then after I attended a session, I felt better. After a few years when I was thinking about that I said Huh...now I understand what this therapy means. At least you empty yourself. Apparently, you find somebody you trust them, to talk to them and you feel a little bit comfortable.” (SP 3)

#### 4.4.3.5 Discrimination

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Negative attitude and behavior towards refugees are common in host countries. Such behavior can create isolation, inequality of care and further limit the refugee women's access to mental healthcare services. Racism and discrimination felt by immigrants and refugees at doctor's offices have already been reported in Canadian studies. The negative attitude or behavior towards refugees can increase their stigma, as found during the interviews.

“.....And then, not everybody looks out at people who are different as that they belong here. There is a section of the society who feels like why they (refugees) are here. So, they (refugees) face that kind of discrimination as well. And I know one of our client’s experience. Somebody on the street was very bad to them and shouted slurs to them and all of that. So that happens a lot, especially because many refugee women wear hijab, they are identifiable, so they do face some kind of discrimination.” (SP 4)

#### 4.4.3.6 New Life and Unfamiliar Environments

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Adjusting to new life, an unfamiliar environment and the cold weather in Canada turned out to be a significant challenge for the refugee women. The lifestyle in Canada is much different than back home in Syria. As discussed earlier, most of the refugee women were dependent on their husband, they did not need to work, and just took care of their family. They had the traditional family support. Here in Canada, they need to work as well as take care of the family, and the traditional family support is non-existent. The situation for the single (widowed) refugee women is even more challenging as she had to do everything by herself (household chores, school appointments, doctor’s appointments etc.) in addition to their full/part-time jobs or attending EAL classes. Burdened with so many responsibilities, many are dropping out of EAL classes, cannot focus on studies, and therefore, are unable to improve their communication skills which could have helped with better access to healthcare or get a job.

“I have stressful life here. Before I was depending on my husband. Back home I didn’t need to work. I only need to take care of the family. But here I should work and take care of the family. So, I have stress. My life is very stressful. And my lifestyle is changed.” (RW 3)

“We try our best to know the language, we go to the school. But we found that we can not concentrate... ..how can I concentrate? Because the teacher needs homework from the children. For each child, I have to take care of them, I have to be with them. I have my teacher (EAL classes), I have my own homework, I have house chores, I have other works and lot of things. How can I concentrate and focus on which one?” (RW 6)

The changed weather conditions, especially the cold winter months, came as a shock to many. It is difficult for those who are already depressed to adjust to the weather conditions since

their outdoor activities are even more limited during this time. Most of the refugee women do not drive and waiting for buses in the cold for appointments is not always ideal.

“I was shocked with the weather, cold weather. I never saw this winter or snow before. That made me frustrated and think about home and crying. I had the idea of cold, but not this cold.” (RW3)

“Then I got shocked from snow, in winter no people walking outside. My first impression was is this Canada? I imagined it as a very nice country with nice natural view; there was nothing but white. All the time I used to stand by the window and looking outside, I was surprised, and I couldn’t believe this is Canada. During the summer, it was different. There was green, trees, people took me to the beach, then I found it good” (RW4)

#### **4.5 Strategies to improve Mental Healthcare Services for Refugee Women**

The second section of results focus on strategies to improve mental healthcare services for refugee women, which include the following themes: education, employment and social status, community and peer support, culturally competent care, increased service efficiency, leadership, resiliency and healing. The mind map outlining which codes fall under each theme is illustrated in Figure 4-4.

##### **4.5.1 Education for Refugee Women**

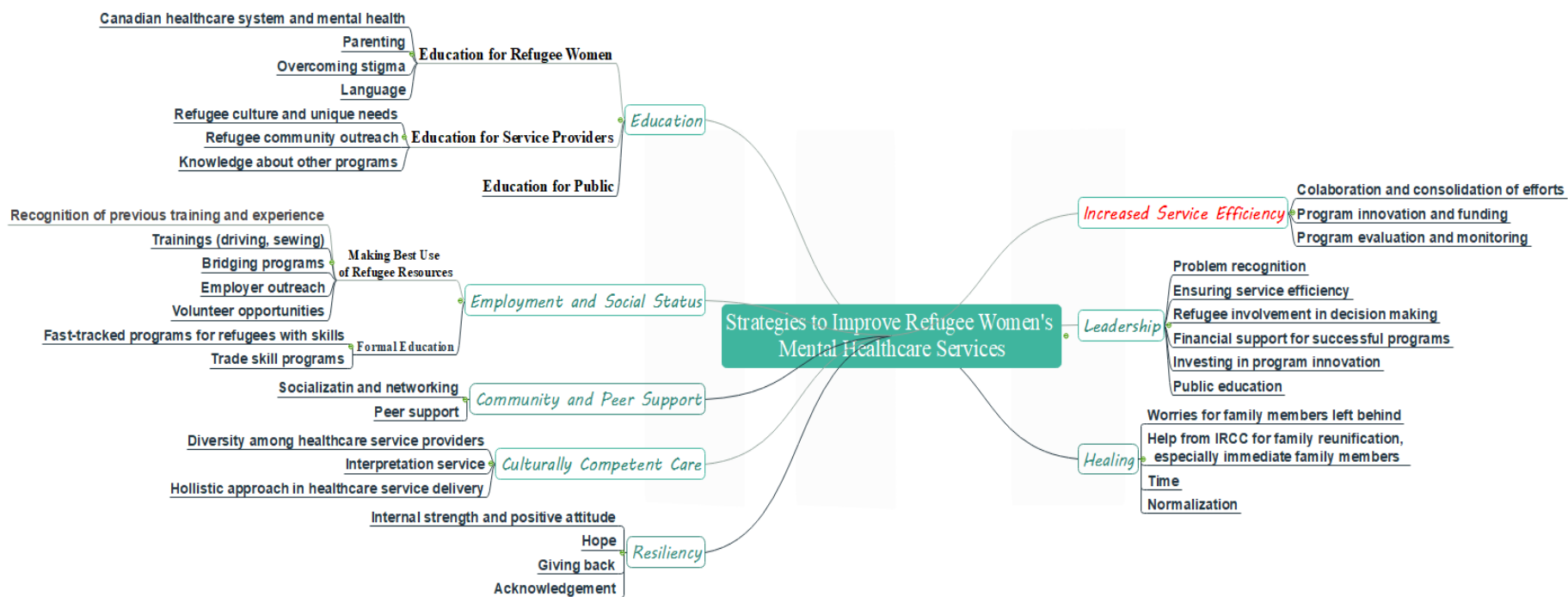
###### **4.5.1.1 Canadian Healthcare System and Mental Health**

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Refugee women lack knowledge about western perspectives of mental health and the Canadian healthcare system in general. Many do not know how to make appointments, obtain a referral to see a specialist, and often end up seeing multiple service providers for the same problem or none at all. During the interviews the refugee women felt that they need education and if there are special programs for women only, that would help them most.

“Yes, I need some advice. I need somebody listen to me and give me guide, how I get rid of what I am suffering from.” (RW 3)

“I insist about programs for women, just for women, for selfcare, teaching about her care only, her study everything. If there is any program special for women, some skills, that makes them relieve their stress.” (RW 2)



**Figure 4-4: Mind Map of Strategies for Improving Mental Healthcare Services for Refugee Women**

During the interviews refugee women showed interest in learning about mental health issues and options to cope with stress. Considering that many refugee women have limited to no formal education, explaining the facts and services to them in a very simple way can help. Just distributing leaflets of programs, giving them a phone number to call or a website address won't be of much help.

“... when I referred them to Aurora, they don't understand at all what is therapy. If they (service providers) can find a way to explain in a simple way at the beginning it might help. Although we do orientation, educated people get it right away. But they (refugee women) don't.” (SP 3)

Presentations on mental health, healthcare services, therapy, counselling, and special programs for women are some options to consider. During the interviews, one refugee woman who is attending a post-secondary institution was able to provide some suggestions around simple ways of explaining things to other refugee women of her community.

“They don't know the fact. We have to make them understand that mental health is illness like diabetes or any other diseases. It is treatable, they can recover. People (refugees) don't say if someone in the house has mental health issues, they are shy, I don't know why. You can recover from it, right? There may be some presentations or something to give them the idea about what is mental health.” (RW 9)

#### 4.5.1.2 Parenting

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Settlement workers reported refugee's misconception around parenting and Child and Family Services (CFS) in Canada and emphasized on the need of educating them about rules and regulations. There is a real fear among refugee families, especially the women, that they will lose the custody of their children if they do this or that. How their children will cope up with the new culture, what if they forget their own culture, how they can make the children understand if they are not cooperating etc. are causing significant mental stresses to the refugee women.

“... there is this misconception, misinformation out there that you know parenting is different in Canada if you don't do it this way then CFS will take your children and that's like a very genuine concern that everybody has.” (SP 4)

“The daughter (of a refugee woman who is [<18 years old]) went through a lot of marital problems and got divorced few months back. CFS got involved into the case now as the girl was not completely agreed during the marriage. At this moment, the mom (refugee participant) is experiencing so much problems with this issue – both from the family (in-laws’ side) and from CFS. This is a major stress of her life at this moment. Being a single mom, this has been extremely difficult for her.” (SP 3)

Now the problem is, the refugee families are not able to communicate very well to the CFS agents due to the language barrier. Therefore, they cannot advocate on their behalf and explain or discuss with the CFS agents to make them understand what happened. While there are not many cases of losing custody of children among refugees, but one or two are enough to create that fear. Providing education to the refugee women about parenting in a very simple way, how to share information, and deal with CFS, arranging meetings with CFS agents, organizing community events etc. are some options that the service providers talked about during the interviews.

#### 4.5.1.3 Overcoming Stigma

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Overcoming stigma is one of the most important strategic areas to improve access to mental healthcare services. Some refugee women also realized the necessity of sharing their mental health concerns, stresses, anxieties with the doctor so that they can access services.

“We need the people to talk openly with the doctor to request those services. It’s not the system, it’s the people who access the system, the refugees. They need to ask for help, then they will get it. The doctors don’t know if they need help.” (RW 4)

There is a need for privacy, which in turn, is also related to the culturally competent care component. Most refugee women will not talk about physical/sexual abuse (past or present) to or in front of a man. While many facilities already offer the privacy that refugee women need, it is also important that the service providing personnel also understand how to engage in discussions around the sensitive subjects like sexual abuse. This will be discussed in more detail in the education for service providers section.

“From one of my counselling experiences, sometimes refugee women are not comfortable to talk about sex (physical relationships) in front of others, especially men. I guess, finding the right words and asking in a respectful way might help. Discussion can proceed by giving examples, say if you were in this situation what would you have done? Like, asking questions in the indirect way. So, you have to know how to talk to the client. This is one thing, and second thing is privacy.” (SP 3)

#### 4.5.1.4 Language

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Nearly every refugee participant is attending EAL classes to improve their communication skills for any need. At the same time, they feel the positive energy of freedom and being able to engage in activities outside home. However, some refugee women have mentioned about scheduling conflict and classes being offered only at one specific time. This makes very challenging for themselves and their husbands to attend the classes. Offering the classes at different times in a day and including childcare facilities while the refugee women attend EAL classes would be beneficial.

“I enjoy the EAL class. It’s something new and different.” (RW 7)

“Before, the English classes were 2 times. From 5-7 (pm) and 7-9 (pm). He (the refugee women’s husband) used to attend from 7-9. But now they make it only one class- from 5:45 – 8:45 (pm). To join the evening classes, when he finish his job, he changes his clothes within the car, once he reach to the class, he is already tired, he can not focus. So, no improving for his language now for 3 years. This also makes me more nervous, stressed.” (RW 3)

#### 4.5.2 Education for Service providers

The interviews with refugee women and service providers revealed important information around the understanding of their culture, their religion, wearing hijab, accommodating requests for female health professionals, priorities of having a big or small family etc. Service providers require some knowledge of the refugee population’s unique needs to provide better services. They also need to reflect on the biases and stereotypes they may hold about refugees or Muslims, in general. The quote below highlights a common stereotype specific to birth control.

“.....culturally competent healthcare. So, what we want from the health service providers. We

would want them to learn more about the cultures or not to put everybody in one category because we are not all in one category. Sometimes what happens is there are misconceptions out there. And they just don't know about what is right and what is not in this culture. For example, birth control. There's a misconception out there that Muslims do not use birth control. That's why they have so many kids. And that's a very prevalent misconception amongst health care providers as far as I know.” (SP 4)

#### 4.5.2.1 Refugee Community Outreach

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During the interviews service providers talked reaching out the refugee communities to learn their culture, and the refugee communities also need to come forward to teach the service providers about their culture.

“I think it would be best if the service providers reach out to the community itself and let them teach the service provider what is their community or culture. They (service providers) have to leave their door open because you cannot be the expert on a different community. I can never be an expert on the Syrian community because I'm not Syrian, but I can ask them, and they can teach me. So, that kind of attitude is needed from our service providers. We should not think that they (refugees) just take a service and what we don't need to know about the culture. But I think it's a necessary process. You have to know the culture before you can provide them culturally sensitive service.” (SP 4)

There are already examples of community outreach initiatives in Winnipeg, such as community hub. The service providers recognized that since many refugee women have past histories of trauma or may be still living with that, it must be difficult for them to look for help. Instead, the service providers can reach out to them. Larger settings such as – community centers, halls, city recreation facilities in communities, gyms etc. can serve as community hub where counsellors, psychiatrists can make visits in certain times.

“The community hub what it does, it brings services within the community. We don't expect them (refugee women) to come to us, what we used to do previously with other refugees. Because of the problems they went through (Syrian refugee women) we want to shift our services to them so that the services become more accessible.” (SP 1)

#### 4.5.2.2 Knowledge About Other Programs

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It is important that service providers are aware of the programs available for refugee women and where they can get help, not only for their mental health related issues, but also



social services. The service providers talked about the need for networking and information sharing among themselves so that they can refer these refugee women to the appropriate service. Since many refugee women are unable to communicate in English, navigation is a significant challenge for them. Therefore, service providers can come a step forward by connecting the refugee women to the other providers whom they are referring to instead of just providing a leaflet, a phone number, or an email address.

“Because we don't have any of those concrete services here, but we will refer them somewhere else. So yes, we are in contact with a lot of different agencies also because we are a family resource center. And there is a network of family resource centers, therefore, we find out regularly what's happening. We have done all these networking meetings, so we know what's going on out there, what are the different programs out there.” (SP 4)

Partnering with other agencies and organizing combined programs is another potential strategy. The service providers get to know each other and their programs, and of course the refugee women will get the most benefits.

“So, we partnered with Norwest. They came here and created a very relaxed kind of an environment and then conducted a program. We called it cooking and conversation, so you could do something while you talk. And we know that process works because other centers are doing that as well. So, they talked about things, how to settle in a new country, children upbringing up in a new country, because those are the issues that they are facing.” (SP 4)

#### **4.5.3 Education for Public**

Negative attitudes, criminalization, racial slurs or discrimination towards refugee women can have serious consequences for their mental health. Since many of the refugee women, and almost all who were interviewed, are identifiable because of wearing hijab, they may become a target for discrimination. One refugee woman shared her own experience of bullying at school. She complained to the school authority about the situation but had a feeling that their actions were not sufficient enough to completely stop the bullying.

“.... they (school authority) were like kind of helpful, not so helpful. For example, they talked

very kindly with the boys, they were not serious with them. So, the boys were not really afraid of being fired from the school; they were just like, ok leave her alone; they were still talking about me and I heard them, but it was not that bad.” (RW 9)

The service providers recognized the issue of racism and emphasized the importance of public education. Settling in a new country and adapting to a new culture are already challenging for these women. Now the feeling of being unwelcomed can be very hurtful for them.

“That happens a lot, especially because our women wear hijab, they are identifiable, so they do face some kind of discrimination. The main thing I would say is there is a need, not just to educate the refugees who came here. There is a big need to educate the people who are living here, the Canadian people and who is going to do that? That's the question who is going to do that?” (SP 4)

“But at the same time there is a lot of work that needs to be done within the mainstream community. You know its sessions for employers, because employers discriminate in hiring them as well, right. Sessions with employers, where we can talk about working with Muslims. There has to be more to come out of our politicians. Advertisement on medias. They have to make an effort saying the right things so that people feel included, there is more sense of belonging. They have to say that these are people who chose this as a home and refugees are not always taking, they give back, they pay taxes. So, that improves your economy, they are bringing new sets of skills. So, the misconceptions around refugees have to be sorted out and dealt with.” (SP 4)

#### **4.5.4 Employment and Social Status**

##### **4.5.4.1 Making Best Use of Refugee Resources**

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Unemployment is one of the major sources of stress for the refugee women, and their families, and was mentioned repeatedly during the interviews. Mental wellbeing, the standard of living, or social status all depend on the level of income, to some extent. Almost all of the refugee women interviewed were dependent on social assistance. Many considered that the Canadian government has already been generous enough to accept them as refugees in Canada. In addition, providing social assistance gives them a feeling of being a burden to the society. Many refugee women, or their husbands, want to work and not be reliant on social assistance programs, but they are unable to do so mainly due to the language barrier and their previous

education or training not being recognized in Canada. The refugee women have urged that the authorities can do more to find a way so that they are able to utilize their skills, work, and earn their living.

“Again, my husband, he has the skill, but he cannot work here with that skill. If the government could make it easier, judged him by his skills, not by education/ certificate, language; it would have been easier. We don’t need to depend on welfare, we want to work and earn from our income, from our jobs. We want to do jobs with our skills, we don’t want help from the Government. Only thing the Government need to do is understand us and help us with the procedure.” (RW 3)

The service providers considered the fact that gaining employment also offers an opportunity to learn English, and where refugee women will get to know new people. Therefore, they have employed some refugee women with minimal to no skills, provided training, and eventually helped them to get better jobs. However, they have limited funding and can offer jobs or training to very few.

“These were the first jobs for them, and they were refugees. They learned all the skills and then they moved on to very good jobs after this. So those are our success stories. So, the current ones that we have, we need to be able to send them on a different kind of trainings where they can learn, how to know where they can develop their skills and also capacity building for them,” (SP 4)

Service providers suggested some excellent programs during the interviews like driving training, sewing training, volunteer opportunities, employer outreach, or bridging programs. A tailor or sewing job would not require much language proficiency to start with. Employer outreach, bridging programs, or volunteering are other excellent options, where the refugees are introduced to potential employers after receiving some training from settlement or service providing organizations. Then the Government either provides incentives to the employers or initially contributes to the salary, as the refugees develop job skills and eventually are hired. I know people personally who were able to gain employment through these employer outreach programs or volunteer opportunities. While it seems that running these programs may be costly

for the Government, investing in refugees in such a way is likely more efficient than providing social assistance alone.

#### 4.5.4.2 Formal Education

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That previous education and training are not recognized is a challenge as well as source of frustration for the refugee women, which has been discussed earlier. Even if the refugee women are interested in formal post-secondary education, there are more obstacles. Many are not able to meet high school entrance requirements or compete with Canadian born applicants. Even those who get accepted in their field of their expertise, they most likely need to take the same courses over again as their previous education and training are not recognized. There is no fast-track option for them.

There is a misconception among immigrant communities, which came out during the interviews, and the author has also personal experience from her background, that only professional jobs such as engineering, medicine, law, accounting etc. are viewed positively. Years of education and training are required to for these positions. Whereas trade skills education, like plumbing, electrician, carpenter etc. requires less school years and have high income potential. These options are not explored in the refugee or immigrant communities, especially by women. Incentives to enroll into these programs, making the admission process more accessible by refugee women, funding and expansions of these programs can be considered by the Governments at all levels.

“They (authorities) have to have more incentives for (refugee) women to go into those (trade skills) professions, because our immigrant communities - they don't even look into that area for education. We only look in other areas what education, we all want to be doctors, pediatricians, engineers and lawyers, but nobody goes into these services. The government must focus on that because they have got a big population of refugees who have moved here. They speak not a lot of English. They need help. And there's not much help.” (SP 4)

## 4.5.5 Community and Peer Support

### 4.5.5.1 Socialization and Networking

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Socialization and networking are very important for the mental wellbeing of the refugee women. The service providers discussed logistical requirements to provide the refugee women with options for socialization and connect with new people. For many refugee women, being alone after coming to Canada, not knowing anyone or the language was such a struggle and of course, a source of stress. Many just wanted a place to gather and be able to speak in their own language so that they can relieve their stress. By knowing what others are doing to cope can be a great help, as well as find some comfort in knowing others are experiencing similar struggles.

“They just need a place where they can gather, and they can talk and especially talk in your own language. Because you can go to different programs, but you can talk in English or try to learn English because they're all learning English. They are in English language classes, but you want to be able to log in your own language. Where they live, those apartments are small and there's no big area where they can all gather. Our biggest asset is the space we have. We have a very big space in the back.” (SP 4)

“While I was in that situation, the Welcome place did the Christmas party, they invited us. I went. I love parties, it was amusing. They took us out, I met people, made some friends. That's the only way that helped me to go out from my stress.” (RW 4)

As mentioned earlier, it is very important for the refugee women to get to know the mainstream community outside their own Syrian or refugee community. The service providers can play an important role here by reaching out to other organizations, community leaders or representatives to arrange events where everyone can participate.

“You have to go out more, you have to be able to attend events that are happening and mingle. If you keep moving in your own circles, then you will not get that information. We have tried one thing. We partnered with another organization which is a Coalition of Manitoba cultural communities and families. So, they work with different cultures, understanding different cultures, and how we can talk to the service providers like the CFS, like the health services and talk to them about what are the cultural needs.” (SP 4)  
“..... the second thing is those cultural events that happen in the community, in the larger community, not just the refugees in the larger community, because communities are not just refugees. These are just the people who came. But there is a bigger community out

there. They should be assimilating, and they should be talking to them.” (SP 4)

#### 4.5.5.2 Peer Support

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Peer support can be a great resource for the refugee women. Those who came earlier can provide guidance and support to the newcomers for so many issues. Again, the means of connecting these two reiterates the necessity of a community hub or a gathering place. Service providers can also play a critical role in making connections among people.

“when I get settled little bit, another family came. They came to Welcome Place. I went to them and welcomed them. When she saw me, the lady was same as me – widow and with children. I told her my experience, here is good and everything available. She said we don’t know language; we don’t know anyone. That lady was crying. I took her to home, invited her to my home, welcome her. I tried to talk to her nicely and gave her information. This is also another way how you can tell the positive information to the newcomers that there is access to any help like mental health or health providers or any services. I mean the community or previous newcomers can help also, not just the service providers.” (RW 4)

“I think it is the connections. it's the connections of people who... you know most of the time you learn from people who have been here for a long time; who have raised their kids...So, you can talk to them and you can see how they manage through this.” (SP 4)

#### 4.5.6 Culturally Competent Care

The importance of providing culturally competent care to these refugee women, especially when it pertains to mental health problems, has been discussed throughout this thesis. Education and training for service providers on culturally competent care, their roles in raising public awareness about the effects of negative attitude towards refugees, refugee community outreach etc. are some strategies that already have been presented. In addition, the interview participants have talked about the need for diversity among healthcare service providers. Although this theme is closely related to the sub-theme of education for service providers, it was decided that culturally competent care merited its own theme, particularly given that culturally competent care is not specific to refugees. Although the results presented here are specific to

refugees, culturally competent care has been proposed in the context of care for many other populations.

The service providers have talked about self-learning or other professional development activities. The settlement service providers should not limit themselves by only knowing where to refer a client who has mental health issues. Having knowledge about refugee religion, islamophobia, racial discrimination, misconception etc. will help the service providers to better serve these women. This will also enable them to take on leadership roles in making other service providers aware of the consequences of negative attitude towards refugee. Education among healthcare providers try not to use family and friends, to use professional interpreters was also recommend by one participant.

“Because when you are talking about people from the society, who are Islamophobic and they are saying negative things to the refugees or to people who look different and especially Muslims because Muslim women can be identifiable. Then we need to counsel them, and we need to tell the Muslim women and the refugees how to cope with that. If something like that has happened, who they should contact to report it.” (SP 4)

#### 4.5.6.1 Diversity Among Healthcare Service Provider

The refugee women have mentioned about their comfort in discussing their health problems with a healthcare service provider who speaks the same language.

“Yes, definitely because women want to talk to women. And within our Muslim community, let alone the Arabic speaking we don't have any women professionals. We have one or two who can but they're not Arabic speaking. So, we see both things.” (SP 4)

“My family doctor is Arabic speaker. He understands me very well, and my feelings.” (RW 2)

#### 4.5.6.2 Interpretation Service

The interpreters and cultural brokers have an important role in minimizing some gaps in communication. This is especially important in the context of mental health given that any diagnosis is based on conversations rather than physical assessments. Interpreters can provide

education and cultural training to both clients and healthcare professionals (mental health focused, or otherwise) as it relates to treatment of mental illness as well as making the therapy sessions successful. It is also important to note that the interpreters are trained well, they know what they are doing and can build rapport with clients as well as can understand medical terminology. The service providers reported that attempts in using family, friends, kids or virtual interpreters have not been successful and they discourage using these options for many reasons, confidentiality being one of them. While discussing the issue of interpretation, the Family Physician who sees many refugee patients, repeatedly emphasized the importance of using professional interpreters. If the interpreters are from the same community as the clients are, that also can pose challenges in terms of confidentiality. Therefore, finding a good fit for the role of interpreter or cultural broker would require considerable effort.

“And language, a lot of healthcare providers might use family and friends to help them to do the translation. But that’s really bad because there is a confidentiality issue, and you don’t get the whole history. We use professional interpreters. All the healthcare service providers or healthcare facilities in Winnipeg, they can use the same thing which is available for them through WRHA. So, education among healthcare providers try not to use family and friends, to use professional interpreters is really important.” (SP 5)

#### 4.5.6.3 Holistic Approach in Healthcare Service Delivery

A holistic approach in healthcare service delivery, aided by longer appointments, that addresses a broader range of socio-economic, ethno-cultural, integration challenges by the refugee women was recommend by service providers. A specialized mental healthcare clinic for refugees, similar to that of BridgeCare Primary Care Clinic, may be better suited to bring a multi-disciplinary team together and provide services incorporating a holistic framework.

“And, there is not only medical need, they have a lot of other needs – social, mental. So, you have to have longer appointments, besides medical there are housing issues. You have to kind of look at it in a holistic way. It’s time consuming.” (SP 5)

“But what I think like the BridgeCare clinic, which was setup by WRHA, if we could



have a mental health center, specifically for refugees. The way BridgeCare clinic is operating, it will operate as same parameter, probably that can alleviate or remove some of these barriers. Because the truth is, we are having refugees with mental health concerns, especially that they came from war countries, they have been traumatized before and during the migration process. So, if we had the centre like that one (BridgeCare) some people may say no, it may be discriminatory; but it's not. Because if there is a specific situation, then it has to be met with appropriate response with that problem. So, this population, this group of refugees, they have problems which are specific to them. Solution to those should be specific to them.” (SP 1)

#### **4.5.7 Increased Service Efficiency**

##### **4.5.7.1 Collaboration and Consolidation of Efforts**

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Almost all service providers interviewed agreed that there are many existing programs providing mental healthcare services, but most of them perform in silos, which has resulted in duplication of efforts and service inefficiency. There has been instances where the refugee women are seeing other counsellors but go to the emergency and then get referred to another counsellor. Afterwards when they come to see a Family Physician, the Physician has no idea about the treatment history unless he or she digs deeper into it.

“I think there is no shortage of the program but there is no collaboration or coordination. Like there are too many programs, they are duplicating, doing the same thing without communicating with us sometimes. At the end, I think, the refugees will suffer because they don't know what's going on since there are too many people involved. They see a counsellor one time and if they don't know how to go back to there, they might get referred to a different counselor, so they have two counselors and that's not good for them. So, these programs need to work together and try not to duplicate.” (SP 5)

The agencies will have to take initiative in showcasing their programs by organizing and attending events at different places and utilizing social and electronic media in reaching out to potential clients in as many ways as they can. It was evident during participant interviews that both refugee women and service providers are not aware of all programs. It is unclear who provides what services. Another important aspect that came out during the interviews is spreading services throughout the city. Most programs are located in or near downtown Winnipeg at present and there are not many options in the south end of the city.

“The second thing I would say is space. We have one center right now and it's here in the downtown. We know there is a big population in the south end of the city. Everybody who moved from here (downtown)- moved in the south. So, they were here (downtown) maybe for the first year or two years and they've moved. They still have needs. But now it becomes too far for them to come here. We don't have a place where we can serve them in the south end of the city. So, we are restricted to serving only the clients who are around here. Space is an issue. Again, I guess it comes down to funding. If we get the funding, we'll have a second office thing.” (SP 4)

#### 4.5.7.2 Program Innovation and Funding

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CMWI has started a food bank as an additional service, especially for the refugee women, which is an excellent idea in reaching out to the Syrian and all other refugee women. From cultural and religious belief, the Muslim refugee women need to get ‘halal’ food for themselves and their families. They do not know where or how to get ‘halal’ food, and many are unable to read the ingredients/labels as well. At CMWI refugee women can shop for ‘halal’ food at an affordable price, while also attending awareness sessions and language classes. This is a good example of program innovation.

The program named ‘Cooking and conversation’ has already been discussed. Such program innovation should be encouraged. The service providers have talked about their challenges of being short staffed, trainings for employees, retention of skilled workers, the need for a larger space etc. Continuation of funding to run the programs and additional funding for expansion of effective services are required.

“Funding is our greatest challenge because we need settlement worker. We know we need a counselor, a social worker. We need employment services person who can find, can sit with them, teach them where to apply, how to apply. I should say getting them ready to be able to work in the Canadian culture and Canadian workplace. And there are programs that are doing the same thing out there, but I think our clients are very unique in the sense that these are refugees who came here, who don't have the language skills, who have not had the skills to find their job yet. And we need to know the way not just to groom but also do a lot of follow ups and that is lacking. So, we know we need these things, but we cannot do it because we don't have the funding right now.” (SP 4)

#### 4.5.7.3 Program Evaluation and Monitoring

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Increased service efficiency can be obtained through program evaluation and monitoring. The Provincial and Federal Governments should focus on collaboration and reporting aspects while approving funding for different programs. As it stands right now, there are many programs out there offering the same services without much collaboration or information sharing. This creates confusion and service inefficiency.

“.....so, Government has to see what’s going on now before approving new programs and start try to facilitate collaboration.” (SP 5)

“I really think there's needs to be better oversight right from the top down to say like who's really responsible for all agencies. That they're doing what they're supposed to do. Number two, that they have the funding and can do what they're going to do. And three, is that they can collaborate. It is important to facilitate collaboration between the different agencies so that there's no duplication.” (SP 2)

#### 4.5.8 Leadership

Leadership at the provincial and federal level, as well as within the service providing organizations can enhance service efficiency and better management of funding. Strong leadership in removing misconceptions and negative attitude towards refugees was also recommended by the interview participants.

“So, the question then becomes who can take the leadership to move and take whatever information you have, and other people have to make the services best.” (SP 2)

“So, the misconceptions around refugees have to be sorted out and dealt with. And there are organizations who have done that, but it has been at a very small level, because everything depends on funding, on the money that you get. So, last year there was one project that happened, but it was only a little bit, and nothing happened after that. So, it has to be more effort from the government. It has to be more effort from the community organizations to actually educate the mainstream society, not just refugees.” (SP 4)

Summarized below are some areas identified during the interviews where there are opportunities for leadership improvement:

- Problem recognition

- Ensuring service efficiency
- Refugee involvement in decision making
- Financial support for successful programs
- Investing in program innovation
- Public education

#### 4.5.9 Resiliency

Many of these refugee women have suffered a lot in their life. They had been through the horror of wars, ran for their lives, and lived in the refugee camps yet have shown great resiliency and strength. Many have moved on. While they may have some complaints, especially in regard to service access, many are very grateful that they were given the opportunity to start a new life here, in Canada. They are in safety and an horrific part of their life has come to an end. They have a great desire to participate in the development and giving back to the Canadian Government and people. Summarized below some quotations and developed codes from analyzing the transcripts.

**Table 4-2 : Resiliency Among Refugee Women**

Codes	Quotes
<b>Internal Strength and Positive Attitude</b>	<p>“What I am amazed at is the resilience of the refugees I've seen. I only can imagine some of the stuff that they have seen and gone through. And yet they're hopeful in essence for their children or at least they're not suicidal.” (SP 2)</p> <p>“I always tried not to say things like if I'm not doing good or I faced some bad things at work. I met different people here. So always I try to be positive, not negative. I don't want them (her children) to be sad or to think about me. I just want them to focus on their study, their future” (RW 8)</p>
<b>Hope</b>	<p>“.....it was from experience, you (talking about other refugees) will eventually learn. I started talking. I used to think they don't want me. I speak different language. Then I thought it's just one life, just go ahead and talk. After that whenever I needed to approach to somebody, I introduced myself and talked. Now I made a lot of friends. Right now, maybe I have 25 friends at the university. Yeah, we have to do it, we are just living one time, we have to encourage ourselves.” (RW 9)</p>

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“They just have to be so brave; they have to face every challenge on their way. If you’re shy you can’t face those bullying, you have to be brave, saying that I’m here. I can be better than you. Just be brave. And everybody must remember that we are just living one time. You shouldn’t care about what other will think.” (RW 9)

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**Giving Back**

“They want to be able to give back; you know self-esteem and all you need to be able to do that. Because right now they are the ones receiving everything. They are receiving the services, the goods, the clothing and whatever. But as a human being you want to be able to give back also. So, because we are such short staffed. Most of the work that happens in the center is through our volunteers as want to give back. A lot of them will stay here and they will work in the donation area, folding clothing, sorting out clothing, cleaning, and they don't feel like this is something that is they're doing it for somebody else. They feel like this is their center and they're helping their own community.” (SP 4)

“And she (a refugee woman) doesn't come here every day for something or to take from here. She comes here to volunteer. She'll stay here from 10:00 to 4:00. She takes a bus, she's spending her own money but the value that she finds in being here and communicating with people who understand her, and her language is priceless. And she says this to me this center made a lot of difference to her. Whatever programs we do she is the first one to register. She is learning the language and way of living in Canada because we do a lot of awareness sessions.” (SP 4)

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**Acknowledgement**

“I appreciate our government; they gave us the chance to come here and save me and my children.” (RW 3)

“I thank Canada to give us the opportunity, they did not judge us. Syrian people are good.” (RW 4)

“In Lebanon we suffered a lot. We suffered discrimination, people were talking, swearing to us. But right now, we are very happy here, we do not have issue. When we came here, we thought that part (horrors of war) of our life is end, we got rid of that. It’s better now.” (RW 7)

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## **4.5.10 Healing**

### **4.5.10.1 Worries for Family Members Left Behind**

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Many of the refugee women have left their family members behind, which includes

immediate family members, children, and partners. They are consistently worried about the safety of their family members. The service providers acknowledged that this is a significant mental stress for them and taking medicine will not address this situation. Family re-unification is the most effective option here.

“I wish I had my children around me! It doesn’t matter where I am or how I’ll be, I want my children around.” (RW 4)

“I have one situation where a husband is without his wife. I won't go into all the details, so that I won't reveal anything. But the problem is that his wife is not here. So, he is here suffering mental health issues without support. Now for me to say, oh...here are some pills. You know this is not going to make a difference.” (SP 2)

#### 4.5.10.2 Help from IRCC in Family Re-unification

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The refugee women have requested the support from IRCC to re-unite with their immediate family members. Where the women might be in safety in Canada, her family members left behind are not, which is contributing to ongoing stress.

“If there is program for the newcomers to help us to bring the families, daughters or sons there left. If they bring that to me, I would be more comfortable. I don’t see the stress anymore.” – RW 1

The service providers also believe that family re-unification can facilitate wellness. These refugee women, and their families would do well and contribute more to the society if they are together. Since the Canadian Government has already taken a step to welcome these refugee women probably one more step in bringing their spouses or children would benefit all.

“these individuals should be given some type of support to host. Now that they're here to host other people coming to us. And we've seen this in other groups, I mean many of those people have slowly come and sponsored other people. I'm sure they have developed, worked hard and have a good relationship within the community to be able to have same kind of mindset. So, this isn't something that's new. It's just a matter of saying how do we do this appropriately so that we can facilitate wellness.” (SP 2)

“I think their main concern is family back home. If they can re-unite with their family their mental health would be fine. Some of them are trying to go back, find their children and bring them back. For that population, I think Government can support them to bring

their loved ones here and they will be much happier. Even the Syrian, they have families or even kids in other countries or in refugee camps. Speeding up the process to bring family members would help with the mental health of the people who are here.” (SP 5)

#### 4.5.10.3 Time

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Time is probably the best healer. While the refugee women have struggled initially, with time they are doing better and getting used to a new normal. They have been trying hard to leave their sufferings and migration journey behind and move forward. During the interviews all refugee women mentioned that being safety in Canada has been a wonderful experience for them. The refugee women are comparatively young, and their children are learning the English language very well. No doubt that they have good times ahead of them.

“After coming to Canada, language was a big challenge for me. I was so shy at first. I had bad time without friends, I was super lonely. Eating my lunch by my own, sitting alone, people didn’t try to be my friends and I didn’t try to as well. Now I just talk, I have no problem talking with anybody.” (RW 9).

#### 4.5.10.4 Normalization

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Refugee women also described their mental wellbeing in comparison to their previous situation. They were living in Syria during a state of war whereas they live in safety in Canada now. In this way many do not feel like complaining about anything. They are happy just being in safety and therefore, persistent sadness, or having anxieties or stresses do not seem to bother many or has become normalized.

“Its normal for us, for back home. I know because I came from war country, it’s normal. We cannot complain about those.” (RW 1)

## **Chapter 5. Discussion**

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This study has examined Syrian refugee women's experiences in accessing and utilizing mental healthcare services in Winnipeg. The study findings were grouped into two sections (1) barriers in accessing mental healthcare services and (2) strategies for service improvements. Both service providers and refugee women have provided their perspective on what are the existing challenges and what options can be considered for service improvements. Barriers in accessing mental healthcare services by refugee women during the interviews were not speaking English, weather, employment and income level, stigma, and system navigation. The service providers mentioned about stigma and lack of resources to provide culturally competent care. While discussing service improvement, service providers mentioned collaboration among agencies, leadership at all levels, and education for both refugee women and service providers. Refugee women were concerned about their financial struggles and identified employment, or specifically lack thereof, as a critical situation that contributes to their mental wellbeing. They also want language programs to be more flexible (in terms of times and locations). This study recommends that the service providers use guidelines developed by UNHCR and Canadian physicians in providing culturally competent care to the refugee women, decision makers take leadership roles in implementing better collaboration among agencies, Manitoban employers be open to hiring refugees, and everyone in the society ensure that the refugee women feel welcomed and included.

### **5.1 Barriers in Accessing Mental Healthcare Services**

The barriers in accessing mental healthcare services were grouped into three themes: material, structural and organizational, and social and cultural. The study found similarities in the barriers that refugee women face in Winnipeg when compared to the literature. However, during



the interviews the refugee women repeatedly mentioned about weather challenge, healthcare system unfamiliarity, complexity and navigation issues in Winnipeg. Moreover, as far as locations, most services are located in or near downtown Winnipeg, not in other parts of the city. Therefore, for the refugee women who do not drive, using public transport can take a long time to get to a service location. The cold winter in Winnipeg adds to the challenge. The reduced number of EAL class offerings (only one time instead of two in select days) makes it less accessible by the refugee women, especially those who need to take care of the kids and both the women and her husband plan to take the class or the husband is at work.

Experiencing war-related trauma and the hardships of losing one's home have profound, diverse and long-lasting effects on mental health beyond the acute traumatizing phase. While refugees need support with PTSD, depression, anxiety disorders and prolonged mental illness, stigma is a major factor in preventing refugees from seeking help. Unfortunately, there are not many examples of successful approaches to healthcare service delivery that have eliminated stigma, especially when this culturally and linguistically diverse group is considered (Guruge, Wang, Jayasuriya-Illesinghe, & Sidani, 2017). A study by Salami et al. (2019) recommended that using culturally appropriate terminology to refer to mental health, honoring confidentiality and building trust with the clients can probably help with overcoming the stigma among refugees and immigrants. Furthermore, the study authors recommend meeting other needs (related to social determinants of health) will set the groundwork for addressing more taboo topics like mental health. During the interviews one service provider mentioned that after they had started the 'halal' food bank program in addition to their other services, they noticed an increased number of refugee women clients.

The refugee women are also unable to express their concerns due to language and cultural

barriers. The use of interpreter services or cultural brokers may mitigate these barriers but would not completely eliminate the issue as information is still lost in translation. Moreover, there are concerns around confidentiality, misinterpretation, and availability. Studies have suggested training for personnel who work as service providers, interpreters, or cultural brokers. Such training would enable them to identify and discuss the unique mental health stressors experienced by their refugee clients as well as guide them through system navigation for mental health and social services supports (Salami et al., 2019; Thomson et al., 2015).

## **5.2 Recommendations for Service Improvement**

This section provides a discussion on the holistic service delivery approach in the light of literature, refers to some excellent resources in providing culturally competent care, then a discussion on how to improve social determinants of healthcare both in the light of literature and current study findings. Some policy planning and innovation strategies have been presented with examples from the literature and other Canadian cities, suggestions from associations like Canadian Medical Association, Canadian Psychiatric Association, Canadian Mental Health Association as well to address the challenges more specific to Winnipeg. A discussion on the ‘Virgo Consulting Report on Provincial Mental Health Strategy’ is included. Finally, an overall summary of the study findings has been presented.

### **5.2.1 Holistic Approach in Service Delivery**

The need for a holistic approach in mental healthcare service has been discussed throughout this thesis. The western healthcare model is a one-way relationship of providing services where the client seeks professional care and often there is no relationship between the client and care provider other than diagnosis and treatment (Vasilevska, 2010). This approach will not be effective in treating refugees with mental health problems. Studies have suggested

that healthcare providers need to keep in mind the circumstances around pre- and post-migration (Guruge et al., 2017; O'Mahony & Donnelly, 2007; Rousseau & Drapeau, 2004; Zunzunegui, Forster, Gauvin, Raynault, & Douglas Willms, 2006). After the difficult migration journey and experiencing war violence, refugee families often arrive in host countries to start life once again from nothing. Therefore, they can find themselves at a disadvantaged socio-economic position. Medical practitioners should be mindful of how postmigration disadvantages may increase or exacerbate the risk of mental distress among refugees (Rousseau & Drapeau, 2004; Simich, Hamilton, & Baya, 2006). Service providers must give enough time to establish a relationship of trust with their refugee clients, be aware of the unique cultural profile of this group, as well as their way of reporting symptoms (Beiser, 2009; Carswell, Blackburn, & Barker, 2011; Cavallera et al., 2016; Donnelly et al., 2011; Fenta, Hyman, & Noh, 2007; G Hassan et al., 2015). According to Huljev & Pandak (2016), *“holistic medicine means consideration of the complete person, physically, psychologically, socially, and spiritually, in the management and prevention of disease.”* While describing the philosophy behind holistic care, Tjale & Bruce (2007), said that *“for human beings the whole is greater than the sum of its parts and that mind and spirit affect the body.”* The care is based on the idea of holism. Service providers must understand the wide range of factors that put people at risk for mental distress and consider the interaction between the individual, community, societal factors, and their relationship while providing services.

### **5.2.2 Providing Culturally Safe Care**

The need for developing and delivery of culturally competent healthcare has been well reported in the literature but rarely mentions cultural safety. Approaches that consider the interaction between the individual, their relationships, community, and societal factors as well as

implement new models of collaborative and integrated care should be encouraged (CDC, 2019; Ganesan, Mok, & McKenna, 2011). The importance of cultural sensitivity training and support for care providers to provide medical and social services to refugee women has already been discussed in the thesis. Salami and colleagues suggested that investing in culturally competent mental healthcare delivery models can help to address the barriers of distrust and lack of familiarity with mainstream mental healthcare services (Salami et al., 2019). They further recommend that services offered to the clients must be flexible, affordable, accessible, and culturally/linguistically appropriate. A study (Jefee-Bahloul, Bajbouj, Alabdullah, Hassan, & Barkil-Oteo, 2016) on mental health in Europe's Syrian refugee crisis had emphasized that providers need to understand their clients' cultural idioms of distress (i.e., the ways in which distress is verbalised in a specific community) and the explanatory models (i.e., the ways in which people understand and explain their symptoms). These can affect the clients' expectations, coping strategies, ways of explaining an illness, and norms in seeking help. For example, during the interviews one service provider mentioned that her refugee clients did not understand terms like 'mental illness', 'psychiatrists', 'psychologists', 'psychotherapists' or even 'counselling' but they understood the term 'therapy'. It was also easy for them to refer to this term considering the clients educational background.

While providing culturally competent care, it is important for the service providers to understand the cultural safety aspect of it, which takes us beyond cultural awareness and recognizes the importance of respecting difference (Hart-Wasekeesikaw, 2009). There is now a growing understanding of the need to move toward culturally safe care, which differs from cultural competency and a focus on the other's culture to a focus on self-reflection among health practitioners. Relevantly, refugee health literature mostly uses the concept of cultural

competency.

In describing cultural competence and cultural safety in nursing education, Hart-Wasekeesikaw (2009) said, “cultural safety helps us to understand the limitations of cultural competence, which focuses on the skills, knowledge, and attitudes of the practitioners”. Service providers have more responsibilities as they are the one to make sure that the refugee women can open up themselves as they talk about their mental health challenges without any stigma or feeling of shame. There should not be any judgement about culture, race, religion in mind as the service providers interact with their refugee clients. According to Spence (2001), by understanding the power differentials inherent in healthcare service delivery and readdressing these inequalities through educational processes, cultural safety can be accomplished. The following points are mentioned from Hart-Wasekeesikaw (2009), who said that addressing inequities, through the lens of cultural safety, enables care providers to:

- Improve healthcare access for patients, aggregates and populations;
- Acknowledge that we all are bearers of culture;
- Expose the social, political, and historical context of healthcare;
- Enable practitioners to consider difficult concepts such as racism, discrimination and prejudice;
- Understand the limitations of culture in terms of having people access and safely move through healthcare systems and encounters with care providers; and
- Challenge unequal power relations.

The UNHCR report on ‘Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians – A Review for Mental Health and Psychological Support Staff Working with Syrians Affected by Armed Conflict’ is an excellent resource that lists common idioms of

distress for Syrians (G Hassan et al., 2015). By using this resource, healthcare providers can develop a cross-cultural understanding of Syrian refugees and design relevant training, education, and consultative services (Jefee-Bahloul et al., 2016). Provided below are some relevant resources, developed by Canadian physicians and researchers which can aid service providers:

- **Common mental health problems in immigrants and refugees: general approach in primary care** (Kirmayer et al., 2011b): Identified risk factors and strategies in the approach to mental health assessment and to prevention and treatment of common mental health problems for immigrants, including refugees, in primary care. This study considered all three components of the migration trajectory: pre-migration, migration, and post-migration resettlement.
- **Evidence-based clinical guidelines for immigrants and refugees** (Pottie et al., 2012): Considered the unique preventive needs and implementation issues for special populations such as immigrants and refugees. Guidelines include treating infectious diseases, mental health and physical and emotional maltreatment (conditions such as depression, PTSD, child maltreatment, intimate partner violence) among immigrants and refugees.
- **Caring for a newly arrived Syrian refugee family (Pottie et al., 2016) :**  
Recommended that preventive interventions be considered at first visit and the importance of screening for mental health problems (based on case study of a Syrian refugee family).

### 5.2.3 Improving the Social Determinants of Health

The effect of poor social determinants of health in accessing mental healthcare services

by refugees has been extensively discussed in the literature (Campbell, Mann, Moffatt, Dave, & Pearce, 2018; Chaze, Thomson, George, & Guruge, 2015; Guruge, Thomson, & Seifi, 2015; Salami et al., 2019; Sherzoi, 2017; Thomson et al., 2015). Unemployment and income insecurity, limited education and literacy, language and communication challenges, substandard living conditions, struggles with healthy child development, isolation and racial discrimination are all associated with access barriers, and hence, contribute to a decline in overall health. During the interviews one refugee woman talked about her husband being unable to find a job with 30 years of experience in trade skills from Syria, which negatively impacts his self-esteem and subsequent mental health. It is unfortunate that a person with such job skills cannot find employment when the country needs more than 167,000 new apprentices in the next 5 years (Weikle, 2019).

Strategies to make the best use of refugee resources, in terms of job skills, would positively contribute to mental wellness, in addition to economic gains. All refugee women who were interviewed expressed strong desire that they and their family members want to work and contribute to the society. They do not want to live on social assistance. This study suggests that policy makers should explore options such as apprentice opportunities, jobs that require fewer communication skills, employer outreach, credit for previous education and skills, fast track or bridging programs. Programs such as these could reach out to potential employers and provide incentives to hire refugees. Initiatives like sewing and driving training programs have already been discussed earlier in the thesis. “A 10-point multi-stakeholder action plan for employers, refugees, governments and civil society” is an excellent guide, developed by a combined effort of OECD and UNHCR, in hiring refugees so that they can contribute economically and participate more fully in their host societies (OECD/UNHCR, 2018). It is understood that living in poverty cannot and will not contribute to the mental wellbeing of refugee women.

The refugee women talked about not being able to attend EAL classes as they need to take care of their children while their husbands are not around or if their husband is attending the same class. The service providers mentioned that many EAL classes are now offered only once in select days due to funding challenges, which disadvantages women. This study recommends that the government continue to support EAL programs, including exploring options for making them more available and accessible, as well as how these programs can be made multifunctional by adding other social services components. Learning a new language could be easier while at work, by engaging in dialogue with others. The agencies can focus on finding more volunteer opportunities for the refugee women, if not employment.

The mainstream community will have to play a role in helping refugee women and their families to better integrate with the society. In collaboration with settlement organizations, communities can arrange large gatherings where refugees can participate and get to know others in the community. Attending such events will make the refugees feel welcomed and that they are part of the society. Public education and media campaigns on the harmful effect of negative attitude towards refugees should be developed; for example, campaigns have been developed to address negative stereotypes about Indigenous people in Winnipeg (CBC News, 2014).

Participants discussed their experiences of discrimination and negative attitude towards refugees. Reinforcement of strict anti-harassment and victimization programs in schools (Abada, Hou, & Ram, 2008) and elimination of racism (Etowa, Keddy, Egbeyemi, & Eghan, 2007) are recommended. Discrimination at doctor's office, as reported in the literature (Pollock et al., 2012) and in the present study, will also need to be addressed. The Provincial Colleges of Medicine and Surgeons will have to take leadership roles by applying strict rules and regulations in such instances. The CMHA has called for a new legislation which must address stigma and



discrimination in the healthcare system, amongst practitioners as well as at the individual level (CMHA, 2018). The CMHA report emphasized improving access for those who are marginalized and investing in social spending by governments; spending would “*address mental illness root causes of poverty, trauma and marginalization, boosting our most vulnerable citizens’ ability to contribute to their communities and lessening the burden of illness nationally.*” Recently published Chief Public Health Officer's Report on the State of Public Health in Canada 2019 had a focus on Stigma and discrimination towards persons with health conditions (Tam, 2019). The report admits that “*many forms of stigma that intersect in complex ways, are very much present in our health system, driving those most in need from getting effective care and accessing services*”. Collectively, these reports and the implementation of their recommendations are important first steps in addressing stigma that refugees, and others, face in the healthcare system.

#### **5.2.4 Acculturation**

The importance of understanding the interplay between the long-term psychological consequences of the process of acculturation and mental health were mentioned in the literature and were observed in the present study. Living entire life in one culture and then attempting to re-establish lives in a new country where the culture is completely different is very challenging for refugee women. Integration seems to be the best process where some degree of cultural integrity is maintained, while seeking to participate as an integral part of the larger social network at the same time (Berry, 1997). During the interviews, the participants talked about the importance of socialization and networking for the mental wellbeing of the refugee women. This needs to happen within their own communities as they can speak their own language, share experiences and grief, express ideas as well as with the mainstream communities where they will be able to learn the culture and language. Living in isolation is an obstacle to mental wellbeing.

Participants discussed different aspects of their culture and life they sought to maintain and would be important for their well-being, like connecting with other refugees and reuniting with family, and other aspects of integration that would facilitate wellbeing, such as learning English and gaining employment. During the interviews one refugee woman talked about the cultural requirement of face covering back home when going outside otherwise being judged by the society. Whereas, in Canada, she enjoys the freedom of expressing of herself and not being judged by society. She thinks that God created us equal, so everyone should be equal. This speaks significantly to the shifts in culture as a result of coming to Canada and the efforts women have made for integration, as well as their perceived benefits.

The refugee women have internal strength and positive attitude, they are hopeful, and they have shown resiliency, as discussed in the previous chapter. This attitude of resiliency can help for better integration into a new society. Instead of defining resilience as the individual's capacity to succeed under stress, Unger (Ungar, 2013) defined resilience as the capacity of both individuals and their environments to interact in ways that optimize developmental processes. According to Ungar, (2013) these processes occur only when the individual's social ecology (formal and informal social networks) has the capacity to provide resources in ways that are culturally meaningful. In this case the resilience the women exhibited, was not about their capacity to "succeed" under stress but does speak to their interactions with their new environment and to their developmental processes. Therefore, it is important that the society and surrounding environment of the refugee women provide adequate support as they are going through the process of establishing a new life in Canada.

### **5.2.5 Policy Planning and Innovations**

The study findings agree with the works by Levesque, Harris, & Russell (2013) and

Woodgate et al., (2017) that access to care is affected by providers, organizations, institutions and systems barriers. The study also agrees with Woodgate et al. (2017) that resource re-adjustment to reduce the systems barriers in the short term while development of policies and programs to eliminate the barriers in the long term could be the right steps for the policy makers. Policies around increasing diversity among healthcare service providers, funding for trained interpreters or cultural brokers, child support services can also contribute to provide better mental healthcare to the refugee women. The challenges with the mainstream healthcare services includes lengthy wait times and high costs for counselling services, which have all been extensively discussed in the literature (Chaze et al., 2015; CMHA, 2018; Guruge et al., 2015, 2017; Salami et al., 2019), and are outside the scope of this discussion.

Community-based mental healthcare programs that incorporate an holistic approach by taking the social determinants of health across pre- and post-migration context into consideration have been highly recommended by researchers (Kanagaratnam, Pain, McKenzie, Ratnalingam, & Toner, 2017a; McKenzie, 2016; Salami et al., 2019). Integration of community-based mental healthcare programs with other social services may be more effective (Salami et al., 2019). The CMHA has reported a chronic underfunding of community-based mental health services and a reliance on intensive, high-cost services like psychiatrists and hospitals (CMHA, 2018). In their report, the association pointed out that while evidence-based healthcare provided by addiction counselors, psychologists, social workers, and specialized peer-support workers is the foundation of the mental health response in other G7 countries, these services are not guaranteed through the public system in Canada. The association has called for more integrated continuum of care provided through community mental health services that can meet the needs of many people with mental health challenges. Services can include early intervention and prevention, enhanced

treatment for those who need it, and longer-term follow-up and supervision for those with severe and persistent illness. Community-based psychiatrists, interdisciplinary family health teams that incorporate psychiatric services and specialized interdisciplinary teams such as assertive community treatment are some specialized services that can be considered for patients with greater needs, according to CMHA.

The findings of this study strongly agree with CMHA recommendations in increasing support for the community-based mental health services. In a joint statement on access to mental healthcare, the Canadian Medical Association and the Canadian Psychiatric Association have advocated for community-based programs to promote and maintain mental health and to facilitate early identification of problems requiring intervention (CMA/CPA, 2016).

‘Community-based protection and mental health and psychosocial support (MHPSS)’ is an excellent resource developed by UNHCR to use as a guide for the service providers (Martin-Archard, Joanian, & Ventevogel, 2016). Studies have reported the success achieved by case managers and community navigators in the roles of community liaisons (Hartley, 2017; Hochhausen, Le, & Perry, 2011). Outreach programs for the refugees who cannot otherwise reach out to the mainstream mental healthcare services due to system complicity and navigation issues have been recommend in this study as well in other studies (Salami et al., 2019).

Researchers have called for modifying the University social work curriculum in Canada to provide the mental health practitioner graduates with much-needed cross cultural communication skills to work with a culturally diverse population (Lai & Surood, 2013). An example of a program to address curriculum was undertaken at Dalhousie University in Nova Scotia; their medical school developed a community-based service learning program for medical students (CMAJ, 2018). Under this year long “reciprocal mentorship” program, groups of 2-3

medical students are matched with a refugee family with the help of a local resettlement agency. Such initiatives provide benefits to both the students and refugee families. The present study calls for a leadership role in program innovation and design by the Provincial College of Physicians and Surgeons in collaboration with the University of Manitoba, Psychiatrists and other health care providers in Manitoba. This group can act as advocates for refugees and advise policy makers and healthcare system developers about the importance of the issue.

The lack of coordination and collaboration among agencies in Winnipeg has been discussed in the thesis. This study has recommended for better collaboration among agencies. During the interviews it was understood that some agencies receive their funding from the WRHA, others from the Federal Government, and some are privately funded or depend on charity. Therefore, program planning and evaluation remains a significant challenge. There is a lack of clarity on who these organizations report to. While there are some uncertainties around consolidation of programs due to the diversity in services and service level, the nature of the service (private, non-profit and government funded etc.), as mentioned by the interview participants, stronger collaboration is very much possible. The Manitoba Association of Newcomer Serving Organizations (MANSO) was created as an umbrella organization for immigrant and refugee service providers in Manitoba. MANSO has the mandate to provide leadership, support and act as a unified voice for the settlement and integration programs. MANSO can promote better collaboration by taking an active role, however, the overall oversight, reporting or program evaluation components still will have to be better planned.

#### **5.2.6 Virgo Consulting Report on Provincial Mental Health Strategy**

The Government of Manitoba retained VIRGO Planning and Evaluation Consultants Inc. (Virgo) to develop a focused provincial mental health and addiction strategic plan by

improving access and coordination of services. The report was published on May 31, 2018 (Virgo Consulting, 2018). It is understood that the Provincial Government's current focus includes Truth and Reconciliation, high suicide rate among Indigenous people, alcohol and substances abuse, and high rates of children in care. The Virgo project included all Manitobans to develop a provincial strategy, and therefore also mentioned refugees and newcomers as a population of concern. According to the Virgo study, Aurora Family Therapy Center reported that among its refugee clients, 27% had probable PTSD, 25% with symptoms of depression, and 27% with symptoms of anxiety disorder. These proportions are all significantly higher than estimated for the general Canadian population (Virgo Consulting, 2018).

The Virgo report identified that trauma experienced by refugees during pre-migration continues in many respects at the post-migration stage, such as lack of trust in government institutions, lack of employment opportunities, challenges understanding different ways of parenting, and accessing services in another language. Similar to the thesis finding, the Virgo study emphasized on the fact that the refugees need to be heard, they must feel as though they are partners and owners in the system rather than feeling left out. Finally, the report has also called for relationship building among services providers and their refugee clients, and collaboration among service providing agencies to avoid duplication in efforts.

### **5.3 Highlight of Study Findings**

A study on mental health and psychological wellbeing of Syrian refugees by a group of Canadian researchers found the most prevalent mental health problems among Syrian refugees to be depression, prolonged grief disorder, PTSD and various forms of anxiety disorders (Ghayda Hassan et al., 2015). Interviewing service providers and the refugee women in Winnipeg, this study also found the same mental health problems among Syrian refugee women. In addition to

financial struggles, language and other access barriers further contribute to the mental stress of these refugee women. This study findings support that *“understanding culture-specific illness models and idioms of distress will allow better practitioner–patient communication, and in turn, this can inform culturally safe interventions to mobilize individual and collective resilience”* (Ghayda Hassan et al., 2015; Pottie et al., 2012). Presented below are some highlighted findings, re-iterated by the Syrian refugee women and service providers during the interviews:

- a. Not speaking the English language was cited as the first barrier in accessing services by almost all interview participants. The refugee women mentioned their challenges of participating in language classes while taking care of their children or if their husbands are at work. This is even more difficult for single refugee women with children and with children with disabilities in some instances. They have requested for more flexible programs (in terms of time and locations), facilities for childcare while attending classes etc.
- b. Transportation was mentioned as a major issue, especially during winter, considering that most Syrian refugee women do not drive. Even if they have an address, it is difficult for them to navigate by using the public transport. Therefore, offering multiple programs at one facility, for example if the refugee women can shop ‘halal’ food or get any skills training while they attend language classes, can reduce their number of trips to a great extent.
- c. The Syrian refugee women are not comfortable to discuss their past experience of physical or sexual abuse in front of a male figure, whether a physician, counsellor or interpreter. There is stigma, and fear of shame. There is a need for female healthcare professionals and interpreters. Unfortunately, the healthcare system is not sufficiently

- equipped to address this need.
- d. Lack of cultural diversity among service providers were mentioned by the interview participants. Service providers who are familiar with the cultural backgrounds of Syrian refugee women can provide better assistance in overcoming the stigma. The study recommends that the service providers use resources developed by UNHCR and Canadian physicians, mentioned in this thesis, to familiarize themselves with components of culturally competent care. The UNHCR guide on ‘Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians 2015’ provides a list of common expressions and idioms of distress in Syrian Arabic, their transcription, translation and emotions, thoughts and physical symptoms that may be conveyed through these expressions. This could be of particular interest to the service providers.
  - e. There is a fear and distrust of Government services, especially around CFS. Losing custody of their children is traumatizing to these refugee women and their families. There are rumours that CFS is ripping families apart. The refugee women are concerned about how their children will cope up with the new culture, what if they forget their own culture, and how they can make the children understand if they are not cooperating. Since the refugee women and their families are not able to communicate very well to the CFS agents due to the language barrier, they cannot advocate on their behalf. There is a need for education around parenting.
  - f. The coordination among services is much needed and could help in achieving better efficiencies by removing the duplication of efforts. Thus, the refugee women won’t have to end up with multiple referrals or visit from place to place.
  - g. The Syrian refugee women have faced racism, discrimination, bullying especially due



to the fact that they wear ‘hijab’ and thus identifiable. Such negative attitude adds additional mental stress to women who are already traumatized. Every individual in the society has responsibilities to stop this. Public education with the help of media can play a key role in eliminating such behaviors.

- h. While designing programs for the refugee women or providing services to them, it is important to keep in mind their pre-migration literacy level. The study recommends that the decision makers consult with the refugee women in program design. It is important to directly hear from who are receiving the services not only just who are providing the services.

#### **5.4 Strengths and Limitations**

The first strength of this study is the wide variety of participants that enabled the capture of diverse perspectives. For examples, in the service provider/decision maker category, the interview participants included settlement worker(s), primary care physician(s), psychiatrist(s) and policy/decision maker(s). Among refugee women participants, the education level varied from grade 5 to graduation, a few were able to communicate in English and there was a mix of privately and government sponsored refugees. To my knowledge this is the first study in Manitoba that was focused on women refugees only and included service providers as well as decision makers to get their perspectives. While the study only considered Syrian refugee women in Winnipeg as target population, the findings were comparable with other similar studies across Canada and in Europe. It is understood that, all refugees, irrespective of country of origin, have been through difficult migration journey as they are forced to flee because of persecution, war or violence. Therefore, have experienced some level of trauma. Some aspects of the study findings, especially barriers in accessing mental healthcare services are applicable to other cities in

Canada and around the world who accept Syrian refugees. The recommendations on service improvements are also applicable to other cities to great extent, depending upon the healthcare coverage, availability of services, level of collaboration among services etc. Few other strengths of this study have been discussed in Section 3.5 – positionality and reflexivity.

Meeting the trustworthiness criteria (credibility, transferability, dependability, confirmability and audit trails) was a great strength of the study. I showed the interview guide to organizations before conducting the interviews to ensure that I was asking the right questions and revised accordingly. My study findings were also similar to other studies, and specifically the Virgo report, which was completed during a similar time period as well as setting. Other professionals working in this area nationally and internationally, whom I met at conferences while presenting my study findings, agreed that my results seemed reasonable. I discussed the study steps with the thesis committee who verified the methods. The second translation of a transcript indicated that the interpreter was not unduly influencing the participant, so I felt confident in the interview process despite being in a different language and requiring an interpreter. Finally, visual data presentation, through mind-maps, contributed to accessible knowledge translation, which can be used by individuals or organizations.

The study participants included are also considered as a limitation of the study. The refugees to Canada are from diverse countries, cultures, languages and varying experiences during their migration journey. The study was focused on a specific refugee group (Syrian refugee women) only, therefore, the study findings cannot be generalized to other refugee groups.

There is a lack of research on how different types of sponsorship programs effect the settlement process. While there were government and privately sponsored refugee women among

the participants, the study did not analyze their experiences depending on sponsorship type. Such study requires more understanding as well as more study participants in both categories. Finally, my own background and values as a woman and immigrant to Canada may have influenced this study right from choosing this topic, to the interpretation of the findings, and representation of the results (what information was deemed important and presented and what was omitted).

## 5.5 Knowledge Translation

The research findings are documented in my MSc thesis. I have also presented my proposal and the research findings at different stages at various conferences and summer institutes. Below is a list of programs where I presented the research findings from different stages:

Literature Review:

- North American Refugee Health Conference, Portland, OR, USA, June 7-9, 2018.
- 31<sup>st</sup> Canadian Student Health Research Forum, University of Manitoba, Winnipeg, MB, Canada, June 11 – 15, 2018.

Data Analysis:

- Canadian Association for Health Services and Policy research (CAHSPR), Halifax, NS, Canada, May 29 – 31, 2019.
- Summer Institute on Migration and Global Health. School of Public Health, University of California, Berkeley, CA, USA, June 9 – 12, 2019.

The thesis will be shared with the Research Ethics Board of WRHA and with Dr. Natasha Howard, Assistant Professor, Global Health and Conflict, London School of Hygiene & Tropical Medicine. Please refer to [Appendix E](#)– *Lessons for Canada from European Experience* for more details. I also shared some of my research findings with refugee-serving organizations in

London, UK during my research internship with Dr. Howard. Finally, a summary of the study findings will be shared with the organizations who helped in recruiting study participants. Then the recruiting organizations can share the results with refugee women participants.

## **5.6 Recommendations for Future Research with Refugee Women**

This research included Syrian refugee women as interview participants. I suggest including refugee women from different ethnic groups as interview participants in future research, especially the ‘Yazidi’ women as they were mentioned by the service providers.

There is also a need for additional research regarding the different challenges faced by privately and government sponsored refugees and the policy implications, as it relates to health. The presence of close relatives helps with the settlement process. The PSR program is very cost effective and by involving Canadians personally, helps maintain high levels of support for Canada’s refugee programs. However, as mentioned in section 2.1.2, with respect to PSRs outnumbering GSRs, researchers have cautioned that civil society’s involvement cannot be considered as substitution of the government’s international obligations towards refugees or the privatization of costs.

In depth understanding of how the different agencies in Winnipeg that serve refugees can collaborate better is required. I suggest more studies with service providers and decision makers, to be focused on exploring options for increased collaborations and achieving service efficiency.

The importance of understanding resilience and factors contributing to refugee women’s’ resilience to improve mental health is acknowledged. While the study focused on barriers and the healthcare system; in-depth understanding on resiliency and the application in improving the refugee women’s mental health is recommend for future studies.

While the refugee literature mostly discussed cultural competency, the need to move

towards culturally safe care is growing. A better understanding of these two concepts are required in the context of refugee health. The service providers may not know the differences between these two concepts and may reflect the continued focus on the other (cultural competency) rather than healthcare providers reflecting on themselves and power differentials (cultural safety). Therefore, an in-depth study that focuses on the cultural safety aspect of the refugee mental healthcare is recommended.

In conducting this study, I am also providing a list of recommendations for other researchers engaging in refugee women's mental health research:

1. Collaboration with refugee serving organizations would be most useful in conducting such research. It is recommended to contact them, as many as possible, well ahead of time for participant recruitment and/or other collaboration.
2. Use of a family as interpreter is not recommended, because of confidentiality issue. The refugee women may not feel comfortable in sharing past histories of trauma/abuse in front of a family member, some even do not want to put stress on their children by disclosing their struggles.
3. I recommend use of both female interpreters and male interpreters. This would provide the opportunity to see how women respond differently to the use of female and male interpreters.
4. Consulting with an interpreter while developing the interview guide would be useful.
5. Ideally, it would probably be better to train a native Arabic speaker to conduct the interviews, however, finding someone with such competency may also be difficult.
6. Researchers should carefully plan the study timeline while considering the need for REB approvals.

## Chapter 6. Conclusions

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People are being killed, injured and forced from their homes by terrifying wars and conflicts. Many are running for their lives. We have moral obligations to respond to a humanitarian crisis. Unfortunately, not all countries have extended their hand to help these vulnerable people, but Canada and few others did. Canada has taken some important steps to address the healthcare needs of refugees. Government funded insurance scheme (IFHP) provides refugees basic and extended coverage up to one year. Specialized clinics for refugees have been set up in many Canadian cities. Some clinics provide one stop services to refugees, including mental healthcare. These efforts were much appreciated by the refugees as they face initial struggles to navigate the Canadian health care system. However, the struggle of refugees when IFHP support is not available after one year have been reported. According to the Immigration department, most jobs so far obtained by the recently arrived Syrian refugees in Canada are typically in the low-paying service and restaurant sector, or in construction (Douglas, 2017). Therefore, many are struggling to pay for medication or mental healthcare if not covered by the employer insurance.

Maintaining a client-provider trust relationship based on socio-cultural elements is very difficult without funding for interpretation services and trainings for healthcare providers on culturally competent care. With the decline in commodity prices and economy in downturn, Canada is facing ongoing challenges in ensuring government and non-government funding for providing services to refugees. Many provinces have seen cuts in healthcare and Manitoba is no different. Nevertheless, from a system perspective, accepting refugees must be simultaneously recognized within health care budgets (McKeary & Newbold, 2010).

Refugee mental healthcare is a complex issue. It is challenging for the provincial

healthcare system to address service access and utilization, quality of service, as well as planning and implementing sustainable, comprehensive mental healthcare for refugees. However, since refugee women have survived through extremely difficult situations and shown resilience, certainly they would be accustomed to Canadian culture and healthcare system in a matter of time. What they need is support at the initial stage, so that their mental health problems get diagnosed and addressed in a timely manner. A welcoming culture in healthcare settings is required to ensure that the refugees do not avoid seeking help. Manitoba has a long history of welcoming refugees and is in a good position to support the healthcare needs of this vulnerable group because it has the right people, knowledge, and integrated systems. With committed leadership, some strategic alignment of services, and a few extra resources, Manitoba will be able to provide refugees with appropriate access to healthcare services and supports. Policy makers should consider that allocating financial and human resources to primary and mental healthcare for refugees is not only a humanitarian necessity, it will eventually pay off. Investing in finding employment for refugees or providing training for jobs seem to be more beneficial in the long run, when compared to the continued cost of providing social assistance.

Given the increasing number of refugees settling in Manitoba and the potentially challenging mental health issues they may face, it is important that the provincial healthcare system is well-equipped to address this potential challenge. Results from this study will assist the decision makers in developing policies to improve mental healthcare for refugees in Manitoba. Many of these Syrian refugee women have lived through war violence; some being widowed, divorced or abandoned with their kids but they showed strength and they survived. This reminds us of women's resilience and spirit, and to celebrate their strength. Manitoba can take pride as a host of these brave women as well as learn a lot from their spirit of survival.

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## Appendices

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**APPENDIX A: INTERVIEW GUIDES**

## Refugee Women Demographic Profile

ID Number:

1. Age:
2. Country of origin (Syria): Yes No
3. Marital status:
4. Children: Yes No. If Yes, how many?
5. Years in Canada:
6. Years in Winnipeg:
7. Occupation (in birth country and Canada):
8. Educational background (in birth country and Canada):
9. Total household income (before tax):  
 Under 15,000     15,000 – 20,000     21,000 – 30,000     31,000 – 40,000  
 41,000 – 50,000     51,000 – 60,000     61,000 – 80,000     Above 80,000
10. Housing accommodation:
11. Personal experience needing help to address mental health: Yes No
12. Personal experience using mental healthcare services: Yes No

## **Interview Guide for Refugee Women (RWQ V3.0)**

1. Do you feel that you had to face additional challenges for being a woman during the migration process?
2. Do you feel overwhelmed by all the changes in your life now?
3. How is mental health understood back home? What is your understanding about mental health and mental healthcare need?
4. What are some major sources of stresses in your life currently? How do you normally/usually deal with stress?
5. Was it difficult to access health care services when first came to Canada? Do you know what to do when you have health concerns?
6. Are you aware of the mental healthcare services available for refugee women in your community and in the city? What are your experiences with these services? Are you seeing a psychiatrist, psychologist, or clinical counsellor?
7. Are there any barriers that make you and other refugee women in your community not use the mental health services available? If yes, what are those? Do you think you need that services?
8. Do you feel that service providers understand your feelings and issues? How? Can you give me an example?
9. Do you use/consult any alternative/traditional forms of care to cope with stress? If so, can you please elaborate/ give me some examples? What kinds of services would you like to have available?
10. Do you have any suggestions to improve the mental healthcare access for refugee women in Winnipeg? What are the changes you would like to see?
11. What kind of outcome would you like to see with this project?
12. Is there anything else you think I should know?

VERSION Date: February 11, 2019

## **Interview Guide for Service Providers/Decision Makers (SPDMQ V2.0)**

1. Can you describe your current role and capacity of your organization to address the mental health needs of refugee women? What kind of mental health needs do you see in refugee women in Winnipeg?
2. How do your refugee clients come into contact with your organization? Do you work with or communicate with other service providers in the city that work with refugee women?
3. Do you think that the mental healthcare needs of refugee women are being met? Why or why not? How can we measure the effectiveness of existing services and programs? Including prevention, diagnosis, treatment, and recovery.
4. Studies conducted in Manitoba by interviewing refugees found evidence that refugees are facing barriers in accessing mental healthcare services that include language, socio-economic, cultural, quality of care, long wait times, referral system, trust issues, discrimination, stigma etc. What are your thoughts about these barriers and mitigation options?
5. Do you think that your work has changed over the last several years to respond to the increasing number of refugees in the province? Did you take any additional training or participate in skill development programs?
6. How have recent policy reforms and related budget cuts affected mental healthcare services for refugee women in Winnipeg/ Manitoba? (consolidating healthcare services, shifting mental healthcare services from 5 major sites to 3 sites etc.)
7. Have you found that gender, family roles, culture/ethnicity, race or refugee status play a role in utilizing healthcare care services? In what ways?
8. What are your thoughts about providing more culturally competent care to refugee women? What does culturally competent health care mean?
9. What have you found to be the greatest challenges in providing adequate services for your refugee clients? Have the challenges changed over time? How have you dealt with these challenges?
10. How can we improve the mental healthcare services for refugee women in Winnipeg? What steps/policies can the province take and/or are possible within the system? What changes would you like to see?

Please add if you have any additional comments.

VERSION Date: November 05, 2018

**APPENDIX B: CONSENT FORMS**





UNIVERSITY  
OF MANITOBA

Rady Faculty of Health Sciences

Max Rady College of Medicine  
Dept. of Community Health Sciences  
S113-750 Bannatyne Ave  
Winnipeg, Manitoba, R3E 3P5  
Phone (204) 789-3250  
Fax (204) 975-7783

## RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM Individual Interview (Refugee Women)

**Title of Study: “Exploring Mental Healthcare Needs and Challenges of Syrian Refugee Women in Winnipeg”**

**Principal Investigator:**

Sanjida Newaz, MSc Student, Department of Community Health Sciences, Rady Faculty of Health Sciences, S113-750 Bannatyne Avenue, University of Manitoba. Phone: xxx-xxx-xxxx. Email: [newazs@myumanitoba.ca](mailto:newazs@myumanitoba.ca)

**Supervisor/ Co-Investigator:**

Natalie Riediger PhD, Assistant Professor, Department of Community Health Sciences, Rady Faculty of Health Sciences, 209 Human Ecology Building, University of Manitoba. Phone: 204-480-1323. Email: [Natalie.riediger@umanitoba.ca](mailto:Natalie.riediger@umanitoba.ca)

**Sponsor:** Not applicable

**Funder:** Canadian Institute of Health Research (CIHR), Manitoba Training Program for Health Services Research, Faculty of Graduate Studies – University of Manitoba.

You are being asked to participate in a research study involving an individual interview. Please take your time to review this consent form and discuss any questions you may have with the study staff, your friends, family before you make your decision. This consent form may contain words that you do not understand. Please ask the study staff to explain any words or information that you do not clearly understand.

### Purpose of this Study

This research study is being conducted to study the current mental healthcare need and services for refugee women in Winnipeg, the barriers to access services and the perspectives of service providers/decision makers in addressing the issues and challenges.

### Participants Selection

You are being asked to participate in this study because you are a Syrian refugee woman of 18 - 45 years and have settled in Winnipeg within the last 1 - 5 years.

A total of 8 -10 participants will be asked to participate.

### Study procedures

- The method of data collection for this study will be an individual interview. Sanjida Newaz will take notes during the interviews. A cultural or language interpreter may be attending if required. Interviews are a way of finding out people’s thoughts and ideas about a specific topic
- Participation in the study will be approximately 1.5 hrs. You will be asked some

questions (please see the interview guide) relating to your understanding about mental health and wellbeing, your experience with mental healthcare services and access to these services and what changes you would like to see to improve mental healthcare services for refugee women in Winnipeg. These questions will help us to better understand how mental healthcare services are offered in Winnipeg and the options for improvement. The provided questions are just for guidance, therefore, subject to change depending upon how the discussions proceed.

- With your consent, the session will be audio-taped, and the audio-tapes will be transcribed by Sanjida Newaz to ensure accurate reporting of the information that you provide. By signing this form, the transcriber states that any item on the tape will not be discussed with anyone other than the researchers. The audio-tapes will be stored in a secured place before and after being transcribed. Audiotapes will be destroyed at the end of this project (tentatively October 2019). The transcriptions and consent forms will be kept for 5 years (till October 2023) for any possible publications from the study before destroying. If you wish not being recorded, the interviewer will take notes instead. Please indicate your choice at the end of this form.
- No one's name will be asked or revealed during this interview.

### **Risks and Discomforts**

Please note that you will be sharing personal experience, therefore, the confidentiality, trust and your comfort levels would be given top priority. However, it is possible that talking about war and trauma related experience might be emotional, embarrassing or stressful for you. Urgent care can be arranged if you feel like there is anything that has come up for you during the interview that is upsetting. A list with the contact information of Crisis Response Center (Phone: (204) 940-1781) and other counselling services is provided with this consent form. The trained professionals will be able to help you with any emotional stress and mental illness. You can discontinue at any time you wish.

### **Benefits**

Being a study participant may not help you directly, but information gained may help other people in your community to have better access to mental healthcare services in the future.

### **Costs**

There is no cost for you to attend this interview.

### **Payment for participation:**

You will be given a \$20 gift card as a compensation for your time. If you require transportation to and from the meeting, bus tickets will be available for you.

### **Confidentiality**

We will do everything possible to keep your personal information confidential. Your name will not be used at all in the study records. A list of names and addresses of participants will be kept in a secure file so we can send you a summary of the results of the study. If the results of this study are presented in a meeting, or published, nobody will be able to tell that you were in the study. Please note that although you will not be identified as the speaker, your words may be used to highlight a specific point. The collection and access to personal and health related information will be in compliance with provincial and federal privacy legislations.

All collected information will be kept confidential. Audiotapes of the discussion will be typed and used to prepare a report. The audiotapes and typed/hand written notes will be kept in a secure locked file cabinet and office. The audio tapes, typed notes will be uploaded electronically

and stored in a password protected personal computer of Sanjida Newaz. Only the principal and co-investigators of this research project will have access to the documents and know your name. Some people or groups may need to check the study records to make sure all the information is correct. All of these people have a professional responsibility to protect your privacy.

These people or groups are:

- The Health Research Ethics Board of the University of Manitoba which is responsible for the protection of people in research and has reviewed this study for ethical acceptability.
- Quality assurance staff of the University of Manitoba who ensure the study is being conducted properly.

**Permission to Quote**

We may wish to quote your words directly in reports and publications resulting from this. With regards to being quoted, please check yes or no for each of the following statements:

Researchers may publish documents that contain quotations by me under the following conditions:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	I agree to be quoted directly (my name is used).
<input type="checkbox"/> Yes <input type="checkbox"/> No	I agree to be quoted directly if my name is not published (I remain anonymous).
<input type="checkbox"/> Yes <input type="checkbox"/> No	I agree to be quoted directly if a made-up name (pseudonym) is used.

**Voluntary Participation/Withdrawal from the Study**

Your decision to take part in this study is voluntary. You may refuse to participate, or you may withdraw from the study at any time.

**Questions**

If any questions come up during or after the study, please contact the principal and co-investigator. The contact information is provided in page 1 of this form.

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389

**Feedback**

If you wish to know about the outcome of your interview or this study in general, it can be provided to you. Please provide your contact information to receive the outcome.

**Consent Signatures:**

1. I have read all 4 pages of the consent form.
2. I have had a chance to ask questions and have received satisfactory answers to all of my questions.
3. I understand that by signing this consent form I have not waived any of my legal rights as a participant in this study.
4. I understand that my records, which may include identifying information, may be reviewed by the research staff working with the Principal Investigator and the agencies and organizations listed in the Confidentiality section of this document.
5. I understand that I may withdraw from the study at any time and my data may be withdrawn prior to publication.

6. I understand I will be provided with a copy of the consent form for my records.
7. I agree to participate in the study.

**Participant signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(day/month/year)

**Participant printed name:** \_\_\_\_\_

**Interviewer signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(day/month/year)

**Interviewer printed name:** \_\_\_\_\_

Third Party Signature (if required)

**I, the undersigned, attest that the information in the Participant Information and Consent Form was accurately explained to and apparently understood by the participant or the participant's legally acceptable representative and that consent to participate in this study was freely given by the participant or the participant's legally acceptable representative.**

**Witness signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(day/month/year)

**Witness printed name:** \_\_\_\_\_



UNIVERSITY  
OF MANITOBA

Rady Faculty of Health Sciences

Max Rady College of Medicine  
Dept. of Community Health Sciences  
S113-740 Bannatyne Avenue  
Winnipeg, Manitoba, R3E 3P5  
Phone (204) 789-3250  
Fax (204) 975-7783

## RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM Individual Interview (Service Providers/Decision Makers)

**Title of Study: “Exploring Mental Healthcare Needs and Challenges of Syrian Refugee Women in Winnipeg”**

### **Principal Investigator:**

Sanjida Newaz, MSc Student, Department of Community Health Sciences, Rady Faculty of Health Sciences, 750 Bannatyne Avenue, University of Manitoba. Phone: xxx-xxx-xxxx. Email: [newazs@myumanitoba.ca](mailto:newazs@myumanitoba.ca)

### **Supervisor/ Co-Investigator:**

Natalie Riediger PhD, Assistant Professor, Department of Food and Human Nutritional Sciences & Community Health Sciences, 209 Human Ecology Building, University of Manitoba.

Phone: 204-480-1323. Email: [Natalie.riediger@umanitoba.ca](mailto:Natalie.riediger@umanitoba.ca)

**Sponsor:** Not applicable

**Funder:** Canadian Institute of Health Research (CIHR), Manitoba Training Program for Health Services Research, Faculty of Graduate Studies – University of Manitoba.

You are being asked to participate in a research study involving an individual interview. Please take your time to review this consent form and discuss any questions you may have with the study staff. Please ask the study staff to explain any words or information that you do not clearly understand.

### **Purpose of this Study**

This research study is being conducted to study the current mental healthcare need and services for refugee women in Winnipeg, the barriers to access services and the perspectives of service providers/decision makers in addressing the issues and challenges.

### **Participants Selection**

You are being asked to participate in this study because you are a service provider / decision maker relevant to refugee health care.

A total of 3 - 5 participants will be asked to participate.

### **Study procedures**

- The method of data collection for this study will be an individual interview. Sanjida Newaz will take notes during the interviews. Interviews are a way of finding out people’s thoughts and ideas about a specific topic.
- Participation in the study will be approximately 1.5 hrs. You will be asked some

questions relating to your understanding about mental health and wellbeing, your experience with mental healthcare services and access to these services and what changes you would like to see to improve mental healthcare services for refugee women in Winnipeg. These questions will help us to better understand how mental healthcare services are offered in Winnipeg and the options for improvement.

- With your consent, the session will be audio-taped, and the audio-tapes will be transcribed by Sanjida Newaz to ensure accurate reporting of the information that you provide. By signing this form, the transcriber states that any item on the tape will not be discussed with anyone other than the researchers. The audio-tapes will be stored in a secured place before and after being transcribed. Audio tapes will be destroyed at the end of this project (tentatively October 2019). The transcriptions and consent forms will be kept for 5 years (till October 2023) or any possible publications from the study before destroying. If you wish not being recorded, the interviewer will take notes instead. Please indicate your choice at the end of this form.
- No one's name will be asked or revealed during this interview.

### **Risks and Discomforts**

There are no anticipated physical risks to participants. However, you may find talking about refugee women who have through war and trauma related experience might be emotional, embarrassing or stressful for you. You do not have to answer any question that makes you feel uncomfortable or that you find too upsetting. You can discontinue at any time you wish.

### **Benefits**

Being a study participant may not help you directly, but information gained may help other people in your community to have better access to mental healthcare services in the future.

### **Costs**

There is no cost to you to attend this interview.

### **Payment for participation:**

N/A

### **Confidentiality**

We will do everything possible to keep your personal information confidential. Your name will not be used at all in the study records. A list of names and addresses of participants will be kept in a secure file so we can send you a summary of the results of the study. If the results of this study are presented in a meeting, or published, nobody will be able to tell that you were in the study. Please note that although you will not be identified as the speaker, your words may be used to highlight a specific point. The collection and access to personal and health related information will be in compliance with provincial and federal privacy legislations.

All collected information will be kept confidential. Audiotapes of the discussion will be typed and used to prepare a report. The audiotapes and typed/hand written notes will be kept in a secure locked file cabinet and office. The audio tapes, typed notes will be uploaded electronically and stored in a password protected personal computer of Sanjida Newaz. Only the principal and co-investigators of this research project will have access to the documents and know your name. Some people or groups may need to check the study records to make sure all the information is correct. All of these people have a professional responsibility to protect your privacy. These people or groups are:

- The Health Research Ethics Board of the University of Manitoba which is responsible for the protection of people in research and has reviewed this study for ethical acceptability.
- Quality assurance staff of the University of Manitoba who ensure the study is being conducted properly.

**Permission to Quote**

We may wish to quote your words directly in reports and publications resulting from this. With regards to being quoted, please check yes or no for each of the following statements:

Researchers may publish documents that contain quotations by me under the following conditions:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	I agree to be quoted directly (my name is used).
<input type="checkbox"/> Yes <input type="checkbox"/> No	I agree to be quoted directly if my name is not published (I remain anonymous).
<input type="checkbox"/> Yes <input type="checkbox"/> No	I agree to be quoted directly if a made-up name (pseudonym) is used.

**Voluntary Participation/Withdrawal from the Study**

Your decision to take part in this study is voluntary. You may refuse to participate, or you may withdraw from the study at any time.

Employee Participation: Your participation or discontinuance in the study will not constitute an element of your job performance or evaluation nor will it be part of your personnel record at your organization.

**Questions**

If any questions come up during or after the study, please contact the principal and co-investigator. The contact information is provided in page 1 of his form.

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389

**Feedback**

If you wish to know about the outcome of your interview or this study in general, it can be provided to you. Please provide your contact information to receive the outcome.

**Consent Signatures:**

8. I have read all 4 pages of the consent form.
9. I have had a chance to ask questions and have received satisfactory answers to all of my questions.
10. I understand that by signing this consent form I have not waived any of my legal rights as a participant in this study.
11. I understand that my records, which may include identifying information, may be reviewed by the research staff working with the Principal Investigator and the agencies and organizations listed in the Confidentiality section of this document.
12. I understand that I may withdraw from the study at any time and my data may be withdrawn prior to publication.

13. I understand I will be provided with a copy of the consent form for my records.  
14. I agree to participate in the study.

**Participant signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(day/month/year)

**Participant printed name:** \_\_\_\_\_

**Interviewer signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(day/month/year)

**Interviewer printed name:** \_\_\_\_\_



**APPENDIX C: INTERPRETER CONFIDENTIALITY AGREEMENT**

## **Confidentiality Agreement for Interpreters**

I understand the purpose of this study “Exploring Mental Healthcare Needs and Challenges of Syrian Refugee Women in Winnipeg” being undertaken by Sanjida Newaz, MSc student – as principal investigator and Dr. Natalie Riediger, Assistant Professor – as research supervisor, both from the Department of Community Health Sciences, University of Manitoba. I also understand that as a interpreter, I will:

1. I will protect the confidentiality of the individual and any statements or observations made by the individual that I am translating for;
2. I agree that all statements reflect the comment(s) made the individual being interviewed;
3. I will keep all research information (in any format) secure while in my possession and return to the researchers named above upon completion of translation;
4. I will destroy all research information after consulting with the above-named researchers upon completion of translation;
5. I agree to participate in the research study as a interpreter and I understand that this will be audio recorded.
6. I have been given a copy of this form.

_____ Name of Interpreter	_____ Signature	_____ Date (DD/MM/YY)
_____ Name of Interviewer	_____ Signature	_____ Date (DD/MM/YY)

**APPENDIX D: RECRUITMENT MATERIALS**

## Research Participant Recruitment E-mail script (Refugee Women)

### Title of Study: “Exploring Mental Healthcare Needs and Challenges of Syrian Refugee Women in Winnipeg”

Re: Request for participation into MSc research project at UofM

Hello,

I am a Master’s student at the Department of Community Health Sciences, University of Manitoba. We are currently conducting research to study the current mental healthcare need and services for Syrian refugee women in Winnipeg, the barriers to access services and the perspectives of service providers in addressing the issues and challenges.

Participation in this study will involve an individual interview with myself. You will be asked some questions relating to your understanding about mental health and wellbeing, your experience with mental healthcare services and access to these services and what changes you would like to see to improve mental healthcare services for refugee women in Winnipeg. These questions will help us to better understand how mental healthcare services are offered in Winnipeg and the options for improvement. Participation in this study will take approximately 1 – 1.5 hour of your time. In appreciation of your time commitment, you will receive a small gift.

I would like to assure you that the study has been reviewed and received ethics clearance through the University of Manitoba’s Health Research Ethics Board, and all data will be kept confidential by the research team. If you are interested in participating or would like more information, please contact [newazs@myumanitoba.ca](mailto:newazs@myumanitoba.ca) or xxx-xxx-xxxx. We will then send a confirmation email or call indicating that you have been signed up and provide you with further information concerning the location and time of interview. If you have to cancel your appointment, please email us at [newazs@myumanitoba.ca](mailto:newazs@myumanitoba.ca).

Participation is voluntary, and you can withdraw from the study at any time. Thank you for considering our request. We sincerely hope you will be able to assist us with this project!

Sincerely,

***Sanjida Newaz***

***Email:*** [newazs@myumanitoba.ca](mailto:newazs@myumanitoba.ca)

***Phone:*** xxx-xxx-xxxx

## Research Participant Recruitment E-mail script (Service Provider)

### Title of Study: “Exploring Mental Healthcare Needs and Challenges of Syrian Refugee Women in Winnipeg”

RE: Request for collaboration into MSc research project at UofM

Hello,

I am Sanjida Newaz, currently enrolled in Community Health Sciences MSc program at the University of Manitoba. For my MSc research I am working on “Exploring Mental Healthcare Needs and Challenges of Syrian Refugee Women in Winnipeg”. I plan to conduct semi-structured interviews with refugee women and service providers to get their perspectives on how refugee women experience mental health, well-being and the healthcare system in Winnipeg. Dr. Natalie Riediger, Assistant Professor, Department of Food and Human Nutritional Sciences and Community Health Sciences is the research supervisor.

We believe that [organization name] can be a community partner and great resource to my research project. We would greatly appreciate your collaboration in reaching out to refugee women and conducting interviews. Participants will be asked some questions relating to their understanding about mental health and wellbeing, experience with mental healthcare services and access to these services and what changes they would like to see to improve mental healthcare services for refugee women in Winnipeg.

I am also requesting your individual interview as a service provider. Participation in this study will take approximately 1 – 1.5 hour of your time. I would like to assure you that the study has been reviewed and received ethics clearance through the University of Manitoba’s Health Research Ethics Board, and all data will be kept confidential by the research team.

Please forward this email to anyone who you think can help or connect me to the individual. I greatly appreciate your time in reading this email. I am happy to answer any questions or provide further details that you require. My contact information is provided below.

I look forward to hearing from you.

Sincerely,

***Sanjida Newaz***

***Email:*** [newazs@myumanitoba.ca](mailto:newazs@myumanitoba.ca)

***Phone:*** xxx-xxx-xxxx

# RESEARCH PARTICIPANT NEEDED

## FOR A STUDY ON “Exploring Mental Healthcare Needs and Challenges of SYRIAN Refugee Women in Winnipeg”

YOU WOULD BE ASKED TO ANSWER SOME QUESTIONS RELATING YOUR

- Understanding about mental health and wellbeing
- Experience with mental healthcare services and access to these services
- Suggestions to improve mental healthcare services for refugee women in Winnipeg.

Your participation is

entirely voluntary and would take up approximately 1 – 1.5 hour of your time. By participating in this study, you will help us to better understand how mental healthcare services are offered in Winnipeg and the options for improvement. You will receive a gift card in appreciation of your time.

To participate or learn more please **contact:**

**Sanjida Newaz**

**Email: [newazs@myumanitoba.ca](mailto:newazs@myumanitoba.ca)**

**Phone: xxx-xxx-xxxx**

This research received ethics clearance through the University of Manitoba's Health Research Ethics Board.

TO PARTICIPATE YOU NEED TO BE

- An adult woman (18 – 45) came to Canada from Syria as refugee
- Have lived in Winnipeg for at least 1 year but not more than 5 years
- You are having or previously had mental health difficulties

## MENTAL HEALTH

# Let's Talk

## RESEARCH SUPERVISOR

Natalie Riediger, PhD  
Assistant Professor  
Department of Community Health Sciences  
University of Manitoba  
[Natalie.riediger@umanitoba.ca](mailto:Natalie.riediger@umanitoba.ca)



UNIVERSITY OF MANITOBA  
Rady Faculty of Health Sciences

[newazs@myumanitoba.ca](mailto:newazs@myumanitoba.ca)  
Sanjida Newaz  
xxx-xxx-xxxx

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xxx-xxx-xxxx

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Sanjida Newaz  
xxx-xxx-xxxx

[newazs@myumanitoba.ca](mailto:newazs@myumanitoba.ca)  
Sanjida Newaz  
xxx-xxx-xxxx

[newazs@myumanitoba.ca](mailto:newazs@myumanitoba.ca)  
Sanjida Newaz  
xxx-xxx-xxxx

[newazs@myumanitoba.ca](mailto:newazs@myumanitoba.ca)  
Sanjida Newaz  
xxx-xxx-xxxx

VERSION Date: September 23, 2018

**APPENDIX E: LESSONS LEARNED FOR CANADA FROM EUROPEAN  
RESPONSE**

# **Lessons Learned for Canada from European Response on Refugee Crisis**

## **1.1 Study Background**

The author received an opportunity to conduct a short-term research internship at the Department of Global Health and Development, Faculty of Public Health and Policy, London School of Hygiene and Tropical Medicine (LSHTM), UK. The study titled ‘Exploring European Response to Mental Healthcare Needs of Women with Insecure Immigration Status’ was funded by Mitacs Globalink Research Award (Mitacs Canada; \$6,000) and Queen Elizabeth II Diamond Jubilee Scholarship Program (QES; \$6,000). The study was conducted under the supervisions of Dr. Natasha Howard (Host Supervisor at LSHTM) and Dr. Natalie Riediger (Home Supervisor at UofM). This chapter presents the research and findings on the European response to the mental healthcare needs of insecure immigration status women (refugees, asylum seekers or undocumented migrants) and applicable lessons learned for Canada.

## **1.2 Introduction**

The UN Refugee Council estimates an increase of forcibly displaced population worldwide by 2.3 million and a total 70.8 million forcibly displaced people by the end of 2018 (UNHCR, 2019b). The Civil war in Syria, break of peace in South Sudan, and communal violence against Rohingya in Myanmar have contributed to the recent refugee crisis. Over one million refugees had arrived in Europe between 2015 – 16 (Pavli & Maltezou, 2017). The European Union experienced unprecedented influx of refugees in 2015 and 2016. Refugees and migrants risked their lives by crossing the Mediterranean Sea in boats to reach Italy and Greece as a gateway to Europe as they fled from war and violence. In 2015, 476,649 refugees applied for asylum in Germany (Grote, 2018), which represented a nearly a 6% annual increase in Germany’s population (Belz, Belz, Ozkan, & Graef-calliess, 2017).



Refugees and migrants arrive in Europe from many places, but the 2015 spike was primarily driven by civil wars in Syria, Iraq and Afghanistan (Trines, 2017). Even three years after the shocking images of a lifeless Syrian toddler, Alan Kurdi, on a Turkish beach stunned the world, a 2019 report by UNHCR reports that crossing the Mediterranean Sea still remains deadly with 6 deaths everyday (UNHCR, 2019a). “*Setting foot in Europe was the final stop of a nightmarish journey on which they had faced torture, rape and sexual assault, and the threat of being kidnapped and held for ransom,*” – as the report describes. The deadly crossing of the Mediterranean Sea has continued and a total of 139,300 refugees arrived in Europe in 2018 (UNHCR, 2019a).

The mental healthcare of refugees or other undocumented migrants remains a prime challenge as many have fled from war with traumatic experiences. As far as refugee women’s mental health is concerned, traumatic experiences related to war, hunger, physical and sexual abuse both in their home countries and during the migration contribute to the mental illness of refugee women (Pavli & Maltezou, 2017). The long and deadly journey across the Mediterranean Sea poses additional stresses on women, especially those who are alone, pregnant and/or have children with them. Many are traumatized and scared of the uncertainties in settling in a new country and culture. The women refugees may face additional social exclusion and isolation compared to men as they are less likely to speak the new language and obtain employment (Cho, 2012; Sullivan, 2009). By not actively seeking help or not knowing how to seek help the refugee women can potentially put themselves and their children at risk of developing long term mental illness.

A scoping review was conducted to explore the mental healthcare needs of insecure immigrant women (refugees/ asylum seekers/ undocumented migrants) in the U.K. and Europe,

how immigration status and cultural differences are affecting their healthcare seeking behavior, and what can be done to improve services in a more culturally competent way. Following the scoping review, a summary and comparison of overall healthcare policies for refugees in Canada and E.U. countries were provided. Finally, the applicable lessons learned for Canada from Europe’s experience in addressing mental healthcare needs of refugee women were documented.

### **1.3 Research Objectives**

The overarching research question was what can the healthcare system do to address the mental health needs of insecure status women in Europe? Then to document Canadian and European healthcare policies for refugees, and finally to extract lessons learned for Canada from the European responses.

Three specific research objectives were:

- 1) To describe the mental health of refugee and insecure status women in Europe;
- 2) To document European policy responses and compare to Canadian policies; and
- 3) To identify lessons learned for Canada.

### **1.4 Methods**

#### **1.4.1 Objective 1: Mental Health Crisis of Refugee and Insecure Status Women**

A scoping review was conducted by following the five-stage methodology developed by Arksey and O’Malley (Arksey & Malley, 2005): 1) identifying the research question, 2) identifying the relevant studies, 3) Study selection by inclusion and exclusion criteria, 4) charting the data, and 5) collating, summarizing and reporting the results.

##### **1.4.1.1 Stage 1: Identifying the Research Question**

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The overarching research question of this scoping review is: “What is, or can the

healthcare system do to address the mental health needs of refugee and undocumented women in Europe?” Key definitions related to this study are presented in Table 1.

**Table 1: Key Definitions**

<b>Term</b>	<b>Definition</b>
<b>Mental Health</b>	“Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”. (WHO)
<b>Health Care System</b>	A health system, also sometimes referred to as health care system or as healthcare system, is the organization of people, institutions, and resources that deliver health care services to meet the health needs of target populations. (Wikipedia)
<b>Refugee</b>	A refugee is someone who has been forced to flee his or her country because of persecution, war or violence. (UNHCR)
<b>Asylum seekers</b>	Asylum seekers are individuals whose requests for refugee sanctuary have not yet been processed. (UNHCR)
<b>Migrant</b>	“Migrant' describes any person who moves, usually across an international border, to join family members already abroad, to search for a livelihood, to escape a natural disaster, or for a range of other purposes”. (UNHCR)
<b>Undocumented Migrants</b>	“Foreign citizens present on the territory of a state, in violation of the regulations on entry and residence, having crossed the border illicitly or at an unauthorized point; those whose immigration/migration status is not regular, and can also include those who have overstayed their visa or work permit, those who are working in violation of some or all of the conditions attached to their immigration status; and failed asylum seekers or immigrants who have no further right to appeal and have not left the country” (European Glossary on undocumented migration)
<b>Insecure Immigration Status</b>	People with ‘insecure immigration status’ means someone is waiting for a decision from the Home Office on permission to stay, where, for example – their status is dependent on a partner, spouse or other family member; their stay in the country is limited; someone is undocumented; or they have no legal right to be in the country, but might secure their legal status if supported to do so (Equalities and Human Rights Committee, The Scottish Parliament).

#### 1.4.1.2 Stage 2: Identifying Relevant Studies

Initially, electronic databases were searched systematically using: (1) Refugee terms, including ‘refugee’, ‘asylum seekers’, ‘migrants’, ‘undocumented’, and ‘illegal immigrants’; (2) Mental health terms, including ‘mental health’, ‘mental health services’, and ‘mental health care needs’; and (3) EU terms, including ‘EU countries’, and ‘European Union’ terms to identify

relevant studies. The search terms were performed alone and in combinations using the Boolean operators “AND” and “OR”. In addition, the search included organizations that serve the refugee group and also WHO, UNHCR websites. An internet search for grey literature was also conducted using the same keywords. Additionally, reference lists of literature were explored to identify relevant articles.

#### 1.4.1.3 Study Selection

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The population of interest for this study were refugees, asylum seekers and undocumented migrant women who migrated and resettled in the 28 European union countries. Studies that did not have women in the population sample were excluded. Articles published from January 2013 to July 2019 were considered to focus on exploring the most recent situation. Moreover, many studies were conducted during and after 2015 – 16 as that period had an unprecedented refugee migration to Europe. Therefore, reviewing the most recent studies was more relevant. To answer the research question the following inclusion and exclusion criteria were followed:

1) Inclusion criteria:

- a. Articles published in English
- b. Primary research only
- c. Articles related to European Union countries
- d. Published from 2013 to 2019
- e. Study population must include adult women with refugee or asylum seeker or undocumented migrant status

2) Exclusion criteria:

- a. Articles published in other language than English

- b. Articles not including primary research (e.g. Surveys, Comments, Editorials, Reviews, Notes, Books etc.)
- c. Articles not related to European Union countries
- d. Data was collected before a respective state was a member of the EU
- e. Published before 2013
- f. Migrant women in the study participants, who are not either refugee or undocumented migrant
- g. Papers focused exclusively on male population or children and adolescents as study participants

After identifying documents from databases and websites, titles and abstracts were screened following the inclusion and exclusion criteria to remove irrelevant articles. Then full texts were screened against the eligibility criteria to remove ineligible documents and to ensure women were included in the study population. Further documents from reference lists of included studies were searched as well.

#### 1.4.1.4 Charting the Data

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Relevant studies were charted in the Excel spreadsheet using the following subheadings –

- Source identifiers, i.e. publication year, lead author, source type (e.g. article, conference abstract/presentation, report), title, and search type/name (e.g. database, website);
- Source characteristics, i.e. country, study design, methods, participant characteristics, year of data collection, and number of study participants;
- Summary of the findings

#### 1.4.1.5 Collating, Summarizing and Reporting the Results

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The number of sources was summarized in a table by publication year, where accessed (i.e. database, journal, website), type (e.g. article, report), context (i.e. publication language, countries included), and study details (i.e. topic, outcomes included, study design, participant characteristics, time-period of data collection). Summaries of findings were guided by the research questions. Next, the articles were analyzed, and the results were presented in the following five inductive themes:

- Mental healthcare needs of insecure immigrant women
- Mental healthcare service utilization
- Barriers to access mental healthcare services
- Social determinants of health affecting the mental health and healthcare seeking behavior, and
- Strategies to improve services.

#### 1.4.2 Objective 2: Compare and Document European Response to Canadian

Objective 1 only included studies conducted in the EU countries. In addition to the articles obtained from the scoping review, the following resources were considered to document and compare European response to Canadian, especially in terms of healthcare policies and access for refugees:

- Articles (in addition to primary research and not considered in previous stage) that provides information on healthcare policies and initiatives by the EU countries for refugees;
- Immigration, Refugees and Citizenship Canada (IRCC) website;
- Relevant articles published in Canada from the reference list of this thesis

### **1.4.3 Objective 3: Identify Lessons Learned for Canada**

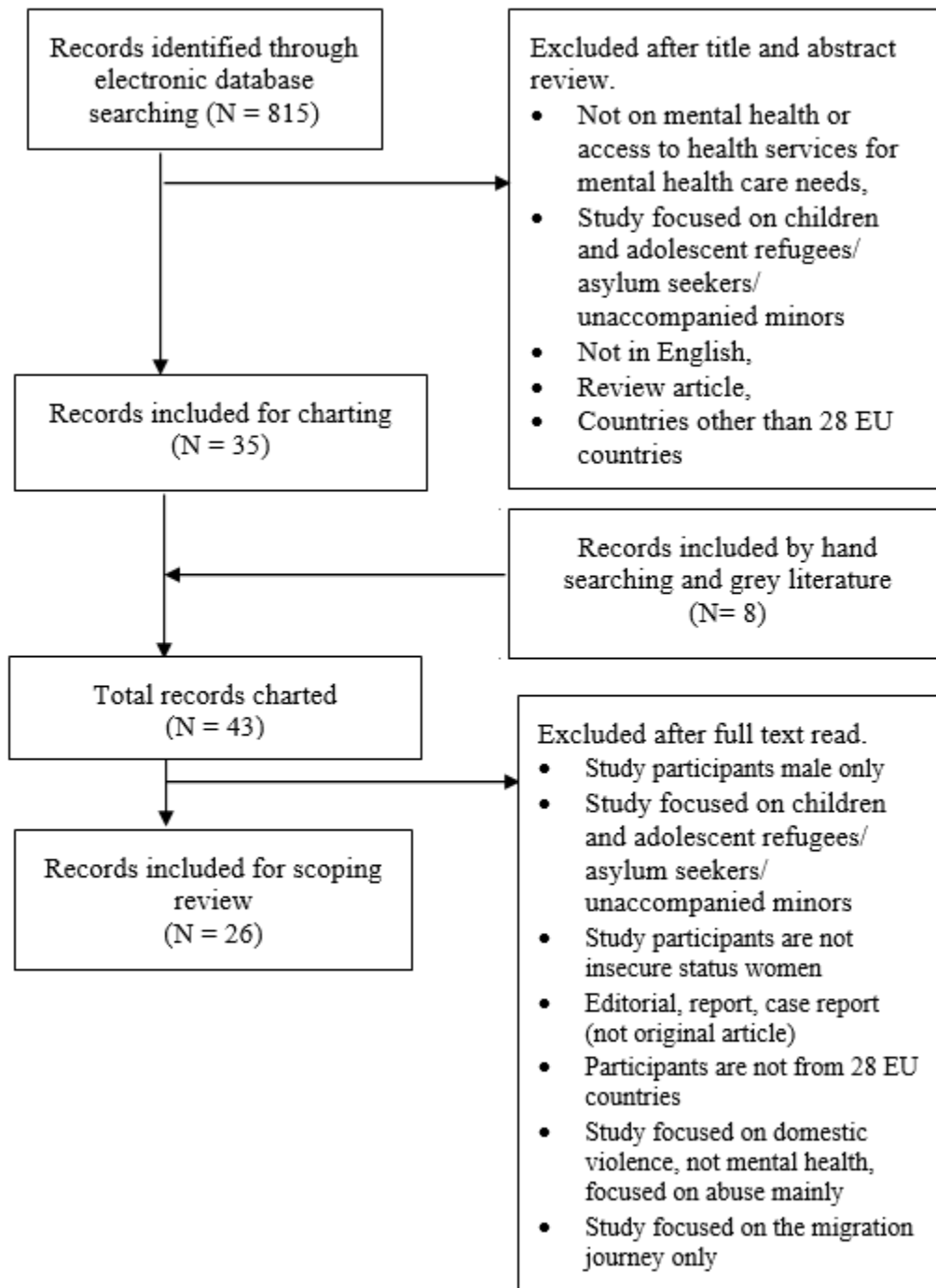
All articles from Objective 1 and Objective 2 were considered to identify and document lessons learned for Canada. While the focus of the study was women only, it was difficult to find any study which had women only as study population. Moreover, the initiatives taken by different countries towards refugee healthcare, barriers in accessing services and ways to improve services are applicable for all refugees, both men and women. Therefore, the identified and documented lessons learned for Canada would benefit all refugees.

## **1.5 Study Findings – Research Objective 1**

Figure 1 is a flow diagram for the 26 sources included of 815 identified. Initial database searching provided 18 sources, followed by hand-searching for grey literature (2 sources) and reference lists (6 sources). Findings were summarized according to mental healthcare needs of refugee and insecure immigrant women, social determinants of health affecting the mental health and healthcare seeking behavior, and strategies to improve services.

### **1.5.1 Mental Healthcare Needs of Insecure Immigrant Status Women**

A German study found that most of the refugees in a reception centre are showing symptoms of intrusion, hyperarousal, avoidance, and dissociation, which suggests the diagnosis of PTSD (Belz et al., 2017). Depression was also seen as a comorbid condition in these refugee population. In the long term, comorbid mental disorders as a consequence of untreated PTSD or other post-migration stressors can lead to other psychotic, affective, and/or neurotic disorders with the increasing duration of stay in the host country, as reported by Belz et al., (2017).



**Figure 1: Flow Diagram of Selection of Records Included in the Scoping Review**



Examining the frequency and nature of asylum seekers' psychiatric diagnoses in a German admission center for 283 asylum seekers (125 women, 158 men), indicated the most common primary diagnosis as stress-related and anxiety disorders, affective disorders and insomnia (Richter et al., 2018). The most frequent diagnosis was PTSD, according to the study.

Researchers found no significant difference between women and men with respect to frequency and symptom scores of PTSD, depression, and anxiety, according to another study in Germany with Arabic asylum seekers (Georgiadou, Morawa, & Erim, 2017). The authors further reported that, the prevalence is high compared to general population and indicates the need of culturally sensitive psychological interventions for the refugee population. However, in another study, females reported a higher prevalence of depressive symptoms when compared to males, although traumatic events and post-migration stress were found to be higher with males (Steel, Dunlavy, & Harding, 2017). Others reported that female asylum seekers were more likely to attempt suicide during the time of asylum decision and become traumatized than the asylum-seeking men (Sundvall, Tidemalm, Titelman, Runeson, & Bäärnhielm, 2015). Female, older and divorced or widowed refugees had more common mental health problems according to a study on Syrian refugees resettled in Sweden (Tinghög et al., 2017).

The study by Lamkaddem and colleagues in Netherlands showed the two main reasons for the persistently high rate of PTSD among refugees are the late onset of PTSD and low utilisation of mental healthcare services (Lamkaddem, Stronks, Devillé, Olf, & Gerritsen, 2014). Depression, anxiety and risk of having PTSD were found to be higher among asylum seekers who do not have residence permit, pointing at the importance of residence status for mental health (Leiler, Bjarta, Ekdahl, & Wasteson, 2019). There were higher levels of psychiatric disability among resettled traumatized refugee outpatients compared to most psychiatric Danish

inpatients, as reported by Palic et al., (2014). The process of integration of concepts and beliefs from the new society, which is known as acculturation, is an important aspect of healthcare seeking patterns for refugees (Brendler-lindqvist, Norredam, & Hjern, 2014).

### **1.5.2 Mental Healthcare Service Utilization**

In Switzerland, asylum seekers are assigned to General Practitioners (GP) as “a gatekeeping system” according to Bartolomei et al., (2016). If psychiatric evaluation is needed, the GP refers the patient to the Transcultural Psychiatry Program of the Geneva University Hospitals. Clinical consultations are translated by an interpreter of the Red Cross Interpretation Service.

Bozorgmehr, Schneider & Joos (2015) reported that asylum-seeking women had higher rates of hospital admission and utilisation of other type of services compared to asylum-seeking men due to the higher medical needs related to pregnancy and childbirth in Sweden. Another study in Sweden showed that recently settled refugees use psychotropic drugs less commonly compared to the Swedish-born population and the use increases with the duration of residence, which suggests the existence of barriers to access mental healthcare at initial stage (Brendler-lindqvist et al., 2014). A study in Denmark found the foremost reason for referrals and admittance in the psychiatric emergency was suicidal ideation and/or suicidal behaviour, usually after receiving a final rejection to an asylum application and being exposed to a threat of deportation (Brendler-lindqvist et al., 2014).

Teunissen et al., (2014) found that many undocumented migrants seek help from friends and religion first in regard to their mental health problems and consider seeking professional advice as their last resort. This finding is also supported by Richter et al., (2018) that despite the high prevalence of mental illness, Muslim asylum seekers coming mainly from Iraq and Iran

were not seeking help, due to gender as well as cultural, ethnic and religious differences in how psychiatric symptoms are understood and ultimately expressed. Women, older adults, and the divorced or widowed refugees have more common mental health problems according to Tinghög et al., (2017).

### **1.5.3 Barriers to Access Mental Healthcare Services**

The study by Bartolomei et al., (2016), conducted in Switzerland, discussed the barriers to access to mental healthcare for asylum seekers, which includes a negative representation and poor information about existing psychiatric services and fear of being stigmatized by their own community. Brendler-Lindqvist et al. (2014) categorized barriers to mental healthcare access into formal and informal. Formal barriers are the organizational barriers, such as elements of user payment in tax financed healthcare, which could be a challenge for low income, newly settled refugees. Informal barriers comprise knowledge about the healthcare system, language skills, socio-cultural factors affecting the self- perceived needs and health seeking behaviour. Also, lack of skilled interpreters, which affects the delivery of quality care, is considered as another significant barrier by Brendler-lindqvist et al. (2014).

A study conducted by Jensen and colleagues in Denmark that included immigrants, refugees and native Danish people found that lack of knowledge and taboos regarding mental illness, trauma, and additional vulnerability were causing barriers in accessing services (Jensen, Norredam, Priebe, & Krasnik, 2013). While seeking treatments patient reported that their concerns were not taken seriously by health professionals, which gives them the feeling of rejection by the system. Moreover, interrupted course of treatment due to lack of funding, transition between services, and assistance from others required to obtain contact with the healthcare system are some other challenges in accessing care. Chiarenza et al., (2019) also listed

the barriers that refugees and migrants persistently faced to access adequate health services.

Table 2 provides a list of barriers faced by insecure immigration status women and man in EU countries as described in different literature. To be consistent with the barriers table presented earlier in the thesis based on Canadian studies, the barriers have been categorized in three main topics – (1) Material; (2) Structural and Organizational; (3) Social and Cultural.

Social determinants of health can affect mental health and healthcare seeking behaviour of refugees and asylum seekers (Campbell, Mann, Moffatt, Dave, & Pearce, 2018). The researchers further noted that refugees who are unemployed, in poor-quality housing, in social isolation, experiencing financial problems, language problem or victims of discrimination experience worse emotional health. Teunissen and colleagues made a valid argument that the majority of undocumented migrants attributed their mental health problems to their status as undocumented migrants (Teunissen et al., 2014). Unemployment, precarious and insecure housing conditions, financial instability, fear of being arrested and deported, and constant worries about documents were mentioned repeatedly by the migrants according to almost all articles reviewed in this study. A second perceived cause was traumatising experiences in the country of origin (war, torture, prostitution) and worries about family members they left behind (Teunissen et al., 2014). While female and male asylum-seeking patients have no significant difference in the diagnoses of PTSD or depression, female patients are more likely to report sexual trauma compared to male patients (Belz et al., 2017).

**Table 2: Barriers in Accessing Mental Healthcare Services by Insecure Status Women in Europe**

<b>Category</b>	<b>Barriers</b>	<b>References</b>
<b>Material</b>	• Financial constraints (such as user fees) and practical difficulties	(Brendler-lindqvist et al., 2014; Teunissen et al., 2014)
	• Distance to the medical centre and inability to pay for transport	(Teunissen et al., 2014)
	• Living conditions and unemployment	(Campbell et al., 2018)
<b>Structural and Organizational</b>	• Administrative obstacles (such as lack of entitlement, difficulties in fulfilling legal access conditions and lack of documentation)	(Pérez-urdiales, Goicolea, Sebastián, Irazusta, & Linander, 2019; Teunissen et al., 2016)
	• Lack of support from the healthcare system	(Teunissen et al., 2016)
	• Lack of knowledge about the healthcare system (where and how to obtain care) and the right to access healthcare	(Bartolomei et al., 2016; Brendler-lindqvist et al., 2014; Chiarenza et al., 2019; Pérez-urdiales et al., 2019; Teunissen et al., 2014)
	• Communication (Difficulties with the local language and lack of skilled interpreters)	(Bartolomei et al., 2016; Brendler-lindqvist et al., 2014; Jensen et al., 2013; Pérez-urdiales et al., 2019; Teunissen et al., 2015)
	• Budget cuts in healthcare resulting in interrupted course of treatment	(Jensen, Johansen, & Kastrup, 2014; Teunissen et al., 2016)
	• Transition between services,	(Jensen et al., 2014)
	• Fear of deportation	(Teunissen et al., 2014)
<b>Social and Cultural</b>	• Increasing societal resistance towards Undocumented Migrants, negative representation	(Bartolomei et al., 2016; Teunissen et al., 2016)
	• Feeling of rejection by the healthcare system (not taken seriously by health professionals)	(Jensen et al., 2014; Pérez-urdiales et al., 2019)

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<ul style="list-style-type: none"> <li>• Fear of being stigmatized by their own community</li> <li>• Taboo</li> <li>• Feelings of shame/ guilt (especially which is associated with sexual traumatization), avoidance</li> </ul>	(Bartolomei et al., 2016; Belz et al., 2017; Jensen et al., 2014; Teunissen et al., 2014)
<ul style="list-style-type: none"> <li>• Low level of education and lack of understanding about mental health problems</li> </ul>	(Bartolomei et al., 2016; Belz et al., 2017; Jensen et al., 2014, 2013)
<ul style="list-style-type: none"> <li>• Depending on others to get involved in the healthcare system</li> </ul>	(Jensen et al., 2014)
<ul style="list-style-type: none"> <li>• Discrimination and racism</li> </ul>	(Pérez-urdiales et al., 2019)
<ul style="list-style-type: none"> <li>• Gender, cultural, ethnic and religious differences in how psychiatric symptoms are understood.</li> </ul>	(Richter et al., 2018; Teunissen et al., 2015)
<ul style="list-style-type: none"> <li>• Lack of trust towards health care professionals, especially by undocumented migrants</li> </ul>	(Teunissen et al., 2015, 2014)
<ul style="list-style-type: none"> <li>• High number of other problems of higher priority in life</li> </ul>	(Teunissen et al., 2015)
<ul style="list-style-type: none"> <li>• Lack of cultural competence among healthcare providers</li> </ul>	(Chiarenza et al., 2019)

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#### **1.5.4 Strategies to Improving Services**

As discussed earlier in the thesis, the policies around granting asylum and providing healthcare, social support to undocumented migrants varies considerably between EU countries. Chiarenza and colleagues urged countries to frame migration as a permanent feature of the European social landscape rather than an emergency issue (Chiarenza et al., 2019). The researchers found that lack of inclusive legislation/policies or insufficient entitlement coverage of healthcare limits undocumented migrants' access to healthcare to a great extent. Moreover, some measures by authorities like repressive police actions, lengthy asylum procedures, and unexpected displacements can create fear of deportation among undocumented migrants, therefore, might lead to psychological disorders.

A study in the Netherlands suggested that primary care organizations can take a leading role to make barriers (mental) healthcare for undocumented migrants more transparent; not only for primary care professionals and policymakers but also for the native population (Teunissen et al., 2014). Unfortunately, undocumented migrants are being criminalised in the current political climate in the Netherlands, thereby, becoming more isolated in society (Teunissen et al., 2014). Criminalisation and isolation can have negative consequences for their mental health and will contribute to further inequity of care. Humphris & Bradby, (2017) reported higher rates of mental illness among refugees, particularly those who have experienced an extended process of asylum seeking that involved detention, social isolation, and poverty.

Another important issue to consider is screening of migrants and refugees for diseases, which is not obligatory according to WHO. Pavli & Maltezos, (2017) emphasized that screening may cause anxiety in individual migrants and refugees as well as the local community. Therefore, the results of screening must never be used as a reason or justification for accepting or

deporting a refugee or a migrant to/from a country. Improvement in healthcare coverage, changes in administrative procedures, making sure refugees are aware of their rights and services available to them, addressing negative attitudes towards refugees, better communication with asylum seekers, and co-ordination between agencies within and beyond the medical system are some measures suggested by researchers (Teunissen et al., 2014).

Refugees and asylum seekers deserve the right to live in dignity. Being dependent on aid and relief can be seen as shameful and humiliating, which was the case for the refugees in Greece, as described by Fleay and Hartley (2016). Refugees may consider themselves as powerless. Therefore, cash transfers for food could be a solution. This can make refugees feel better about themselves and they can be independent to make decisions about what they want to buy and eat (Juul et al., 2018).

Engaging undocumented migrants as stakeholders to help other undocumented migrants to gain access to primary care can be an excellent step towards improving access to healthcare. The authorities can actually reach out to more refugees by informing their peers about the key role of the GP in the recognition and treatment of mental health problems. Teunissen et al., (2015) suggested that the recruitment of undocumented migrant stakeholders needs to be done in close co-operation with primary care organisations, mental healthcare organisations, and advocacy groups.

The researchers have emphasized the importance of providing culturally competent healthcare to refugees and migrants. Spirituality or Spiritual Education Program, which is a non-western intervention, helps with positive coping, builds resiliency and promotes mental health of refugees (Pandya, 2018). A pre- and post-test experimental study with 4,504 refugees in 38 camps across nine destination countries found that spirituality-based group context interventions



creates a safe place for refugees to share experiences, create universality, and a sense that they are not alone by promoting interconnectedness between them (Pandya, 2018). The study recommends conducting a spiritual assessment with refugees to identify their spiritual strengths, which might help them to cope (Pandya, 2018). Pavli & Maltezou, (2017) suggested that if a multidisciplinary team could provide a more systematic health-reception based on a holistic approach, this would not only benefit refugees and migrants but also can protect the public health of host countries. Recommendations on improving the mental healthcare services for refugees and migrants from the reference articles of this study were examined and the information has been summarized in Table 3.

**Table 3: Recommendations for Improving Mental Healthcare Services for Refugees and Migrants in the EU Countries**

<b>Category</b>	<b>Service Improvement Recommendations</b>	<b>Reference</b>	
<b>Culturally Competent Care</b>	<ul style="list-style-type: none"> <li>Health professionals need to acknowledge conditions specific to the individual patients. Refugees want to feel respected and understood by the health professionals.</li> </ul>	(Jensen et al., 2014)	
	<ul style="list-style-type: none"> <li>Recognition of the importance of adopting alternative approaches to traditional mental health services.</li> <li>Adopting a narrative approach that is informal yet respectful, keeping the person at the centre without being judgemental.</li> </ul>	(Chiarenza et al., 2019)	
	<ul style="list-style-type: none"> <li>Professional interpreters to mitigate communication challenges,</li> <li>Development of conversational models for general practitioners including points to be aware of in the treatment of refugee patients</li> </ul>	(Jensen et al., 2013)	
	<ul style="list-style-type: none"> <li>Group-based interventions grounded in cultural competency and spirituality to promote mental well-being of refugees</li> </ul>	(Pandya, 2018)	
	<ul style="list-style-type: none"> <li>Reinforcing non-discrimination values and addressing the importance of providing a culturally appropriate curriculum</li> <li>Use of cultural mediation and having more approachable sources of information</li> </ul>	(Pérez-urdales et al., 2019)	
	<ul style="list-style-type: none"> <li>Culturally appropriate mental health assessment and service provision</li> <li>Training for health professionals (both in primary care and psychiatry) on the impact of culture or pre-migration trauma to mental health</li> </ul>	(Steel et al., 2017; Sundvall et al., 2015)	
	<ul style="list-style-type: none"> <li>Confidence in the ability of GP, assurance of confidentiality</li> <li>Building meaningful relationships and trust</li> </ul>	(Steel et al., 2017; Teunissen et al., 2014)	
	<b>Training/Education (both Service Providers and Migrants)</b>	<ul style="list-style-type: none"> <li>Ongoing supervision and training for the personnel working in refugee reception centers or similar facilities to avoid secondary traumatization.</li> <li>More trained personnel and more cooperation with clinicians for better assessment of refugees.</li> </ul>	(Belz et al., 2017)
		<ul style="list-style-type: none"> <li>Ensuring vital information for migrants and staff on rights to healthcare are available and understood</li> </ul>	(Chiarenza et al., 2019)

	<ul style="list-style-type: none"> <li>• Psycho-education and information to relieve stigma around mental illness, especially among males and Muslim asylum seekers</li> <li>• Outpatient psychiatric-psychological services for screening and supportive consultation upon arrival</li> <li>• Reducing the temporal duration of the application procedure for asylum status and limiting the time spent at admission centre</li> </ul>	(Richter et al., 2018)
<b>Policy Changes in Asylum Program</b>	<ul style="list-style-type: none"> <li>• Overcoming the fear of deportation by repressive police actions, unexpected displacements etc.</li> </ul>	(Chiarenza et al., 2019)
	<ul style="list-style-type: none"> <li>• Faster and transparent asylum procedures. Extended process of asylum seeking that has involved detention, social isolation, and poverty causes higher rates of mental illness among refugees.</li> <li>• Policy changes in relation to restrictive regulations to access healthcare based on legal status or insufficient entitlement coverage</li> </ul>	(Chiarenza et al., 2019; Humphris & Bradby, 2017; Juul et al., 2018; Leiler et al., 2019; Pavli & Maltezou, 2017)
	<ul style="list-style-type: none"> <li>• Frame migration as a permanent feature of the European social landscape rather than an emergency issue</li> <li>• Promoting advocacy actions to drive national government policies</li> </ul>	(Chiarenza et al., 2019)
	<ul style="list-style-type: none"> <li>• Improvements of the housing facilities and psychosocial interventions for asylum seekers while waiting.</li> </ul>	(Leiler et al., 2019)
<b>Social Status and Empowerment</b>	<ul style="list-style-type: none"> <li>• Increasing psychological support to help refugees with traumatic experiences and removing difficulties in accessing specialist therapies.</li> </ul>	(Chiarenza et al., 2019)
	<ul style="list-style-type: none"> <li>• Financial assistance</li> <li>• Cash transfers for food to establish the autonomy of refugees by giving them the power to spend independently.</li> </ul>	(Juul et al., 2018; Teunissen et al., 2014)
	<ul style="list-style-type: none"> <li>• Improving the conditions of life post-migration. Development of meaningful and empowering activities and fostered social interactions with the surrounding society to alleviate their psychosocial suffering.</li> <li>• Need to overcome the criminalisation and isolation of refugees as these have negative consequences on their mental health and will contribute to further inequity of care.</li> </ul>	(Humphris & Bradby, 2017; Juul et al., 2018; Teunissen et al., 2014)

	<ul style="list-style-type: none"> <li>• Improvements in contextual factors such as social/family networks, becoming familiar with the new culture, and social position</li> <li>• Community centres with the participation of refugees to <ul style="list-style-type: none"> <li>○ Foster engagement and empowerment by information sharing, recreational, and educational activities.</li> <li>○ Reduce feelings of discrimination and isolation and to link refugees more closely to European society, international and national volunteers.</li> </ul> </li> </ul>	(Juil et al., 2018; Lamkaddem et al., 2014)
<b>Increased Service Efficiency</b>	<ul style="list-style-type: none"> <li>• Improving the presence of well-trained professionals especially at arrival/transit phases</li> </ul>	(Chiarenza et al., 2019)
	<ul style="list-style-type: none"> <li>• Faster referral to mental health specialists by GPs</li> </ul>	(Lamkaddem et al., 2014)
	<ul style="list-style-type: none"> <li>• Improving service efficiency by concentrating the care of a migrant individual or family on one GP, thus avoiding duplication in efforts and by explaining the importance of continuity of care to the migrants</li> </ul>	(Teunissen et al., 2015)
	<ul style="list-style-type: none"> <li>• Actively addressing migrant’s mental health problems by GPs and providing patient-centred, culturally sensitive mental health care in equal quality like other patients</li> </ul>	(Teunissen et al., 2015)
	<ul style="list-style-type: none"> <li>• Establishing forms of collaboration among all partners involved in the provision of social and health services for migrants and refugees,</li> <li>• Improving information on available services for both migrants and health care professionals</li> <li>• Improvement in communication with asylum seekers and co-ordination between agencies within and beyond the medical system.</li> <li>• Coordination should begin at the planning stages of service delivery. Uncoordinated interventions by many different care providers, complex relationships between organizations can lead to confusion for refugees and migrants, thus preventing them from seeking care.</li> </ul>	(Chiarenza et al., 2019)
<b>Leadership</b>	<ul style="list-style-type: none"> <li>• Leadership role by primary care organizations in getting the message on the political and public agenda that criminalisation and isolation are harmful to the migrants’ mental health and creates further inequity of care. It is important to understand and protect the fundamental rights of this vulnerable group of patients.</li> </ul>	(Teunissen et al., 2014)

## **1.6 Objective 2 Findings: Comparison of European Response to Canadian**

### **1.6.1 General**

Refugees from nearly every country have come to Canada over the years. Since becoming a party to the Refugee Convention in 1969, Canada has gained the reputation of being a world leader in protecting refugees. Approximately 26,000 refugees arrive in Canada every year through government-assisted and privately-sponsored refugee programs as well as through In-Canada asylum program (Schwartz, 2015).

As mentioned earlier in the thesis, the European Union experienced an unprecedented influx of refugees in 2015 and 2016. The war and conflict in the Middle East, in particular Syria, resulted in the German government granting protection to hundreds of thousands of refugees. On August 31, 2015 German Chancellor Angela Merkel famously declared "We can do this" as Europe faced the largest refugee crisis in years (Dockery, 2017). She called it a "national duty" to do so. Germany adopted an "open border" policy by suspending the Dublin Procedure for Syrians, which meant that refugees from that country no longer had to be sent back to the first EU country that they entered (Dockery, 2017). That year, Germany took in 890,000 refugees - the highest annual number in the history of the Federal Republic (Dockery, 2017). However, the government had reinstated the border controls, therefore the number dropped down to 280,000 in 2016 and 186,644 in 2017 (Chase, 2018). Another country which opened its heart to refugees seeking shelter was Sweden. Being a country of 9.5 million, it took 190,000 refugees in 2015, which is 2 % of its entire population (Cerrotti, 2017). Besides Germany and Sweden, several countries in Europe including UK have also accepted refugees. The agreement signed between Turkey and EU in March 2016, allowed Greece to return "irregular migrants" to Turkey and made it difficult for refugees from the Middle East to reach Western Europe overland (Trines,

2017).

While the European countries showed remarkable humanitarian gesture by accepting tens of thousands of refugees in recent years, the stress on their health care system was enormous. Ensuring access to emergency care to migrants while their asylum application is being processed, integrating them into the health care system as quickly as possible, and providing more comprehensive care once they have been granted asylum all together was a very challenging task to achieve (Palmieri, 2017).

Mental and psychosocial illness were significant among refugees both in Canada and in the European Countries which included depression, anxiety disorder, and PTSD. Traumatic experiences related to war, hunger, physical and sexual abuse both in their home countries and during the migration have contributed to the mental illness of refugees (Pavli & Maltezou, 2017). The refugee's country of origin accounted for specific epidemiologic profiles and for both communicable/non-communicable diseases (Pavli & Maltezou, 2017). The poor living conditions in camps, journey during migration, and overcrowded reception centers have exacerbated the situation.

### **1.6.2 Healthcare Policies for Refugees**

Refugees usually undergo a health screening upon their arrival at reception centers in host countries. Since most refugees to Canada are sponsored, they are required to take medical tests before coming to Canada according to the Immigration law. The Interim Federal Health Program (IFHP) covers certain pre-departure medical services for refugees coming to Canada for resettlement. Screening programs of refugees upon arrival in the EU vary among EU countries and may also be voluntary or involuntary ((Pavli & Maltezou, 2017; Simich L et al., 2014; Ahmed S et al. 2016).

In principal, newly arrived migrants are irregular migrants as unauthorised entrants to any country. There are differences in the process how Canada and EU countries receives refugees and undocumented migrants. As described detailed in Chapter 2, Canada's refugee resettlement process consists of (1) Refugee and Humanitarian Resettlement Program (RHRP) and (2) In-Canada Asylum Program (ICAP). Most refugees to Canada arrive through the first program by applying from outside of Canada. They receive permanent resident status as refugees, hence considered as 'regular' migrants. Whereas, the second category applicants are considered as 'irregular' migrants who make refugee protection claims from within Canada either at a port of entry or at an IRCC office.

If we compare Canada's refugee program to Europe's, then most migrants who come to Europe will fall under the 'In-Canada Asylum Program (ICAP)', if they had arrived in Canada in the same way (as irregular migrants). This is because the majority of refugees in the E.U. arrived by boarder crossing, primarily via boat across the Mediterranean. Therefore, they are considered as refugee claimants or asylum seekers and depending upon their outcome of claim could be granted status as protected persons or not. In Europe, as soon as the irregular migrants apply for asylum, their presence in the country becomes legal. Irregular migrants are referred to as both refugees and asylum seekers. A positive outcome of their application grants irregular migrants (asylum seekers and refugees) a residence permit. A negative outcome means the individuals will continue being an irregular migrant or undocumented migrant. Also, if refugees move on to other countries, they returned to irregular status.

#### 1.6.2.1 Canada

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According to IRCC, the Interim Federal Health Program (IFHP) provides limited, temporary coverage of health-care benefits to people of certain groups in Canada. The length of

health-care benefits depends upon of the immigration status of the individual. IFHP coverage will be cancelled immediately if the refugee claimant is not eligible to apply for a Pre-Removal Risk Assessment (PRRA). Therefore, any ‘undocumented’ status personnel is not eligible for healthcare coverage in Canada. Table 4 provides a summary of healthcare coverage for ‘regular’ – refugees only and ‘irregular’ migrant categories in Canada.

**Table 4: Healthcare Coverage for Regular and Irregular Migrants in Canada**  
(Source: IRCC)

<b>Eligible Beneficiaries</b>	<b>Healthcare Coverage</b>
<b>Resettled Refugees</b>	<ul style="list-style-type: none"> <li>• Basic coverage is provided only until the beneficiary qualifies for provincial or territorial health insurance.</li> <li>• Supplemental and prescription drug coverage is provided as long as the beneficiary receives income support from the Resettlement Assistance Program (RAP) (or its equivalent in Quebec) or until the beneficiary is no longer under private sponsorship.</li> </ul>
<b>Protected Persons (individuals who receive a positive decision on their asylum claim/PRRA)</b>	<ul style="list-style-type: none"> <li>• Basic, supplemental and prescription drug coverage is provided for 90 days from the date the asylum claim or PRRA is accepted, or until they become eligible for provincial or territorial health insurance.</li> </ul>
<b>Refugee claimants (waiting for a decision on their claim or whose claim for refugee protection has been rejected but eligible to apply for PRRA and who gets a positive decision on PRRA)</b>	<ul style="list-style-type: none"> <li>• Basic, supplemental and prescription drug coverage continues until the beneficiary leaves Canada or becomes eligible for provincial or territorial health insurance.</li> </ul>
<b>Victims of human trafficking</b>	<ul style="list-style-type: none"> <li>• Basic, supplemental and prescription drug coverage continues for the duration of the temporary resident permit.</li> </ul>
<b>Detainees (Individuals detained under the Immigration and Refugee Protection Act (IRPA) while in detention)</b>	<ul style="list-style-type: none"> <li>• Coverage continues for the period that the individual is detained by the Canada Border Service Agency (CBSA) under the IRPA.</li> </ul>

#### 1.6.2.2 EU Countries

According to the 1951 UNHCR Convention regarding the Status of Refugees, a refugee has the same right to access the national health services in the country of refuge as the citizens of



that country (Norredam, Mygind, & Krasnik, 2006). However, access to health care of newly arrived migrants and refugees is shaped by legal frameworks in regard to migration status of each person (De Vito et al., 2016). Health regulations towards refugees vary significantly among the EU countries and may influence a refugee's access to health care services, as described earlier in this chapter. There are different entitlements to care for different migrant groups; undocumented migrants and unaccompanied minors need special attention. In most EU countries, undocumented migrants only have access to emergency healthcare (WHO, 2015). Table 5 provides a summary of current healthcare regulations and benefits provided to the refugees, asylum seekers and/or undocumented migrants in number of EU countries (Frydryszak, Macherey, & Simonnot, 2016; Norredam et al., 2006; Roberfroid et al., 2015).

Refugees were, in theory, granted protection from formal registration of their application for asylum in the first receiving country. Although the EU countries offer healthcare coverage to refugees or other undocumented migrants, the reality could be very different. Studies found that refugees and migrants persistently faced barriers to access adequate health services, therefore no effective healthcare coverage, awaiting an often long overdue response to their application for refugee status, at times at the stage of an appeal, or even refusal (Chiarenza et al., 2019; Pavli & Maltezou, 2017). Certain barriers had already been identified and presented in Table 2. Those who had been refused protected status but had not been deported remained irregular migrants.

### **1.7 Objective 3 Findings: Lessons Learned for Canada**

Access to health care both in Canada and across the EU countries depends upon the immigration status of the individual and is further influenced by communication, language and economic difficulties, and socio-cultural circumstances. Therefore, similarities also exist in suggestions for improvement in Canadian and EU studies. However, discussed below, are few

**Table 5 : Healthcare Regulations and Benefits for Refugees, Asylum Seekers and Undocumented Migrants in EU Countries**

<b>Country</b>	<b>Applicable Healthcare Regulation</b>	<b>Healthcare Benefits for Refugees, Asylum seekers and Undocumented Migrants</b>
<b>Belgium</b>	Article 23 of the Belgian Constitution of 1994, The 2007 law on the reception of asylum seekers and other categories of foreign nationals and stateless people, Royal Decree of 12 December 1996 relating to “urgent medical assistance granted by the CPAS to foreign nationals residing in Belgium illegally	All asylum seekers are entitled free of charge to health services. Undocumented migrants have access to healthcare through the Urgent Medical Aid (Aide Médicale Urgente – AMU). Despite its name, AMU covers both preventive and curative care. Usually, the AMU agreement is valid for 92 days. However, this duration can vary from to one year.
<b>Germany</b>	The Asylum Seekers Benefits Act 1993	Refugees are entitled to basic healthcare for first 15 months. Asylum seekers and refugees are entitled to welfare benefits and they may have access to healthcare under the same conditions that apply to German citizens after 15 months. However, a reduction in benefits may be applied for more than 48 months. Undocumented migrants are afforded by law the same access to health services as asylum seekers who have been in Germany for less than 15 months.
<b>Greece</b>	Article 33 Section 2 of the 4368/2016	Asylum seekers and refugees have access to the public healthcare system for free, same as Greek nationals. Care for adult undocumented migrants beyond emergency is unavailable except for vulnerable groups such as Pregnant women, children, Chronically ill individuals, Disabled individuals, Victims of severe crimes, Seriously ill individuals etc.
<b>Ireland</b>	Health (Amendment) Act 1991	Entitlement to access healthcare is based on residency rather than on citizenship and “ordinary residence” condition (minimum 1 year stay) has be met. Asylum seekers and refugees have access to healthcare on the same basis as Irish citizens. As long as the refugees and asylum seekers reside in the Direct Provision Centres while their application is being processed, they do not have to fulfil the “ordinary residence” condition. The Irish law excludes undocumented migrants, including children, from the entitlement to access all but urgent free medical treatment.

<b>Italy</b>	Article 32 of the Italian Constitution, Ministerial Circular no. 5 of 24th March 2000, Legislative Decree no. 286/98, art.35, paragraph 4	For irregular migrants, the services provided, and co-payment modalities are similar to those in force for the Italian citizens. If an irregular migrant is poor and signs a “statement of poverty”, they can get urgent care services without co-payment for 6 months.
<b>Luxembourg</b>	International and Temporary Protection Law (2015), Reception of Applicants for International Protection and Temporary Protection (2015)	Asylum seekers are entitled to a standard of living that “ensures their subsistence and protects their physical and mental health”. Medical care is provided by the Luxembourg Reception and Integration Agency (OLAI). Undocumented migrants have no access to healthcare.
<b>Norway</b>	Immigration Act - 2008	Asylum seekers and refugees are entitled to the same access to healthcare as Norwegian citizens, though with some exceptions related to the National Insurance Scheme. Undocumented migrants are only entitled to emergency healthcare, and to “most necessary healthcare”.
<b>Romania</b>	Article 7 of the 2004 Government Ordinance no. 44/2004, 2006 law no. 122/2006 regarding asylum in Romania	Foreigners who received a form of international protection in Romania have access to medical care in the same conditions as Romanian citizens, Undocumented migrants are only entitled to free emergency care in case of epidemic diseases, pregnancy related care and family planning support.
<b>Slovenia</b>	Article 84 and 89 of International Protection Act, Article 73 of the Foreigners Act	Refugees have the same rights as the nationals of the Republic of Slovenia concerning access to healthcare. Asylum seekers are only entitled to urgent medical assistance. Undocumented migrants are not covered by compulsory health insurance. They are only entitled to free urgent treatment.
<b>Spain</b>	Articles 16, §2 and 18§1 of Law 12/2009 as well as by the fourth additional provision of Royal Decree 1192/2012	Asylum seekers and refugees are entitled to access healthcare on equal grounds to Spanish nationals and authorised residents with regard to coverage and conditions. Undocumented migrants are completely excluded from the healthcare scheme except emergency care. Undocumented migrants who are excluded from the healthcare scheme may obtain personal health insurance after at least one year of residence in Spain, if they can afford to pay for it
<b>Sweden</b>	Health and Medical Services Act 1982, Proper Documentation Act (2013:407) July 2013	Asylum seekers are entitled to subsidised health and dental care that “cannot be postponed”. They are required to pay user fees which are usually covered by daily allowance. Undocumented migrants have the same access to healthcare as asylum seekers and refugees.

<b>Switzerland</b>	Swiss Federal Law on Compulsory Health Care (LAMal) entered into force on 1 January 1996, Articles 80-81 of the Asylum Act (LASI)	Any person residing in Switzerland must get health insurance within three months of residence or birth, including undocumented migrants, asylum seekers and refugees. They can make a claim for premium reductions if they are “ <i>on a low income</i> ”. They can also benefit from social assistance. This social assistance covers basic medical care, including compulsory insurance (especially the amount remaining after premium reductions and franchises). According to the Asylum Act, asylum seekers who receive a negative asylum decision or a rejection of their application still benefit from ordinary social assistance. Social assistance is automatically withdrawn from individuals who receive a removal decision with a fixed departure deadline, except for emergency. Undocumented migrants do not have access to premium reductions. Therefore, in practice, undocumented migrants try to obtain health coverage, even if it is expensive.
<b>France</b>	Article R. 380-1 of the Social Security Code, Article L251-1 of the Social Action and Family Code	Asylum seekers and refugees have the same access to healthcare as authorised residents. In theory, they obtain social security health coverage upon arrival on French territory. Undocumented migrants benefit from specific healthcare mechanism: The State Medical Help - AME (Aide Médicale d’Etat). Undocumented individual is entitled to AME if he/she has been residing illegally in France for more than three month and if his/her resources are lower than a certain amount. The AME is valid for one year but can be extended.
<b>Netherlands</b>	Healthcare for Asylum Seekers Regulation (Regeling Zorg Asielzoekers) - Article 9(1)	Asylum seekers can only turn to GPs, physiotherapists, dentists, hospitals and pharmacies that are contracted by Menzis, a non-profit insurance company commissioned by the Central Agency for the Reception of Asylum Seekers. Upon entry, asylum seekers undergo compulsory TB screening. Asylum seekers coming from high-risk countries are offered voluntary follow-up screening for a period of two years.
<b>United Kingdom</b>	National Health Service (NHS) Act of 1946, NHS (Amendment) Act 1949, Immigration Act 2014	Refugees, asylum seekers, immigration detainees are free from any health care charges. In Scotland and Wales, asylum seekers and refused asylum seekers are entitled to free secondary health care on the same terms as any other ordinary resident.

great initiatives either already implemented in selected EU countries or suggested by researchers that seemed either missing or under-represented in Canadian studies.

### **1.7.1 Cultural Sensitivity Training and Support for Healthcare Providers**

Nearly all literature, focused in Canada and EU countries, suggested cultural sensitivity training and support for care providers while planning for the integration of refugees into the medical and social services. According to Jefee-Bahloul and colleagues (2016), the providers need to understand the following, which affect the clients' expectations, coping strategies, ways of explaining an illness, and norms in seeking help:

- Clients' cultural idioms of distress (i.e., the ways in which distress is verbalised in a specific community) and
- The explanatory models (i.e., the ways in which people understand and explain their symptoms),

UNHCR has documented a list of common idioms of distress for Syrians (Jefee-Bahloul et al., 2016), which can help providers in obtaining a cross-cultural understanding of Syrian refugees and in designing relevant training, education, and consultative services.

In their article, Jefee-Bahloul and colleagues (2016) described the Charité University Hospital's (Berlin, Germany) mental healthcare initiatives for Syrian refugees in Jordan for 3 years. This initiative is now spearheading similar government-led efforts in Germany. Lessons learned from this CharitéHelp4Syria project (CH4S) could be helpful in making policy decisions and designing Mental healthcare programs in Canada:

- It is important to understand that there are traumas beyond war experiences. One in three outpatients in the Berlin clinic reported traumatic experiences that occurred in the course of migration and relocation.

- Similarly, there are disorders beyond PTSD. Patients reported a broad range of psychiatric disorders (i.e. anxiety, affective) resulting from traumatic experiences in all three treatment centres in Jordan.
- Stigma prevented the use of mental health services. Patients preferred therapists of their peer group (e.g., Syrian psychologists).

### **1.7.2 Consideration of Refugees Circumstances and Background in Program Design**

The experience of asylum-seeking individuals who reached Europe by crossing the Mediterranean Sea could be different from refugees who were funded through various programs and traveled by air to reunite with family members already residing in Europe. In fact, experiences at the German outpatient clinics showed that the two groups differ greatly in their adjustment processes (Jefee-Bahloul et al., 2016). Therefore, all mental health initiatives planned for Syrian refugees at German outpatient clinics, temporary camps, and permanent resettlement sites take the refugees' circumstances and background into consideration, as described by the authors. Similarly, in Canada, the experience of privately sponsored refugees could be different than the Government-sponsored refugees or asylum seekers, and healthcare programs should be designed accordingly.

### **1.7.3 Engaging Undocumented Migrants as Stakeholders in Program Design**

A study by Teunissen et al. (2014) on the mental health problems of undocumented migrants in the Netherlands recommended engaging undocumented migrants as stakeholders to help others to gain access to healthcare. For example, undocumented migrants who had received services can inform fellow undocumented migrants about the key role of the GP in the

recognition and treatment of mental health problems. The recruitment of undocumented migrant stakeholders should be done in close co-operation with primary healthcare and mental healthcare services providing organizations as well as advocacy groups.

Another example is Sweden. An online article by Palmieri (2015) provided insights of how Sweden has thought of using refugees as human resources to perform minor roles in the healthcare as the system is constantly struggling with staffing shortages. A search for more literature in English related to this specific experience was unsuccessful, however, in the article Palmieri has briefly discussed about some initiatives. For example, since many refugees (especially from Syria) arrived in Sweden were medically trained, the country considered their integration into the labour market as an opportunity to solve both staffing shortage in healthcare as well as refugee unemployment problems. Sweden introduced a number of fast-tracking programs intended to facilitate integration into the labour market. The medically trained professionals among refugees could work in minor roles while waiting for their authorization documents as well as were given faster access to language classes and entry to the work market.

Policymakers in Canada should consider the best use of refugee resources, especially the trained professionals. Poverty, unemployment and living on social assistance will not help the refugees with their mental wellbeing. The feeling of being a burden or powerless will adversely affect their mental health. Integrating the refugee resources, especially the trained personnel into the labour market will be a win-win situation for all.

#### **1.7.4 Creation of Community Centers for Social Interaction**

No doubt that improving the conditions of life post-migration is very important. The development of meaningful and empowering activities and fostered social interactions with the surrounding society can ease the psychosocial sufferings of this vulnerable population, as

described by Humphris & Bradby, (2017). Lamkaddem et al. (2014) made an excellent recommendation to create community centers which can link refugees more closely to the society, thereby reduce feelings of discrimination and isolation. As a gathering place the community centers can foster engagement and empowerment by information sharing and offering recreational and educational activities. The idea of creating community centers of gathering places for refugees is underrepresented in Canadian studies.

## **1.8 Conclusion**

The world refugee crisis is at critical level. Despite the report of six deaths per day, refugees have continued the deadly journey of crossing the Mediterranean Sea in search of safety. Many of these refugees are challenged with physical and mental health problems, social isolation, and economic devastation. They have different rights to access of care depending upon which European country they are in and their documentation. As many EU countries are experiencing an increased influx of refugees and asylum seekers, it is time that countries reassess their overall preparedness and response capacity for the management of the new needs brought by migrants. Studies suggest that addressing the new healthcare by already heavily burdened services won't be easy. However, healthcare systems should consider migration flows, culture and ethnicity, experience during the migration journey including war violence, global disease patterns, and consequent needs (Pavli & Maltezou, 2017).

As mentioned earlier, it is crucial to frame migration as a permanent feature of the European social landscape rather than an emergency issue. This is also true for Canada; therefore, policy makers should seek intersectoral and international collaboration in their program design to meet the heterogeneous needs of these populations, which could foster integration. Chiarenza and colleagues (2019) also mentioned the extended role of mental health



professionals. They have responsibilities to evaluate the complexity of ongoing challenges of this vulnerable group in order not only to support them through effective treatments, but also to stand up for them as advocates for their rights, anti discriminatory policies, service development, and social justice.

While literature suggest that mental health of refugees may worsen over time in the host country, time could be a good healer for them as long as the recovery is aided by safety, stability, and socioeconomic development (Jefee-Bahloul et al., 2016). An opportunity exists for policy makers both in Europe and Canada, to include mental health in their agendas and to proactively prepare for the surge of refugees by studying existing programmes and efforts in other countries (Jefee-Bahloul et al., 2016).

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