

# Exploring the Settlement Trajectories of Refugee Newcomers in Southern Ontario

by

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## **AUTHOR'S DECLARATION**

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

## **Abstract**

Beginning life in a new country means adjusting to new systems of law, education, work, and health. Individuals who arrive in Canada as refugees face unique challenges during this process of re-settling due in part to the forced nature of their migration. Many organizations exist that seek to assist refugee newcomers in Canada. Few studies have examined the success of these organizations, especially refugee focused primary health clinics. In addition, few studies have examined health and settlement from the perspective of refugees themselves. This qualitative research study consisted of semi-structured interviews with twenty-two participants including refugee newcomers, key informants from the refugee resettlement sector, and representatives from refugee-focused health clinics across Southern Ontario. Findings from this study highlight how many settlement trajectory factors appear to be beyond any individual newcomer's control. The program through which refugee newcomers enter Canada, whether they have certain assets including English language ability or personal finances, and whether they gain access to high quality refugee resettlement supports are examples of such factors that were influential in determining resettlement success for the participants in this study. A new framework is proposed for refugee resettlement relevant in the Canadian context, with the goal of enhancing the long-term success of refugee resettlement in Canada.

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## Definitions and Acronyms

**UNHCR:** *United Nations High Commission for Refugees*

**GSR:** *Government-sponsored refugee.* Refugee resettlement program through which UNHCR refugees come to Canada with government support.

**PSR:** *Privately-sponsored refugee.* Refugee resettlement program through which UNHCR refugees come to Canada with private support.

**BVOR:** *Blended-visa office referred.* Refugee resettlement program through which UNHCR refugees come to Canada with a combination of government and private support.

**JAS:** *Joint Assistance Sponsorship.* Refugee resettlement program through which UNHCR refugees with exceptional needs come to Canada with a combination of government and private support.

**WUSC:** *World University Service of Canada.* Refugee resettlement program through which UNHCR refugees come to Canada in partnership with Canadian universities and private support.

**Refugee Claimant:** Used in this thesis to describe individuals who came to Canada without prior refugee status as determined by the UNHCR, and who went through a refugee determination hearing in Canada. This term is used to describe individuals who were successful in their refugee determination hearing, those going through an appeal process, and those for whom the hearing had not yet occurred at the time of the interview.

**OHIP:** *Ontario health insurance plan.*

**IFH:** *Interim federal health.* Temporary health insurance plan provided by the federal government for most refugee newcomers after arriving in Canada.

**Refugee health clinic:** Used in this thesis to describe a primary health clinic with a specific focus on providing health care services to refugee newcomers. The clinic may be exclusively serving this population or serving this population in conjunction with other patients.



# Chapter 1: Introduction and Literature Review

## 1.1 Introduction

The number of people displaced from their homes and countries worldwide is increasing; the United Nations High Commission for Refugees (UNHCR) reports the number of displaced persons in 2018 is the highest ever on record. Of the 68.5 million people who are displaced, 25.4 million are refugees unable to return home (UNHCR, 2018). Canada has a rich history in refugee resettlement and this precedent continues with Canada resettling a high number of refugees each year. Recently, refugees from Syria have been a particular focus of the Canadian Government, and over 35,000 Syrian refugees were resettled in Canada between November 2015 and November 2016 (Government of Canada, 2016a).

Starting life in a new country is complex for any immigrant. Resettling includes such activities as finding housing or shelter, employment, education, building a community, and learning new languages and/or cultures. For refugees, resettling can be especially difficult due to the forced nature of migration. Often displacement is preceded by violence or the threat of violence; individuals may have very little time to prepare or gather resources before leaving their homes (Kissoon, 2010). In recognition of these challenges, many countries that engage with refugee resettlement offer a number of resettlement supports. Canada is no exception: there is a wide variety of both government and non-government organizations that assist refugee newcomers upon arrival to Canada. Previous research studies have explored the needs of refugee newcomers upon arrival to Canada in the domains of health, shelter, and employment (Beiser, 2015; Murdie, 2008; Newbold, Cho, & McKeary, 2013). Very little scientific literature exists, however, that examines the appropriateness of supports that are provided in Canada for refugee newcomers. Especially in the domain of health services, the voices of refugee newcomers themselves are often absent from scientific literature (Immigration Refugees and Citizenship Canada, 2016; McKeary & Newbold, 2010).

This study, therefore, aims to understand resettlement experiences of refugee newcomers in Southern Ontario. The perspective of individuals who arrived as refugees themselves are included, as well as key informants, resettlement sponsors, and directors at refugee focused health clinics. Resettlement experiences across different domains are explored including health

care, housing, employment, and broader settlement and legal systems. Consideration is given to the reasons why resettlement trajectories differed across participants in this study, and to this end, a framework for refugee resettlement relevant in the Canadian context is proposed.

## **1.2 Literature Review**

### **1.2.1 Introduction**

This literature review starts with an exploration of the definition of refugee. Next, an overview of refugee policy in Canada is provided with a focus on health policy changes that have contributed to the development of refugee-specific health care. Relevant literature is explored about settlement needs after arriving in Canada, including housing, employment, and health. This includes attention to the barriers that prevent refugees from accessing health care and other supports in Canada. Models for refugee health care that have been proposed are then considered, along with some Canadian examples of specific refugee health clinics. Finally, major gaps in the literature are noted along with justification for the present study.

### **1.2.2 Definition of ‘Refugee’**

The UNHCR has determined a refugee to be someone in part, with 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 unable or, owing to such fear, is unwilling to avail himself of the protection of that country (United Nations High Commissioner for Refugees, 1961).

Meeting the definition of refugee put forward by the UNHCR involves a formal process. Many refugees who come to Canada have gone through a refugee determination process initiated by the UNHCR; if an individual is found to meet the definition and is eligible for resettlement, a referral is made to visa offices in Canada (Immigration Refugees and Citizenship Canada, 2018). For individuals making a claim for refuge in Canada, this formal determination process has not occurred prior their arrival in Canada. Refugee status is therefore determined at a refugee division hearing, with lawyers and decision makers from the Immigration Refugee Board of Canada (Immigration and Refugee Board of Canada, 2017).

This formal definition of the UNHCR used to determine eligibility for entry into a safe country does not necessarily capture the experiences of individuals. If someone has been

determined to be a refugee by the UNHCR or the Canadian Immigration and Refugee board, they may not necessarily ascribe this term to themselves. Similarly, individuals who have failed to meet the requirements set out by these organizations may nonetheless feel the term is appropriate to their experience. Qualitative research has added important context to the term in describing characteristics that relate to refugee identity, or refugeeness. Common experiences of refugeeness include migration processes marked by trauma and persecution, separation from family members, arrival in a new country without having necessarily chosen the destination, a lack of identity documents or evidence of qualifications for work, and temporary admittance into a country with risk of detention or deportation (Kissoon, 2010).

In addition, the formal UNHCR definition does not capture meaning ascribed to the term colloquially. Citizens, governments, and non-government organizations in countries with refugee resettlement all contribute to a negotiated understanding of the term in society. Scholars in Canada have explored the discourses of these varied stakeholders as expressed in media; examples emerge where 'refugee' is associated with the terms "fraud", "victim", and "privileged". Discourses can be found that pit paternalism against empowerment and sovereignty against human rights when considering the role of Canada in refugee resettlement (Hardy & Phillips, 1999).

The term 'refugee', therefore, can mean different things to different people, in different contexts. It is beyond the scope of this paper to consider the merits of these varied definitions but it is important to clarify what is intended by the use of the term 'refugee' for this paper. The working definition in this thesis for the term 'refugee' refers to individuals who have formally met the UNHCR definition, those who are awaiting a decision from a refugee determination hearing, and those who were successful in a refugee determination hearing in Canada. The term is applied to persons who came to Canada as a refugee or seeking refugee status at some point in their past. Where appropriate, additional details are added in describing individual cases.

### **1.2.3 Canadian Refugee and Immigration Health Policy**

The Immigration and Refugee Protection Act outlines obligations of the Government of Canada in offering protection to individuals who have been granted refugee status (Elgersma, 2015). Responsibility for refugees upon arrival in Canada is largely delegated to the Federal Government. Support is provided through the resettlement assistance program and includes

support with income, housing, language training, employment, and information on life in Canada. The availability of these supports, and the responsibility for providing them can, however, differ for various types of refugees (Government of Canada, 2017).

The exact nature of support or interpretation of responsibilities for refugees can change with various governments. Recently, many changes have been focused in the area of health coverage; at present, refugees receive a form of federally funded health insurance under the Interim Federal Health Plan (IFH) (Enns, Okeke-Ihejirika, Kirova, & McMenemy, 2017). In 2012, the Conservative-led federal government made substantial cuts to what was covered by the IFH plan, citing that the cuts would result in cost savings; instead, costs were transferred to provinces, who were required to provide care when refugees eventually became eligible for provincial coverage (Enns et al., 2017). Eligibility for provincial coverage generally occurred when an individual had met the requirements of permanent residence in Canada, and after a positive decision at their refugee hearing. The delay between arriving in Canada and attending this hearing could be more than a year in duration. It is possible that the cuts to the federal health plan resulted in higher costs for care because of a delay in treatment during the eligibility waiting period.

With the cuts to IFH, different categories of refugees were created and health care coverage was different for each of these groups. At one point these groupings amounted to eleven categories and four different levels of health care coverage (Abdihalim, 2012) (See Appendix A for details). The IFH cuts were highly contested for many reasons, including fears among advocacy groups that these changes would deter private sponsors of refugees with complex health needs (Enns et al., 2017). Among the protesters was a coalition of physicians and other health care providers, who eventually brought a case to the Supreme Court of Canada in opposition to the IFH cuts. The changes were eventually struck down, being termed cruel and unusual and subsequently in violation of Sections 12 and 15 of the Charter of Rights and Freedoms. Following this announcement, IFH was reinstated, although at first only for certain categories of refugees as the Government announced its intention to appeal the decision (Enns et al., 2017).

With the 2015 change to a Liberal federal government, refugee health insurance coverage was reinstated. The numerous changes between 2012 and 2017 as the plan was reinstated have resulted in a complicated reimbursement scheme. Changes to the IFH plan was the topic of an

investigation by the Wellesley Institute. The study found that the now complicated coverage framework is an administrative barrier that prevents some health care providers from willingness to provide health care to persons who qualify for IFH. It was also found that the cuts resulted in an increase in emergency room usage, increased health care complications, and delayed care for patients with chronic conditions (Marwah, 2014). Presently, physicians or other providers who want to provide health care services to refugees must become registered with the insurance company tasked with managing IFH, and then must ensure that their patients are eligible each and every time they seeks care. This hassle has resulted in some clinics denying care to patients who are covered by the IFH plan (Abdihalim, 2012).

The changes noted above created confusion for health care providers, delayed care for a number of refugees who arrived in Canada between 2012 and 2015 while these changes were taking place, and delayed care for those who arrived after 2015 into a complicated system. These changes also complicate the scientific literature, as results about health status, needs, and barriers to access must be considered against the policies and legislation which existed at different times.

#### **1.2.4 Refugee Demographics and Health Care Utilization**

Upon arrival in Canada, research has shown that refugees often have different health needs and utilization patterns compared to Canadian-born citizens or permanent residents. When considering health in general, refugees have been found to have a higher prevalence of mental health conditions, partially from the migration process itself. Higher prevalence has been found in areas of depression, schizophrenia, PTSD, suicide, and psychosis (Donnelly et al., 2011; Gabriel, Morgan-Jonker, Phung, Barrios, & Kaczorowski, 2011; Joshi et al., 2013). There is some evidence to suggest that these mental health risks can persist for some time even after resettlement, due in part to the stress of resettling in an unfamiliar environment and concern for others who remain in danger (Grove & Zwi, 2006). Indeed, a scoping review of mental health and mental illness for immigrant and refugee youth found that both pre and post-migration challenges effected mental health. Post-migration factors included family structure and societal discrimination (Guruge & Butt, 2015).

In addition to mental health, research has found the proportion of illness that is infectious or parasitic is also higher in refugee populations (Kiss, Pim, Hemmelgarn, & Quan, 2013) including diseases such as TB, syphilis, and hepatitis B (Gabriel et al., 2011). Refugee children

face challenges with immunization coverage, growth and development issues, nutritional deficiency, and poor dental health (Woodland, Burgner, Paxton, & Zwi, 2010).

Research by the Government of Canada has been conducted of health needs among a group of refugees that arrived from Syria in 2015 and 2016. This research found that Syrian refugees were twice as likely as the general refugee population to report signs of psychological distress; one in five was expected to be affected by physical, sensory, or intellectual impairment, and one in seven was affected by chronic disease (Ontario Ministry of Health and Long-Term Care, 2015). This suggests that particular health needs may differ across different refugee groups, and likely depend in part on country of origin.

The scientific literature provides mixed reviews when it comes to health care utilization by refugee newcomers. Some studies show that immigrants and refugees use more health services than Canadian permanent-resident counterparts, (Kiss et al., 2013), while others find that refugees use fewer health care services (Gabriel et al., 2011; Ng, Sanmartin, & Manuel, 2016). The appropriateness of this utilization is also important to consider. Some studies have shown that refugees are more likely than non-refugees to use the emergency department, and this use is related to urgent conditions (Kiss et al., 2013). Refugee families often do not have a family doctor, and have been found to use walk-in clinics for care. This form of care often means refugee patients are able to address only one issue per visit and face long wait times, resulting in dissatisfaction and frustration (Campbell, Klei, Hodges, Fisman, & Kitto, 2014). One study compared new immigrants to a matched cohort of permanent residents in Ontario, and found that recent immigrants were more likely to live in deprived neighbourhoods, and living in deprived neighbourhoods was more associated with higher use of mental health services, but the immigrants used less mental health services than their matched residents (Durbin, Moineddin, Lin, Steele, & Glazier, 2015).

Ultimately, literature suggests that refugee health profiles and health care utilization are different for refugees than Canadian permanent residents, and overall, they experience higher rates of both infectious and chronic diseases, have increased morbidity and lower life expectancies (Joshi et al., 2013; PSTG Consulting, 2012). It is unclear whether utilization of the health care system that occurs is appropriate given these care needs. Complicating literature on health care utilization and health needs is the frequent grouping of immigrants and refugees together, even when the migration experiences of these two groups are quite different.

### **1.2.5 Health Care Barriers**

Studies have described in detail many barriers that are present when it comes to health care access for refugees in Canada. In this section, these barriers are considered in the domains of access, culture, and providers. Although many of these issues are not unique only to refugees, the vulnerability of this group makes these issues especially urgent (McKeary & Newbold, 2010).

#### **1.2.5.1 Access**

Many of the barriers faced by refugees can be characterized as barriers of access to health care providers at many different points of care. Language is a common and debilitating barrier for access to appropriate health care services; especially in hospitals, refugees are often unable to access interpreters to facilitate effective communication (Campbell et al., 2014; Donnelly et al., 2011). Written health information is also scarce in the variety of languages that are native to refugee newcomers (Nicol, Al-Hanbali, King, Slack-Smith, & Cherian, 2014). Refugee health care access is also prevented by general unfamiliarity with the health system, and a lack of knowledge about how to navigate health care (McKeary & Newbold, 2010). The siloed nature of care in Canada adds to these challenges when people are required to visit several different offices or move between mental health and physical health sectors to have their health needs met (Joshi et al., 2013). This problem has been found to persist in different refugee groups, including both government sponsored or privately sponsored refugees. Private sponsors are also often unable to get important information they require to help with care access (Immigration Refugees and Citizenship Canada, 2016). Logistical challenges related to refugee newcomers temporary phone numbers and addresses also makes communication between health care providers and patients challenging, when follow up is required for further care or information dissemination (Merry, Gagnon, Kalim, & Bouris, 2011). In all, accessing health care services is a formidable barrier for refugees.

#### **1.2.5.2 Culture**

Even when access to a health care provider is achieved, cultural differences constitute another type of barrier. Depending on the culture in their country of origin, refugee newcomers understanding of health, health interventions, and stigma can be vastly different than for non-newcomers in the Canadian context. For example, some refugees have posited that mental health

is a family rather than medical issue, and is therefore not amenable within the health care context (Donnelly et al., 2011). Racism exhibited by health care providers towards patients has been found to have tangible health effects relating to quality of the care provided by health providers and can manifest in negative health care interactions involving racial slurs, inferior care, and insensitive or ignorant treatment (Edge & Newbold, 2012). In Canada, biomedical models of health are predominant, and may not be reflective of different beliefs held by refugee patients (Donnelly et al., 2011). In cases where patients perceive the cultural competency and respect of their health care provider to be low, they become less likely to visit for a health concern (Edge & Newbold, 2012). Fear and distrust of health care providers, and a lack of confidence in the health system also contribute to refugee newcomer's unwillingness to seek out treatment (Duncan, Harding, Gilmour, & Seal, 2013). Gender issues also come into play when there is a sensitivity around certain health conditions, and a mismatch between the gender of the patient and the gender of the provider (Donnelly et al., 2011). Refugees, therefore, can experience many challenges in communicating their health needs and receiving culturally appropriate treatment.

#### 1.2.5.3 Providers

When considering the health care system as a whole, barriers are not only present for refugee patients. As noted earlier, the complicated reimbursement scheme in Canada dissuades many health care providers from being willing to provide care to patients who present with IFH coverage (Abdihalim, 2012). Some health care professionals are further dissuaded due to perceived complexity of health needs, and linguistic challenges (Edge & Newbold, 2012; Gould, Viney, Greenwood, Kramer, & Corben, 2010; McKeary & Newbold, 2010). In cases where there is a lack of appropriate providers, some communities have gone so far as to refuse to accept refugees at all (Immigration Refugees and Citizenship Canada, 2016). Adding to difficulties of providers is a lack of important data. Information exchange on pre-existing health conditions and health records does not occur in an effective manner. Cases have been documented in which refugees were given vaccinations or had x-rays taken twice due to lack of information sharing across providers (Immigration Refugees and Citizenship Canada, 2016). Some of these challenges can be contributed to the fact that at least 34% of government assisted refugees in Canada do not have a regular family physician or health care provider (McMurray, Breward,

Breward, Alder, & Arya, 2014); this number is not available for refugees arriving from other channels.

### **1.2.6 Existing Health Models and Proposed Examples**

Due in part to these formidable barriers, there are examples in Canada and around the world where health clinics have begun to specialize in care for refugees. In this study, these clinics are referred to as refugee health clinics. Models developed through research have suggested elements that are important for refugee health, including components of accessibility, affordability, and responsiveness. It has been suggested that health and community services should be integrated, interpretation should be available, and care should be taken to train staff and workers in culture competence and cultural sensitivity (Grove & Zwi, 2006). In a few cases, evaluative literature describes aspects of these clinics that help promote success. In Ontario, one example is presented where the introduction of a refugee-specific clinic resulted in a 30% decrease in wait times for refugees to see a health provider, and an 18% increase in success in finding a permanent family physician for these refugee patients (McMurray et al., 2014). Primary health care models, as compared to primary medical models, for example, have been found to better address cultural barriers, social support, and educational needs (Batista et al., 2016). Community-based services with ethnically matched health care providers have been found to be more accessible than other health clinics for immigrant populations (Donnelly et al., 2011). Inter-sectoral action has also been found to be an important component, given the complexities and connections between health and other factors such as employment and socio-economic status (Chomik, 2007; Woodland et al., 2010). Case management has been shown to result in improved access, coordination, and quality of health care for refugees, when coupled with specialized refugee health workers and interpreters or bilingual staff (Joshi et al., 2013).

Taking into account some of these components, an Australian framework of good practice has been proposed for offering health care to refugees. This framework includes the following components: comprehensive health screening, consumer participation, culturally and linguistically appropriate care, inter-sectoral collaboration, accessible and affordable service and treatments, and data collection and evaluation to inform evidence based practice (Woodland et al., 2010).

Looking at the Canadian context, a commissioned report investigating refugee health services in Ontario found that no program guidelines or specific funding exists, and as such, there is no health service consistency across the province (PSTG Consulting, 2012). In Ontario, Community Health Centers (CHCs) have been identified as appropriate places for refugee newcomers, especially those without insurance (Marwah, 2014). CHC models have been found to play an important role for disadvantaged populations; in Ontario, compared to the rest of the population, CHCs generally have a higher proportion of newcomers (Glazier, Zagorski, & Rayner, 2012). Across Canada, various other solutions have been implemented. A clinic in Calgary, Alberta operates as an entry point for care for refugee newcomers by providing health assessments, immunization, preventative screening, health teaching in a culturally competent manner, and offering links to various other health care services (Kiss et al., 2013). In Victoria, British Columbia, one mental health clinic offers workshops, comprehensive trauma training, and counseling for children from an interdisciplinary team of professionals, many of whom were previous refugees or immigrants themselves (Patrick & Galts, 2016). Evaluative literature on the success of these interventions is lacking.

### **1.2.7 Other Resettlement Needs**

It is well understood that in addition to access to health care services, the social conditions surrounding where we live, work, and play can have profound effects on our health (Mikkonen & Raphael, 2010). As an example, social exclusion, perhaps due to racism or stigmatization, has been found to result in a greater risk of health problems such as cardiovascular disease. Social isolation has been associated with premature death, higher rates of depression, and greater disability resulting from chronic disease. Unemployment, stress, and housing have also been tied to some of these health outcomes (Mikkonen & Raphael, 2010; World Health Organization, 2003). Refugee newcomers often experience both social exclusion and isolation, periods of unemployment, challenges with housing, and other factors that relate to the social determinants of health (Aery, 2017); efforts focused on refugee resettlement can, therefore, have positive effects on health and wellbeing. This section explores literature related to experiences of social determinants of health for refugee newcomers, including housing and employment, as well as an overview of the supports typically provided for refugee newcomers across different categories in Ontario.

### 1.2.7.1 Housing

Similar to the challenges present in accessing health services, refugees can face numerous challenges finding appropriate housing. A number of barriers have been articulated in the research literature, including a lack of social connections such as family or friends to facilitate initial housing access (Murdie, 2008). Refugee newcomers often do not have a lot of information about housing upon arrival. Individuals quickly find that the allowance provided for shelter through social assistance is not enough to find good housing in expensive cities like Toronto; this effect is exacerbated when a number of barriers also delay employment (Ryan & Woodill, 2000). Bigger cities like Toronto also have very low vacancy rates for market rent, and a low supply of social housing that further limit chances of finding shelter (Murdie, 2008). Even if these barriers are overcome, many refugee newcomers then perceive discrimination in the rental market from landlords not wanting to rent to newcomers or racial minorities (Murdie, 2008; Ryan & Woodill, 2000).

As a result of these challenges, many refugee newcomers find themselves housed precariously. A study in Toronto found that a majority of refugee newcomers in their sample spent over 50% on rent (Murdie, 2008). Traditionally, homelessness has been understood as the absence of shelter or having to live outside. The City of Toronto has offered an expanded definition to include those who are precariously housed either by spending a majority of income on rent, or living in overcrowded, substandard conditions, meaning the risk of becoming homeless is high (Kissoon, 2010). Qualitative research with refugee newcomers has also suggested that isolation from family, friends, and culture combined with a lack of security, isolation and loneliness are other factors that should be considered in a definition of homelessness (Ryan & Woodill, 2000). When homelessness is considered in this way, a significant number of newcomers could be considered at risk of experiencing homelessness upon arrival in Canada.

Temporary shelters offer one form of protection to help mitigate the risks associated with homelessness. Refugees who come as GSRs or PSRs are provided housing through government shelters or the private groups sponsoring them. Refugee Claimants are able to access city run homeless shelters or may find shelter at refugee-specific shelter locations. These refugee-specific shelters may be faith-based, or may be funded through provincial or municipal governments

(Kissoon, 2010). Even with this access to shelters that provide an abundance of support, research with refugee newcomers reveals that the reality of housing in Canada is far away from the expectations that many refugee newcomers have before arriving (Murdie, 2008).

#### 1.2.7.2 Employment

Unemployment or underemployment is a major factor that contributes to experiences of homelessness, or difficulty finding stable, ongoing shelter. Barriers to employment have also been well articulated in the academic literature. Key among these is the failure of many employers to recognize international, foreign credentials for many types of work (Beiser, 2015). Many newcomers have to turn to unskilled labour, even when they have formal training. In some cases, the credential process is linked to citizenship or permanent residency, leaving some professions or industries completely out of reach for refugee newcomers (Jackson & Bauder, 2014).

Discrimination in the workplace due to race has also been articulated as a formidable barrier for some newcomers trying to enter the labour market (Beiser, 2015). This is sometimes manifest in the form of an employer requirement for Canadian experience. Many newcomers start a search for employment as volunteers in order to circumvent this, even if they have many years of experience in another country. Inability to speak English or French is also a significant barrier, and has been experienced by some newcomer job seekers as another form of employment discrimination (Jackson & Bauder, 2014).

A survey report commissioned by Immigration, Refugees, and Citizenship Canada examined the situation of refugees from Syria who settled in Canada's prairie provinces as recently as 2017. Survey respondents echoed what had been previously articulated in the literature: insufficient English language ability, challenges with foreign credential recognition, and a lack of Canadian experience were cited as barriers to employment. Participants in this study also added challenges with finding daycare and challenges with transportation to be additional barriers (Wilkinson, Garcea, Bhattacharyya, & Riziki, 2017). These factors likely contribute to the finding that both refugee and family class immigrants experience the lowest annual employment earnings in Canada when compared to other immigrant categories, and the Canadian average (Yu, Ouellet, & Warmington, 2007). In addition to these financial implications, research has linked under-employment and unemployment to mental health. Many

newcomers forced to rely on social assistance do not feel like contributing members of society, and cite feelings of humiliation or lack of social value (Jackson & Bauder, 2014). Barriers to meaningful employment are significant for refugee newcomers in Canada.

### **1.2.8 Conclusion**

Refugee newcomers arriving in Canada face significant barriers around access to health care and other elements of resettlement, including housing and employment. Given Canada's ongoing commitment to accepting refugees from around the world, provision of necessary health services and settlement assistance after arrival is an important component for continued success of this government commitment.

Currently, the scientific literature has many gaps related to the provision of health care and resettlement services for refugees in Canada. Information on refugee-specific health needs and utilization, as well as quality, and effectiveness of health care solutions is lacking in the Canadian context. Some researchers have gone so far as to say that the lack of information available undermines Canada's mandate of universal health care, and contributes to social inequalities (Edge & Newbold, 2012). In general, few studies have explored models of refugee health care, or the effectiveness of proposed models and interventions (Feldman, 2006; Gabriel et al., 2011; Joshi et al., 2013).

A wider body of literature has examined refugee settlement, including barriers to finding housing and meaningful employment. Across literature examining refugee health and settlement, however, it is often the case that refugees are grouped with other immigrants. Refugees have been found to have drastically different health care utilization and attitudes towards seeking health care compared to even economic or family class immigrants (Campbell et al., 2014). Even within the refugee category of immigration, many different streams exist. It is likely that health needs, access, and settlement experiences differ even among these groups, although distinction is rarely made in existing literature (Immigration Refugees and Citizenship Canada, 2016). In addition, research about health needs and barriers is often explored from the perspective of service providers rather than newcomers themselves (McKeary & Newbold, 2010).

## Chapter 2: Methods

### 2.1 Overall Design/Theoretical Orientation

Qualitative research is an especially appropriate research tool when conducting research that is explanator and evaluative in nature. Explanatory research helps explain why certain phenomena occur and the influences and drives of that occurrence. Evaluative research seeks to understand how well something works such as programs, initiatives or organizations (Ritchie & Lewis, 2003). As such, qualitative methods are well suited for this study that aims to explore and evaluate the health and resettlement experiences of refugees in Southern Ontario.

A critical interpretive paradigm guided this study. Interpretivism postulates that knowledge is gained through understanding of the meanings and interpretations given in understanding the social world, and that both the researcher and the social world impact upon each other (Ritchie, Lewis, McNaughton Nicholls, & Ormston, 2013). A critical lens was also applied. Harvey (1990) describes critical social research as a dynamic process where knowledge and critique are intertwined. Critical social research importantly includes consideration of underlying processes and structures (Harvey, 1990). This lens is important for the present study for a number of reasons. Consideration is made in this study to place refugee resettlement into a broader political context, evidenced by the ways that support for refugees have waxed and waned over time. Currently, a predominant narrative is that Canada is a world leader in refugee resettlement; a critical lens in this study challenges this widely held belief. The ways in which structures influence both public perception and supports available to refugee newcomers arriving through different streams of resettlement are highlighted throughout this work.

There were many circumstances within this study where participants expressed gratitude for the supports they were given in Canada. Gratitude was expressed for the chance to live in a safe country where participants could make better lives for their children than the ones they had left behind. Given the traumatic and dangerous circumstances that can cause refugee migration, it is reasonable for people to experience gratitude upon coming to Canada. A critical lens allows for recognition and validation of this feeling by participants while also critically examining the way that the settlement system in Canada has supported or failed to support refugees after arriving in Canada.

## 2.2 Sample

This study utilized a purposive sampling approach to explore issues related to the provision of health care services and resettlement supports to refugee newcomers. Specifically, this study used a stratified purposive sampling, where the aim was to include groups that displayed variation on certain criteria, but represent a fairly homogenous group so that subgroup comparison is possible (Ritchie & Lewis, 2003).

The study took place in Southern Ontario. This location was chosen based on what was accessible to the researcher with respect to time and resource limitations. The homogenous group was made up refugees in Southern Ontario who interacted with the Canadian health care system, who arrived in Canada less than five years before the study commenced. Subgroup comparison was sought across different streams through which a refugee can arrive in Canada, and different experiences with settlement support both across and within these refugee streams. In particular, experiences of those who are often excluded from academic literature were sought.

Some variation was achieved across the domains of gender, age, and country of origin. There were six male and eight female refugee participants in the final sample. Ages ranged between 20 and 50; countries of origin included some from South America, Africa, and the Middle East. Eleven of the fourteen participants came to Canada through the refugee claimant stream. Two participants in the study came through the WUSC stream, and one participant came through family reunification. These streams of refugee arrival are less common in the literature than those of GSR or PSR refugees. Other resettlement sector participants were able to speak to the experiences of refugees coming through other streams, to some extent.

Refugee participants were pre-screened for a number of characteristics. English ability was a requirement, due to limited resources available for translation services. The participants were required to be over the age of 18 to ensure that participants were legal adults and informed consent could be obtained. Participants that had been in Canada for over five years were excluded, as this may have meant that they have acclimatized enough that barriers relevant to new arrivals are no longer relevant. As well, reflection on health needs and challenges may have been difficult to recall. Further information on the refugee-level participants is presented in Table 1 below.

Table 1: Refugee-Level Participant Demographics

<b>Pseudonym</b>	<b>Gender</b>	<b>Age</b>	<b>Refugee Type</b>	<b>Level of Education</b>	<b>Country of Origin</b>	<b>Length of time in Canada at time of Study</b>
Cabdi	Male	20-30	WUSC	Some university	Somalia	2 years
Faven	Female	20-30	Refugee Claim	Grade 10	Eritrea	1 year
Manesh	Male	20-30	WUSC	Some university	South Sudan	2 years
Dani	Female	40-50	Refugee claim	--	Honduras	2 years
James	Male	40-50	Refugee Claim	--	Honduras	2 years
Tom	Male	30-40	Refugee Claim	University	Uganda	5 months
Cameron	Male	40-50	Refugee Claim	University	Colombia	2 years
Amanda	Female	40-50	Refugee Claim	University	Colombia	2 years
Amoy	Female	40-50	Refugee Claim	University	Bahamas	2 years
Spring	Female	30-40	Refugee Claim	University	Turkey	3 years
Asha	Female	30-40	Family Reunification	High school	Eritrea	4 years
Leo	Male	30-40	Refugee Claim	Some university	Afghanistan	2 months
Maria	Female	30-40	Refugee Claim	High school	Afghanistan	2 months
Maarika	Female	40-50	Refugee Claim	University	Turkey	1 year

-- indicates information was not available

Directors at five refugee health clinics represented clinics across three metropolitan centers in Southern Ontario. These participants were required to have been at their organization for at least one year, to ensure they had enough information about the organization to describe its activities. Staff were also required to be in a director or other leadership role, to ensure they were

able to accurately describe the clinic's activities. Key informants were selected on the basis of their experience working with in the refugee resettlement sector.

## **2.3 Recruitment**

Recruitment strategies differed for refugee and non-refugee participants. Each of the recruitment methods are described in detail below.

### **2.3.1 Refugee Participants**

Gatekeeper recruitment methods were discussed in the literature as a useful and appropriate way to reach individuals who have come to Canada as refugees (Chapple, 1998; Singer & Adams, 2011). Using this method means that a trusted relationship can be leveraged to help explain the study and ensure informed consent of the individuals. This requires individuals to be connected to formal services, and therefore excludes people who have not been connected to the particular gatekeepers chosen for the study.

The first recruitment strategy for refugee participants followed this gatekeeper approach, with refugee health clinics in Southern Ontario acting as gatekeepers. Clinics were sent an information letter and consent form that included provisions for their own participation as well as an invitation to help in the recruitment of refugee-level participants (See Appendix B). This strategy would ensure that all refugee participants recruited for this study would have had some contact with refugee health clinics to speak about during the interview. Staff at refugee clinics were reluctant to provide support in this way; gatekeeper recruitment through clinics resulted in only one refugee participant.

An ethics request was made to expand recruitment strategies for refugee participants to include word of mouth recruitment, and an expansion of gatekeepers to include other individuals involved in refugee resettlement. Recruitment emails were sent to some refugee resettlement organizations known to the researcher, as well as through snowball word of mouth techniques. In total, 14 refugee participants were recruited for this study through these methods (See Appendix C for Refugee participant information letter and consent form).

### **2.3.2 Settlement Sector Participants**

Settlement sector participants were a second participant group recruited for this study. These included directors at primary health clinics, two individuals involved in refugee sponsorship, and a refugee lawyer.

Primary health clinics that have a focus on refugee health in Southern Ontario were identified through an internet search and prior knowledge of the researcher. Southern Ontario was defined to include the metropolitan areas of London, Kitchener-Waterloo, Hamilton, and the Greater Toronto Area. In total, 13 possible refugee health clinics were identified through this search. Clinics were sent a recruitment email (See Appendix D), followed by a reminder email and/or a phone call after a period of two weeks. Directors at five refugee health clinics agreed to participate in this study, from three different metropolitan areas in Southern Ontario. Specific cities are not named in order to protect organizational anonymity.

The two participants involved in refugee sponsorship were initially contacted as potential gatekeepers, with a recruitment email (See Appendix E for Sponsor Information Letter and Consent form).

The refugee lawyer was recruited as a key informant to clarify information presented by refugee participants. The refugee lawyer was previously known to the researcher and was contacted via email (See Appendix F for Lawyer Information Letter and Consent form).

### **2.4 Data Collection**

A total of 18 interviews were conducted between October 2017 and June 2018. Interviews were conducted with fourteen participants who came to Canada as refugees or refugee claimants, five participants from health clinics focused specifically on refugee health, two participants involved in refugee sponsorship, and one refugee lawyer. In depth interviews are appropriate when personal experience is being sought, in a detailed manner, and when subjects are of a complex or delicate nature (Ritchie & Lewis, 2003).

All data were stored on a secure, password-protected, University of Waterloo server. Pseudonyms were used for all participants, with separate documents linking participant to pseudonym stored in a separate, password protected document.

### **2.4.1 Refugee Participants**

Semi-structured, in-depth interviews occurred in person with refugee participants, at private-public locations suitable for the participant and researcher. These included meeting rooms on university campuses, at community centres, and other community spaces. Due to the confidential nature of the interviews, care was taken to ensure the interviews would not be overheard by people passing by. Public spaces were used to ensure the safety of both the researcher and the participants. The interviews ranged from 32 minutes, to 1 hour and 25 minutes in length. In three cases, interviews were conducted with refugee participants who were husband and wife both present at the same time. It is possible this dynamic changed how people answered certain questions.

Interview questions focused on experiences with health and resettlement in Canada, including gaps, challenges, and successes (See Appendix G). Questions focused on health needs sometimes produced moments of awkwardness, especially those related to mental health. Participants responded with generic statements indicating they were okay, or that they did not have any mental health needs. When looking at the interview as a whole, however, there were many examples where people did share experiences that could be considered related to mental health. This suggests that more nuanced interview techniques may be necessary for future research in this area.

### **2.4.2 Settlement Sector Participants**

Semi-structured, in-depth interviews occurred in person at the offices of the various settlement sector participants. In the case of refugee health clinic directors, interview questions focused on the structure and format of the clinic, approximate number of patients, staff roles, perceived challenges, and successes in the care of refugee patients (See Appendix H). Interviews were approximately 1 hour in length. Interviews were recorded and subsequently transcribed verbatim for analysis.

In the case of the refugee sponsors, interview questions focused on the challenges and successes related to sponsorship of refugees in Southern Ontario (See Appendix I) The interview lasted 55 minutes; the interview was recorded and subsequently transcribed verbatim for analysis. In the case of the refugee lawyer, an interview was requested to clarify information presented by refugee patients about their refugee determination hearing. The interview lasted thirty minutes.

Responses to various anonymized data from refugee participant transcripts were presented and discussed with the refugee lawyer.

## 2.5 Data Analysis

Thematic content analysis was used to analyze study data. After each interview, field notes were created to capture initial impressions and to note possible themes for future analysis. Memo writing was also used throughout the data collection process to reflect on emergent themes. These documents were discussed extensively between the lead researcher and supervisor. Each interview was recorded and subsequently transcribed verbatim by the lead researcher. Notes were added to memos during the transcribing process.

Following transcription, each transcript was systematically coded by the lead researcher. Codes included deductive and inductive codes: deductive codes were pre-determined from the study aims and objectives, while inductive codes emerged from the research. Code descriptions were created and modified throughout the coding process in consultation with the study supervisor and committee members. Coding was facilitated with NVivo software. Table 2 below highlights both deductive and inductive codes, along with descriptions of each.

Table 2: Inductive and Deductive Code Descriptions

<b>Deductive Codes</b>	<b>Description</b>
Health needs	Any specific health needs described by participants, i.e. infections, pregnancy, dental. Includes descriptions provided by health clinic participants. Excludes mental health.
Mental Health	Participant description of mental health needs or experiences, including counselling or other clinical visits. Can be analyst assessment.
Language	Experiences with language, learning a new language, taking classes, interpretation services.
Health Services	Experiences, positive or negative, that participants have had in health settings. I.e. doctors office, hospital, physio AND descriptions of refugee-specific health care settings by clinic participants, i.e. structure, model, specialists present. Excludes mental health related, like counselling.
Formal Support	Experiences of formal support provided during resettlement in Canada, i.e. government programs, i.e. case workers at shelters, YMCA programming, ESL courses. Excludes health services like clinics, hospitals.
Resettlement Challenges	Specific challenges faced by newcomers in their resettlement in Canada. Excludes health needs; likely more to do with social determinants of health, including employment, housing. Excludes language.

Positive Resettlement	Describes positive aspects of resettling in Canada separate from specific supports, i.e. feeling confident, finding community
Gaps	Describes any gaps noted by participants in services or needs that were unmet. Also includes gaps described by health care service participants; what they would like to offer but are unable to. i.e. expansion needs, goals, wish list.
Type	Captures aspects of experience related to the designation of how the refugee arrived. (GSR, PSR, BVOR). Especially includes assessment from health care clinic participants.
Gender	Any mention of a gendered aspect of resettlement; can be analyst assessment, i.e. different experiences from members of LGBTQ community, changing family roles in new country.
Work/School	Participants goals or aspirations for work or school after arriving in Canada. Separate from challenges of finding work (resettlement challenges).
<b>Inductive Codes</b>	<b>Description</b>
Informal Supports	Experiences of informal support provided during resettlement in Canada i.e. private support, friends, strangers.
Arrival	Experiences with arriving in Canada; includes contact with immigration officers, support from strangers in becoming connected with settlement supports
Hearing	Captures experiences related to refugee hearing, including lawyers, appeals, et cetera.
Safe	Participants feeling safe in Canada
Family	Mention of family either in Canada or abroad, challenges with reuniting family, stress of family members abroad, family focused challenges.
Waiting	Descriptions of the many things that refugees wait for – PR cards, hearing dates, highlight the amount of time waiting
Research	Describes research or data gathering that is occurring in refugee-specific health care clinics, as well as identified research or data gathering needs. i.e. collecting demographic information on patients, and how this is being used.
Why RS	Short for why or why not refugee specialty? Describes examples of why or why not a special clinic for refugee health may be necessary. Can be participant or analyst assessment, e.g. longer appointment times necessary for refugee population

Following coding of each transcript, key codes were chosen in consultation with the study supervisor for further in-depth analysis. These key codes were analyzed across all study data, and summary documents were created. After this in-depth coding, important themes were identified for further analysis across codes. These themes were decided on by the lead researcher in consultation with the study supervisor and committee members and were informed by field notes and memos documented throughout the data gathering process. These themes were then explored across codes for inclusion in this thesis.

## **2.6 Ethical Considerations**

Ethics approval was obtained from the University of Waterloo Office of Research Ethics on August 2nd, 2017. A number of ethics modifications were requested throughout this research study. The initial recruitment methods did not work as intended, and so a request was made to expand recruitment methods to include word of mouth and snowball recruiting. Another small amendment was made at this time to change information presented in the information letter to refugee participants. Previously, the information letter had said that clinic staff at refugee health clinics who helped with recruitment would not know who participated in the study as an over-recruitment method would be used. A change was made to include the refugee health clinics themselves as possible locations for interviews or focus groups to take place, and therefore staff may know who participated, but not what was said during the interview. This modification included changes to the information-consent letter for refugee participants and was approved on October 13<sup>th</sup>, 2017.

Next, an amendment was requested to expand the sample to include refugee sponsors as a way to capture the experiences of another type of refugee stream in alignment with the study objectives. This was approved on November 6<sup>th</sup>, 2017. A final request was submitted to expand the sample to include key informants on the refugee settlement sector to help clarify some of the information presented by refugee participants. This request was approved on May 25<sup>th</sup>, 2018.

### **2.6.1 Reflections on Ethics**

When particularly difficult information was being shared by refugee participants about their experiences there was reason to question the appropriateness of those questions being asked. Research ethics requires consideration to be given to how interview questions may affect participants. A list of resources was made available to refugee newcomers in each of the cities where interviews took place, in the case that difficult topics arose during the conversation. Many participants noted during interviews that they knew of resources that were available to them, however barriers existed that prevented them from being able to access these resources. Simply providing another list of possible supports was not helpful. Mental health is an important component of health research and was a relevant topic for this study. In the future, researchers could first learn from mental health experts about how to safely and respectfully ask questions

about mental health. There is an opportunity for tools and training for researchers to be developed to ensure that research does not cause undue distress for participants.

## **Chapter 3: Refugee Health Clinics**

### **3.1 Introduction**

Canada has a rich history in refugee resettlement. There are many organizations that assist with refugee resettlement across domains such as housing, employment, language training, and the legal process of resettling in Canada. Support is provided in the domain of health, too; some primary health clinics across Canada have begun to specialize in care for newcomer populations. A number of these clinics exist in southern Ontario and were a focus of this study. There is no formal definition for what will be referred to as ‘refugee health clinics’. In this thesis, the term will be used to describe a primary health practice that has a specific mandate to serve refugee patients, and where modifications have been made in effort to specifically address refugee health. These clinics may serve only refugee patients, may have a focus on refugee and other newcomer populations including immigrants, or may see a wide variety of patients; what is important is a specific focus on refugee newcomers as part of the clinical practice. To further clarify, there are some clinics that perform a mandatory immigration health check for newcomers to Canada. These clinics would not be automatically considered refugee health clinics, unless they continue to provide ongoing care in addition to this one-time screening. In this definition, refugee newcomers will include both UNHCR refugees and refugee claimants.

### **3.2 Organizational Structure of Refugee Health Clinics**

Interviews with staff at refugee health clinics highlighted that in addition to there being no formal definition for a refugee health clinic, there is also no formal mechanism by which these clinics are created and organized. Descriptions of how different refugee health clinics operate are noted in this section. In order to protect organizational anonymity, descriptions are not attached to specific organization pseudonyms.

Models of funding varied across each of the refugee health clinics included in this study. Three clinics of the sample had salaried staff positions, while the other two operated under a fee-for-service model. Two clinics were situated under larger parent organizations with consistent, ongoing funding. Two clinics relied heavily upon volunteers and occasional grants to support specific staff or programs for short periods of time. In these cases, physicians often volunteered time in order to put funds earned from billing OHIP or IFH back into the organization. One clinic

operated in somewhat of a middle ground, as it was a registered charity that had for many years received significant funding from the government.

Three of the clinics exclusively served patients who were refugee newcomers, although occasionally they provided services to patients who were new to Canada through other streams of immigration with complex health or social needs. One clinic was focused on mental health and sought to serve refugees alongside non-refugee patients with significant mental health needs. The final clinic saw patients based on marginalization and clinical or social complexity. This included refugees, other newcomers, and Canadian citizens.

Across the sample, clinics had various determinations for how long they would see specific patients. One clinic had no pre-determined end-point for services and took on patients as a typical family doctor in Ontario, although all of the patients would have arrived in Canada as refugees. Two clinics had a set end point, intending to see refugee patients only during the first two or three years of their settlement in Canada. After this time, they transitioned patients to other primary care facilities. The final two clinics saw patients based on a particular complex clinical need. If or when the clinical needs were met, patients were transitioned to other ongoing primary care facilities.

### **3.3 Refugee Health Clinics Redefined ‘Health’ Services**

While the organizational structure and funding models of each of the five refugee health clinics included in this study varied, a number of practices were found to be consistent across them. Chief among these was the provision of a broad range of supplementary services not necessarily typical of most primary health practices in Ontario. All of the clinics incorporated an understanding of the social determinants that contributed to health and wellbeing, such as housing, employment, income, and culture. It may be that for newcomers to the country, social determinants of health present in very direct ways. Directors from all of the refugee health clinics cited providing assistance in domains beyond traditional health services, as highlighted by a director at organization C:

*“[The clinic] is a place where [refugee patients] will come if they have a problem – that I think is why [Dr.X] spends so much time filling out forms. So, you know, somebody who has a nutritional problem doesn’t know where to go, we can direct them to the foodbank, we know how to do that. We know where to go if they’ve got needs. They come to use us*

*as a resource; a community resource, looking for us not necessarily to provide, but for us to direct. And that is how we would want it to be too.” (Director, Org C)*

Refugee health clinics assisted patients with many aspects of settling in Canada, including connecting people to language services and legal support for hearing proceedings. In three of the five cases, these kinds of connecting supports were provided directly by staff employed at the organizations, who tended to be social workers or client care coordinators. In other cases, refugee newcomers were referred to these kinds of supports in the community. Some of the clinics had specialists on staff related to other care disciplines such as diabetic education, chiropractic care, and respiratory therapy. Having these staff incorporated into the clinic reduced the challenges associated with referrals for refugee newcomers. These expanded services were positively received by refugee newcomers and others involved in the resettlement sector. Chris, a private sponsor, expressed how helpful it was for himself and the family he was supporting to have a wide variety of services available in one place:

*“One thing that is really great is finding these [refugee health clinics] that have everything there! Right? Amazing, and they even have social workers and everything.”  
(Chris, private sponsor)*

Chris had spent a lot of time calling health clinics in his area to find supports for the refugee family he was involved in sponsoring and had been pleasantly surprised to find a place that was able to help with a broad range of services. The alternative would have been for him to spend much more time driving between multiple different health care facilities.

Providing orientation to the health care system, rather formally in specific classroom like settings, or in the form of one-on-one conversations between physicians and patients was also described by representatives of refugee health clinics as a part of regular service:

*“...the hope is that if you invest the time in people within those first couple of years, then they can transition into other models of care much easier. We like to think that we tee people up so by the time they leave here a lot of the screening is done, most people have OHIP by the time they leave, they understand how the system works. They understand the difference between walk in care and primary care. The idea is that you invest early and help transition people into the system.” (Director, Org A)*

Health care system orientation was specifically appreciated by refugee participants in this study. Cabdi explained that, without some kind of orientation, refugee newcomers simply do not know how things work:

*“There is a lot of stuff about the health system that I think [refugees] have to understand. Its very different from – I’m always connecting this to the experience that I had in Kenya. Canada sponsors refugees from around the world, so they have to always explain to them the difference between where they came from and how the health care system works here. So one thing to do that specifically is to actually employ people who are from the community, speak the language, and from experience doing things in a language that they understand.” (Cabdi, WUSC refugee)*

Cabdi included a suggestion to include people from various parts of the world, likely previous newcomers, in this knowledge translation. This strategy was not explicitly mentioned by the refugee health clinic representatives.

For directors at refugee health clinics, assisting with peripheral services was considered to be a part of providing excellent health care. Staff working in refugee health were well aware of the barriers that exist for newcomers in accessing health and settlement services. Some of the ways these barriers were addressed included providing warm introductions when referrals were needed for care at another health care facility or providing space within the clinic for specialists and staff from other settlement services. In this manner, directors hoped to reduce barriers of access across the health care and settlement system:

*“And then part of it is helping people connect to the system....that can be a challenge for all of those issues that you would imagine – language, access, not being able to understand the system. And I think working in other models of care you often don’t have the time or perhaps the understanding that when you give someone a prescription that there’s a lot of other challenges that come into place. They have to know to go to a pharmacist, they have to know what ID to use, they have to sometimes navigate that without or with limited English proficiency. And because refugee clinics see people in larger numbers, I’m hoping - I know, most of us are quite conscious of those obstacles.” (Director, Org A)*

One of the significant barriers of access for refugee newcomers is language. Interpretation was available at all five of the clinics interviewed in this study. In some cases, interpretation was also

provided by the clinic for patient appointments outside the clinic, such as specialist appointments. Although interpretation was cited as an essential component of refugee health, directors at some clinics described experiencing difficulties finding funding for this service. One clinic had an annual budget for interpretation, and if this was used up, paying for interpretation meant that less money was available for other programs or services. Interpretation may not be considered a supplementary service, but is often not available in primary practices across Ontario, and is therefore one way that refugee health clinics are unique.

All of the refugee participants in the study were required to speak English, and as such, language barriers were not discussed extensively by participants. Cabdi did note the importance of interpretation based on anecdotes he heard from other refugee newcomers in his network:

*“I think one thing is that they don’t have the confidence to go to the doctor because of the language and when you don’t know how to explain your things you don’t – they is just afraid,” (Cabdi, WUSC refugee)*

Language barriers are well articulated in the literature as a prevalent health need among refugee patients (McKeary & Newbold, 2010), and interpretation is an important component of refugee health clinics.

The expanded nature of services offered at refugee health clinics, which included education on the health system, interpretation, support on filling out forms for housing, or directing clients to settlement supports was appreciated by refugee participants and private sponsors in this study. Consideration of the broader health and settlement needs of refugee newcomers is, in some ways, a redefining of responsibilities that are typically understood to be a part of primary health care.

### **3.4 Refugee Health Clinics Demonstrated Cultural Awareness**

A third consistent practice noted by directors of refugee health clinics was an acknowledgement of the various ways that culture affects health care. Culture is present in any conversation between a health provider and a patient, regardless of whether both patient and provider are from the same country. When cultures are vastly different, however, the effect can be much stronger. A director from one of the refugee health clinics noted that the opportunity to see patients from all around the world on a regular basis means lessons can be learned to improve health and well being:

*“As an example, four/ five years ago we saw a large group of people coming from North Korea, and you know there’s very little in the literature to guide us in terms of the communications in North Korean refugee, I mean there’s a little bit but not a tremendous amount. I think being able to see a group in mass helps us really to fine tune our approach to particular groups. For all those reasons I think there’s tremendous advantages to seeing refugee patients in large numbers which is what happens at refugee clinics across the country. I also think there’s a benefit in terms of research so being able to document what we’re seeing. And that is in terms of the prevalence of certain conditions, but also in terms of health advocacy.” (Director, Org A)*

Having primary clinics that specialize in refugee health means staff at these clinics will encounter patients from various countries in the world on a more frequent basis. This exposure can be beneficial for developing an understanding of cultural nuances as well as specific disease prevalence. Clinicians described women’s health as one area where cultural differences meant significant differences in treatment; in North America, birth control pills are a common form of contraceptive medicine, but intra-uterine devices are more common in other countries around the world. This type of knowledge helped facilitate important health conversations, and presumably improved outcomes at organization A.

Refugee participant interviews were full of examples where culture influenced experiences with health care in Canada. Many refugee participants in this study had experiences with health care in Canada at non-refugee-specific health care clinics including Asha, who sought help with a migraine:

*“Anyway... [the doctor] said oh you better wait. I think its migraine, so I will just give you a prescription and then you can buy and take this one...is that how they do the medical things here? I don’t like it, he should give me like – I should do some tests, how can he judge, or come into some conclusion by letting my words? Sometimes if I say I have a very bad headache, it can be – it may not be a migraine, it may be something different.” (Asha, family reunification refugee)*

Asha was used to having many tests performed when presenting with a health concern in Sudan. In Canada, she was taken at her word for complaining of a migraine. It may be less common for extensive diagnostic tests to be used in Canada compared to her health clinic in Sudan, however,

this was not explained to Asha at the time of her appointment. This left her feeling uncertain about the treatment she had received.

Cabdi noticed a difference in prescribing of medicines when he presented to a non-refugee health clinic in Canada, complaining of generally feeling unwell:

*“That’s the first difference I noticed, because if I was in Kenya, they would have prescribed me all this medicine, you know what I mean? Because its just one of the...in Kenya, you go to the hospital, you will never come back without medicine, definitely...so here, they just explained to me...that happens, there is jet lag and all those things, you have to feel better, just don’t worry about it.” (Cabdi, WUSC refugee)*

Cabdi was told his symptoms were likely due to jet lag, and he should give it a few days to see if things improved. Before attending the appointment, Cabdi expected he would be given some sort of medicine. He went on to say staff in Kenyan hospitals made money from prescribing medicine, and corruption has been a problem in this regard.

When Cabdi and Asha went to non-refugee health clinics for care, they were not asked by staff about their expectations, nor were they provided with education about norms in Canada. When these opportunities are not provided patients may take treatment into their own hands. This was the case with Faven, a refugee Claimant whose daughter had a loose tooth. It was common in Eritrea where Faven originated for baby teeth to be pulled out by a dentist prior to them falling out on their own. In Canada, it is common practice to wait. When Faven took her daughter to the dentist, the dentist did not agree to pull the loose tooth. Faven decided, therefore, to do this herself afterwards at home.

Cultural differences were not only present in inclinations towards certain treatment options, but they also related to how certain medical concerns were talked about. As part of an immigrant medical intake exam, Faven was asked to do an HIV blood test. This made her uncomfortable due to the stigma associated around HIV; Faven did not think this was appropriate information for the government to know, and did not understand why this was required. Culture also came up when Faven sought help for menstrual pain. In Eritrea, Faven explained any doctor visit started with small talk between the doctor and patient to create a comfortable environment before the reason for the visit was discussed. Faven’s appointment in Canada started immediately with the reason for her visit. She was uncomfortable, and described doctors having

‘angry faces’, that ‘make you feel scared.’ After this experience, she did not want to return to the clinic for a future health concern.

Faven went on to articulate that when an effort is not made to create a comfortable environment, women from her culture would be likely to withhold relevant information about their health concern. If physicians at refugee health clinics are aware of some of these cultural nuances, and learn how to ask about things in a respectful way, more information will be provided by the patient about their health care needs.

Manesh, a WUSC refugee, relayed how culture is also present in what is considered common knowledge. Manesh came from a country where malaria was a common condition that he himself had experienced many times. He presented with a case of malaria to a hospital only days after arriving in Canada, and was subsequently enrolled in a research study:

*“The drama that was taken place that I observe silently where you know all the doctors were coming all around and stand beside me and want to check me, in fact one of them confessed to me and said, you know, I have never seen a patient with malaria. ...and I’m trying to do a study of how a malaria patient look like.” (Manesh, WUSC refugee)*

Doctors at the hospital where he was admitted wanted to learn from his case, and so kept him in hospital for observation as a part of the research study longer than would have been necessary for his immediate health issue. This is an example of where certain medical conditions common in other parts of the world are often not seen by Canadian physicians. Staff at refugee health clinics might begin to develop a familiarity with some of these less common diseases in terms of both diagnosis and treatment, which would be advantageous to the people who present with these conditions.

Mental health is an area where cultural differences may be the most prevalent. The very definition of being a refugee implies hardship, and while not all individuals will require or benefit from mental health treatment, it is likely that a significant number of them will. In Canada, significant effort is being made to try and reduce the stigma around mental health, and yet much stigma still persists. Stigma was therefore hyper-present in some of the countries of refugee participants where little effort has yet been made in this regard. Upon arriving to Canada, many refugee participants were introduced to the idea of mental health services or treatment. Amoy, a refugee Claimant described her reaction to this idea:

*“Our culture, if you go see a counsellor, you are walking in the streets naked. There is something re-al-ly wrong with you....there is stigma, yes.” (Amoy, refugee Claimant)*

Information about mental health services was not always taken seriously as an option for refugee newcomers in this study. Cabdi described some of the possible effects of speaking about mental health to refugee newcomers:

*“For example, if you just go up....standing in front of tons of refugees, and just explain to them, ‘okay, we have these services if you need’ – they just don’t understand how does it work. I will be stereotyped...they think, ‘I will be compared with someone with HIV and AIDS its even worse....if you tell them to go [seek mental health services] they will hate you. They will hate you so bad as soon as you tell them that.” (Cabdi, WUSC refugee)*

A more nuanced approach to these discussions is likely required if refugee newcomers are to consider seeking assistance for mental health. Amoy eventually did seek help, but only after her symptoms escalated to the point where she was losing sleep. Her first experience was not positive:

*“I: Were you comfortable with the idea of counselling from a culture like that when you came to Canada?*

*Amoy: No. I was like, ‘why do you want to know my business? I am strong, I can handle it’. But then I started having these dreams and whatnot. It was time to talk to somebody. It was time to talk to somebody. And I think its important to know who you are going to, and which counselling...you have to connect with the person, because some people can still be judgemental. I wouldn’t tell you who it was, but I went to one and I was sitting down and they said ‘so tell me about yourself’, and I started for about 3 minutes before they interrupt and they spoke for 27 minutes afterwards.”*

If stigma around seeking help is high, and then a first experience with a mental health services is not positive, a refugee patient may be unlikely to continue seeking care. Mental health may be a particularly important area for culturally responsive care. Scientific literature has elucidated that culture relates to mental health in a variety of ways. This can include initial health-seeking behaviour by an individual, reaction to treatment options, and responsiveness to promotion or prevention initiatives (Kirmayer, 2012). Cultural awareness is an important component of treatment success.

Culture can also manifest in how appointments for health care are made. Built in flexibility was another way that refugee health clinics demonstrated cultural awareness. Many primary practice health clinics in Canada require an appointment to be made in advance, except for urgent needs. Directors from refugee health clinics understood that this is not necessarily a common practice around the world. The director from organization C described how this was managed at their clinic:

*“Many of our patients come from backgrounds where appointments are not the way that the world works. They may be late, they may be early, they may mistake the day, the time...huge flexibility, and we, by and large – if somebody comes with an urgent need, they will be dealt with.” (Director, Org C)*

Many of the clinics still cited a general requirement of asking people to make an appointment. In order to ensure attendance at these appointments, directors described making multiple phone call reminders to be a regular practice. Flexibility at refugee health clinics was appreciated by Asha:

*“Well the good thing actually is sometimes you don’t need to call even, when you come they don’t say ‘oh you didn’t call, you don’t have an appointment, sorry’ – they just squeeze and then they create an opportunity. They are – yeah, they are very cooperative.” (Asha, family reunification refugee)*

Flexibility was also cited in the length of appointments. Ten minutes was described by clinic directors as average for a visit with a physician for most patients in Ontario, however refugee health clinics often booked patients in for thirty minute appointments. Even thirty minutes was not always enough, as cited by a director at organization B:

*“[30 minutes] is often not enough, without a doubt – be it for refugees or other clients, for sure, just because of the level of complexity that we are seeing....so we do try to accommodate that as much as possible.” (Director, Org B)*

Finally, flexibility was also demonstrated in hours of service. Many newcomers attend English language classes that run during the day, meaning day time appointments can be hard to fit in. Directors from refugee health clinics described changing hours to include evenings and weekends in an effort to meet the needs of their refugee patients.

Flexibility, it seems, is an important component for providing services to refugee newcomers. Cultural norms around seeking health care services are not the same around the

world as they are in Canada; the practice of making appointments is an example of one such difference. In addition, language barriers and clinical complexity can mean longer appointment times are necessary. Directors at refugee health clinics appear to acknowledge that a period of adjustment is necessary for patients arriving from various countries around the world. Flexibility in various services and procedures was discussed by all of the refugee health clinic directors in this study, and was appreciated by refugee participants who had benefited from this policy. Directors at refugee health clinics acknowledged culture as being a part of refugee health but did not elaborate as extensively about it as the refugee patients in this study. Culture impacted health seeking behaviours as well as treatment expectations and preferences. It is likely that a clinic that works with individuals from a variety of cultures frequently is well positioned to be responsive to the ways that culture is present in health care. Given the many ways culture was discussed by refugee participants, it may be this is an area where refugee health clinics could continue to focus additional efforts.

### **3.5 Refugee Health Clinics Only Work if People Know About Them**

Across the experiences of refugee participants in this study, some were familiar with and had sought care at refugee health clinics, while others were not aware of their existence. Chris, a private sponsor, stumbled across one by accident while making phone calls to many different health clinics in his area. If information about refugee-specific care is hard to track down for English speaking Canadians already familiar with the health system in Canada, it is easy to imagine how much harder this is for refugee newcomers.

Misinformation about health services was noted by refugee participants. Leo, a refugee Claimant, was told by another refugee Claimant at the shelter where he was staying that he was only entitled to health care for emergency situations:

*“Just in case, if something happened – what is that – my heart will stop, in this case I do have the right to go to a doctor? In this case I have to, its emergency. Other things if you have the flu or something like that – totally different case, you can stay at home.” (Leo, refugee Claimant)*

This, of course, was inaccurate information. Leo was at the time in possession of an OHIP card but was not given accurate information about what this was to be used for. Cabdi also was given

an OHIP card without knowing what it meant. He described seeking care when he fell ill at a non-refugee clinic and wondering throughout the appointment when he would be required to pay, and how much it would cost.

In addition to these examples of misinformation, examples were also present across the study where refugee newcomers had a lack of information about health care services. Faven did not know where she could go when she fell ill, and turned to her ESL instructor for help:

*“One day I’m sick, I have an infection I think, ‘Maybe its my kidney’? I have to go and I have a health card, but I don’t know where to go? How can I use this? Where? Where do I have to go...I need my own doctor? My own family doctor? I don’t have a family doctor...but I’m sick, I need like urgent. I need to go and I just ask my [ESL] teacher.”*  
(Faven, refugee Claimant)

Like Cabdi and Leo, Faven had a health card without much knowledge on how to use it. It seems that there is a point in time where an OHIP card is delivered to an individual, and yet, the crucial information on how to use the card is either not present, or not described in a way or a language that is getting through to refugee newcomers. The way information is communicated has a large role to play in determining whether or not the information is understood:

*“[The government] have to provide seminars and discussion sessions for the orientation...they have to vigorously and clearly explain to [refugees] how the system works in a language they understand, you know...the government should not do, they should not mail them papers, you know, they just don’t understand....help them in a way that they can understand.”* (Cabdi, WUSC refugee)

Staff at refugee health clinics described providing some of this orientation to the health care system for their patients, as was described in a previous section. If this information is left only to refugee-specific health clinics to communicate, a large gap will exist for people who are not connected to these services. Misinformation can be easily spread through informal newcomer networks; knowledge translation outside what is provided at refugee-specific health clinics is essential for refugee health.

### **3.6 Funding Health Services**

Directors at all of the refugee health clinics in the sample described accepting patients who were covered by either OHIP or IFH, and cited occasions where they accepted refugee patients with no

insurance coverage at all. This is an important dimension of refugee health clinics, as there are many health clinics across Southern Ontario who refuse to see patients with IFH coverage. This is likely due to a different reimbursement mechanism from the government compared to the rest of the population covered by OHIP. The refugee resettlement system in Canada is designed to provide health insurance to refugees across the various refugee programs, however, details of coverage depend on specific refugee categories.

Individuals who come to Canada as GSRs or PSRs come with an approved refugee determination, meaning they do not have to go through a hearing upon arrival. These individuals are entitled to OHIP immediately and are exempt from an otherwise mandatory 3 month wait time (Government of Ontario, 2017). Delays in paperwork may mean there is a gap between arriving in Canada and receiving OHIP cards. These refugees are also entitled to supplementary IFH coverage. This plan covers basic services during any delay from getting OHIP, and services such as prescription assistance, vision, and dental for one year (Government of Canada, 2016b). Refugee Claimants who make a claim in Canada are entitled to IFH after they have been determined eligible to make a refugee claim. This occurs after an interview with an immigration officer either at the border or at an inland immigration office. For claimants, IFH coverage lasts until they are eligible for provincial coverage; OHIP is usually granted after a positive decision at a refugee determination hearing (Community Legal Education Ontario, 2016). If a claimant has a negative decision at a refugee determination hearing, they will still be granted IFH coverage if they are going through an appeal process or applying for residence in Canada through another channel. If they have exhausted all options and decide to remain in the country illegally, they will not have any health coverage (Government of Canada, 2018a).

The combination of IFH and OHIP described above is intended to ensure that any refugee in Canada has access to health insurance most of the time. Interviews with refugee participants revealed, however, that gaps in health coverage do occur. Claimants who made an inland claim, for example, did not have any coverage prior to them presenting to an immigration office, and for a few weeks after their initial interview. Asha came to Canada through family reunification, five years after her husband had come to Canada through a private refugee sponsorship program. This meant Asha and her children were subject to the three month delay for OHIP, and were not eligible for IFH. Her son became very sick at one point during this delay, and they went to the hospital by ambulance. During the hospital visit Asha was presented with various options for care

that each came with a cost. She asked the nurse how critical her son was to try and help her determine next steps, asking the following questions:

*“Do you think my son is very – do you think he need it? Because I am more concerned about his health, I am not concerned about money even though its not fair.” (Asha, family reunification)*

The suggestion was for her son to try Tylenol and come back if things did not improve, as this was a less expensive option than running many tests. Her bill ended up being \$557.50 for the ambulance and the visit, illustrative of cost demands put on people during a period with no coverage.

Asha also had a migraine during this waiting period. A non-refugee clinic doctor agreed to see her, but did not send her for additional tests because the cost would have been a barrier. She instead was given a prescription for the pain. In this case she was fine, but testing was not recommended due to cost. Because of these examples, Asha is critical of the three month wait period:

*“I hope they will think about it, because you know the – you don’t know what will happen tomorrow to you, you can get sick – a very critical sickness, and if they say you have to wait 90 days or you have to pay and then you don’t have that much money to pay, means you are going to die. Who is responsible? Who is faulty for that?” (Asha, family reunification)*

Spring also had a unique circumstance that resulted in a significant gap without health coverage. She had come to Canada on a student visa and was on a scholarship from her home country that included health coverage. While in Canada, a civil war broke out and her country stopped paying any bills. Spring and her family lost their health coverage and were then required to make a claim for refugee status while already living in Canada. Spring describes very expensive care during this time:

*“Its just so hard. When we just see the doctor we pay \$55, that is the cheapest doctor. The rest of them \$70 just to see them, without a prescription, without nothing. Yeah. Like the – emergency too, its about \$580. So lots of things that just -health is very,very,very expensive in Canada. Health insurance is so expensive.” (Spring, refugee Claimant)*

Experiences of refugee participants reveal that gaps in health coverage do occur as part of the refugee claim process. The provision of services regardless of ability to pay described by

representatives at refugee health clinics seems to fill an essential need described by refugee participants if they are connected to services such as these.

### **3.7 Conclusion**

Refugee health clinics in this study were broadly characterized by cultural awareness, flexible administrative policies, and having a broad range of services related to social determinants of health. All of these aspects were well matched to needs and experiences of refugee participants around health. In addition, refugee health clinics played an essential role in providing health services to newcomers regardless of having formal coverage through IFH or OHIP. The cost of services to refugee participants who had to pay for health services during periods of no coverage was substantial. These practices, however, only help in the case where patients are aware of and able to access care at refugee health clinics. Smaller communities are unlikely to have the population to support a clinic that focuses specifically on refugee or newcomer health. Capacity for patients at refugee health clinics may become a concern if refugee and newcomer numbers continue to increase in Canada.

Interpretation was discussed at greater length by staff at refugee health clinics than by refugee participants. This is likely due to the requirement of English for participation in the study; the need for interpretation services for newcomers is well documented in the academic literature (McKeary & Newbold, 2010).

There were some areas where needs identified by refugee participants were not entirely matched by responses from refugee health clinic representatives. For example, refugee participants described in more detail than refugee health clinic representatives the ways that cultural norms and expectations are present in health interactions. Faven expressed the importance of physicians creating a comfortable environment for discussion of sensitive topics, as a cultural expectation; this particular cultural norm was not discussed by directors at refugee health clinics. The ways that culture impacts health is an ongoing topic of study in the academic literature. Models of cultural competence, cultural responsiveness, and cultural safety have been implemented in a variety of health settings; critiques of all of these have also been articulated (Kirmayer, 2012). It is beyond the scope of this thesis to debate the merits of these models in relation to refugee health care, however, it is important to note that there are a variety of models that could be explored at refugee health clinics to best meet the needs of their patients.

## Chapter 4: Experiences with Resettlement

### 4.1 Introduction

One of the common elements described by directors from refugee health clinics was the incorporation of social determinants of health into their practice. Clinic directors noted that access to housing, employment, and financial resources were relevant to the health of their patients. The type and amount of supports available to refugee newcomers as they settle in Canada likely has implications for health needs and health outcomes over a longer term. This chapter highlights experiences of resettlement in this study, focused on the act of arriving in Canada, finding housing, and finding employment. Particular attention is paid to the underlying reasons why experiences of resettlement in Canada differed across the study participants, especially as they relate to the stream through which an individual came to be in Canada. Arrival experiences are considered first, followed by experiences finding shelter, longer term housing, and finally employment.

### 4.2 Arrival

Differences among participants started with the very act of arriving in Canada and depended upon both refugee category and presence of lack of certain assets. In terms of refugee category, GSR, PSR, BVOR, JAS, and WUSC refugees are most often met at an airport, either by staff of formal refugee reception centres or private Canadian sponsors. These individuals are then accompanied to shelter that has been pre-arranged on their behalf. This was the experience of both Manesh and Cabdi, who came as part of the WUSC program. The sponsorship group associated with the university they would be studying at picked them up and took them to their student residence.

Cabdi described the privilege of being accepted into this program, noting it is a rare opportunity:

*“In the back of my mind I always wanted to be a part of this program, you know....it was the only way to get out of the refugee camp. It is intense and everything – so the process, first of all, it depends on your grade. There is a certain grade, so like from 500 students they only take 20 students from Kenya.” (Cabdi, WUSC refugee)*

Not all refugees that come to Canada have this kind of an experience; arriving in Canada is especially different for refugee Claimants. Refugee Claimants can enter Canada through an airport, or by walking across a border at a non-formal port of entry. Claims for refuge can be made either at the airport at time of entry, or inland at an immigration office. Some people arrive at an airport and enter the country on a tourist or student visa, and then present to make an inland claim sometime later. Luke, a refugee lawyer interviewed for this study, confirmed that some refugee Claimants begin their arrival in Canada with detention in a Canadian Border Security detention centre. This most often occurs when someone arrives with no identity documents, or there is a concern of possible criminality. Examples of many of these types of arrival were present in this study.

Faven is an example of someone who made an inland claim after walking across the border. Faven left Eritrea and came to Quebec from the United States with her two young daughters in winter time. They were intercepted by police officers and taken to an immigration centre in Montreal. Here, it was determined that they had valid grounds for a refugee claim. Immigration officers informed Faven that she would be notified of a date for her refugee determination hearing; she was then told she could leave the processing centre. Faven did not have anywhere to go, as she did not speak English, or have any connections in Montreal. Immigration officers gave her the phone number of a taxi company only after Faven had broken into tears explaining she could not stay outside with her children in the winter:

*“They just told me you can go now, finish....maybe they think I know where – like its easy for me because I crossed the border? That’s... the hardest decision I make...I feel like I’m choosing the death. I just – I pray, and I cry at in front of them. I cry- they saw me and they told me...okay this is the taxi number, you can go. And I can’t – every people that I know, that....lives in Canada, but I don’t know where, and [it’s] winter. I tried to call them, and they didn’t even pick me, because they have their own life, they are not my family. They are not my brother – they are just people.” (Faven, refugee Claimant)*

On her own, with no resources to support her family for the night, Faven had to rely on a series of support from strangers. She contacted someone she had met before crossing the border who had ended up in Kitchener, Ontario; this woman contacted her sister, who knew someone in Montreal. Faven was put in contact with this man from Montreal who came to meet her and her daughters, although they had no common language between them. This man brought them to a

bus terminal and realized there was no direct bus from Montreal to Kitchener. Faven would have to go through Toronto. Somehow, the man communicated this to Faven, and arranged for someone he knew in Toronto to meet them at the Toronto bus station. Faven was given money for a pay phone to place a call upon arrival in Toronto. Two strangers met Faven and her daughters in Toronto and put them up in their home for the night. Faven commented on how she felt needing to trust the women who met her in Toronto:

*“I don’t have no choice. I have no choice-like –for example, if someone drinks, or smokes....I don’t know about that stuff, I just.... oh my god, the one she’s smoking. Okay, I’m going to lose my kids....But they are good we went to their house, they gave us food and they make a bed for my kids.” (Faven, refugee claimant)*

Faven was fearful of spending the night in the care of strangers but felt she did not have any choice. The women who put Faven and her family up for the night brought them back to the bus station the next morning, and helped them catch a bus to Kitchener. In Kitchener, Faven and her daughters were met by the individual to whom she had first placed a call. These individuals put Faven in contact with an organization that supports refugee Claimants. This organization has a network of Canadian volunteers who provide temporary accommodation in their homes. Faven and her daughters were given a room by one of these volunteers for a few months.

Tom came to Canada on an airplane. When he arrived in Canada, he was not aware that it was possible for him to make a claim for refuge directly at the airport. Instead, Tom entered Canada as a temporary visitor and did not have any information about next steps. He did not have much money saved and was hesitant to call a cab to take him somewhere. Instead, he remained nearby the airport and spent his first night in Canada sleeping outside. He eventually overheard a stranger speaking Swahili, a language he could understand, and approached her for help. This stranger put Tom up in her house overnight:

*“Yes she gave me shelter that night. And then the next day she told me you are going to go to this place, she wrote down something, I remember the place? The shelter, and then....she told me we are going to take a bus...then you are going to take a train, and then from the train you look for bus with this number, and then when you reach here, ask anybody.” (Tom, refugee Claimant)*

The stranger subsequently gave Tom directions on how to take public transit to a refugee shelter the next morning. This shelter provided Tom with assistance from that point onward, with the remainder of his refugee claim.

Unlike Tom, other individuals in this study knew ahead of time that they could make a claim at the airport, or other port of entry. The ability to do research ahead of time made for a very different initial experience in Canada. Amoy, as an example, spoke fluent English and was able to inquire about shelter from immigration officials at the airport. Immigration officials gave her the phone number of the Red Cross and told her the Red Cross could help to arrange shelter and other supports. The Red Cross office was closed by the time Amoy and her partner made it through the airport, but they had sufficient financial resources to stay in a hotel on their first night. Within fifteen minutes of making a phone call the next morning, they were connected to a shelter that provided them with ongoing assistance. Cameron and Amanda knew ahead of time about an organization that would support them during their claim for refuge, and proceeded to this organization directly after entering Canada.

James and his wife Dani had personal connections who lived near the airport. When they made a claim and were told to come back the following day to finish paperwork, they were able to stay with family friends nearby. Leo, Maria, and Maarika also benefited from friends and family living close by when making their claim.

Having prior knowledge, the ability to speak English, friends or family, and financial resources were assets that made for very different experiences of arrival across participants in this study. The type or category of refugee also made an immense difference, as most refugee streams are met at the airport with pre-arranged shelter. For Faven and Tom, having to rely on strangers or sleeping outside on the streets was a re-traumatizing experience. All of the individuals in this study were eventually connected to refugee-supporting organizations that ensured shelter and support for settling in Canada. For some, there was a significant pre-support gap. The challenges shared by participants about their initial days and weeks in Canada in finding supports could have adverse impacts long term on physical and mental health.

### **4.3 Shelter**

After arriving in Canada, shelter is one of the most immediate needs of refugee newcomers. In addition to the variety seen in newcomer's initial days in Canada, differences persisted over first

months and years. Maarika had initially stayed for a few nights with a friend, although in her mind, this was a temporary arrangement:

*“I did a few days, and then I chose to just experience – um everything as a single woman coming to Canada as a refugee, so I found a shelter.” (Maarika, refugee Claimant)*

The shelter Maarika found first was a homeless shelter. The structure and services provided at homeless shelters differ greatly from refugee-specific shelters that exist in large cities across Canada. Maarika noted the homeless shelter had a lot of people with addictions and mental health needs, and the focus was providing shelter for an evening; people were not allowed to stay in during the day. The staff at the homeless shelter realized that it was not the most appropriate place for Maarika and arranged to move her to a refugee-specific shelter in the city. Maarika describes the feeling of the refugee-specific shelter she eventually stayed at:

*“So this is the difference – what brings [refugees] to Canada is mostly political issues, or some wars, or some other stuff in their countries...What happens there is they just try to provide you a home feeling. It is a house, it is an old, classic Toronto house...they provide food all the time, there are volunteers to cook your lunch...we would have dinner altogether, it was very nice.” (Maarika, refugee Claimant)*

Maarika explained how settlement workers and volunteers were on hand at the refugee shelter to direct her to anything she may have needed help with, including legal aid for support with her refugee hearing, social workers, help with social assistance or welfare, and running mock hearings to practice. These particular needs would not have been addressed had she remained at the homeless shelter where she first sought assistance.

Amoy also found shelter at a refugee-specific centre, and described further some of the resources that were available where she stayed:

*“My shelter offered everything. They offered the fax machine, they offered the telephone that you could call, they had a computer room that you could use upstairs...they had different classes, they had access to food bank, clothing bank, everything...even now, I could go back to the shelter for support.” (Amoy, refugee Claimant)*

When Leo arrived in Canada, he too was connected to the refugee shelter system, but was put up in a hotel through the shelter, because they were out of beds in their usual space. Leo noted this space exceeded expectations of many people, who had come from less means:

*“There is people who like – they have never seen this kind of life before. There is people we have had in shelter, in this hotel – I don’t want to say shelter, it is not a shelter, it is a hotel. We have also people here that – they have never seen this kind of life before. When they come here, like – ‘wow’.” (Leo, refugee Claimant)*

Refugee-specific shelters seemed to provide well for the needs of refugee participants in this study. The support provided at refugee shelters, similar to refugee health clinics only helps those who are able to find them. One director at a refugee health clinic noted that this process of finding shelter can be very difficult for refugee Claimants compared to other refugees who are more directly provided with resources:

*“GARs are the ‘cream of the crop’ as we call them, because they have the support and the resources....for the first year, and then another agency continues with their support for another year, and some -those are the folks that we find, that they have those supports, but the refugee claimants, they come here and they have to find services, and it is just really diffi[cult].” (Director, Org D)*

Additionally, refugee shelters are intended to fill a gap for refugee Claimants who are awaiting a decision from their refugee hearing. If people are denied at the hearing, it is less likely they will remain in Canada. If they are approved, shelter staff often expect that they will look for more permanent housing. Amoy described understanding this, but wishing it were different. She and her partner were asked by shelter staff to move on after their hearing was complete:

*“[Shelter staff] was pushing us out and we didn’t want to go....but once I am out, I understand because there is a demand for housing, and if I go there, they are shelters. They are not permanent residence, and sometimes we want it to be permanent residence, especially if we find a good shelter.” (Amoy, refugee Claimant).*

Refugee shelters were not the only accommodation available to refugee Claimants. Some participants learned through their own prior research or word of mouth within the refugee newcomer community about an organization that connects refugee Claimants to private supports for a period of time. Individuals in this case are often housed privately by willing homeowners, and a group of volunteers is on hand to help with whatever needs may arise. Faven was supported in this way and described her support group feeling like ‘family’. James and Dani also experienced this support:

*“I can’t imagine without [organization] – we know people that came as refugees and they didn’t have [it], and they say it was very hard for them. It is a different story.”*

*(James, refugee Claimant)*

Regardless of whether support was provided in refugee shelters or privately, many of the individuals in this study reached a point when they needed to find more permanent housing. In these cases, the high cost of housing became a burden for individuals who did not have extensive personal finances, or employment. For example, Spring made an inland claim for refugee status after coming to Canada on a student visa because while in Canada, civil war broke out in her home country. The scholarship she had previously been provided by her home country disappeared because of the war. She was strapped to afford to pay rent, and was on a wait list for social housing that seemed not to be moving:

*“For the system, there is a waiting list. So the waiting list – it didn’t move yet...I want to move out [of condo] because I just pay the child benefit to the rent.” (Spring, refugee Claimant)*

In order to continue to afford the rent on the condo she lived in, she used the child tax benefit she received from the Ontario government.

Amoy painted a picture of what housing costs for her and her partner, with the assistance that they received from the government:

*“The rent in Toronto is \$900 for a bachelor. Okay, 1 bedroom is anything from \$1000, sometimes \$1200. You want to stay as a claimant, you want to stay in Toronto, because that is where the hearing and the places you have to go, right? So you can’t live in Mississauga or Brampton. You have to live in Toronto...Social services for a couple is \$600, \$600 plus dollars, not \$700, for shelter...so please tell me...how are you going to take care of yourself?” (Amoy, refugee Claimant)*

Maarika too, faced the realities of high housing costs after her stay with the refugee shelter ended:

*“I was looking for a little bachelor apartment. I said I need my – I need my privacy, I’m 42 now. I shared a house many years and stayed in the shelter – I want my own. It wasn’t so easy because rents were not so cheap – the cheapest bachelor was \$700 217 square feet...I change my mind, and start to look for a room again.” (Maarika, refugee Claimant)*

The cost of housing kept Maarika sharing rooms in houses with people she had met after arriving in Toronto.

James and Dani were fortunate in that a Canadian homeowner that they met had a house for rent, and offered them the house at a price that James and Dani could afford. They benefited from this personal connection, and the generosity of the homeowners.

Experiences with initial shelter was different across individuals in this study. Some were referred quickly to appropriate shelters, while others went through other organizations, like homeless shelters. Refugee shelters and willing homeowners both provided good support to individuals in this sample, but only as a temporary measure. Market rent costs in certain cities like Toronto are higher than what people can afford with social assistance; moving to a new city during a refugee claim, however, can make for expensive transit costs, and efforts made to build connections in a given neighbourhood are seen by refugee participants as important to maintain. Personal connection was helpful for Maarika in finding housemates to share the cost of rent, and for James and Dani, who were given a home at a price they could afford. Without these options, more drastic measures are required, as demonstrated by Spring who used a child tax benefit from the government to cover her rent.

#### **4.4 Employment**

In addition to shelter, finding employment was a key aspect of settling in Canada for participants in this study. Many participants in this study experienced challenges with employment at some point after arriving in Canada, consistent with barriers described in the literature such as non-recognition of foreign credentials, and low English language ability (Beiser, 2015)

Cameron and Amanda are one example; they were both practicing lawyers in Colombia before coming to Canada, with one of them additionally teaching at a local university. After coming to Canada, their degrees were not formally recognized and so finding work related to their many years of education and experience was impossible. Instead, they both work at a meat packaging plant from 1:30 to 11PM every day. They are fortunate that of their two children, one of them is old enough to stay home with the other after school while they are at work. Adjusting to the physical demands of the work was very challenging for them.

Asha came to Canada through family reunification after her husband was accepted as a refugee in Canada five years prior. Asha described the immense pressure her husband felt to be

able to demonstrate that he could provide for his family, so that the reunification process could occur. He finished a high school degree online and had a desire to continue onto university or college in order to improve his employment chances. Instead, he stopped going to school to find an entry level job. Asha felt that him remaining in school would have been better for her family in the long run:

*“If you don’t go to school, you will not have the best – our future will not be good, you have to have the minimum wage...but if he go to school of course he will have light work, and much income. But because I was in Sudan, he cannot concentrate in that – ‘I have to work, I have to have income to show...’that he can provide me when I am here, so it was very – so he became like at the point of he loose his habit to go to school so finally he decide to drive.” (Asha, family reunification)*

Demonstrating an ability to provide financially for his family was a requirement for family reunification, and so Asha’s husband took work as a long-distance truck driver in an effort to reunite his family. Asha also commented on the irony of him spending many weeks away from his family, even though the goal of this job was to allow them to be together.

James and Dani were encouraged by the private sponsor group that supported them to start engaging in volunteer work as soon as possible, to overcome the requirement for Canadian experience. Even with this advice, Dani has not been able to find work related to her previous experience. Dani used to work in marketing for a private hospital, and now works in retail. Language skills have been a barrier for her in this regard.

Spring and her husband both came to Canada with professional degrees and were looking to continue their education with full funding from a scholarship offered from their home country. When the scholarship was lost due to civil war in their home country, they were unable to stay in school and needed to find work to support their family. Spring has been unable to find work, and her husband has had only short-term contracts, recently as a driver for UPS. Spring describes her frustration with this:

*“Its so hard here – its like they don’t care about you or all the experience that you had, its just if you are raised up here in Canada, you can get all that. I’m sorry for saying that, its just this is the truth.” (Spring, refugee Claimant)*

Maarika was able to eventually find work in her area of expertise, but she received a lot of help from employment support centres and applied to over 150 jobs before being hired as a graphic designer.

Employment is essential for refugees as they need the income to support the cost of living in Canada, particularly after support from shelter systems has ended. As was previously discussed, the cost of housing alone is more than what is often provided by social assistance. At the time of my interview with Leo, he had only recently arrived in Canada as a refugee Claimant. Leo was focused immediately on trying to find work, as he was well aware of the financial pressures his family would soon face even with social assistance support:

*“They will offer us \$1800, \$1700. If the house is \$1500, that leaves two hundred. There is also hydro...water, whatever so with two hundred, I don’t know what to do. To eat myself? To give it for the children?” (Leo, refugee Claimant)*

Employment did not come easily to refugee participants in this study. Some participants found help from formal resources such as employment centers, and others had private sponsors encouraging them to start with volunteering as a way to increase future job chances. Even with advanced international degrees, many jobs available to participants in this sample did not match the work they did before arriving in Canada. For those with limited financial resources or a need to demonstrate financial independence in order to be reunited with direct family members, additional pressures exist to take available work with low pay, instead of pursuing education to increase employment opportunities.

#### **4.5 Conclusion**

Across the various refugee participants in this study, experiences with settling in Canada were varied. The very act of arriving in Canada and the supports that were available in the immediate hours, days and weeks made for different settlement trajectories. Some individuals were met at the airport, while others had harrowing, retraumatizing experiences even after interacting with immigration officials. This appears to be a critical point. Refugee Claimants can be among the most vulnerable of any refugee stream arriving in Canada. Some refugee Claimants in this study arrived without English language ability, personal financial resources, or any personal connection. These individuals relied upon the kindness of strangers to keep them from spending multiple nights sleeping outside. Critically, these individuals all had a point in time where they

were in contact with immigration officials in Canada and remained unconnected to supports. There is an opportunity for the refugee claim intake process with immigration officials to include an analysis of immediate needs like shelter. This would not address the gap for individuals who make an inland claim.

After arriving in Canada, immediate next priorities identified by refugee participants in this study included shelter and employment. Even with financial support being offered from the government, finding appropriate shelter was a difficulty for many participants. While many found temporary shelter either at refugee shelters or in the homes of willing Canadian homeowners, this eventually came to a close. The cost of living in some Canadian cities, including Toronto, is more than what is provided for shelter within social assistance programs. Many participants identified that this challenge could be mitigated with employment. Barriers to employment were difficult to overcome, however, and when work was found, it was rarely related to prior education and experience.

Across these stages of resettlement, differences in both the nature and amount of support can be partially explained by the different refugee streams through which these participants came to be in Canada. Personal assets such as ability to speak English, financial resources, and personal social connections also changed the settlement trajectory of participants in this study. These ideas are explored further in the discussion section of this report.

## Chapter 5: Legal, Immigration and Settlement Systems

### 5.1 Introduction

In the previous two chapters, health and resettlement experiences of refugee newcomers in Canada were explored. Experiences of refugee resettlement occur within the broader context of legal, immigration, and settlement systems in Canada. Many participants in this study had experiences with one or more of these systems that affected their resettlement. Taking a system lens, this chapter explores experiences related to the refugee determination hearing, family reunification through the immigration system, and the formal settlement supports provided by the Government of Canada.

### 5.2 Legal System: Refugee Determination Hearing

In Canada, refugee Claimants must go through a refugee determination hearing as a part of their claim for refuge. This process does not apply to other refugees who have been given a refugee designation from the UNHCR prior to arriving in Canada. For many participants in this study who came to Canada as refugee Claimants, the process of going through this refugee determination hearing took up to a year to be completed. The director at organization A noted a connection between refugee determination hearings and health:

*“What happens often is in terms of those mental health struggles, in those first few months are a tremendous challenge. Once they are accepted a lot of those headaches go away and the back pain eases. Then sometimes there’s that secondary challenge where recognizing that you do have some sense of permanency in a place but there are those other challenges, how do you find a place, how do you find a job?” (Director, Org A)*

The director at Organization A notes that there can be physical health challenges that accompany the stress and uncertainty prior to a decision from the refugee determination hearing. This quote also suggests that it is difficult for refugee Claimants to attend to aspects of resettling in Canada, such as finding a house or a job with such an important decision pending. The stress involved with going through a refugee determination hearing was articulated by many refugee Claimant participants in this study, including Tom:

*“Its actually stressing. I don’t want to worry, but this [hearing] is something that we have to go through, you know? You have to go through, you are not going to dodge, to go around, you know you have to go through. It is a bit stressing – sometimes you have these bad dreams, you have -we come from countries with issues, you know? So when you come here there is that freedom, that freedom and I am really grateful, but then you have to go through this hearing. You just have to be strong – you have to go.” (Tom, refugee Claimant)*

James and Dani also shared the stress of going through a hearing process. James attributed health problems they experienced to this stress:

*“It was very hard before the hearing. I lost my voice, I remember I lost my voice the day before – I can’t even talk! That never happened before for me, and it never happen again – just that day. And Dani gets very, very sick. I guess it was all the stress.” (James, refugee Claimant)*

Hearings can be even more stressful when they are accompanied by delays. Many participants received an initial date for their hearing, only to be told as the date approached that it had been pushed back. Before her initial hearing date, Spring felt her life could not start until after the hearing. Upon being given notice of delay, she decided she could no longer wait to start her life in Canada:

*“So last year, I stop everything – I am jut waiting, but now I live my day. I am not going to wait anything – who knows, I am going to be alive for tomorrow or not? So I just enjoy my moment with my kids, with my husband, with my neighbours, with my friends, with my community – lovely community, so I enjoy every single thing.” (Spring, refugee Claimant)*

Waiting for a positive decision for a hearing may mean putting life on hold for many months; by contrast, receiving a negative decision after making conscious efforts to settle in a neighbourhood or a community may be even more difficult. Either way, the process is immensely challenging. Amoy described it in relation to holding one’s breath, in that she was “waiting to exhale” (Amoy, refugee Claimant).

Central to the refugee determination process are immigration lawyers, who represent clients at their refugee determination hearing. The quality of the relationship between refugee Claimant and lawyer can be another source of mental health distress. Leo and Maria came as

claimants and were provided a lawyer through legal aid. The initial meeting with the lawyer did not go well, and Leo explained the significance of this relationship:

*“When you don’t have good communication with somebody, like – its very difficult to explain it...if you don’t have really good communication with your teacher, I assume maybe you have, or know sometime – its totally different. When you have...when it – that is belongs to your life, belong to your future, when you don’t have good communication with somebody, then who can help you with how to sur[vive]?” (Leo, refugee Claimant)*

There are some options for refugee Claimants to appeal if their initial claim is denied in a refugee determination hearing. Challenges with lawyers can persist with appeals; participants noted often lawyers who help with an initial case do not assist with appeals. Amoy had her initial claim denied and had to go through an appeal that was not covered at that time by Legal Aid. She was required to come up with \$5800 herself. This has since changed since, as she went through the system a number of years ago, but she has heard anecdotally that some lawyers feel the compensation for appeals covered by legal aid is not sufficient and so they will either not take the case, or will demand additional cash. A refugee lawyer interviewed for this study, Luke, confirmed that legal aid does cover some appeals based on the evidence for appeal, at their own discretion. Some individuals may still need to pay out of pocket if they feel they have valid grounds for appeal, and legal aid has denied funding. Lawyers who work within the legal aid system are required to have a certificate for work with legal aid, and work under the restrictions of this certificate that includes fees. According to Luke, lawyers therefore accept the fees provided by legal aid, or choose to charge personal fees, but they cannot do both.

Adding to the complexity of the hearing process is the multiple ways in which a refugee Claimant came to be in Canada. Individuals either make claims at a port of entry (airport or border), or at an inland immigration office. Forms documenting specific details about the reason for the refugee claim are required in either case; these forms are used as evidence in the refugee determination hearing. Luke clarified the differences between port of entry and inland claims. With a port of entry claim, individuals fill out forms with an immigration officer immediately. This is sometimes done in open spaces, or in queues where many strangers could be within earshot. People are not always comfortable sharing details of their trauma in such spaces. In addition, in-person interpreters are not always available, or if they are, they may not be able to

understand certain specific dialects. Over-the phone interpreters are then used, with details about the refugee claim communicated in a three-way conversation over a phone.

Some refugee Claimants may be less than 24 hours removed from very traumatic situations. They may have travelled far distances on foot and are often exhausted. The importance of the information being communicated is not always impressed upon or understood by refugee Claimants; yet any discrepancies between information communicated to an immigration officer at this time and other documents or evidence required for the determination hearing can be used to discredit the claim. Lawyers are not present for this process. For individuals who make a port-of-entry claim, there are strict timelines for additional documentation and evidence. Individuals must submit supplementary materials within 15 days of presenting to an immigration officer. They are, however, eligible for health insurance and social assistance immediately.

Individuals who make an inland claim by contrast have some advantages over those who make a port of entry claim. First and foremost, forms can be filled out with the assistance of a refugee lawyer. The importance of getting details correct can be impressed upon the client. An in-person interpreter can be arranged with knowledge of regional dialects. The forms can be filled out in a quiet, private space after the claimant has had time to reset and prepare. The same 15 day time limit does not apply, as the individual can choose to submit forms when they have supporting documentation ready.

Making an inland claim may be preferable in many ways, however, it is not always available to individuals seeking refuge. To make an inland claim, the individual will have had to enter Canada first through other means, such as a student or work visa, or through being smuggled into the country. Often the participants in this study did not know the differences between inland or port of entry claims to make an informed decision. Even if they did, much was dependent upon the options available to them in entering Canada. According to Luke, those who made an inland claim often experience a delay between presenting to an inland immigration office and receiving health insurance and social assistance. This may be significant for someone who has urgent health needs. These legal systems impact the settlement trajectories of refugee newcomers as they begin life in Canada.

### 5.3 Settlement Systems

From a systems perspective, a significant difference is also seen in the amount and nature of resettlement supports from the government of Canada across the different refugee streams. Generally, the government provides supports under two programs. The first, called the Resettlement Assistance Program is provided for those individuals who have a UNHCR refugee designation prior to coming to Canada (GSR, PSR, BVOR, JAS). Under this program, resettled refugees receive financial support for a year or until they are able to support themselves. Additional supports include meeting the refugee newcomers at the airport, finding shelter, assessing needs, providing information about Canada, and connecting to settlement services. The other main program, called the Settlement Program, is open to immigrants, UNHCR refugees, and refugee claimants. This program is operated in partnership with provinces, territories, and other service providing organizations. Services provided include assessing settlement needs, linking newcomers to services in the community, English or French language training, help with employment, and introduction to life in Canada. Access to these settlement services continues until the individual becomes a citizen in Canada (Government of Canada, 2017).

Refugee Claimants can receive formal government support through the Settlement program, but not through the Resettlement Assistance Program; UNHCR refugees could receive support from both programs. In the very way the settlement system is set up, less support is available for refugee Claimants from the government.

Two participants in this sample, Chris and Karen, were involved in sponsoring a family who came through the JAS program. The theory behind the JAS program is to combine formal supports typically allotted by the government of Canada to GSRs, with the somewhat more personal or flexible support provided through private sponsorship for a certain refugees, as described by Karen:

*“The scope of what is considered a JAS case is very broad – so the [ family] is very unique, because of how high the medical needs are- all JAS cases don’t always have as high of medical needs. Sometimes JAS cases are put into that category because they are a large number of members in a family, so a family of 14 for example, will be put into JAS because they recognize that their reception centres won’t have the capacity to support*

*that large of a family – also for trauma based on violence or torture, and then medical disabilities, so its spectrum.” (Karen, settlement worker)*

Instead of benefiting from both systems, however, the family that Chris and Karen were involved in sponsoring seemed to be falling through the cracks. Chris described misinformation among various players involved in settlement:

*“The problem is multisectoral...so Immigration Canada, I don’t think they are fully bought into yet – they’ve increased the money provided to families, I think, like this, but they still are kind of directing the social support worker to be more hands off, which is not what you get in a government sponsor situation. I think there is still confusion. And then you go and talk to health care professionals, and they don’t know what this is – they don’t understand...and then you apply for, I don’t know – incontinence supplies, and ‘no, no you’re privately sponsored, and you don’t get this’ ...there is a shocking amount of poor information, misinformation, inaccurate information in the different touch points of the health care and social services organizations.” (Chris, private sponsor)*

The way that this family came to Canada, through the JAS program, adversely impacted the supports that were available to them upon arrival.

There were no formal PSRs in this study, however, directors at refugee clinics noted that the experience of a PSR is related to the amount of support the group is able to provide. This can result in either good support, or very little support at all:

*“We recognize that a lot of the sponsors – they obviously don’t have the resources like an agency, who is funded to take care of the government assisted refugees, where you have a worker, a social worker, an intensive case worker.” (Director, Org D)*

The different streams for refugees in Canada are inherently set up with differing amounts and quality of support. Participants in this study note that some refugee newcomers will experience more and/or better support than others; this is partially due to the structure of these various refugee streams.

## **5.4 Immigration Systems**

The literature review for this thesis explored the meaning given to the word “refugee”, including that formal processes that are required to meet the definition of refugee put forward by the

UNHCR. There are individuals who fall outside this formal definition but who have similar circumstances and needs as these official refugees.

One participant in this study, Asha, did not come through any of the streams normally available to refugees, and instead came through an immigration process of family reunification. The Government of Canada would, therefore not consider Asha to be a refugee. This meant Asha was not provided with any of the usual supports for refugee newcomers. Asha ascribed the term refugee to herself, having come to join her husband who was a privately sponsored refugee five-years prior.

Immigration systems impacted Asha's experience. Asha believes that the five-year delay that prevented her and her children from being able to join her husband was influenced in part by a clerical error made when her husband entered the country:

*"I think at the beginning it was a language barrier that my husband had, so, we got married and then he came. He informed at the airport that he got married, he is not anymore single, and then he showed the person who was on duty in that day...she saw the marriage certificate, she saw some wedding photos, and then she said, 'oh its okay, you will apply when you settle'. But she give him a paper to sign, and he sign a paper that says single...so that was the main cause of the problem that it took very long." (Asha, family reunification)*

The immigration system significantly disrupted Asha and her family. The sampling approach for this study did not include seeking out individuals like Asha. However, it is important to note that this as an example of non-traditional and unrecognized way that individuals may come to be in Canada. The immigration system, even separate from the particular refugee streams, can have an impact on the experiences of refugee newcomers.

## **5.5 Conclusion**

The settlement system in Canada is designed in such a way that available supports and the settlement experience differs greatly across different refugee categories; only refugee Claimants have to go through a refugee determination hearing in Canada. For many in this category, life is on hold until they know the result of their hearing. Whether people make a claim at airports or inland changes the deadlines for key documents and influences whether a lawyer is present to clarify key information used in the hearing. Wait times for this process vary greatly; some people

in this study experienced relatively short waiting periods of two months, while others had a hearing over a year after arriving in Canada. Relationships with lawyers, and financial resources to support an appeal process are other factors that put some people at a relative advantage over others.

Individuals who arrive as GSRs, PSRs, or JAS also have very different experiences. Privately sponsored refugees' experiences depend immensely on the resources of the group that has agreed to sponsor them. JAS refugees fall somewhere in between GSR and PSR, and this means many health providers and other resettlement workers are unsure what supports they are entitled to. Privately sponsored refugees with well resourced support groups, and government sponsored refugees with clearly defined settlement entitlements appear to benefit more than refugee Claimants, JAS refugees, and those who come to Canada through other unconventional means.

## **Chapter 6: Discussion and Conclusion**

### **6.1 Introduction**

In the preceding chapters, various aspects of refugee resettlement have been considered including the experiences of refugee newcomers with health care services, settlement systems, and various resettlement supports. In this discussion, key knowledge gained across this research is identified. Previous researchers have considered refugee resettlement in a stage-based model. Findings from this research are used to build upon a model for refugee resettlement previously proposed by Diane Drachman in 1992. First, this stage-based approach proposed by Drachman is introduced. Areas where findings from this research affirm Drachman's model are identified in addition to findings that require the model to change. Updates to Drachman's model are proposed first in the form of overarching variables that supersede specific stages, followed by updates that are stage-specific. Finally, strengths and limitations of this research are considered along with areas for future research.

### **6.2 Stage-based Approach**

When considering complex processes, some researchers have proposed the use of a time-based, or stage-based approach. This strategy has proven useful when a situation is dynamic and one policy or one solution does not fit. For example, this approach has been used in the field of return to work. Researchers found that breaking the return to work process down into various phases helped to demonstrate how the needs of various actors shifted over time. In addition, this approach highlighted how across participants in the study, there was not one demonstrative pathway of how return to work occurred. Instead, there were many possible pathways across the various stages (Tjulin, MacEachen, & Ekberg, 2010).

Refugee resettlement can certainly be considered a complex, dynamic process. Similar to what was observed in the return to work study cited above, there was not one demonstrative experience across participants in this study with regard to refugee resettlement in Canada. Few researchers in the field of refugee resettlement have applied the idea of a time or stage-based approach in their work. Richmond & Shields (2005) offer one example in a study where they

critically examined the Canadian settlement system. Three stages were proposed; an initial stage including arrival, language training and short-term shelter; a middle stage, including longer term access to meaningful employment, housing and education; and a final stage, characterized by a sense of belonging or attachment to Canada. This research highlighted the importance of considering settlement in Canada as a life-long process (Richmond & Shields, 2005).

Diane Drachman is another researcher who proposed a stage-based approach to refugee resettlement in 1992. Drachman described three key stages: pre-migration and departure, transit, and resettlement. Importantly, Drachman included a number of critical variables within each of these stages that influence settlement trajectories and needs of refugees over time. Drachman’s suggested phases and critical variables are shown below, in Table 3.

Table 3: Stage-of-Migration Framework

Stage of Migration	Critical Variables
Pre-migration and Departure	Social, political, and economic factors Separation from family and friends Decisions regarding who leaves and who is left behind Act of leaving a familiar environment Life-threatening circumstances Experiences of violence Loss of significant others
Transit	Perilous or safe journey of short or long duration Refugee camp or detention centre stay of short or long duration Act of awaiting a foreign country’s decision regarding final relocation Immediate and final relocation or long wait before final relocation Loss of significant others
Resettlement	Cultural issues Reception from host country Opportunity structure of host country Discrepancy between expectations and reality Degree of cumulative stress throughout migration process

*Note.* Reproduced from Drachman, D. (1992). A stage-of-migration framework for service to immigrant populations. *Social Work (United States)*, 37(1), 68–72. <http://doi.org/10.1093/sw/37.1.68>

Importantly, Drachman included a number of other variables that both interact with and influence the experience of refugee migration, across these stages. These included age, family composition, socioeconomic status, education, culture, occupation, rural or urban backgrounds, belief systems, and social supports (Drachman, 1992). These variables are referred to as overarching variables for this thesis.

Drachman's model is the only one known to the researcher that uses a stage-based approach, combined with both critical stage-based variables, and overarching variables. This model provides a useful starting point to consider what factors impact refugee resettlement, and in what ways.

The present study addresses two of Drachman's stages: transit and resettlement. It did not capture pre-migration or departure, as it had a focus on experiences of refugee newcomers only after arriving to Canada. Therefore, this discussion only refers to these final two stages. In many ways, results from this study affirm the stages and many of the critical variables put forward by Drachman in Table 3 above. For example, participants who came to Canada as refugee Claimants experienced stress and anxiety while awaiting the results of their refugee determination hearing; this aligns with the act of awaiting a foreign country's decision regarding final relocation noted above in 'Transit'. In 'Resettlement', Drachman includes consideration of the opportunity structure of the host country. Participants encountered this in many ways, including challenges finding meaningful employment due to their lack of Canadian experience, or non-recognition of foreign credentials. Culture is also listed as a critical variable during the resettlement stage. This was well evidenced by study participants in relation to health care. Refugee participants cited many times their cultural background influenced the experiences they had seeking health care, including the expectation for small talk to precede discussing the reason for a doctor visit, and expectations about prescription medications.

Some of the overarching variables articulated by Drachman were also affirmed by results from this research. Socioeconomic status, as an example, made for very different initial arrival experiences for Amoy and Tom. While both arrived at an airport, Amoy had sufficient financial resources to afford a hotel and a taxi cab for her first night in Canada. By contrast, Tom had limited financial resources, and spent his first night sleeping outdoors. Social supports as another example, were highlighted by the arrival experiences of Maarika, James and Dani, and Leo and Maria. All of these individuals had friends or family nearby who allowed them to stay in their

homes for a few nights after arriving in Canada, instead of sleeping outdoors. Social supports were further influential for James and Dani when finding housing, as a member of their newly formed social network offered them a home at a price they could afford. Other overarching variables put forward by Drachman did not emerge within this study as significant for settlement trajectories. These included rural or urban background, age, family composition, belief systems, education and occupation. It is likely that the education and occupation variables would be more influential in Canada if the opportunity structure differed in terms of employment for refugee newcomers. Individuals in this study with extensive prior education, such as Cameron and Amanda who were previously practicing lawyers, were unable to find work in their field. All of the participants in this study were of a similar age, and family composition and belief systems were not a specific point of inquiry.

### **6.3 Overarching Variables**

Findings from this study suggest there are critical and overarching variables relevant for refugee resettlement that were not identified in Drachman's model. First, overarching variables that transcend specific stages of migration found in this research are addressed. These include refugee stream and health status.

#### **6.3.1 Refugee Stream**

As noted in previous sections of this thesis, there are different refugee streams by which someone seeking refuge can enter Canada. A novel finding of this study is how the settlement trajectory and supports available to newcomers as they settle in Canada is affected by the structural design of these various streams. Much of the previous literature groups refugee newcomers into analysis with other immigrants (Batista et al., 2016; Fuller-Thomson, Noack, & Usha, 2011; George, 2002; Lum, Swartz, & Kwan, 2016). However, the factors sparking migration between refugees and immigrant newcomers are immensely different. Social support and/or personal socioeconomic resources prior to entering the country are required of immigrants for entry in the family or economic class. This, too, represents a major difference between refugee and immigrant newcomers. It is reasonable then to question whether the analytical grouping of refugees and immigrants into the same category is appropriate.

In recent years, a growing body of literature has begun to separate refugees and immigrants. In some cases, research has also further analytically focused on the experiences of refugees based on the refugee stream through which they entered Canada (Hyndman, D'Addario, & Stevens, 2014; Newbold et al., 2013). This study affirms that consideration of refugee stream, at least in the current resettlement system in Canada is relevant to refugee resettlement experiences.

Evidence of how refugee stream matters for health and other settlement activities across multiple stages of migration were found within this present study. First, examples related to the stage of transit are considered. One of the critical variables under transit is the nature of the journey from country of origin to country of resettlement. Drachman considers it an important factors whether the journey was safe or perilous, and the journey duration. Those who arrive with refugee status pre-determined by the UNHCR arrive from refugee camps having already been displaced from their countries of origin. This likely means the duration from leaving initial country of origin to arrival in Canada is quite significant. Refugee Claimants can have multiple paths to arriving in Canada, but as noted by an immigration lawyer participant in this study, some can arrive less than 24 hours removed from violent or otherwise traumatic experiences. This immediacy is not observed with UNHCR refugees.

Drachman also considers the possibility of detention in the stage of 'transit'. Some refugee Claimants are smuggled into Canada and may also experience a period of detention after arriving; this is not the case for UNHCR refugees. In addition, Drachman poses the timing around decisions from a host country about final resettlement, and the possibility of relocation to be critical variables at this stage. Only refugee Claimants have to await results of a refugee determination hearing to determine whether they will be allowed to remain in the country. Some participants in this sample waited over a year for this decision, and this meant immense prolonged stress. Stream of refugee, therefore, impacts settlement trajectories within the 'transit' stage.

The impact of refugee stream can also be seen in the 'resettlement' stage. Crucially, Drachman notes that the reception of a host country towards refugee newcomers is critical at the time of resettlement. Support from the Canadian public about immigration and refugee resettlement seems to wax and wane over time (Wilkes, Guppy, & Farris, 2008). When tensions are high, it is often the refugee Claimant stream that is a target. As documented in the literature

review, refugee Claimants have been portrayed by as ‘bogus’ or ‘queue-jumpers’. There is often a public perception that refugee Claimants have less legitimacy than refugees coming from other streams (Hyndman et al., 2014). Stream, therefore, may play a role in the reception from a host country.

Also included in the ‘resettlement’ stream is a critical variable related to the opportunity structure present in a host country. Findings from this research show that available supports differ across refugee streams, and therefore, it is likely that opportunity also differs. JAS cases, as an example, are meant to combine supports from government and private sponsorship, but in practice, conflicts over who is responsible leaves JAS refugees with no supports. Directors at some refugee health clinics described GSRs as the ‘cream of the crop’, due to the formal supports they receive during their first year in Canada. The experience of PSR refugees depends immensely on the quality of the private sponsorship group that supports them, and the relationship they form with this group. Refugee Claimants are not eligible for many of the supports provided to UNHCR refugees, and therefore likely have limited opportunities. The refugee stream through which someone enters Canada continues to have an effect on the longer-term process of resettling.

In considering refugee stream, this study also finds that the distinction between immigrants and refugees, and between the different refugee streams is not always clear cut. Two individuals in this study, Spring and Asha had experiences of arriving in Canada that do not fit well into the categories previously defined. On paper, Spring would fall under the category of ‘refugee Claimant’, as she made a claim from within Canada. Her arrival in Canada was initially as an international student, however, and she had been living in the country for some time before circumstances changed that required her to make a claim for refugee status. Refugee claimants include people, like Spring, who may have been in Canada for some time prior to making a claim. Therefore, within the stream of refugee Claimant, significant variability exists.

Asha technically came to Canada under the immigration category of family reunification. Her husband, however, came to Canada five years prior as a privately sponsored refugee. Asha’s husband was still in the process of resettling in Canada when Asha arrived. Asha describes herself and her experience in Canada as that of a refugee, and she received some support from refugee support organizations that had also helped her husband when he arrived. Asha would not fall under any of the refugee streams offered in Canada, and yet her experience after arrival

would likely more closely resemble that of a refugee than that of an immigrant. Immigration categories may, therefore, also be relevant to consider here.

Findings from this research reveal that across the stages of ‘transit’ and ‘resettlement’ the stream of refugee could be considered alongside other overarching variables that impact refugee resettlement trajectories in Canada.

### **6.3.2 Health Status**

Health status was not explicitly considered within Drachman’s framework, either as a critical or overarching variable. Some evidence from this study suggests that health status could be another overarching variable, having an effect across multiple stages of resettlement.

Mental health was a key topic discussed by refugee participants during their resettlement in Canada. The period of resettlement may be where refugee newcomers are most likely to address or seek help for mental health needs, however, the experiences that contribute to the need for mental health services begin with pre-migration and departure. Refugee participants in this study shared experiences of poor mental health. Amoy, as an example, decided to seek help when bad dreams prevented her from getting sufficient sleep. Stress around refugee hearing claims resulted in James losing his voice right before his initial refugee determination hearing. Drachman does include a critical variable that relates to mental health in her description of the ‘resettlement’ stage; degree of cumulative stress. This implies stress was ‘accumulated’ throughout earlier stages of migration.

Physical health could also impact the trajectory of resettlement. Manesh, who came through the WUSC program, missed an important week of orientation to his new school campus and life in Canada when he fell ill with malaria. Not many participants in this sample had experienced a significant physical health event after arriving in Canada, but this may actually be indicative of the ways that health status can be a barrier for some refugee Claimants in migration. People who were experiencing significant health challenges may not have made it as far as Canada to resettle. Further research could examine the impact of poor health on migration opportunity and success.

Significant health needs, either physical or mental, could change the trajectory of refugee resettlement at any stage. Falling ill may mean an inability to travel to a new country in the first

place, or an inability to begin the process of resettlement. Health status, therefore, may be another appropriate overarching variable to consider in a framework of refugee resettlement.

## **6.4 Critical Variables**

In addition to refugee stream and health status being relevant overarching variables, findings from this research suggest that there are some additional critical variables that fit under the stages of ‘transit’ and ‘resettlement’. A novel finding of this research is the arrival experiences of refugee newcomers in Canada. To the best knowledge of the researcher, there is limited prior research highlighting experiences of refugees in the immediate hours and days after arriving in Canada. Participants in this sample had significantly different experiences in this domain; a stage-based approach, along with critical variables helps to explain why this may be the case. Evidence from this study suggests expansion of the ‘transit’ stage to include arrival in the host country. This section explores critical variables that fit under a newly defined ‘transit and arrival’ stage, followed by an additional critical variable to be added to the ‘resettlement’ stage.

### **6.4.1 Transit and Arrival Stage**

Drachman previously articulated a number of variables critical in a ‘transit’ stage of refugee migration. Between ‘transit’ and ‘resettlement’, however, there is the act of arriving in Canada. Across this study, the length of time between initial arrival in Canada and connection to formal supports made for different settlement trajectories. For some, this period contained significant re-traumatizing experiences, such as those of Faven and Tom.

Findings suggest that an expanded ‘transit and arrival’ stage may better explain settlement experiences, with the following additional critical variables: presence or absence of prior knowledge, nature of certain assets (friends or family, personal financial resources and language), and length of time between arrival and connection to formal resettlement supports. Each of these are addressed below.

#### **6.4.1.1 Prior Knowledge**

One of the ways that participants in this study had different experiences arriving in Canada was related to prior knowledge. This was especially true for those who came through the refugee Claimant stream. An immigration lawyer highlighted that there are subtle differences in how the

refugee determination process occurs, depending on whether the claim is initiated at a Port of Entry, or at an inland immigration office. Individuals who are privy to this information prior to making a claim in Canada may be able to make a more informed decision about which of these options is best for them. In many cases, however, it seems this information is often not available. Tom didn't know that making a claim at the airport was a possibility when he entered Canada with the intention of making a refugee claim. Cameron and Amanda, by contrast, had done prior research to learn of an organization known to help refugee Claimants. After arriving in Canada, they were able to proceed directly to this organization for assistance from that point onward. Prior knowledge, therefore, impacted arrival experiences.

#### 6.4.1.2 Assets

Another way to describe the difference in arrival experiences across refugee participants in this study is to consider the presence or absence of certain assets: language ability, friends or family, and personal financial resources. Faven's story of arrival represents a case where none of these assets were present. Her initial arrival in Canada as a result, was re-traumatizing. She relied on a series of strangers for support in a harrowing journey across two Canadian provinces in the winter with her two young children in tow. In contrast, Amoy had language ability and personal resources; her initial arrival included asking for help from immigration officers, and spending her first night in a hotel. Maarika and others had friends or family who hosted them for their initial nights in Canada.

The presence or absence of these critical assets can immensely impact resettlement trajectories. Individuals who have none of these assets and come as refugee Claimants can face significant hardship in the immediate hours and days after arriving in Canada. Language ability in particular has been cited in previous research as a significant determinant of wellbeing for refugee newcomers (El-Bialy & Mulay, 2015).

#### 6.4.1.3 Pre-support gap

A third critical variable to consider under the stage of 'transit and arrival', is that of the pre-support gap. All refugee participants in this study were connected to formal resettlement supports relatively quickly after arriving in Canada. Some, such as Cabdi and Manesh as part of the WUSC program, were met at the airport by a committee that would support them for their first

year in Canada. For these refugee newcomers, the gap between arriving and formal support was non-existent.

Tom and Faven experienced a delay of a couple days in their arrival. Walking ill-prepared in the winter for Faven and sleeping outdoors for Tom in these critical first few days could have had implications for health and safety; a delay of even a few days can be significant. Maarika had a friend to stay with for her first few nights. In looking for a longer-term solution, Maarika initially went to a homeless shelter. This shelter did not have the right kind of supports for Maarika in filling out her claim for refugee status. Maarika was helped by the homeless shelter in finding a spot at a refugee-specific centre; this occurred about a week after her arrival in Canada. Making a claim for refugee status can come with very particular, short timelines. Delays like this could make a significant difference in the ability of a refugee Claimant to be successful in their refugee determination hearing.

Connection to formal refugee support services is another critical point in the trajectory of refugee newcomers. Formal supports in this case is being used very broadly. This may be not-for-profit refugee supporting organizations, government sponsored programming, or the private sponsorship group or committee found for PSRs, BVORs, JAS and WUSC refugees. Connection to some form of support sooner likely improves the resettlement trajectory for newcomers.

### **6.4.2 Resettlement Stage**

This study also suggests an additional critical variable for the ‘Resettlement’ Stage. Drachman poses the following critical variables as impacting longer term refugee resettlement: cultural issues, reception from host country, opportunity structure of host country, discrepancy between expectations and reality, and degree of cumulative stress throughout the migration process. Experiences from refugee newcomers in this study suggest that access to, and quality of resettlement supports are also critical considerations during the stage of resettlement.

#### **6.4.2.1 Access and Quality of Supports**

A recent report examined the structure of the supports available to both refugee and immigrant newcomers across Canada (Shields & Praznik, 2018). This report highlighted the complexity of the settlement system in Canada. The complexity begins with considering the many types of supports that overlap with newcomer resettlement, including but not limited to the following:

information and orientation services, employment related services, language services, health services, housing services, and community connection services. The types of providers for this broad range of services is also varied and included non-profit organizations, provincial governments, municipal governments, and school boards. In some cases, many supports were provided within the same organization. In other cases, organizations focused only on one type of support. Further, eligibility criteria differed across these various supporting organizations. Some were available only to UNHCR refugees, others were based on certain ethnic groups, and still others were based on home address (Shields & Praznik, 2018).

Participants in this research study had experiences with support from many of the different types cited above. Faven, Cabdi, Manesh, James, Dani, Cameron and Amanda all received support from a non-government, non-profit agency aimed specifically at helping refugee Claimants. Amoy, Tom and Maarika stayed in non-government refugee shelters. Chris and Karen represented a government-private partnership through the JAS program. The following table, Table 4, highlights some of the diversity of supports cited by participants in this study.

Table 4: Supports cited by refugee newcomers

<b>Category</b>	<b>Includes</b>
Social Networks	Friends, family, strangers, private sponsors
Non-profit organizations	Community centres, employment centres, shelters, immigrant and refugee supporting organizations
Religious organizations	Various churches and church-affiliated charities
Government organizations	Schools, immigration offices, some refugee shelters
Other	Health clinics, lawyers

There are a large number of supports in Canada for refugee newcomers, and participants in this study had received help from a variety of places. Accessing these supports was not always easy, partially due to misinformation and the different eligibility criteria of the various organizations. Refugee health clinics were one source of support cited in this study; they provide a case study to examine issues of access and quality.

A novel contribution of this research is the description of the structure and practices at these specialized refugee health clinics. Health needs articulated by refugee participants were

well matched by services and polices described by refugee health clinic directors. Clinics had translation available, provided orientation to the Canadian health care system, tried to help facilitate connection to other supports as necessary, and were flexible in both setting up of appointments and length of appointments for refugee patients. Patients who were able to access services at these clinics spoke highly of them. These elements of care are supported by previous research that speculated on what excellent care for refugee newcomers could look like (Grove & Zwi, 2006). Further research is needed, however, to examine whether these specialized clinics result in better long-term health outcomes. Some evidence from this study suggests that they may be better suited to meeting the needs of refugee patients than other health supports. Refugee participants in this study provided examples of how culture and language barriers at non-refugee-specific health clinics prevented excellent care; Faven took treatment into her own hands in removing her daughter's tooth, as an example. Faven also added some patients may withhold important health information when they are not made to feel comfortable in a health setting.

Refugee health clinics appear to be providing high quality support and are working at removing barriers for refugee newcomers in accessing health services. Even among these clinics, however, access to services was not ubiquitous. Refugee health clinics appear to be situated in geographic locations with a large population; newcomers in smaller cities or towns would not have access to this refugee-specific health care. Sometimes, access was prevented due to lack of knowledge; many participants in the study were not aware of refugee-specific health care options. For clinics themselves, capacity and financial resources were another barrier to access. Many of the refugee health clinics did not have secure and ongoing funding. They sought to see any patient who came seeking help regardless of formal insurance coverage, but this meant relying upon many volunteers including physicians to donate time. Some clinics had a set budget provided for interpretation: if this budget was exceeded, cuts needed to be made in other care areas in order to be able to continue to communicate with patients.

If refugees have access to high quality supports during resettlement such as services like refugee health clinics, it is likely these supports will have a positive impact on long-term wellbeing, and settlement success. Findings from this study suggest this could be considered a critical variable in refugee resettlement. The complexity of the settlement system in Canada makes it difficult to evaluate the impact of any one of these supportive services in relation to long-term refugee resettlement success. The complexity also highlights how misinformation and

inequalities within settlement supports can develop. Further research could examine the access and quality of other resettlement supports available within the current Canadian system.

### 6.5 Towards a New Canadian Framework for Refugee Resettlement

To this end, an updated stage-based Canadian framework for refugee resettlement, based on work initially put forward by Diane Drachman is proposed in Figure 1, below. An \* denotes variables added as a result of this research.

Figure 1: A Canadian Framework for Refugee Resettlement

Stage	Critical Variables
<b>Transit and Arrival*</b>	Perilous or safe journey of short or long duration Refugee camp or detention centre stay of short or long duration Act of awaiting a foreign country’s decision regarding final relocation Immediate and final relocation or long wait before final relocation Loss of significant others Ability to research host country resettlement ahead of time* Presence or absence of certain assets: * <ul style="list-style-type: none"> <li>• English or French language ability</li> <li>• Personal financial resources</li> <li>• Friends or family in country of resettlement</li> </ul> Length of time between arrival and connection to formal supports*
<b>Resettlement</b>	Cultural issues Reception from host country Opportunity structure of host country Discrepancy between expectations and reality Degree of cumulative stress throughout migration process Access and quality of resettlement supports in host country*

Drachman also indicated a number of overarching variables that affect settlement across all resettlement stages. These have been re-organized into categories, with additions from this research indicated with an\* in Table 5, below.

Table 5: Overarching Variables

Personal Factors	Background	Social Factors	Structural Factors
Age Family composition Socio-economic status Health Status*	Education Occupation Rural or urban background	Belief systems Social supports Culture	Refugee stream*

The Government of Canada cites humanitarianism as the reason for their refugee resettlement programs (Government of Canada, 2018b). If humanitarianism is the intent, it follows that successful resettlement of refugee newcomers in Canada would be a primary goal of resettlement programs.

There is some previous academic literature that affirms some of the variables proposed by findings from this study. A 2010 study examining the experiences of refugee Claimants in both London and Toronto, Ontario similarly found refugee Claimants to have different arrival experiences than other refugee streams. The study author highlighted that refugee Claimants had to compete with other immigrant classes and Canadians for limited resources, and found that refugee Claimants were largely left to fend for themselves during the determination of their refugee claim (Kissoon, 2010). A study examining pathways to housing for refugees in Toronto, Ontario found that refugees who had come through a sponsorship program, either government or private, found permanent housing faster than refugee claimants. The authors suggested this was due to larger social networks (Murdie, 2008). This affirms the notion that refugee stream is likely to impact an individual’s resettlement trajectory.

Another study exploring refugee Claimants search for home and shelter in Toronto, Ontario found similar examples of a gap between arriving in Canada and being connected to formal supports. To this end, authors suggested implementation of an ‘Arrive Right’ program at all ports of entry to ensure appropriate information and connection to supports occurred for every refugee claimant very shortly after arriving in Canada (Ryan & Woodill, 2000). This affirms the critical variable proposed by this study, length of time between arrival and connection to formal supports. If the Arrive Right program were to be implemented across Canada, refugee claimants would be connected to supports in a similar amount of time as other refugee streams; that is, immediately after arrival to Canada. Another initiative that has been proposed is the Red Cross ‘First Contact’ Program. Through this program, refugee claimants can call a Red Cross hotline

for information at any time, offered in a variety of languages (Murdie, 2008). This program has been in place since 2002 but was not cited by any of the participants in this study.

## **6.6 Global Perspective**

This study takes a critical approach in evaluating experiences of refugees resettling in Canada. There are many aspects of refugee resettlement that Canada appears to support well; all of the participants in this study had either received supports or were involved in providing supports to refugee newcomers. A critical approach allows for recognition of these successes and opportunities for improvement.

Often, Canada is recognized for its refugee resettlement programs internationally. A 2015 article in the *Globe and Mail* evaluated Canada's refugee resettlement based on numbers. This analysis showed that on a per-capita basis, Canada was near the top of countries worldwide in terms of refugee resettlement (Ibbitson, 2015). An Amnesty International survey showed Canada ranked 8<sup>th</sup> in the world for countries most welcoming to refugees (McCarthy, 2018). Beyond these news pieces, however, there is little in the academic literature to determine where Canada actually stands. The lack of high quality evaluations of resettlement programs for refugees worldwide was the topic of an investigation conducted by the Migration Policy Institute Europe (Beirens & Fratzke, 2017). Researchers found that very few countries involved in refugee resettlement had any sort of formal evaluation of their refugee resettlement programs. Beyond this, the researchers found that the goals of refugee resettlement differed from country to country, and within countries, goals differed across various stakeholders. The lack of a common, well defined goal makes comparative evaluation efforts extremely difficult. Countries also differed on the criterion they set for priority groups; some countries explicitly prioritized individuals with more vulnerability. In these cases, evaluative criterion likely also differ. Objectively, then, it is difficult to assess how Canadian refugee resettlement programs compare to other countries (Beirens & Fratzke, 2017).

Internationally, Canada is one of the few countries that has conducted evaluations of refugee resettlement programs. A 2016 evaluation conducted by Immigration, Refugees and Citizenship Canada looked at the GSR, PSR, BVOR streams of refugee resettlement in Canada and found that the immediate and essential needs of these refugees were generally being met. There were, however, a number of areas identified where improvements could be made. These

included higher income support through the Resettlement Assistance Program, more clarity around roles and responsibilities associated with the BVOR program, improvement for application processing times, and increased availability of mental health supports (Immigration Refugees and Citizenship Canada, 2016). This report did not include consideration of the WUSC, JAS or refugee claimant streams of settlement.

Further evaluations like the one conducted by Immigration, Refugees and Citizenship Canada are needed both within Canada and globally. Regardless of how Canada compares to other countries, there are many opportunities for our refugee resettlement programs to be improved to better meet the needs of refugee newcomers who are starting new lives here. Evaluations can help to determine both areas for improvement and identify aspects of our settlement systems that are working well for dissemination to other countries.

## **6.7 Strengths and Limitations**

Strengths of this research include the participation of individuals who came to Canada as refugees themselves, especially those who came through a refugee Claimant stream. Refugee Claimant experiences are not often included in the scientific literature. Analysis of refugee health clinics as one type of support is another strength of this study. To date, there is a paucity of scientific literature describing the structure and organization of health clinics specifically focused on refugee health.

Importantly, this study has a number of limitations. There were no refugee participants from the BVOR, JAS, PSR, or GSR streams of refugee resettlement. Aspects of these experiences were described by other settlement participants in this study, but the perspective of individuals from these streams would have enhanced the present study. This study is also limited to resettlement experiences of newcomers in large, metropolitan areas in Southern Ontario. In general, there are quite a few services available for newcomers in these large urban areas; experiences in smaller towns or cities may differ. This study was also limited in that all participants were required to speak English. Some participants in this study were not fluent in English, and so communication between the researcher and the participant was limited at times. This may have changed how or what a participant chose to speak about. The scientific literature describing refugee resettlement often highlights the importance of language ability across many activities of resettlement; future research could continue to explore how language ability

influences refugee resettlement trajectories. Finally, the resettlement sector in Canada is dynamic. This study captures experiences of individuals who have arrived in Canada between 2012 and 2017. It is possible that practices and procedures across the resettlement sector have changed since participants in this study arrived to Canada.

## **6.8 Conclusion**

This study examined experiences of refugee resettlement in southern Ontario, including refugee-specific health clinics as an example of one type of support. Findings from this work identified many variables that impact any refugee newcomer's settlement trajectory, leading to a new Canadian framework for refugee resettlement that builds on Drachman's 1992. The use of a time-based, or stage-based approach highlights how certain critical variables emerge as important at the different stages of resettlement, and how others persist across all stages.

This model also highlights the complexity of Canada's current refugee resettlement system. There are cases where services are duplicated; refugee health clinics provide peripheral social-determinants of health services that are also being provided by refugee shelters, formal government programs, and non-government agencies. There are also cases where people are falling through the cracks; private-sponsor key informants highlighted challenges in supporting a family in the JAS program, because of lack of clarity around responsibility between private sponsors and the government. Refugee Claimants are another example of people falling through the cracks, as evidenced by individuals who went days without any formal support after arriving in Canada. Refugee resettlement impacts federal, provincial, and municipal governments. Support comes from all of these sources, and when governments change, supports can also change. A significant recent example of this was the reduction in the IFH coverage for refugees in 2011 by the then federal government.

A Canadian specific framework mapping out refugee resettlement in Canada has the potential to be of value both by governments in planning for refugee resettlement and by the many government and non-government agencies that currently play a role in this regard. Tackling settlement one stage at a time highlights what supports are needed when, and for which people. Understanding the broader factors that help define an individual's needs early on can increase the chances that they receive the support they need. Additionally, a framework such as this may help to point out where inefficiencies currently exist within refugee resettlement and

where gaps persist, so that resources can be shifted. This could result both in a more efficient system, and an increased chance of long term success for refugee newcomers in meeting Canada's stated goals of humanitarianism.

This framework also sets the stage for future research directions. This current study did not consider premigration and departure, and so future research could determine if the critical variables set out by Drachman apply in the Canadian setting. Future research could also examine the impact of a number of these factors on longer term success, with the goal of reducing harm throughout the migration process. As suggested by other scholars, a fourth stage may need to be considered to capture longer term experiences. The effectiveness of this framework in practice should also be evaluated.

## Appendix A: Interim Federal Health Plan Details

The Interim Federal Health Plan is a complex patchwork of coverage, which has proved difficult for health care providers to manage. The following tables describe the various levels of coverage for refugees, in an effort to highlight the administrative complexity required to receive coverage for treating refugee patients. This information is modified from the Immigration and Citizenship branch of the Government of Canada’s website, found here:

<http://www.cic.gc.ca/english/refugees/outside/arriving-healthcare/individuals/apply-who.asp>,  
<http://www.cic.gc.ca/english/refugees/outside/summary-ifhp.asp>, and was up to date as of March 3, 2017.

Table 1: Description of Coverage

Basic	<ul style="list-style-type: none"> <li>• In-patient and outpatient hospital services</li> <li>• Medical doctors, pre and postnatal care</li> <li>• Laboratory, diagnostic, ambulance services</li> </ul>
Supplemental and prescription drug	<ul style="list-style-type: none"> <li>• Similar to provincial/territorial social assistance levels</li> <li>• Limited vision and dental</li> <li>• Home care, long term care</li> <li>• Allied health practitioners</li> <li>• Assistive devices, medical supplies, and equipment</li> <li>• IFHP has prescription drug coverage list</li> </ul>

Table 2: Types of Coverage, Duration

Type 1: Resettled Refugees	<ul style="list-style-type: none"> <li>• GSR</li> <li>• BVOR</li> <li>• Joint Assistance Sponsorship Program Refugees</li> <li>• PSRs</li> <li>• People being resettled as result of public policy or humanitarian and compassionate considerations on the Minister's own initiative</li> <li>• Certain refugees sponsored by organizations in cost-sharing arrangements with IRCC</li> </ul>	<p>Basic coverage provided until beneficiary qualifies for provincial or territorial health insurance</p> <p>Supplemental and prescription drug coverage provided while beneficiary receives income support from Resettlement Assistance Program, or until no longer under private sponsorship</p>
Type 2: Protected persons in Canada	<ul style="list-style-type: none"> <li>• Individuals who receive a positive decision on their asylum claim</li> <li>• Individuals who receive a positive decision on their pre-removal risk</li> </ul>	Basic, supplemental, and prescription coverage provided for 90 days from the date asylum or PRRA is accepted, or until

	assessment, and become a protected person	eligible for provincial or territorial coverage
Type 3: Refugee Claimants	<ul style="list-style-type: none"> <li>• Refugee claimants awaiting decision</li> <li>• Rejected refugee claimants</li> <li>• Ineligible refugee claimants</li> <li>• Positive PRRA decision</li> </ul>	<p>Basic, supplemental, and prescription drug coverage until beneficiary leaves Canada or becomes eligible for provincial or territorial insurance</p> <p>IFHP cancelled immediately when asylum claim is :</p> <ul style="list-style-type: none"> <li>• Withdrawn</li> <li>• Abandoned by the IRB</li> <li>• Re-determined as ineligible</li> </ul>
Type 4: Victims of human trafficking		Basic, supplemental, and prescription coverage continues for duration of temporary resident permit
Type 5: Detainees	Persons detained under <i>Immigration and Refugee Protection Act</i>	Basic, supplemental, and prescription continues while detained by the Canada Border Service Agency under IRPA

## Appendix B: Clinic Information Letter and Consent Form

**Title of Study:** Health Needs and System Response for Refugee Arrivals in Southern Ontario

**Faculty Supervisor:** Dr. Ellen MacEachen, University of Waterloo, School of Public Health and Health Systems  
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To help you make an informed decision regarding your participation, this letter will explain what the study is about, the possible risks and benefits, and your rights as a research participant. If you do not understand something in this letter, please ask one of the investigators prior to consenting to the study. You will be provided with a copy of this information letter and consent form if you choose to participate in the study.

### Invitation to Participate

You are invited to participate in a research study about refugee health and resettlement in Southern Ontario. Providing high quality health care and resettlement assistance to refugees who arrive in Canada is a complex process, as refugees have needs that are different from the mainstream population of Canada and other immigrants. There is a lack of Canadian-specific scientific literature that examines these health and settlement needs of refugees, and examines solutions that have been proposed to address those needs.

The purpose of this study is to learn from refugees themselves what health and settlement needs they experience after arrival to Canada, to learn from managers of primary health clinics about how they are addressing these needs in their practice. We aim to ultimately put forward examples of best practice to promote refugee health and wellbeing. This research is being completed as a thesis requirement for a Master of Science degree.

### 1. Responsibilities as a participant

#### What does participation involve?

Participation in this study consists of an interview of up to one hour, to take place in person at a time that is mutually agreeable. Interview questions relate to the organization and programming at your clinic, challenges you find in your practice, and recommendations you have for future improvement.

There is also an opportunity to assist in recruitment of potential refugee participants. This component is voluntary, and is independent of participation in an interview capacity. Assistance would be welcomed in one of the following ways;

- A) Placement of a recruitment poster in your clinic;

- B) Identification of possible participants for this study, and with participant permission, provision of contact information;
- C) Identification of possible participants for this study, and facilitation of an information session to be held with a member from your staff, the researcher, and possible participants identified from your practice. This information session would provide an opportunity to inform potential participants about involvement in the study, and provide a chance to ask questions.

If you are interested in participating in one of these ways, we can discuss which is the most appropriate and feasible for your clinic.

### **Who may participate in the study?**

This study will involve interviews with up to 6 clinic managers from various clinics in southern Ontario specializing in refugee health or other resettlement sponsors, and interviews with up to 15 refugee participants. In order to participate in the study you must have been at your organization for at least 1 year, and be in a director or other leadership role. These requirements are meant to ensure sufficient knowledge to address structural organization questions.

## **2. Your rights as a participant**

### **Is participation in this study voluntary?**

Your participation in this study is voluntary, and you may decide to withdraw from the study at any time by notifying the researcher. You may decline to answer any questions you prefer not to answer by requesting to skip the question. You can request your data be removed from the study up until December of 2017, as it is not possible to withdraw your information once papers and publications have been submitted.

### **Will I receive anything for participating in this study?**

You will not receive payment for participating in this study.

### **What are possible benefits of the study?**

Results from this study may help to fill in gaps in the scientific literature about the health and integration of resettled refugees in Canada. This study contributes to our knowledge by obtaining the voice of refugees themselves about health and resettlement needs. Additionally, this study will provide gender sensitive analysis of both male and female refugee arrivals. This research will provide details about how some clinics in Ontario, Canada are providing health care to refugees, adding to the literature by providing groundwork for future evaluation.

This research may help those planning settlement activities to better understand what aspects of health and resettlement services matter to refugee arrivals, and inform thinking about what sort of supports and services could be in place when considering an appropriate designated city for new refugees. Specialized clinics already in operation and engaged with this population can learn from these study results how some common challenges are being addressed, in order to work towards the development of Ontario-specific best practice guidelines.

Following study completion, feedback reports will be sent to you, other clinics that participated, and refugee participants.

**What are the risks associated with the study?**

Given the small sample size associated with this study, and the unique nature of refugee clinics in Southern Ontario, there is a risk that reporting of results may inadvertently reveal the identify of your clinic. The researcher will make every effort to ensure that reporting of results does not result in this outcome. If you desire, the researcher can work with your clinic to confirm segments of data pertaining to your clinic prior to any publication to mitigate this risk.

**Will my identity be known?**

The research team, consisting of the student researcher, faculty supervisor, and two other faculty committee members will know which data is from your participation. Any reports or publications resulting from the research will contain pseudonyms, and will not reveal your identity, or the identity of the clinic.

**Will my information be kept confidential?**

The information you share will be kept confidential. All data that is collected will be assigned a pseudonym, and as such individual or clinic names will not be associated with the data. Your information will be securely stored in a locked research office, and on a secure drive on a password protected computer. Research data will be retained for a minimum of 1 year as per established guidelines, after which time it will be destroyed. Only the research team will have access to the data.

3. Questions, comments or concerns

**Has the study received ethics clearance?**

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#22336). If you have questions for the Committee, contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567 ext. 36005 or [ore-ceo@uwaterloo.ca](mailto:ore-ceo@uwaterloo.ca)

**Who should I contact if I have questions regarding my participation in the study?**

If you have questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact Emma Bartel at 519-804-4238 or by email at [embartel@uwaterloo.ca](mailto:embartel@uwaterloo.ca).

You may also contact any member of the research team listed on the first page of the consent form.

## Consent Form

By providing your consent, you are not waiving your legal rights or releasing the investigators or involved institution from their legal and professional responsibilities.

**Title of the Study:** Health Needs and System Response for Refugee Arrivals in Southern Ontario

I have read the information presented in this information letter about a study conducted by Emma Bartel and Dr. Ellen MacEachen, School of Public Health and Health Systems, University of Waterloo. I have had the opportunity to ask questions related to the study and have received satisfactory answers to my questions and any additional study details.

I was informed that participation in the study is voluntary and that I can withdraw this consent by informing the researcher.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE22336). If you have questions for the Committee, contact the Chief Ethics Officer, Office of Research Ethics, at 519-888-4567 ext. 36005 or [ore-ceo@uwaterloo.ca](mailto:ore-ceo@uwaterloo.ca).

For all other questions, contact Emma Bartel, at 519-804-4238 or [embartel@uwaterloo.ca](mailto:embartel@uwaterloo.ca).

- I agree to my interview being audio recorded to ensure accurate transcription and analysis
- I agree to the use of anonymous quotations in any thesis, presentation, or publication that comes from this research

I agree of my own free will to participate in the study.

Participant's name: \_\_\_\_\_

Participant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix C: Refugee Participant Information Letter

**Title of Study:** Health Needs and System Response for Refugee Arrivals in Southern Ontario

**Faculty Supervisor:** Dr. Ellen MacEachen, Ph.D, University of Waterloo, School of Public Health and Health Systems 519-888-4567 ext. 37248 [ellen.maceachen@uwaterloo.ca](mailto:ellen.maceachen@uwaterloo.ca).

**Student Investigator:** Emma Bartel, University of Waterloo, School of Public Health and Health Systems. 519-804-4238 [embartel@uwaterloo.ca](mailto:embartel@uwaterloo.ca)

My name is Emma Bartel, and I am a student at the University of Waterloo. This letter explains a research study I am working on. If you do not understand something in this letter, please ask myself or a member of the clinic staff.

### Invitation

You are invited to help with a research study about refugee health and settlement in Ontario. Canada has many programs that try to help refugees when they arrive. We don't know very much about these programs and what works best. I would like to learn from you about your story moving to Canada, so that we can make these programs better. I am also talking to health clinics, and asking them what they think Canada can do better. The purpose of this study is to understand how some clinics are supporting refugee health in Ontario.

I am working on this study as a part of my Masters degree.

### What does volunteering for this study mean?

If you would like to volunteer, we would sit down together for a conversation that will last up to one hour. We will decide on a space and time that works well for you. I will ask you questions about moving to Canada, finding a house or a job, and what it is like for you to see a doctor or a nurse.

### Who may volunteer for this study?

I will be talking to 15 people who came to Ontario as refugees, and 6 people who work at health clinics or who sponsor refugees. To volunteer, you must be:

- Older than 18 years of age
- Able to speak English
- Arrived in Canada after 2011

### Is it my choice to volunteer?

Yes, it is your choice to volunteer. If we talk and you change your mind about being in this study, you may contact Emma Bartel any time before December of 2017. I will remove our conversation from the study at that time. While we are talking, you may also choose not to answer any of the questions.

**Will I receive money for volunteering?**

No, you will not receive money for volunteering in this study.

**What are the benefits of this study?**

Although Canadians have lots of experience helping refugees when they come to Canada, little of this is captured in the scientific literature. This study may help planners know more about what refugees need when they come to Canada. I will be speaking to different refugees and different clinics. This study will be shared with clinics, and the Government of Canada who are planning for refugee arrival.

I would like to be able to share your story with parts of the government so that we may do a better job of helping refugees in the future. If you agree to volunteer, one of the questions I will ask you is,

“What would you like me to tell the Canadian Government about your settlement in Canada?”

I will prepare a report with answers from this question and may share it with the Government of Canada.

If you like, I will send you this report. I can also send a report with results from the study when it is done. A report will also be sent to the health clinic volunteers and other refuge volunteers.

**Are there any risks for me?**

If you volunteer, I will ask questions about your story as a refugee. Some questions may be hard to answer, and may remind you of difficult times. If you don't want to answer a question, you may skip it.

**Will anyone know that I volunteered?**

Only the research team will know who you are. After our conversation, I will change your name so that any reports or publications about this study will not reveal your identity. The clinic staff will not know if you volunteered. If you are part of a focus group, the other members of the group will know that you volunteered.

**Will my information be confidential?**

All information you share will be kept confidential. Your information will be securely stored in a locked research office, and on a secure drive on a password protected computer. Research data will be retained for at least 1 year. After 1 year it will be destroyed. Only the research team will have access to the data.

### **Has the study received ethics clearance?**

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE #22336). If you have questions for the Committee, contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567 ext. 36005 or [ore-ceo@uwaterloo.ca](mailto:ore-ceo@uwaterloo.ca)

### **Who should I contact if I have questions about volunteering for the study?**

If you have questions about this study, or would like more information, you may contact me here:

Emma Bartel 519-804-4238

[embartel@uwaterloo.ca](mailto:embartel@uwaterloo.ca)

You may also contact my supervisor at the University of Waterloo here:

Dr. Ellen MacEachen 519-888-4567 ext. 37248

[ellen.maceachen@uwaterloo.ca](mailto:ellen.maceachen@uwaterloo.ca).

### **Verbal Consent**

If you agree to be in this study, you are not waiving your legal rights or releasing the investigators or involved institution from their legal and professional responsibilities.

If you volunteer, you agree to these things:

- You have read this letter and had a chance to ask questions
- You know the study is voluntary
- You know you may leave the study any time before December 2017 by contacting Emma Bartel
- You know this study has been approved from the University of Waterloo Research Ethics Committee, and you may contact them at 519-888-4567 ext. 36005 or [ore-ceo@uwaterloo.ca](mailto:ore-ceo@uwaterloo.ca)
- You agree to have our conversation recorded
- You agree to have quotes without your name used in reports or publications

## Appendix D: Gatekeeper Recruitment Email

Dear \_\_\_\_\_,

My name is Emma Bartel and I am a Masters of Science student working under the supervision of Dr. Ellen MacEachen in the School of Public Health and Health Systems at the University of Waterloo.

I am working on a research study that investigates the health care and settlement needs of refugees in Ontario, and the experiences of providers in health clinics that are working with this population.

(If Health Clinic: I am currently seeking participants from the health care clinics that have made modifications to their practice in an effort to improve the health and integration of refugees in Ontario. I am contacting you because I came across your clinic while searching for potential clinic participants for this study. This study is an extension of an undergraduate thesis for which you may have been contacted over a year ago.

Participation in this study involves a semi-structured interview that may last up to an hour, which will be audio recorded for analysis. I will ask you questions about the organization and programming at your clinic, challenges you perceive in your practice, and recommendations for future improvement. I will also invite you to participate in recruitment of possible refugee participants. Options for this type of involvement, as well as additional details about the study can be found in the attached information letter. )

(If Other gatekeeper: I am currently seeking volunteer participants who arrived in Canada as refugees within the last 5 years. I am contacting you, as an agency that works with refugee arrivals to invite you to assist with recruitment of these participants. )

I would like to assure you that this study has been reviewed and has received ethics clearance through the University of Waterloo Research Ethics Board. The final decision about participation is yours. If you are interested in participating, please contact me at [embartel@uwaterloo.ca](mailto:embartel@uwaterloo.ca) with suggestions of dates and times that would work well for you. I may also follow up with a phone call.

Thank you for your consideration.

Emma Bartel

## Appendix E: Sponsor Participants Information Letter and Consent Form

**Title of Study:** Health Needs and System Response for Refugee Arrivals in Southern Ontario

**Faculty Supervisor:** Dr. Ellen MacEachen, University of Waterloo, School of Public Health and Health Systems  
519-888-4567 ext. 37248 [ellen.maceachen@uwaterloo.ca](mailto:ellen.maceachen@uwaterloo.ca).

**Student Investigator:** Emma Bartel, University of Waterloo, School of Public Health and Health Systems. 519-804-4238 [embartel@uwaterloo.ca](mailto:embartel@uwaterloo.ca)

To help you make an informed decision regarding your participation, this letter will explain what the study is about, the possible risks and benefits, and your rights as a research participant. If you do not understand something in this letter, please ask one of the investigators prior to consenting to the study. You will be provided with a copy of this information letter and consent form if you choose to participate in the study.

### Invitation to Participate

You are invited to participate in a research study about refugee health and resettlement in Southern Ontario. Providing high quality health care and resettlement assistance to refugees who arrive in Canada is a complex process, as refugees have needs that are different from the mainstream population of Canada and other immigrants. There is a lack of Canadian-specific scientific literature that examines these health and settlement needs of refugees, and examines solutions that have been proposed to address those needs.

The purpose of this study is to learn from refugees themselves what health and settlement needs they experience after arrival to Canada, to learn from managers of primary health clinics about how they are addressing these needs in their practice. We aim to ultimately put forward examples of best practice to promote refugee health and wellbeing. This research is being completed as a thesis requirement for a Master of Science degree.

### 1. Responsibilities as a participant

#### What does participation involve?

Participation in this study consists of an interview of up to one hour, to take place in person at a time that is mutually agreeable. Interview questions relate to your experience as a private sponsor, including challenges you and the family you are supporting have experienced, and recommendations you have for future improvement. \

#### Who may participate in the study?

This study will involve interviews with up to 6 clinic managers and/or resettlement sponsors from across Southern Ontario, and interviews with up to 15 refugee participants.

### 2. Your rights as a participant

**Is participation in this study voluntary?**

Your participation in this study is voluntary, and you may decide to withdraw from the study at any time by notifying the researcher. You may decline to answer any questions you prefer not to answer by requesting to skip the question. You can request your data be removed from the study up until December of 2017, as it is not possible to withdraw your information once papers and publications have been submitted.

**Will I receive anything for participating in this study?**

You will not receive payment for participating in this study.

**What are possible benefits of the study?**

Results from this study may help to fill in gaps in the scientific literature about the health and integration of resettled refugees in Canada. This study contributes to our knowledge by obtaining the voice of refugees themselves about health and resettlement needs. Additionally, this study will provide gender sensitive analysis of both male and female refugee arrivals. This research will provide details about how some clinics in Ontario, Canada are providing health care to refugees, adding to the literature by providing groundwork for future evaluation.

This research may help those planning settlement activities to better understand what aspects of health and resettlement services matter to refugee arrivals, and inform thinking about what sort of supports and services could be in place when considering an appropriate designated city for new refugees. Specialized clinics already in operation and engaged with this population can learn from these study results how some common challenges are being addressed, in order to work towards the development of Ontario-specific best practice guidelines.

Following study completion, feedback reports will be sent to you, other clinics that participated, and refugee participants.

**What are the risks associated with the study?**

There are no known risks to participating in this study.

**Will my identity be known?**

The research team, consisting of the student researcher, faculty supervisor, and two other faculty committee members will know which data is from your participation. Any reports or publications resulting from the research will contain pseudonyms, and will not reveal your identity, or the identity of the clinic.

**Will my information be kept confidential?**

The information you share will be kept confidential. All data that is collected will be assigned a pseudonym, and as such individual or clinic names will not be associated with the data. Your information will be securely stored in a locked research office, and on a secure drive on a password protected computer. Research data will be retained for a minimum of 1 year as per established guidelines, after which time it will be destroyed. Only the research team will have access to the data.

### 3. Questions, comments or concerns

#### **Has the study received ethics clearance?**

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#22336). If you have questions for the Committee, contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567 ext. 36005 or [ore-ceo@uwaterloo.ca](mailto:ore-ceo@uwaterloo.ca)

#### **Who should I contact if I have questions regarding my participation in the study?**

If you have questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact Emma Bartel at 519-804-4238 or by email at [embartel@uwaterloo.ca](mailto:embartel@uwaterloo.ca).

You may also contact any member of the research team listed on the first page of the consent form. **Consent Form**

By providing your consent, you are not waiving your legal rights or releasing the investigators or involved institution from their legal and professional responsibilities.

**Title of the Study:** Health Needs and System Response for Refugee Arrivals in Southern Ontario

I have read the information presented in this information letter about a study conducted by Emma Bartel and Dr. Ellen MacEachen, School of Public Health and Health Systems, University of Waterloo. I have had the opportunity to ask questions related to the study and have received satisfactory answers to my questions and any additional study details.

I was informed that participation in the study is voluntary and that I can withdraw this consent by informing the researcher.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE22336). If you have questions for the Committee, contact the Chief Ethics Officer, Office of Research Ethics, at 519-888-4567 ext. 36005 or [ore-ceo@uwaterloo.ca](mailto:ore-ceo@uwaterloo.ca).

For all other questions, contact Emma Bartel, at 519-804-4238 or [embartel@uwaterloo.ca](mailto:embartel@uwaterloo.ca).

- I agree to my interview being audio recorded to ensure accurate transcription and analysis
- I agree to the use of anonymous quotations in any thesis, presentation, or publication that comes from this research

I agree of my own free will to participate in the study.

Participant's name: \_\_\_\_\_

Participant's signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix F: Refugee Lawyer Information Letter and Consent Form

**Title of Study:** Health Needs and System Response for Refugee Arrivals in Southern Ontario

**Faculty Supervisor:** Dr. Ellen MacEachen, University of Waterloo, School of Public Health and Health Systems  
519-888-4567 ext. 37248 [ellen.maceachen@uwaterloo.ca](mailto:ellen.maceachen@uwaterloo.ca).

**Student Investigator:** Emma Bartel, University of Waterloo, School of Public Health and Health Systems. 519-804-4238 [embartel@uwaterloo.ca](mailto:embartel@uwaterloo.ca)

To help you make an informed decision regarding your participation, this letter will explain what the study is about, the possible risks and benefits, and your rights as a research participant. If you do not understand something in this letter, please ask one of the investigators prior to consenting to the study. You will be provided with a copy of this information letter and consent form if you choose to participate in the study.

### Invitation to Participate

You are invited to participate in a research study about refugee health and resettlement in Southern Ontario. Providing high quality health care and resettlement assistance to refugees who arrive in Canada is a complex process, as refugees have needs that are different from the mainstream population of Canada and other immigrants. There is a lack of Canadian-specific scientific literature that examines these health and settlement needs of refugees, and examines solutions that have been proposed to address those needs.

The purpose of this study is to learn from refugees themselves what health and settlement needs they experience after arrival to Canada, to learn from managers of primary health clinics about how they are addressing these needs in their practice. We aim to ultimately put forward examples of best practice to promote refugee health and wellbeing. This research is being completed as a thesis requirement for a Master of Science degree.

### 1. Responsibilities as a participant

#### What does participation involve?

Participation in this study consists of an interview of up to one hour, to take place in person at a time that is mutually agreeable. Interview questions relate to your experience in the refugee resettlement sector, including challenges you perceive in your work, and recommendations you have for future improvement. \

#### Who may participate in the study?

This study will involve interviews with up to 6 clinic managers and/or resettlement sponsors, and/or key informants from across Southern Ontario, and interviews with up to 15 refugee participants.

### 2. Your rights as a participant

**Is participation in this study voluntary?**

Your participation in this study is voluntary, and you may decide to withdraw from the study at any time by notifying the researcher. You may decline to answer any questions you prefer not to answer by requesting to skip the question. You can request your data be removed from the study up until July of 2018 , as it is not possible to withdraw your information once papers and publications have been submitted.

**Will I receive anything for participating in this study?**

You will not receive payment for participating in this study.

**What are possible benefits of the study?**

Results from this study may help to fill in gaps in the scientific literature about the health and integration of resettled refugees in Canada. This study contributes to our knowledge by obtaining the voice of refugees themselves about health and resettlement needs. Additionally, this study will provide gender sensitive analysis of both male and female refugee arrivals. This research will provide details about how some clinics in Ontario, Canada are providing health care to refugees, adding to the literature by providing groundwork for future evaluation.

This research may help those planning settlement activities to better understand what aspects of health and resettlement services matter to refugee arrivals, and inform thinking about what sort of supports and services could be in place when considering an appropriate designated city for new refugees. Specialized clinics already in operation and engaged with this population can learn from these study results how some common challenges are being addressed, in order to work towards the development of Ontario-specific best practice guidelines.

Following study completion, feedback reports will be sent to you, other clinics that participated, and refugee participants.

**What are the risks associated with the study?**

There are no known risks to participating in this study.

**Will my identity be known?**

The research team, consisting of the student researcher, faculty supervisor, and two other faculty committee members will know which data is from your participation. Any reports or publications resulting from the research will contain pseudonyms, and will not reveal your identity, or the identity of the clinic.

**Will my information be kept confidential?**

The information you share will be kept confidential. All data that is collected will be assigned a pseudonym, and as such individual or clinic names will not be associated with the data. Your information will be securely stored in a locked research office, and on a secure drive on a password protected computer. Research data will be retained for a minimum of 1 year as per established guidelines, after which time it will be destroyed. Only the research team will have access to the data.

### 3. Questions, comments or concerns

#### **Has the study received ethics clearance?**

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#22336). If you have questions for the Committee, contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567 ext. 36005 or [ore-ceo@uwaterloo.ca](mailto:ore-ceo@uwaterloo.ca)

#### **Who should I contact if I have questions regarding my participation in the study?**

If you have questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact Emma Bartel at 519-804-4238 or by email at [embartel@uwaterloo.ca](mailto:embartel@uwaterloo.ca).

You may also contact any member of the research team listed on the first page of the consent form. **Consent Form**

By providing your consent, you are not waiving your legal rights or releasing the investigators or involved institution from their legal and professional responsibilities.

**Title of the Study:** Health Needs and System Response for Refugee Arrivals in Southern Ontario

I have read the information presented in this information letter about a study conducted by Emma Bartel and Dr. Ellen MacEachen, School of Public Health and Health Systems, University of Waterloo. I have had the opportunity to ask questions related to the study and have received satisfactory answers to my questions and any additional study details.

I was informed that participation in the study is voluntary and that I can withdraw this consent by informing the researcher.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE22336). If you have questions for the Committee, contact the Chief Ethics Officer, Office of Research Ethics, at 519-888-4567 ext. 36005 or [ore-ceo@uwaterloo.ca](mailto:ore-ceo@uwaterloo.ca).

For all other questions, contact Emma Bartel, at 519-804-4238 or [embartel@uwaterloo.ca](mailto:embartel@uwaterloo.ca).

- I agree to my interview being audio recorded to ensure accurate transcription and analysis
- I agree to the use of anonymous quotations in any thesis, presentation, or publication that comes from this research

I agree of my own free will to participate in the study.

Participant's name: \_\_\_\_\_

Participant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_

## Appendix G: Refugee Participant Interview Guide

For Refugee Participants:

Thank you for agreeing to speak with me today. I am a student at the University of Waterloo, conducting this research as a part of my master's degree. My research is focused on understanding the needs of individuals who arrive in Canada as refugees, especially needs about health care, housing, finding work, and feeling settled in Canada. I am also speaking with staff who work at health clinics focused on assisting individuals, to understand how they are trying to help with this process.

1. Can you tell me a little about your situation, including where you are from, what kind of work or studies you did in your home country, and how and why you came to Canada?
2. How was your health, or the health of your family when you first came to Canada? How has it changed since then?
3. When you arrived in Canada, what aspects of settling in went well for you? Why? How?
4. When you arrived in Canada, what aspects of settling in were more difficult? Why? How?
5. Can you describe what health services and other supports you've used since coming to Canada?
  - a. Probes:
    - i. Housing
    - ii. Language
    - iii. Employment/training
    - iv. Childcare
    - v. Social services
6. Have you had help from anyone with housing? Language? Employment? Childcare? Other things?
7. If you had help, what was the most helpful? have helped you the most since you arrived in Canada? Please describe.
8. What kinds of help would have made arrival in Canada better for you or your family?
  - a. In the first year after you arrived? Why? How?
  - b. 1 year and later than that after you arrived? Why? How?
9. Are there things that would have helped you with health and integration but that didn't exist or that you have not been able to access? Probe: (health, language, education)

10. Are there some help that are particularly needed for women? Why? Please explain.
11. Are there some help that are particularly needed for men? Why? Please explain.
12. If we could make changes to health services for refugees coping to Canada, what changes should we make? In what areas? Why? What would you like me to tell the Canadian government about health services for refugees? (Adapted from Mackenzie, McDowell, & Pittaway, 2007)
13. Is there anything about Canadian health care or settling in that I haven't asked about that you would like to add?
14. Demographics: Age, gender, country of origin, highest level of education completed

\*Note: Questions for refugee participants have been put through The Hemingway Editor, and have been graded at a Grade 3 level.

## Appendix H: Clinic Staff Interview Guide

For Clinic Staff:

Thank you for agreeing to meet with me today. I am a Masters student at the University of Waterloo within the School of Public Health and Health Systems, and am conducting this work for my thesis. This study is investigating health service provision for refugees within Southern Ontario. I will be speaking directly with about 15 refugees who have arrived in Canada within the last 5 years about their health service needs, in order to better understand how our health system can provide quality health services. I am also speaking to clinic managers at about 6 organizations who have modified their primary practice in an effort to help refugee patients.

1. Please tell me about your role at the health clinic and how long you have worked here. How long have you been caring for refugees?
2. Can you describe your health clinic for me, in terms of size, how you are funded and so on?
  - a. Probes:
    - i. How many patients?
    - ii. What model of care? (i.e. community health centre, fee for service family practice, Nurse Practitioner led clinic)
    - iii. How many staff do you have, in what roles?
    - iv. How are you funded?
    - v. How long have you been operating?
3. Tell me about your patient population?
  - a. Probes:
    - i. What is the make up of this patient group (where from, what kinds of problems they arrive with)
    - ii. Do you have a time limit for how long you see patients after they come to Canada? I.e. 1 year, or a certain number of appointments?
    - iii. Where do they go if/when they stop coming to your clinic?
    - iv. Government sponsored vs. privately sponsored, age, country of origin
4. Do you see a difference between people who have arrived as refugees from the government sponsored stream vs. the privately sponsored stream in terms of access to health care? Please describe. (ask for an example)
5. Do you see any different between the needs of male and female refugees? Please describe. Are there services that would address these needs? Please describe.

6. In your view, what are some of the biggest challenges in providing health and other social integration services to recently-arrived refugees?
  - a. Probe:
    - i. Insurance process?
7. In relation to any of these challenges, what supports is your clinic able to offer to refugee patients?
  - a. What is working well?
  - b. What areas do you see for improvement?
8. What supports are you aware of in the community that address some of these noted challenges?
  - a. What is working well?
  - b. What areas do you see for improvement?
9. Does your clinic collect data on who you are treating? If so, please describe. If not, is that a goal and if so what information do you think should be collected?
10. Does your clinic have any hopes or plans for expansion?
  - a. What would you do with an expansion?
  - b. Is there anything preventing you from achieving this? Please describe.
11. Are there any issues relevant to health clinics and refugee health and integration support that I have not asked you about and that you think are important for me to know as I pursue this research?

# Appendix I: Settlement Sector

## Participants Interview Guide

For Sponsors

Thank you for agreeing to meet with me today. I am a Masters student at the University of Waterloo within the School of Public Health and Health Systems, and am conducting this work for my thesis. This study is investigating health service provision for refugees within Southern Ontario. I will be speaking directly with about 15 refugees who have arrived in Canada within the last 5 years about their health service needs, in order to better understand how our health system can provide quality health services. I am also speaking to clinic managers at about 6 organizations who have modified their primary practice in an effort to help refugee patients, or sponsors.

1. Please tell me about your role as a private sponsor and how long you have been in this role?
2. Tell me about your sponsorship?
  - a. Probes:
    - i. Describe the responsibilities of sponsor group, government, et cetera
    - ii. how many people are sponsoring the same family with you?
    - iii. How often/what kind of contact do you have with the family?
    - iv. What kind of support or preparation were you given before your sponsorship started?
3. Have you had experience in the past with other refugee sponsoring? If yes, Do you see a difference between different families?
4. Do you see any different between the needs of male and female refugees? Please describe. Are there services that would address these needs? Please describe.
5. In your view, what are some of the biggest challenges in providing health and other social integration services to recently-arrived refugees?
  - a. Probe:
    - i. Insurance process?
6. In relation to any of these challenges, what supports are you able to offer?
  - a. What is working well?
  - b. What areas do you see for improvement?
7. What supports are you aware of in the community that address some of these noted challenges?

- a. What is working well?
  - b. What areas do you see for improvement?
8. Are there any issues relevant to health clinics and refugee health and integration support that I have not asked you about and that you think are important for me to know as I pursue this research?

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