

EXPLORING THE HEALTH AND HEALTH CARE EXPERIENCES OF REFUGEE AND
REFUGEE CLAIMANT WOMEN IN HAMILTON, ONTARIO: A QUALITATIVE STUDY

By

JENNY CHO, B.A. (HONS)

A Thesis

Submitted to the School of Graduate Studies

In Partial Fulfillment of the Requirements

For the Degree

Master of Arts

McMaster University

© Copyright by Jenny Cho, September 2012

EXPLORING THE HEALTH AND HEALTH CARE EXPERIENCES OF REFUGEE
AND REFUGEE CLAIMANT WOMEN IN HAMILTON, ONTARIO:

A QUALITATIVE STUDY

MA Thesis McMaster University- School of Geography and Earth Sciences
Cho, Jenny

MASTER OF ARTS (2012)

McMaster University

(School of Geography and Earth Sciences)

Hamilton, Ontario

TITLE: Exploring the Health and Health Care Experiences of Refugee and
Refugee Claimant Women in Hamilton, Ontario: A Qualitative
Study

AUTHOR: Jenny Cho, B.A. Hons. (Concordia University, 2009)

SUPERVISOR: Dr. K. Bruce Newbold

NUMBER OF PAGES: ix, 143

Abstract

Refugee women experience important physical and mental health disparities which are often unmet during resettlement to host countries. These health disparities have been attributed to the gendering of the refugee process, such that women are more vulnerable to gender-specific violence and abuse during flight from war and conflict. Despite having unmet health needs, they face multiple barriers to leading healthy lives and healing during resettlement to a new host country. This paper seeks to respond to the need for research in understanding the health of refugee women in western nations within feminist geographical scholarship by exploring the ‘lived experiences’ of refugee and refugee claimant women during resettlement to Hamilton, Ontario. Data was collected through in-depth interviews and focus groups with key informants (n=9) and refugee women and refugee claimant women (n=37) from various source countries. Results from this study provide in-depth understandings on the experiences of resettlement including the particular challenges refugee and refugee claimant women face in attempting to rebuild their lives in Canada. Perceptions of good health are closely related to various dimensions of gender (roles and identities) and citizenship (status). This paper explores important health determinants as expressed by the participants: pre-migration experiences, citizenship (status), employment and housing experiences and health care during resettlement. Accounts from this study reflect the need to address ongoing immigration reform and refugee policy in a manner that will honour Canada’s commitment to international humanitarian agreements such as the 1951 Geneva Convention.

Acknowledgements

This research would not have been possible without the support and guidance of many individuals as well as the financial contributions of the Canadian Institutes of Health Research (CIHR).

I would like to thank my supervisor, Dr. Bruce Newbold, for granting me the privilege of carrying out a master's program, for allowing me to experience research beyond the academic walls, and for the opportunity to experience life as a Hamiltonian. I am grateful for the freedom you entrusted me with, for your support and guidance throughout, for your *countless* edits and revisions throughout this research process, and for sending me on numerous conferences that have opened up important opportunities for me.

I am also grateful to Dr. Vera Chouinard for introducing me to the field of feminist geography and for helping me with my thesis work on numerous occasions. I would also like to express my gratitude towards Dr. John Eyles and Dr. Allison Williams for your insight and expertise.

Thank you to the many participants who took part in this study. This study would not have been possible without you. Although our encounters may have been brief, your stories, passion and perseverance continue to encourage and inspire me daily.

I am grateful for the meaningful and lasting friendships formed throughout my time at McMaster. To Aman, Dirk, Huyen, Jeanette, Kim, Kristina, Lily, and Yui, thank you for your support, love and encouragement. Most of all, thank you for the gift of companionship.

I would like to thank a very special organization for which I have had the greatest pleasure and privilege to be a part of. In that short time, I have learned much about living out compassion, justice, and love. I would also like express my heartfelt gratitude towards those at George St. HC, including the Howe family for your love, encouragement and community.

I would like to thank my Albrecht family for your unconditional love and support over the years. I know I always have somewhere to go if I need to talk things out, find inspiration, eat good food, and do laundry!

I would like to thank my grandmother, mother, and aunt for your love and sacrifice. I would also like to thank my brother Danny and sister Sonia.

I would like to thank my husband, life partner, and best friend Derek for managing to listen to me talk through my research for hours upon hours, while always maintaining interest and enthusiasm. The last two years have been both incredibly challenging and incredibly blessed. I am thankful to have had each other through it all.

Finally, I would like to dedicate this work to my father, Dung-un Cho (1941-2010). There were many times throughout this research where I felt vastly inadequate and in those moments your love and encouragement carried me forward. Thank you.

TABLE OF CONTENTS

ABSTRACT	iv
ACKNOWLEDGEMENTS	v
TABLE OF CONTENTS	vii
LIST OF ABBREVIATIONS	x
CHAPTER ONE: Introduction	1
1.1 Research Context	1
1.1.1 Forced Migration.....	1
1.1.2 Situating Refugee and Refugee Claimant women in Canada.....	3
1.2 Research Objectives and Outline	4
1.3 Study Area.....	6
1.4 Theoretical Frameworks.....	7
1.5 Chapter Outline.....	8
1.6 References.....	9
CHAPTER TWO: Exploring health at the Intersections of Gender and Status: the Experiences of Refugee and Refugee Claimant Women in Hamilton, Ontario	12
2.1 Abstract	12
2.2 Introduction.....	13
2.2.1 Policy Context: Situating Refugee and Refugee Claimant Women in Canada.....	14
2.2.2 Forced Migration through a Feminist Lens.....	16
2.2.3 Conceptualizing the Health of Refugee and Refugee Claimant Women: from Gender to Intersectionality.....	17

2.3 Methods and Participants.....	21
2.3.1 The Women.....	25
2.3.2 Analysis.....	27
2.4 Results	27
2.4.1 Pre-migration experiences: they escaped.....	28
2.4.2 Separation from Family.....	30
2.4.3 Citizenship: Having status is a determinant of health.....	33
2.4.4 Un-Employment: I want to work! I want to be in good health to work.....	35
2.4.5 Housing: Like if someone is not happy at home, how do we be healthy?....	40
2.5 Discussion and Conclusion.....	43
2.6 References	52

**CHAPTER THREE: Access to Health Care: The Experiences of Refugee and
Refugee Claimant Women in Hamilton, Ontario.....**

3.1 Abstract	58
3.2 Introduction	59
3.2.1 Refugees and Refugee Claimants.....	63
3.2.2 Refugee and Refugee Claimant Women.....	64
3.3 Methods and Participants.....	67
3.3.1 The Women.....	71
3.3.2 Analysis.....	73
3.4 Results.....	74
3.4.1 Language and Interpretation.....	74
3.4.2 Quality of Care and Appropriate Care.....	80
3.4.3 Health Coverage: IFH Program.....	83
3.5 Discussion and Conclusion.....	90
3.6 References.....	95

CHAPTER FOUR: Conclusion	100
4.1 Introduction	100
4.2 Summary of Major Findings	100
4.3 Limitations	104
4.4 Policy Implications and Suggestions for Future Research.....	106
4.5 Concluding Thoughts.....	107
4.6 References	109
APPENDICES A: Research Ethics Material	111
APPENDICES B: Data Collection Tools	134

ABBREVIATIONS

CCRWEB: Canadian Council for Refugees

CIC: Citizenship and Immigration Canada

GAR: Government Assisted Refugee

UNHCR: United Nations High Commissioner for Refugees

CHAPTER ONE

Introduction

1.1 Research Context

1.1.1 Forced Migration

By the end of 2010, there were an estimated 10.55 million refugees and 2,837,500 asylum seekers worldwide (United Nations High Commissioner for Refugees (UNHCR), 2011). On a global scale, women make up the majority of displaced migrants due to war. While the vast majority of refugees flee to neighbouring countries, some relocate to a safe third country such as Canada. In Canada, individuals are granted ‘refugee’ status abroad and given landed residency upon arrival if they are recognized according to the 1951 Convention as:

Someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion (Citizenship and Immigration Canada (CIC), 2011).

Refugee claimants are those who claim asylum from within Canada, have temporary status and only receive Canada’s protection if they are found to be a Convention refugee according to the definition above or found to be a Person in Need of Protection:

An individual who is afraid to return to his or her country because of the risk of torture, risk to life, risk of cruel or unusual treatment or punishment (CIC, 2011).

Canada and the United States receive a large number of asylum-seekers and have the largest number of resettled refugees in the world (UNHCR, 2012). By 2011, there were 165,549 resettled refugees and 51,025 asylum seekers residing in Canada (UNHCR, 2012). In 2010, Canada resettled 7,425 Government Assisted Refugees (GARs) and 5,036 Privately Sponsored Refugees. Additionally, 33,161 refugee claimants – individuals claiming refugee status within Canada – entered the country in the same year. However, it is projected that there will be fewer resettled refugees and refugee claimants due to ongoing policy changes driven by budget reductions and national security concerns which will lead to an overall reduction of assistance (and therefore protection) for refugees in need of resettlement (UNHCR, 2012).

Immigrants to Canada may enter according to one of three classes: family class, economic class, and refugee (Chui, 2003). Canada's immigration System is based on a 'Point system' which was created in 1967 to encourage the flow of skilled migrants. Under this system, applicants are assessed based on (economic) merit and potential including factors such as age, education, work experience, intended occupation, knowledge of Canadian languages and adaptability. Additional points are allotted to those with pre-arranged employment in Canada. Between 2005 and 2010, the total number of new permanent residents in Canada increased by 10% (Canadian Council for Refugees (CCRWEB), 2011). Economic class immigrants represent an increasingly greater proportion compared to declining representations within family class (12% decline) and refugees (31% decline).

1.1.2 Situating Refugee and Refugee Claimant Women in Canada

It is important to begin by noting a distinction between refugees/refugee claimants and immigrants. Refugees and refugee claimants are often subsumed under the ‘newcomer’ or immigrant umbrella category, yet there are important distinctions that set them apart from other immigrant classes in Canada. As forced migrants, they have fled circumstances often associated with conflict, and as such, they are differentiated by ‘choice’ (Hyndman, 2010). While immigrants may choose to relocate and enter Canada as measured by the human capital they possess under a ‘points-system’ ideology (Chui, 2003), refugees are forced to flee their country of origin. Immigrants also tend to be healthier than refugees upon arrival, in large part owing to the selectivity and screening processes at the time of entry into Canada (Newbold, 2009), while refugees may spend significant time transiting through refugee camps where they may have been exposed to poor sanitation, poor nutrition and lack of access to health care (Fowler, 1998). As a result, they are more likely to suffer from infectious diseases such as tuberculosis, syphilis, hepatitis B and gastrointestinal parasites, as well as mental health, and other critical health conditions such as anaemia, dental caries, and nutritional deficiencies during resettlement (Fowler, 1998; Gabriel et al., 2011; Zhao, 2010). Studies have shown that despite having significant health needs, refugees and refugee claimants are less likely than non-immigrant Canadians to seek health care services.

More specifically, refugee women experience important physical and mental health disparities which are often unmet during resettlement to host countries (Deacon & Sullivan, 2009). These health disparities have been attributed to the gendering of the

refugee process such that women are more vulnerable to gender-specific violence (i.e., rape) and abuse during flight from war and conflict (Berman et al., 2009; Deacon & Sullivan, 2009, Fowler, 1998; Gagnon et al., 2007; Redwood-Campbell et al., 2007). During resettlement, gender roles such as mothering, nurturing, caring, and their work, whether paid or domestic, are important for the health of refugee women (Dyck, 2006). Refugee women with children maintain ‘mothering’ throughout forced flight and resettlement, including the responsibilities of caring for, protecting, and nurturing their families amidst contexts of conflict and trauma (Adanu & Johnson, 2009; Berman et al., 2009). Despite having higher health needs, refugee women may face barriers to accessing health services (Walsh et al., 2008) which may lead to lower uptake of preventive care such as cervical and breast cancer screening (Redwood-Campbell et al., 2007). Given that refugees may be particularly vulnerable to poor health and may require urgent care in the early stages of resettlement (Gabriel et al., 2011; Miedema et al., 2008), there is a need to understand the health needs of refugee and refugee claimant women and their experiences in attempting to meet these needs during resettlement, a topic which this thesis addresses.

1.2 Research Objectives and Chapter Outline

This thesis research sought to focus specifically on the experiences of refugee and refugee claimant women from the perspective of refugee and refugee claimant women and health and social service providers in Hamilton. Guiding this thesis research was the following research questions:

- *How do refugee and refugee claimant women, who have resettled in Hamilton, Ontario from various source countries, experience 'health', well-being, and the Canadian health care system?*
- *What are the health needs of refugee and refugee claimant women during resettlement? What health determinants do they value? What are the challenges and barriers that they experience while attempting to lead healthy lives?*

This thesis encompasses two separate research papers, each with the intention of addressing the major research goals. Both papers answer the larger research question and the results represent the analysis of data collected through in-depth interviews and focus groups with refugee and refugee claimant women (n=37) and social and health service providers (n=9) in Hamilton. Results from this study are presented as two separate papers in Chapters 2 and 3 of this thesis.

Chapter 2 presents the results of a qualitative study a on the health experiences of refugee and refugee claimant women from interviews with health and social service providers and with refugee and refugee claimant women in Hamilton. This paper uses the concept of intersectionality (Crenshaw, 1991) to explore the experiences situated at the intersection of gender and status/citizenship and sought to understand the health determinants that are of particular importance to the women, as well as the social differences that are important/ marginalising for them as they attempt to rebuild and lead healthy lives during resettlement to Hamilton. Results demonstrate that their multiple identities related to their gender (sex, gender roles) and status (refugees, refugee

claimants) often intersected to produce differential experiences of health and access to health determinants during resettlement. This paper explores the lasting effects of pre-migration traumas, separation from family, citizenship, un-employment and housing which were of particular importance to the women's health during resettlement

Chapter 3 presents the results of a qualitative study involving the same participants as in Chapter 2. Additionally, this paper builds on the findings presented in Chapter two and focuses specifically on accessibility to health and social services for both refugee and refugee claimant women during resettlement and is set within a 'determinants of health' perspective (Evans and Stoddart, 1990). The goal was to understand the challenges refugee and refugee claimant women face in navigating the Canadian health care system, paying attention to the system and individual level barriers to accessing health services. Further, the study sought to understand how the women cope with these challenges and barriers and the changes they would like to see. Findings from this study explore access to primary care (physicians, family physicians), secondary (medical specialists, hospital emergency department) and tertiary health care services from the perspective of the refugee and refugee claimant women and of providers.

1.3 Study Area

The study is set in Hamilton, Ontario, a mid-sized city with a 2011 population of 519,949 located in southern Ontario approximately 65 kilometres west of Toronto (Statistics Canada, 2012). The city is home to 166, 635 immigrants, of which approximately one third are refugees, including refugee claimants, a proportion which is

higher than the national average, with Hamilton attracting refugee settlement due to its relatively close proximity to Toronto, and comparatively lower cost of living (Newbold et al., 2008). Hamilton is one of six communities in Ontario (Toronto, London, Ottawa, Kitchener, and Windsor) that accepts GARs (Wayland, 2010). In addition, Hamilton's refugee population sources from a diversity of backgrounds, including refugees from Kosovo, Burma, Vietnam, China, Pakistan, India, Turkey, Afghanistan, El Salvador, Columbia, Honduras, and Somalia.

1.4 Theoretical Frameworks

This research is largely informed by feminist geographical scholarship (intersectionality) (Crenshaw, 1991) and population health (social determinants of health framework) (Evans & Stoddart, 1990). Under a 'determinants of health' framework the mechanisms that produce health inequalities and disparities are influential across class, gender, race, ethnicity, language, age, and socio-economic status (Evans and Stoddart, 1990; Raphael, 2004). Health care is an important determinant of health for those with precarious or 'irregular' status (Simich, Wu & Nerad, 2007) and the literature has also explored access to care for immigrants more generally (Asanin & Wilson, 2008; Dunn & Dyck, 2000; Newbold 2005) as well as for immigrant women (Newbold & Willinsky, 2009; Ng & Newbold, 2011) and for immigrant and refugee women from the perspectives of health practitioners (McKeary and Newbold, 2010). Further, health care is deemed one of twelve key health determinants by Health Canada guided by the premise that health services play an important role in maintaining health, preventing disease and restoring health in populations (Public Health Agency of Canada (PHAC), 2011). Thus,

understanding the factors that affect accessibility for refugee and refugee claimant women is necessary.

Gender (roles and identities), migration, age, social isolation, language barriers, separation from family, change in family roles, unemployment and health care are found to be important for determinants of health for refugee women during resettlement (Fowler, 1998). Beyond gender, refugee and refugee claimant women may embody multiple axes of social difference – such as ethnicity-race, (dis)ability, class, religious affiliation and citizenship – which may work together or ‘intersect’ (Crenshaw, 1991) to limit their health agency and access to social and health services during resettlement to Canada (Hankivsky, 2011 et al., 2011; Hankivsky & Christoffersen, 2008). This research is therefore also informed by the concept of intersectionality (Crenshaw, 1991) to understand when and where refugee and refugee claimant women experience oppression and exclusion which may reduce their capacity to be healthy and limit their choices during resettlement to Canada.

1.5 Chapter Outline

As the thesis conclusion, Chapter 4 presents an overview of the key findings and contributions of this thesis work, including an overview of the study’s major findings and contributions, limitations, policy implications and suggestions for future research. Finally, this section reflects on the limitations to the research and concludes with suggestions for future research directions.

1.6 References

- Adanu, Richard M.K., & Johnson, Timothy R.B. (2009). Migration and women's health. *International Journal of Gynecology & Obstetrics*, 106(2), 179–181.
- Berman, Helene, Girón E R Irías, & Marroquín P Antonia (2009). A Narrative Study of Refugee Women who have Experienced Violence in the Context of War. *CJNR*, 41(1), 144 –165.
- Canadian Council for Refugees (CCRWEB). (2011). *Canadian Immigration - Changing Priorities*. Canadian Council for Refugees. Retrieved from <http://ccrweb.ca/en/canadian-immigration-changing-priorities>
- Chui, T. (2003). Longitudinal Survey of Immigrants to Canada: Process, progress and prospects. Catalogue no. 88-611-XIE. Ottawa: Statistics Canada.
- Crenshaw, Kimberle. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review*, 43(6), 1241-1299.
- Deacon, Z. & Sullivan, C. (2009). Responding to the Complex and Gendered Needs of Refugee Women. *Affilia-Journal of Women and Social Work*, 24(3), 272-284.
- Dyck , Isabel. (2006). Travelling tales and migratory meanings: South Asian migrant women talk of place, health and healing. *Social & Cultural Geography*, 7(1) 1-18.
- Evans, Robert G., & Stosddart, Gregory L. (1990). Producing Health, Consuming Health Care. *Social Science and Medicine*, 31(12), 1347-1363.
- Fowler, Nancy. (1998). Providing Primary Health Care to Immigrants and Refugees: the North Hamilton Experience. *Canadian Medical Association Journal*, 159(4), 388–391.
- Gabriel, Patricia S., Morgan-Jonker, Cecily, Phung, Charlene M.W., Barrios, Rolando, & Kaczorowski, Janusz (2011). Refugees and Health Care: The Need for Data: Understanding the Health of Government-assisted Refugees in Canada Through a Prospective Longitudinal Cohort. *Can J Public Health*, 102(4), 269-72.
- Gagnon, A.J., Dougherty, G., Platt, R.W., Wahoush, O., George, A., Stanger, E., Oxman-Martinez, J., Saucier, J.F., Merry, L., & Stewart, D.E. (2007). Refugee and refugee-claimant women and infants post-birth – Migration histories as a predictor of Canadian health system response to needs. *Canadian Journal of Public Health*, 98(4), 287- 291.

- Hankivsky, Olena & Christoffersen, Ashlee. (2008). Intersectionality and the determinants of health: a Canadian perspective. *Critical Public Health*, 18(3), 271–283.
- Hankivsky, Olena, De Leeuw, Sarah, Lee, Jo-Anne, Vissandjée, Bilkis, & Khanlou, Nazilla (Eds.) (2011). *Health Inequalities in Canada: Intersectional Frameworks and Practices*. Victoria, British Columbia: UBC Press.
- Hyndman, Jennifer. (2010). Introduction: the feminist politics of refugee migration. *Gender, Place and Culture*, 17(4), 453–459.
- Miedema, B., Hamilton, R., & Easley, J. (2008). ‘Climbing the walls - Structural barriers to accessing primary care for refugee newcomers in Canada’. *Canadian Family Physician*, 54(3), 335-336.
- Newbold, K.B. (2007). *Journey to Health: An investigation of the social production of health and access to health care within Hamilton’s refugee community*. Research Proposal.
- Newbold, K.B. (2009). ‘The Short-Term Health of Canada’s New Immigrant Arrivals: Evidence from LSIC’. *Ethnicity and Health*, 14(3), 1-22.
- Newbold, K.B. Eyles, J. Birch, S. & Wilson, K. (2008). ‘Building a Profile of Health Related Services: Hamilton’s Immigrant and Refugee Communities’. CERIS Working Paper #64, University of Toronto.
- Redwood-Campbell L., Thind H., Howard M., Koteles J. Fowler N., Kaczorowski J. (2007). ‘Understanding the Health of Refugee Women in Host Countries: Lessons from the Kosovar Re-Settlement in Canada’. *Prehospital and Disaster Medicine*, 23(4), 130-135.
- Statistics Canada. (2012). *Hamilton, Ontario (Code 537) and Ontario (Code 35) (table)*. *Census Profile*. 2011 Census. Statistics Canada (Catalogue No. 98-316-XWE). Ottawa. Released May 29, 2012. Retrieved from <http://www12.statcan.gc.ca/censusrecensement/2011/dppd/prof/details/page.cfm?Lang=E&Geo1=CSD&Code1=3525005&Geo2=CD&Code2=3525&Data=Count&SearchText=Hamilton&SearchType=Begins&SearchPR=35&B1=All&Custom=&TABID=1>
- United Nations High Commissioner for Refugees (UNHCR). (2011). *UNHCR Statistical Yearbook 2010, 10th edition Country Data Sheets*. Retrieved from <http://www.unhcr.org/4ef9cc9c9.html>

United Nations High Commissioner for Refugees. (UNHCR). (2012) *2012 Regional Operations Profile - North America and the Caribbean*. Retrieved from <http://www.unhcr.org/cgi-bin/txis/vtx/page?page=49e491336&submit=GO>

Walsh, C., Este, D., and Krieg, B. (2006). The Enculturation Experience of Roma Refugees: A Canadian Perspective. *British Journal of Social Work* (2008) 38, 900–917.

Wayland, Sarah. (2010). ‘A Demographic Profile of Immigrants in Hamilton’. Prepared for the City of Hamilton Immigration Strategy.

CHAPTER TWO

Exploring health at the Intersections of Gender and Status: the Experiences of Refugee and Refugee Claimant Women in Hamilton, Ontario

2.1 Abstract

Refugee women experience important physical and mental health disparities that are qualitatively different from their male counterparts, which are often unaddressed during resettlement to host countries. During resettlement, poor health is compounded by negative impacts of social isolation, poverty and discrimination. This qualitative exploratory study seeks to offer an in-depth and nuanced understanding of refugee and refugee claimant women's health experiences and access to health determinants (such as income and housing) during resettlement to Hamilton, Ontario, Canada. Drawing on the concept of intersectionality, this paper seeks to understand refugee and refugee claimant women's experiences at the intersection of various social locations in Canadian society. Data was collected through a combination of in-depth interviews and focus groups with key informants (n=9) and refugee and refugee claimant women (n=37) from various source countries who have resettled to Hamilton. Results from this study are examined according to five emerging themes: pre-migration, separation from family, status/citizenship, (un)employment, and housing. Findings from this study demonstrate that refugee and refugee claimant women face numerous obstacles to maintaining healthy lives during resettlement, which are in large part, directly related to their gender roles,

expectations of resettlement, and refugee status. The importance of accounting for the voices of refugee and refugee claimant women within the formation of refugee policy is highlighted in this study.

2.2 Introduction

On a global scale, women make up the majority of displaced migrants due to war and conflict (UNHCR 2011). Refugee women are said to experience important physical and mental health disparities that are qualitatively different from their male counterparts, which are often unaddressed during resettlement to host countries (Deacon & Sullivan, 2009). These health disparities have been attributed to the gendering of the refugee process such that women are more vulnerable to gender-specific violence (i.e., rape) and abuse during flight from war and conflict (Berman et al., 2009; Deacon & Sullivan, 2009, Fowler, 1998; Gagnon et al., 2007; Redwood-Campbell et al., 2007) which are reported to lead to mental illnesses such as depression, schizophrenia, posttraumatic stress disorder, suicide, and psychosis in migrant women who have fled violence and persecution during resettlement (Donnelly et al., 2011). During resettlement, poor mental health is compounded by negative impacts of social isolation, poverty and discrimination (Burnett & Peel, 2001).

This qualitative exploratory study seeks to offer an in-depth and nuanced understanding of refugee and refugee claimant women's health experiences and access to health determinants (such as income and housing) during resettlement to Hamilton, Ontario, Canada. Drawing on the concept of intersectionality as first introduced by critical race theorist, Kimberle Crenshaw (1991), this paper seeks to understand refugee

and refugee claimant women's experiences at the intersection of various social locations in Canadian society. Often, they experience barriers in accessing healthy lives during resettlement as a result of the intersecting social differences they embody. For instance, the women's legal status as refugees, refugee claimants and their gender as women, and gendered roles have various implications for their settlement and health trajectories. These experiences will be further explored in this paper. Data was collected through a combination of in-depth interviews and focus groups with key informants (n=9) and refugee and refugee claimant women (n=37) from various source countries who have resettled to Hamilton. Results from this study are examined according to five emerging themes: pre-migration, separation from family, status/ citizenship, (un)employment, and housing.

This paper will begin with a brief overview of the background context, including policies to help situate refugee and refugee claimant women in Canada. What follows is a brief review of literature in the area of forced migration, focusing on those works that document the experiences from a feminist perspective. The next section briefly reviews the refugee health literature in order to provide a better understanding of the factors that affect refugee women's health during resettlement. We then describe the conceptual framework (intersectionality) and research methods before presenting the study results and concluding with a discussion of the results and their implications for future research.

2.2.1 Policy Context: Situating Refugee and Refugee Claimant Women in Canada

Canada is a signatory to the 1951 Convention which is grounded in Article 14 of the 1948 Universal Declaration of human rights which recognises the rights of persons to

seek asylum from persecution in other countries. The 1967 Protocol removed the geographic and temporal limits of the 1951 Convention (United Nations High Commissioner for Refugees (UNHCR), 2010). While the refugee determination process in Canada can be traced to a complicated history of highly contested Canadian immigration policies, we limit our discussion in this section to these two documents as they are responsible for providing the guidelines regarding the rights of refugees and asylum seekers today. They are underpinned by principles of non-discrimination, non-penalization and non-refoulement (UNHCR, 2010).

According to the 1951 Convention, a refugee is:

Someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion (Citizenship and Immigration Canada (CIC), 2011a).

In Canada, refugees are resettled from abroad as individuals identified through the United Nations High Commissioner for Refugees (UNHCR) and sponsored by the Canadian government (Government Assisted Refugees (GARs)) or by private groups (family members, churches or Non-Governmental Organizations (NGOs)) if they are recognised as Convention Refugees. Refugees receive permanent residency status upon arrival to Canada, with Canada resettling 7,425 Government Assisted Refugees (GARs) and 5,036 Privately Sponsored Refugees in 2010 (Citizenship and Immigration Canada (CIC), 2011b). Additionally, 33,161 refugee claimants – individuals claiming refugee status within Canada – entered the country in the same year. They only receive Canada's protection if they are found to be a Convention refugee according to the definition above

or found to be a Person in Need of Protection, which the government defines as:

An individual who is afraid to return to his or her country because of the risk of torture, risk to life, risk of cruel or unusual treatment or punishment (CIC, 2011a).

2.2.2 Forced Migration through a Feminist Lens

On a global scale, women make up the majority of displaced migrants due to war and conflict (Berman et al., 2009). Feminist scholarship has recognised the highly gendered nature of forced migration (Hopkins, 2006; Hyndman, 2010) and has pointed to the absence of gender guidelines, acknowledging the particular needs and conditions of women in forced migration contexts within major refugee legislation at international and national (Canadian) levels. It has been argued that there is an existing bias and discrimination against women in the refugee system such that the 1951 Geneva Convention Relating to the Status of Refugees ('1951 Convention') and other international human rights conventions have been written from predominantly male perspectives whereby the situations and interests of women—including violations and persecutions deemed valid for granting refugee status—have been subsequently ignored (Berman et al., 2009, Freedman, 2010a).

Canada was the first country to integrate gender guidelines to more fully account for the particularities of women's experiences of persecution into the national asylum policies and legislation, thereby broadening the definition of a refugee to include those women seeking asylum based on a well-founded fear of gender-related persecution (Freedman, 2010b). However, Canadian immigration policy has been criticized for the ways in which women have tended to fall into more dependent categories and more

precarious statuses, which have serious implications with regards to accessing health and social services (Dyck & McLaren, 2004; Oxman- Martinez et al., 2005; Simich, Wu, & Nerad, 2007; Wahoush, 2009). For example, Dyck & Dossa (2007) argue that family reunification reinforces gendering of women's activities, such as those involved in taking on the primary responsibility for child care and domestic labour. Similarly, Hyndman (2010) argues that the sponsoring of refugee women (as men are over-represented in primary applicant categories in Canada, USA and Australia) by families or spouses may subject refugee women to abuse and authority of their sponsors, resulting in the relegation of women to marginal roles and also may raise women's health risks during resettlement.

2.2.3 Conceptualizing the Health of Refugee and Refugee Claimant Women: from Gender to Intersectionality

The literature has shown that gender roles such as mothering, nurturing, caring, and their work, whether paid or domestic, are important for the health of refugee women during migration and resettlement (Dyck, 2006). Refugee women with children maintain 'mothering' throughout forced flight and resettlement, including the responsibilities of caring for, protecting, and nurturing their families amidst contexts of conflict and trauma (Adanu & Johnson, 2009; Berman et al., 2009). Further, women who are forcibly displaced from the consequences of war and conflict may be separated from their spouses (and social support networks), and become the primary caregivers for ensuring the safety and well-being of their families. Thus, working to reduce isolation and ensuring suitable accommodation, improving education and employment opportunities, and enhancing

family reunification may help to relieve depression and anxiety for refugee women during resettlement.

While gender is an important determinant of health for women fleeing war or persecution, particularly with respect to the gendering of refugee processes as briefly discussed above, recent works in feminist scholarship argue that an overemphasis on the role of gender may not capture the complexity of the multiple axes of social difference - such as ethnicity-race, (dis)ability, class, and citizenship - that may be important for refugee and refugee claimant women's health during resettlement. For example, Hankivsky et al. (2011) argues that gender, race, sexual identity, religion, status, and class may work together or 'intersect' to limit access to employment, fair immigration, health care, or education. Hankivsky & Christoffersen (2008) argue that while in theory, the population health approach seeks to understand the 'interaction' of multiple determinants of health, in practice, this has not been achieved. As such, the authors advocate for the use of an intersectional approach "as a transformative paradigm" for understanding health determinants (Hankivsky & Christoffersen, 2008, p. 275). In responding to such calls, this study takes on the intersectional perspective in understanding the health experiences of refugee and refugee claimant women during resettlement.

The concept of 'intersectionality' has emerged across a wide range of disciplines, mainly in the social sciences, and, as such, there is no single, agreed upon definition and function (Hankivsky & Cormier, 2009). Despite variations in its definition, a central tenet of intersectionality is the pursuit of social justice and research that seeks to account for

the experiences of those individuals or sub-populations whose voices are systematically unaccounted for, unheard, silenced, and missing from social policy formation. The concept of intersectionality was first developed by Crenshaw (1991) out of a need to legally recognise the ways that women of color simultaneously experienced multiple strands of discrimination and oppression specifically in employment arenas at a time when gender and race were perceived as separate and fixed identities (Crenshaw, 1991). Crenshaw used an analogy of accidents that occur and may reoccur at certain junctions (intersections), but go unheard of or unaccounted for to illustrate that the simultaneous discrimination of gender and race towards women of color had not even been recognized. Thus, an intersectional approach seeks to counter inequities stemming from multiple axes of oppression and power, including but not limited to sexism, racism, patriarchy, ageism, ableism, and class exploitation.

An intersectional lens has been employed for understanding the health experiences of marginalized women with knowledge being gained from the voices, experiences, perspectives and agency of those that have been predominantly “Othered” (Crenshaw, 1989; Dhamoon & Hankivsky, 2011; Dixon & Jones III, 2006; Hyndman, 2004; Hyndman, 2010; Kelly, 2009; McGibbon & McPherson, 2011). The principle of giving voice means that it is the participants who identify what categories of difference are important or marginalizing for them, rather than assuming or giving primacy to the role of gender over other axes of difference.

Intersectionality also emphasizes ‘lived experience’ of research participants (Valentine, 2007). In women’s health research, intersectionality has been recognised as a

method and concept that is grounded in lived experiences of marginalized people (Hankivsky & Cormier, 2009). The intersectional framework has also been advocated for within mental health research with immigrant and refugee women during resettlement in nursing research (Berman, Irias Giron & Marroquin, 2009; Donnelly et al., 2011; Guruge & Khanlou, 2004), as well as with racialized women who have experienced violence (Kelly, 2009). While many have strongly advocated for the use of an intersectional approach, few studies have adopted the method in practice (Valentine, 2007; Hankivsky & Christoffersen, 2008). This is attributed to practical limitations such as the complexity of analyses which make it difficult to include in a single publication, as well as the pressure stemming from funding bodies to demonstrate that one category is more oppressive than another (Valentine 2007). Additionally, there are methodological challenges in the measurement or capacity to capture the multiple strands of difference. Despite these challenges, the promises of intersectionality offer an important route to understanding the health needs and challenges faced by refugee and refugee claimant women, a sub-population of whom little is known.

Guided by the core premise of intersectionality and following Crenshaw (1991), this study seeks to shed light on the health experiences of refugee and refugee claimant women whose voices are missing from the literature and from social and immigration/refugee policy. Further, an intersectional lens helps to understand where the women are socially, economically, and politically positioned in Canadian society and how they may experience barriers to health as a result. In this study, we differentiate the women by their permanent or temporary status, and therefore the women are either

referred to as ‘refugee women’ or ‘refugee claimant women’, respectively. The women who have come to Canada as Convention refugees, privately sponsored refugees, and government sponsored refugees are referred to as refugee women, as all three categories share permanent status upon arrival to Canada and receive financial and/or social support from their respective sponsors. By contrast, refugee claimant women have temporary status and are restricted in terms of the financial and social support available to them. In keeping with principles of intersectionality, there is no assumption – ‘a priori’ – that their gendered roles are more important than their refugee status in terms of affecting their health (Hankivsky & Christoffersen, 2008). Through this lens, we may begin to uncover whether and where the needs and situations of refugee and refugee claimant women are systematically missing from social programs and policy – and whether they experience discrimination and barriers from one or multiple forms of oppression as they seek access to health during resettlement.

2.3 Methods and Participants

This research is guided by the following questions: *What health determinants are important for refugee and refugee claimant women during resettlement to Hamilton? What social differences are important/ marginalising for them as they attempt to rebuild, and lead healthy lives during resettlement?*

The study is set in Hamilton, Ontario, a mid-sized city with a population of 519,949 (2011) and located in southern Ontario, approximately 65 kilometres from Toronto (Statistics Canada, 2012). Hamilton may continue to attract more settlement due to its relatively close proximity to Toronto, and comparatively lower cost of living

(Newbold et al., 2008). Approximately one third of immigrants to Hamilton are refugees, including refugee claimants.

Recruitment of interview participants and data collection occurred in two separate phases: first with providers and then with refugee and refugee claimant women. In the first phase, providers representing a small but diverse community of social and health services for refugee and refugee claimant women in Hamilton were interviewed. Providers were recruited by way of a standard introduction letter via email and/or a phone call inviting them to participate in a one-on-one in-depth interview. The purpose of including providers in this study was twofold: 1) to develop a more comprehensive understanding of priority needs and challenges faced by refugee and refugee claimant women, and 2) to determine whether their perceptions either diverge or converge with those of the women in this study. Following each interview, providers were asked to recommend other potential providers and/or refugee and refugee claimant women to participate in the study. A total of nine providers, representing major settlement organizations, community health care centres, and dental clinics, accepted the invitation to be interviewed. Three providers were male and six were female. Eight of the nine interviews were semi-structured, in-depth, face-to-face interviews that took place in their places of work and one was completed electronically. Interviews lasted an average of 30 minutes and were recorded and transcribed verbatim following written or verbal consent before the start of each interview.

The second phase of data collection involved recruitment of refugee and refugee claimant women. For ease of organization, providers generously offered to coordinate

and facilitate recruitment of their clients. In order to foster an atmosphere of confidentiality, trust and comfort levels in sharing personal experiences, women were offered the choice of participating in either one-on-one interviews or focus groups at a time and place of their choosing. We wanted to accommodate both those individuals who may find focus group settings less conducive to discussing issues they may deem personal, as well as those who felt most comfortable in their own homes. The focus group process has been advocated within feminist research for its potential to offer 'safe spaces' for groups to discuss issues and disrupt or shift power from the researcher to the researched (Pratt, 2002).

A total of 43 women participated; 39 in four focus groups and four in one-on-one interviews. However, we limit our total sample to 37 women as six of the women that participated in the focus groups had entered Canada as immigrants (permanent status) or visitors and are presently considered 'non-status' women (those who remain in Canada after their visitors/tourists visas have expired). Providers organized all four focus groups according to the language that the women were most comfortable communicating in, and all focus groups took place at a settlement centre or community health center. Two groups were comprised of predominantly Spanish speaking women, and two were predominantly (several dialects of) Arabic speaking women. Interpreters were present in each focus group. Direct translation was encouraged and summarization discouraged. Within the focus groups, 18 women came to Canada as government sponsored refugees, five as privately sponsored refugees, and 10 as refugee claimants, in addition to the three visitors and three family sponsored immigrants mentioned earlier. Focus groups lasted

approximately one hour and were recorded and transcribed verbatim following written and verbal consent. An additional four respondents who came to Canada as refugee claimants chose to participate in one-one-one interviews. They were also recruited through providers and took place in locations of their choosing: one was conducted in a settlement agency; one at a coffee shop, and two were conducted in the women's homes. All four interviews were conducted in English and without an interpreter present as requested by the women. These interviews took an average of one hour, and all except one were recorded and transcribed verbatim following written and verbal consent.

In the second phase, maximum variation sampling (Patton, 1990) was employed to recruit a socio-demographically diverse sample of refugee (Convention, Government Sponsored, or Privately Sponsored) and refugee claimant (those seeking asylum within Canada) women who had resettled to Hamilton. Using this strategy, data collection and analyses yielded the uniqueness of individual experiences, as well as important aspects and patterns that were shared across multiple diverse experiences. Participants were recruited until a point of data 'saturation' was reached, meaning at the point in which no new themes emerged (Barbour, 2007). All interviews occurred over a span of ten months, between July of 2011 and April of 2012. The identities of all participants remain anonymous and are referred to by individual numeric identities in this paper. All of the women (refugees, refugee claimants, non-status/visitors) and translators who participated in focus groups or one-on-one interviews during the second phase of the study's data collection received honoraria of \$20. This research and all methods and procedures were approved by the McMaster University Research Ethics Board.

Before commencement of interviews, participants were reminded that discussions and any material from the interviews were confidential and participants would remain anonymous outside the interviews. Participants were also reminded of their right to withdraw information or discontinue the discussion at any time. Separate interview guides were created for providers and the women respectively, with the key difference between the two scripts being that the provider script was adjusted to represent different areas of expertise and sectors. Refugee and refugee claimant women recruited to the study were asked to share their pre-migration experiences and talk about their health experiences during resettlement. The purpose was to understand what the priority needs were during resettlement, the barriers to accessing these needs, and how these experiences shaped their health. As is common in qualitative research, we encouraged respondents in all cases to raise issues and topics that were important for them and reminded them of their right to omit questions they did not feel comfortable answering.

2.3.1 The Women

The women in this study came from various source countries, predominantly from Colombia and Iraq. The two focus groups that were comprised of predominantly Arabic speaking women were also mostly GARs and privately sponsored and mostly from Iraq. The two focus groups that were comprised of predominantly Spanish speaking women were mostly refugee claimants and mostly from Colombia. Other participants (n =16) came from countries including Argentina, Chile, Cuba, Dominican Republic, Ecuador, El Salvador, Honduras, Jordan, Kosovo, Pakistan, Syria, Venezuela and Yemen. A few of the women who initially entered Canada as refugee claimants or

GARS have since been granted permanent residency or Canadian citizenship. Of the four refugee claimant women who participated in one-on-one interviews, two had been granted permanent residency, one was denied refugee status and one had not yet had her hearing. Many of the GAR women were denied protection in neighbouring countries before the Canadian government sponsored them to come to Canada. Similarly, many of the women currently seeking asylum (refugee claimants) were denied status in the United States before coming to Canada and applying for refugee status. Few were privately sponsored by churches or family members who were residing in Canada.

While their legal immigration status may serve to locate the women in different social and political realms within Canadian society, they share experiences of fleeing violence, insecurity, war, instability, persecution and have sought safety and refuge in Canada. Some women came alone, but most arrived with their children and/or husbands. Some of the women have unintentionally been separated from family members and spouses during flight and have resettled alone or as single mothers. At the time of the interview, the majority of the women were married, and comparatively few were divorced or single. A little over half of the women were mothers to children under the age of 18. The majority of the women belonged to the 35-44 year age category, followed by those in 45-54 and 55-64, categories with only a few women in the 18-24 and 25-34 categories. Hamilton was the primary settlement location for all the women and most arrived between 2005-2010, while a few arrived before 2005 and some of the women had been in Canada for less than one year at the time of the interview. The majority of the women's annual total household income at the time of the interview was below \$15,000.

Most were unemployed and seeking employment opportunities, and most were enrolled in English as Second Language (ESL) courses. Approximately half of the women had completed post-secondary education (college, university) as their highest level of educational attainment in their country of origin, while the remaining half had completed high school or elementary level education.

2.3.2 Analysis

Data was analysed thematically following a modified process adopted from Burnard (1991). Analyses were conducted in an iterative and reflexive manner and the purpose was to draw meanings out of experience (Ayres, Kavanaugh & Knafl, 2003). The analytic framework acknowledged that experiences and meanings are socially and culturally situated, but are also perceived as possessing integrity and value in the study of social life (Lawrence & Kearns, 2005). Inter and intra group differences between focus groups were acknowledged in order to avoid overemphasizing consensus within groups and homogenizing experiences (Barbour, 2007).

2.4 Results

Interviews with providers and the women reveal that the refugee and refugee claimant women in this study often had multiple unmet health needs during and after resettlement. Analysis yielded five inter-related themes: pre-migration, separation from family, citizenship (status), (un)employment and housing. These themes represent factors that affect the women's health during resettlement and will be explored in this section. According to the findings, the women's social location in Canadian society can be understood at the intersection of gender and citizenship/status (i.e. as mothers, lone

mothers, women, refugees, refugee claimants).

2.4.1 Pre-migration experiences: they escaped...

The women have come from various source countries and under varying circumstances, with most leaving their countries of origin for the purpose of seeking safety from persecution by paramilitary or rebel groups and/or war. F20 is presently a permanent resident, who sought asylum in Canada in 1998 due to persecution from a paramilitary group. While her journey is unique, her story of sudden flight is one shared by many of the women interviewed, regardless of status. Having endured significantly life-changing events, she expresses a desire to extend her gratitude for having been granted safety in Canada by “giving back” to the greater community:

... And I had to abandon everything that day for the success of my house. I lived and my daughter lived too because God is big (awesome)! Four men with machine guns and they started to shoot and one bullet hit the car but I had to abandon everything from that day. I never went back to that house again. We entered here (Canada) with some baggage and nothing more (...) Yeah, and I made a promise to God when I came to Canada, for him to let me command the language to help and I've been working at the centre... for almost 20 years... as a volunteer... I wanna give something back to the community because it's – it's the least I can do! (F20)

For many of the women, their pre-migration journeys of fleeing are deeply entrenched in their everyday lives. Many are reminded daily of their pre-migration experiences via missing family members or belongings, or through permanent wounds and physical impairments as a direct consequence of the violence they fled. Also due to war, F26 fled her home country in 1999 and came to Canada as a GAR. Below, she recounts her experience and – as was common with the vast majority of the women interviewed – expressed her gratitude towards Canada for offering safety:

... it was war in that time- 1999. And I had small child at that time and I had you know, they shot me on the foot and we came at the war. Canada sponsored us to come here for free and then we came (as) refugees. Now I have status, I thank Canada for that. (F26)

I12 fled her home country during a civil war resulting from violent conflicts between ethnic groups and came to Canada as a refugee claimant in 2006. Today she is a protected person, awaiting sponsorship for the rest of her family (children and husband) to be approved. She recounts a very painful and vivid image of unrest and violence in her home country. This is especially difficult for her to recall knowing that the lives of her children and husband are still vulnerable to the ongoing conflict and violence:

We were all the time move, return home, move, very unhappy... People killing people... killing... People killing themselves! grenades, bombs... (I12)

Throughout the interviews, memories of forced flight appeared to serve as persistent reminders of their lives uprooted and disrupted, regardless of status and differences in period of arrival. Their lives in Canada are torn between negotiating local processes of resettlement and rebuilding, while their memories of flight serve to emotionally and psychologically anchor them to their homelands. These accounts of displacement help inform our understanding of the women's social position as refugee or refugee claimant women and how they may shape their identities and affect their health during resettlement (O'Mahony & Donnelly, 2010). While their legal status inscribes marked differences between refugee and refugee claimant women, the refugee claimant women wanted to continuously reinforce that their reasons for fleeing their homeland and coming to Canada warrant official refugee status. As refugee and refugee claimant

women, the women perceived themselves as survivors of violence and/or persecution and thus identified themselves as refugees in limbo, rather than refugee claimants per se.

2.4.2 Separation from Family

A second prominent theme that emerged from the interviews had to do with separation from family members. Some refugee and refugee claimant women recalled unwillingly being separated from family, including their children or spouses, during flight. Many of these women remain separated and struggle to cope with the stress of separation and uncertainty of reunification. In fact, there were instances when some women expressed that coping was not always possible. This section is bound by a shared experience of being separated from family members during flight; however, the individual experiences of separation differ for each of the women, as does the ability or capacity to cope with the loss or separation while navigating life in a new (host) country.

Depression and anxiety from fear and worry were expressed by a provider below:

It is horrible! It is horrible because these people tend to suffer from depression because of the separation from family. It's not just about being separated from family. It's about knowing that it's going to take a long time to be reunited. And another thing it's about where are they? Are they in a place of conflict? Are they safe? Do they even have food? You know? So all of that.... the way it affects people – it's oh my God! I put myself in their place... (I7)

One participant had been awaiting sponsorship for her husband and children for approximately five years at the time of the interview. When she first submitted her visa requests in 2007 to sponsor her family, she was told the process would take around 6 months. Throughout the interview, she spoke of missing her family and how she constantly worried for their lives and feared she may never see them again:

My son called me last week, told me, young men from rebellion. He told me that the Tutsi came and asked him for physical and financial support.... I am stressed! They continue to kill and take away people! (I12, Protected Person)

Some women were separated from their spouses during flight, leaving them to resettle as single mothers. The stress of single motherhood seemed to compound the stress of adjusting to life in a new country, and sometimes these women felt overwhelmed by the responsibilities of settlement such as learning English. When asked to talk about her overall health, F42, talked about the stress of negotiating single motherhood, finding her husband and maintaining her health:

... like my health is OK, but my ... my mood like stressed out... because I'm almost like a single mom. I have seven kids. (my) husband is not here and (I am) looking for the husband... and according to my health, it's almost five years and now I'm not drinking milk. I don't know how that affects my calcium or whatever, minerals in my body... It's hard to manage my kids... (F42, GAR woman)

... she arrived to Canada with her family, but her husband left there so now she's in the process to sponsor her husband. But... it's very hard. And she had four children and she's surviving to take care of four children alone and the husband is outside and that's the situation (...) I can't go to school to learn language, that's a number one barrier uh... the language and being a mother too. Being a mother and on top of that, the disabled child. Like in a day, three times I have to take him to different appointments, hospitals, planning this and that ... (F35, GAR woman)

Overall, the stress of suddenly negotiating single motherhood, of caring for their children during a time when the women carried additional responsibilities associated with resettlement, in addition to facing the loss and separation of spouses, led these women to feel a sense of role overload.

While they are limited in improving the chances for reunification, they remain

hopeful that they will eventually reunite. The women demonstrate great resiliency in their ability to navigate such dramatic changes, and their coping strategies varied. The majority of the women brought up coping with stress and struggles through spiritual or religious beliefs. For example, I12 talked about coping through prayer and religious music:

I listen to Christian CDs. It is my *great* occupation at home and I feel better with the CDs. At that time, I think of my families (I12, Protected Person)

Providers and many of the women also spoke of finding support through reaching out to counsellors at local settlement agencies and community health care centres. However, providers pointed out an important barrier faced by refugee claimant women, as they remain ineligible for services provided at (federally funded) settlement and integration agencies and have limited access to health and social services in general due to their temporary status and limited incomes:

... The one that are really in the bad shape are the refugee claimants. And they are the ones who are having the – really struggling with the whole system. Not just when it comes to the health, but when it comes to everything else... because they have extremely limited access to any kind of resources – if any – in the city right now. (I1)

Forced migration and separation from spouses and children has considerable life-changing effects and is a traumatic experience according to the women in this study. It can be argued that these traumatic experiences may have long lasting effects with restricted access to resources and support during resettlement. The GAR women and those whose refugee claims were accepted valued the support of their settlement counsellors and felt they were able to better cope with separation or loss of family and their limited social networks during resettlement. This suggests a strong need for the

extension of resettlement services toward those with non-permanent status.

2.4.3 Citizenship: Having status is a determinant of health...

Various dimensions around ‘citizenship’ or status contributed to mental health, psychosocial health, as well as varied access to social and material needs, specifically for the refugee claimant women during resettlement. Both refugee and refugee claimant women and providers equated having permanent status in Canada to having security; likewise, not having status meant living in insecurity, uncertainty, and fear:

Because (of) the situation, she has been through- the most important thing for her is the landing, the landing paper. Now she feels safe and secure because in Iraq, they ran away, they flee to Syria and in Syria they didn’t give them- they haven’t been recognised, so no ID, no anything until they brought them here. So the most important thing for her-because she has been here for a month now- is the landing paper and being safe and secure in this country. (F41, GAR woman)

The refugee claimant women and providers felt that the stress of claiming status and perceived insecurity affected the women’s mental health and they reported losing sleep, experiencing anxiety, depression, and frequent migraines. A former refugee claimant woman who had recently been granted permanent residency on the basis of Humanitarian and Compassionate Grounds, who is also a single mother of three young children and remains separated from her husband, described the determination process as one of waiting in “limbo”. She also coped with depression while maintaining full-time employment and felt she struggled to care for her children as a sole provider and caregiver:

I have problems with depression. But... now I’m getting better... because I have a solution of this. Now I’m no worry about that. Finally, I get my residence but during those times, it was very hard for me because I have

by myself with my kids and I have to work harder because... I don't have the opportunity to have like support from assistance (...) I had to support by myself with my three kids. (...) It was so tired, I feel- but now... this solution, I finish with my paper.... Before it was day and night, day and night, thinking of my papers ... If I'm gonna' stay or not... It's stay like in limbo... You know, thinking if you're gonna' stay or not, like limbo. I'm thinking about my kids, how are they gonna' – if we go back to my country, where they don't (know) nothing about it (...) I'm coming out from this yeah. A little by a little bit... And my kids are so happy too-about that. You know, but now it's OK. ... the problems... are little for me now! (I19, former refugee claimant, Permanent Resident)

Because sometimes people say, 'Why am I getting migraines every day? I never got migraines before!' And I say, 'You are *very* stressed out!' Yeah, the mind, you know, has an effect on the body... if you constantly worry and you are afraid that something is gonna' happen to you or your family back home (I7, Provider)

While both refugee and refugee claimant women had multiple responsibilities during the early stages of resettlement, the refugee claimant women felt additional burdens stemming from the determination process and felt the added pressure of “creating merit” to stay in Canada. Creating merit meant becoming largely self-sufficient and avoiding reliance on social assistance by becoming proficient in English, securing employment and income, and being active in their respective communities by volunteering.

So some of those (refused) people will be referred to me, because sometimes in agency they tell them 'you don't have English. You have to focus on school. Study one or two years in school and go on welfare.' That's not my position. My position is you're gonna' take between four to six months to get a work permit, go to work- as soon as you get your work permit, try to continue studying in the evenings if you can and if you get a job in the evenings. Try to go to school in the day time because you need to create merit for you in Canada to... to work at getting status if you get refused... (I7, Provider)

The above quote suggests that there may be a potential disjuncture between

refugee policy as laid out in the Convention and the determination process as experienced by refugee claimants who seek asylum in Canada. The quote speaks to the experiences of the refugee claimant women in this study defined by creating merit in a relatively short period of time. These findings are indicative of the concept of 'refugeeness' (Lacroix, 2004) which refers to understanding the essence of the refugee experience and journey which at an individual level is unique, but commonly shared by those in the process of 'becoming' refugees. Inherent to this notion is recognition of the multiple gender related struggles and socio-political, legal tensions that are faced by those seeking asylum in western countries such as Canada.

These findings reinforce those of other studies that living with precarious status - as is the case for refugee claimant women - is strongly related to severe psychological distress (Simich et al., 2007). The refugee claimant women felt that their coping mechanisms were greatly limited by their lack of access to social networks and social support which further compounded feelings of stress and insecurity. There are very few agencies that are able to serve clients without permanent status in Hamilton, and many of the refugee claimant women spoke of dealing with these issues on their own. This suggests that refugee claimant women are systematically denied mental health treatment at a time when they may need it the most.

2.4.4 Un-Employment: I want to work! I want to be in good health to work...

Providers identified finding employment and income opportunities as a key priority and an unmet need. It appeared that the women wanted to contest any notion that they preferred or chose to depend on social assistance compared to earning income. Many

of the women, regardless of status, consistently stated that while they have not been successful in securing employment and rely on social assistance, they are actively seeking opportunities and would prefer to work. Consistent with the literature (Murray & Skull, 2004; Tomlinson, 2010), most of the women in this study were unemployed or employed part-time, but took on volunteer positions, and very few women were employed in janitorial related fields. The women's efforts to obtain employment were made evident and included a variety of methods. All of the women were enrolled in English as a Second Language (ESL) courses and many had taken on various volunteer positions in their efforts to increase their chances at securing employment. Language barriers were more pronounced for newly arrived GAR women compared to those that had been in Canada longer and also compared to the refugee claimant women. Most of the refugee claimant women in this study had lived in the United States before entering Canada and had acquired English language proficiency there. Thus, while language barriers did prevent some of the women from accessing employment opportunities, those participants without language barriers still faced barriers to accessing employment. For example, one participant felt she was reduced to full-time volunteer positions despite her English language proficiency, professional experience, and educational background:

... I have a bachelor in mathematics, I'm working in (that field in) Iraq for 16 years and I can easily make it with English but I'm suffering too much to find a job here... I was volunteering with (a hospital and settlement agency) for two years, sometimes full-time volunteering until like I get a part-time job with (the hospital) and I'm working with (another organization). So it's not easy, even you are educated, even you know the language, if you have the basic English, it's not easy to find a job... (F33, Privately sponsored Refugee Woman)

Barriers to accessing employment differed slightly as identified by providers and the women. For instance, there was a strong consensus among providers that barriers to employment had to do with power relations in patriarchal, nuclear families whereby the men were often more likely than the women to access language skills while the women were expected to take on domestic responsibilities of caring for the home and children.

Below is a statement from a provider:

One big one, that we always see is happening and I don't know. It's very hard to say why is it. Let's say the whole family comes and somehow women is always in the second place when it comes to accessing services and going to school and putting everything in the right place. So husband always has the priority. So women are mostly secondary in all of this. Like a focus is always on the male- to you know, get English and all this. So woman, that's the one thing. Another thing is that woman have children as well. Which again, it really makes it hard to access many things. So that traditional role of women and especially for women who have, you know, number of kids, it becomes extremely hard. So that holds many of them back when it comes to learning a language. When it comes to accessing any schooling, looking for job, etcetera, etcetera... So it slows down and puts them back in the whole settlement process (I1, Provider)

The majority of the women in this study regardless of status strongly emphasized that they preferred finding employment over receiving social assistance, but faced multiple barriers to accessing these opportunities, and often referenced both the lack of 'Canadian experience' or issues of skill transfer and recognition that is seen commonly in the literature (Stewart et al., 2008). However, domestic barriers of caring for children and maintaining the home were a further complicating factor, although these were mostly expressed by single mothers and not by married women:

So they say like the income, the family income... OK, most of them after the year they have no income, what do they do? They go on Ontario social assistance and the social assistance, like they really want to work. But they

don't speak the language. They cannot find jobs. They cannot even on themselves and the social assistance is very low for the income. So she says like, they pay me 1100 or maybe 500 even but my rent is 900 so, most of the money goes to the rent. How can I manage and make them survive seven or nine children (Focus Group 3)

Few women associated good health with being able to do domestic chores and care for their families, but they identified this as a choice and the issue of autonomy was not brought up, even when prompted. The majority of women associated being unemployed with poor psychosocial health which in turn compromised their coping mechanisms in dealing with pre-migration stressors and the stress in rebuilding lives and resettling to new countries. Unemployment was often accompanied by feelings of social isolation and depression, which further complicated experiences of separation and loss of extended family and friends. The following quotes speak to a variety of ways that unemployment intersects with various spheres of life during resettlement:

...thanks God I have nothing, but I'm going to get sick... Because like she says, without joke, I will get sick. I'm not working here and I really want to work and.... she says that's all everybody's problem – finding jobs (...) I'm not used to like, staying like that without activity, working and being active and being, having, promoting stuff to the community and at the same time, gaining my finances. But this will give me depression and stress (F43, Privately Sponsored Refugee Woman)

... like staying at home because we are looking for job and we- it's very hard to find job. When you don't find job and the weather is not helping too, you get depressed and plus homesick. Like in back home you have family, relatives, friends uh... all of that. Like if you don't find a job or you have some, some depressed and stressed out, you go and talk to someone and then you, you forget it. But here you- we don't have anyone and that makes our mood lower and stressed out more and sometimes it reach we get depressed and she has some friends they are taking medication for that.... (in) Canada, if you have your job, you are working, if you have a house and a little car, even (if) your mood goes down and you get stressed out, you for a Tim Horton's, you go walking. But if you are save and you

don't think about, you don't have income, you don't have this, you don't work (...) But even Tim Horton's, you have to pay some money (Focus Group 3)

Some of the women in the study had chronic conditions and one woman in particular had chronic pain, due to a combination of accidents. While the pain was evident throughout the interview and indeed a significant source of stress, she identified her subsequent inability to work as being most important for her mental health and sense and loss of identity. Her previous work as a teacher in her homeland and then a lunch room monitor in Canada involved working with children. Her disability left her homebound, and, while at home, her disability prevents her from performing simple, everyday chores such as cleaning and cooking. She feels isolated and lonely and has had very little opportunity to build social relationships outside her home owing to her illness and lack of social ties. Her disability, inability to work and to be around children, compounds social isolation and reduces her capacity to deal with the consequences of being ill and being separated from her family:

I liked the job because it was in my career. I was a teacher, it was at school. I like children! All of my career I was a teacher. But now, I miss children at my school because of my back. I don't feel good. I don't feel happy because I miss children at my school... It's not easy, I stay home. I feel bad, I'm alone, I miss my family (I12, former Refugee Claimant woman, Protected Person)

As described in the quotes above, being employed meant being able to cope with the various stresses that the women faced. It also meant being able to fulfill roles beyond providing for their families, as many women expressed experiencing loss of identity in not being able to carry on the employment positions they once held. Most participants are

actively seeking employment opportunities and while they have been unsuccessful since arrival to Canada, they display a strong sense of determination, as evidenced by their pursuit of multiple volunteer positions. Beyond individual health effects, unemployment had the greatest affect on family and social life, especially as related to housing which we will discuss in the following section.

2.4.5 Housing: Like if someone is not happy at home, how do we be healthy?

While the women shared their illnesses and medical concerns during discussions about priority needs and health status, many also discussed the ways that substandard housing conditions and their inability to access more appropriate housing options greatly affected their mental health and compounded additional stressors related to the settlement process. Housing conditions were often identified as dirty, cramped, and pest infested, and the women felt that their quality of life, especially when trying to cope with pre-migration and settlement stressors, was directly affected. As most of the women were unemployed, and given that the vast majority of the women's total household earnings were less than \$15,000 per annum, most lacked the financial means of accessing better housing options. In addition, they also spoke of non-financial barriers including discrimination based on their status as non-Canadians. These issues were shared by providers and the women alike. Providers talked about safe, clean, and affordable housing as an unmet need. The following statement comes from a provider who works closely with refugee claimants:

Housing stock is not good... so that's a need, you know obviously... the CMHC... talk about – they have definitions on their website... safe and affordable housing, that's what every Canadian should aspire to, or

whatever, that's their goal. But I mean I think basically our (clients) also need to *choose* between those things... Are we going to have a safe house, a place that's nice, that's clean or are we going to have something we can actually afford, that's kind of gross, but then again, now we can eat. So... that's a problem... that's a problem. (I5, Provider)

Some women reported facing attitudinal barriers such as incidences of perceived mistreatment and discrimination by landlords who they felt expected the women to have lower standards of living conditions because of their refugee or refugee claimant status. Many of the women expressed their disappointment and frustration in dealing with their landlords on issues relating to building hygiene and safety. One refugee claimant woman visited approximately 20 apartments over four months in her efforts to find a clean, safe and affordable apartment for herself and her young child:

... And the problem is, when you are going because they know you are not from Canada, they want to let you apartment in bad condition because they think- Oh, you are from another country. That's normal for you to live like this. And they don't care for give you apartment in good condition because they know we are not from Canada. (I13, Refugee Claimant woman)

Substandard housing conditions presented a significant source of stress and the women felt that it compounded existing stressors and compromised their ability to maintain their health. The women felt that their mental and physical health suffered, especially in feeling a sense of powerlessness and lack of choice. There were several accounts of having to live in conditions that failed to meet their basic housing needs. F21 is a GAR who raised her issues on housing when asked to talk about her overall health. She feels that her poor housing conditions compromised her ability to deal with the multiple stresses of resettling, including caring for multiple children as a single mother, and maintaining household chores:

... I'm very unhealthy because I have eight children and living in small apartment, like a sardine in a can... because there's no – like I'm trying to manage to make them see that's the difficult part other than the rest of the daily work I have to do, so my health is not good... there's another like ninth member of the family with like eight children and (myself) nine uh living in a three bedroom apartment. It's very hard... You have nine members of the family managing to live in the place and the house is not clean. There is like bugs and cockroaches and stuff like that and nobody follow up to... that affects our health too! (F28, GAR woman)

F35 (also a GAR) struggles to cope with multiple responsibilities: having been separated from her husband, she cares for her children on her own, including a disabled son. As mentioned earlier, her responsibilities include getting her son to multiple medical appointments, sometimes on a daily basis. She also struggles to maintain enrolment at ESL courses so that she is able to eventually find employment. The statement below offers some insight into her challenges of trying to navigate everyday responsibilities such as taking her son in and out of the apartment:

OK, specifically in my situation I have a disabled son and he is using a wheel chair and the neighbours, the other tenants and everybody get upset with me because I have to hold the elevator and instead of helping me, supporting me in moving my son- my disabled son, they get angry at me and say you are holding the elevator for that long and when I applied for housing, they told me I have to wait for five years, even if I have urgent application, nobody listen to me. (F35, GAR woman)

These accounts of feeling unheard is reminiscent of Crenshaw`s (1991) analogy of accidents that occur and may reoccur at certain junctions (intersections) but go unaccounted for. The women it seems are desperate to have their voices heard, and to have their concerns addressed.

The relationship between housing, income, and health has been well established (Bryant, 2009; Dunn et al., 2009). Low or precarious income and substandard housing work in tandem to produce the conditions that negatively affect health. As evidenced in the above discussion, income largely determines financial access to housing of choice, and low-income housing is often comprised of overcrowding and pest-infestation which have physical and psychosocial health effects. While the above experience may not differ in comparison to Canadian-born populations who are disabled and living below the poverty line, it can be argued that refugee and refugee claimant women are particularly vulnerable to poor health given their histories of fleeing and compromised mental health, limited social support, and access to material needs. These findings suggest that the lack of suitable housing options for refugee and refugee claimant women present significant barriers to successful resettlement and may intensify feelings of insecurity, which contribute to poor psychosocial health.

2.5 Discussion and Conclusion

This paper sought to understand refugee and refugee claimant women's experiences of health during resettlement to Hamilton, Ontario. Through an intersectional lens, the study sought to understand the health determinants that are of particular importance to the women during resettlement to Hamilton. Their multiple identities related to their gender (sex, gender roles) and status (refugees, refugee claimants) often intersected to produce differential experiences of health and access to health determinants during resettlement. While the women in the study are generally thankful to have found safety in Canada, and remain hopeful for potentially improved health outcomes and an

improved quality of life in Canada, they report a variety of factors that affect their health, including the lasting effects of pre-migration trauma, separation from family, (difficulty of attaining) citizenship, un-employment, and substandard housing. While their lives have been uprooted and displaced, their journeys are marked with resiliency, determination, and hope.

Overall, this study demonstrates that both refugee and refugee claimant women face unique stress in dealing with pre-migration traumas, the stress and worry concerning separated family members, the lack of social support networks, social isolation, and shifting gender roles during resettlement. Results from this study also reveal that mental health needs are profound and largely unmet for both refugee and refugee claimant women, which affirms the findings of other studies (see Fowler, 1998; Sypek Clugston, & Phillips, 2008). Another common experience amongst the women was that they lacked the capacity to choose meaningful employment and suitable housing. Both refugee and refugee claimant women experienced a sense of feeling unheard and invisible and experienced forms of ‘othering’ during their attempts to change the conditions that negatively impacted their health. While they wanted to have their concerns heard, they felt silenced and powerless. Findings suggest that the voice of refugees and refugee claimants is limited possibly because they are a small, heterogenous group with limited power and options, and potentially limited legal status.

Regardless of their status, refugees also experience limbo in that they continue to remain very much attached to their homelands where their children or spouses wait to be reunited. Their experiences of flight appear to remain vivid and they continue to fear for

the safety of their families while they wait for reunification. At the same time, they are committed to move forward and fulfil the expectations of resettlement, including acquisition of the English language and the pursuit of becoming financially self-sufficient which in turn complicate healing. As a result, many of the women experience role overload, regardless of status, with refugee claimant women feeling as though their status determination is contingent on their ability to succeed. Likewise, employment is valued by both refugee and refugee claimant women because it is a validation that they are permanent and productive members of society.

While both refugee and refugee claimant women share a collective experience of dealing with the lasting consequences of fleeing, trauma, forced displacement, and the challenges of resettlement, their experiences in navigating and coping with these challenges differ, in large part owing to the resources (or lack thereof) that each group are able to access. One of the most prominent differences between the two groups is based on status: refugee claimant women may only begin their processes of healing from those pre-migration traumas when those experiences are acknowledged via their status determination. Their experience is one of being caught in limbo as they await status determination. The long refugee determination process hindered the women's desires to move forward, rebuild, and cope with their pre-migration experiences. Not surprisingly, these women reported various mental and physical health outcomes as a result. The refugee claimant women perceived permanent status as an identity that would afford them the power to resettle and address their health needs. Their temporary status prevented these women from accessing settlement and integration services available to

refugee and immigrant women (or those with permanent status). Perhaps such complexities may manifest in health inequities if such considerations are not recognised in the formation of social, health, and refugee policy. There is a need to address the systematic exclusion of refugee claimant women from programs and services currently reserved for those with permanent status. There is also a need to adjust resettlement expectations, especially with respect to relieving the pressure of refugee women to become self-sufficient in a relatively short timeline during a time when their health needs should take precedence.

Research findings also suggest that the experience of refugees and refugee claimants diverge on entry to Canada. While the former are granted landed residency, the latter remain in limbo while their file is processed, an outcome which may take months or even years to finalize, with no certainty of success as measured by recognition of their claim. In the interim, there are few services that are available to claimants. Consequently, as Kisson (2010) noted, refugee claimants are left to struggle to rebuild their lives at the very margins of society during a period of tremendous stress, with implications for their physical and mental health. As such, there is a need for current federally funded services that serve refugee and immigrant women inclusively to be extended to refugee claimant women. In other words, the needs of refugee claimant women need to be explicitly included in refugee policy frameworks, a need that has been raised concerning temporary residents more generally by Simich et al. (2007).

For both refugee and refugee claimant women alike, coping with pre-migration traumas and separation from family is understood to be further complicated by

substandard housing and unemployment during resettlement to Canada. The experiences of coping with the stress of economic hardships during resettlement in this study are also comparable to those found in other studies (Simich et al., 2010). The women in this study more often experienced limitations in accessing employment and income opportunities due to a lack of Canadian experience rather than lack of skill set. Additional barriers that the women faced were related to responsibilities within family and in the home, especially in the case of caring for multiple children after being separated from their spouses and/or extended family and other social support networks. Key informants identified issues related to patriarchal power relations within domestic spheres whereby their female refugee and refugee claimant clients were reduced to staying home while their husbands participated in learning English and accessing employment opportunities. However, the majority of the women who participated in this study expressed a strong desire for a chance at gaining employment and made direct connections between employment and health and sense of identity. Protracted periods of unemployment had a wide ranging effect. It further compounded struggles in managing multiple responsibilities as single heads of households and also added to feelings of insecurity and depression. Safe, clean, and affordable housing was identified as a significant unmet need and source of stress that directly affected the women`s health in their everyday lives. The women felt that this was largely due to direct discrimination and assumptions that they should have lower expectations for living conditions and were financially limited due to being unemployed. Findings also affirm that the gendering of resettlement processes reduce migrant women`s employment and education opportunities (Redwood-Campbell

et al., 2007), especially for those who take on responsibilities of single heads of households during resettlement. Refugee and refugee claimants need for appropriate and affordable housing and fair and equal access to employment opportunities is particularly critical given the precariousness of their social position in Canada.

Consequently, gender is indeed a very important determinant of health given that refugee and refugee claimant women face different health needs and expectations during resettlement than their male counterparts, as suggested in the literature. While the gendering of forced migration is indisputable and a defining facet of the refugee experience, research that gives primacy to the role of gender may risk overlooking the new and multiple challenges that refugee and refugee claimant women face during resettlement to new host countries such as Canada. According to the women in this study, their health is affected by myriad of factors. Their pre-migration histories of sudden flight and escaping violence are deeply entrenched in their identities as refugee and refugee claimant women. While the women negotiate new gender roles during resettlement such as those of single mothers or primary providers, they also negotiate their new identities, as refugees or refugee claimants, or as a result of not being able to procure meaningful employment. These identities are in no way fixed and there are times when it is important for the women to contest them such as the case with some of the refugee claimant women.

Since the start of this research in 2010, major legislative changes have taken place within Canadian Immigration and Refugee Policy. More specifically, Bill C-31, an Act to amend the Immigration and Refugee Protection Act (“IRPA”), the Balanced Refugee

Reform Act (“BRRA”), the Marine Transportation Security Act and the Department of Citizenship and Immigration Act – *Protecting Canada’s Immigration System Act* have been put forward. Changes laid out in the Bill largely affect asylum-seekers rather than government sponsored refugees and concerns surrounding the implications of the subsequent changes have been shared by various stakeholders including the UNHCR and have garnered criticism and attention within refugee serving communities in Canada. Underlying much of the concerns is to what extent such changes compromise Canada’s international humanitarian obligations and the rights of refugees and asylum-seekers outlined in the 1951 Convention and the 1967 Protocol (UNHCR, 2012).

Although this research was largely conducted before these changes were implemented, the findings from this study suggest that the current direction of immigration reform as it affects refugees and refugee claimants living in Canada is indicative of a move towards a ‘shrinking humanitarian space’ (Hyndman and Giles, 2011, p. 366), whereby host countries implement exclusionary policies which seek to reduce opportunities for refugees from reaching them and seeking protection. Understanding the impact of the specific legislative changes on the broader refugee, asylum seeking and humanitarian community are needed. Such changes may contribute to a social environment that is potentially harmful and stigmatizing and further reduce an already limited range of social assistance available to these communities. Findings from this study strongly suggest a need to enhance resettlement programs and social support for women who have fled violence and persecution to facilitate coping with pre-migration traumas so that they may continue to rebuild their lives in spaces which are safe and

secure. There is also a need to consider the implications and impact of policy changes on individual lives and whether changes in refugee legislation are in agreement with the core principles of non-discrimination, non-penalization, and non-refoulement, as laid out in the 1951 Convention.

Through an intersectional lens, findings from this study suggest that issues of autonomy might be better addressed if the gaze is shifted from the individual and domestic spheres toward the broader socio-political landscape. Further research is needed to understand whether the gendering of forced migration is fully accounted for in the changes within refugee and immigration policy in light of the recent legislative changes to the refugee determination process and immigration reform. Additionally, research is needed to understand how refugee and refugee claimant women living at the very margins of society are affected by the restructuring of refugee and immigration policy such as those mentioned above. Finally, in keeping with key tenets of feminist scholarship, research should seek to uncover how the changes are experienced and how they may work to limit the choices that refugee and refugee claimant women can make.

Finally, there are four limitations to this study that warrant further discussion. First, the participants in this study represent refugee serving centres as well as refugee and refugee claimant women living in Hamilton, Ontario. While the emphasis was on health, the perspectives of physicians (general practitioners) are missing, as we were unable to recruit them to our study. However, several studies have specifically accounted for physician perspectives to date (see for example Fowler, 1998; Merry et al., 2011; McKeary & Newbold, 2010; Ng & Newbold, 2011). Second, women were recruited to

the study through various settlement organizations, community health care centres, or refugee receiving centres, raising the potential that we missed those who do not access such agencies and are therefore potentially isolated and marginalised. This suggests that there is a need for research to incorporate more inclusive research agendas so that the experiences and voices of those women who are without formal social support are brought to light. Third, focus groups are limiting when discussing potentially traumatic experiences or raising personal concerns which may lead to perceived or actual stigmatization, such as when discussing histories of sexual violence or lack of autonomy within domestic spheres, and some women may have chosen not to disclose such personal details for various reasons. To address these potential limitations, participants were reminded at various points prior to and during focus groups that they are invited to discuss more personal issues one-on-one. Further, participants were given the choice between focus group interviews and one-on-one interviews, and only four participants chose the latter option. Finally, there are issues of doing research in cross-cultural settings, especially in this study where the women represent a diverse sub-population, having come from various parts of the world and having experienced tremendous life-altering and traumatic events, with varying levels of English language proficiency. To facilitate communication and comfort, all of the focus group interviews were accompanied and facilitated through one or multiple translators, who were in some cases also providers interviewed in this study. It is possible that through translation, meanings may not have been interpreted as they were intended. Thus, some interpretations were checked by a second interpreter after initial transcription.

2.6 References

- Adanu, Richard M.K., & Johnson, Timothy R.B. (2009). Migration and women's health. *International Journal of Gynecology & Obstetrics*, 106(2), 179-181.
- Ayres , Lioness, Kavanaugh, Karen, Knafl, & Kathleen A. (2003). Within-Case and Across-Case Approaches to Qualitative Data Analysis. *Qualitative Health Research*, 13 (6), 871-883.
- Barbour, Rosaline. (2007). *Doing focus Groups: The Sage Qualitative Research Kit* Edited by Uwe Flick. London : SAGE 2007.\
- Berman, Helene, Girón E R Irías, & Marroquín P Antonia. (2009). A Narrative Study of Refugee Women who have Experienced Violence in the Context of War. *CJNR*, 41(1) 144-165.
- Bryant, T. (2009). Housing, income and gender as social determinants of women's health. *Women's Health and Urban Life*, 8(2), 1-20.
- Burnard, P. (1991). A method of analyzing interview transcripts in qualitative research. *Nurse education today*, 11, 461-466.
- Burnett, Angela & Peel, Michael. (2001). Asylum seekers and refugees in Britain: Health needs of asylum seekers and refugees. *BMJ*, 322, 544–547.
- Canadian Council for Refugees (CCRWEB). (2011). *Canadian Immigration - Changing Priorities*. Canadian Council for Refugees. Retrieved from <http://ccrweb.ca/en/canadian-immigration-changing-priorities>
- Citizenship and immigration Canada (CIC). (2011a). *The Refugee System in Canada*. Citizenship and Immigration Canada. <http://www.cic.gc.ca/english/refugees/canada.asp>
- Citizenship and Immigration Canada (CIC). (2011b). *Immigration Overview: Permanent and temporary residents*. Retrieved from <http://www.cic.gc.ca/english/resources/statistics/facts2010/temporary/27.asp>
- Crenshaw, Kimberle. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review*, 43(6), 1241-1299.
- Deacon, Z. & Sullivan, C. (2009). Responding to the Complex and Gendered Needs of Refugee Women. *Affilia-Journal of Women and Social Work*, 24(3), 272-284.

- Dhamoon, Rita Kaur, & Hankivsky, Olena (2011). Why the Theory and Practice of Intersectionality Matter to Health Research and Policy. In Olena Hankivsky, Sarah de Leeuw, Jo-Anne Lee, Bilkis Vissandjée, & Nazilla Khanlou (Eds.), *Health Inequalities in Canada: Intersectional Frameworks and Practices* (pp. 16-53). Victoria, British Columbia: UBC Press.
- Dixon P. Deborah, & Jones III Paul Jones. (2006). "Feminist Geographies of Difference, Relation, and Construction" in Stuart Aitken and Gill Valentine (Eds.), *Approaches to Human Geography*, Thousand Oaks: Sage Publications. 42-56.
- Donnelly TT, Hwang JJ, Este D, Ewashen C, Adair C, & Clinton M. (2011). If I was going to kill myself, I wouldn't be calling you. I am asking for help: challenges influencing immigrant and refugee women's mental health. *Issues in Mental Health Nursing*, 32(5), 279-90.
- Dunn, J. R., M. V. Hayes, J. D. Hulchanski, S. W. Hwang, & L. Potvin. (2006). Housing as a socio-economic determinant of health: Findings of a national needs, gaps and opportunities assessment. *Canadian Journal of Public Health*, 97(3), S11-S15.
- Dyck , Isabel. (2006). Travelling tales and migratory meanings: South Asian migrant women talk of place, health and healing. *Social & Cultural Geography*, 7(1), 1-18.
- Dyck, Isabel, & Dossa, Parin. (2007). Place, health and home: Gender and migration in the constitution of healthy space. *Health and Place*, 13, 691-701.
- Dyck, Isabel, & McLaren, T. Arlene. (2004). Telling it Like it is? Constructing Accounts of Settlement with Immigrant and Refugee Women in Canada. *Gender, Place and Culture*, 11(4), 513-534.
- Fowler, Nancy. (1998). Providing Primary Health Care to Immigrants and Refugees: the North Hamilton Experience. *Canadian Medical Association Journal*, 159(4), 388–391.
- Freedman, Jane. (2010a). Mainstreaming Gender in Refugee Protection. *Cambridge Review of International Affairs*, 23(4) 589-607.
- Freedman, Jane. (2010b). Protecting Women Asylum Seekers and Refugees: From International Norms to National Protection? *International Migration*, 48, 175–198.
- Gagnon, A.J., Dougherty, G., Platt, R.W., Wahoush, O., George, A., Stanger, E., Oxman-

- Martinez, J., Saucier, J.F., Merry, L., & Stewart, D.E. (2007). Refugee and refugee-claimant women and infants post-birth – Migration histories as a predictor of Canadian health system response to needs. *Canadian Journal of Public Health*, 98(4), 287- 291.
- Guruge, Sepali & Khanlou, Nazilla. (2004). Intersectionalities of Influence: Researching the Health of Immigrant and Refugee Women. *Canadian Journal of Nursing Research (CJNR)*, 36(3), 32-47.
- Hankivsky, Olena & Christoffersen, Ashlee. (2008). Intersectionality and the determinants of health: a Canadian perspective. *Critical Public Health*, 18(3), 271-283.
- Hankivsky, Olena., & Cormier, Renée . (2009). *Intersectionality: Moving Women's Health Research and Policy Forward*. Vancouver: Women's Health Research Network. Retrieved from <http://people.stfx.ca/accamero/Gender%20and%20Health/Health%20Research/intersctionaliy-moving-womens-health-research-and-policy-forward.pdf>
- Hankivsky, Olena, De Leeuw, Sarah, Lee, Jo-Anne, Vissandjée, Bilkis & Khanlou, Nazilla (Eds.). (2011). *Health Inequalities in Canada: Intersectional Frameworks and Practices*. Victoria, British Columbia: UBC Press.
- Hopkins, Gail. (2006). Somali community organizations in London and Toronto: Collaboration and effectiveness. *Journal of Refugee Studies*, 19(3), 361–80.
- Hyndman, Jennifer. (2004). Mind the gap: bridging feminist and political geography through geopolitics. *Political Geography*, 23(3), 307–322.
- Hyndman, Jennifer. (2010) Introduction: the feminist politics of refugee migration. *Gender, Place and Culture*, 17(4), 453–459.
- Hyndman, Jennifer & Giles Wenona. (2011). Waiting for what? The feminization of asylum in protracted situations. *Gender, Place and Culture*, 18(3), 361–379.
- Kelly, Ursula, A. (2009) Integrating Intersectionality and Biomedicine in Health Disparities Research. *Advances in Nursing Science*, 32(2), E42–E56.
- Kissoon, Priya. (2010). From Persecution to Destitution: A Snapshot of Asylum Seekers' Housing and Settlement Experiences in Canada and the United Kingdom. *Journal of Immigrant & Refugee Studies*, 8, 4–31.
- Lacroix, Marie. (2004). Canadian Refugee Policy and the Social Construction of the

Refugee Claimant Subjectivity: Understanding Refugeeeness. *Journal of Refugee Studies*, 17(2), 147-166.

Lawrence, J., & Kearns, R. (2005). 'Exploring the 'fit' between people and providers: Refugee health needs and health care services in Mt. Roskill, Auckland, New Zealand'. *Health and Social Care in the Community* 13(5), 451-461.

McGibbon, Elizabeth, & McPherson, Charmaine. (2011). Applying Intersectionality & Complexity Theory to Address the Social Determinants of Women's Health. *Women's Health and Urban Life*, 10 (1) 59-86.

McKeary, M. & Newbold, K.B., (2010). Barriers to Care: The Challenges for Canadian Refugees and their Health Care Providers. *Journal of Refugee Studies*, 23(4), 523-545.

Merry, Lisa A., Gagnon, Anita J., Kalim, Nahid, Bouris, & Stephanie S. (2011). Refugee Claimant Women and Barriers to Health and Social Services Post-birth. *Canadian Journal of Public Health*, 102(4) 286-90.

Murray, S.B., & Skull, S.A. (2004). Hurdles to health: immigrant and refugee health care in Australia, *Aust Health Rev*, 29(1), 25–29.

Newbold, K.B. Eyles, J. Birch, S. & Wilson, K. (2008). 'Building a Profile of Health Related Services: Hamilton's Immigrant and Refugee Communities'. CERIS Working Paper #64, University of Toronto.

Ng, Carita, & Newbold, K. Bruce. (2011). Health Care Providers' Perspectives on the Provision of Prenatal Care to Immigrants. *Culture, Health & Sexuality*, 13(5) 561–574.

O'Mahony, Joyce M. & Donnelly, Tam T. (2007). Health Care Providers' Perspective of the Gender Influences on Immigrant Women's Mental Health Care Experiences. *Issues in Mental Health Nursing*, 28, 1171–1188

Oxman-Martinez, Jacqueline, Hanley, Jill, Lach, Lucyna, Khanlou Nazilla, Weerasinghe, Swarna & Agnew, Vijay. (2005). Intersection of Canadian Policy Parameters Affecting Women with Precarious Immigration Status: A Baseline for Understanding Barriers to Health. *Journal of Immigrant Health*, 7(4), 247-258.

Patton, M. (1990). *Qualitative evaluation and research methods* (pp. 169-186). Beverly Hills, CA: Sage.

Pratt, Geraldine. (2002). *Studying Immigrants in Focus Groups*. In Pamela Moss (Ed).

Feminist Geography in Practice (pp. 214-229). Blackwell.

Raphael, D. (ed.) (2004). *Social Determinants of Health: Canadian Perspectives*. Toronto, Ontario: Canadian Scholars Press Inc.

Redwood-Campbell L., Thind H., Howard M., Koteles J. Fowler N., & Kaczorowski J. (2007). 'Understanding the Health of Refugee Women in Host Countries: Lessons from the Kosovar Re-Settlement in Canada'. *Prehospital and Disaster Medicine*, 23(4) 130-135.

Rose, Gillian. (1997). Situating knowledges: positionality, reflexivities and other tactics. *Progress in Human Geography*, 21(3), 305-320.

Simich, Laura, Este, David, & Hamilton, Hayley. (2010). 'Meanings of home and mental well-being among Sudanese refugees in Canada', *Ethnicity & Health*, 15(2), 199-212.

Simich, Laura, Wu, Fei, & Nerad, Sonja. (2007). Status and Health Security: An Exploratory Study of Irregular Immigrants in Toronto. *Canadian Journal of Public Health*, 98(5) 369-73.

Statistics Canada. (2012). *Hamilton, Ontario (Code 537) and Ontario (Code 35)* (table). *Census Profile*. 2011 Census. Statistics Canada (Catalogue No. 98-316-XWE). Ottawa. Released May 29, 2012. Retrieved from <http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CSD&Code1=3525005&Geo2=CD&Code2=3525&Data=Count&SearchText=Hamilton&SearchType=Begins&SearchPR=35&B1=All&Custom=&TABID=1>

Stewart, Miriam, Anderson, Joan, Beiser, Morton, Mwakarimba, Edward, Neufeld, Anne, Simich, Laura, & Spitzer, Denise (2008). Multicultural Meanings of Social Support among Immigrants and Refugees. *International Migration*, 46(3) 123-159.

Sypek, S., Clugston, G., & Phillips, C. (2008). 'Critical health infrastructure for refugee resettlement in rural Australia: Case study of four rural towns. *Aust. J. Rural Health* 16, 349-354.

Tomlinson, Frances. (2010). Marking Difference and Negotiating Belonging: Refugee Women, Volunteering and Employment. *Gender, Work and Organization*, 17(3), 277-281.

United Nations High Commissioner for Refugees (UNHCR). (2010). *Convention and*

Protocol relating to the Status of Refugees. Text of the 1951 Convention Relating to the Status of Refugees. Text of the 1967 Protocol Relating to the Status of Refugees. Resolution 2198 (XXI) adopted by the United Nations General Assembly. Retrieved from <http://www.unhcr.org/3b66c2aa10.pdf>

United Nations High Commissioner for Refugees (UNHCR). (2011). *UNHCR Statistical Yearbook 2010, 10th edition Country Data Sheets*. Retrieved from <http://www.unhcr.org/4ef9cc9c9.html>

United Nations High Commissioner for Refugees (UNHCR). (2012). UNHCR Submission on Bill C-31 *Protecting Canada's Immigration System Act*. Retrieved from <http://www.unhcr.ca/news/2012-05-08-e.pdf>

United Nations High Commissioner for Refugees. (UNHCR). (2012b) *2012 Regional Operations Profile - North America and the Caribbean*. Retrieved from <http://www.unhcr.org/cgi-bin/tehis/vtx/page?page=49e491336&submit=GO>

Valentine, Gill. (2007). Theorizing and Researching Intersectionality: A Challenge for Feminist Geography. *The Professional Geographer*, 59(1), 10–2.

Wahoush O., Ellen. (2009). Equitable Health-Care Access: The Experiences of Refugee and Refugee Claimant Mothers with an Ill Preschooler. *CJNR*, 41(3), 186–206.

CHAPTER THREE

Access to Health Care: The Experiences of Refugee and Refugee Claimant Women in Hamilton, Ontario

3.1 Abstract

Refugee and refugee claimant women represent a unique and vulnerable subpopulation due to the gendering of the migration process and the gender roles they embody throughout flight and resettlement. Despite having multiple, unmet health needs, health services remain under-used among refugee women. In extending the previous work, a key goal of this paper is to respond to the need for understanding the factors that affect accessibility to health and social services for refugee and refugee claimant women as they resettle to Canada. This paper also seeks to explore whether the experiences of refugee and refugee claimant women in navigating the health care system may differ. Using a determinants of health framework, this paper therefore seeks to explore the accessibility of health services from the viewpoint of both social and health service providers (n=9) and refugee and refugee claimant women (n=37) from various source countries who have resettled to Hamilton, Ontario. While this study recognizes refugee and refugee claimant women's marginal social and political positions in Canadian society, a key goal of this study is to uncover the women's agency in navigating the Canadian health care system and the strategies they employ when faced with challenges and barriers to accessing health services. Results from this study reveal that language barriers, quality of care, and appropriateness of care, as well as limitations of refugee

health care coverage present important barriers to accessing necessary health services for both refugee and refugee claimant women.

3.2 Introduction

On a global scale, women make up the majority of displaced migrants and bear a disproportionate burden of the consequences of war, conflict and violence (United Nations High Commissioner for Refugees (UNHCR), 2011). While the vast majority of refugees flee to neighbouring countries, some relocate to a safe third country such as Canada. In Canada, refugees are resettled from abroad as individuals identified through the UNHCR and sponsored by the Canadian government or by private groups (family members, churches or Non-Governmental Organizations (NGOs)) if they are recognized as Convention Refugees. According to the 1951 Convention, a refugee is:

Someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion (Citizenship and Immigration Canada (CIC), 2011).

In 2010, Canada resettled 7,425 Government Assisted Refugees (GARs) and 5,036 Privately Sponsored Refugees. Additionally, another 33,161 refugee claimants, or individuals applying for refugee status after arrival entered Canada in the same year. Refugee claimants (or asylum seekers) differ by their refugee designation and immigration status as temporary residents compared to their refugee counterparts who have permanent status. GARs, for instance, receive financial assistance from the Canadian government. Likewise, privately sponsored refugees receive financial assistance from their sponsors, and both GARs and sponsored refugees receive permanent residency

status upon arrival to Canada (CIC, 2011). Refugee claimants, on the other hand, do not receive any financial assistance for settlement and only receive Canada's protection if they are found to be a Convention refugee according to the definition above or found to be a Person in Need of Protection:

An individual who is afraid to return to his or her country because of the risk of torture, risk to life, risk of cruel or unusual treatment or punishment (CIC, 2011).

While refugee claimants are eligible to apply for social assistance upon arrival, they remain ineligible for accessing settlement and integration services until they have attained permanent status (Kissoon, 2010). Prior to changes to refugee health care (enacted by the Canadian Federal government in June, 2011), both refugees and refugee claimants were eligible to apply for health coverage under the Interim Federal Health Program (IFH) until the individual is eligible for provincial health care coverage. Coverage under the IFH included emergency and essential health care including prenatal, contraception and obstetrical care; essential prescription medications; emergency dental treatments; and treatment and prevention of serious medical conditions. Counselling or psychotherapy, diagnostic procedures, certain ambulance services and vision are also covered to an extent but required preapproval from Citizenship and Immigration Canada, and coverage could be extended for up to 24 months for recipients identified with special needs (Zhao, 2010). Consequently, given differences in the level of support, health care coverage, and residency status by refugee status, it is important that studies distinguish between these refugee classes.

This paper builds on previous work (Cho 2012, submitted) which sought to understand the health experiences of refugee and refugee claimant women during resettlement to Canada. Refugee and refugee claimant women represent a unique and vulnerable subpopulation due to the gendering of the migration process and the gender roles they embody throughout flight and resettlement (Berman et al., 2009). During resettlement, refugee women may have critical and unmet health needs that they have incurred during flight (Redwood-Campbell et al., 2007). The literature suggests that despite having multiple, unmet health needs, health services remain under-used among refugee women (Fung & Wong, 2007). Findings from the previous study showed that refugee and refugee claimant women face numerous obstacles to maintaining healthy lives during resettlement, which are in large part, directly related to their gender roles, expectations of resettlement, and refugee status. They share in common experiences of flight and dealing with the consequences of separation of from loved ones. Both are also torn between a desire and expectation to move forward, rebuild, and become self-sufficient while remaining tied to their homelands, fearing the safety of their families, and hopeful for reunification. Despite these commonalities, there were important distinctions between refugee and refugee claimant women in terms of health status and their capacities to cope. Coping strategies differed according to status as refugee claimants could not access services at settlement centres and their social networks were limited. Mental health needs were profound for both due to pre-migration traumas. However, refugee claimant women's mental health was further compounded by the stress of status determination which often added feelings of insecurity. Thus, this paper seeks to explore

whether the experiences of refugee and refugee claimant women in navigating the health care system might also differ.

In extending the previous work, this paper focuses on accessibility to health care. Unlike Canadians, they are not directly entitled to fair and ‘reasonable’ access as outlined in the Canada Health Act (Oxman-Martinez et al., 2005). A key goal of this paper is to respond to the need for understanding the factors that affect accessibility to health and social services for refugee and refugee claimant women as they resettle to Canada. The research is guided by the following research questions: *What challenges do refugee and refugee claimant women face in navigating the Canadian health care system? What are the (system and individual level) barriers to accessing health services when they are needed? How do the women cope with these challenges and barriers and what changes would they like to see?* Using a determinants of health framework (Evans & Stoddart, 1990), this paper therefore seeks to explore the accessibility of health services from the viewpoint of both social and health service providers (n=9) and refugee and refugee claimant women (n=37) from various source countries who have resettled to Hamilton, Ontario. The refugee and refugee claimant women in this study represent a unique subpopulation whose voices are generally missing from scholarly literature and policy formation. While this study recognizes their marginal social and political positions in Canadian society, a key goal of this study is to uncover the women’s agency in navigating the Canadian health care system and the strategies they employ when faced with challenges and barriers to accessing health services. Results from this study reveal that language barriers, quality of care, and appropriateness of care, as well as limitations of

refugee health care coverage present important barriers to accessing necessary health services for both refugee and refugee claimant women.

The next section of the paper provides a brief overview of the health and health care literature concerning refugee and refugee claimants as well as of refugee and refugee claimant women more specifically. The focus is on those studies conducted within the Canadian context more specifically. The following section discusses the research design and methods before presenting the results of the focus group and one-on-one interviews. The final section reflects the implications of the findings in terms of guiding future research and policy directions.

3.2.1 Refugee and Refugee Claimants

Compared to other immigrant classes, refugees (GARs and privately sponsored) and refugee claimants experience unique mental and physical health needs during resettlement owing to their pre-migration experiences such as sudden flight, having escaped persecution from war or conflict, or having endured protracted periods of time in refugee camps where they may have been exposed to poor sanitation, poor nutrition and lack of access to health care (Fowler, 1998). As a result, they are more likely to suffer from infectious diseases such as tuberculosis, syphilis, hepatitis B and gastrointestinal parasites, as well as mental health, and other critical health conditions such as anaemia, dental caries, and nutritional deficiencies during resettlement (Fowler, 1998; Gabriel et al., 2011; Zhao, 2010). Studies have shown that despite having significant health needs, refugees and refugee claimants are less likely than non-immigrant Canadians to seek health care services. As a result, they are less likely to receive preventative care, long-

term health management, and specialist care (Gagnon et al., 2010). Refugee claimants in particular may choose not to disclose medical information for fear that negative health attributes may be used against them in granting status (Berman et al., 2009; Gagnon et al., 2010).

3.2.2 Refugee and Refugee Claimant Women

There is a strong consensus within the literature that recognizes refugee women as a particularly vulnerable group, as they are said to experience important physical and mental health disparities which are qualitatively different from their male counterparts during resettlement (Access Alliance, 2005; Fung & Wong, 2007; Redwood-Campbell et al., 2007). This is partly due to the consequences of pre-migration experiences in cases where women are more vulnerable to sexual and gender-specific violence (i.e., rape) and abuse during flight from war and conflict (Berman et al., 2009; Deacon & Sullivan, 2009, Fowler, 1998; Gagnon et al., 2007; Redwood-Campbell et al., 2007; Newbold & Willinsky, 2010). Mental illnesses such as depression, schizophrenia, posttraumatic stress disorder, and psychosis in refugee women following resettlement to host countries have been attributed to pre-migration traumas (Donnelly et al., 2011), with a substantive amount of literature focusing on the incidence of Post Traumatic Stress Disorder (PTSD) in women exposed to trauma during war and conflict (Fowler, 1998; Redwood-Campbell et al., 2007). Symptoms include recurrent and intrusive recollections, dreams, flashbacks, and intense feelings associated with the event. During resettlement, women who are displaced from the consequences of war and conflict may be separated from their spouses, but remain the primary caregivers for ensuring the safety and well-being of their families

(Adanu & Johnson, 2009; Berman et al., 2009) and as a result, may neglect their own healthcare needs (Fung & Wong, 2007; Murty, 1998).

Studies to date have consistently noted that while refugee women may face additional health needs, services remain under-utilized for various reasons. Refugee women are generally less likely to use preventative health care measures such as cervical and breast cancer (Donnelly & McKellin, 2007; Redwood-Campbell et al., 2007). Underuse of preventative health services has been attributed to differences in other priorities upon settlement, lack of access to family physicians, lack of knowledge about prevention, or fear of the procedure (Redwood-Campbell et al., 2007). A study by Gagnon et al. (2010) explored inhibitors and facilitators for following through with postpartum referrals for care in refugee and immigrant women in the Canadian context. The study found that the women faced language barriers, transportation problems, problems scheduling appointments, absence of spouses, absence of childcare, cold weather, perceived inappropriate referrals, and cultural practice differences to inhibit access to follow-up appointments. Alternatively, access to follow-up facilitators, appropriate services, empathetic professionals, and early receipt of information were deemed facilitators. Another study focussing on access of postpartum services in refugee claimant women found that the women faced barriers due to isolation, difficulties reaching mothers postpartum, language, low health literacy, lack of psychosocial assessments, support and referrals, and limitations stemming from the IFH program (Merry et al., 2011).

Although almost half of all claimants make successful claims and become permanent residents, the experiences of refugee claimant women are notably missing from the literature (Wahoush, 2009). Further, very few studies in the Canadian context (with the exception of Gagnon et al., 2007; Merry et al., 2011; Wahoush, 2009) include or focus on the health care experiences and needs of refugee claimant women, although they may share common experiences of fleeing violence and persecution in their home countries and have similar health needs during resettlement.

The literature adequately addresses refugee health and health care exclusively from the perspectives of health care providers (McKeary & Newbold, 2010; Miedema et al., 2008; O'Mahony & Donnelly (2007). Although these perspectives are important and indeed reflective of refugee needs, the voices and perspectives of individual refugee and refugee women is further warranted (Newbold, 2010). The literature also tends to examine specific ethnic populations and while ethnicity-race and culture are found to have important implications for differences in health behaviour, an overemphasis on the role of culture or cultural beliefs is problematic for various reasons. They tend to overlook the systemic or structural factors that shape access to care, especially at the institutional or policy level (Gabriel et al., 2011; Mulvihill, Mailloux & Atkin, 2001) or contribute to further marginalization and differential treatment by physicians due to cultural stereotypes (Jiwani, 2001) and implies that the women are without agency and perhaps not interested in seeking health (Donnelly & McKellin, 2007).

In sum, this study intends to address three noticeable gaps in the literature to date concerning the health care experiences of refugee and refugee claimant women: the

inclusion of refugee claimant women accounting for differences (where appropriate) in experiences of refugee women; the perspective of refugee and refugee claimant women from varying socio-demographic backgrounds; and the examination of both systemic and individual factors that shape access to health care. In seeking a comprehensive understanding of the experiences of participants in this study, we consider the roles of both system and individual level barriers as determinants of access to healthcare (Wellstood, Wilson & Eyles, 2006).

3.3 Methods and Participants

The study is set in Hamilton, Ontario, a mid-sized city with a 2011 population of 519,949 located in southern Ontario approximately 65 kilometres west of Toronto (Statistics Canada, 2012). Approximately one third of immigrants to Hamilton are refugees, including refugee claimants, a proportion which is higher than the national average, with Hamilton attracting refugee settlement due to its relatively close proximity to Toronto, and comparatively lower cost of living (Newbold et al., 2008). In addition, Hamilton's refugee population sources from a diversity of backgrounds, including refugees from Kosovo, Burma, Vietnam, China, Pakistan, India, Turkey, Afghanistan, El Salvador, Colombia, Honduras, and Somalia.

The work is guided by a 'determinants of health' perspective, whereby health is understood as an outcome of a wide range of contributing factors including individual characteristics, physical environments as well as socio-economic conditions that affect individual and population health and well-being (Evans & Stoddart, 1990; Raphael, 2004). Under this framework, the mechanisms that produce health inequalities and

disparities are influential across class, gender, race, ethnicity, language, age, and socio-economic status. Gender (roles and identities), migration, age, social isolation, language barriers, separation from family, change in family roles, unemployment, and health care are important for determinants of health for immigrant and refugee women during resettlement (Fowler, 1998).

For the purpose of this study, we distinguish between refugees (inclusive of privately sponsored refugee women and government sponsored refugees) and refugee claimants who have temporary status. Recruitment of interview participants and data collection occurred in two separate phases: first with providers and then with refugee and refugee claimant women. In the first phase, providers representing a small but diverse community of social and health services to refugee and refugee claimant women in Hamilton were interviewed. Providers were recruited by way of a standard introduction letter via email and/or a phone call inviting them to participate in a one-on-one in-depth interview. The purpose of including providers in this study was twofold: 1) to develop a more comprehensive understanding of the health care needs and challenges faced by refugee and refugee claimant women 2) to determine whether their perceptions either diverge or converge with those of the women in this study. A total of nine providers, representing major settlement organizations, community health care centres, and dental clinics accepted the invitation to be interviewed. Three providers were male and six were female. Eight of the nine interviews were semi-structured in-depth, face-to-face interviews that took place in their places of work and one was completed electronically. Interviews lasted an average of 30 minutes and were recorded and transcribed verbatim

following written or verbal consent before the start of each interview. Following each interview, providers were asked to recommend a service provider and/or their female clients who were or are considered refugees and refugee claimants.

The second phase of data collection involved recruitment of refugee and refugee claimant women. Amongst refugees, maximum variation sampling (Patton, 1990) was employed to recruit a socio-demographically diverse sample of refugee (Convention, Government Sponsored or Privately Sponsored) and refugee claimant (those seeking asylum within Canada) women who had resettled to Hamilton. Using this strategy, data collection and analyses yielded the uniqueness of individual experiences as well as important aspects and patterns that were shared across multiple diverse experiences. Participants were recruited until a point of data 'saturation' was reached. All interviews occurred over a span of ten months, between July of 2011 and April of 2012. The identities of all participants remain anonymous and are referred to by individual numeric identities in this paper.

Providers generously offered to coordinate and facilitate recruitment of participants. In order to foster an atmosphere of confidentiality, trust and comfort levels in sharing personal experiences, women were offered the choice of participating in either one-on-one interviews or focus groups at a time and place of their choosing. We wanted to accommodate those individuals who may find focus group settings as not conducive to discussing issues they may deem personal and as well as those who felt most comfortable in their own homes. The focus group process has been advocated for greater pursuit in

feminist research for its potential in offering 'safe spaces' for groups to discuss issues and disrupt or shift power from the researcher to the researched (Pratt, 2002).

A total of 43 women participated; 39 in four focus groups and four in one-on-one interviews. However, we limit our total sample to 37 women as six of the women that participated in the focus groups were later found to have entered Canada as immigrants (permanent status) or visitors and are presently considered 'non-status' women. Providers organized all four focus groups according to the language that the women were most comfortable communicating in and all focus group interviews took place at a settlement centre or community health center. Two groups were comprised of predominantly Spanish speaking women and two predominantly (several dialects of) Arabic speaking women. A cultural and linguistic interpreter participated in each group. Direct translation was encouraged (and summarization discouraged). Within the focus groups, 18 women came to Canada as government sponsored refugees, five as privately sponsored refugees, 10 as refugee claimants, in addition to the three visitors and three family sponsored immigrants mentioned earlier. Focus groups lasted approximately one hour and were recorded and transcribed verbatim following written and verbal consent. An additional four respondents who came to Canada as refugee claimants chose to participate in one-on-one interviews. They were also recruited through providers and took place in locations of their choosing: one was conducted in a settlement agency; one at a coffee shop and two were conducted in the women's homes. All four interviews were conducted in English and without an interpreter present as requested by the women. These

interviews took an average of one hour and all except one were recorded and transcribed verbatim following written and verbal consent.

Before commencement of interviews, participants were reminded that discussions and any material from the interviews were confidential and participants would remain anonymous outside the interviews. Participants were also briefed on overall expectations and reminded of their right to withdraw information or discontinue the discussion at any time. Separate interview guides were created for providers and the women respectively, with the exception of adjusting certain questions for providers representing different areas of expertise and sector. The women were asked to share their pre-migration experiences and talk about their health and health care experiences during resettlement, with the purpose being to uncover both individual and system barriers to accessing health services in Hamilton. As common in qualitative research, we encouraged respondents in all cases to raise issues and topics that were important for them and reminded them of their right to omit questions they did not feel comfortable answering. All of the women (refugees, refugee claimants, non-status/visitors) and translators who participated in focus groups or one-on-one interviews during the second phase of the study's data collection received honoraria of \$20. This research and all methods and procedures were approved by the McMaster University Research Ethics Board.

3.3.1 The Women

The women in this study came from various source countries, predominantly from Colombia and Iraq. The two focus groups that were comprised of predominantly Arabic speaking women were also mostly GARs and privately sponsored and mostly from Iraq.

The two focus groups that were comprised of predominantly Spanish speaking women were mostly refugee claimants and mostly from Colombia. A few of the women who initially entered Canada as refugee claimants, GARS, or Convention Refugees have since been granted permanent residency or Canadian citizenship. Of the four refugee claimant women who participated in one-on-one interviews, two had been granted permanent residency, one was denied refugee status and one had not yet had her hearing. Many of the GAR women were denied protection in neighbouring countries before the Canadian government sponsored them to come to Canada. Similarly, many of the women currently seeking asylum (refugee claimants) were denied status in the United States before coming to Canada and applying for refugee status. Few were privately sponsored by churches or family members who were residing in Canada.

While their legal immigration status may serve to locate the women into different social and political realms within Canadian society, they share experiences of fleeing violence, insecurity, war, instability, persecution and have sought safety and refuge in Canada. Some women came alone, but most with their children and/or husbands. However, as is common in the case of fleeing, they have unintentionally been separated from family members and spouses during flight and are hoping to be reunited. Experiences of flight were often not planned and were a result of fleeing situations where their lives were at immediate risk. At the time of the interview, the majority of the women were married, and comparatively few were divorced or single. A little over half of the women were mothers to children under the age of 18. The majority of the women belonged to the 35-44 year age category, followed by those in 45-54 and 55-64

categories, with only a few women in the 18-24 and 25-34 categories. Hamilton was the primary settlement location for all the women and most arrived between 2005-2010, while a few arrived before 2005 and some of the women had been in Canada for less than one year at the time of the interview. The majority of the women's annual total household income at the time of the interview was below \$15,000. Most were unemployed and seeking employment opportunities and most were enrolled in English as Second Language (ESL) courses. Approximately half of the women had completed post-secondary education (college, university) as their highest level of educational attainment in their country of origin while the remaining half had completed high school or elementary level education.

3.3.2 Analysis

Data was analysed thematically in an iterative and reflexive manner and the purpose was to draw meanings out of experience (Ayres, Kavanaugh and Knafl, 2003). The analytic framework acknowledged that experiences and meanings are socially and culturally situated, but are also perceived as possessing integrity and value in the study of social life (Lawrence & Kearns, 2005). The coding process was based on a framework adopted from Burnard (1991) which incorporates both 'a priori' codes based on the literature as a starting point as well as 'in-vivo' (or inductive) codes which stem from phrases used or concepts appealed to by participants. A priori codes refer to those set of existing codes that are developed before examination of existing data usually informed by initial research goals and inform interview topics, while in-vivo or inductive codes refer to those emerging issues and topics raised by respondents themselves. Inter- and intra-

group differences between focus groups were acknowledged in order to avoid overemphasizing consensus within groups and homogenizing experiences (Barbour, 2007).

3.4 Results

For many of the women, being healthy was directly associated with having access to health services, yet they faced multiple barriers in accessing services when needed. The following section explores access to primary care (physicians, family physicians), secondary (medical specialists, hospital emergency department), and tertiary health care services from the perspective of the refugee and refugee claimant women and of providers in this study. Following thematic analyses of interview transcripts, three major categories of accessibility have emerged: language and interpretation; quality of care; and IFH coverage.

To begin, it is important to highlight that while the focus of this paper is on accessibility to health care, the women in this study, regardless of refugee status, stressed the importance of being able to care for themselves and their families'. They highlighted a need for the continuity of community programs that promoted knowledge translation and health education programs in addition to providing opportunities for women to share knowledge and develop social support networks for the purpose of maintaining their own health and preventing illness. Below is a statement from a refugee (GAR) woman representing a shared view in one of the focus group discussions, as well as one that was shared by many other participants in this study:

First of all, like we have to know how to take care of our health, so like health education and maybe not everybody knows about that- what's good for our health... the nutrition, what kind of nutrition we have to give... exercise, like maybe most of the women they don't know ... certain nutrition they have to get and exercises. So... health education is important... once you prevent yourself in being sick and getting sick, that's a saviour for the person and for the country. (F37)

3.4.1 Language and Interpretation

Consistent with existing literature regarding language as a barrier to care (McKeary & Newbold, 2010; Ng & Newbold, 2011), the lack of interpretation services was identified as a persistent systemic barrier to accessing mental health, oral health, and primary health care services according to providers and the refugee and refugee claimant women, and appeared to be more pronounced among more recently-arrived refugee women and in older refugee claimant women. Language barriers prevented the women from accessing knowledge needed to maintain their own health as they found it difficult to communicate with health practitioners:

I had appointment with my doctor, dentist... She was speaking Arabic... that was good. She left for maternity. Now she says I don't mind to see a Canadian doctor who speaks English but I need interpreter. There's no interpreter and there's not service for interpretation because if you request you have to pay. Who's going to pay for that? So that's a concern. (F48, GAR woman)

They all agree that language is the number one barrier in being able to communicate or taking care of ourselves- like finding proper ways (focus group with GARs)

Echoing the broader literature regarding the importance of available and low-cost interpretation and language services, local service providers had worked to create such services. However, providers noted that while the refugee (and newcomer) community had faced language barriers for many years, they felt that there were even fewer

interpretation services available to the refugee community than in the past. The closure of a major settlement organization resulted in the loss in of interpretation services and the need to re-invent the system. As such, the exit of a service provider had severely disrupted the services available to newcomers and refugees in particular, and it is important to note that provider networks are rarely a ‘steady state’, with the exit or reduction of services by providers owing to funding issues being particularly problematic.

There are not too many doctors out there who will take in somebody who *doesn't* speak the language. And if they do, they have to bring their own interpreter. So that's an issue... if you want an interpreter, you have to pay for it. There are some volunteers, but the volunteers work through agencies, and you have to access an agency that will send a volunteer interpreter... Sometimes they are referred to specialists and they wait for six months to go to the specialist just to be told that their English is not good enough, that they have to wait another six months because they have to get an interpreter. And I think this is not a new issue. It's not a new issue, but it was better. But now went back to bad. And now it's even worse than before. (I7, Provider)

While critics might note that professional interpretation services are available, they are not widely used due to their high cost (i.e., McKeary & Newbold, 2010), and were not mentioned as an option by any of the participants in this study. Given the cost of professional services, and the dearth of low-cost interpretation services, many individuals have turned to volunteers or family members for translation. However, volunteer interpreters are typically only accessible through settlement and integration organizations which are limited to those with permanent status, meaning that refugee claimants are ineligible, placing them at a disadvantage. As a result, refugee and refugee claimant women who are financially constrained, rely on the limited pool of volunteer interpreters and a relatively small pool of health providers, as some physicians refuse clients with

language barriers. Providers also noted that reliance on a relatively small group of volunteers to meet interpretation needs was insufficient and sometimes precarious:

The main barrier nowadays- that's after (the organization) closed, they had the interpretation services- the main barrier is now the language and the lack of interpreters. Like, it's not a lack of interpreters, there are lots of volunteers who are willing to do it, but you know how much you can do as a volunteer! So, the language is one of the big issues and then also the, of course the gender issue. (I2, Provider)

A long time ago, (the organization) had one program ...money, for whatever they are providing; interpreters for ... any needs the client had. So it was also for doctor's appointments. Not anymore. And we are struggling with volunteers...what can be very dangerous I would say...Depends on what kind of health problem. (I3, Provider)

Alternatively, when interpreter services were not provided, clients were often forced to pay out-of-pocket or rely on family and friends to assist, complicating access to health care. Instead, most of the women in this study appeared to rely on the interpretation services of volunteers or the help of family members and friends, both of which are less than ideal as the use of family and friends compromise patient confidentiality. Moreover, the lack of interpretation appeared to prevent women from accessing care altogether.

The women in this study dealt with language barriers in a variety of ways. All of the women were enrolled in English as a Second Language program (ESL), but some faced barriers to attending classes regularly, especially women with children. Newly arrived refugee women who had been separated from their spouses during flight and were subsequently single mothers during resettlement were among those who struggled the most to consistently attend ESL courses. Some participants prepared lists of medical

terms in English in advance, consulting the internet or bilingual friends, and many had their (adult) children, friends or church members accompany them on their appointments to help interpret and translate. For some of the women who had some knowledge of the English language prior to arrival, they were determined to become proficient in English to satisfy language requirements in hopes of gaining meaningful employment. One refugee claimant woman found that she needed to supplement ESL courses and pursued a high school diploma at a local high school. While she found this to be beneficial and saw improvements as it offered opportunities to engage with native English speakers, she recalled experiences of overt and more discrete racism in that setting:

That's the reason I went to high school again because (the employer) said you want to make your skills better and also be more comfortable with the language.... And ESL program didn't help you very much for the ... written English... and I think I have to go to the basics. And I said I'm willing to go to the basics (referring to the fact that she has post secondary education)... but it was good. (...)... I don't worry about what the others say and I tried to be helpful toward others. It's difficult... They are twenty (adults)... some of them, you can say that they are... racist. (...) They are. And... sometimes they laugh at your mistakes... and we are two, three persons who were... not Canadian. And there was a younger girl, she was from Thailand and she was with me like (I was) her mother because I know for her it was worse because she's a young girl and obviously that affects you a lot. But I ignore it and I continue doing things, and helping them... (I12, Refugee Claimant)

The women shared their suggestions of potential improvements to health care services to better meet their needs. Among the women, there appeared to be a shared view that the health care system should recognize and account for the needs of an increasingly diverse population. In this sense, they referred to themselves, not as a unique subpopulation given their refugee status, but from the perspective of patients who belong

to the increasingly multicultural and diverse landscape that defines Canada. Both providers and the women advocated for programs that trained foreign-trained health professionals to address both the shortage of physicians and to help expand services available in multiple languages which is also noted in another study of immigrants (Asanin & Wilson, 2008). The most common suggestion was that healthcare workers speak multiple languages as demonstrated by this refugee claimant woman:

I'm happy to live in Canada. I'm happy for the health card. But the problem is when the people come older, and some people...for them (it's) so hard to learn English and I understand Canada is a multi-cultural country and even Canada have two official language, like English and French...many people, we speak different kind of languages and it's a big deficit in the hospital. They don't have interpreter and this is the reason some people die because they don't have the way to communicate. And some people suffering... painful and because they don't able to ask for a cure... This is one of the barrier... in the general hospital or even in any hospital they don't have different kind interpreters. One of the suggestion is ... One of the requirement they ask for the staff is speak at least two language – French and her natural language. This is another thing we can encourage in the schools too... (F23, Refugee Claimant woman)

Only a few of the women (in both groups) had access to providers in their native language and appeared to be generally more satisfied with the quality of care they received. Providers advocated for the provision of interpretation services by the health care system rather than placing responsibilities on individual patients to provide their own.

We have to really resolve two things. First of all, the shortage, or somehow short coming from the healthcare... waiting times of course, family physicians of course. But I think that is more for all of us (Canadians in general). The second thing is accessibility itself and the interpretation. The healthcare system has to somehow assist... it cannot just be left on us. Because we are talking about accessibility here... So if someone is, let's say in the wheel chair, you wouldn't tell them, "bring your own wheel

chair” or you know, “bring your own ramp... So wherever you go, take this ramp and put it in front of the door because it’s not my responsibility to... you know, be accessible to you.” So I don’t know why is it any different with the language. So why is always put on the client? (I1, Provider)

The above quote suggests that the women are active in overcoming their language barriers, but are limited by the services available to them. Attaining the level of English proficiency to effectively communicate with health professionals and fit employment criteria (among other elements of resettlement) takes time and additional resources while their health needs may be immediate.

3.4.2 Quality of Care and Appropriate Care

Most of the women in the study did not have a family physician and relied on walk-in clinics as well as hospital emergency rooms. Perhaps not surprisingly, a second prominent theme that emerged was therefore the quality of care in various care settings, with the general consensus among the women without family doctors (regardless of status) that they were dissatisfied with the quality of care they received. The women were frustrated with the lack of continuity and consistency in delivery of care (common in walk-in clinics) and long wait times (common in emergency room visits). Adding to their frustrations was when physicians rushed appointments and employed the ‘one problem per visit’ rule, commonly used as a time-management strategy (Fullerton, 2009).

(Health services) are not very good. Because you know... many – first of all (there is a) lack of family doctors. So, if lack of family doctors, family doctors have a lot of patients, so... many family doctor... they say, “today, we will discuss just one... health issue. Next time, you come for another one”. Now, can you imagine somebody... who’s English is second language... So that’s a big, big issue... So that means, there is not even space for that to be a culturally sensitive. There is not space... because you have your 15 (minutes) or whatever. They tell you one issue, that’s that.

So...I cannot see that that doctor can be culturally sensitive, I cannot... My clients they don't have good experience. (I3, Provider)

Another thing because we don't have too much physician and they don't have the time to give to the patient, because only just 10 or 15 minutes for every patient and sometimes, they need more time. (F22, Family Sponsored Refugee claimant)

Providers and the women felt that they often felt rushed through their appointments and did not always have enough time to fully communicate their needs during appointments. They felt that this was attributed to the general shortage of services within the health care system. As a result, some of the women chose to avoid seeking care due to their dissatisfaction with the quality of care after a number of negative experiences. The failure to seek care may increase the risk for more serious (and more costly) complications in the long-term. The following quote represents a concern that was repeatedly raised by various participants:

They say like even if I get something... I prefer not to contact my doctor because when I contact, like it takes a long time... OK it takes a long time until I get the appointment. And once I get the appointment, like I said before, we wait four hours and then he says we have nothing. Even if there is something, then he doesn't do follow up. She says like I did a blood test, he never called me back until I went and said what happened to my blood test? Oh yeah, you have lack of calcium. (F47, F44, GAR women)

The perceived urgent need for specialists (rather than general practitioners) and dissatisfaction with the referral system coupled with long wait times to see specialists was raised by many of the women, regardless of status and providers. Providers noted a high demand among their refugee and refugee claimant clients and felt that those needs were often unmet:

There is a big need for health services, like we all know. Most of the services are, you know by the time person has a problem and by the time they get an appointment with the specialist, the problem is gone or either *they* are gone, so that's a thing. (I2, Provider)

Participants appeared to feel a sense of urgency to see a specialist and expressed their frustration in dealing with physicians whom they felt denied them referrals and overlooked their concerns and needs which they deemed urgent:

She's like feeling dizzy all the time. She has family doctor and I asked her is he taking caring of you or... that's her problem. She says 'I have thyroid, I have lack of calcium and my family doctor doesn't schedule me appointment with a specialist. I really need to see specialist.' And she's not taking any medication because the family doctor is not specialist in thyroid. He cannot just give any medication just without specialist being seen here. ... She says like I requested (a referral) I asked but he didn't do anything. He says you are fine, just... she requested OK, give me calcium to take and he said no. ... She- they did blood check and it turns out she has lack in calcium... OK, now she has a specialist in thyroid because the family doctor recognized and found out she has thyroid.... But it took a long time. (F40, GAR woman)

I think the system is very poor. Because my daughter, she wait almost one year for a surgery, and she was sick, and another thing is to see a specialist, I think it's stupid when you know what you know what problem you have, you need to wait until your family doctor say, 'Oh, you can go to the specialist, I make the appointment for you' (F15, Refugee Claimant woman)

These quotes suggest that the expectations of the quality of care for refugee and refugee claimant women may in some ways be very similar to those of the Canadian immigrant (Asanin & Wilson, 2008) and non-immigrant populations (Wellstood et al., 2006) even though they may be coming from countries in which health service delivery is culturally and socially different. The women in this study expect to be given the time needed to fully communicate their medical concerns, and for their concerns to be taken

seriously. Perceived mistreatment and an overall dissatisfaction with the quality of care may tend to result in avoidance of health services and may indicate the underutilization of care and subsequent unmet needs.

3.4.3 Health Coverage: IFH program

A third and final category of accessibility raised by both providers and the women had to do with barriers to accessing services based on the women's health coverage (IFH) and status as refugee or refugee claimants. At the time of this study, both refugees and refugee claimants were eligible for basic health care coverage including 'supplemental health care benefits' through the IFH program.

Barriers stemming from the IFH program including lengthy paperwork, slow reimbursement waiting periods, and ambiguity in terms of eligibility and subsequent underuse of the program have been documented in the literature (McKeary & Newbold, 2010; Miedema et al., 2008; Newbold, 2010) and were also mentioned by participants in this study. Of particular concern was the lack of health services available due to a limited number of health providers willing to accept refugee and refugee claimant patients in Hamilton. Both providers and the women recalled experiences of direct refusal of services by physicians, walk-in clinics, dentists and pharmacies on the basis of status and IFHP coverage. According to the providers, there are only a few community health centres (CHCs) that serve newcomers in general, including refugees and refugee claimants and these centres have long reached capacity and are unable to accept new patients. Providers, including settlement counsellors expressed their ongoing struggle to

maintain a record of physicians that accept refugee and refugee claimant (IFH) clients, especially for continuous care.

IFH is... tricky, because many physicians don't want... to deal anything with it. Especially dentists. Apparently, getting money from IFH takes forever; there's lots of paper work that's involved. So let's say, in the last few years, pharmacies are becoming OK. At least we know a pharmacy would take it- IFH- so we send clients to them. For some family physicians, very few of them are accepting the new clients... in general. And then if you have a client who, you know has a IFH for certain things, they are not really too keen on it. Dentists- you cannot imagine how hard it is to find a dentist who will take IFH... we have maybe three/four in the whole city that we know of, that they would take IFH. (I1, Provider).

It appeared that settlement counsellors played an important role for refugee women in facilitating access to health and social services as they acted as key disseminators of health/health service information as well as providing translation services. Providers were careful to acknowledge that the general Canadian population has long experienced physician shortages and the lack of a regular family physician. However, it appears that refugee and refugee claimants may also experience refusal of care based on their status (as non-citizens). In light of this barrier, one provider relied on health providers who offered a one-time visit as an act of charity for their refugee claimant clients:

Sometimes you find people that are genuinely altruistic, you know, a doctor, or a dentist or optometrist or something like that. And it's great and you kind of use them for a season because they'll offer that and they'll say 'hey, send them my way and so forth' but then it kind of comes to an end and that's hard you know and then sometimes it'll even be a day. Like they'll say '... you know on September 20th, I'm going to book appointments for your people all day long'... And so that's really great, but then, it's not like it's happening once every five months or something. It's like it happened once... which is great, right. They're saying 'I'm gonna take a day in my practice and I'm gonna close the doors and I'm gonna

just make it available to, you guys'. So we've had that happen a couple of times. ...It's funny because usually there's a stipulation... that would kind of insinuate that they don't want to take them on long term you know. If there's anyone with an immediate need, something that I can fix in a day, you know... I get that a lot. ...they sort of put up a boundary, they will help which is great, it's just going to happen in this window and then that's it. (15, Provider)

But, this service suffers the same problems as the use of walk-in-clinics – there is a lack of continuity of care, with little recourse to follow-up appointments or needs. There appeared to be some notable but slight differences among the refugee and refugee claimant women in terms of resources to facilitate access to health services in spite of these challenges. For instance, the refugee women in this study had access to (federally funded) settlement organizations and often relied on their settlement counsellors to find physicians and make appointments for them. Although this partially helped to overcome language barriers, findings from this study suggest that it did not always guarantee access to services since there remains a seemingly small pool of services providers willing to take on refugee (and refugee claimant) clients and that the service environment itself seems to shift over time.

The refugee claimant women in this study were responsible for finding health services on their own as they are not eligible to access settlement services which are limited to refugees and immigrants (those with permanent status). The refugee claimant women experienced challenges in finding care for themselves and their children, especially in the early stages of resettlement. As mentioned, some of the women shared experiences of mistreatment and perceived discrimination while attempting to access

care. One refugee claimant woman shared this experience while attempting to seek care for her mother:

I hope that there is a good secretary, because sometimes (if) you're not... a Canadian, or immigrant or you are receiving Ontario Works or you are someone that is under the government (receiving social assistance), they give you... less support to that. Sometimes it's like, for example... the first time we... went there, we paid, but we went there and she said '(your mother) have no coverage for that! Remember, you are on Ontario Works!' (I said) We're going to pay you (because) you have to pay for that... very like, saying we are less... and I was angry and I said, 'We are going to pay that and I need that you check my mom'... because my mom have the immigration ID (IFH) and that's the reason. I think that it's not fair. I think this is one of the things... (I11, Refugee Claimant woman)

While the literature has noted that refugee claimant women often rely on informal social networks due to the lack of more formal social and material support due to their ineligibility to use resettlement services (Wahoush, 2009, Simich, 2007), many of the newly arrived refugee claimant women in this study had not been able to develop those connections. However, those with religious affiliations frequently spoke of their church members actively engaging in their settlement journey, helping to raise financial support for immigration procedures and helping to connect them with medical clinics.

Oral health needs were high and unmet in both refugee and refugee claimant women.

Providers in all sectors spoke of the difficulties locating dentists who accept IFH clients and refugees and refugee claimants in general:

Dentists are difficult to find. So, that's not uncommon either, mouth like pain, you know broken teeth, rotting teeth, it's not uncommon, you see a lot of it here. Dentists are a real gold mine for us. If we find people that will (take them)... we know of a couple um...it's not a lot, it's not a lot. (I5, Provider)

As such, many of the women (regardless of status) had been experiencing mouth pain stemming from unaddressed oral health needs:

She needs a root canal... since she arrived to Canada, she is suffering from that. In Syria they cut the nerve and they were planning to make the root canal for her and then her visa to Canada came, she came to Canada and since she is in Canada, most of the time, she has pain here and numbness because the nerve is cut and there is no root canal...It's one year and a month... She says like I didn't see any dentist here because it's very costly. I can't afford...She has another health problem. Once she does any kind of operation, it doesn't heal. So like, it's very hard to do any operation for her because she- it's very hard to heal- the- it doesn't heal. So maybe that's one of the reasons. ...I schedule the appointment with her for the, with the dentist and she specifically ask me she needs the doctor who speaks Arabic. So I called one, because in this area it is hard to find. There was one woman, she left for maternity so... I have to refer her to Upper James, there is an Arabic spoken dentist. And the secretary was not nice and because it's root canal the issue. Even like you have the card from social assistance, it doesn't cover. (F44, GAR woman)

Participants also felt that the extent of coverage provided by the IFH program was insufficient to meet their needs, particularly with respect to oral and vision health which is considered 'supplemental coverage' under the IFH program:

Like, we have a health care system in this country but eye and teeth, these are not health? Like if I get blind, that means that's OK. Why should I pay when I go to eye doctor? So, it's supposed to be covered with the health care system right? The teeth it's the same thing. Because sometimes, little problem happen, it goes to cause other big problems in human's body so... (Focus Group with predominantly GAR women)

The quotes above speaks to the mutually reinforcing barriers that refugee women face in attempting to access care such as language barriers, attitudinal barriers, financial barriers and limitations of IFH. The quote also raises an important issue discussed by both refugee and refugee claimant women in this study regarding perceived mistreatment and attitudinal barriers from front line health service providers such as when providers

assumed refugee women were unable to pay for services and procedures not covered under IFH. The women expressed that those incidences left them frustrated and instilled feelings of exclusion.

An oral health provider (I4) provided further insight into the implications of the limitations to oral health coverage in the IFH program. For example, this provider noted that the exclusion of treatments considered ‘routine care’ such as incipient cavities and coverage of procedures considered ‘emergency dental treatment’ results in tooth extractions which lead to poor oral health and overall health in the long-term:

And then, what will be the only option for the refugee or the client... is to take the tooth out. In this way, instead of helping the person you know to keep and maintain his or her teeth, on the contrary, we are promoting tooth extractions and later on, multiple missing teeth, which will have impact later on, on his diet and nutrition... So, the package of benefit, what I want to say, it covers only emergencies. So, it helps to alleviate pain or to relieve pain, but on the long run it does not help to promote good oral health status for the person. And as I said ... if you have incipient cavity... or the cavity is not visible on X-ray, they will consider this is like routine care and it’s not included in the emergencies. (I4, Provider)

It is not surprising that most of the women were not able to access care for oral health concerns even though they were priority needs as voiced by the following GAR women and other members in their focus group:

They say like, for us and for our children too, she says I have problem it’s more than a year and four months I’m here, I suffer from that pain I have here in my teeth and there’s no dentist, I don’t know where to go. There are but it’s very expensive. It’s not like- I can’t afford, I don’t have that money to manage and go to the dentist and there’s no kind of support in that matter. And for the kids specifically like she- her son called and broke his- he lost his front teeth- her son and now he can hardly communicate because of the loose of the teeth and they don’t know where to go. Because anywhere they go- I provide, I found some dentists, but it’s very expensive and they cannot.... (F28, F29, GAR women)

The above quotes suggest that the women perceive lack of access to oral health care as a systemic barrier that they feel should be accounted for in the IFH program. They also recognize the inter-related health effects of oral health and overall health and well-being. Providers who work in the oral health sector agreed that the IFH coverage for dental services was limited and felt that this was a reason dentists did not to accept IFH clients, as they assumed IFH clients would not be able to afford to pay for the services. In recognition of the above barriers stemming from limited IFH coverage, one oral health practitioner recommended the following changes:

At least to have.... root canal treatment included and prevention. I'm not asking more than that. Because if with what we practice here... the goal of the World Health Organization, they say.. they would like to see on the dental arc, like 20 teeth, you know. Where there is no space, or fragmentation in between them. What that means, you *have* to keep up the last pre-molar, that means from one to five, one to five. That's ten... And from one to five, one to five... And in this way, if you keep these teeth healthy, that doesn't need replacement, that means you could make crowns you know. You could keep the pre-molars, they don't qualify for root canal treatment but this strategy, you can keep them through root canal treatment and if they are weak, you can cap them. At least something like that. (I4, Provider)

The above statement reflects the importance of consulting both health practitioners specialized in serving refugee and refugee claimant communities as well as those communities themselves to tailor policies that recognise the unique health needs of refugees and refugee claimants. According to findings from this study, the IFH program had serious implications, sometimes leading to exclusion, rejection and even under-utilization of necessary and urgent services.

3.5 Discussion and Conclusion

This paper focussed on access to health care as an important determinant of health for refugee and refugee claimant women, while building on previous work (Cho, 2012 submitted) that noted important differences between health experiences by status. This paper explored the factors that affect accessibility to health services from the perspective of both providers and refugee and refugee claimant women who have resettled to Hamilton, Ontario. In doing so, we attempted to represent a unique subpopulation whose direct voices are generally missing from scholarly literature and policy formation. With the exceptions of IFH insurance coverage and the benefits that it provides, access to resettlement services and a few incidents of perceived discrimination, there were limited differences in the experience of refugees and refugee claimants, with results from this study revealing that access to health care for these two groups are largely similar. In both groups, health care needs remain largely unmet due to the persistence of language barriers, dissatisfaction with the quality of care and appropriateness of care as well as limitations of refugee health care coverage (IFH program). The majority of the women lacked continuous primary care as most did not have family physicians and even faced barriers accessing walk-in clinics owing to their status, language barriers (lack of affordable interpretation services) and limited IFH coverage.

According to the results from this study, individuals at settlement organizations and other refugee and refugee claimant supporting organizations appear to bear the greatest responsibility (compared to the health care system itself) in facilitating access to health and social services for the women in this study. Yet, the women in the study appear

to rely on scarce resources comprised mostly of volunteers and a handful of physicians, dentists and pharmacies willing to accept them as clients. Continued refusal of care by health providers based on language barriers and their IFH coverage will result in greater reliance on hospital emergency visits for both urgent and non-urgent health conditions. Reliance on a limited pool of providers is not sustainable and suggests that refugee and refugee claimant women may lack equitable access to care.

Perhaps not surprisingly, the set of service providers does not remain constant over time, with exits or changes in the service provision landscape necessitating juggling of resources. At least over the short-term, however, clients are forced to find other alternatives as exemplified through the loss of interpretation services within the city. The small pool of providers, typical of second-tier immigrant reception centers such as Hamilton, further complicates the provision of services given the lack of suitable alternatives. As such, the loss of a key provider of interpretation services due to the closure of a major settlement organization disrupts care for the clients through loss of continuity and the resource itself.

The women in this study (regardless of status) reported high, unmet oral health needs due to systemic barriers to accessing dental health services stemming from a lack of sufficient coverage (IFH) and scarcity of dentists willing to accept IFH patients. Furthermore, both of these barriers were mutually reinforcing. Removal of the pre-approval procedure through Citizenship and Immigration Canada as suggested by other studies (Merry et al., 2011) and extension of health services beyond emergency treatments may encourage more dentists to accept IFH clients.

Combined, there appears to be clear need for services geared towards refugee and refugee claimant women, including the extension of settlement services to refugee claimants. Although the availability of services to refugee and refugee claimant women appear to be limited, those women that were able to access the support of settlement counsellors had greater chances at accessing services when needed. Fortunately, counsellors and other providers were able to manoeuvre around and overcome some of the barriers that the women themselves could not. Counsellors and other providers facilitated language barriers, and acted as key disseminators of health services. Further, counsellors appeared to bear the greatest responsibility in terms of facilitating access to appropriate health and social services as they worked continuously and closely with their clients at various stages of their resettlement process. However, individual counsellors appeared to struggle to meet the various needs of their clients, largely due to the sheer number of clients each were responsible for. For instance, one counsellor noted having eighty clients. A potential reason for the apparent shortage of counsellors could be attributed to the closure of a major settlement organization, although this was not directly discussed or prompted during the interviews. Refugee claimant women are unable to access services as settlement organizations and also appear to be more socially isolated and have fewer opportunities to develop informal social support networks during resettlement than GAR women.

While the women hope to establish continuous care through a regular family physician, they also strongly emphasize the need for access to health education. They advocate for community-based programs that seek to enable and facilitate their desires to

achieve healthy lives in spite of the ways they are excluded from mainstream health and social services.

Given the recent legislative changes to refugee health care, we anticipate that the barriers outlined in this paper will be magnified as refugees face additional financial barriers in having to cover the costs of health services on their own. As a legislative change implemented without consultation with refugee and refugee claimants, the potential health effects are unknown, although shifting the burden of paying to refugees will likely result in decreased health care utilization and ultimately poorer health, which in turn results in more frequent visits to emergency departments and increased hospital admissions (Donnelly & McKellin, 2007). Further research is needed to understand health effects of these changes.

Due to recent changes in refugee health care in Canada, it will also be increasingly important to understand the health needs and health care experiences of refugee claimant women who experience additional stress owing to their uncertain futures and have even more limited health and social service eligibility. In sum, there is a strong consensus that refugee and refugee claimant women experience multiple barriers in accessing health services. Findings suggest that the women want long-term solutions to maintaining health and overcome illness and that refugee health care reform should consider the potential long-term effects of a health care system that restricts care to the most vulnerable populations.

Finally, there are four limitations to this study that warrant further discussion. The first limitation relates to the focus group setting. While the focus group setting facilitated

recruitment and translation and often encouraged group discussions, it limited certain discussions surrounding more personal experiences. For instance, several providers raised the lack of autonomy in decision making processes due to patriarchal power relations in the home. The women were asked to share these experiences and offered to disclose these experiences in a one-on-one interview following the focus group interviews. Only one participant responded and shared her experience. In-depth research examining the role of patriarchal power relations in domestic spheres is needed, and this study suggests that focus group setting may not be conducive to exploring this topic. Finally, there are issues of doing research in cross-cultural settings, especially in this study where the women represent a diverse sub-population, having come from various parts of the world and having experienced tremendous life-altering and traumatic events, with varying levels of English language proficiency. To facilitate communication and comfort, all of the focus group interviews were accompanied and facilitated through one or multiple translators who were in some cases, also providers interviewed in this study. It is possible that through translation, meanings may not have been interpreted as they were intended. Thus, some interpretations were checked by a second interpreter after initial transcription.

3.6 References

- Access Alliance. (2005). *Racialized Groups and Health Status: A Literature Review Exploring Poverty, Housing, Race-Based Discrimination and Access to Health Care as Determinants of Health for Racialized Groups*. Toronto: Access Alliance Multicultural Community Health Centre.
- Adanu, Richard M.K., & Johnson, Timothy R.B. (2009). Migration and women's health. *International Journal of Gynecology & Obstetrics*, 106(2), 179–181.
- Asanin, Jennifer & Wilson, Kathi. (2008). “I spent nine years looking for a doctor’’: Exploring access to health care among immigrants in Mississauga, Ontario, Canada. *Social Science & Medicine*, 66, 1271-1283.
- Ayres , Lioness, Kavanaugh, Karen, Knafl, & Kathleen A. (2003). Within-Case and Across-Case Approaches to Qualitative Data Analysis. *Qualitative Health Research*, 13 (6), 871-883.
- Barbour Rosaline. (2007). *Doing focus Groups: The Sage Qualitative Research Kit* Edited by Uwe Flick. London : SAGE 2007
- Berman, Helene, Girón E R Irías, & Marroquín P Antonia. (2009). A Narrative Study of Refugee Women who have Experienced Violence in the Context of War. *CJNR*, 41(1), 144 –165.
- Burnard, P. (1991). A method of analyzing interview transcripts in qualitative research. *Nurse Education Today*, 11, 461-466.
- Cho, Jenny. (2012). *Exploring health at the Intersections of Gender and Status: The Experiences of Refugee and Refugee Claimant Women in Hamilton, Ontario*. (Master’s Thesis submission, McMaster University, submitted, 2012).
- Citizenship and immigration Canada (CIC). (2011). *Interim Federal Health Program: Summary of Benefits*. Citizenship and Immigration Canada.
<http://www.cic.gc.ca/english/refugees/outside/summary-ifhp.asp>

- Deacon, Z. & Sullivan, C. (2009). Responding to the Complex and Gendered Needs of Refugee Women. *Affilia-Journal of Women and Social Work*, 24(3), 272-284.
- Donnelly, Tam Truong & McKellin, William. (2007). Keeping healthy! Whose responsibility is it anyway? Vietnamese Canadian women and their healthcare providers' perspectives. *Nursing Inquiry*, 14(1), 2–12.
- Donnelly TT, Hwang JJ, Este D, Ewashen C, Adair C, & Clinton M. (2011). If I was going to kill myself, I wouldn't be calling you. I am asking for help: challenges influencing immigrant and refugee women's mental health. *Issues in Mental Health Nursing*, 32(5), 279-90.
- Evans, Robert G., & Stosddart, Gregory L. (1990). Producing Health, Consuming Health Care. *Social Science and Medicine*, 31(12), 1347-1363.
- Fowler, Nancy. (1998). Providing Primary Health Care to Immigrants and Refugees: the North Hamilton Experience. *Canadian Medical Association Journal*, 159(4), 388–391.
- Fullerton, Merrilee (2008). Understanding and improving on 1 problem per visit, *CMAJ*, 179, 62.
- Fung, K. & Wong, YLR. (2007). 'Factors Influencing Attitudes Towards Seeking Professional Help Among East And Southeast Asian Immigrant And Refugee Women'. *International Journal of Social Psychiatry*. 53(3), 216-231.
- Gabriel, Patricia S., Morgan-Jonker, Cecily, Phung, Charlene M.W., Barrios, Rolando, & Kaczorowski, Janusz. (2011). Refugees and Health Care: The Need for Data: Understanding the Health of Government-assisted Refugees in Canada Through a Prospective Longitudinal Cohort. *Can J Public Health*, 102(4), 269-72.
- Gagnon, A.J., Dougherty, G., Platt, R.W., Wahoush, O., George, A., Stanger, E., Oxman-Martinez, J., Saucier, J.F., Merry, L., & Stewart, D.E. (2007). Refugee and refugee-claimant women and infants post-birth – Migration histories as a predictor of Canadian health system response to needs. *Canadian Journal of Public Health*, 98(4), 287- 291.
- Gagnon, A. J., Carnevale, F.A., Saucier J.F., Clausen, C., Jeannotte, J., & Oxman-Martinez, J. (2010). Do Referrals Work? Responses of Childbearing Newcomers to Referrals for Care. *Journal of Immigrant Minority Health*. 12, 559–568.

- Jiwani, Y. (2001). *Intersecting Inequalities: Immigrant Women of Colour, Violence, and Health Care*. Retrieved from Feminist Research, Education, Development and Action (FREDA) Centre: <http://www.harbour.sfu.ca/freda/pdf/inequal.pdf>
- Kissoon, Priya. (2010). From Persecution to Destitution: A Snapshot of Asylum Seekers' Housing and Settlement Experiences in Canada and the United Kingdom. *Journal of Immigrant & Refugee Studies*, 8, 4–31.
- Lawrence, J., & Kearns, R. (2005). 'Exploring the 'fit' between people and providers: Refugee health needs and health care services in Mt. Roskill, Auckland, New Zealand'. *Health and Social Care in the Community* 13(5), 451-461.
- McKeary, M. & Newbold, K.B., (2010). Barriers to Care: The Challenges for Canadian Refugees and their Health Care Providers. *Journal of Refugee Studies*, 23(4), 523-545.
- Merry, Lisa A., Gagnon, Anita J., Kalim, Nahid, & Bouris, Stephanie S. (2011). Refugee Claimant Women and Barriers to Health and Social Services Post-birth. *Canadian Journal of Public Health*, 102(4), 286-290.
- Miedema B, Hamilton R, Easley J. (2008) Climbing the walls: Structural barriers to accessing primary care for refugee newcomers in Canada. *Can Fam Phys*, 54(3), 335-339.
- Mulvihill, Mailloux & Atkin (2001). *Advancing Policy and Research Responses to Immigrant and Refugee Women's Health in Canada*. Ottawa: Women's Health Bureau, Health Canada.
- Murty, Mano. (1998). Healthy living for immigrant women: a health education community outreach program. *CMA*. 159, 385-7.
- Newbold, K.B. (2010). *Immigrant and Refugee Health Needs and Service Provision in Hamilton*. Hamilton Immigration Partnership Council.
- Newbold, K.B. Eyles, J. Birch, S. and Wilson, K. (2008). 'Building a Profile of Health Related Services: Hamilton's Immigrant and Refugee Communities'. CERIS Working Paper #64, University of Toronto.

- Newbold, K. B. and Willinsky, J. (2009). Providing Family Planning and Reproductive Health Care to Canadian Immigrants: Perceptions of Health Care Providers. *Culture, Health and Sexuality*, 11(4): 369-382.
- Ng, Carita, & Newbold, K. Bruce. (2011). Health Care Providers' Perspectives on the Provision of Prenatal Care to Immigrants. *Culture, Health & Sexuality*, 13(5), 561-574.
- O'Mahony, Joyce M. & Donnelly, Tam T. (2007). Health Care Providers' Perspective of the Gender Influences on Immigrant Women's Mental Health Care Experiences. *Issues in Mental Health Nursing*, 28, 1171-1188
- Oxman-Martinez, Jacqueline, Hanley, Jill, Lach, Lucyna, Khanlou Nazilla, Weerasinghe, Swarna, & Agnew, Vijay. (2005). Intersection of Canadian Policy Parameters Affecting Women with Precarious Immigration Status: A Baseline for Understanding Barriers to Health. *Journal of Immigrant Health*, 7(4), 247-258.
- Raphael, D. (ed.) (2004). *Social Determinants of Health: Canadian Perspectives*. Toronto, Ontario: Canadian Scholars Press Inc.
- Redwood-Campbell L., Thind H., Howard M., Koteles J. Fowler N., Kaczorowski J. (2007). ' Understanding the Health of Refugee Women in Host Countries: Lessons from the Kosovar Re-Settlement in Canada'. *Prehospital and Disaster Medicine*, 23(4) 130-135.
- Statistics Canada. (2012). *Hamilton, Ontario (Code 537) and Ontario (Code 35) (table)*. *Census Profile*. 2011 Census. Statistics Canada (Catalogue No. 98-316-XWE). Ottawa. Released May 29, 2012. Retrieved from <http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/prof/index.cfm?Lang=E>
- Simich, Laura, Wu, Fei, & Nerad, Sonja. (2007). Status and Health Security: An Exploratory Study of Irregular Immigrants in Toronto. *Canadian Journal of Public Health*, 98(5) 369-73.
- United Nations High Commissioner for Refugees (UNHCR). (2010). *Convention and Protocol relating to the Status of Refugees. Text of the 1951 Convention Relating to the Status of Refugees. Text of the 1967 Protocol Relating to the Status of Refugees. Resolution 2198 (XXI) adopted by the United Nations General Assembly*. Retrieved from <http://www.unhcr.org/3b66c2aa10.pdf>

United Nations High Commissioner for Refugees (UNHCR). (2011). *UNHCR Statistical Yearbook 2010, 10th edition Country Data Sheets*. Retrieved from <http://www.unhcr.org/4ef9cc9c9.html>

Wahoush O., Ellen. (2009). Equitable Health-Care Access: The Experiences of Refugee and Refugee Claimant Mothers with an Ill Preschooler. *CJNR*, 41(3), 186–206.

Wellstood, Katie, Wilson, Kathi, & Eyles, John (2006). 'Reasonable Access' to Primary Care: Assessing the Role of Individual and System Characteristics. *Health and Place*, 12, 121-130.

Zhao, Jun, Xue, Li, & Gilkinson, Tara. (2010). Health Status and Social Capital of Recent Immigrants in Canada: Evidence from the Longitudinal Survey of Immigrants to Canada. Citizenship and Immigration Canada.

CHAPTER FOUR

Conclusion

4.1 Introduction

This thesis presents the results of a qualitative research project comprised of two separate but related research papers. The focus of this thesis work on the health experiences of refugee and refugee claimant women during resettlement to Hamilton. The research was guided by the following overarching research questions:

- *How do refugee and refugee claimant women, who have resettled in Hamilton, Ontario from various source countries, experience 'health', well-being, and the Canadian health care system?*
- *What are the health needs of refugee and refugee claimant women during resettlement? What health determinants do they value? What are the challenges and barriers they experience while attempting to lead healthy lives?*

In-depth interviews and focus groups were conducted with refugee and refugee claimant women (n=37) as well as health and social providers (n=9). Results from this study are presented in two separate papers in Chapters 2 and 3 of this thesis. This concluding chapter provides an overview of the study's major findings and contributions, limitations, policy implications and suggestions for future research.

4.2 Summary of Major Findings

The women in this study are generally thankful to have found safety in Canada, and remain hopeful for potentially improved health outcomes and an improved quality of life in Canada. There were common experiences between the refugee and refugee claimant women despite their differences in legal status. For both groups, leaving their homelands was not one of choice, as they fled from violence and/or persecution. For both groups, the resettlement journey is difficult and complicated as they face road blocks and hardships and experience ongoing fear and pain. Yet, in their determination, they forge new meanings of self and home as they actively seek healthier lives for themselves and their families. The women have left their homelands, families, friends, spouses and children, sometimes having to negotiate new roles as lone mothers or primary providers. Having come from various parts of the world, the women must learn to speak English and become proficient enough to enter employment fields. They also must learn to navigate a new health care system, one in which many of the women experience multiple barriers.

Through an intersectional lens, the first paper (Chapter 2) sought to understand the health determinants that are of particular importance to the women, as well as the social differences that are important/ marginalising for them as they attempt to rebuild, and lead healthy lives during resettlement to Hamilton. Results demonstrate that their multiple identities related to their gender (sex, gender roles) and status (refugees, refugee claimants) often intersected to produce differential experiences of health and access to health determinants during resettlement. This paper explores the lasting effects of pre-migration traumas, separation from family, citizenship, un-employment and housing which were of particular importance to the women's health during resettlement.

Overall, this study demonstrates that refugee and refugee claimant women have various unmet health needs during resettlement as a result of the lasting effects of pre-migration traumas, the stress and worry concerning separated family members, the lack of social support networks, social isolation, and shifting gender roles during resettlement. Findings from this study suggests that resettlement for both refugee and refugee claimants may be understood as varying states of limbo, whether in terms of healing, finding employment, and moving forward. Their experiences of flight appear to remain vivid and they continue to fear for the safety of their families while they wait for reunification. Yet, they exhibit a determination to move forward, acculturate, resettle, with the goals of becoming financially self-sufficient, in part, sacrificing healing. Status or citizenship and gender intersect many spheres of everyday life with both subtle and more direct differences between the refugee and refugee claimant women. For the refugee claimant women, their uncertain and temporary status is a daily reminder that their lives are uprooted, and that perhaps they, unlike refugees, must succeed. Success is defined by their human capital as they demonstrate that they are productive members of society as they await status determination.

As the literature suggested, this research also found that women – in the context of forced migration – maintain mothering, caring and nurturing throughout. Results demonstrate that their gender roles, both within and outside domestic spheres are instrumental for the health and well being of their families. In this study, protracted periods of unemployment had varying effects on health, especially in terms of meeting the needs of their families during relocation to a new country as single heads of

households. The inability to secure income and employment also added to feelings of insecurity and depression. While the circumstances in a new country and the combined effects of forced flight offer few choices for securing income and procuring meaningful employment, the majority of the women desire and are determined to overcome these barriers.

The second paper (Chapter 3), builds on findings in the first paper and focuses on accessibility to health care, guided by a determinants of health framework (Evans and Stoddart, 1990). The goal was to understand the challenges refugee and refugee claimant women face in navigating the Canadian health care system, paying attention to the system and individual level barriers to accessing health services. Further, the study sought to understand how the women cope with these challenges and barriers and the changes they would like to see. Findings from this study explore access to primary care (physicians, family physicians), secondary (medical specialists, hospital emergency department) and tertiary health care services from the perspective of the refugee and refugee claimant women and of providers.

For many of the women, being healthy was directly associated with having access to health services, yet they faced multiple barriers in accessing services when needed. More specifically, there were three major barriers that affected the women's access to care: language and interpretation; quality of care; and IFH coverage. The women are active in attaining the level of English proficiency to effectively communicate with health professionals, but require additional time while their health needs appear to be immediate. There appears to be an urgent and unmet need for specialists (rather than general

practitioners). Of particular concern is the lack of health services available due to a limited number of health providers willing to accept refugee and refugee claimant patients in Hamilton leading to experiences of direct refusal of services by physicians, walk-in clinics, dentists and pharmacies which is alarming. Settlement counsellors play an important role for refugee women in facilitating access to health and social services and are key disseminators of health/health service information. They also bear the greatest responsibility of providing translation services yet rely on a limited pool of resources to meet increasing demands. Further, these services are limited to those with permanent status which excludes refugee claimant women. Refugee claimant women appear to struggle to find health providers on their own and have very limited social support networks to rely on outside their immediate families.

Findings from this study suggest that continued refusal of care by health providers based on language barriers and their IFH coverage will result in greater reliance on hospital emergency visits for both urgent and non-urgent health conditions. Reliance on a limited pool of providers is not sustainable and suggests that refugee and refugee claimant women may lack equitable access to care.

4.3 Limitations

There are some important limitations to this study that warrant further discussion. First, the participants in this study represent refugee serving centres as well as refugee and refugee claimant women living in Hamilton, Ontario. While the emphasis was on health, the perspectives of physicians (general practitioners) are missing, as we were unable to recruit them to our study. However, several studies have specifically accounted

for physician perspectives to date (see for example Fowler, 1998; Merry et al., 2011; McKeary & Newbold, 2010; Ng & Newbold, 2011). Second, women were recruited to the study through various settlement organizations, community health care centres or refugee receiving centres, raising the potential that we missed those who do not access such agencies and are therefore potentially isolated and marginalised are missing from this study. This suggests that there is a need for research to incorporate more inclusive research agendas so that the experiences and voices of those women who are without formal social support are brought to light. Third, focus groups are limiting when discussing potentially traumatic experiences or raising personal concerns which may lead to perceived or actual stigmatization such as when discussing histories of sexual violence or lack of autonomy within domestic spheres, and some women may have chosen not to disclose such personal details for various reasons. To address these potential limitations, participants were reminded at various points prior to and during focus groups that they are invited to discuss more personal issues one-on-one. Further, participants were given the choice between focus group interviews and one-on-one interviews and only four participants chose the latter option. Finally, there are issues of doing research in cross-cultural settings, especially in this study where the women represent a diverse sub-population, having come from various parts of the world and having experienced tremendous life-altering and traumatic events, with varying levels of English language proficiency. To facilitate communication and comfort, all of the focus group interviews were accompanied and facilitated through one or multiple translators who were in some cases, also providers interviewed in this study. It is possible that through translation,

meanings may not have been interpreted as they were intended. Thus, some interpretations were checked by a second interpreter after initial transcription.

4.4 Policy Implications and Suggestions for Future Research

There are a number of important policy implications to consider which may in part be strengthened with further research. First, there is a need to bridge the apparent dissonance between refugee and health policy and its implications on the everyday lives of refugee and refugees themselves. Results from this study reveal that the choices of refugee and refugee claimant women are extremely limited and while the women recognize the relationships between various health determinants – such as gender, status, income, housing, employment and healthcare – they face multiple barriers to accessing these determinants and forging healthy lives for themselves and their families during resettlement. Providers who work in the oral health sector have pointed to a number of very specific limitations in refugee health coverage (IFH) such as the refusal of care by health practitioners and the extent of coverage in dental services which are mutually enforcing. Thus, working with health practitioners specialized in serving refugee and refugee claimant communities as well as those communities themselves in the formation of health and refugee policy may provide an important and necessary starting point for recognising the unique health needs of refugees and refugee claimants.

There is also an urgent need to address the systematic exclusion of refugee claimant women from programs and services currently reserved for those with permanent status. There is an overwhelming consensus and evidence provided in this research that refugee claimant women experience multiple forms of exclusion and oppression owing to

their marginal social location. Their status, in effect, is itself stigmatizing, which suggests an alarming divergence from the fundamental rights of those seeking asylum as laid out in the 1951 Convention. These sources of oppression and their needs need to be explicitly included in refugee policy frameworks, a need that has been raised concerning temporary residents more generally, by Simich et al. (2007).

Understanding the impact of major legislative changes have taken place within Canadian Immigration and Refugee Policy such as Bill C-31, an Act which appear to largely affect asylum-seekers rather than government sponsored refugees especially in terms of the extent such changes compromise Canada's international humanitarian obligations and the rights of refugees and asylum-seekers outlined in the 1951 Convention and the 1967 Protocol (UNHCR, 2012). Results from this study suggest that such changes may contribute to a social environment that is potentially harmful and stigmatizing and further reduce an already limited range of social assistance available to these communities. Additionally, research is needed to understand how refugee and refugee claimant women living at the very margins of society are affected by the restructuring of refugee and immigration policy such as those mentioned above.

4.5 Concluding Thoughts

As suggested in the literature, gender is a very important determinant of health given that refugee and refugee claimant women face different health needs and expectations during resettlement than their male counterparts (Dyck, 2006). Results from this study also demonstrate that status/ citizenship is also an important determinant of health for refugee and refugee claimant women during resettlement. Further, many of the

women experience multiple barriers to accessing the health determinants they value, which occur at the intersection of gender and status. While the women negotiate new gender roles during resettlement such as those of single mothers or primary providers, they also negotiate their new identities, as refugees or refugee claimants, or as a result of not being able to procure meaningful employment. During resettlement, refugee and refugee claimant women appear to experience a sense of feeling unheard, invisible and experience forms of ‘othering’ (Dyck and Dossa, 2007) perhaps because they are a small, heterogenous group with limited power and options, and potentially limited legal status. An important contribution of this research is the application of the intersectional lens, provided through the works of various scholars across various disciplines (Gurguge and Khanlou, 2004; Hankivsky and Christoffersen, 2008; Valentine, 2007). Despite the variations, the work presented here is a reflection of Crenshaw’s (1991) inception of the concept, ultimately seeking to uncover the experiences which occur at the intersection of identities which are absent from social policy formation. Such a view challenges the hegemonic social normativities which produce exclusion and oppression so that those living at the very margins of society are heard, accounted for, and whose voices and knowledge are valued in their own right.

4.6 References

- Crenshaw, Kimberle. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review*, 43(6), 1241-1299.
- Dyck, Isabel. (2006). Travelling tales and migratory meanings: South Asian migrant women talk of place, health and healing. *Social & Cultural Geography*, 7(1) 1-18.
- Evans, Robert G., & Stosddart, Gregory L. (1990). Producing Health, Consuming Health Care. *Social Science and Medicine*, 31(12), 1347-1363.
- Fowler, Nancy. (1998). Providing Primary Health Care to Immigrants and Refugees: the North Hamilton Experience. *Canadian Medical Association Journal*, 159(4), 388–391.
- Guruge, Sepali & Khanlou, Nazilla. (2004). Intersectionalities of Influence: Researching the Health of Immigrant and Refugee Women. *Canadian Journal of Nursing Research (CJNR)*, 36(3), 32–47.
- Hankivsky, Olena & Christoffersen, Ashlee. (2008). Intersectionality and the determinants of health: a Canadian perspective. *Critical Public Health*, 18(3), 271–283.
- McKeary, M. & Newbold, K.B., (2010). Barriers to Care: The Challenges for Canadian Refugees and their Health Care Providers. *Journal of Refugee Studies* 3(1).
- Merry, Lisa A., Gagnon, Anita J., Kalim, Nahid, & Bouris, Stephanie S. (2011). Refugee Claimant Women and Barriers to Health and Social Services Post-birth. *Canadian Journal of Public Health*, 102(4), 286-90.
- Ng, Carita, Newbold, K. Bruce. (2011). Health Care Providers' Perspectives on the Provision of Prenatal Care to Immigrants. *Culture, Health & Sexuality*, 13(5) 561–574.
- Newbold, K.B. (2007). *Journey to Health: An investigation of the social production of health and access to health care within Hamilton's refugee community*. Research Proposal.
- Simich, Laura, Wu, Fei, & Nerad, Sonja. (2007). Status and Health Security: An Exploratory Study of Irregular Immigrants in Toronto. *Canadian Journal of Public Health*, 98(5), 369–73.

United Nations High Commissioner for Refugees (UNHCR). (2012a). UNHCR Submission on Bill C-31 *Protecting Canada's Immigration System Act*. Retrieved from <http://www.unhcr.ca/news/2012-05-08-e.pdf>

Valentine, Gill. (2007). Theorizing and Researching Intersectionality: A Challenge for Feminist Geography. *The Professional Geographer*, 59(1), 10–2.

APPENDICES A: Research Ethics Material

Recruitment Letter for Providers



Jenny Cho
Masters Candidate,
School of Geography and Earth Sciences
McMaster University
905-525-9140 ext. 20441
choj4@mcmaster.ca

September 2, 2011

Dear _____,

Thank you for your interest in our study on refugees in Hamilton. The purpose of this study is to examine the needs of Hamilton's refugee population (including refugee claimants and Protected Persons) and those of women in particular. Should you agree to participate in the interview you will be asked a series of questions about the health needs and the provision of health care and other social services for members of the refugee population. You will also be asked to talk about your experience working with the local refugee population. The interview is to last approximately one hour or as long as you need, and will occur at a time and place of your choosing. You do not need to answer any questions you would prefer not to answer.

Any information you share with the research team will **not** be attributed to you personally, unless you have authorized the research team to reveal this information (see consent form). All of your personal information will be protected during and after the completion of the study, including any reports or presentations of the study findings. You have the right to be treated with respect and your privacy protected at all stages of the research study and by all members of the research team.

Please remember that your participation in this study is voluntary. Even after you have signed the consent form you may end the interview at any time and for any reason. Should you decide to end the interview there will be no penalty to yourself. You may refuse to answer any question in the interview script. We will accept both complete and partial interview data. You may request to have your information removed from the study at any time.

Your interview and transcription will be numbered and kept in a locked filing cabinet separate from your consent form. This information will be available only to the research

team. At the completion of the study, your interview, audiotape and transcription of your interview will be destroyed.

Have we addressed any questions or concerns you may have regarding the purpose and the process involved in the research study, “*Journey to Health: An Investigation of the Social Production Health and Access to Health Care within Hamilton’s Refugee Community*” led by Dr. Bruce Newbold, of McMaster University? We hope that you will be willing to be interviewed. Dr. Newbold can be reached at (905) 525-9140 ext. 27948 or newbold@mcmaster.ca

Sincerely,
Jenny Cho

**Letter of Information/Consent Form
for Service Providers from both Health Care and
Social Service Organizations.**

Project Title: *Journey to Health: An Investigation of the Social Production of Health and Access to Health Care within Hamilton's Refugee Community*

Principle Investigator: Dr. Bruce Newbold
School of Geography & Earth Sciences
McMaster University
905-525-9140 ext. 27948
newbold@mcmaster.ca

Student Investigator: Jenny Cho
McMaster Institute of Environment and Health
McMaster University
905-525-9140 ext. 20441
choj4@mcmaster.ca

Thank you for accepting our invitation to be interviewed. Your experience and expertise are important sources of knowledge which will enhance our research findings. The following information letter will outline the purpose of our study and the care we have taken to protect your privacy. With your permission we will take a few minutes, before we begin, to review the information and answer any questions you may have with regards to the interview and the larger study.

Purpose of the Study:

The purpose of this study is to examine the needs of Hamilton's refugee population (including refugee claimants and Protected Persons) and those of women in particular. More specifically, the study will seek to understand experiences of health, and health care services as well as other social services related to the settlement experience. A further goal is to understand whether experiences may differ within the refugee community according to gender, ethnicity and refugee designation.

Procedure:

Should you agree to participate in the interview you will be asked a series of semi-structured and open-ended questions about the health needs and the provision of health care services for members of the refugee population. In order to ensure accuracy we would like to audiotape, as well as, take notes. If however, you are uncomfortable with

the tape recorder we can work from the interview script and notes. The interview will take as long as you need and the time you have available to answer our questions.

Potential Risks:

The risks associated with participating in the study are no greater than the risks you encounter in everyday life. Please feel free to skip any questions you do not wish to answer. At your request we will be happy to send you a summary of the study results at the completion of the research.

Potential Benefits:

The aim of this study is to inform the academic community and stakeholders within the local community of the major health needs and the accessibility of health care services available for members of the local refugee community. Your experience and expertise will assist in addressing this research gap and hopefully, lead to the development of Best Practices and an awareness of both the challenges and rewards experienced by providers.

Confidentiality:

Your personal information, including your name, title, and organization will not be identified in our research report. Your interview script and transcript will be coded and numbered and kept in a locked filing cabinet separate from your consent form. Only the research team will have access to the information and all of the team are committed to protecting your privacy. Individuals participating in the interviews will not be identified in any report or presentation. You may also withdraw from the study at any time by contacting Dr. Newbold (the P.I.) and, at your information will be destroyed. All original interview scripts and audiotapes will be destroyed at the completion of the study.

Participation and Withdrawal:

Your participation in this study is voluntary. You are welcome to stop the interview, at any time, and for any reason, even after signing the consent form. Should you decide to withdraw from the study, after completion of the interview, we will destroy any information we have gathered. As previously discussed, you may choose the questions you wish to answer. The information you share with us, whether complete or partial, is still important to the overall study results. There is no penalty for withdrawal from the study and we thank you for your time.

Study Debriefing:

Should you wish a summary of our findings we would be happy to mail them to you after the completion of the study. The interviewer will ask for your mailing information so we may follow through on your request.

Rights of Research Participants:

You have the right to be treated respectfully and your privacy to be protected. As outlined above the research team have taken a number of precautions to ensure confidentiality. If you have any further questions or concerns about the research study, please feel free to contact Dr. Bruce Newbold (905-525-9140, ext. 27948).

This study has been reviewed and approved by the McMaster Research Ethics Board. If you have concerns or questions regarding your rights as a research participant or about the way the study is conducted, you may contact:

McMaster Research Ethics Board Secretariat
Telephone: 905-525-9140 ext. 23142
c/o Office of Research Services
E-mail: ethicsoffice@mcmaster.ca

Name of Interviewer

Date (DD/MM/YY)

Signature of Interviewer



Female Participants Needed for Research in Study on Refugee Health

Dear Clients,

We are looking for volunteers to take part in a study of health and health care experiences of women who are refugees or refugee claimants currently living in Hamilton, Ontario. This study is called "*Journey to Health: An Investigation of the Social Production Health and Access to Health Care within Hamilton's Refugee Community*". It will be conducted by Jenny Cho (a master's student at McMaster University) under the supervision of Dr. Bruce Newbold.

If you agree to participate, you will be asked to participate in either a one-one-one interview or a focus group. During the interview or focus group, you will be asked a series of questions about your health and health care experiences. The interview will last approximately one hour. You do not need to answer any questions you would prefer not to answer and may discontinue to interview at anytime. Your identity will remain anonymous and the information you share will be kept confidential. In appreciation for your time, you will receive two HSR transit tickets as well as a 10\$ Tim Horton's gift card.

Please remember that your participation in this study is entirely voluntary and your decision to participate or not, is confidential and will in no way affect your use or receipt of services here at North Hamilton Community Health Centre. Should you agree to participate, you will be asked to sign a consent form. Please know that even after you have signed the consent form, you may end the interview at any time and for any reason. Should you decide to end the interview there will be no penalty to yourself, and non-participation will not affect your use of services or receipt of compensation.

This study has been reviewed by, and received ethics clearance by the
McMaster Research Ethics Board.

If you wish to learn more about the project or are interested in
volunteering for an interview or focus group, you may directly contact
Jenny Cho or Dr. Bruce Newbold at:

Jenny Cho

School of Geography and Earth
Sciences

McMaster University
905-525-9140 ext. 20441

Or 905-517-3658

choj4@mcmaster.ca

Dr. Bruce Newbold

School of Geography & Earth
Sciences

McMaster University
905-525-9140 ext. 27948

newbold@mcmaster.ca

Letter of Information/Consent Form for Interviews
Project Title: “Journey to Health: An Investigation of the Social Production Health and Access to Health Care within Hamilton’s Refugee Community”

Date: _____

Interview Number: _____

Principle Investigator: Dr. Bruce Newbold
School of Geography & Earth Sciences
McMaster University
905-525-9140 ext. 27948
newbold@mcmaster.ca

Student Investigator: Jenny Cho
School of Geography & Earth Sciences
McMaster University
905-525-9140 ext. 20441
choj4@mcmaster.ca

Thank you for accepting our invitation to be interviewed. The following information letter will outline the purpose of our study and the care we have taken to protect your privacy. With your permission we will take a few minutes, before we begin, to review the information and answer any questions you may have with regards to the interview and the larger study.

Purpose of the Study:

This study is called “*Journey to Health: An Investigation of the Social Production Health and Access to Health Care within Hamilton’s Refugee Community*”. It will be conducted by Jenny Cho (a master’s student at McMaster University) under the supervision of Dr. Bruce Newbold as part of a requirement to fulfill my master’s thesis.

This study aims to achieve a better understanding of health needs and challenges to health care as experienced by local refugee and refugee claimant women in Hamilton, Ontario. The hope is that results from this study will in some way, better inform immigration and health policy. As well, it is hoped that local health and settlement service providers may be able to use the findings to meet your needs and address your concerns in more specific ways.

Procedure:

If you agree to participate in the interview, you will be asked a series of questions about your health and health care experiences. The interview will last approximately one hour. In order to ensure accuracy we would like to audiotape, as well as take notes. If however, you are uncomfortable with the audio recorder, we can work from the interview script and notes. The interview will take as long as you need and the time you have available to answer our questions.

Potential Risks:

The risks associated with participating in the study are no greater than the risks you encounter in everyday life, although it may be stressful to recall some of your experiences. Remember that you can skip any question you like or stop the interview at any time. At your request we will be happy to send you a summary of the study results at the completion of the research.

Potential Benefits:

The aim of this study is to inform the community of the health needs and issues within the local refugee community. Your experience and expertise will assist in addressing this knowledge gap and hopefully lead to an improved awareness of the challenges faced by new immigrants.

Confidentiality:

We will make every effort to keep your information confidential, and your personal information, including your name, will not be identified in our research report. Your interview script and transcript will be coded and numbered and kept in a locked filing cabinet separate from your consent form. Only the research team will have access to the information and all of the team are committed to protecting your privacy. Individuals participating in the interviews will not be identified in any report or presentation. Should you decide to end the interview there will be no penalty to yourself, and non-participation will not affect your use of services or receipt of compensation.

You may also withdraw from the study at any time by contacting Dr. Newbold (the P.I.) and, at your request; your information will be destroyed. All original interview scripts and audiotapes will be destroyed at the completion of the study.

Participation and Withdrawal:

Your participation in this study is voluntary. You are welcome to stop the interview at any time and for any reason, even after signing the consent form. Should you decide to withdraw from the study, we will destroy any information we have gathered. Should you decide to end the interview there will be no penalty to yourself, and non-participation will not affect your use of services or receipt of compensation. You may withdraw from the study at any time, and if you choose to do so, this will not affect your use of services or receipt of compensation. As previously discussed, you may choose the questions you wish to answer. The information you share with us, whether complete or partial, is still important to the overall study results. There is no penalty for withdrawal from the study and we thank you for your time.

Study Debriefing:

Should you wish a summary of our findings we would be happy to mail them to you after the completion of the study. The interviewer will ask for your contact information so we may follow through on your request.

Remuneration Confirmation

As a small thank-you for participating in this work, we are able to offer you a \$20 honorarium. We are required by our funding agency (CIHR) to demonstrate that interview participants have received remuneration for their time. We will ask you to initialize and date the form indicating that you have received this. The interviewer will also sign and date the form.

Rights of Research Participants:

You have the right to be treated respectfully and your privacy to be protected. As outlined above, the research team has taken a number of precautions to ensure confidentiality. We will make every effort to keep your information confidential, and your personal information, including your name, will not be identified in our research report. If you have any further questions or concerns about the research study, please feel free to contact Dr. Bruce Newbold (905-525-9140, ext. 27948, or via email at newbold@mcmaster.ca).

As noted, your participation in this study is voluntary, and you are welcome to terminate the interview at any time, or refuse to answer any questions. If you decide to withdraw, we will destroy any information. Should you decide to end

the interview there will be no penalty to yourself, and non-participation will not affect your use of services or receipt of compensation.

This study has been reviewed and approved by the McMaster Research Ethics Board. If you have concerns or questions regarding your rights as a research participant or about the way the study is conducted, you may contact:

McMaster Research Ethics Board Secretariat
Telephone: 905-525-9140 ext. 23142
c/o Office of Research Services
E-mail: ethicsoffice@mcmaster.ca

Signature of Interviewer

Confidentiality Script

Confidentiality

We will make every effort to keep your information confidential, and your personal information, including your name, will not be identified in our research report. All of your personal information will be protected during and after the completion of the study, including any reports or presentations of the study findings. You have the right to be treated with respect and your privacy protected at all stages of the research study and by all members of the research team.

Please remember that your participation in this study is voluntary. Even after you have signed the consent form you may end the interview at any time and for any reason. Should you decide to end the interview there will be no penalty to yourself, and non-participation will not affect your use of services. You may refuse to answer any question in the interview script. We will accept both complete and partial interview data. You may request to have your information removed from the study at any time.

Your interview will be recorded with your permission. Both the recording and transcription will be numbered and kept in a locked filing cabinet separate from your consent form. This information will be available only to the research team. At the completion of the study, your interview, audiotape and transcription of your interview will be destroyed.

Have we addressed any questions or concerns you may have regarding the purpose and the process involved in the research study, "*Journey to Health: An Investigation of the Social Production Health and Access to Health Care within Hamilton's Refugee Community*", led by Dr. Bruce Newbold and Jenny Cho of McMaster University?

Confidentiality Script for Translators

Interview Number: _____

I understand the purpose of the study , ***“Journey to Health: An Investigation of the Social Production Health and Access to Health Care within Hamilton’s Refugee Community”***, conducted by Dr. Bruce Newbold of McMaster University. I also understand that as a translator, I will protect the confidentiality of the individual that I am translating for, as well as any statements or observations made by that individual. I agree that all statements reflect the comment(s) made by the person being interviewed. I agree to participate in the research study as a translator, and I understand that this will be recorded. I have been given a copy of this form.

Name of Translator

Signature of Translator

Date _____
(DD/MM/YY)

Name of Interviewer

Signature of Interviewer

Date _____
(DD/MM/YY)

Letter of Information/Consent Form for Focus Groups
Project Title: “*Journey to Health: An Investigation of the Social Production Health and Access to Health Care within Hamilton’s Refugee Community*”

Date: _____

Interview Number: _____

Principle Investigator: Dr. Bruce Newbold
School of Geography & Earth Sciences
McMaster University
905-525-9140 ext. 27948
newbold@mcmaster.ca

Student Investigator: Jenny Cho
School of Geography & Earth Sciences
McMaster University
905-525-9140 ext. 20441
choj4@mcmaster.ca

Thank you for accepting our invitation to be interviewed. The following information letter will outline the purpose of our study and the care we have taken to protect your privacy. With your permission we will take a few minutes, before we begin, to review the information and answer any questions you may have with regards to the focus group session and the larger study.

Purpose of the Study:

This study is called “*Journey to Health: An Investigation of the Social Production of Health and Access to Health Care within Hamilton’s Refugee Community*”. It will be conducted by Jenny Cho (a master’s student at McMaster University) under the supervision of Dr. Bruce Newbold as part of a requirement to fulfill my master’s thesis.

This study aims to achieve a better understanding of health needs and challenges to health care as experienced by local refugee and refugee claimant women in Hamilton, Ontario. The hope is that results from this study will in some way, better inform immigration and health policy. As well, it is hoped that local health and settlement service providers may be able to use the findings to meet your needs and address your concerns in more specific ways.

Procedure:

If you agree to participate in the focus group session, you will be asked a series of questions about your health and health care experiences. The session will last approximately one hour. In order to ensure accuracy we would like to audiotape, as well as take notes. If however, you are uncomfortable with the audio recorder, we can work from the interview script and notes. The interview will take as long as you need and the time you have available to answer our questions.

Potential Risks:

The risks associated with participating in the study are no greater than the risks you encounter in everyday life, although it may be stressful to recall some of your experiences. Remember that you can skip any question you like or stop the interview at any time. At your request we will be happy to send you a summary of the study results at the completion of the research.

Potential Benefits:

The aim of this study is to inform the community of the health needs and issues within the local refugee community. Your experience and expertise will assist in addressing this knowledge gap and hopefully lead to an improved awareness of the challenges faced by new immigrants.

Confidentiality:

We will make every effort to keep your information confidential, and your personal information, including your name, will not be identified in our research report. As well, we ask that whatever information is shared during the focus group session remain confidential. Your focus group script and transcript will be coded and numbered and kept in a locked filing cabinet separate from your consent form. Only the research team will have access to the information and all of the team are committed to protecting your privacy. Individuals participating in the focus groups will not be identified in any report or presentation. Should you decide to end the session there will be no penalty to yourself, and non-participation will not affect your use of services or receipt of compensation.

You may also withdraw from the study at any time either during the focus group session or thereafter by contacting Dr. Newbold (the P.I.) or Jenny Cho and, at

your request; your information will be destroyed. All original interview scripts and audiotapes will be destroyed at the completion of the study.

Participation and Withdrawal:

Your participation in this study is voluntary. You are welcome to withdraw from the focus group session at any time and for any reason, even after signing the consent form. Should you decide to withdraw from the study, we will destroy any information we have gathered. Should you decide to end the session there will be no penalty to yourself, and non-participation will not affect your use of services or receipt of compensation. You may withdraw from the study at any time, and if you choose to do so, this will not affect your use of services or receipt of compensation. As previously discussed, you may choose the questions you wish to answer. The information you share with us, whether complete or partial, is still important to the overall study results. There is no penalty for withdrawal from the study and we thank you for your time.

Study Debriefing:

Should you wish a summary of our findings we would be happy to mail them to you after the completion of the study. The interviewer will ask for your contact information so we may follow through on your request.

Remuneration Confirmation

As a small thank-you for participating in this work, we are able to offer you a \$20 Honorarium per participant. We are required by our funding agency (CIHR) to demonstrate that interview participants have received remuneration for their time. We will ask you to initialize and date the form indicating that you have received this. The interviewer will also sign and date the form.

Rights of Research Participants:

You have the right to be treated respectfully and your privacy to be protected. As outlined above, the research team has taken a number of precautions to ensure confidentiality. We will make every effort to keep your information confidential, and your personal information, including your name, will not be identified in our research report. If you have any further questions or concerns about the research study, please feel free to contact Dr. Bruce Newbold (905-525-9140, ext. 27948, or via email at newbold@mcmaster.ca).

Email Address (only provided if Email is preferred method of communication):

Mailing Address :

Apt/House # and Street: _____

City: _____

Postal Code: _____

Signature of Interviewer:

In my opinion, the participant is voluntarily and knowingly giving informed consent to participate in this research study.

Name of Interviewer

Date (DD/MM/YY)

Signature of Interviewer

Confidentiality Script

Confidentiality

We will make every effort to keep your information confidential, and your personal information, including your name, will not be identified in our research report. All of your personal information will be protected during and after the completion of the study, including any reports or presentations of the study findings. You have the right to be treated with respect and your privacy protected at all stages of the research study and by all members of the research team.

Please remember that your participation in this study is voluntary. Even after you have signed the consent form you may end the interview at any time and for any reason. Should you decide to end the interview there will be no penalty to yourself, and non-participation will not affect your use of services. You may refuse to answer any question in the interview script. We will accept both complete and partial interview data. You may request to have your information removed from the study at any time.

Your interview will be recorded with your permission. Both the recording and transcription will be numbered and kept in a locked filing cabinet separate from your consent form. This information will be available only to the research team. At the completion of the study, your interview, audiotape and transcription of your interview will be destroyed.

Have we addressed any questions or concerns you may have regarding the purpose and the process involved in the research study, "*Journey to Health: An Investigation of the Social Production Health and Access to Health Care within Hamilton's Refugee Community*", led by Dr. Bruce Newbold and Jenny Cho of McMaster University?

Confidentiality Script for Translators

Interview Number: _____

I understand the purpose of the study , ***“Journey to Health: An Investigation of the Social Production Health and Access to Health Care within Hamilton’s Refugee Community”***, conducted by Dr. Bruce Newbold of McMaster University. I also understand that as a translator, I will protect the confidentiality of the individual that I am translating for, as well as any statements or observations made by that individual. I agree that all statements reflect the comment(s) made by the person being interviewed. I agree to participate in the research study as a translator, and I understand that this will be recorded. I have been given a copy of this form.

Name of Translator

Signature of Translator

Date _____
(DD/MM/YY)

Name of Interviewer

Signature of Interviewer

Date _____
(DD/MM/YY)

Remuneration Confirmation

As a participant in the , ***“Journey to Health: An Investigation of the Social Production Health and Access to Health Care within Hamilton’s Refugee Community”***, study conducted by Dr. Bruce Newbold and Jenny Cho of McMaster University, I have received the following remuneration for my time:

(List all remuneration received, i.e., \$10 Tims Card, 2 HSR Bus tickets, etc.)

By initialing this form I confirm that I participated in the *Journey to Health: An Investigation of the Social Production Health and Access to Health Care within Hamilton’s Refugee Community* study and that I have received the above listed remuneration for my participation.

Participant Initials: _____

Date: _____
(DD/MM/YY)

By signing this form I confirm that the above individual participated in the Exploring the Links study and that I have provided him/her with the remuneration listed above for this participation.

Signature of interviewer: _____

Date: _____
(DD/MM/YY)

APPENDICES B: Data Collection Tools

Health Profile Survey

Name (or ID number): _____

1) How would you rate your physical health upon arrival to Canada?

Very Unhealthy Unhealthy Somewhat healthy Very Healthy N/A

2) How would you rate your mental health upon arrival to Canada?

Very Unhealthy Unhealthy Somewhat healthy Very Healthy N/A

3) How would you rate your physical health currently (after x years/months in Canada).

Very Unhealthy Unhealthy Somewhat healthy Very Healthy N/A

4) How would you rate your mental health currently (after x years/months in Canada).

Very Unhealthy Unhealthy Somewhat healthy Very Healthy N/A

5) Gender

Female Male N/A

6) Can you share with us your marital status upon arrival? Currently?

7) Age *currently*?

18-24 25-34 35-44 45-54 55-64 65-74 75+ N/A

Age *upon arrival*?

18-24 25-34 35-44 45-54 55-64 65-74 75+ N/A

8) Can you tell us your highest level of education *completed* in your birth country?

Elementary School High School College/Trade/Apprentice
University (undergraduate) Professional/Graduate Program
Other _____ N/A

9) Can you tell us your highest level of education *completed* here in Canada?

Elementary School High School College/Trade/Apprentice
University (undergraduate) Professional/Graduate Program
Other _____ N/A

10) Can you share with us your occupation/profession in *your birth* country?

11) Can you share with us your occupation/profession *currently* in Canada?

12) Which of the following best describes your total household income *your first year* in Canada, before taxes?

Under 15,000 15,000 – 20,000 21,000-30,000 31,000-40,000
41,000-50,000 51,000 – 60,000 61,000-70,000 71,000–80,000
81,000 + N/A

Which of the following best describes your total household income *for last year, before* taxes?

Under 15,000 15,000 – 20,000 21,000-30,000 31,000-40,000
41,000-50,000 51,000 – 60,000 61,000-70,000 71,000–80,000
81,000 + N/A

13) Can you describe your housing accommodation *when you first arrived* in Canada?

Shared housing Multi-unit building Apartment in house

Semi-detached home Single dwelling home Shelter
Reception House Hotel/Motel Other _____

Can you describe your *current* housing accommodation in Canada?

Shared housing Multi-unit building Apartment in house
Semi-detached home Single dwelling home Other

Interview Questions for Providers
***Journey to Health: An Investigation of the Social Production of Health and Access to Health
Care within Hamilton's Refugee Community***

1. Background:

1a. Can you describe your involvement with the refugee community and your role at _____?
(What types of services do you involved with?)

1b. How long have you worked at _____ and/or with refugee clients?

1c. Are you involved with the refugee community outside of the _____?

2. Definition of Refugee:

2a. How would you define the term refugee? Do you believe there are different categories of this term?

2b. What percentage of your clientele are refugees? Has this changed over time?

2c. How do your refugee clients come into contact with _____? (Do you get patients/clients referred to you by other refugee/immigrant serving centres?)

2d. Do you work with or communicate with other services providers in the city that work with the refugee population? Such as?

3. Demographics of refugee clients:

3a. What is the age and gender composition of your refugee clientele and has this changed over time? If so, how?

3b. Can you describe the different nationalities/cultural groups that represent your clientele and any changes over time? (Is there a majority group that the centre has served? Has this changed over time?)

3c. Are most of your refugee clients families or individuals or both?

4. Priority needs:

4a. In your opinion, are there any needs which should take priority for refugees (ie. health care, shelter, housing, counselling, employment, other)?

4b. How do these priorities change over time?

4c. Are priority needs different for refugee men and women? How so?

4d. Are priority needs different among refugee women according to either race, culture, ethnicity, refugee status or other? How so?

4d. Do you feel that these needs are being met? Why or Why not?

5. Health :

5a. How would you describe the health status of your refugee clients?

5b. In your opinion, are there any noticeable differences in health status or needs according to gender, age, ethnicity, refugee status? (ie. Do women have different health needs than men? Do women of certain backgrounds have different needs compared to women of other backgrounds?)

5c. What types of health related changes have you observed in your refugee clients over time? How does this compare to your non-refugee clients?

6. Prevention:

6a. In general, do your refugee clients participate in preventative health care measures? Can you provide some examples?

6b. Have you found that gender, family roles, culture/ethnicity, race or refugee status play a role in utilizing preventive care services? In what ways?

7. Usage of Health Services:

7a. Do you feel that there are members of the refugee population that do not utilize available mainstream health services, even at times of need? Such as? Why do you think this is?

7b. Have you found that gender, family roles, culture/ethnicity, race or refugee status play a role in utilizing mainstream healthcare services? In what ways?

7c. Are there any preventative measures or mainstream healthcare services that are 'under-utilized' by members of the refugee community? If so, what are they? Why do you think this is?

7d. What role/responsibility should the individual or family play in achieving 'good' health?

8. Access and Barriers to Healthcare:

8a. In your opinion, do refugees face barriers in accessing health services to meet their needs? For example?

8b. Do barriers differ for men and women? How so?

8c. Do barriers differ by ethnicity/culture, race, age and/or refugee designation? How so?

8d. Have you seen improvements over time, in terms of the quality of services, especially the development of culturally sensitive services in the city of Hamilton?

8e. At present, would you say there are more or less health resources available to the refugee community?

8f. Do you think that the health needs are being met within the refugee population? Why or why not?

8g. What improvements would you suggest? What improvements do you believe are possible within the system?

9. Consumer Satisfactions:

9a. Do you believe, if we were to survey, members of the refugee community, they would be satisfied with the level of service available to them? Why or Why not?

9b. What changes do you believe they would like to see?

10. Challenges:

10a. What have you found to be the greatest challenges in providing adequate services for your refugee clients? Have the challenges changed over time? How have you dealt with these challenges?

11. Final Comments:

11a. Do you have any additional comments you would like to add to our study results?

12. Recruitment:

12a. Would you be able to assist me in recruiting other health care or service providers to be interviewed?

12b. I am also going to be recruiting members of the refugee community-women to interview in the coming months. Would you be able to assist me in recruiting potential participants for an

interview or focus group session? (cultural/language interpretation services will be provided where necessary)

Interview Script for Refugee and Refugee Claimant Women

1. Background: When did you come to Canada? (Date of arrival) How long was your journey from your home country/country of residence to your arrival in Canada? Under what circumstances did you come to Canada? Where is your homeland? Can you describe your journey (via countries/circumstances to Canada)? Why did you settle in Hamilton? How long have you lived in Hamilton?
2. Definition: Under what refugee/immigrant status/definition did you enter Canada? If you, your family, or your community came to Canada as refugees - do you still see yourselves as refugees? Why or why not?
3. Do you consider yourself a healthy person? Please tell us a little bit about your health, in your home country? During your journey? When you first came to Canada. In the present? Can you describe the health care systems' you have experienced and the home countries? When you first came to Canada, how did you learn about the health care system? Did someone help you with the health care system? If so, how? How easy or hard was it to get information/help about available health care services? Do you have a family doctor here in Canada? Did you have one back home? Or any other country you have resided in?

4. What are your thoughts/ideas/beliefs on good health and poor health? What does it mean to be healthy in your opinion? Physically and mentally? Is one more important than the other for you? How would you rank your own health? In the past? In the present? Is it excellent, very good, good, fair or poor?
5. We all experience stress in life. How would you describe stress in your life? What are some major sources of stress in your life at this time? What about in comparison to life in your home country? Do you try to deal with your stress? How do you normally/usually deal with stress? What practices do you use to deal with stress in your life? Your families' life?
6. In general, where do you usually seek health care services either when you need to or on a regular basis?
7. Do you have a family doctor? Do you attend the same clinic? Walk in clinic? Hospital?
8. Obstetrician? Breast and cervical screening?
9. How often would you say you see a medical professional?
10. Do you use/consult alternative/traditional forms of care? If so, what are they?
11. Do you feel you are aware of the services available to you? Do you feel that when you have a particular health need, that you are aware of where to go to receive this necessary care?
12. Are there barriers to seeking care? Can you describe? What could be done to make it easier for you? Your family? To be healthier.
13. Do you worry about your children's health? Are they healthy?

14. Have there been times when you needed care, but did not seek it? If not, why? Can you talk about this experience? What was the reason for needing care and what prevented you from seeking care? Do you believe you should seek care more often but cannot? Can you tell us why?
15. When you have sought care would you say it was a positive or a negative experience? Was the care sought from a hospital, clinic, doctor, pharmacist, dentist, or other? Were you seeking care for yourself or for others, in your family? In your community? (friend, neighbour) Have there been times when you sought care and felt you did not receive the proper care you needed or deserved? Can you tell me about the experience (the reason for the visit and things that happened during and around the visit?) Did you ever feel that the care was inappropriate for you or made you feel uncomfortable? How did you react? How did that make you feel?
16. Do you have practices outside of the health care system which you perform to keep healthy? To help you when you are sick?
17. Do you attend (doctor's) appointments alone or does your spouse or someone else accompany you?
18. Would you say you generally make some, most or all of the decisions concerning your own health? Do you make decisions for the health of others? (children, family, parents, others in the community ?)

19. Are you more or less comfortable having someone with you at medical visits appointments?

Why or why not? Is it your preference?

20. Do you think that the quality of care you receive is different for the following groups?

21. Immigrants? From which countries? Refugees? From which countries?

22. Canadian born?

23. Natives in Canada?

24. Men? Women? Children?

25. Are there major/minor differences? Can you describe them for us?

26. Do you have any suggestions for steps/solutions to improve health care/services for the above groups? Can you share with us?

27. Do you find the health care system in Canada to be different from other countries you have lived in and can you tell us why and where?

28. Why did you agreed to be interviewed for this project? Why do you believe it is important?

What would you like to have happen with the results/analysis? Do you have any suggestions/solutions regarding the health care system in Hamilton? Canada?

29. Do you have any suggestions for changes which could improve the health status of refugees?

Changes you would like to see?

30. Do you believe immigrants are treated differently than refugees in Canada? Can you describe the differences?