

EXPLORING REFUGEE WOMEN'S ACCESS TO HEALTH CARE SERVICES:
THE FIRST YEAR

A THESIS SUBMITTED TO THE COLLEGE OF
GRADUATE AND POSTDOCTORAL STUDIES
IN PARTIAL FULFILMENT OF THE REQUIREMENTS
FOR THE DEGREE OF MASTER OF SCIENCE
IN THE DEPARTMENT OF COMMUNITY HEALTH AND EPIDEMIOLOGY
UNIVERSITY OF SASKATCHEWAN
SASKATOON

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Acknowledgements

Undertaking an academic journey such as this does not happen independently or in isolation. There have been so many wonderful people who have guided me during my journey through graduate school. It is with much gratitude and recognition that I acknowledge the profound support and guidance I have received from numerous individuals. I wish to express my sincere thanks to Almighty God for bringing me to this far in my academic career and scholarly pursuits.

I remain eternally grateful to my academic advisor, Dr. Lori Hanson, for your outstanding mentorship, constructive criticism, and supervision, which have guided me throughout the stages of this research. I have learned a tremendous amount through your mentorship and have gained not only academic knowledge, but also life skills from you. I would like to sincerely acknowledge Dr. Punam Pawha for her role in chairing my thesis committee and providing logistical support. To Drs. Sylvia Abonyi and Michael Schwandt, who served as committee members, thank you for your commitment to this project and for always providing thoughtful comments and suggestions, which shaped the outcome of this thesis. Also, to Dr Marwa Farag of the School of Public health for her role as external examiner for my thesis defense, thank you for your remarkable insights, advice and feedback at the final stage of this thesis.

I would also like to acknowledge the faculty, staff, and students in Community Health and Epidemiology for providing me tremendous support during my time at the University of Saskatchewan, and for giving me the opportunity to critically explore population health/global health with my peers and colleagues in the department. I am indebted to Drs. Enoch Pambour, Teddy Bandima, and Hazel Williams-Roberts for taking time from their heavy schedules to help me edit and fine-tune my thesis. My profound appreciation to Olawale Salaam for his continual support and encouragement during the research process.

Thank you to all the resettlement agencies and health professional representatives in Saskatoon for your support and contributions to this study. To the women participants who took part in this study, this project 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. Thank you all for sharing your intimate life stories with me.

Many thanks to my amazing family and friends back home, who always made me laugh when I wanted to cry and never gave up on supporting me. To Rev. Frs. Vincent Agbeyome-Akpah and Emmanuel Adjei Adjetey, thank you for your prayers and support. Your unending faith in me is overwhelming, and I appreciate it so. You supported me in many ways, big and small, and I am humbled.

Finally, I would like to express my appreciation to my biggest supporters—my parents, brother and my cousins—for their abundant love, prayers, and encouragement, which urged me on during the difficult times when I almost gave up. Without them, I would not be where I am today, and for that, I will be eternally grateful.

Dedication

I dedicate this study to my dearest parents, Gp Capt (Rtd). F.A. Gyimah-Kwakye, Eileen Martinson, and Kweku Acheampong.

Also, to all refugees, their host countries around the globe, all individuals and organizations who provide quality health care to these vulnerable populations, and the UNHCR for the good things they are doing for these homeless people, refugees.

Abstract

Over the past few years, the world has seen a significant rise in the number of refugees due to wars and conflicts, making war, conflicts and the increasing number of refugees a global concern. Before entering a host country, refugees often live in camps, with limited health care resources, inadequate food and water, and no access to education. Refugee women may have also experienced sexual violence, gender-based discrimination, and reproductive health problems. Resettled refugees often know little to nothing about their medical needs until a health assessment is done upon their arrival in their host country. Refugees face many challenges during their first year of resettlement, including language barriers, adapting to new culture and context, and difficulty accessing health care services. Despite significant strides made by the Canadian government towards providing refugees adequate health care services, health care disparities continue to persist between this population and the general population of a Canada. This study reveals the experiences of refugee women's access to health care services during their first year of resettlement in Saskatoon, Saskatchewan, between 2014 and 2015.

This analysis examines the lives of eight post-migration refugee women from Somalia and Eritrea who arrived in Saskatoon and accessed health care services there through the Interim Federal Health Program (IFHP). The IFHP serves as the primary government program that provides limited and temporary health care benefits to protected persons, including refugees and refugee claimants. Contextually, the study took place after the 2012 cuts to the IFHP were restored in 2014. In order to understand how these refugees access health care services, three health care providers and four resettlement agency representatives were interviewed.

The study was conducted within the theoretical framework of intersectionality. Data collected through interviews were analyzed and interpreted through a social constructionist

epistemological lens, employing an inductive thematic analysis approach. The findings revealed mixed experiences and perceptions regarding refugee access to health care services. The results also show the various ways health service providers and resettlement agencies interpret and deliver health care services to refugees. Refugees are perceived to have experienced many difficulties during their transition and upon entry to Canada. Some refugees may be unaware of the variety of health care services in Canada as these services may differ from those provided in their country of origin. Language, transportation, cultural factors, and discrimination and racism also impede refugees' access to health care. Perceived discrimination and racism was an interesting finding that emerged from this study. The study's results could not establish if there were actual experiences of discrimination and racism, or the refugee women did not understand how the Canadian health system operates. The study found that health service providers and resettlement agencies' representatives shared their experiences and perceptions regarding health care services for refugees and that their services were largely appreciated by the refugee women interviewed; however, much remains to be done in the provision of accessible services.

Overall, the study is intended to assist in informing programs and policies in that will help refugees in their access to health care services during the first year of resettlement.

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CIA	Canadian Immigration Act
CIC	Citizenship Immigration Canada
DCO	Designated Countries of Origin
IRB	Immigration and Refugee Board of Canada
IRPA	Immigration and Refugee Protection Act
ICCPR	International Covenant on Civil and Political Rights
IFH	Interim Federal Health
IFHP	Interim Federal Health Program
IDPs	Internally Displaced Persons
LGBT	Lesbian, Gay, Bisexual, and Transgender
PTSD	Post-Traumatic Stress Disorder
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNRWA	United Nations Relief and Works Agency
U of S REB	University of Saskatchewan Behavioural Research Ethics Board

Chapter One

1.0 Introduction

Over the past few years, continuous wars and conflicts around the world have led to an increase in the number of refugees across the globe, especially in Canada. During these tumultuous times, refugees experience social disconnection, displacement, isolation, famine, and overcrowding (Al-Khatib, et al., 2003; Banjong, Menefee, Sranacharoenpong, Eg-kantrong, et al., 2003). Countries such as Syria, Afghanistan, Congo, Somalia, and Sudan exhibit ongoing conflicts with little prospects of an end. As a result, these countries produce mass outflows of individuals seeking a safe haven for themselves and their families (UNHCR, 2014b). These adverse conditions predispose refugees to various social, physical, emotional, and mental health problems. Despite the significant advance made by the Canadian government towards the provision of universal health care, disparities in health care continue to persist among all marginalized populations, including refugees (Singh, Lynch, Abrahamowicz, Tousignant, & Quesnel-Vallee, 2011). Refugees' first year of resettlement in host countries may present many challenges, including language barriers, adapting to the new culture, and difficulties accessing health care services. In situations where there is increased understanding of health care systems, needs, and barriers by refugees, the health of newly resettled refugees will be improved.

This study explores the experiences of refugees' health care utilization during their first year of resettlement in Saskatoon, building on similar emerging research on the lives of refugees in Canada. The study examines the lives of eight refugee women from Somalia and Eritrea who arrived in Saskatoon during the period in which cuts to Canada's Interim Federal Health Program (IFHP) had been recently reinstated. To better understand whether or how these contexts of their access to health care is affected within the first year, eight refugee women, three health care

providers and four resettlement agency representatives were also included in the study. For the purposes of this study, statistics on refugees were taken from 2009 to 2015. The study included government-assisted refugee populations who had arrived between 2014 and 2015.

This chapter provides an introduction to migration, its stages, and the underlying reasons people migrate from their home countries, in addition to providing a global context for refugees' migration trends. The rationale, objectives, and research questions that guided this study are delineated.

1.1 Background

Migration has always been a way for individuals to improve their lives. Since ancient times, people have moved periodically, following hunting or gathering cycles, and migration patterns have become increasingly complex over time. Migration remains an important component of globalization, and involves not only refugees, but also economic migrants, in general. Historically, humans have migrated not only in search of food, work, and security, but also as a result of forced migration from their home countries (Singh,

Lynch, Abrahamowicz, Tousignant, & Quesnel-Vallee, 2011). The most common form of migration is caused by man-made disasters, such as war. Forced migration has been on the rise due to violence and human rights violations in countries such as Syria, Somalia, Afghanistan, Congo, and Sudan, all of which are experiencing ongoing conflicts, with little prospect of improvement. As a result, these countries produce mass numbers of individuals seeking a haven for their well-being and that of their families (UNHCR, 2014b; UNHCR, 2015b). Migration routes of refugees can be categorized into stages: pre-migration, migration, and post-migration settlement. These transition phase will be discussed in detail in Chapter 2.

In 1951, during the United Nations (UN) Convention, a refugee was defined as “a person who is outside his or her country of nationality or habitual residence; has a well-founded fear of persecution because of his or her race, religion, nationality, membership in a particular social group or political opinion; and is unable or unwilling to avail himself or herself of the protection of that country, or to return there, for fear of persecution” (UNHCR, 2010). The 1951 Convention stated refugees should enjoy access to health care services, including physical and mental health care that is equivalent to that of the host population to minimize the risk of contagious diseases, as well as mortality and morbidity rates (UN General Assembly, 1951). Canada is a signatory to the 1951 UN Convention, the 1966 International Covenant on Civil and Political Rights, and the 1967 Protocol on Refugees.

Similar with other host countries that accept immigrants, Canada’s demography and identity continue to be shaped by immigrants. Canada receives several types of refugees each year, including government-assisted, privately sponsored, and refugee claimants. Government-assisted refugees are defined as “permanent residents who are selected abroad for resettlement in Canada, either as ‘Convention refugees’ as defined under the Immigration and Refugee Protection Act, or as members of the ‘Convention refugees’ abroad class” (Immigration and Refugee Protection Act [IRPA], 2001). This class of refugees receives resettlement assistance¹ from the federal government while in the host country. On the other hand, privately sponsored refugees are “permanent residents selected abroad for resettlement in Canada” (IRPA, 2001). Under this category, refugees may arrive under the “Convention refugees abroad class, the source country class or the country of asylum class and are supported by organizations, individuals or groups of

¹ Resettlement Assistance is the initial resettlement support given Government-assisted refugees by the in Government of Canada. This support normally last up to one year from the date of arrival in Canada, or until the refugee is able to support himself or herself. It may include: accommodation, clothing, food, help in finding employment and becoming self-supporting, and other resettlement-related assistance.

individuals but they do not receive any sponsorship or resettlement assistance from the government” (IRPA, 2001).

According to the UNHCR, an asylum-seeker, or refugee claimant, is an in-land refugee applicant whose claim has yet to be determined. Also, refugee claimants are classified as in-land claimants who have temporary status and only receive protection if they are found to be a Convention refugee according 1951 UN Convention definition or found to be a Person in Need of Protection. A refugee claimant is a person

who request[s] refugee protection upon or after arrival in Canada. A refugee claimant receives Canada’s protection when found to be a Convention refugee, or when found to be a person needing protection based on risk to life, risk of cruel and unusual treatment or punishment, or in danger of torture as defined in the Convention Against Torture. A refugee claimant whose claim is accepted can make an application in Canada for permanent residence. This application may include family members in Canada and abroad (Citizenship and Immigration Canada [CIC], 2016).

Canada’s immigration policy framework governs immigration selection and processing, including regulatory policies regarding the health of immigrants. Based on these principles, Canadian immigration health policy remained relatively constant for immigrants and refugees alike until recently, when some health care privileges refugees and asylum-seekers previously enjoyed were eliminated (Beiser, 2004; Gushulak & Williams, 2004). Canada received an estimated 263,702 refugees as of October 2015 (CIC, 2015), from various ethnic and cultural groups.

Unlike economic migrants, refugees are considered forced migrants or displaced persons. According to the UN, as of January 2009, women, children, and youth comprised 80% of refugees,

asylum-seekers, and internally displaced persons (IDPs) (Ferris & Winthrop, 2010). This may be as a result of the loss of husbands, parents, deaths of family relations, total or mass destruction of livelihood, imprisonment, or participation in warfare (Beiser, 2004; CIC, 2012a). Due to this global migration of refugees, whether voluntary or forced, health care professionals and staff need to improve their communication skills in order to care for more diverse communities, often with specific health needs and varied language abilities and literacy (CIC, 2015).

The health needs of these refugee populations sometimes deviate from those of the general population because of differences in regional disease exposure, vulnerabilities, socioeconomic status, and access to health services before, during, and after migration (Swinkels, Pottie, Tugwell, Rashid, & Narasiah, 2011). Health concerns associated with the movement of large numbers of people have current and future implications for migrants, health practitioners, and health care systems (Edwards, 2012). In some cases, immigrants arrive with better health than the people of the host country, but their health deteriorates over time, making them more vulnerable than the host population, a phenomenon known as the “healthy immigrant effect.” Immigrants such as refugees face health problems and health disparities and bear a greater burden of infectious diseases than the general population (Ali, McDermott, & Gravel, 2004; Swinkels, Pottie, Tugwell, Rashid, & Narasiah, 2011).

Women’s health issues are not unique to refugees, but female refugees are confronted with health issues ranging from malaria to gender-based violence, maternal health, and chronic diseases such as hypertension, diabetes, and cancer (Ali, McDermott, & Gravel, 2004; Shaw, 2009). Refugees face multiple and additional health concerns because of external factors such as lack of access to health care facilities, high population density in refugee camps, low levels of education, gender inequality, and limited mobility within refugee camps (Ali, McDermott, & Gravel, 2004).

During resettlement, women refugees are likely to experience stress-related issues, which may arise from pressing needs and concerns such as housing, transport, and finances. Refugees' health is made more fragile by the existence of community and societal norms based on fear, misinformation, and harmful traditional practices (Fathalla, Sinding, Rosenfield, & Fathalla, 2006; Lawrence & Kearns, 2005).

During the first years of refugees' resettlement, they are faced with multiple challenges that may obstruct access to health care. Refugees' proficiency in other languages, such as those spoken in transitional and host countries, interpretations, cultural beliefs, and literacy levels may hamper their access to health care services. One challenge for health practitioners in resettlement communities is how to reach these newcomers, in particular reaching refugees who may be isolated due to language barriers or lack of knowledge of how to seek available health care (CIC, 2015). Access to health care can be considered a social determinant of health, since experiences of and assistance from health care are connected to a refugee's gender, education, occupation, income, ethnicity, and place of residence (McGinn, 2000). Refugees' health can be seen as a product of the environmental, economic, and socio-cultural factors that determined when, where, and how people migrated to and live in a host country. The health of refugees is affected by post-migration factors that include, but are not limited to, employment, education, and the extent to which refugees integrate into their new communities, as well as access to and utilization of services in the host country's health care systems (Wood & Newbold, 2012).

Social determinants that influence an individual's health include income, social status, employment and working conditions, physical and social environments, social networks, gender, culture, and access to health services (Public Health Agency of Canada, 2007). Social isolation, lack of community support, language barrier, traumas, racial discrimination, financial problems,

and lack of employment opportunities are the major causes of mental health issues for immigrants (UNHCR, 2013), including refugees. To better serve refugees, resettlement agencies need to understand refugees' struggles during the first year of resettlement into host countries.

In 2012, the government of Canada revised its policies related to refugees' health. As part of the revised policies to the IFHP, health coverage for refugees was reduced limiting their access to health care services including preventive and primary care. Furthermore, the provision of health care coverage was categorized depending on immigration status and country of origin, and eliminated access to emergency care. Contextually, the study was conducted after the cuts had been restored.

This impact of the 2012 cuts affected some categories of refugees, resulting in a reduction of some health benefits previously enjoyed by this vulnerable population. Refugees who were government-assisted and privately sponsored were not affected by this policy. The main categories of changes included (Wood & Newbold, 2012):

1. basic, supplemental, and prescription drug coverage;
2. primary and prescription drug coverage;
3. public health or safety prescription drug coverage;
4. public health or critical security and prescription drug coverage;
5. coverage for persons detained under the Immigration and Refugee Protection Act;
6. coverage for Immigration Medical Examination.

Study area. This study was conducted in Saskatoon, Saskatchewan, Canada. Immigration has played a major role in Saskatoon's history by bringing cultural diversity and economic vitality to the city. Saskatoon is the largest city in the province of Saskatchewan, with an estimated population of 248,700 and growing, as of December 31, 2013. In 2009 and 2010, Saskatoon

welcomed people from a number of countries, giving it the highest growth of people, including refugees, in the country. The 2011 National Household Survey showed that 27,355 immigrants were living in Saskatoon, constituting 11% of the province's total population; 11,470 of those immigrants arrived between 2006 and 2011 (Ali, McDermott, & Gravel, 2004). In the last five years, Saskatoon has adopted and implemented a number of flexible immigration plans, making it easier for immigrant newcomers, refugees, and their families to settle in Saskatoon and feel at home (Ali, McDermott, & Gravel, 2004).

Several governmental and non-profit organizations and services are available in Saskatoon to help immigrants and refugees integrate into the Canadian social environment during their initial years of resettlement. These resettlement agencies are partially or fully funded by the government at the federal and provincial level to provide various services, which include language/ESL classes, community settlement outreach programs, employment search, life skills, daycare, and counselling. The resettlement agencies in Saskatoon include the Saskatoon Open Door Society, Global Gathering Place, the Saskatchewan Intercultural Association, International Women of Saskatoon, and the Newcomers Information Centre.

1.2 Rationale for the Study

Due to Canada's commitment to resettling refugees (UNHCR, 2013), the necessity of providing resettlement and health care services to the refugee population is likely to grow. The forced nature of their relocation and adverse migration experiences leave many at risk of mental health problems, malnutrition, poor dental health, and infectious diseases (CIC, 2015). Additionally, women refugees, in particular, encounter reproductive health issues due to barriers when seeking health care. Health care services utilization by refugees has been well researched in the United States, Germany, France, and Australia (Wahoush, 2009). However, there has been

little research conducted in Canada on Canadian refugees and how refugees access health care services during their first year of resettlement (Deacon & Sullivan, 2009; Hollifield, Martin, & Orrenius, 2014). There have been some studies in areas of refugee research in Canada such as mental health and reproductive health (Berman, Girón, & Marroquín, 2009; Deacon & Sullivan, 2009; Hollifield, Martin, & Orrenius, 2014). Canada plays an important role in protecting refugees through the in-Canada asylum system and the resettlement of refugees selected abroad, both of which save lives and also provide stability for those fleeing persecution. Canadian resettlement programs are internationally respected because they provide permanent residence as a long-term solution to refugee placing Canada among the top fifteen countries resettling refugees worldwide (Deacon & Sullivan, 2009; Hollifield, Martin, & Orrenius, 2014).

Although research has been conducted in Canada on refugees' health care, it has been restricted to urban centres in higher-populated provinces such as Ontario and Quebec. To date, there is limited understanding of refugees' health care access during their permanent resettlement in less-populated provinces, such as Saskatchewan. Research in this area will deepen knowledge and understanding of resettlement experiences and provide insight into the challenges and obstacles preventing refugees from accessing health care services during their first few years of relocation. Given that refugees maybe susceptible to poor health requires that during their first year of resettlement, there is the need to understand the health needs and concerns of refugees to provide them with the appropriate health care services. This research intends to inform the development of policies, programs, and medical interventions that will improve refugees' health care experiences in Saskatchewan, and Canada as a whole.

1.3 Statement of the Problem

As previously discussed, refugees encounter numerous challenges during the first year of resettlement, which affects their adaptation and acculturation. Stress, inadequate resources, and disease are common occurrences within the refugee population; however, most resettled refugees know little or nothing about their health until it is assessed by their host country. This is mostly because refugees in refugee camps or temporary countries have limited access to health care. As refugees resettle and integrate into their new environment, they encounter unique challenges, such as language and communication barriers, cultural and religious beliefs, and transportation needs that affect their access to health care. Cultural values, religious practices, and beliefs interfere with refugees' meaning of health and their perception of health problems and causes. These barriers can be perceived to have the greatest impact on their access to health care, particularly during their first year of resettlement, where refugees are susceptible to many health issues during their migration phases.

Each migration phase provides unique experiences that add to refugees' integration into their permanent stage of resettlement. Examining the first year of transitioning resettlement of refugee women helps increase understanding of how they access health care. According to Wood et al., for decades, refugees have enjoyed access to quality health care in Canada, even though some health policies continued to be revised (Wood & Newbold, 2012). Changes in Canadian health care policy—particularly the cuts to for refugees' health care implemented in 2012—led to a reduction in health care services rendered to refugees, which threatened their health (Deacon & Sullivan, 2009; Hollifield, Martin, & Orrenius, 2014), until service levels were restored in 2014. This study explores the experiences of refugees' health care utilization during their first year of

resettlement, building on this emerging body of work and examining the health issues and needs of government-assisted women refugees in Saskatoon.

1.4 Research Objective

This research examines the experiences and perceptions of women refugees and how they accessed health care services during their first year of resettlement in Saskatoon, Saskatchewan, Canada. The study seeks to understand how health care access is affected by interconnecting systems of social, cultural, economic, and political structures, lived experiences, and intersecting factors such as race, religious beliefs, class, socio-economic factors just to mention few. Stated simply, the objective of this study was to explore and understand the context, experiences, and perceptions affecting how government-assisted female refugees in Saskatoon access health care services in their first year of permanent settlement in Saskatoon.

1.5 Research Questions

To gather relevant data to satisfy the objectives of this study, the following research questions were developed:

1. What are the experiences of women refugees in accessing health care services in Saskatoon?
2. What are the perceptions of the context in which those experiences unfold, from the perspective of resettlement agencies and medical practitioners?

1.6 Conclusion

The chapter provides an introduction to migration, its stages, and some underlying reasons why people migrate from their home countries. Furthermore, it provides a brief background of the global context of refugees' migration trends. With the rising number of refugees making refugees one of the leading issues globally, a background in refugee migration will help understand the

experiences they encounter during the different phases of their journey. The various health needs and concerns that refugees encounter in their transition from their country of origin or a temporary country before finally arriving in the host country is discussed. Finally, the rationale, objectives, and questions regarding this study are outlined. Each of the following chapters expands on these introductory notes, beginning with a review of pertinent literature, and leading to methodology, findings, and discussion.

Chapter Two

Literature and Background

2.0 Introduction

This chapter presents a review of existing research on refugees' access to health care services. Health care access is an essential element in the lives of refugees, who have experienced a great deal of trauma and pain in times of war and conflicts, and it is therefore important that refugees are given access to appropriate, high-quality health care services. Within this population, access to health services contributes to better health as it reduces complex health problems, prevents diseases, and reduces the mortality rate. However, access is affected by many contextual factors and by refugees' experiences.

This chapter provides an overview of the global context of refugees, the definition of the term *refugee*, and some countries that are experiencing inflows of refugees. In addition, trends on the inflow of refugees in some Canadian provinces, as well as insight into Saskatchewan's immigration trends, are provided. Legislation and immigration policy in Canada are discussed, as well as policy that permits people from other countries to immigrate to Canada. A critique of Canada's new immigration policy is offered, which reveals failures and some concerns raised by individuals and Canadian refugee support groups. Moreover, the chapter also discusses the background of the changes that brought about the introduction of the cuts to IFHP. In addition, insight is provided on refugees' health status, health concerns, how they access health care services upon their arrival, and some barriers they encounter in health care access. Building upon these insights, issues in health care delivery in Saskatoon are highlighted, along with the role resettlement agencies play in refugees' health care access. Finally, Somalian and Eritrean refugees'

background is briefly discussed. Overall, a detailed discussion on these sections mentioned above will inform how refugees' experiences and perceptions affect their health care access.

2.1 Global Overview of Refugees

According to *UNHCR Global Trends*, by the middle of 2015, there were an estimated 59.5 million people who were forcibly displaced globally (Fuller-Thomson, Noack, & George, 2011; UNHCR, 2014a; UNHCR, 2016a). The 2014 report also showed that there was an increase of 8.3 million displaced persons as compared with the previous year. It was estimated that 19.5 million of the total number of displaced persons were refugees, with at least 14.4 million under the UNHCR, with 5 million Palestinians registered under the United Nations Relief and Works Agency (UNHCR, 2015b; UNHCR, 2017; UNRWA). The UN report for 2015 showed that an estimated 42,500 persons left their homes and sought protection either within their country of origin or in other countries. Most of these refugees were of working age (20 to 64 years) and accounted for 74% of the total refugees, of which 48% were women. The United States of America has historically been ranked as the first host nation for migrants, including refugees, in the past, although the country still receives immigrants and refugees. However, that changed in the recent past as a result of conflicts in the Middle East and parts of Asia (Fuller-Thomson, Noack, & George, 2011; UNHCR, 2014a; UNHCR, 2016a). For the first time, Turkey emerged in 2014 as the largest refugee-hosting country with 1,590,000 refugees, replacing Pakistan, which had been the leading host nation for more than a decade (UNHCR, 2014a; UNHCR, 2016a).

Global refugee source countries. According to the UNHCR's 2015 mid-year report, the total number of refugees has increased significantly and consistently over the past four years (UNHCR, 2015b). The primary reason for this trend has been the war in the Syrian Arab Republic. The devastating effect of the Syrian conflict has been felt far beyond its neighbouring borders. In

addition to the Syrian crisis, the outbreak of conflicts and the deterioration of ongoing crises in countries such as Afghanistan, South Sudan, the Democratic Republic of the Congo, Mali, Burundi, and Somalia, among others, have contributed to the current increasing trends in global numbers of refugees.

By mid-2014, Syria replaced Afghanistan as the main source country of refugees worldwide and outranked Afghanistan, which had previously been the largest source country for about three decades (UNHCR, 2015b; UNHCR, 2016a; UNHCR, 2017). By mid-2015, the Syrian Arab Republic had for years remained the largest source country of refugees, with a refugee population of 4.2 million. Somalia remains the third largest source country, producing 1.1 million refugees, with South Sudan and Sudan being the fourth (744,100 refugees) and fifth (640,900) leading source countries (UNHCR, 2015a; UNHCR, 2016a). With the increasing number of wars and conflicts, a greater number of innocent people are rendered displaced, leaving already poorer countries to accepting the majority of refugees and also leaving significant responsibilities on humanitarian organizations and the international community to ensure these individuals are safe and secure, at huge humanitarian relief and assistance cost.

2.2 Refugee Experiences and Transition Phases

Refugees are often forced to leave their villages, towns, cities, or countries to where they can feel secure. Most often, refugees are settled in refugee camps while they wait to be transitioned, a process that is often a major challenge. Studies of refugees suggest they face three major periods or stages during their transition phase, namely pre-migration, migration, and post-migration (Bhugra, 2001; Bhugra & Jones, 2001). Despite the challenges that come with refugees' transitioning, the ultimate aim of refugee organizations and bodies, such as UNHCR, is to provide a lasting solution that allows refugees to rebuild and restore their lives in dignity and peace. These

solutions can be done through voluntary repatriation, local integration, and resettlement (Bhugra, 2001; Bhugra & Jones, 2001).

Voluntary repatriation is when refugees make an informed decision and choose to return to their country of origin in safety and dignity. In certain situations, some refugees may wish to leave their asylum state and return to their home country. This is usually done if peace has been restored to their country of origin. During this period, refugees require the full support of their home country, as well as international communities and bodies, to help them fully re-integrate with their people. Ideally, the home government will have taken measures to re-integrate them and implemented a safety plan to ensure their security (Bhugra, 2001).

Where voluntary repatriation is not a possible option, refugees may seek *integration* into the local community of a new country, with the necessary support and assistance. During integration, refugees most often live in risky and unsafe circumstances, and may have particular needs and concerns that cannot be addressed or tackled in countries where they have sought safety and protection. In such circumstances, refugees are sent to other states that have agreed to admit and immerse them in their societies. This process provides refugees with legal protection and access to political, economic, social, and cultural rights similar to those enjoyed by citizens.

Transition phases. *Resettlement* involves the selection, transfer, and movement of refugees from an asylum country or state in which they have sought protection to another state or country that has agreed to admit them as refugees and grant them a permanent status of settlement (Beiser, 2004; Gushulak & Williams, 2004; Swinkels, Pottie, Tugwell, Rashid, & Narasiah, 2011). Often, this permanent status provides resettlement for the refugee and their families with equal rights of access as those enjoyed by the citizenry of the host country. This section discusses the three transition phases: *pre- migration, migration and post-migration* below.

Pre-migration. The first, or *pre-migration phase* of transition begins before refugees escape and flee their country of origin to seek refuge or protection in the midst of war or conflict that is threatening their lives. During this phase, refugees are exposed to anxiety, gender-specific violence, and abuse, leading to personal, physical, and psychological trauma (Beiser, 2004; Gushulak & Williams, 2004; Swinkels, Pottie, Tugwell, Rashid, & Narasiah, 2011). Given this, they are left to face new challenges as they try to survive and begin their new transition, which often exposes them to various harms, leaving them vulnerable. The process through which refugees flee from their countries of origin can be experienced as simply as moving to stay with their family members in other cities, or as complex as moving across the globe, which may involve just one person or a large movement of people (UNHCR, 2015a). Often, refugees go for days without food, appropriate shelter, and water. Furthermore, refugees often flee without funds or belongings, and their separation from family and other attachments may be abrupt, forced, and unplanned. During their movement, refugees may encounter the death of loved ones or family members, which often becomes part of their pre-migration experiences (UNHCR, 2015a).

Migration. Migration can be defined as movement of people to a new area or country in order to find work or better living conditions. During the *migration* or transitioning phase, refugees encounter additional life-changing events. Resettlement is the initial phase of post-migration that aims to provide support, safety, and protection to ease integration into the host country. Refugee resettlement is the process through which refugees are allowed to leave a country of asylum and start life anew in a second or third country that is willing to receive and protect them on a permanent basis. Refugee resettlement remains an essential tool for providing support, safety, protection, and international burden sharing to aid integration. Resettling of refugees is done in a unique way, based on the eligibility and admission levels of refugees during and after their arrival

in host countries (CIC, 2015; Gushulak & Williams, 2004; Swinkels, Pottie, Tugwell, Rashid, & Narasiah, 2011; UNHCR, 2013b).

Post-migration. The final stage of relocation, *post-migration*, occurs when the refugees are living in a developed host country. During the post-migration phase, refugees learn their host country's societal and cultural structures, and are absorbed into the current context of the communities in which they live (Bhugra & Jones, 2001). As they attempt to smoothly settle and integrate into their new environment during the post-migration phase, refugees face a multitude of challenges. For instance, refugees may encounter problems with acculturation, which “involves those phenomena which result when groups of individuals sharing different cultures come together into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups” (Garcea, 2006; Sanmartin & Ross, 2006). This assimilation policy can be considered a huge problem, not only for refugees but for example for indigenous people in the country in which refugees settle. Among the various struggles refugees may encounter as part of their acculturation process are learning a new language, adjusting to new legal structures, finding employment, and financially supporting themselves (Garcea, 2006; Sanmartin & Ross, 2006). Also, refugees may encounter social isolation, identity confusion, loss of cultural community and family members, loss of important life projects, poverty, and loss of valued societal roles during this phase.

The refugee transition process in times of war and conflicts is an important piece that cannot be overlooked due to numerous migration crises, which can be seen as more than humanitarian drama. The various phases of refugee transition assist in knowing the processes through which refugees adjust to the meaning of being in exile and the dilemmas of their status.

The transition process is important in the lives of refugees, although different phases may come with their own challenges of making long, dangerous, and sometimes illicit journeys and often having to live in very difficult conditions in refugee camps before resettlement. Therefore, this process is vital for vulnerable populations whose life, liberty, safety, health, or other human rights had been affected by wars and conflicts to be refugees at risk in the country where they sought refuge. Although the different phases merge into each other, refugees are better assisted and receive the support, protection, and opportunity to rebuild their lives, regardless of the various phases involved in their journey.

2.3 Legislation and Policies on Immigration

Immigration policies in most host or receiving countries have undergone significant changes, fueled by economic challenges, aging populations, and internal migration of populations. Several countries, such as Australia, Canada, and New Zealand, are noted for such policy changes and increasing views on refugees and immigrants as contributing to targeted selection based on labour market demands. Selection based on specific skills has increased temporary foreign worker programs, international students, and led to an overhaul of the refugee systems in the above-mentioned countries (Edge & Newbold, 2013; Gushulak & Williams, 2004). Before World War II, all immigrant-receiving countries used immigration as a way of nation building (Edge & Newbold, 2013; Gushulak & Williams, 2004). Since World War II, global restrictions have been placed on immigration based on immigrants' countries of origin (CIC, 2015). Across the world, policies toward humanitarian or refugee migrants have been an important component of every country's overall immigration policy. In countries that accept them, refugees are sponsored by the government, private groups, or individuals who recognize refugees, as defined by the 1951 Geneva

Convention (CIC, 2015; Edge & Newbold, 2013; Gushulak & Williams, 2004), as is reflected in the Canadian context.

Canadian immigration policy. Throughout history, Canadian national identity has been founded, in part, on notions of humanitarianism and equity for all (CIC, 2015; McKeary & Newbold, 2010; Setia, Quesnel-Vallee, Abrahamowicz, Tousignant, & Lynch, 2011). Known for its policy of multiculturalism, Canada has a long history of accepting immigrants and refugees. In addition, Canada has been a signatory to a number of UN conventions including the 1951 Refugee Convention, the 1966 International Covenant on Civil and Political Rights (ICCPR), and the 1984 Convention against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment (McKeary & Newbold, 2010; Setia, Quesnel-Vallee, Abrahamowicz, Tousignant, & Lynch, 2011). As part of Canada's obligations to these conventions, the government of Canada and its partnering organizations have funded numerous programs to assist and support immigrants and refugees in the country (Swinkels, Pottie, Tugwell, Rashid, & Narasiah, 2011).

Immigration policies across the world have been designed to give preference to certain groups. Such preferences, policies, and systems vary greatly across all countries, and are frequently at the centre of public debate (McKeary & Newbold, 2010). Since 1962, the government of Canada has formulated its immigration policy based on national origin and has selected immigrants based on specific sets of criteria. In Canada, immigrant candidates can enter the country as either economic, family class, or refugee immigrants. For the government, integration of all immigrants, including refugees, into the Canadian environment is promoted as a source of pride and nation-building, adding to the richness and diversity of the Canadian population (McKeary & Newbold, 2010; Setia, Quesnel-Vallee, Abrahamowicz, Tousignant, & Lynch, 2011).

Canadian immigration policy defines who gains and loses entry into the country, and has three main objectives: social, humanitarian, and economic (Laroche, 2000; Setia, Quesnel-Vallee, Abrahamowicz, Tousignant, & Lynch, 2011). Based on these goals, immigrants are grouped into three broad admission classes that include:

1. the family class, which includes spouses, fiancées/fiancés, dependent children, parents, and grandparents of persons who are Canadian residents living in Canada, corresponding to the social stream;
2. refugees, which corresponds to the humanitarian immigration stream; and,
3. economic migrants, which corresponds to the economic stream.

Economic migrants are further grouped into business migrants, skilled workers/migrants, and the family class, where these groups are selected based on a point system that focuses on and helps select migrants according to the skills needed in the Canadian labour market (Bauer, Lofstrom, & Zimmermann, 2000; Laroche, 2000; McKeary & Newbold, 2010).

Additionally, in Canada, every immigrant applicant is subjected to a mandatory medical examination under the Canadian Immigration Act (CIA). According to section 19(1a) of the CIA, applicants are judged inadmissible to immigrate if they are considered to be a danger or threat to public safety or health, or if they are likely to generate excessive demands on health or social services (Laroche, 2000; McKeary & Newbold, 2010). These examinations include a medical history check, a general examination, blood sample analysis, as well as a chest X-ray (Laroche, 2000; McKeary & Newbold, 2010).

Background to Interim Federal Health Program. The IFHP acts as a temporary health insurance body and has been available to protected persons and refugee claimants in Canada since 1957. The program's objective is to "contribute to ideal health outcomes in a fair, equitable and

cost-effective manner’’ (Bauer, Lofstrom, & Zimmermann, 2000; Canadian Healthcare Association, 2012) to marginalized and vulnerable populations, including refugees. The IFHP operated within a universal coverage framework that included all refugees, regardless of their refugee category, since refugees often lack financial resources, but still need to access health care (Bauer, Lofstrom, & Zimmermann, 2000; Olsen, El-Baily, Mckelvie, Rauman, & Brunger, 2016; Stanbrook, 2014). Hospital visits and services, as well as some additional health benefits, including emergency dental and vision care, vaccinations, and medications, were covered similarly to those provided by provincial social assistance (Bauer, Lofstrom, & Zimmermann, 2000; Stanbrook, 2014). Since 1995, the IFHP has been administered by Citizenship and Immigration Canada (CIC), with the Blue Cross Company as the primary insurance program provider (Bauer, Lofstrom, & Zimmermann, 2000; Stanbrook, 2014).

Health care providers found the 2012 IFHP’s administrative process cumbersome due to the unique billing requirements, lack of information about the cuts from the government, confusing paperwork, and slow, complex reimbursement procedures (Olsen, El-Baily, Mckelvie, Rauman, & Brunger, 2016; Stanbrook, 2014). Further, Stanbrook’s article revealed that some health service providers were not culturally well-informed in their practice, and could, therefore, be insensitive to individuals who hold non-Western values (Stanbrook, 2014). While these challenges were significant and changes were required, the initial IFH program provided essential health care services to all refugee categories (Bauer, Lofstrom, & Zimmermann, 2000; Stanbrook, 2014).

Cuts to IFHP policy for refugees. Up until 2012, refugees enjoyed access to quality health care services upon their arrival in Canada, receiving similar health coverage as that accorded Canadian citizens (Olsen, El-Baily, Mckelvie, Rauman, & Brunger, 2016). However, on June 30, 2012, refugees in Canada faced major reductions in primary health care coverage when the federal

government introduced substantial cuts to the IFHP (Fowler, 1998; Olsen, El-Baily, Mckelvie, Rauman, & Brunger, 2016; Stanbrook, 2014) with the 2012 Budget, whereby the 1957 Order-in-Council was repealed and replaced with the Order Respecting the Interim Federal Health Program (Fowler, 1998; Gagnon, et al., 2007; Olsen, El-Baily, Mckelvie, Rauman, & Brunger, 2016). These cuts reduced health care access for most refugees, decreasing included primary and preventive care, as well as supplemental coverage similar to that of low-income Canadians. Some refugees, especially refugee claimants, lost all health care coverage except for treatment of conditions deemed a risk to public health or safety (Gagnon, et al., 2007; Redwood-Campbell, et al., 2008). In some situations, refugee claimants' applications were delayed during the process of confirming their Interim Federal Health (IFH) certificate and were thus more affected by the IFHP's limitations than government-assisted refugees (Bauer, Lofstrom, & Zimmermann, 2000; Stanbrook, 2014). These changes in health care policy contradict the principles underlying the Canada Health Act (Government of Canada, 2012; Redwood-Campbell, et al., 2008), which governs the provision of health services in Canada (Canadian Healthcare Association, 2012; Gagnon, et al., 2007).

Table 1 shows the primary goals of the 2012 IFHP amendments and shows the official policy document put forth by the federal Minister of Citizenship and Immigration.

Table 1: The Primary Goals of the IFHP Amendments, as Stated by the Federal Government of Canada (Government of Canada, 2012)

Number	Primary Goals of the IFHP Amendments
1	Ensure IFHP coverage is limited to urgent or essential health care services
2	Continue to provide health services (e.g. hospital and physician services) under the “Health Care Coverage” package to refugee claimants, resettled refugees, and other protected persons.
3	End coverage of supplemental benefits (e.g. pharmaceutical, dental, or vision services), but will provide for immunization and medication needed to protect public health or public safety.
4	End all IFHP coverage to rejected refugee claimants, other than services and products that protect public health or public safety.
5	Limit coverage to refugee claimants from Designated Countries of Origin by providing only services and products that protect public health or public safety.
6	End all IFHP coverage for Pre-Removal Risk Assessment (PRRA) applicants who have not applied for refugee status during their current stay, providing benefits only once protected person status is conferred.
7	To retain ministerial discretion to provide IFHP coverage in exceptional and compelling circumstances, including to individuals admitted under public policies.

Note: Order Respecting the Interim Federal Health Program, 2012, <http://www.gazette.gc.ca/rp-pr/p2/2012/2012-04-25/html/si-tr26-eng.html>.

The cuts established two different categories of inland refugee claimants: refugee claimants from a Designated Country of Origin (DCO) and those from a non-Designated Country of Origin (non-DCO). DCO refugees experienced shorter processing periods, were not allowed to appeal when their refugee claims were denied, and were not permitted to reapply (Bhuyan, Osborne, Sajedeh, & Tarshis, 2014).

DCO countries include countries that do not produce refugees, and which respect human rights and also offer state protection. The DCO policy’s object is to prevent and discourage refugees from these countries from abusing the refugee system as these countries lack the political conflict and wars that produce refugees. The DCO category has the largest number of refugee claimants awaiting approval of their application by Citizenship and Immigration Canada (Barnes,

2013; Canadian Council for Refugees, 2013; CICS Immigration Team, 2012). Countries listed under the DCO categories include Australia, Austria, Belgium, Denmark, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, South Korea, Spain, Sweden, Switzerland, the United Kingdom, and the United States of America, among others.

IFHP coverage was categorized into three new sections: *Expanded Health Care Coverage*, *Health Care Coverage*, and *Public Health or Public Safety Health Care Coverage*. Expanded Coverage was available for government-assisted refugees whose initial resettlement was supported and provided by the Canadian government (Government of Canada, 2012; Order respecting the IFHP, 2012; Redwood-Campbell, et al., 2008) and was similar to that provided by the IFHP before the 2012 cuts. Health Care Coverage is available for non-DCO privately sponsored refugees and refugee claimants (Government of Canada, 2012; Order respecting the IFHP, 2012; Redwood-Campbell, et al., 2008; Bragg, 2013; Alboim & Cohl, 2012) and covers hospital, physician, laboratory, and diagnostic services. Public Health or Public Safety Health-Care Coverage is available to failed refugee claimants and claimants from DCOs (Government of Canada, 2012; Order respecting the IFHP, 2012; Redwood-Campbell, et al., 2008) and covers only those services necessary to prevent, diagnose, or treat conditions that pose a threat to Canadians' health and safety (Bragg, 2013; Order respecting the IFHP, 2012). The changes to the IFHP imposed by Canada on refugees might have complicated the refugee settlement process and hampered their health care access. The gap in medical insurance created by the IFHP changes for these particular groups of refugees prompted six provinces—Alberta, Manitoba, Saskatchewan, Nova Scotia, Quebec, and Ontario—to reinstate essential and urgent care for refugees (Alboim & Cohl, 2012) by instituting a temporary health care program for refugee claimants to receive essential and urgent health care coverage.

Studies undertaken by the Wellesley Institute between 2012 and 2014 suggested that the health of some refugees would be negatively affected by the IFHP's changes, with some populations, such as women and children, disproportionately impacted (Barnes, 2013). The study also predicted there would be an increase in emergency room visits, health care costs for provinces and territories, and prevalence of chronic conditions among refugee populations (Beiser & Bauder, 2014; Sheikh, Rashid, Berger, & Hulme, 2013). While cuts to refugee health care may have negatively affected refugees' health outcomes, confusion surrounding the changes to the program created barriers to health care access, even for those with substantial coverage, with some refugees requested to pay up front for their visits (Barnes, 2013; Canadian Healthcare Association, 2012; The Canadian Press, 2012).

Part of the primary rationale for the cuts was to save \$100 million between 2012 and 2017 in the delivery of health care services, including emergency room visits and complications arising from neglected illnesses. The government of Canada justified the health care cuts for refugees as "fairness" to the Canadian public (Barnes, 2013; Canadian Healthcare Association, 2012; The Canadian Press, 2012) and as a means to would discourage potential refugees wanting to avail themselves of Canada's public health care services (Barnes, 2013; Canadian Healthcare Association, 2012). However, it is quite unlikely that potential use of public health care services would take precedence for refugees over fleeing war, famine, or persecution (Bragg, 2013). The government argued that refugees receive higher-quality health care services than those received by Canadian citizens (Barnes, 2013; Bauer, Lofstrom, & Zimmermann, 2000; Bragg, 2013); however, before the cuts, refugees received health care coverage equivalent to what the lowest income Canadians on social assistance received (Bragg, 2013). The government's argument placed the medical needs of Canadian citizens as being equal to those of refugees, when the latter group

experiences more physical and emotional traumas than the former group, in general (Barnes, 2013; Bragg, 2013).

Figure 1 illustrates the flow chart used by frontline health care and social service providers throughout Canada in December 2012 as a guide to health care delivery. Developed by the No IFH Coalition and Canadian Clinicians for Refugee Care this figure shows the changes to the IFHP negatively affected certain categories of refugees more than others. Refugees who qualified for Expanded Health Care Coverage were least affected by the changes as their benefits remained more or less the same; however, refugees who were eligible for Health Care Coverage and Immigrant Medical Examinations experienced a reduction in covered health care services, as did refugees eligible for Public Health or Public Safety Health Care Coverage, who received only

those medications and vaccines deemed necessary for the protection of public health.

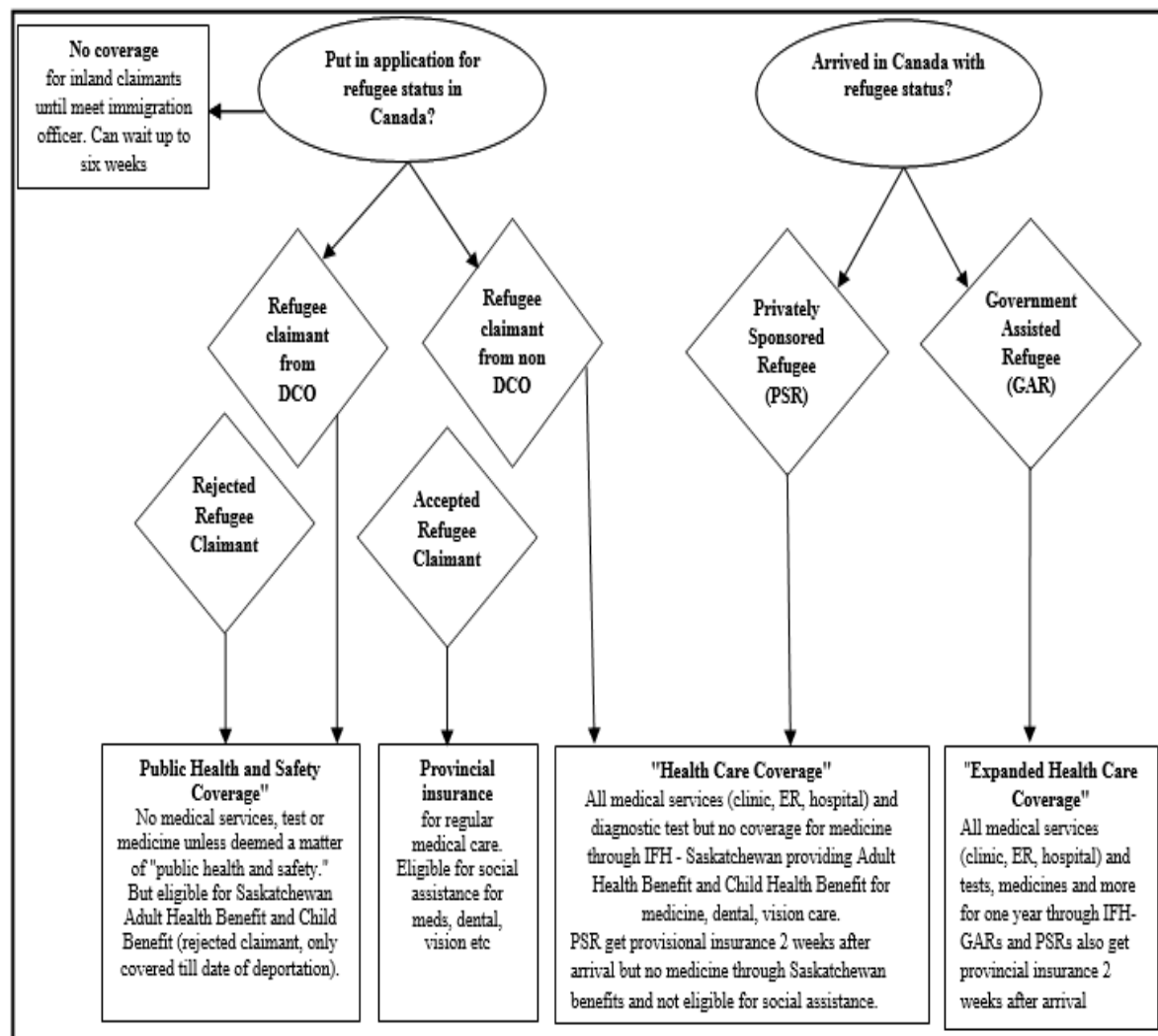


Figure 1. *The 2012 refugee health cuts flowchart. The flow chart was developed by the No IFH Coalition and Canadian Clinicians for Refugee Care and used by frontline healthcare and social service providers throughout Canada in December 2012 as a guide to health care delivery for refugees. Adapted from Ontario Council of Agencies Serving Immigrants. (2012). Refugee health cuts flowchart for frontline workers in Ontario. Retrieved from OCASI -- Ontario Council of Agencies Serving Immigrants: <http://www.ocasi.org/sites/default/files/IFH%20Dec%202012%20Flowchart-ON.pdf>*

According to the UN, every individual must have access to health care services (Barnes, 2013). However, the flowchart shows that some categories of refugees had greater access to health care than did others, revealing the discriminatory nature of the 2012 changes to the IFHP.

Critiques of Canada's immigration policy, April 2012 – February 2016. In the recent past, there have been growing concerns about Canada's immigration policies relating to the international community. Issues thought as worrisome, regarding policies and programs for immigrants, have included debate on national identities and the criteria for accessing services, as well as a refugee's "fit" with a nation's social, economic, and political societies or countries across the globe (CIC, 2014; Government of Canada, 2012; Redwood-Campbell, et al., 2008). Such debates revealed much about the quality of a country's democracy and whether it would refuse immigrants and other vulnerable populations, like refugees, access to health care services. There have been very strong legal and ethical policies restricting the movements and rights of migrants, as well as some basic grounds for refusing immigrants, refugees, and asylum-seekers, when need be (Government of Canada, 2012; Redwood-Campbell, et al., 2008).

Skeldon suggests that issues concerning migration and development have always been centred on four main areas: remittance and development; brain drain; diaspora investments in countries of origin; and, circular labour migration between countries of origin and destination (Skeldon, 2008). Although there is an emergent recognition of economic migrant contributions to the development of their host countries, this recognition is not always extended to refugees, since the international community may perceive refugees as a menace to the security of host country.

Immigration policy in Canada has changed since 2008, which may have a big impact on the lives of immigrants in Canada. Most immigrants come to Canada through the economic pathway, with 37% coming through the Federal Skilled Worker program (Bragg, 2013; McKeary & Newbold, 2010). With the skill-based selection process, there has been an increase in temporary immigrants with a decrease in permanent resident applicants (Bragg, 2013; McKeary & Newbold, 2010). Although Canada values family life—immigrants can sponsor a spouse, dependent

children, parents, and grandparents—the new policy had limited the number of family members an immigrant could sponsor (Alboim & Cohl, 2012; Beiser & Bauder, 2014; Bragg, 2013).

Canada's revised immigration policy and the cuts to IFHP regarding refugee health access were met with objections from provincial governments, the Canadian Association of Refugee Lawyers, and leading health care associations such as Canadian Doctors for Refugee Care (Canadian Doctors for Refugee Care, 2016). These organizations, among others, claimed cuts to health insurance brought into question Canada's moral commitment to provide health care services to one of Canada's most vulnerable groups. Critics argued that the immigration points system continued to be discriminative in a more hidden manner, even if the system no longer discriminated on the grounds of race or religion (Canadian Council for Refugees, 2013; Government of Canada, 2012; Order respecting the IFHP, 2012). The critics argued that the education, skill, employment, and financial requirements of the points system represented a barrier to many immigrant groups. This may be because not all immigrants have the same chances to meet the education prerequisite because accessible education may not be available in their country of origin. Critics also noted that the immigration points system was phased out in 2015 and replaced with "Express Entry." Critics saw the introduction of the Express Entry program as a job bank, serving government and industry, matching prospective immigrants with employers seeking workers. Again, critics see the new immigration policy as inexpensive labour and a racist way of changing immigration (Government of Canada, 2012; Order respecting the IFHP, 2012). Despite this, the position of CIC on the debate and objection concerning the cuts to IFHP was that under the old health care insurance system, Canada was placing an unfair burden on the Canadian taxpayers by offering refugees and protected persons medical services beyond those covered by provincial and territorial medical coverage (Government of Canada, 2012; Order respecting the IFHP, 2012).

2.4 Refugee Trends in Canada

Canada's immigration policy framework maintains a certain number of new immigrants each year (Stanbrook, 2014). According to Statistics Canada's immigration overview for 2013, Canada welcomed 248,776 (11.4%) new immigrants, of which 156,119 (62%) were economic migrants and 26,739 refugees (CIC, 2014). In 2008, Canada resettled almost 11,000 refugees from overseas (government-assisted and privately sponsored refugees) (Stanbrook, 2014). Since 2000, resettlement has fluctuated between 11,000 and 19,000 refugees, based on yearly targets and external events worldwide (Olsen, El-Baily, Mckelvie, Rauman, & Brunger, 2016). It is believed most refugees prefer to settle in medium to large urban centres (Olsen, El-Baily, Mckelvie, Rauman, & Brunger, 2016).

Table 2 shows the number of refugees who settled in Canada between 2009 to 2012, and the provinces in which they settled. During these years, Ontario had the highest number of refugees in 2011, standing at 15,921 refugees, followed by Quebec, with 5,020 refugees (CIC, 2012). During the latter part of 2015 and well into 2016, Canada received approximately 25,000 Syrian refugees, with 15,768 being government-assisted refugees (CIC, 2016). As part of the federal government's initiative to help settle refugees from Syria in mid-December 2015, Saskatchewan received 1,094 refugees out of the total (CIC, 2016)

Table 2: Top Provincial Destinations for Refugees and Asylum-Seekers in Canada

Province/Territory	2009	2010	2011	2012
Ontario	12,654	13,914	15,921	12,589
Quebec	4,057	4,711	5,020	4,609
Alberta	2,237	2,205	2,638	2,250
British Columbia	1,634	1,667	1,310	1,438
Manitoba	1,098	1,032	1,303	1,140
Saskatchewan	646	574	547	549
Total	22,326	24,102	26,739	1,7966

Note: Table data sourced from CIC's Facts and Figures: Immigration Overview Permanent and Temporary Residents, 2008. Ottawa, Ontario; 2012 Available from: <http://www.cic.gc.ca/english/resources/statistics/menu-fact.asp>.

Immigration trends in Saskatchewan. According to Garcea's report in 1995, Saskatchewan has always had a diverse immigrant population (Garcea, 2006). Saskatchewan has an even more diverse immigrant population than had five years ago, with many of its immigrant populations arriving from different parts of the globe through various significant government programs and policies from European countries. However, in the past few years, a large population of immigrants arrived from Africa, Asia, the Middle East, and Europe, among others, through government initiatives and policies (Kumaran, 2010). These immigrant populations come as economic migrants, refugees, and international students with their families (Kumaran, 2010). Like most of the provinces in Canada, Saskatchewan continues to attract and retain a number of immigrants per year (Ministry of the Economy, Government of Saskatchewan [Gov't of SK], 2014; CIC, 2013). Of the total immigrants received in 2011 in Saskatchewan, 50.8% were male and 49.2% female (Ministry of the Economy, Gov't of SK, 2014; CIC, 2013). Among the cities in

Saskatchewan, Saskatoon had the highest number of immigrants, at 3,681, followed by Regina, with 3,179 (Ministry of the Economy, Gov't of SK, 2014; CIC, 2013).

Immigrants from the Philippines are the largest immigrant population in Saskatchewan (Fleras, 2015). This could be due to the positive bilateral relationship that has existed for years between Canada and Philippines (Fleras, 2015). Filipino immigrants are among the fastest growing groups in Canada, contributing to the economic, social, and cultural dynamic of the country (Fleras, 2015). Many Filipinos, especially skilled workers, have relatively easy visa processes and greater employment opportunities in Canada (CIC News, 2013; Fleras, 2015) than other nationals. In addition to the Philippines, the majority of Saskatchewan immigrants come from Asian countries, with China, Pakistan, and India as major source countries (Fleras, 2015). As well, the Ukraine continues to maintain its position as a major source country for European immigrants. Even though Canada experienced a significant increase in the number of African economic migrants in recent times, the number of economic migrants from Asian and European countries overshadows that of Africa, which could be due to strict immigration rules that most African nationals are unable to meet (Deacon & Sullivan, 2009). Furthermore, along with diversity in immigrant population as a whole, diversity in the refugee population is also increasing (Ministry of the Economy, Gov't of SK, 2014; CIC, 2013). According to a migration policy report in 2015, the immigrant population from Asia and the Pacific, Africa, and the Middle East has seen tremendous increase, not forgetting populations from South and Central America (Zong, 2015). Not only is this diverse immigrant population growing, but the social makeup of the new immigrants is also changing.

Table 3 shows the immigration categories in Canada from 2011 to 2014. The table illustrates an increase in the number of refugees in Saskatchewan, from 616 in 2011 to 636 in 2013

(Ministry of the Economy, Gov't of SK, 2015; CIC, 2014). In general, over the four years, there has been a steady increase in the number of the immigrants in Saskatchewan, with 10,680 immigrants, including refugees, gaining entrance in 2013, compared to 8,995 in 2011 (CIC, 2014).

Table 3: Immigrants to the Province of Saskatchewan by Category

Immigration Category	2011		2012		2013		2014	
	No.	%	No.	%	No.	%	No.	%
Provincial Nominee	6,959	77.7	9,021	81	8,182	77	8,791	74
Other Economic Migrants	699	7.8	715	6	630	6	1,101	9
Total Economic Migrants	7,658	85.5	9,021	81	8,182	77	9892	84
Family Class	689	7.7	827	7	8,812	83	1,233	10
Refugees and Other Immigrants	61	0.7	616	6	636	6	701	6
Grand Total	8,955	100	11,179	100	10,680	100	11,826	100

Note: Table data sourced from CIC's Facts and Figures: Immigration Overview Permanent and Temporary Residents, 2008. Ottawa, Ontario; 2015 Available from: <http://www.cic.gc.ca/english/resources/statistics/menu-fact.asp>.

Refugee trends in Saskatchewan. From 2009 to 2011, Saskatchewan received 2,316 refugees, with new immigrants and refugees more dispersed throughout the province than in the past. As indicated in Table 4, in 2013, out of a total number of immigrants who arrived in Saskatchewan, 590 were refugees while in 2011 there were 547 refugees. In Saskatchewan in 2011, Iraq had the highest number of refugees, 141 (26%), as compared to Nepal with 17 (3%). In 2012, Kenya had the lowest number of refugees, 14 (3%), as compared with Iraq with 134 (24%) (UNHCR, 2011b). Again, from the table, Zambia was not on the list for 2011–2012, but was there

for 2013. As per the 2013 immigration report, Saskatoon continues to be the leading city for attracting immigrants in Saskatchewan. It received 3,682 immigrants, followed by Regina with 3,640. According to the CIC report in 2014, among the immigrants and refugees that came into the province, there were more male immigrants and refugees than females (Ministry of the Economy, Gov't of SK, 2015).

Table 4: Sources of Saskatchewan Refugees

Source	2011		2012		2013	
Country	Rank	No.	Rank	No.	Rank	No.
Congo			7	28	1	99
Iraq	1	141	1	134	2	94
Somalia	2	59	6	32	3	66
Eritrea	4	39	2	52	4	49
Sudan	5	38	8	22	5	31
Ethiopia	6	37	5	38	6	29
Bhutan	3	46	3	46	7	24
Kenya	9	13	10	14	8	22
Zambia					9	18
Nepal	8	17	4	43	10	17
Afghanistan	9	13		19		
Pakistan	7	23				
Burma	7	23				
Thailand	10	10				
Others		88		121		141
Total		547		549		590

Note: Table data sourced from CIC's Facts and Figures: Immigration Overview Permanent and Temporary Residents, 2008. Ottawa, Ontario; 2014 Available from: <http://www.cic.gc.ca/english/resources/statistics/menu-fact.asp>.

Table 5 shows the number of refugees in Saskatchewan, by their sub-categories, between 2011 and 2014. In 2011, there were a total of 508 government-assisted and privately sponsored

refugees admitted into Saskatchewan. The table reveals a slight decrease in the total number of refugees received in 2011 as compared to 2012. In 2011, Saskatchewan received 355 refugees under the government-assisted category. There was a slight increase in intake of government-assisted refugees in 2013, with 339, as compared to 2012, when there were 332. For the privately sponsored category, the numbers remain very similar between 2011 and 2013, with 153 (2011), 155 (2012), and 154 (2013).

Table 5: Refugee Categories in Saskatchewan—Four-Year Trend

Category	2011	2102	2013	2014
Refugee Claimants and Dependents	39	62	74	31
Government-Assisted Refugees	355	332	339	484
Privately Sponsored Refugees	153	155	154	139
Total	547	549	567*	654

Note: Table data sourced from CIC's Facts and Figures: Immigration Overview Permanent and Temporary Residents, 2008. Ottawa, Ontario; 2014 Available from: <http://www.cic.gc.ca/english/resources/statistics/menu-fact.asp>.

*Note: *Excluding 23 referred refugees from the total number of refugees for 2013.*

Background to Somali and Eritrean refugees. This section discusses the background information of the history context behind these two unique groups of refugee-participating countries in this study. Further, this section increasingly gives a broader understanding of why these two particular crises are important to this study. Many countries across the globe have seen decades of war, conflicts, and persecution, which have left many of their nationals displaced. Countries like Sudan, Syria, Libya, Congo, Iraq, and South Sudan have suffered or are suffering

the effects of war and conflicts. In undertaking a study involving Somali and Eritrean refugees, two particular crises are important to discuss in understanding the study population.

The Eritrean crisis. Eritrea is a country also known as the “Horn of Africa.” It is bordered to the west by Sudan, Ethiopia in the south, Djibouti in the southeast and the Red Sea at the northeastern and eastern part of the country (British Broadcasting Corporation, 2016; Eritrean War of Independence, 2017). The current conflict in Eritrea, which can be traced back to the beginning of Eritrea’s EPLF’s fight for independence in 1970, has continued past its winning independence from Ethiopia in 1991 (British Broadcasting Corporation, 2016; Eritrean War of Independence, 2017). This related civil war has been ongoing for the last 40 years. Eritreans have been leaving their country, seeking asylum in other countries, for numerous reasons including civil war, breakdown of law and order, drought, and famine, to name a few (Mogos, 2016; Selam, 2002).

Although there is no longer a civil war in Eritrea, because of a highly repressive regime and what *The Guardian* refers to as “an intensified recruitment drive into the mandatory and indefinite national service” (Tran, 2015), people are still desperate to escape and seek refuge elsewhere. According to the UN commission of inquiry, the national service involves “arbitrary detention, torture, sexual torture, forced labour, absence of leave, and the ludicrous pay,” thereby referring it to as “an institution where slavery-like practices are routine” (United Nations, 2015). During the period for the war, large numbers of refugees were generated, with a minimum of five thousand Eritreans leaving the country each month in search of a better life (Selam, 2002; Tran, 2015). Many of these refugees found themselves settling in refugee camps in other neighbouring African countries, while some migrated to Europe, especially Italy, and to Canada. Ethiopia and Sudan have the highest number of Eritrean refugees and asylum-seekers. In 2014, Canada received 1,725 refugees from Eritrea, with Eritrea ranking first for the highest number of privately sponsored

refugees, with 1,150 refugees and ranked fifth with 435 refugees for the government-assisted refugee category (CIC, 2014).

As Eritreans are forced to leave their country to seek refuge in other countries, they are exposed various forms of trauma. Often, a large number of Eritreans live in refugee camps with poor living conditions, malnutrition, lack of adequate health facilities and housing, as well as the general conditions in the camps, which add to the existing challenging situation they face (Bruton, 2010; Guha-Sapir & Ratnayake, 2009; Hammond, 2014). Mostly, the Eritrean refugees escape through Ethiopia and Sudan through the Sahara Desert to war-torn Libya, where they board vessels to Europe. During their journey, thousands of Eritreans die while crossing the Mediterranean Sea before reaching Europe (Laub, 2016; Mogos, 2016).

The Somali crisis. The crisis in Somalia has also been ongoing on for decades, with the present phase of the civil war dating back to 2009. Since the 1970s, many Somalis have been displaced as a result of different calamities, such a war, political conflict, natural disaster, and economic hardship (Bruton, 2010; Guha-Sapir & Ratnayake, 2009; Hammond, 2014). Though Somalis have a have a long history of migration, the majority of exiles left their country as refugees at the outbreak of the civil wars, which started in late 1988 in the northern part of the country, and from 1991, in the rest of the country. The recent crisis there was a series of peace talks and military interventions, which failed during the 1990s and the early 2000s, between the warlords and other militia groups.

Prior to the civil war, Somalia itself was a major refugee-hosting country. During the war in Somalia, many nationals sought refuge in neighbouring countries such as Djibouti, Burundi, Tanzania, and Yemen, with the largest numbers settling in Ethiopia and Kenya (Guha-Sapir & Ratnayake, 2009). Today, Somali refugees and asylum-seekers are amongst the largest refugee

populations in many countries in the world, and the Somali diaspora is very widely scattered. Like other refugees, Somali refugees flee to neighbouring countries for safety while others make it to Europe and Canada. Canada in 2013 received 1,320 Somali refugees, with Somalia the fifth-highest source country for refugees. In 2014, there were 590 and 460 refugees from Somali for the privately sponsored and government-assisted categories of refugees, respectively.

Most refugees travelled on foot for weeks without adequate food and water to reach Ethiopian camps located just across its borders. The war has destroyed the Somalia's economy, as well as its health care and education systems. Since the war started, the country has heavily relied on international aid for food, water, health, and education services (Guha-Sapir & Ratnayake, 2009). Since the collapse of the Somali state in 1991 (Bruton, 2010; Guha-Sapir & Ratnayake, 2009; Hammond, 2014), Somalia has been viewed as a country with unending violence and displacement (Bruton, 2010; Guha-Sapir & Ratnayake, 2009; Hammond, 2014).

With all the risky means through which refugees escape war, conflict, and persecution, refugees are faced with new challenges and life-threatening health needs and concerns upon resettlement in host countries, which can aggravate their health and which make them more vulnerable and susceptible to adverse outcomes.

2.5 Health Status of Immigrants and Refugees in Canada

Pre-migration struggle and forced migration can result in various physical, mental, economic, and social consequences. Some of these are related to routine difficulties associated with poverty and deprivation, while others are related to more extreme problems such as war-related injuries, torture, and sexual abuse. Forced migration, in situations of war and violence, has substantial implications for the health of refugees. Refugee women experience significant physical and psychological trauma, which is often untreated during their transition to resettlement in the

host nation. These health disparities among refugee populations are attributed to the various ordeals and exposures during refugees' seeking of safety during conflicts, war, and persecution in their country of origin. Among the various individuals who are vulnerable are women, unaccompanied children, and people with significant ill mental health (CIC, 2015; Wahoush, 2009). Canadian immigration health policy has remained comparatively constant towards immigrants, including refugees, until recently, as noted in the above discussion of the IFHP's background, when there was a cut of some privileges refugees and asylum-seekers enjoyed, especially in the area of health (Edge & Newbold, 2013; UNHCR, 2014; UNHCR, 2016a).

Health status of immigrants. Research in the past suggests new immigrants have fewer chronic conditions and better health at the time of entry into the host country as compared to average Canadians (Setia, Quesnel-Vallee, Abrahamowicz, Tousignant, & Lynch, 2011), a phenomenon referred to as the "healthy immigrant effect" (CIC News, 2013; Government of Canada, 2012). As these immigrants and refugees are exposed to and experience the physical, social, environmental, and cultural effects of living in a new country, their health deteriorates and becomes comparable to that of an average Canadian—the convergence paradigm of acculturation (UNHCR, 2014b).

Some evidence suggests that mental health of immigrants starts to decline as early as two years after arrival in the host country, with non-European refugees being at higher risk of experiencing this decline than their European counterparts (McKeary & Newbold, 2010). Furthermore, female immigrants are vulnerable and more likely to experience mental health issues than their male counterparts shortly after they arrive (CIC, 2015; Wahoush, 2009). This can be attributed mainly to a sense of isolation resulting from socio-cultural and language barriers (Barnes, 2013).

Health status of refugees. The health status of refugees is associated with quality of life and the accessibility of health care services available to them. Refugees' exposure during war and conflict has a lot of health implications for this population. The health status of refugees is influenced by their post-migration in their host country. In some cases, refugees may have experienced torture in their home country, which can lead to both physical and psychological trauma. In addition, many refugees are separated from family members, and may have had to part with their material possessions, thereby losing their social standing; both of these occurrences can contribute to psychological distress, which can contribute to psychological trauma. Refugees, in general, often experience language barriers, making it difficult for them to navigate the health care services and social systems of their host countries (Beiser, 2004). In some situations, they experience racism and discrimination, which can contribute to psychological distress and long-term illness (UNHCR, 2011a). All these factors explain why refugees are likely to have poorer health status upon arrival compared to the host country's average (UNHCR, 2011a; UNHCR, 2015b; Wessels, 2014).

Conversely, refugees can sometimes have significant health problems even prior to leaving their home country of origin. This is because the majority of refugees have limited literacy skills, come from low-income families, and have low social-economic status (UNHCR, 2013b), all of which may have combined to prevent access to medical care in their home country. Also, refugees lived in crowded camps and received limited medical attention, so they are vulnerable to infectious diseases (UNHCR, 2011a). Women and children form the majority of the displaced populations and are also most vulnerable to diseases. Refugee women are particularly high risk developing health issues due to gender-based violence and abuse during times of persecution, war, and conflict (CIC, 2015; Wahoush, 2009). Existing research on refugee health does not adequately address the

various health care concerns of female refugees, even though they are likely to have more diverse and unique health care needs compared to economic immigrants in general (Wessels, 2014).

Physical health. Refugees have many physical health needs when they arrive in Canada that are not typical of the Canadian population. Often, refugees come from disadvantaged situations, putting them at risk of poor health even before to their departure for Canada. Mostly, refugees become victims of war, torture, and imprisonment during this period (CIC, 2015). Many refugees suffer physical health problems as a result of torture and trauma as they often leave their homes and countries of origin with minimal or no preparation. This population may also have non-specific health concerns of physical and/or psychological origin (CIC, 2015; UNHCR, 2013; UNHCR, 2014b).

The physical trauma of refugee women includes, but is not limited to, bone fractures, soft tissue injuries, head injuries, epilepsy, hearing loss, and vision impairment, some of which are directly attributable to sexual violence, such as rape (Dick, 1984). Refugee populations are disproportionately affected by infectious and transmissible diseases, such as tuberculosis, HIV/AIDS, and hepatitis B (Wahoush, 2009). Moreover, refugees have also been shown to have high rates of dental and nutritional problems (anemia, iron, and vitamin deficiencies), and high prevalence of chronic diseases such as diabetes and hypertension (Ali, McDermott, & Gravel, 2004; Beiser, 2004; Gushulak & Williams, 2004; Shaw, 2009; UNHCR, 2014b; UNHCR, 2015b).

Additionally, during war and conflicts, many refugee women experience unwanted pregnancies at the hands of war criminals and fellow refugee camp inhabitants (UNHCR, 2011; UNHCR, 2015). The absence of access to sexual and reproductive health care resources can lead to disease, disability, and death among female refugees (UNHCR, 2011a; UNHCR, 2014a). Moreover, during the transition from home country to host country, refugee women do not have

access to health care services required to prevent unsafe abortions, internal hemorrhage during childbirth, and prolonged labour, among other pregnancy-related health risks (UNHCR, 2011a; UNHCR, 2014a).

Mental health During the various phases of transition, refugees experience or undergo tremendous hardship that is likely to put a strain on their mental health. Often refugees face many potentially traumatic experiences—leaving their home country due to war or conflict, being separated from family, losing social status, and the long and dangerous journey from the homeland to host country, among many others—that influence their mental health outcomes. There is a huge mental illness burden among refugees, which is significantly increased among those who are not allowed to work (CIC, 2012b; Beiser, 2004). According to studies, there is a high prevalence of poor mental health amongst refugee populations (Dillmann, Pablo, & Wilson, 1993; Norredam, et al., 2004), including post-traumatic stress disorder (PTSD), depression, and anxiety, which are all common among refugees (CIC, 2015). The mental health concerns of refugees vary between different refugee groups and across the phases of migration due to varied experiences before, during, and after their resettlement into host countries.

In addition to pre-migration difficulties, resettlement, past traumas, and burdens, refugees encounter psychological distress as a part of their acculturation process in their new environment. According to Bhugra & Becker (2005), as refugees settle in the host country, they are likely to experience adjustment-related stress and adaptation problems. Refugees arrive with varying degrees of preparation for their new environment and the majority face similar adaptation problems. In some cases, adjustment-stress for refugees in their host countries may be powerful due to their experiences prior to their journey

Acculturative stress² has been found in studies to lead to serious psychological issues like depression and incapacitating anxiety (CIC, 2012a; Beiser, 2004). The most common mental health diagnoses relating to refugee populations include PTSD, major depression, generalized anxiety, panic attacks, and adjustment disorder (Laroche, 2000). To make matters worse, refugees make minimal use of mental health services (Dick, 1984; Wood & Newbold, 2012), which can happen if they grew up in a culture that does not recognize or which stigmatizes mental illness. In addition, refugees may have no source of accessing information related to mental illness (Ali, 2002; Ali, McDermott, & Gravel, 2004). The treatment of some mental illness (though not all) often involves high cost, which makes it inaccessible to refugees, thereby increasing the care gap; people experiencing mental health problems may not receive the necessary support and treatment in their access to services.

2.6 Refugees' Access to Health Care

Access to health care services is linked to how aware one is of available health care resources (Setia, Quesnel-Vallee, Abrahamowicz, Tousignant, & Lynch, 2011). Proof of access to health care is better reflected by actual use of services (Bragg, 2013; Setia, Quesnel-Vallee, Abrahamowicz, Tousignant, & Lynch, 2011) than by factors such as human health resources, which may influence access to health care services. In other words, the quality of health care access to services received by refugees is reflected in how accessible it is to this population.

In order for everyone to have equal right to enjoy health care access, including physical and mental health, Article 14 of *The 1948 Universal Declaration of Human Rights* specifically spells out that:

² Acculturative stress is defined as a reduction in health status (including psychological, somatic, and social aspects) of individuals who are undergoing acculturation, and for which there is evidence that these health phenomena are related systematically to acculturation.

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (United Nations, 1948).

In the same way, the *International Covenant on Economic, Social, and Cultural Rights* asserts and acknowledges the right of everyone to the enjoyment of “the highest attainable standard of physical and mental health” (UN Economic and Social Council, 2000; Dura & Mititelu, 2013). This supports the World Health Organization’s 2002 interpretation of the rights for everyone to enjoy to appropriate health by referring to “[...] the right to health as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants” (United Nations, 2015). Therefore, the right to health care can be seen as part of one’s right to health, itself (The Canadian Press, 2012; Hunt, 2007; Martin, Rodríguez-Pinzón, & Brown, 2015).

Mary Robinson, a former United Nations High Commissioner for Human Rights, stated, “The right to individual health does not mean the right to be healthy... Rather, the right to health requires governments and public authorities to put in place policies, measures, and action plans that will make health care available to and accessible by all” (Evans, 2005). The health challenges of refugees can be partially attributed to lack of timely access to appropriate health care pre- and post-immigration (Government of Canada, 2012). Thus, there is a need for improved understanding of the past experiences of refugees in each specific assessment upon their arrival in Canada.

Ensuring effective health care access for refugees is an increasing global concern. Refugees are racially, culturally, and linguistically diverse and have often suffered life-threatening mental

and physical trauma (Setia, Lynch, Abrahamowicz, Tousignant, & Quesnel-Vallee, 2011), which makes them more likely to have increased morbidity, poor health, and a decreased life expectancy (Setia, Lynch, Abrahamowicz, Tousignant, & Quesnel-Vallee, 2011; UNHCR, 2011a; UNHCR, 2015b). It is therefore crucial that refugees receive access to timely, high-quality health care that will aid their smooth settlement and integration in their new host country, as this will help promote better health and well-being (CIC, 2015; UNHCR, 2011a; UNHCR, 2015b). Although other population groups may face barriers in accessing health care, the diverse and complex nature of refugees' needs requires specific attention (CIC, 2015; UNHCR, 2011a; UNHCR, 2015b). These challenges to health care access come with individuals having difficulties finding the appropriate care to treat their illnesses as well as experiencing long waiting times (Setia, Quesnel-Vallee, Abrahamowicz, Tousignant, & Lynch, 2011). Despite the high health needs and the challenges refugees may encounter in accessing health care services, there is the need for refugees not only to have physical access to health services in order to have positive health outcomes, but the nature, quality and appropriateness of such services must also be considered.

Canada's universal health care system is aimed at ensuring accessibility to health care for all of its citizens, regardless of their level of need, financial circumstance, geographic location, age, or ethnicity. Nevertheless, health disparities still exist for vulnerable and marginalized populations (Hankivsky and Christoffersen, 2008; Spitzer, 2005; Varcoe, Hankivsky & Morrow, 2007). This has remained a national concern, especially for health policy-makers and planners, despite Canada's endorsement of equal access to health care for all (Berman, Girón, & Marroquín, 2009; Fuller-Thomson, Noack, & George, 2011; UNHCR, 2014b). The Canadian health care system was established on the principles of universality, equity, and accessibility. Policies, services, and programs are designed to promote health equity and address inequities in access

status for all Canadians, including those within the refugee population (UNHCR, 2017). Compared to the general Canadian population, the vulnerable refugee population still has a greater burden of disease and illness, in addition to increased likelihood of having unmet health care needs due to issues impeding access to appropriate health care services (UNHCR, 2014b). For instance, mental health, safe motherhood (including antenatal, delivery, and post-partum care), prevention and management of the consequences of sexual and gender violence, communicable diseases, and non-communicable diseases can be unmet health care needs of refugees arriving in Canada.

Access to health care services. Over the years, several models have been developed to measure the accessibility of health care services (Setia, Lynch, Abrahamowicz, Tousignant, & Quesnel-Vallee, 2011). Aday and Andersen's model is most popular for this purpose, as it considers the health status of an individual along with his or her level of satisfaction with the health care system (Aday & Andersen, 1974; Andersen, 1995; Newbold, 2009). Though the model has seen several revisions since its first inception, the model seeks to make a clear distinction between equitable and inequitable access to care (Canadian Healthcare Association, 2012). The model incorporates an individual's health beliefs that influence his or her use of the available health care services (Aday & Andersen, 1974; Andersen, 1995). According to Aday and Andersen, access to care is frequently used to study economic, political, and physical factors, which interrelate with one another to determine an individual's personal health practices and the use of health care services (Aday & Andersen, 1974; Andersen, 1995). As refugee populations experience various barriers that hamper their access to health care services, Aday and Andersen's model considers the barriers that explicitly obstruct their access to health care services.

Despite Canada's universal health care system, refugees continue to face multiple barriers to accessing health care services, the biggest of which is a language barrier. To gain access to

health care services, one has to be familiar with the health care system and its procedures, as well as the expectations of the health care provider (Hankivsky, 2012; Read & Gorman, 2010), all of which are dependent on linguistic fluency, including good communication and comprehension skills. A large proportion of refugees have difficulties speaking English or French during their everyday interactions, as well as with health care providers during appointments. According to Pottie et al., the language barrier is a major factor contributing to the poor health of refugees (Pottie, et al., 2011). The communication gap between refugees and health care service providers means the difference in socio-cultural beliefs between the two groups is heightened. This may lead to misunderstanding and mistrust between service providers and refugees (Canadian Council for Refugees, 2013; Canadian Doctors for Refugee Care, 2016). An interpreter may seem to be an easy solution to this problem; however, this arrangement brings forth privacy and confidentiality concerns.

Lack of transportation is another barrier refugees encounter in accessing health care services during the resettlement stage. According to Rask et al., this lack is the major reason refugees miss appointments and delay seeking health care services (Rask, Williams, Parker, & McNaghy, 1994). During their post-arrival period, the majority of refugees depend on public transportation such as buses taxis and other public transit as they either cannot afford a private mode of transportation or do not know their way around the city in which they live. Even with public transportation, unfamiliarity with the city can act as a deterrent in seeking health care services. Besides, for those refugees coming with no family in Canada, there is no possibility to rely upon family for a ride, and there are other issues such as inability to safely transport their children.

Moreover, according to Newbold (2009), until a few months after arriving in Canada, refugees and immigrants lack access to health care as a result of lack of insurance in all provinces. Also, there is a long waiting list of refugees seeking access to the health care services of specialists (Newbold, 2009).

2.7 Health Care Delivery in Saskatoon

Health care is described as the routine care that an individual need to protect, maintain, and restore his/her health (Garcea, 2006). Health care coverage in Canada generally includes visits to physicians, radiology and laboratory services, diagnostic and surgical procedures, and other inpatient or outpatient hospital care (Garcea, 2006). Like most Canadian provinces, Saskatchewan has a comprehensive health care delivery system throughout the province. Everyone in the province, regardless of their location, ethnicity, or social status, has access to health care services through either provincial health care, or in the case of First Nations, federal coverage. To provide better health care access, improved patient experience, more stable and sustainable health care, in 2012 Saskatchewan developed a framework for primary health care services (Hankivsky, Reid, Varcoe, Benoit, & Brotman, 2010; Huang, Weng, Lai, & Hu, 2008; Sanmartin & Ross, 2006), although refugees were not mentioned.

Health care services utilization in Saskatoon is not limited to Canadian citizens, but also extends to permanent residents and immigrants, including refugees and international students on study visas and their families. The majority of Saskatoon residents access health care services by visiting walk-in clinics, community clinics, and hospitals. According to Beiser, most refugees visit health care centres or varied health care services, for reasons including mental health, high fevers, malaria and other parasite-related concerns, dental care, AIDS and other STIs, and chronic conditions such as diabetes, cancer, and liver- and kidney-related problems (Beiser, 2004).

Refugees are often taken through a series of health screenings shortly after their arrival to a host country, often facilitated by resettlement agencies. In some situations, refugees who arrive at the host country with life-threatening health concerns receive immediate medical attention shortly after their arrival. Some of what selected representatives (participants) from the resettlement agencies stated regarding immediate health care access to new refugees with life-threatening concerns is presented in the next sections.

2.8 Resettlement Agencies' Roles in Health Care Access

Saskatoon's resettlement agencies work in partnership with other sister agencies, such as Open Door Society, Global Gathering Place, International Women of Saskatoon, and Saskatchewan Intercultural Association, with the Open Door Society being the largest agency. All the above-mentioned agencies are non-profit community-based organization that have been providing services to immigrant and refugee women and their families for many years. This interagency collaboration helps refugees integrate smoothly into their new society, including how to move within the city and access health care.

These agencies make and receive refugee referrals from their collaborators and share information on clients, when needed. The main role of resettlement agencies is integration and settlement of refugees who arrive in the country. Resettlement agencies provide refugees with support to help in their transitioning into their new environment by making refugees feel more comfortable as they rebuild their lives within Canadian society. Accessing health care services is difficult for new immigrants and refugee due to their lack of familiarity with the health care system of the host country. In order to reduce the stress that refugees will experience in accessing health care and also to reduce refugee health burden and concerns, resettlement agencies have programs that aim to develop and maintain partnerships among the Saskatoon Health Region in order to

ensure that timely and culturally sensitive health services are provided for immigrants and refugees with high and special health needs.

Among the services offered by the representatives of refugee agencies are language/ESL classes, community settlement outreach, employment search, life skills, daycare, and counselling. They also serve as advocates for refugees, who are seen generally as vulnerable and voiceless within their new environment due to pre-migration traumas associated with conflict and war. The vision of the refugee agencies is to provide a welcoming community where refugees can connect with the people in the community, and to provide opportunities for refugees to choose and attend programs they are interested in, including those established specifically for supporting refugees after their arrival. For instance, arriving refugees are met at the airport by volunteers or staff from the Open Door Society who assist them with their initial settlement into the city. After they have been settled by their counsellors, refugees are referred to Global Gathering Place to enrol in essential life skills training programs.

2.9 Conclusion

It is essential for refugees to have full access to health care services so they can be treated for any health problems they accumulated before, during, and after their resettlement into the host country. This chapter provided a brief background to global trends on migration and introduced pre-migration, migration, and post-migration phases as a way of understanding migration issues. It also included discussion on the number of newly displaced persons in 2014 and variations in the trends from 2009 to 2014. At the beginning of this chapter, a broad discussion of the legislation and immigration policy in Canada was provided. Further, criticisms of Canada's new immigration policy were highlighted, unveiling the failures, perceptions, and some concerns raised by individuals and other groups in the country. Also, this chapter provided an insight on refugees'

health status, health concerns, and how refugees access health care services upon their arrival into the country, as well as some barriers that are faced in the health care utilization of refugees. Finally, other topics discussed include how health care is accessed in Saskatoon, the role of resettlement agencies in refugees' health care access, and a background on Somali and Eritrea, the home countries of the study participants.

Chapter Three

Methodology

3.0 Introduction

This chapter outlines the research methodology and procedures used to conduct this study, in addition to providing a rationale for employing qualitative research to explore refugees' health care access in Saskatoon during the cuts to the IFHP. An overview of the methodological framework and rationale used to design this study is presented, and a discussion undertaken of the study's methodological approach and the associated data collection tools used to facilitate the exploration of the multiple contextual layers outlined in the analytical framework. Details of the stages employed in recruiting participants for the study are provided, in addition to a review of the techniques of data collection through the use of semi-structured interviews and how the thematic analysis was carried out. A technical discussion is undertaken of the main tools used for data collection. Sampling strategies are discussed, and a summary of participants is provided. A discussion of rigour is followed by a detailed description of the analytical process used to organize and present the data.

3.1 Theoretical Approaches

Women's health research strives to make changes that seek to produce knowledge and understanding to promote action on the various factors that affect women's lives and their health. Intersectionality has increasingly emerged in recent years as one of the approaches researchers and policy makers use to study women's health, to recognize how education, race, class, immigration status, and income intersect and influence women's ability to seek health care (Schultz & Mullings, 2006; Weber & Fore, 2007; Weber, 2006).

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. Despite variations in its definition, intersectionality is the quest for social justice and research that seeks to account for the experiences of those individuals or sub-populations whose voices are subjugated, unheard, silenced, and missing from social policy formation. It is also employed to understand the health experiences and disparities of marginalized and vulnerable women or individuals or sub-populations and the immigration/refugee policy (Gushulak & Williams, 2004) that may influence their health-seeking behaviour.

First defined in 1989, intersectionality has been proposed as a theory, methodology, paradigm, lens, or framework, in some cases (Hankivsky, 2014). It was introduced by an American critical legal race scholar, Kimberlé Williams Crenshaw (Hankivsky, 2012; Hankivsky & Christoffersen, 2008; Read & Gorman, 2010), and later gained prominence in the 1990s. However, the significant ideas governing intersectionality have a long history around the world (Hankivsky, 2012; Read & Gorman, 2010). Many renowned scholars and activists have produced works that reveal the complex factors and practices that shape human lives (Hankivsky, 2012; Hankivsky & Christoffersen, 2008). For instance, in the United States of America, there has been intersectionality research on black women, Latinas, and the LGBT community (Hankivsky, 2012; Hankivsky & Christoffersen, 2008). Similarly, intersectionality has been widely used in different disciplines of academia, such as philosophy, history, literature, sociology, and anthropology (Hankivsky & Christoffersen, 2008). In addition, an intersectionality approach has been explored in women's, gender, cultural, and media studies, and in other interdisciplinary fields of study with strong narrative backgrounds and traditions (Hankivsky, 2007; Hankivsky, 2014).

In women's health research, intersectionality has been recognized as a method and concept that is grounded in the lived experiences of a marginalized group (Government of Canada, 2012) and offers an important route to understanding the health needs of and challenges faced by women refugees, about whom little is known. This theoretical paradigm places an explicit focus on the differences among groups and seeks to illuminate various interacting social, cultural, economic, and political contexts that affect human lives, including social locations, health status, and quality of life (Fowler, 1998; Government of Canada, 2012; Hankivsky, 2012). Intersectionality emphasizes that multiple factors simultaneously intersect to produce transformation and contribute to unique experiences of health outcomes for different individuals and groups (Hankivsky, 2007; Hankivsky & Christoffersen, 2008).

According to Hankivsky, intersectionality challenges practices that privilege specific health disparities and of inequality, such as race, class, or gender, immigration status, and education, among others. This places much attention on the differences that exist among different groups and seeks to bridge the gap through various interrelating factors that affect human lives, including social locations, health status, and quality of life (Hankivsky, 2012). The literature suggests that intersectionality is mindful of systemic differences that privilege certain groups and render others invisible (Hankivsky, 2012; Hankivsky & Christoffersen, 2008). The intersectionality lens has supported research concerning mental health and trauma among immigrant and refugee women, who are faced with racism and who experience violence, as part of their transition (Hankivsky & Christoffersen, 2008).

Although intersectionality has gained much support and popularity, limited studies have adopted this approach in health research (Hankivsky & Christoffersen, 2008; Hankivsky, Reid, Varcoe, Benoit, & Brotman, 2010). This has been attributed to the complexity of analyses, which

make it challenging to include in a single publication, as well as to pressure from funding bodies (Hankivsky, 2007; Hovorka, 2012). Despite these challenges, intersectionality offers an important route to understanding the health needs and challenges faced by refugees and refugee women.

An intersectional lens helps to understand where women are socioeconomically and politically positioned in Canadian society, and how their experiences stand as barriers to accessing health care. The use of an intersectionality lens in this study allowed the exploration of social, cultural, religious, economic, and political factors that intersect to affect the experiences and perceptions of refugees in Saskatoon. Further, using this lens, the study uncovered multiple experiences of discrimination and barriers that make it difficult for female refugees to access or seek health care. Through the use of intersectionality, this study reveals the health care experiences of refugee and refugee claimant women whose voices are missing from the literature and social and immigration/refugee policy. The use of open-ended questions that are rooted in the intersectionality approach permitted an exploration of refugees' experiences and perceptions about their access to health care services during their first year of resettlement, asking questions on multiple dimensions of their lives and about various social structures that affect them.

Through this lens, refugees' stories were analyzed to uncover whether they experienced any form of discrimination and barriers from one or multiple forms of oppression in accessing health care. Similarly, health service providers and representatives from resettlement agencies were interviewed to explore their perceptions, experiences of barriers, and how these unfold in the context of refugees' first year of resettlement. Additionally, these resettlement and health care workers explained the support they provide for refugees and women in Saskatoon.

Intersectional factors in refugee health care utilization. A multi-disciplinary perspective brings to the fore the various factors that may influence refugees' access to health care.

Their health outcomes may be influenced by factors such as economic, socio-cultural, and political structures (Hovorka, 2012; Viruell-Fuentes, Miranda, & Abdulrahim, 2012).

Economic factors that may be barriers to refugees' health care access include poverty, employment, and income. These factors particularly affect refugees' access due to their low income and unemployment status, since rates of unemployment are high in this population (Viruell-Fuentes, Miranda, & Abdulrahim, 2012). Again, refugees may have lost their fortunes and jobs during their transition to their host country (Beiser & Bauder, 2014; Setia, Quesnel-Vallee, Abrahamowicz, Tousignant, & Lynch, 2011). Socio-cultural barriers may include health literacy and health beliefs that may affect refugees in their access to health care services. Refugees may often find themselves dislocated or disassociated from things that provide a sense of identity and community. Refugees' behaviours, lifestyles, and health care access inequalities, as well as differences in risk behaviour and health status, may make it difficult for refugees to accept and adopt new health practices, which may affect their accustomed ways of maintaining health and well-being, as well affecting their access to new health services (Sheikh, Rashid, Berger, & Hulme, 2013).

Language and communication gaps between refugees and health care service providers are also a major barrier for refugees in accessing health care services (Sheikh, Rashid, Berger, & Hulme, 2013). This barrier includes the lack of interpretation services, bilingual staff, and translated health education materials in the health care system (Kiss, Pim, Hemmelgarn, & Quan, 2013; Oxman-Martinez, et al., 2005). Language barriers can affect all stages of health care access, from booking an appointment to filling a prescription (Kiss, Pim, Hemmelgarn, & Quan, 2013; Oxman-Martinez, et al., 2005). Cultural beliefs influence knowledge about experiences and perceptions, as the health needs of specific refugee are differently expressed due to the differences

in their communities, and cultural norms may be influenced when accessing health care (Banjong, Menefee, Sranacharoenpong, Eg-kantrong, & et al., 2003).

Political barriers may impede refugees' access to health care through the implementation of policies, structures, and legal frameworks (Edge & Newbold, 2013). Refugees may also encounter barriers when accessing health care due to availability, accessibility, acceptability³, and affordability of health services (CIC, 2015; Penchanskym & Thomas, 1981). Thus, although health care accessibility is universal in Canada, this population group may have difficulty accessing health care because of the barriers they face (Miles & Huberman, 1994; Morris, Popper, Rodwell, Brodine, & Brouwer, 2009; Whiteman, 2006). Further, as refugees' health care utilization may be influenced in this manner, it could be established that these factors intersect and buttress the theoretical framework lens of intersectionality.

3.2 Social Constructivism

Philosophical perspectives, implicitly or explicitly, underlie all research activities, determining research questions, design, and methodologies (CIC, 2015). According to Saunders et al., the research philosophy adopted “contains important assumptions about the way in which one views the world” (Miles & Huberman, 1994). Creswell points out that epistemological and ontological considerations, and their associated paradigms, influence the philosophical perspective adopted (Creswell, 2009). Ontology deals with the general understanding of the world around us and is important to delineate as we base our research findings on basic assumptions of the world.

³ Acceptability of health care means health care institutions and providers must provide culturally appropriate care, and be responsive to needs based on gender, age, culture, language, and different ways of life and abilities. Also, one should be able to navigate through the health systems with any gap.

At its core, “ontology is the study of reality and being, and researchers need to take a position regarding their perceptions of how things are and how things work” (Crotty, 1989; Scotland., 2012).

A social constructivist epistemological lens underpins this research. The social constructivist paradigm seeks to understand how one’s life experience is shaped by one’s social interactions (Bhugra & Jones, 2001). Further, the methodological approaches within social constructivist paradigms aim at social understanding and transformation, and to change policy and practices. Understanding the broad conditions that shape health care institutions is not sufficient for analyzing barriers in access to care, or how those barriers can be overcome. In the context of similar societal conditions, some institutions are better able to respond to the needs of ethnically diverse communities than others (Beiser & Steward, 2005). This study employed the social constructivist paradigm that believes “social phenomenon and categories are not only produced through social interaction but that they are in a constant state of revision” (Miles & Huberman, 1994). The study considers the participants’ views on refugee access to health care and takes into account the economic, cultural, social, and historical background of health care to understand the health care experience of refugees. Using a social constructivist lens allowed the interpretation of social interactions that influence refugees’ health care access.

3.3 Methodology/Methods

In developing a descriptive and comparative analysis of refugee health care access in Saskatoon, a qualitative approach was used for the study. The study draws primarily on the use of interviews. This section discusses the qualitative method and study design employed for the study. The analytical framework guiding the study, inclusion criteria, and stages of analysis are elaborated in this section.

Qualitative methodology. A qualitative approach was used in this study. This section describes the background methodology, examines the relevance of the methodology, and explores the characteristics and misconceptions regarding qualitative methods. Qualitative research permits a study of an exploratory nature (Creswell, 2009; Miles & Huberman, 1994) and has been developed to study those aspects of human experience and action that are not accessible by quantitative measurement methods, which cannot take into account that humans do not just react, but describe circumstances as a way to understand meaning that is socially constructed by individuals' interaction with their world (Crotty, 1989; Creswell, 2009). Also, this method of inquiry has been described to understand the meaning composed by individuals in interaction in their world (Bromley, 1990; Sargeant, 2012).

Qualitative research allows social researchers to assume that subjects within a social experience construct their reality through their social interactions, which is a social phenomenon best understood through the subject's narrative of his or her experience (Merriam, 2014). Data can be processed through analytical induction to develop theories and concepts (Merriam, 2014). Generally, within qualitative inquiry, the research design is contingent on the specifics of the phenomenon under study and is determined by the research team (Berg, 2001; Merriam, 2014).

Berg (2001) states that qualitative research allows the researcher to nominally—rather than numerically—seek realistic answers to research questions by employing logical procedures to data collected from individuals in particular situations. In addition, qualitative research is used to assess unquantifiable facts about actual people, bringing understanding to how people see themselves and others in varied social structures (Stake, 2013; Yin, 2009). Yin adds that qualitative research methodology is a beneficial approach used in collecting nominal information about people from their natural viewpoints (Yin, 2014).

The choice to explore refugees' access to health from a qualitative perspective was appropriate since I was concerned with refugees who had experienced this phenomenon, identified with the concept of being refugees, and was also concerned with refugees who were willing to describe and explain how their experiences and perceptions had impacted their lives as refugees. The rationale behind exploring the experiences and perceptions of refugee women and how they access health care upon their arrival in Canada from a qualitative viewpoint stemmed from my interest in knowing how the context, their experiences, and their perceptions affect their health access.

Study design and methods. This qualitative study explores the experiences and perceptions of health care access to services in Saskatoon during their first year of permanent resettlement. This study signifies how women refugees, resettlement agencies, and health service providers' experiences and perceptions influence refugees' health care access. The study brought forth the various intersecting factors that may affect refugee women's access to health care in Saskatoon. Also, the representatives from resettlement agencies and the health care providers illustrated the impacts of the IFHP's cuts to refugee health care access and the larger context in which those intersecting factors evolved.

The study used interviews with refugee women to obtain information from the study population and used interviews with the key informants to glean an understanding of various contextual factors that affected refugees' health care access in Saskatoon. These methods helped to give an in-depth understanding of the intricacies of access to health care services, drawn from the personal views, perceptions, and experiences both of specific refugee women and of caregivers in Saskatoon (Lubrosky, 1994; Oakley, 1993), and assisted the women in voicing their

experiences, perceptions, and concerns about health care accessibility in Saskatoon in their own words (Yin, 2013; Yin, 2014).

Recruitment of interpreter and transcriber. Due to the inclusion of refugee women for this study, the participants' linguistic diversity required the recruitment of someone fluent in Somali⁴, Tigriya⁵, and English to interpret, transcribe, and translate the data collected. In research, when interpreters or translators are used, it is fundamental that interpreters and translators have a common knowledge and understanding of the study's topic, their roles and responsibilities, and the confidentiality/ethical issues governing the study (Shimpuku & Norr, 2012). It was necessary to recruit an interpreter and a translator with similar gender, as well as cultural, social, linguistic backgrounds as the participants. Literature suggests that involving interpreters and translators who have related cultural, social, and linguistic experiences might enhance the research (Shimpuku & Norr, 2012). In other situations, it has been shown that data collection is enhanced when the interpreter/translator and participants share a similar background, since they share common ways of expressing emotions, and create understanding based on their culture (Pitchforth & Tejilingen, 2005; Shimpuku & Norr, 2012). Similarly, Pitchforth and Tejilingen assert that interpreters and translators promote trust and easy flow of information between participants and interpreter, especially in sensitive and gender-oriented topics (Pitchforth & Tejilingen, 2005).

The search for a suitable interpreter was difficult and frustrating since there is limited availability of professional individuals who speak these participants' language and English with fluency. A young refugee woman was identified who had finished her high school and was fluent

⁴ Somali: Somali is the official language of Somalia, and a working language in the Somali Region of Ethiopia. It is used as an adoptive language by a few neighbouring ethnic minority groups and individuals.

⁵ Tigrinya: Tigrinya is of the nine main languages in Eritrea and is spoken by at least half of the population. It is also spoken in the northern part of Ethiopia.

in English and Somali. She had experience in qualitative research and was familiar with the culture, social, and linguistic reality of the participants. She had also lived in a Kenyan refugee camp for years, and was interested in the study. The interpreter had one day of training about the research procedures and the aims and expectations of the study.

The training involved a broad description of the study, highlighting the purpose and objectives of the study, participants, and data management protocol. The ethical considerations governing the study and the ethical responsibility of the interpreter were also discussed. The interpreter was advised to respect the participants and maintain their privacy and confidentiality in the conduct of the research. The interpreter was encouraged to be punctual, attentive, and a good observer during the study. She was informed of her role in welcoming and thanking participants at the beginning and the end of the interview. In addition, the interpreter was instructed to ask questions verbatim from the interview guide and to use prompts and follow-up questions in order to encourage participants to express themselves well during the interview. The interpreter was given the mandate to explain the consent form and obtain written or oral consent from participants. To ensure that the interpreter was in line with the expectations, her role, and her responsibility, time was set aside to clarify the research protocols, goals, roles, and responsibilities for her understanding.

A male transcriber/translator was also recruited for this study. The transcriber/translator was a PhD student in the Department of Education at the University of Saskatchewan. He had extensive experience and knowledge in qualitative research with high proficiency in written and oral English and the Somali language. In order to ensure that the translator/transcriber was accurate and consistent in producing an outstanding and true reflection of the transcripts, the transcriber/translator was provided training that highlighted the purpose and objectives of the

study. The transcriber was instructed to transcribe interviews verbatim from speech/voice to Somali text before translating them from the local language to English, to avoid loss or sway of the meaning of the interview transcript.

The ethical responsibilities of keeping all research documents/materials in his custody confidential were discussed. It was explained to the transcriber that part of the ethical responsibilities of his role would transcend beyond the interview guides, audio-recorded interviews, and conversation/correspondence, both oral and email. Prior to the beginning of the work, the transcriber was informed he would be required to sign a confidentiality agreement. Further, he was asked not to discuss anything about the study with anyone, and was told if he were to encounter any difficulties relating to the study, he was not to hesitate to contact the researcher for clarification. The transcriber was also encouraged not to rush the transcription and translation processes, as this could lead to loss or sway of salient/vital information or meaning. Further, it was explained to the transcriber that at the end of the study, he had an ethical responsibility to return all research materials in his custody and delete all email correspondence containing information regarding the research.

In recruiting women refugees for the study, the initial contact with the participants was done by a refugee who had a well-established relationship within the refugee community and who, through his assistance, referred me to one of the women. Through the initial participant, contact information was provided, often a telephone number of a potential participant who could participate or contribute to the study. Through the interpreter, each participant was contacted with an explanation of the study and an invitation to participate. If they met the criteria for the study and were still interested in participating in the study, a date for the interview was scheduled. Resettlement agency participants for the study were recruited through three resettlement agencies

as well as health service professionals serving refugee populations in the Saskatoon. These organizations were located through referrals by individual and colleagues, who provided contact information, often an email. An email was sent to these individuals with a description of the study proposal and an invitation to participate. After showing interest in participating in the study, a time and place of their preference were arranged to conduct interviews.

Study phases and data collection techniques. Primarily utilizing in-depth interviews for data collection, this study was conducted in two phases. The first phase had a view to establish rapport and explain the rationale of the study, seeking the partnership and cooperation of agencies and requesting their participation in this study. The study's questions and goals were honed at this time, to align the researcher's requests with the agencies' needs for information and action. The first phase of the study informed the design of study instruments for the second phase. The second phase involved in-depth interviews with refugees and representatives from the various participating resettlement agencies and health service providers.

Inclusion criteria for the study. The inclusion criteria for this study were developed by defining each of the three groups of participants: refugees, representatives from resettlement agencies, and health service providers (see Appendix B). The inclusion criteria for the refugee women of the study were as follows:

- female refugees ≥ 18 years old;
- refugee in Canada for first year of resettlement, residing in Saskatoon; and,
- able to communicate and understand some level of English or French.

Representatives from resettlement agencies (Saskatoon Open-door Organization, Global Gathering Place, Saskatchewan Intercultural Association, and International Women in Saskatoon) were defined as individuals working as counsellors, within Saskatoon resettlement agencies, who

have had regular, direct interaction with refugees as part of their work-related responsibilities. Often, it is this group of people who welcome refugees upon their arrival and who later become refugees' first point of contact during resettlement. The final group of participants was comprised of health service providers who have had experience delivering health care to refugees.

Study participants. To examine how access barriers are addressed in the health care system, the study was designed to interview people in different position, vis-a-vis the health care system, and their everyday experiences of working to improve health care access for immigrants/refugees. A total of fifteen participants were drawn from the different study populations for the study. These included eight refugee women aged ≥ 18 years old; four participants (three women and one man) from resettlement agencies, including one special resource person who was working with one of the resettlement agencies; two female health service providers working with refugees; and, to provide a different perspective on the perceptions on refugees' health care access, one female health provider who is an activist for refugee health. For the purpose of this study, the selected participants were individuals who could offer rich and supportive information based on their experiences in the context of exploring refugee health care utilization. Exploring three different groups of participants provided diverse vantage points from which to explore refugees' access to health care services within their first year of resettlement in the city of Saskatoon.

Socio-demographics of refugee population. The primary participants in this study were Somali and Eritrean refugee women residing in the city of Saskatoon. In Saskatchewan, Somalia and Eritrea have been among the top refugee source countries; hence, the need to consider these two countries. Refugees are identified, for the purposes of this study, as people who were under the humanitarian resettlement program in Canada. In total, eight government-assisted refugee

women participated in the study, seven Somalis, and one Eritrean. All women were 19 years or above who had been living in Canada for the first year of permanent resettlement at the time of the interviews. Table 6, below, provides an overview of the refugee participants' age, gender, marital status, and their countries of origin. More than half of the refugees were married, and the rest were either separated or divorced, which provides an additional perspective on the existing variation in the characteristics of the participants. Table 6, below, provides an overview of the refugee participants' age, gender, marital status, and their countries of origin.

Table 6: Refugee Participants' Age and Marital Status

	Sample Size	Total
Age	20-35	4
	36-56	4
Marital status	Married	5
	Separated	2
	Divorced	1

Despite some variability, most of the women in this study can be characterized as having little or no formal education. Table 7, below, shows the refugees' level of education and their number of children. Some education includes elementary to diploma level. The categories collapsed due to its small numbers. As can be seen from the table, the majority of the refugee women had no formal education.

Table 7: Refugee Participants' Level of Education and Number of Children

	Response	Total
Level of education	No education	5
	Some education	3
Number of children	1-2	4
	3-4	3
	5+	1

Resettlement agencies. Canadian resettlement agencies provide support and assist refugees in ensuring their smooth transitioning into Canada. With the goal of achieving successful refugee integration, resettlement agencies help them become more comfortable in their new environment to aid in rebuilding their lives as they integrate into Canadian society. Including representatives from the resettlement agencies allowed for exploration of their point of view on the accessibility of health care services for refugees. Three representatives from resettlement agencies participated in this study and were recruited using purposive sampling based on their association with refugees during resettlement (see Appendix A).

Health service providers. Refugees are taught how to access health care services when they need them; however, just as this study was unfolding, there had been key cuts made to the IFHP these refugees accessed. To explore how health service providers interpreted the IFHP's cuts and how health care access for refugees was being affected, two health service providers working with refugees were included in this study. To explore perceptions of that context, health services providers working with refugees were selected using a purposive sample technique. A health service provider who is an activist for refugee health was also included.

Sampling strategy. Minimum sample size for qualitative studies is not clearly defined in the literature; however, saturation can be anticipated in sample sizes of twelve to twenty data sources (Tuckett, 2004; Ulin, Robinson, & Tolley, 2005). A combination of purposive and snowball sampling techniques was employed to select participants, with purposive sampling technique the predominant method.

The decision to use purposive sampling technique was in part prompted by the hard-to-reach nature of the study population, and in part a desire to locate participants who could best capture the phenomenon under study. Use of the snowball sampling technique allowed the selection of participants based on distinct characteristics that made them suitable candidates for the study, and also provided the opportunity to refer individuals who fit the criteria for the study (Tuckett, 2004; Ulin, Robinson, & Tolley, 2005). This unique sampling enabled recruitment of participants based on diversity regarding their education, age, and number of years living in Canada.

The snowball sampling technique permitted current participants to nominate prospective participants. The nominator was instructed to inform the nominee. All eligible women were first contacted or referred by their fellow national from the prospective participant regarding the research. The women were contacted, and the purpose of the study was explained to them. Those who showed interest to take part were given dates and venue for the interview.

Purposive sampling was used to recruit participants through various organizations where resettlement representatives and health service providers work. All participating organizations were provided with a copy of the letter of ethics approval for the study, the exact interview protocol, and the research proposal detailing the purpose of the study and use of information. Once potential participants expressed interest in taking part in the study, their contact information was

provided. Each participant was contacted with an explanation of the study and invited to participate; a day, time, and place of their choice was arranged for the interviews.

Data collection. Data collection is the procedure of gathering and measuring information on a targeted group of participants in an established systematic order, which then enables one to answer relevant questions and build a convincing and credible answer to the research questions that have been posed for the study (Berg, 2001; Pathak, Jena, & Kalra, 2013). During the data collection, interview guides were used, comprised of semi-structured and open-ended questions designed to explore participants' experiences and perceptions of refugees' health care access during their first year of settlement. Before the commencement of the data collection, the interview guides were pilot-tested with some international students at the University of Saskatchewan to determine the guides' appropriateness (Kivnick & Murray, 2001).

In the study, interviews were used, together with some interview notes, for data collection. The use of interviews during data collection in qualitative research is an approach that is used to achieve crystallization of information (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014; Patton, 2002). *Crystallization* is "a postmodernist tradition of triangulation" (Richardson, 1998, p. 934). According to Richardson, crystallization differs from triangulation; triangulation focuses on the use of different methods in validating findings whiles crystallization goes beyond that (Richardson, 1998; Richardson, 2000). Crystallization is a process where the process of examining data is temporarily halted to reflect on different views, dimensions, shapes, colours, and patterns of the experience under study to find patterns or themes (Polsa, 2013). Though crystallization can lead to a multi-dimensional understanding of complex situations (Farmer, Robinson, Elliott, & Eyles, 2006), it does not authenticate the data as triangulation, provides room for various opinions to be heard, and recognizes the voices that were not heard (Polsa, 2013).

In this study, interviews with some interview notes permitted the gathering information about intersecting factors that affect the experiences and perceptions influencing refugees' health care access. Throughout the study, I used my senses of seeing and hearing, as well as my writing ability to gather interview notes. Although this study was not designed as observation study, the interview notes gathered through the study added richness to the quality of overall research data. Through the use of this data collection method, a clear picture of the context in which the refugees access health care services will be presented.

Semi-structured interviews. Interviews, the primary source of data collection for this study, were used to explore refugees' access to health care during their first year of resettlement. Yin (2003; 2014) suggested the semi-structured interview as an important source of information in the study. Semi-structured interviews take the form of guided conversations (Yin, 2014), which is a fluid form of data collection (Yin, 2003), as opposed to forms of inquiry that may be more rigid, such as surveys (Yin, 2009). Data for this study was collected using semi-structured and open-ended questions during an interview with each participant. The question guide used for the interviews explored, in detail, refugees' experiences and perceptions of accessibility of health care during their first year of permanent resettlement (see Appendix E). Also, resettlement representatives and health care providers were asked questions regarding their views on the overall health of refugees, how refugees access health care services, and what challenges refugees face in their health care access, among others.

Conducted predominantly in Somali with the assistance of a Somali national interpreter, the semi-structured interviews provided rich, detailed, and comprehensive data regarding refugees' access to health care. The interview for the participant from Eritrea was conducted in English.

As I prepared to meet with each of the refugee women, I was filled with so much excitement. I was given a fantastic welcome into the homes of each of the women I interviewed. I was delighted to meet with them to hear their wonderful experiences and unique stories. After the introductions, with the help of the interpreter, I explained my background and purpose of my visit.

It was established, with the help of the interpreter, that Somali and English would be the medium for conversation. During interviews, all questions were in English, which the interpreter translated into Somali for the participants from Somalia. During data collection, the purpose of the study and the ethical protocol for the study were explained to participants before asking for consent. Each refugee participant was asked to share her story on her health status, health needs, concerns, and barriers she faced in accessing health care. Furthermore, the interpreter explained to participants how their privacy and the confidentiality of the interview would be maintained throughout the study.

The interview guides that were used had been approved by University of Saskatchewan Behavioural Research Ethics Board (U of S REB). No identifiers were used in the study, to ensure confidentiality. The interview process was continued until it was clear that no new information was emerging from the participants. At the same time, control was retained over the process so as not sway from the main themes that the research sought to explore. The interviews were conducted at the most convenient location for each participant. Since this study was about a marginalized population (refugee women), the interview guide allowed the participants to express their experiences and perceptions of health care services in Canada. The in-depth interviews lasted between 40 – 80 minutes and were digitally recorded with the approval of participants. Two audio recorders were used at each interview to efficiently capture the interviews on tape. All participants were provided with gift cards as appreciation for their participation.

3.4 Data Analysis

In research, data analysis is a creative process where the researcher explores and reflects on the meaning of the data, and transforms data into findings (Farmer, Robinson, Elliott, & Eyles, 2006). As data analysis begins, the researcher moves back and forth between data analysis and data collection in order to explain the findings. During data analysis, the organization and interpreting of the collected data require more time than the actual data collection (Farmer, Robinson, Elliott, & Eyles, 2006). Qualitative data analysis involves the transformation of data into an explanation, understanding, or interpretation of the phenomenon studied. It is usually based on an interpretative philosophy, in that the main idea is to examine the content of the qualitative data. The objective of qualitative analysis is to interpret the patterns found in the data to facilitate understanding of the phenomenon being studied (Farmer, Robinson, Elliott, & Eyles, 2006). Qualitative data analysis is an ongoing, iterative process where data are systematically searched and analyzed in order to provide a comprehensive description of a phenomenon (Whiteman, 2006).

The initial data analysis guides later data collection, and this reciprocal process continues until no new findings are identified. Data analysis continues after data collection has been completed. Bogdan and Biklen recognize data analysis as a two-stage process where the first step can be described as the “process of systematically searching and arranging the data” (Bogdan & Biklen, 2003, p. 419; Jacelon & O’Dell, 2005;), in which the researcher organizes the data into manageable units, and where interpretation is the second step of data analysis. According to Braun and Clarke, qualitative data analysis is not a linear process of simply moving from one phase to the next; instead, it is a more recursive process, where one has to move back and forth between the two phases, as needed (Polit & Beck, 2006).

These data were analyzed for repeated themes using an adaptation of the six-phase method of thematic analysis outlined by Braun and Clarke (2006). The goal was to identify, analyze, and report patterns of meaning that were repeated across the data set. The process required me as a researcher to gain familiarity with the data collected and discern emerging categories. Each phase of data analysis involves data reduction—as the reams of collected data are brought into manageable chunks—and interpretation, as the researcher brings meaning and insight to the words and acts of the study’s participants (Marshall & Rossman, 2006).

Stages of analysis. The data was analyzed using thematic analysis, which, according to Braun and Clarke, is a method for systematically identifying, organizing, and offering insight into patterns of meaning (themes) across a data set (Braun & Clarke, 2006). The phases of this method are familiarization with data, generating initial codes, searching for themes, reviewing themes, and defining, naming themes and producing the report (Braun & Clarke, 2006). This six-phase pattern of analysis was used to establish and create a meaningful analysis of the data.

The use of the social constructivist theory in framing the data analysis process facilitated understanding of the diverse construction of women refugees’ experiences and perceptions of their access to health care services during their first year of resettlement. Through the intersectionality theoretical approach and the social constructivist paradigm, an exploration was undertaken of the social, cultural, religious, economic, and political factors that intersect with one another to influence how women refugees perceived access to health care services in Saskatoon. Furthermore, analyzing the study data within the social constructivist paradigm provided insight into why some women expressed different opinions about their experiences in access to health care. The thematic analysis of data in this study followed the social constructivist paradigm.

Table 8 depicts the six stages and a detail description of the process employed in the analysis. During the first stage of the analysis, after the interviews had been transcribed verbatim from voice to written Somali before being translated into English, each interviewee was given pseudonyms, and interview notes were broken up into segments identified by date or context. The entire text was read without coding or writing memos using the Braun and Clarke approach (Braun & Clarke, 2006). In order to reduce inconsistencies and errors in the data, the text was read several times. This approach helped check whether participants' stories were transcribed accurately and attributed to the right individual.

Table 8: Stages of Thematic Analysis

Stages/phases	Process description
Familiarization of data	Transcribing data, reading and re-reading the data, and noting down initial ideas.
Generating initial codes	Coding interesting features of the data in systematic fashion across the entire data set, collating data relevant to each code.
Searching for themes among codes	Collating codes into potential themes, gathering all data relevant to each potential theme.
Reviewing potential themes	Checking how the themes work in relation to the coded extract and the entire data set, generating a thematic map of the analysis.
Defining and naming themes	Ongoing analysis to refine the specifics of each theme and the overall story the analysis tells; generating clear definitions and names for each theme.
Writing final report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Note: Adapted from Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. Available from: <http://eprints.uwe.ac.uk/11735>.

Coding is the systematic organizing, and gaining of meaningful parts of data as it relates to the research question. The coding process advances through an inductive analysis, which is not considered a linear process, but is rather a cyclical process in which the codes emerge throughout

the research process. This cyclical process involves going back and forth between phases of data analysis, as needed, until the researcher is satisfied with the final theme (Polit & Beck, 2006). The text was read to detect and highlight inconsistencies and also to remove typographical errors in order to clean the data (Wahyuni, 2012). Further, through several readings of the data, a sense of the whole data was obtained where memos, margin notes, and initial tentative thoughts/ideas for codes were written on the data. Rich or important words, quotes, or passages in the data were underlined to inform the coding process. Braun & Clarke (2006) asserted that reading and re-reading provides the bedrock for data analysis.

Some codes eventually became embedded in multiple categories due to their underlying concepts. For example, the code “trust” appeared in the categories privacy and confidentiality, compassionate care, and health system characteristics. A manual coding was adopted that allowed immersive engagement with the data. A code tracking was created that allowed organization of the codes and which was useful when the codes were categorized. Related codes were fused into sub-themes or groups, which were later merged to create themes based on commonality (Braun & Clarke, 2006). Further, “a ‘theme’ can be defined as something important about a data about the research question which represents some level of patterned response or meaning within the data set” (Braun & Clarke, 2006, p. 82). Therefore, it was endeavoured to systematically examine all of the data and interpret the meaning of the themes for this study’s research questions. The research questions and conceptual framework guided the choice of this analytic method. Through this, it was possible to identify from the data the experiences and perceptions of the participants on refugees’ access to health care.

The analysis stage was characterized by identifying which aspects of the data captured what was interesting about the themes, and why themes were interesting. In order to identify

whether current themes contained sub-themes and to discover further depth of themes, it was important to consider themes within the whole picture and watch for autonomous themes. The findings from this thematic analysis provided rich qualitative accounts of the experiences and perceptions associated with women refugees' access to health in their first year of resettlement.

3.5 Role of Researcher

We live in an era where health problems transcend national borders and have global, political, and economic impact. Health research targets various segments of the human population can expose gaps in health delivery; thus, global health is concerned about the worldwide improvement of health, reduction of disparities, and protection against global threats. Again, there is also the need to promote prevention, diagnosis, and treatment of diseases in order to enhance growth and people's general well-being. Today, the refugee problem is worldwide: no inhabited region or continent lacks refugees. People caught between dangers at home and fear of persecution have fled their homes and sought safety in strange societies where they may lose their identity, in addition to potentially being isolated, impoverished, and perceived as different. There is therefore the need to attach importance to address issues related to refugee health needs and concern.

From an early age, I have always been fascinated with the notion of what good health means and how it can be achieved for a community. Being interested in exploring facets of public health, as it pertains to public policy, advocacy, civil society, and the individual, motivated my desire to study social determinants of health, as they have a much greater influence on the well-being of a population. I am interested in facilitating a paradigm shift in general health treatment to a more vigorous population-based approach for tackling the ever-expanding health needs of refugees in Canada and the world. I hail from Ghana, in the western part of Africa, where I had taken my basic through to my university education, including my undergraduate degree, before

undertaking my master's degree in Canada. My background in Population Health at the undergraduate level put me in a position to understand and appreciate health issues from an interdisciplinary and collaborative perspective with a focus on health inequities. My interest in health promotion and health issues has attracted me to pursue research in this direction. Therefore, the need to build on my expertise will require that I learn prevention and primary health care rather than tertiary care.

There are a number of refugees in Ghana who have migrated from various countries due to war, persecutions, natural disasters, and human rights violations, leading to decreased health and food and economic insecurity for these marginalized, stigmatized, and vulnerable groups. Also, the courses I took during my undergraduate degree provided me with a basic but thorough understanding of the issues faced by refugees in health care, especially about refugee health. In the last two years, I have continued to learn about public health by reading related health books and online resources.

Despite the tens of millions of refugees in this century, there has been surprisingly improvement in refugee research. Although refugee problems have existed for a long time and have created great suffering for refugees, as well as major difficulties for those who have tried to assist refugees, there has been little research that might relieve the refugees' suffering and assist those who try to aid them. Thus, my research interest lies in the area of refugees' access to health care services. During my undergraduate years, I participated in a research project where I was exposed to both qualitative and quantitative research methodologies. As a graduate student and a young researcher, this passion continues to develop and, I am aware that refugee research is a sensitive topic in various research circles, though refugee research sensitivity may not be applicable to Canada. I believe that in order to address the health concerns/issues that researchers

have about this topic I needed to conduct rigorous study in this area of research. I recount as I prepared to meet with each of the refugee women, I was filled with so much excitement. I was given a fantastic welcome into the homes of each of the women I interviewed. I was delighted to meet with them to hear their wonderful experiences and unique stories. After the introductions, with the help of the interpreter, I explained my background and purpose of my visit. This study has offered and taught me lifetime experience which is valuable.

My main research goal was to produce research that will help improve the health and well-being of refugee women. I strongly believe this research will equip me with the leadership and research skills I need to advocate for real-world change.

3.6 Ethical Concerns/Considerations

In carrying out a study that involves a vulnerable population, there is the need for ethical considerations in every aspect of the study and the participants under study must be treated in accordance with the ethical guidance of the U of S REB. Appropriate ethical clearance was obtained from the U of S REB before commencing the study (see Appendix B) to ensure this.

Since the participants were vulnerable and marginalized refugees, there was maximum respect for human dignity, which entailed high ethical obligations. Ethical responsibilities to vulnerable individuals in the research enterprise often translate into special procedures to protect participants' interests, such as autonomy, dignity, and self-esteem. The study did not in any way expose the participants to any harm, discomfort, or perceived harm during the course of the study. While an in-depth interview presents minimal risks, participants might have been uncomfortable answering some questions; this study had no risk posed to participants. Given that fact, the participants were informed that the study could lead to their past experience, which could pose some discomfort during the interview. Participants were informed they could decide to end the

interview during situations such as those. Participation in this study was voluntary, and a participant had the right to opt out or leave at any time during the study. Participants were told to answer only the questions they were comfortable with during interviews.

At the beginning of the data collection, consent forms were given to all study participants, seeking their approval to participate in the study (see Appendix B). Each participant had the opportunity to read and sign the consent form before the interview commenced. Participants who could not read the consent form had it read and explained to them before they signed or gave their oral consent. The purpose of the study, the content of the consent form, and the interview process was explained to study participants before the commencement of the in-depth interview. All participants signed a transcript release waiver form (see Appendix D). In addition, the participants were informed about the security of all raw data and digital records used during the data collection.

Furthermore, all participants were informed that all the information gathered will solely be used for the purpose of the study. To ensure that each participant's identity was protected, an identification code was given to recordings and documents, and names were coded and kept in a secure filing cabinet at the University of Saskatchewan. There was no use of personal identifiers in the study's research report, or direct quotations containing identifying study participants' information in this study, or during focus group and in-depth interviews.

Privacy and confidentiality were top priorities throughout the study process. I assessed the chosen location for the in-depth interview to be suitable and non-threatening to participants. The interpreter and transcriber signed confidentiality forms and agreed to maintain the confidentiality of the participants, up to and beyond the research stage. In addition, I informed all refugee participants in the study (in-depth interviews) that I could not guarantee their anonymity since they were referred to the study by other refugees in Saskatoon.

I informed participants that data collected from the study would be kept in a filing cabinet in a protected office at the University of Saskatchewan for five years. After the five years, all data collected will be shredded beyond recognition or electronically deleted. I have no potential or perceived conflict of interest in the conduct of this research study.

The ethics procedures were strictly followed. The ethics procedures state that the researcher informs all participants of their right to express their concerns regarding the study to University of Saskatchewan Behavioural Research Ethics Board or my supervisor at the University of Saskatchewan.

3.7 Study Dissemination/Knowledge Transmission

Dissemination is important in this study because it gives the researcher an opportunity to relay back findings of the collaborative efforts and to assist in effecting policy changes to improve refugee quality of life. In view of this, it is very important that the results of the study be shared with the primary participants and collaborators, as well as other interested organizations. As part of seeking participants' consent for their participation in the study, they were informed about the purpose of the study and that the results will be presented at seminars, conferences, and in academic journals. A summary document will be presented to the resettlement agencies as well as health service providers who work with refugees in Saskatoon.

3.8 Strengths/ Limitations of the Study

Although the research has reached its aim, there were some strengths and limitations to the study.

Strengths. As a novice researcher undertaking this research, I have become aware of the difficulties in conducting research with a vulnerable population. Throughout the research, I learned how to develop trust and confidence in my research interpreter and transcriber in order to delegate control over the interviews and transcription to them. I have also learned the virtues of patience,

trust, and self-confidence, and the importance of networking with regards to research. As the study respondents were drawn from the refugee population, resettlement agencies, and health service providers, I am very confident that the information collected will provide new insight on refugee access health care and the challenges refugees face. Specifically, I hope this study will add information to help address health inequalities in refugees' access to health by informing actions that can be taken to prevent health inequities through policies, programs, and activities. This study helps identify barriers and facilitators as well as female refugees' perceptions of accessing available health care services. I hope organizations and communities that welcome refugees will utilize the knowledge gained from the study's findings to proactively and appropriately address barriers that contribute to refugees' poor health.

Another strength of the study was that it was restricted to refugee women who had been in Canada during their first year of resettlement. This was a difficult population to target and talk with as they are faced with various challenges during their resettlement. These challenges range from getting to know their new environment, searching for jobs, attending ESL classes, and communicating in English. Despite these challenges, the women refugees exhibited their interest in participating in the study by sharing their stories and experiences.

Limitations. I encountered a number of methodological challenges in conducting my research. As a novice researcher, I found the data analysis using the intersectionality framework to be particularly challenging due to the absence of clear methodological guidelines to be adopted in intersectional research. While the existing literature on intersectionality as a theoretical framework abounds, empirical studies that use intersectionality as an analytic tool with explicit methodological guidelines remain scant. I encountered numerous challenges in finding and recruiting participants. Initially, I was glad to find that there were many resettlement agencies for

Saskatoon refugees. Though there had been communication with gatekeepers as well as establishing a very good rapport between resettlement agencies through the exchange of emails, phone calls, and in-person meetings, the resettlement agencies were cautious about their involvement in the research. As a result, I was turned down on numerous occasions.

I also encountered challenges in finding a qualified interpreter in the local languages of the refugees. It took a long time searching before the commencement of the study. I approached several contacts within the University of Saskatchewan Campus and resettlement agencies to recommend potential interpreters to me. The process proved difficult and frustrating as there were no people available to be recommended to me, which prevented these agencies from committing to supporting me in this research. Further, there was a significant challenge to getting a transcriber to transcribe the interviews into the local languages and then translate these into English.

Issues of language and translation were also limitations of the study. English was not the first language for this diverse refugee population in the study; however, even though there were language barriers, the participants were found to be conversant with the majority having limited English vocabulary. Their inability to explain issues in depth might have resulted in missing out on relevant information, and this might have hindered the women's ability to bring out the true reflection of their experiences and perceptions of their access to health care.

Ethnic diversity was also another limitation for this study. The study primarily is about Somali and Eritrean refugees only. As the refugees were from different countries, it was quite complex to gain their understanding and trust during the study as their culture and religious backgrounds may have restricted them in sharing more information helpful for the study. The identified issues may not be the same as those faced by other refugee women.

3.9 Credibility and Validity of the Study

It is important that in every research inquiry, the data collection and analytical method be checked to main acceptable standards. In qualitative research, the quality of the results can be identified by its trustworthiness (Bradley, Leslie, & Devers, 2007; Leung, 2015); thus, qualitative researchers employ various validation strategies to ensure the study's quality, credibility, and rigour (Bradley, Leslie, & Devers, 2007; Leung, 2015; Rolfe, 2006). Accordingly, Lincoln and Guba (1985) define and suggest that trustworthiness of the qualitative research can be confirmed by four criteria—credibility, transferability, dependability, and conformability—which have been utilized in this research.

Credibility. According to Lincoln and Guba (Lincoln & Guba, 1985), the *credibility* of the study demonstrates the value of truth by representing those multiple constructions adequately; that is, the reconstructions via the inquiry must be credible to constructors of the original multiple realities. In other words, credibility refers to the confidence the researchers have in the truth of the findings (Lincoln & Guba, 1985). This multiple construction is done through member checking, peer debriefing, developing trust, and ensuring that the interpretations of the findings are accurate. Therefore, in this research, two methods of the methods that were suggested by Lincoln and Guba (Lincoln & Guba, 1985) are used to ensure credibility: crystallization⁶ and member checking. Regarding crystallization, all the data was collected by using different interviews with diverse groups to grasp the multiple realities, so that different types of data can provide cross-data validity checks (Miles & Huberman, 1994). Further, the data provided room for multiple views and acknowledged the views that were unable to be heard and seen (Stake, 2013). Consequently, all

⁶ Crystallization refers to a myriad number of crystals that all reflect different views, dimensions, shapes, colours, patterns, and arrays of the phenomenon that we study.

transcriptions were reviewed, compared, and analyzed within the data analysis process. Participants were met with to review the interview transcript and for confirmation of their stories, to employ member checking. This helped confirm accuracy and gain more feedback on this study's findings and interpretations. Member checking helped not to only affirm the views and experiences of participants, but also provided findings that were authentic, original and reliable (Lincoln & Guba, 1985).

Transferability. According to Lincoln and Guba (1985), *transferability* demonstrates the responsibility of the researcher in providing sufficient descriptive data to make contextual meanings. Transferability indicates that researchers can relate the findings of the study on their own. Lincoln and Guba (1985), suggested that thick description must be provided to judge transferability (Ballinger, 2006; Lincoln & Guba, 1985). Thick description⁷ was adopted in this research by transcribing all the interviews carefully and thoroughly, and by making sure that certain context and meaning, as well as interpretation of participant intentions, can be involved in the rigorous data analysis (Lincoln & Guba, 1985).

Dependability. According to Lincoln and Guba (1985), *dependability* stresses the audit of the research process to make sure the study reflects the participants' realities, without impact from the researcher. In other words, dependability refers to the internal coherence of the data, including findings, interpretations, and recommendation (Ballinger, 2006; Denzin & Lincoln, 2011). Therefore, in this study, the same approach was used in all in-depth interviews for each participant in all of the categories. Finally, all of the data was analyzed using the same rigorous analysis procedure to ensure the dependability of this study.

⁷ Thick description is used to characterize the process of paying attention to contextual detail in observing and interpreting social meaning when conducting qualitative research. Detailed description in this area is an important provision for promoting credibility as it helps to convey the actual situations that have been investigated and, to an extent, the contexts that surround them.

Confirmability. Lincoln and Guba (1985) further suggested that an audit trail must be prepared for data collection and analysis methods to ensure *confirmability*. An audit trail was used to capture the decisions made, from the study design through data collection to data analysis. The reflective data trail used included interview notes, memos, transcribed interviews, coding schemes, themes/categories, and the draft report. An audit trail is vital in reviewing the views of the researcher by attesting to the interpretations of the data and also establish the rigour of the study findings (Ballinger, 2006; Lincoln & Guba, 1985;).

3.10 Conclusion

This chapter identified the theoretical perspectives underpinning the research design. It described the methodology used to conduct this study. The reason for choosing a qualitative approach for conducting the study was explained, as this enabled the study to gain an understanding of the interpretations and perspectives of refugees' access to health care during their first year of resettlement in the midst of the cuts to the IFHP. The chapter also provided a detailed account of the research sequence, how the data were organized for analysis, and the procedures developed for analysis of the data were discussed. Finally, the ethical issues and the rigour of the research were also considered.

Chapter Four

Results

4.0 Introduction

Access to health care is essential and paramount to improving individual and population health outcomes in every country. This chapter provides the findings of the study, which explored women refugees' experiences and perceptions of their access to health care services in Saskatoon. Refugee experiences and perceptions are mostly attributed to their pre-migration and migration experiences during wars, persecution, and conflicts. Throughout the chapter, the term "refugees" is used to connote the eight refugees interviewed in this study; however, health service providers and representatives from resettlement agencies speak broadly about refugees based on experiences beyond this sample. For the purpose of this study, "access to health care" or "access to services" refers to the ability of refugees to seek and obtain health care services.

The challenges that refugees in Saskatoon encounter when accessing health care services upon their arrival and during their resettlement in Saskatoon are described and examined in the diverse findings on women refugees' access to health care services that follow. This chapter focuses on the interpretations and actions resulting from the participants' stories about their access to health care during their resettlement. It begins with a brief discussion of the participants' backgrounds, in addition to providing an insight into refugees' health care access, which was previously discussed in chapter 2.

This chapter is divided into sections, where the study's research questions are answered, including discussion of: (1) the experiences of women refugees' in accessing health care services in Saskatoon, and the quest for safety; (2) the perceptions of refugee resettlement agencies and health service providers regarding the context of refugees, based on their past experiences; and,

(3) the perceptions and experiences of caregivers. Sections 4.1 through to 4.2 capture the voices of the refugee women. These sections capture their experiences in the quest and search for safety and address the first question, which has been divided into pre-migration, migration, and post-migration (Bhugra, 2001; Bhugra & Jones, 2001). Further, the section provides a composite description of the various health concerns of women refugees. Section 4.3 capture a mixed views of refugee women, representatives of resettlement agencies and the health service providers. The experiences and perceptions of the respondents are varied which denote there is a mixture of reactions to people's perception to access to health care. The section discusses their views on health, health concerns, health care delivery, and quality of health care services.

Sections 4.4 through 4.5 represent the voices of the representatives of resettlement agencies and the health service providers. These sections discuss the context of refugee access to health care as described by health service providers and resettlement agencies, limited to refugees' access to health care services within their first year of permanent resettlement in Saskatoon. These sections explore sources of IFHP information, as well as perceptions of the effects of the cuts to IFHP on refugees' health care access. The final component of the section examines the opinions, perceptions, and interpretations health care providers revealed about their provision of services to refugee women.

Sections 4.6 through to 4.8 integrate the voices of all the participants in the study. These sections provide insight into their experiences and what motivates health providers in their call to provide continuous and quality health care to refugees. Furthermore, these sections examine the barriers that impede refugees' access to health care and discuss the impact of refugee health care services.

Data sources are noted throughout the presentation of the results, which relies heavily on the use of selected quotes from the participants' interviews. The extensive use of quotations ensures that many different voices and views are represented in the findings from the study. Also, the chapter examines the impacts of the refugees' access to health care within their first year of resettlement. Lastly, it contemplates the alternatives ways in which health service providers helped refugees to gain access to health care services in the face of IFHP cuts during their resettlement.

4.1 Refugee Women's Migration Experiences

Refugees experience stressful events in their search for safety during war and conflicts. These migration experiences inform their lives and perceptions throughout the various stages in their journey. During the various phases of their movement before reaching a safe haven, they encounter various forms of ordeal. This session highlight refugees' experiences during the three migration phases.

Refugees' migration experiences. As mentioned in chapter 3, the women in this study came from Somalia and Eritrea, and all became refugees on personal journeys under different social and political circumstances. These refugee women fled their countries of origin because they had been subjected to conflicts, war, and persecution in their home countries and had travelled through various countries in search of refuge. This section begins with their pre-migration and migration experiences, sharing stories of the women's experiences of fleeing violence, conflicts, insecurity, war, instability, and persecution, and their efforts to seek safety and refuge in Canada.

Pre-migration: Reasons for leaving. Prior to fleeing, the refugees interviewed for this study were subjected to various conditions that had a substantial impact on their physical and mental health. The women who participated in this study came to Canada through various countries outside their countries of origin and had been living in very dangerous situations or exposed to an

imminent risk of disaster in the countries in which they sought protection. When asked to describe the state of their countries at the time, the women shared their reasons for leaving their home countries.

There was a war in Somalia in 1991. They were fighting too much. Two groups were fighting. They were fighting the government. (Suzzy: Refugee)

There was war in Somalia, civil war in Somalia. You know I was working before the war started. So when it started, I had to run into the bush to save my life together with my children and husband. We were in the bush for very long time. (Mary: Refugee)

Another woman shared a different reason: she had to relocate from her country because the practise of her religious beliefs was no longer permitted in her country.

There was war in my country for 40 years. So during the war in my country for 40, I fled to Ethiopia when I was young and lived there. I returned to Eritrea after the country attained independence. I then lived there until the government was not in support of the Christian religious practice. (Nora: Refugee)

Some women revealed that they had been through various countries—including Botswana, Kenya, Zambia, and South Africa—in their search for peace and refuge, before arriving in Canada.

I have been through a number of countries before finally coming to Canada. When I left Somalia, I went to Mozambique for some days then I continued to Durban [South Africa]. From there, I continued my journey to Botswana where I lived there for fifteen (15) years. (Mary: Refugee)

I was in Ethiopia for 23 years where I later went back after my country Eritrea had attained independence. I later relocated to Kenya with my husband and children for 3 years before coming here. (Nora: Refugee)

From Somalia, I decided to move to Kenya where I lived at the refugee camp for five (5) years before I moved to Tanzania. I stayed in Tanzania for some time before heading to Mozambique and finally settled in South Africa before I came to Canada. (Getty: Refugee)

The interviews also revealed that refugees sometimes had to sell properties they had acquired before the onset of war and conflict in order to flee or relocate to a safe and secure place. One of the women shared this:

I decided to sell the things that my husband and I have acquired after he was arrested and ran away to South Africa with my youngest child. I used the money I had from selling the things in the house to pay for my fare to South Africa. (Ferouza: Refugee)

As most refugees often tell stories of being vulnerable and prone to various degrees of harm during their journey in search of safety, the women in this study also discussed the various encounters and ordeals they went through as they fled for protection.

Migration. During the migration phase, refugees experience many traumatic events. Often, for refugees to leave their country of origin, they live their everyday lives in distress and may lack necessities. Refugees use various means to flee and may trek on foot for days, weeks, or months before reaching a safe place. During flight, refugees normally endure malnutrition, physical assault, and rape, in addition to witnessing torture. Some women recounted their violent experiences.

I was arrested and put in prison. [...] After three months in jail, we were released. The government of Botswana knew we are refugees from Somalia and the problem that was going on in the country. In prison, there were about one hundred something people from Somali that had been arrested. (Mary; Refugee)

I was arrested and put in jail for five months. We were always beaten, but I never experienced anything like that. (Ivy; Refugee)

I was beaten with the butt of a gun. I was not treated in the right way. The people are rude. They kill people easily. Yeah. It wasn't good at all. Sometimes, you don't know if you're going to be killed the next moment or not. (Hannah; Refugee)

Some women had to pay a lot of money for transportation by boat from their home countries to a safe country.

I was charged \$300 [USD] from Kismayo to Maputo, Mozambique. I gave him the money, me together with another guy from Mozambique and the boat that took me to Durban. I paid 500 rand. That was very cheap; cheap because that place from Mozambique to Durban was very close and not too far. (Mary; Refugee)

One woman shared her experience, where her husband was a truck driver who operated between his home country and other neighbouring countries. As a refugee who came to Kenya from Somalia, she recounts that she met her husband who was a truck driver when she relocated to a refugee camp in Kenya. She never had to worry about her mode of transportation because it was easy moving from one country whenever her husband got transferred.

While in Nairobi as a refugee, I got stuck, and it was during that time I met my husband. He was a truck driver so we stayed in Nairobi for five years. Anytime my husband gets transferred, I have to be on the move. So when my husband was transferred to Tanzania, we had to move there together. After staying in Tanzania, we moved to Mozambique. Travelling from one place to the other was very easy since my husband had his own means of transport. (Getty: Refugee)

In some cases, during the transition, refugees hid in bushes while living in fear and hunger.

When we were running away from Somalia to Kenya, we heard the sound of bullet but didn't know where it was coming from. My friends and I had to hide toward the bushes to get to safety. We were afraid someone might kill us. (Suzzy: Refugee)

Refugees fleeing from one locale to another may encounter many dangers, including lack of clean drinking water, lack of food, and the danger of being captured by enemies. Another woman shared her experience of living in fear and hunger.

The people were going around killing and arresting people for no reasons; they just get to your place or where you live, and it is either you move out from the place, or you will be killed. In 2008, I went to Kismayo, which is another part or town in Somalia where I stayed there for a week. During that one week, I lived in fear and hunger. I didn't know where I was going. In fact, I was so confused. There was no food and all the only food the people I was with could eat were dates, biscuits, and leaves. (Ivy: Refugee)

Some women were threatened and attacked by the citizens of their host nations and forced to leave. Refugees lived in fear based on their past experiences, or because their lives and those of their children and family were at risk. This fear made them vulnerable and marginalized.

Each time they come they tell us to leave to your country. You will hear them saying “you came here to make money”; “You destroyed your country and you want to destroy ours too.” (Getty: Refugee)

It was evident from the stories and comments from the women that there were other situations they suffered during their flight to safety. Some recounted how they had lost some of their family members and relatives to the war.

I had my brother-in-law killed there and also there was xenophobia in South Africa.
(Getty: Refugee)

One of my sisters and a brother passed away to the fight. (Ferouza: Refugee)

Some women also mentioned how they unwillingly lost contact with their children, husbands, and other family, as well as their loved ones due to the war and in their transition to their host countries.

My husband is in Ethiopia, but I don’t know the whereabouts of my daughter. I lost both of them when I was running away for safety. I would be happy to know my husband’s where about. (Suzzy: Refugee)

I don’t know where one of them is. I was told one of my children is currently in Somalia, but there was no news on the other child. You see, my leg got broken here and here. (Mary: Refugee)

I came into Canada alone but currently my husband is in Kenya while my children are in Ethiopia. I am in contact with my family, and they are doing very well though I lost

contact with them when I was in Kenya. I will be happy to reunite with my family someday. (Nora: Refugee)

Some women shared how it was through their transition from their countries into a second or third country where they moved for safety, that they met their new husbands, who became their backbone and source of help in their adjustment and integration. This gave them the opportunity to make a new family for themselves after losing their partners during their quest to search for safety. Ferouza shared this:

In South Africa, I met my present husband after I had lost my husband to war in Ethiopia. He was very supportive and helped me while I was in South Africa. He is such a nice person, and we are here together happy with each other. (Ferouza: Refugee)

Many of these women are single parents; some hope to reconnect with their partners someday. The rest were living together with their partners. Some women came alone, but most arrived with their children and husbands. Some women had become separated from family members and spouses during flight and resettled alone or as single mothers.

Post-migration: Integration. Refugee resettlement remains an essential tool for providing support, safety, and protection for refugees' integration process. Refugee resettlement is the means by which refugees are allowed to leave a country of asylum and start life anew in a second or third country that is willing to receive and protect them on a permanent basis (UNHCR, 2016b). Resettling of refugees is done in a distinctive way during and after their arrival in the host country. Saskatoon has some resettlement agencies that welcome refugees daily and help them in their integration process. As refugees make a new home for themselves in their new country, resettlement agencies provide the needed assistance for refugees to settle without encountering major difficulties during the adaptation process. As part of the integration and settlement process,

resettlement agencies help provide for refugees as well as assist them with services such as accommodation, jobs, and familiarization with society and culture.

Refugees receive assistance through programs that were established by the Federal government, individuals, and non-profit organizations. Resettlement agencies in Saskatoon welcome and usher refugees into their new country. These programs are heavily focused on integration that will help the refugees to feel more at home than just to be settled. For the refugees to feel welcome and connected to their new environment, there is often the need to build social networks and make friends to feel well connected to the community of which they have become a part.

All the refugee women reported that they were met upon arrival by representatives and counsellors from resettlement agencies in Saskatoon. The following excerpts illustrate this experience:

When I first came, I was helped by Open Door Society. They came to meet me at the airport and then got me a place to sleep. The counsellor I was given took me around and showed me around and helped me to get this room. I was taught how to use the washing machine and where to buy groceries cheap. The counsellor took me to see my family doctor for a check-up. (Getty: Refugee)

My family and I were helped by the Global Gathering and a counsellor from Open Door Society when I came to Saskatoon. When we came to Canada, for the first time our counsellor came to meet us at the airport. And she picked taxi where we all came to Appleby house; we stayed there for seven days, and we moved into this house. (Ferouza: Refugee)

I am very grateful to the women from Open Doors for their help. I am also grateful to Canada government for their help in bringing my children here and me. The counsellor from Open Door took us around the city and showed us so many beautiful places. She took us to the hospital where they checked our blood to see if we are not sick in any part of our body. There was also a woman that came to our house from Global Gathering Place showed us how to do laundry, how to use the stove and to do shopping. The people from Global Gathering also helped us with where we can get cheap things like food, utensils and clothing. (Hannah: Refugee)

In contrast to the above, one of the women shared an evident gap in service:

My husband and I settled in Prince Edward Island when we first arrived in Canada for 2 weeks before we decided to come to Saskatoon. When we came to Saskatoon, my husband and I went to Open Door for assistance but we were told that we were supposed to stay and settle where we landed when we first came into Canada for some months before moving to another city. Based on that the counsellors were not willing to help us. (Ivy: Refugee)

The resettlement agencies refugees mentioned most included the Open Door Society and the Global Gathering Place. Counsellors in these agencies become refugees' first contact in their new country. Among the services these agencies provide for refugees upon their arrival are housing support, government financial assistance, language classes, and life skills programs. During an in-depth interview, the refugee participants recalled that shortly after their arrival, their counsellors arranged and got them screened to make sure they had no life-threatening health concerns.

When we came in to Canada, the counsellor from Open Door Society told us everything about how we can go to the hospital and she even took us to the hospital where we were checked to see if any of us was sick or not. She helped us to get health card and told us that we don't have to pay for anything because the government will pay for everything. (Ferouza: Refugee)

In addition to the above services, refugees are given the opportunity to choose and attend programs in which they are interested. For instance, arriving refugees are met at the airport by the Open Door Society and helped with their settlement. After they have been settled by their counsellors, refugees are referred to Global Gathering Place for a life skills training program. As part of the integration process, resettlement agency representatives take the women through a three-month life skills training where they are taught basic housekeeping—including how to use the stove and washing machine, how to clean their homes, the uses and precautions for using various cleaning products—and other necessary skills, such as how to use the bus.

Global Gathering, also was here every day to see us. They show us the bus stop, where the shops are so we can buy food and also took us around to show us places. When we got to Superstore, they told us that foodstuff and everything we need is cheap from that shop. We were also told that certain things are expensive, so we should always look out for things with no name. That is, we should all the time look out for yellow stuff that is very cheap and we can save some money. The Global Gathering Place also brought us things we can use to clean the washrooms and the dishwasher. We were taught how to use the dishwasher and the washing machine. (Ferouza: Refugee)

The other participants also expressed that they were taken to Superstore where they were shown how to get inexpensive food and other things they may need to survive. Not all experiences

were positive. A woman expressed how insensitive and inconsiderate some counsellors were by not listening to their pleas, especially in a situation where the refugees are physically challenged.

You know, I do not see correctly, and it was snowing so heavily when I came. She was the one that got me this place. They put other people on the lower floors, but she put me here. She knows I can't see properly. I want to leave here and move to another place but they are forcing me to stay here. I don't want to remain in this house; it is too high for me You know, when I walk and look down, I can't see properly. I can't see the stairs, so I end up hurting myself. I keep falling so many times on the stairs, and there are no elevators in the building I have been through many things, but never in my life I see forcing like this I get in Canada now. (Mary: Refugee)

4.2 Refugee Health Concerns

Refugees have varied health needs and concerns during their integration into their new country of settlement. These concerns and needs vary from individual to individual and may make it difficult for them to settle in successfully. In this study, it was evident that these women were faced with multiple issues despite the various forms of assistance that were offered to them by Saskatoon resettlement agencies.

The majority of the women said that they did not have any health needs or concerns. Some women expressed that they were having some reproductive health-related issues, as well as various birth matters but were hoping to see their family doctors for treatment. For instance,

You know, the first place where I gave birth, they cut me too deep and told me that it would, the wound will heal and come together, and that I will be fine. But I have never been fine. The place just keeps on tearing up. (Ferouza: Refugee)

Some women participants had chronic pain and physical deformity with swelling conditions. One woman, in particular, had chronic pain in the leg due to her pre-migration experiences. This pain was very evident throughout the interview. She expressed,

I am fine except that I have the problem with my leg. I have had this since I was in Somali during the war. I was shot in my leg and since then, one of my legs is taller than the other. I always have pain in the leg, but nothing has been done about it. The doctor refused to have my leg scanned when I visited the hospital. (Suzzy: Refugee)

It was evident that some women were not happy with the experience of visiting family doctors. They complained about the lengthy wait time in scheduling appointments to see their family doctors. The women were concerned about the length of time between booking an appointment and their appointment. They were of the view that during this long wait time, anything could happen to them and since they require an appointment before seeing their family doctors, it becomes difficult for them to go to the hospital during those times to see the doctors. Others also talked about their inability to get necessary health care from their family doctors during visits.

I have and feel severe pain in my body; my nerves, eyes, and hands. Every part of my body is paining me. The family doctor I was given, anytime I visit just prescribes her medicine. When I requested that I would like to see a specialist, he says “no, no, no, wait if it doesn’t go then you will see one.” Right now, I feel pain even in my throat. My family doctor has still not gotten me an appointment with the specialist. Sometimes, all I just want is to have a general checkup which I am not getting it, and no one is helping me to get one. I still haven’t found a good doctor to help me with this. (Suzzy: Refugee)

4.3 Facilitating Access to Health Care Services

The Canadian health care system offers government-covered health care to refugees through the IFHP, which is new to them, when they first arrive in the country. The IFHP provides limited health coverage geared to refugees and adequate coverage for government-assisted refugees. In defining what refugee health entails, Andrew, a resettlement agency representative had this to share when he defined refugee health in the context of poverty:

Poverty can be defined in two different contexts. Poverty in Canada has a different definition as compared to how poverty is defined in Kenya, Ethiopia, etc. also with a different definition. Having clean water to drink as well as having a three (3) square meals is a luxury in these countries while it is taken for granted here in Canada. There are places where it is difficult to get just one meal in a day. So when I look into the health of the immigrant, who are not coming from a regular environment; with many of them left their countries of origin and moved to other countries where they have lived in camps. (Andrew: Resettlement rep)

Poverty is one of the factors that affects refugees in their health care access. Poverty and lack of access to services have an adverse effect on health care to refugees and comes with its own unique challenges. Also, prior to refugees migrating from their home countries, several refugee families live below the poverty line due to resettlement stress and exposure to bad environments. Poverty increases their chances of having poor health, which in turn increases and leaves them at higher risk of disease.

Although some of the refugees have low levels of confidence when they visit clinics and hospitals, representatives from the refugee agencies created some personal connection as well as a comfortable relationship with refugees so they can gain their trust. The representatives asserted

that this relationship made refugees comfortable to share their stories with them. After refugees' arrival and settlement by their counsellors from the refugee agencies, the representatives from the agencies take the initiative for arranging refugees' first appointment with their family doctors for a screening and assessment check-up.

We accompany refugees for their appointments, though, we do inform them of all new changes, we are always with them during their appointments to remind them of what is accessible and what is not ... for instance an emergency, and then we do it outright without waiting for their settlement. Those that are not emergency are done after their settlement. (Sandra: Resettlement rep)

In situations where refugees upon arrival have threatening health concerns, the representative arranges for an emergency physical check-up so that there will be an immediate intervention to address refugees' health concern. Refugees mostly access health care from walk-in clinics and community clinics except on special occasions when they need specialized care then they are referred to the hospitals.

The caseload of refugees receiving health care from clinics and hospitals varies from month to month depending on the number who arrived in a particular month. According to Angelina, a health service provider,

The number of patients I see vary from month to month. I have already seen about 30 refugees though we are in the middle of the month (it had been a busy month). The number depends on the flow Immigration Canada is sending into Saskatoon. (Angelina: Health service provider)

Health service providers revealed that although health care services are available to the refugee population, the IFHP cuts sometimes denied some refugees access to health care and some

of the refugees were not aware of the health care services to which they were entitled. However, some health service providers asserted that the counsellors from the resettlement agencies provide them with all the needed information on how to access health care.

Usually, the settlement counsellors arrange refugees' first medical visit and help them out within the first three months of their stay. After the first 3-month period, refugees are on their own in accessing health care concerning who they are going to see, how they are going to get there, how to communicate with the physician or the health care provider etc. are left out to them unless they have other outside agency assistance. They also provide refugees with the needed health care information upon their arrival.

(Angelina: Health service provider)

Although the women refugees generally commended the resettlement agencies' representatives for their good work in helping them adjust and integrate easily into Canadian society, the majority, when asked about whether they were aware of the various health services that are available to them, responded in the negative.

I am not aware of any health services available to me or for the refugees. The women who helped me with the health card didn't tell me of anything. That is whether there are special doctors or services for refugees. I was only told that health care service in Canada is free and you can go to any doctor, and that is how I went to my current doctor. (Shelly: refugee)

Other women shared different opinions; they said that upon their arrival, their counsellors informed them of all the health care services that are due them. The women revealed that in most cases, they were also accompanied for their first visit to the health centres by their counsellors.

Before we come into the country, the counsellors from the resettlement agencies had already prepared and booked for a family doctor for us; who to go to and every step we need to go. They don't give us the information until we arrive. When you come in, they tell you us everything we need to know within the three (3) months. (Hannah: Refugee)

Having endured significant life-changing events, the women expressed a desire to extend their gratitude for having been granted safety in Canada by "giving back" to the greater community.

I am very grateful to the government of Canada for allowing refugees into the country. We are safe here. No more war and fighting. If not for Canada government, I wouldn't have ever sat in a classroom. Everything is free here. I will do my best to help the people around me whenever I can. Good Canada! (Hannah: Refugee)

Hannah was full of appreciation for the Canadian government, for the health care system that had been put in place. According to her, she had been to no other country that offered free health care services to people.

One thing I can say is that, every time I went to the hospital, they treated me very well. Good Canada! Here I go to hospital free and they will give you all the medicine also for free. You don't need to pay for anything. I was checked for ovarian cancer and they did everything for free. Back home you don't get anything for free. Canada has helped me so much because where I came from, it was very difficult and expensive to get treatment when you are sick. It was very bad. (Hannah: Refugee)

Refugees' health care access is sometimes informed by their cultural background, place of origin, health-seeking behaviours, and the kind of services they seek. Health service providers mentioned that they treated refugees in a safe and comfortable environment during health care

delivery, for which the refugees were grateful. Many health service providers asserted that their presence adds value to refugees' access to health care services.

I am open to seeing them anytime, any day, and one cannot forget to look at the very safe and comfortable environment we give to somebody who had come from their home to something entirely new. [...] Refugees are always thankful for the health care they receive from us and anything we do for them. (Delany: Health service provider)

Health service providers admitted that treating refugees is time-consuming because of the language barrier between them. They stressed that they provided simple and complex health care services to the refugees and also made the referrals, when necessary, for further diagnoses and treatment.

My patients tend to spend a lot of time when they have a lot of needs and I do spend a lot of time for them and do not rush in attending to them. For instance, there is this lady when I do see her; I continually spend more than 16 minutes with her depending on her level of need. I must admit it is sometimes very challenging. (Angelina: Health service provider)

A representative from the resettlement agencies also shared the same sentiment:

I will say it may affect me on the part that I had to spend more time at the doctors' appointments and also when there is the need to contact the doctor and the pharmacist on prescribed medication for clients that are not covered. (Sandra: Resettlement rep)

Both the health service providers and the resettlement agency representatives further revealed that some refugees were accompanied by their husbands or wives during appointments. The health service providers revealed that through that they are able to know the health need and concerns of the whole family and offer the appropriate support and care.

Some refugees will need to shift their appointments to weekends so they can have their husbands to accompany them during their visits. This helped us to know what their health needs and concerns are and give us the opportunity to assist and give them the needed health care as well as treatment. (Delany: Health service provider)

The health service providers emphasized that sometimes they encountered disruptions during appointments and also that there were significant challenges with documentation of refugee treatment of past illnesses and medical history since some refugees had no documents on their past medical records.

Childcare can present a challenge to refugee women's ability to access health care. One experience shared by a health service provider involved attending to a refugee who was accompanied by a child while receiving treatment during an appointment. She continued by saying sometimes refugees have to bring along their children when they have appointments since they have no one with whom to leave the child. The visit brought much disruption in the services provided, but at the same time, there were no options for the woman since she needed to show up for their appointments.

They sometimes bring along their children when coming in for appointment which can be disrupting I remember doing a pap smear with a baby on top of the mother because the child would not stop crying for the mother to go through it. The mother held the child throughout the whole process until she was done. (Angelina: Health service provider)

In addition, the way Canadians and refugees discuss their reproductive health concerns differ. Canadian women are open to discussing their sexual and reproductive health needs, whereas refugee women are conservative about their reproductive health needs. As Angelina describes,

There is the difference between Canadian women and refugees. Canadian women are more likely to discuss their reproductive health concerns unlike the latter. For example, Canadian women may discuss issues relating to their menstrual period such as the irregularities, heaviness, etc. They are also more likely to discuss their unhappiness with their contraceptive methods, complain and express concern over/with that area of their body (vagina) when there is lumps or discharge. Refugees, unlike the former, are always shy or a bit reserved when it comes to issues like this. (Angelina: Health service provider)

Perceptions/ Views of Health and Quality of Health Care. When I asked the women about their health status, each shared a story about her perceived health status. The women revealed that they and their families were generally in good health despite all the challenges they had experienced throughout their transition period. The majority of the women stated that since their arrival in the country, they had not experienced many health concerns. They expressed concern about the importance of being in good health, and the majority reported that their health was as good as it had been before their arrival.

As conversations continued with the women during their interviews, they said that being in good health was important to them for various reasons. They perceived that if one had not been to the hospital for some months, then one is very healthy. Other women also thought that the sign of good health is when one has no prescribed medications. One of the refugees said that she was doing well except that one of her children could not talk. She revealed that though the child had been assessed, he was still not able to talk. Other women also attributed their good health to their belief in God.

My son who could not talk is at the moment talking. I believe my son is talking a little because of God's miracle. I hope he will be able to talk properly someday. (Shelly: Refugee)

I was sick and when I went to the hospital, the doctor checked my blood pressure and was given a prescription to be taken to the pharmacy. I prayed to God to heal me and since then I have not fallen sick again. (Nora: Refugee)

The refugee women in this study shared their thoughts on and perceptions of the quality of care they had received. During the interviews, they expressed that though the health care systems were different and new to them, they compared the quality of care provided in their previous host countries to that in Canada. It was evident that all the women could not be happier to have such health care system in place, and they appreciated the policy of free access to health care for all. They recalled how expensive it was for to access health care in their previous host countries. On the quality of health care and services received by the women, some of them were grateful for and satisfied with the level of care services during visits to the hospitals, and to community and walk-in clinics. They attributed the quality of care received to the experience and professionalism with which the doctors discharged their duties. For instance,

Basically, what matters here in Canada is that it's peaceful and not like back home that anyone is approaching you might kill you. You'll always just freak out. You'll live paralyzed state all your life. Canada is so peaceful than South Africa. That's what matters most. (Hannah: Refugee)

If I want to compare health care in Somalia or Botswana to Canada, then it is like comparing zero to hundred. (Ivy: Refugee)

Some refugees revealed that the level of care among Canadians and non-Canadians, including refugees, was the same. There were mixed reactions of refugees' perceptions on some assertions and allegations of discrimination and racism discussed later in this chapter. Some women emphasized that there was no form of discrimination as far as the quality of care and services were concerned. Some women perceived that for every visit to the clinic or hospital, one must be given medication, but they were surprised when service providers asked them to go back without prescribing any medicine, stating only that they would be fine.

I don't understand the way things are done here that much, and it's going to take me some time to understand it. For health wise, I feel the people at the hospital are good; the only thing is they don't give you any medication; they will only smile at you. What they can do to improve the health care is when they check a patient and diagnose them for some sickness they should be given proper treatment that can relief the patient and make them happy. (Shelly: Refugee)

Refugee Access to Health Care Delivery. Given refugees' health challenges, many of which can be attributed to the pre-migration experiences, timely access to appropriate health care is essential to their physical and mental wellness, and their ability to settle successfully in Canada. Facilitating health care access is concerned with helping people to command appropriate health care services and their availability to improve refugees' health (Berman, Girón, & Marroquín, 2009). Four issues or themes that stood out from the interviews with the refugee women regarding their efforts to seek health care services. These are physical accessibility, availability of services, quality of services (discussed in the previous section), and cultural accessibility.

Physical accessibility. The women mentioned they mostly sought health care from walk-in clinics and community clinics, but they also sometimes visited city's hospitals, when they were referred for further treatment or diagnoses. The women mentioned that most often, their means of transportation to the health facilities was public bus services.

The majority of the women further spoke about how much easier it was for them to buy medications from drug shops or pharmacies without prescription in their countries of origin in comparison to Canada. Some of the women complained they were not happy with the health care they received from service providers in the city. Some of the women shared how they evaluated the health care services that are provided to them. Ferouza, for example, expressed her frustration:

When we took the child to the clinic in Superstore, we were then asked if the child is sick and we said yes; my daughter she is sick. The man there said okay, okay, okay! I told him that the baby is very sick and had pain. He just gave us the containers for stool and urine. Instead of checking the baby or doing anything. So we decided not to go back to him. We then went to another clinic. (Ferouza: Refugee)

Availability of Health Care Services. Some of the women said that when they arrived their resettlement agency counsellors, informed them of how to access health care services. The refugee women stated that their first appointment to see a family doctor had been booked before they arrived in Canada. The women mentioned that a series of medical screenings were conducted for them upon arrival. For example, cervical screening, diabetes, hypertension, cancer, and kidney functioning tests, among others. Some of the women further stated that they were happy that there is easy access to health information and that they did not need to struggle to get the necessary information on health care. Though refugees receive screening upon arrival, some of the women said they were not aware of the health care services that are available to them.

Though the women felt very comfortable accessing health care, they were not happy about some of the treatment they had encountered from some health service providers. They expressed their dissatisfaction when there were long wait times for schedule appointment made by their providers as well as making appointments to see their providers.

My family doctor has asked me to come back in three months for my next appointment.

I wonder if I get sick what will I do? You know three months is a very long time, and anything can happen. Sometimes, they will tell you when it is a time they will call you, but you will not hear from them. My appointment is up but since I haven't heard from them. (Mary: Refugee)

Cultural Accessibility. Some of the women shed more light on refugee women being uncomfortable to discuss certain health concerns when they were assigned to male providers. For example, Ivy said,

You know how the difference in cultural and religious beliefs play in our lives. Based on my cultural and religious beliefs, it is sometimes difficult as female to see a male doctor to complain about a certain sickness that concerns our private part. Besides, my religion doesn't support this. I think this is a very big problem and something must be done about it. (Ivy: Refugee)

One of the women commented on the perceived racism she had encountered during her access. Feruoza said,

I think there is a bit of racism towards the blacks than the whites here in Canada. I met an Algerian, who had at age 15 been kicked by someone when he was playing football. He got injured and started bleeding. When the father sent him to the hospital, no one helped him. He kept on bleeding for so many hours, from 8 p.m. to 6 a.m. No one

attended to him. I was just feeling sorry for him. That guy was complaining a lot. You can see the culture wasn't good; they weren't helping him. (Feruoz: Refugee)

Some of the women also mentioned of perceived discrimination during their access.

Some doctors are not friendly at all. When they are talking, they use a tone of voice that sound quite harsh and seemed they are angry or irritated. This makes it uncomfortable to ask questions when you don't understand what they are telling you. I don't think they do this to the whites as a friend also mentioned the same attitude by a doctor. (Ivy: Refugee)

When you go to see the doctor, they spend less time with you and do not assess your properly. They will quickly provide full medical instructions or explanations and will not explain things properly for you to understand. (Shelly: Refugee)

The women expressed that, they felt they were not treated well because of their refugee status. Because of these, they felt it was better not to seek health care whenever they were sick.

I went to the doctor after I had given birth to my daughter, I had my stomach swollen. He didn't give anything; he only gave me a painkiller. Africa is not like that. When you go to the hospital, you will be given medication but not here in Canada. You sit there for 3-4 hours and waste your time but when other people who are not refugees come they are quickly attended to and given medication. Sometimes I ask myself, is it because we are refugees' that is why they treat us that way. Now whenever I am seriously ill I don't go to the hospital, I ask myself what I gain from it. (Shelly: Refugee)

I went to the hospital when I had severe pain in my leg. I was not treated because they felt I was trying to get pain medications out of them. I was not diagnosed or help at all.

I was asked to go home and I will be fine. I felt I the doctor was insensitive about the pain I was going through and that I felt very discriminated upon. (Mary: Refugee)

In contrast to the negative experiences and perceptions outlined above, other women had these stories to share:

The doctor I went to see doesn't discriminate against anyone based on their colour; whether black or white she doesn't care which part the person is coming from. It is a good thing because it makes those of us who are not from here feel comfortable. (Hannah: Refugee)

Whether you are white, black, or refugee, everybody is treated the same. (Getty: Refugee)

I think the services for everyone here in Canada is the same. It doesn't matter whether you are Canadians or not. We are all treated the same way. (Ivy: Refugee)

4.4 Perceptions of Context: Resettlement Agencies Representatives and Health Service Providers

As the majority of refugees spend the greater part of their lives in refugee camps and temporary settlements before resettlement to a host country, they are exposed to trauma and limited resources, which lead them to develop a variety of acute and chronic health needs and concerns. Resettlement agencies representatives and health service providers know little about the health needs and concerns of refugees upon their arrival. This section discusses the perceptions of resettlement agency representatives and health service providers on refugee health care services.

General experiences. Refugees have unique experiences and stories they share with representatives when they arrive in Canada. These stories speak volumes of their agonies, plights, and endurance. Representatives from the resettlement agencies are sometimes seen by refugees as relatives, since they are always the first point of contact. In some instances, the refugees see resettlement representatives to be an integral part of their everyday lives.

Being the first point of contact for new refugees, we are assigned to be with them the first few months before they are transferred to someone else. We normally meet on a daily basis or, at least, three times in a week where we provide them with assistance and integration support such as housing. We, first of all, do an assessment to know their level of needs for each refugee. We also ask them closely the various kinds of help they need from us in order to build their trust. By way of communicating with them, they tend to build their confidence in us. (Sandra: Resettlement rep)

Another resettlement representative shared that building trust and relationships with health service providers and their counsellors does not come quickly for refugees; rather, it will take a little time for them to be comfortable in sharing their needs.

When you try to create that personal connection, people will then open up and start to share and talk to you about what is going on. I remember there was this client who was a refugee I saw one day who was really depressed; when I asked what the issue was, he gave me all his list of problems. When he came in and I was trying to register him, I noticed his birthday was in 2 days, so I asked him to come back in 2 days for an appointment. We walked him into one of the classrooms when he turned up for the appointment and there was a cake we had baked for him. We sang “Happy Birthday” and to our surprise, he said that is the first time his birthday has been celebrated since

he came to Canada five years ago. For him, he has found people who really care so much about him. After that day, he was able to connect with us as he needed to and we ended finding out what was really the problem. As a staff, we need to create the time this relationship with this people so that they will feel comfortable to share their story and problem. (Laura: Resettlement rep)

It emerged from this study that despite the support refugees receive from representatives of refugee agencies, refugees still had some difficulties in their integration process, making it challenging for them to settle smoothly into their new environment.

Refugees do not have access to their own vehicles and will need to use the bus service in order to access health care. Most often, they need to pick multiple bus services to get to the health care facility. This is sometimes frustrating and may discourage refugees to seek health care whenever the need be. (Sandra: Resettlement rep)

Erica, another resettlement representative, also stated, “The stress of trying to integrate here, the isolation, the challenges, the stress alone can contribute to ill health.”

Sources of information on IFHP. As mentioned previously, the IFHP is the main insurance body that pays for refugees’ medical services. In 2012, the IFHP introduced cuts to refugee health care services. Notwithstanding the rapid changes to IFH policy, the two professional participant groups—resettlement agency representatives and health service providers—expressed their lack of information surrounding the cuts to the IFHP. This is problematic because these two groups of people are the primary sources of assistance for refugees.

The majority of respondents’ resettlement agencies and health service providers showed that there was no formal communication from IFH about the cuts to the IFHP. Poor communication existed between the various participant groups, and they had to depend on other colleagues or sister

agencies across the country to be informed about the cuts. In some cases, the participant groups had to do their own online research to find out more about the cuts. Reflecting his views on the source of information on cuts to IFHP, Delany, a health service provider, stated,

I got to know about IFHP when I first started working with this population years ago where they come with a piece of paper which has their photo on it with their immigrant refugee status on it where their health care access is covered for a whole year, but I think they no longer have that coverage. Immediately they come in as the refugee; they are issued health card where they have access to health care. It will interest you that though they have the health card that gives them coverage, certain things and treatment are not covered. (Delany: Health service provider)

Representatives from the resettlement agencies stressed that there was an emerging communication network within the city, which was helping to circulate information among the agencies. Some of the refugee agencies received information on the cuts to health care from the Canada Immigration, Refugee and Citizenship Canada offices in the city. Some of the participants revealed the federal government made all information about the cuts available on the governmental websites. Andrew, a representative from one of the resettlement agency, said,

There is no system in place to inform people formally when there are changes or not. Informally, agencies get to know when there are changes either by visiting their website or when someone tells you about it but not directly coming from them. I will say, there are some networks building in the city which connect you to new and different sources of information.

Other representatives mentioned there were multiple sources of information on the cuts for resettlement agencies, yet they were not aware of all the entitlements for the refugees. As a result, of this, several refugees had been denied access to health care.

The health service providers stated that poor communication exists between the IFHP and health service providers. They mentioned that any changes made by the IFHP concerning refugees affect service providers' delivery to the refugee population. Therefore, it is necessary services providers be informed at all time when any changes occur. According to Delany, a health service provider, "The IFHP is an establishment that constantly keeps changing things and coverage concerning refugees where one will hear or have to read to know of any changes."

Perceptions of IFHP cuts' effects on refugee health care utilization. According to representatives of resettlement agencies, refugees are not as healthy as they may seem, and they have varied health concerns that need to be attended to before they can be considered healthy. The representatives stressed that if refugees are asked to pay for their health care, then the health status of refugees will decline since they will not be in a position to pay for services. Given this, they felt refugees would decrease their utilization of health care services when they need to, and that would increase the risk they are exposed to by complicating and jeopardizing their health.

Healthcare providers who participated in this study also believed that health care should be accessible to all refugees, regardless of their category. The health service providers asserted that the different categorization of refugees were making it difficult to provide adequate health care to refugees, especially refugee claimants. They mentioned that the health conditions of refugees would worsen if refugees do not receive the needed health care services for untended health needs.

In situations where refugees will have to pay for health care services, I think there will be a decline in the number of people who will access health care services and this may

diminish their health leaving them at risk. In my opinion, I think Canada as a country should be able to provide health care to people who are coming here to asylum-seekers. (Angelina: Health service provider)

But I don't think it's okay to categorize them regarding coverage. Refugees should be covered as refugees and not according to the way they crossed into Canada. (Erica: Resettlement rep)

Despite the difficulty encountered by health service providers in accessing information on IFHP, they continue to provide services and necessary care to this group of people.

The health service providers revealed that under the IFHP, there had been some documentation of refugees who had been refused care. They stressed that if refugees who have refused services were tracked and monitored, it would help to reveal the number of refugees who were not receiving health care services. Although health service providers from local clinics and hospitals are filling the gap by offering a range of high-quality health care services for clients, it was established that the cuts affected health care negatively and reduced services for refugees. The health service providers emphasized that due to billing issues, some patients were being turned away by some providers since their services were not being paid by the IFHP. As Angelina, a health service provider, stated,

Billing for refugee health services are done differently than people who work in other services. For instance, in my case, my pay is not dependent on the number of refugees that are billed based on the services I provide them. We have an alternative way to see patients without getting them to pay anything [...] but for the fee for service physicians

or clinicians will have to bill them to IFH and it is always the billing issue. It is a bit of a hurdle for health service providers to have to get over.

4.5 Captivating Stories Emerging from the Study by Health Providers

Most often, little is known about refugees' health needs and concerns, and there is the need for proper examination and needs assessment by health service providers upon the refugees' arrival in their new host country—whether Canada or elsewhere. In this regard, the need for timely access to appropriate health care is essential to their physical and mental health wellness, and their ability to settle successfully in Canada. In light of this, health providers are working to ensure the quality of services provided to refugees and to eliminate the barriers they face in health care utilization.

Both health service providers and resettlement agency representatives revealed that they deliver services to every individual in the country, including vulnerable populations like the refugees. The services provided by health care providers are not limited to any particular gender or group. They also provide referrals to specialists when cases require specialized assessment, diagnosis, and treatment.

Education/advocacy. Health service providers stressed that they offer their services for those people seeking health care within a safe and comfortable clinic environment. Providers go an extra mile to spend quality time during the appointment to make sure all refugee health care needs are met. In some cases, refugees were taught about how to access health care during their appointment.

Most of the refugees need little or no immediate health care or intervention. They come to see me but what really takes a lot of time is teaching them about how to access medical care, what is appropriate, and the idea of provided health care which is very foreign and new; especially the idea of going to see the doctor once or twice a year

when not sick becomes odd for them. Having the time to educate refugees when they are see you about optometric, dental, gynecologist, the importance of diet, physical activity and mental health is vital. (Angelina: Resettlement rep)

The participants suggested that with the introduction of cuts in refugee access to health care, there was the need for intensive education for refugees to address their various immediate health needs, which deserve immediate attention or intervention to reduce refugees' health concerns. Delany shared that educating refugees about how to access appropriate health care is vital, although it takes a lot of time to get refugees to understand how the Canadian health system works.

The refugees normally are taken through the various steps and procedures in accessing health care services. They are constantly reminded to use walk-in clinics or the emergencies when they have to access health care since they will need appointments booked before seeing their primary physicians. (Delany: Health service provider)

Healthcare providers also revealed they act as advocates for refugees through community mobilization and activities that promote health care access for the refugee population. Health service providers explained that with the introduction of the cuts to refugee health care services, the service provision for health care delivery is still the same for government-assisted and privately sponsored refugees.

Refugees may just leave the pharmacy without getting their medications. My personal experience dealing with the language barrier is writing a note to the pharmacist "language barrier; please show them where they can buy their medication and the cost involved." (Delany: Health service provider)

They mentioned that the cuts to the refugee health care access program were complex and challenging to understand. They felt health care delivery to refugees had been reduced, leaving some refugees at greater risk. Some health service providers were disappointed by the cuts to refugee health and asserted that the Canadian health system had failed to provide refugees with adequate and quality health care.

In situations where refugees needed to access health care and had limited health coverage to access health care, health service providers and resettlement agencies representatives went beyond their duty in ensuring these refugees received the needed health care.

We sometimes take them to the University Hospital where they have the option to have payment plans for their health care services by paying \$50 every month towards their health care services. This is an instance where refugees are not covered for a particular health service under the coverage. We also aid them in securing their spectacles by not going in for expensive frames but cheaper one with the same lenses. In other situations, where our clients are given medications that are not covered under IFH, we contact the doctor to change the medication to a different one with the same effect. I normally inform the doctors about the limited coverage of the clients and if it will be possible to check first on the various medications that will be given to the client to see if it is covered or not. (Sandra: Resettlement rep)

An older lady who just came into the country was diagnosed with cancer; she was arranged to see a surgeon immediately and had surgery right away. After her surgery, she had the appropriate home care and everything was done fairly quickly. Except for few hitches on the part of the pharmacies in instances where they do not cover

everything but by and large, they have been pretty good. [...] I have met only one family in that sort of predicament. Though they had no coverage, it was great and wonderful to come to their aid although I do not know how other things they need went for them since I met them for a very short term. I cannot tell if they moved out of the city or they are still around. In my opinion, it is a very difficult thing for them or any refugee without coverage to navigate. (Angelina: Health service provider)

Delany also had this to share to underscore the extent health service providers go to ensure refugee get the health care they need, since they may have no jobs or limited benefits that could help cover their health care access expenses.

Since refugees may have no jobs and benefits, or health coverage will cover, there are certain things that I will have to come in to ensure that they have health care access. The majority of the time, we are able to work around it just that it takes extra time. (Delany: Health service provider)

Despite the fact that both health service providers and resettlement agency representatives went to extra lengths to provide refugees with the needed health care services, they realized that it was difficult to track down refugees without coverage to know how well they did after they had been treated.

4.6 Personal and Social Barriers to Access

Refugees encounter various barriers accessing health care, barriers that often lead to decreased utilization of the health care services required by refugees. This may worsen the health and concerns of refugees by posing increased risk and complications, as well as resulting in low utilization of services, which can be a major threat to access to health care services. Despite the

high levels of satisfaction with the Canadian health system and the health care facilities, several of the women had difficulties accessing health care.

Language, communication, and interpretation barriers. Language and communication are primary barriers encountered by refugees in their access to health care service. All the participants in this study established that language and interpretation were a huge barrier with regard to providing refugees with health care services. It is important for one to have the ability to speak and communicate in the language of the country of one's settlement during all stages of seeking health care services. Due to poor English language proficiency, it was difficult for health care providers to schedule appointments, and to understand and diagnose accurately. Because of this barrier, refugees were not able to make appointments for themselves, and may even turn up at a later incorrect time/date because of their struggles to come with family members who may be working during the day to help them with the language.

The women interviewed recalled situations where they had to call on family relations or counsellors, among others, to accompany them to appointments. The majority of the women stressed that though there is computer software for translation available, most health facilities do not have it. As a result, the women disclosed that they were sometimes unsure of the quality of translation by the families and close friends, since they are not providers.

Sometimes we go there with a translator or somebody who we think understand the English language, but we are not sure if the person is telling the doctor exactly what the problem is. Also, we don't know if he is also telling us exactly what the doctor said. There is also no privacy when you are talking to the doctor about some problems, and there are other people there. Since I don't understand English and I prefer to go to the hospital with my husband or son to help explain things to me. (Getty: Refugee)

The health service providers established that due to language and communication barriers, misinterpretation of health needs and concerns had a significant toll on the quality of health care provided to refugees. They stressed the difficulty of having a proper diagnosis as a result of the barrier to communication between the providers and the women. Lack of proper communication and language difficulties also had a negative impact on health conditions during times of emergency. The providers revealed that although there are interpretation and translation services available in health facilities to help facilitate health care delivery to people who may lack fluency of language, interpretation and translation services are not available to all as it is deemed expensive when refugees are asked to pay for such services. As Angelina, a health service provider stated,

I am very fortunate to have access to the phone in interpretation that is medically trained translators so that I can see patients without a translator/interpreter [...]. There is already a company that is providing that services, and it does not need a lot of logistics to get this; it is fairly easy just that someone has to pay for it. I feel all one need is to subscribe and have an account with them.

Also interpretation and translation can cause significant communication barriers to occur, with the distinct possibility of misinterpretation and miscommunication. Although some health service providers resort to technological forms of interpretation to reduce language and communication barriers, this service is not available in all health facilities.

Refugees are not able to understand what the physician is trying to communicate to them. As a result of this, refugees face so many difficulties when they visit the doctor without an interpreter or a family member who can communicate in English and then play the role of a middleman for them to understand and receive health care services. Most often refugees

do not have family doctors who speak their languages. Most often, refugees do not have family doctors who speak their local languages which make it difficult for them to understand the family doctors in their health care. (Sandra: Resettlement rep)

Delany had also found a way to better communicate with patients with the language barrier. She said,

In my situation, I have worked with the Government institution where we used to use translators, so my experience working with translators work for me in dealing and helping this population. (Delany: Health service provider)

In all, taking into account the limited time available to the provider considering the volume of patients they have, the language barrier makes interpretation difficult. It was evident health care providers found it difficult to find interpreters for refugees' various languages. Health service providers mentioned that they were relying on the interpretations of volunteers, which sometimes might not depict the actual state of the diagnosis.

When family members try to help with translating from English into their local languages, it is not easy to do so. Sometimes when they bring in a translator whose English is terrible, you tend to ask yourself how well the conversation went, and also you wonder whether the right information was passed on to the refugee. (Angelina: Health service provider)

Health information of refugees. It was evident health service providers had difficulty collecting health information from refugees. Refugees may fall through the cracks, as important health concerns might be unnoticed during health care delivery. Health service providers emphasized that often there are concerns of refugees unable to receive continuous care for their health needs, and this may lead to episodic care. According to Angelina,

The big piece that is missing so far as continuity is concerned since it has to do episodic care, there is very little to talk to refugees about preventive health, lifestyle. Engaging communities on things that promote well-being not necessary relating to their blood pressure or blood sugar, they have a tough time.

Disruption in scheduling appointments. Other barriers that were mentioned were the complex situations under which health service is provided to refugees. It was revealed that refugees were engaged with school (ESL classes), work, and helping to take care of their young children. These activities made it very challenging for the health service providers to schedule appointments with them.

Some these refugees are so busy with school (ESL classes), work and helping keep their young children, so it is very challenging scheduling appointments with them. They will never come for an appointment when they are working since some of them are working on a low pay part time job. They will rather choose work rather than come to see a physician or a specialist. As a provider, you always have to think of how you can make things work for them so they can go to work as well as their English classes.

(Angelina: Health service provider)

Transportation barriers. As with the refugees, the providers also mentioned that transportation as another barrier to health care delivery. All the participants in the study mentioned that sometimes they need to connect with multiple bus services before getting to their destination, which means they may not be punctual at appointments due to lack of individual transportation. All these factors reduce the likelihood of a person successfully making and keeping their health care appointment. The refugee women mentioned that they sometimes got on the correct bus, but became confused as to what stop they needed to get off at and were unable to ask. However, some

of the women also shared how they kept picking the wrong bus, which made them late or caused them to miss their appointments.

Socio-economic context/barrier. Resettlement agencies' representatives take the time to explain to refugees the various health care services that are due them during their time of resettlement. According to these representatives, the majority of refugees live below the poverty line, which makes it difficult when they have to pay for health care services when they are not on benefits; as Laura stated, "With most refugees living below the poverty line, little is known about refugee past health concerns, needs, and history." Andrew, a resettlement agency representative, had this to share on refugees living below the poverty line:

I think about 99% of the refugees are living under the poverty line and cannot afford private medical bills like dental care without benefits. I feel if refugees are able to get access to basic jobs, there will be no problem when health care benefits are cut since they will not be able to afford health care on their own. On the other hand, people with better jobs will be able to afford health care no matter what the cost. (Andrew: Resettlement rep)

Furthermore, there were situations where resettlement representatives thought refugees were not happy with the schedules and treatment that were given to them by their health service providers. Although the government is trying hard to give refugees the needed health care, there is room for improvement. They think the government is not being fair, as far as refugee health care delivery is concerned. As Erica, a resettlement rep, stated, "I feel that they are not fair to their agreement. [...] IFHP program is supposed to be funding refugee health care. How can you say one thing and doing another."

Cultural/religious barriers. It is evident from the findings that health service providers are faced with cultural barriers in providing health care to refugees. They mentioned in some cultures, women's health is not necessarily seen as a priority. Despite this revelation, refugee women in this study have seen the benefit of accessing health care in Canada.

It will interest you to know that despite the differences in the way of accessing health care by refugees in their home country and their new host country, they are embracing the new way of accessing health care, and they are quite keen on seeing a physician for assistance. (Angelina: Health service provider)

It was also revealed by health care providers that refugees' first visit to a health care centre is influenced by their cultural and religious preferences, which determine their choices and health-seeking behaviours. Some refugees may find it difficult to talk to health service providers about certain health concerns/needs. Therefore, health service providers will need to give refugees ample time to discuss those health concerns when refugees are ready to open up.

Most of the time, the first visit by refugees is awkward since they are always accompanied by their settlement translator/counsellor or community member. They are often or not the same gender so sometime in their visit, particularly Muslims; it's very difficult to ask questions concerning their reproductive health since it makes them very uncomfortable. I normally take my cue from the patients through their gestures and body language to see how comfortable they are. I often ask about their menstrual cycle etc. and this may help with how the conversation will go. In cases where patients are not ready to talk about, I do not persuade them to do so or go there. Sometimes, you need to give patients some time to get to know you and figure out if they are good to discuss issues of that nature with you. (Angela: Health service provider)

In some cases, the refugees mentioned that they were not comfortable receiving health care services from male health providers during their visits to their health care centre.

Some refugees are not comfortable seeing a specialist or doctor who is of the opposite sex. The refugee population we deal in are mostly from the Muslim countries and as part of their culture, are not comfortable to talk about or answer questions regarding some of their health concerns particularly issues concerning birth control issues and their reproductive health. Sometimes, patients will go and see fee for service physicians as providers but due to the gender of the physician may come over when they receive their pap smear letter. In such instance, I tend to have more patients or workload which demands more from me. (Angelina: Heath service provider)

Although different cultural practices of refugees most often created some barriers to refugees' health care access, there are important ways through which refugees' cultures help resettlement agencies to provide and offer health care that is respectful of people's cultural differences. As Laura, a resettlement rep, stated,

Having a cultural interpreter is a good thing to understand the cultural barriers and what they might be taking but that is part of the assessment which is happening at the moment. (Laura: resettlement rep)

Complex health care delivery. The health service providers revealed there were complex service provision under the IFHP. They mentioned that they did not rely on the directives of the IFHP in the city, but went ahead to provide services to refugees as needed and required.

I attended to a pregnant female from Zimbabwe who was HIV positive and had no coverage for health care, I had her fees waived off so she could be seen here at Appleby Drive since not most places do not do that. We normally do this most often so we can

provide as much care as we can as far as healthy positive pregnancy is concerned.

(Delany: Health service provider)

The above anecdote reveals a situation where health service providers had to intervene and provide health care services without any cost or fee to an individual who had no health care coverage. Normally, physicians or nurse practitioners recommend services that refugees should receive and ensure that the refugees are provided with the appropriate service, especially in situations where they are not covered by the insurance. This is done by explaining need for the individual to receive the service.

Health service providers emphasized that refugees in the city receive all the needed health care services without any difficulty. However, with little or no information on the IFHP, some providers did not understand the whole system of the IFHP in service delivery in the context of the cuts. The complex billing system is another factor that affects health care access. Health service providers emphasized that it is sometimes confusing to know which services and medications are accepted under the IFHP.

4.7 Impact of the IFHP on Refugee Health Care

According to the participants from resettlement agencies and health service providers, the IFHP cuts had a significant impact on refugees' health care delivery in their health care access. Since the introduction of the cuts to refugees' health care access by the IFHP, the findings reveal there had been inequities in service provision. The cuts brought about some disparities in services that are available to government-assisted refugees and privately sponsored refugees. The participants also mentioned that the lack of communication by the government regarding changes that affect refugees' access to health care affected health service providers in their service provision since they do not know what services were covered for refugees. Furthermore, the

participants mentioned that the IFHP was confusing, difficult to deal with, and provided limited service delivery for refugees. They emphasized that some health service providers were not comfortable with the whole IFH program. As Erica, a resettlement representative, stated, “The confusion has only gotten greater, perhaps [...] it’s hard because you know, it’s not covering everything”. (Erica: Resettlement rep)

While some participants stated that the cuts to the IFHP had a significant impact on refugee access to health care, the majority were of the view that the cuts to refugees’ access to health care had not affected service provision. Rather, they felt, whether there were cuts in refugee health access or not, service delivery for refugees was more or less the same. Laura, a resettlement representative, stated:

I don’t see, and I don’t think there is any impact of the cuts on refugee’s health access. We try to see from the perspective of the newcomer who may not know about if they are missing out on something or whether it existed or not. But maybe if we should see it from the perspective of the health service provider, then we will say yes. For the newcomer’s perspective, we work with what is available at all times. What we do see is that it can be difficult sometimes to have access to some services since it is not every health care service that is accepted by IFH. So what we have noticed is that sometimes, access to service is not open even when it should be. Comparing Saskatoon to other provinces or cities, I would say Saskatoon is far better since refugees are not denied access to health care service and the impact is so huge. The health practitioners in Saskatoon are always ready to provide services to the refugee population whether they have coverage or not.

Furthermore, representatives from the resettlement agencies revealed that the cuts to refugees' health care access resulted in strict requirements for accessing some health care services such as dental care and X-rays. These make it very stressful for refugees during their access to health care services. As Erica, a resettlement representative, stated:

For dentistry, your health provider needs approval from IFHP before actually doing it.

I've seen some people who have done an x-ray, they have to call their immigration number before they can perform the x-ray or dental service.

Andrew, a resettlement agency representative, was of the view that refugees' education and health needs deserve more attention from the government.

I think the two most important services for every individual are education and health.

If you look at every province in the country; you will realize that most of their budget is allocated to health and education. So if services are cut for anyone either or official or regular regarding of health or education, this becomes a challenge for all of us.

Instead of putting in more money, we end up cutting it. I find it necessary to provide them with all the services once we bring them into the country.

He further stressed that despite refugees having perceived health needs, there is the need for skills training for all refugee youth to equip them so that, within the first few years in their resettlement, they would not be a burden on the government. As he stated, "Concerning education, the focus should not be university education but others like polytechnic and other trade schools which will help them to gain some skills for employment." He stressed that with these skills, they would be employed and their access to health care will not be a problem. To buttress his point, he further stated that there is a need to get refugees out of isolation, which can be done when they have economic opportunities available to them.

There is the need to get them out of isolation and this can be done once they have economic opportunities and independence. This will not make them economically sound but it will also help them with their mental health issues. Once someone is living in isolation, it reminds them of where they come from but they can be useful not only to themselves but also to the community. (Andrew: Resettlement rep)

Also, participants were of the view that IFH should have communicated with health providers and cleared the misconceptions on the cuts to refugee health care delivery. As Erica, a resettlement representative, stated, “The misconception around the cuts and the fact that you need to look at the category. This is the case in which the category matters and to remember that access is for all.” Some participants felt the Canadian health care system could do more to deliver health care to refugees. They expressed that there should be more advocacy work to put the health needs and concerns of refugees to discussion to reduce the risk.

I will not say it has failed but rather I will say it need more research and evidence based information to take a step forward in implementing evidence base policies. If any government should work on those gaps using this lines, there will be more opportunities and chances on more funding to assist these population groups. (Andrew: Resettlement rep)

I think there is the reason for improvement and I think that is what our PATH program is all about. We trying to make things better. The potential is there but I don’t want to complain about what we have. I am appreciative and I realize that we have something good. Because of that, I want to make it better. (Laura: Resettlement rep)

4.8 Conclusion

In this chapter, the stories and interpretations of all study participants, were explored. This chapter began with the past migration experiences of the refugee women and their journey. Refugees' health concerns and how their access to health care utilization was also explored as well as the perceptions and views of health and the quality of health care refugees receive. One interesting piece that came up in the study result was perceived discrimination and racism of the refugee women. More light was shed on the various perceptions of representatives of resettlement agencies and health care providers on refugee health care access. The chapter also shed light on the various health care barriers that impede refugee health care access. The chapter further described the alternate ways representatives from resettlement agencies and health providers provided the refugee population with the quality health care services during their access.

Chapter Five

Discussion and Conclusion

5.0 Introduction

This thesis focuses on refugee access to health care services, which is an important element of refugees' health. In this chapter, the major findings of the study are discussed, and compared to literature on the themes identified, including how transitioning experiences influence refugees' access to health care services. Refugees' overall health care access, as well as challenges and barriers affecting refugees' health care access and knowledge of health care systems and services, are also examined in light of relevant literature. Lastly, the chapter discusses perceptions of and satisfaction with access to health care services, as well as the impact of the cuts to the IHFP on the delivery of health care to refugees.

5.1 Summary of Major Findings

Here, a summary of the results of study's results is presented, as participants shared their stories concerning women refugees' access to health care services. The women refugees shared many painful experiences they faced throughout their journey to Canada. Traumatic and painful exposure to torture, abuse, and imprisonment formed part of refugee women's transition, which had a substantial impact on their physical and mental health. While fleeing their country of origin, the women lost relatives, loved ones, and friends, as well as property and livelihoods.

The study revealed the overall quality of services offered to refugees and their level of satisfaction regarding these services. As refugees enter the country, there is always variation in the various health care services, compared to what they have in their country of origin. Also, the refugees shared their concerns of long waiting periods—up to several months—before appointments are scheduled to see their physician. Further, the women revealed their

dissatisfaction with treatment and the consistency of service delivery. The women were disappointed by not receiving prescribed medications for health concerns during visits and appointments.

There is one potentially interesting finding regarding discrimination and racism. The results indicated that, there were varied perceptions regarding discrimination and racism which interferes with refugee access to health care. Among those perceptions, are several women who perceived discrimination. The observation in the results is unknown or undiscernible if there are actual experiences of discrimination and racism or it is the misunderstanding of how the health system works. Although the resettlement agency representatives and the health service providers did not mention in the results whether there is any form of discrimination, some of the women were very positive about service providers while some women were negative regarding service providers. It will be very surprising to service providers to hear that some refugee women think there is some form of discrimination in the services provided.

The health service providers, meanwhile, expressed concerns with the cultural dynamics or traditions of refugees, which prevent some refugee women from receiving screening, prevention, and treatment services from medical practitioners of the opposite sex. They also discussed the challenges experienced when providing services to the refugee population, including differing cultural expectations, poor access to interpreter services, and communication issues, which proved to be the most significant barriers. It was also revealed that the cultural and religious beliefs or preferences of refugees can interfere with and determine individual health-seeking behaviours towards health care services. Though health care access is important, some cultures do not recognize women's health as a necessary priority. Socio-economic issues such as transportation barriers are also among other challenges that refugees faced in accessing health care.

This may worsen the health concerns of refugees by posing increased risk and complications, as well as low utilization of services by refugee populations, which could be a major threat to health care access.

Lastly, the study revealed that despite the IFHP's role in refugee health care, there was no formal communication about the 2012 cuts to the IFHP between health service providers and resettlement agencies that provide services for refugees. Both health service providers and resettlement agencies mentioned that poor communication existed among the refugee service providers, and there were instances where resettlement agencies had to depend on colleagues or sister agencies across the country to be informed about the cuts. In some cases, the participant groups had to do their own research to find out more about the cuts. The participants also noted that the lack of communication provided by the government regarding the cuts that affected refugees' access to health care was confusing, difficult to understand, and had limited some service delivery. Another related concern raised with the introduction of the cuts to IFHP was the complex and complicated billing systems that were associated with refugee access to health care.

5.2 Refugees' Transitioning Experiences

The study sought to examine the experiences of refugee women in their first year of resettlement. This section sets out to compare those experiences with literature that explores them in other contexts, using the transition framework introduced earlier.

In chapter 2, frameworks were introduced and discussed as involving three phases of transitioning: pre-migration, migration and post-migration (Bhugra, 2001; Bhugra & Jones, 2001). The sample population for the study were primarily in the post-migration stage of their transition process. However, the participants' stories revealed aspects of each phase and these are briefly explored below.

Pre-migration. The pre-migration phase of refugee transition is mostly unplanned, as many refugees tend to escape danger in their home countries, searching for safety without a planned destination in mind (Bhugra, 2001; Bhugra & Jones, 2001; Wessels, 2014). As many refugees have experienced traumatic events resulting in psychological and physical pain and trauma, refugees may be battling depression, anxiety, and PTSD, leaving them with a greater risk of mental health concerns (Ali, 2002; Dillmann, Pablo, & Wilson, 1993; Norredam, et al., 2004). As described in the literature, these issues continue to affect the lives of refugees, leaving them emotionally troubled.

In the women's stories, experiences were relayed that corroborate this literature. Some of the women in the study lost relatives and friends, children and husbands. They reflected on the way that they had died, or were lost, and those reflections were laced with sadness. Some lost livelihoods, businesses, or possessions, and all talked of loss and of pain. Surprisingly, no women cried during the interviews, even as they relayed deeply troubling and difficult stories.

Migration. During the migration phase, as they are fleeing their home countries, refugee women are often subjected to painful experiences; some due to their exposure to torture, abuse, and imprisonment during their transition (UNHCR, 2014b; Edwards, 2012; CIC, 2015). Some also experience physical pain and injury while fleeing to safety; these physical problems can include, for example, bone fractures and head injuries, but also other health concerns such as hypertension, diabetes, or acquisition of infectious disease like STIs (Ali, McDermott, & Gravel, 2004; Beiser, 2004; Gushulak & Williams, 2004; Shaw, 2009; UNHCR, 2014b; UNHCR, 2015b). As discussed in the thesis, there are many traumatic events and health concerns experienced during this phase.

As recounted by the women in the study, the migration phase of their journey was filled with traumatic events encountered in refugee camps or asylum-seeking centres, where routine or

normal life was hard to establish. While safe from the threats that characterized life in their home country, the processes of negotiating assistance, legal recognition, family reunification, etc. in the country of asylum were frequently experienced as highly stressful, with the conditions and circumstances of many refugee camps significantly adding to this. Many of the women in the study recalled frequent threats and attacks from citizens of their host nations and the fear of forcible repatriation and possible jail term in prisons.

Despite some access to health care in refugee camps, the women talked of enduring difficulties in accessing appropriate health care; some had no medical documents upon arrival in Canada. Some of the women recounted experiences that included physical injuries—one had been shot in the leg. The women also encountered many dangers to their health as basic necessities such as food and lack of clean drinking water were problematic, leaving them malnourished.

Skeldon discussed in the literature is how this phase can also lead to positive, life-changing events. For some of the women in this study, the migration phase was an opportunity for them to build new families, friends, and relationships. As recalled by one of the women, she met her husband when she relocated to a refugee camp. For refugees who are needing to confront their losses and develop a new sense of hope for the future, these new partners, families, and friends provided emotional and social support to combat depression and emotional distress. These new social networks were a significant support offsetting the many difficulties, including symptoms of depression.

Post-migration. The third phase of transitioning sees refugees safely arriving in a host country (Bhugra & Jones, 2001). Transitioning by refugees into host countries entails their leaving behind familiar cultural norms, beliefs, and values as they embrace and begin life in a new country with unfamiliar customs, social conditions, and language(s) (Padilla & Perez, 2003). The first year

of resettlement will be the most difficult period for acculturation, adaptation, and integration; refugees who do well exhibit resilience and a strong will to survive such difficult conditions (Bhugra, 2001; Bhugra & Jones, 2001).

Though beginning their new lives was accompanied by many kinds of stress and depression, the refugee women in the study revealed that they had received tremendous support and had experienced feelings of acceptance upon arrival from resettlement agencies and the people in the community. For the women, it was also useful to be introduced to other immigrants or refugees from their home country who had successfully resettled into society, and who could provide them with social support and help them to meet other local people from their country of origin. This kind of support appeared to help greatly improve the psychological health of new refugees.

Indeed it would seem that not all immigrants and refugees are equally negatively affected during the integration process. While all the participants were confronting issues relating to housing, job opportunities, and insufficient financial assistance, they did not openly exhibit the kinds of issues regarding the post-traumatic, psychological, and mental health needs after upon arrival in Canada that are so commonly noted in the literature. Yet, among the women in this study, some expressed being on their way to recovery from this phase of the experience, and others expressed relief and peace in their lives at the present time.

Affordable and appropriate housing is an important requirement for refugees' smooth integration. The refugees' cultural norms and notions of safety and comfort are of great importance to the choice of housing as well as their location of settlement. Generally, there was a preference to share common space with neighbours from the same ethnic background, town, or country of origin since this may have a better understanding among themselves where they can give and

receive support from each other. Often, the refugees received temporary or permanent accommodation upon arrival, through the assistance of Saskatoon's resettlement agencies. The suitability of the location depended partly on the individual circumstances of each refugee. For example, two women struggled with living in high-rise buildings. One participant had a visual impairment that made navigating multiple levels of stairs difficult, if not dangerous. One who had physical mobility issues due to the injury she had incurred en route also disliked stairs and complained excessively about them during the interview.

Generally, literature on the refugee transitioning phases was supported and confirmed in the study with little significant differences in the findings. However, there was some ambiguity in feelings and experiences of health care access—a point to which I now turn.

5.3 Barriers to Refugees' Health Care Access

Aday and Anderson (1974) suggest refugees face challenges with health care access. This section discusses barriers that the refugees in this study face and the ways health service providers attempt to address them. A barrier to health care can be defined as anything that prevents the use of health services by making it difficult for some individuals to obtain, use, or benefit from care (CIC, 2015; UNHCR, 2011a; UNHCR, 2015b). Using Aday and Anderson for this study was useful, even though the model was not developed for the refugee population, because it incorporates determinants that intersect with refugee access to care. The Aday and Anderson model also echoes the intersectionality perspective used in the study by laying out some of the factors to which attention needs to be paid to. For the purposes of this study, barriers to access and the ways they were addressed by health service providers are based on these categories: language, interpretation and communication, socio-economic status, and cultural and religious beliefs.

Language and communication barriers. Several studies have examined barriers to adequate health care utilization that contribute to health disparities between minorities and the majority population (Laroche, 2000; McKeary & Newbold, 2010). Language and communication between refugees and their health care providers are considered a major barrier that limits refugees' health care access (UNHCR, 2013). Barriers relating to language, interpretation, and translation pose great difficulty in health care access and health promotion for refugees in Canada (McKeary & Newbold, 2010).

As revealed in this study, the majority of refugees who arrive in Canada, including those in my sample population, are from non-English-speaking countries and, as such, may not be functionally fluent in either of Canada's two official languages. In the health care setting, making sure that they were able to explain their medical needs and to understand information provided to them was mentioned by all as a real challenge.

Results from this study also confirmed the assertion that language difficulties, both from a provider and a client perspective, impact service provision, particularly in terms of capability to read and understand medical instructions and prescriptions. In addition, it can be very intimidating when refugees are unable to understand health providers' descriptions of their diagnoses and proposed treatment. In the same way, existing literature stresses that miscommunication between refugees and their health care providers due to language barriers, was perceived to be the most important health care access barrier (Shaw, 2009; Swinkels, Pottie, Tugwell, Rashid, & Narasiah, 2011). From my experience of the study, I would add that language difficulties also limit the capacity for research on health care access.

Finding a suitable interpreter or translator causes further problems and often delays appropriate health care when most needed. Although it is a problem when the patient is unable to

communicate with the health care provider, engaging the services of professional interpreters to assist during consultation was felt to introduce different issues. Health care providers wondered at having the third-party interpreter present during a medical examination, thinking that presence might compromise the confidentiality of the refugee. They expressed concern about accurate interpretation, as well.

Another challenge occurs when several different interpreters are used for the same patient. In situations where there are inconsistencies in the usage of interpreters, refugees will have to re-tell their stories through different interpreters, which further increases the possibility of compromising refugees' confidentiality (Pottie, et al., 2011). A study also by Meyer confirms that when family and friends are used as interpreters, they may translate incorrectly or may leave out some of the information, which can potentially lead to a wrong diagnosis (Meyer, Pawlack, & Kliche, 2013). As in the literature, this study found that health service providers currently make use of various interpretation services, including by phone and face-to-face. However, in the study, not all health providers know about these services or use them. This study suggests that to bridge this barrier, all health providers should be given access to translation technology—such as phone interpretation and face-to-face interpreters—to aid in alleviating language barriers, as in emergency situations, there may not be time to find an interpreter or to deploy an interpretation service.

Socioeconomic barriers. Socio-economic barriers also affect refugees' access to health care services. Refugees' level of education influences how they access health care services and affects their level of knowledge and understanding of health issues, as well as treatment of diseases (Gabriel, Morgan-Jonker, Phung, Barrios, & Kaczorowski, 2011). The study found that the majority of refugees had a relatively low level of education; when that fact is combined with the

linguistics barriers noted above, it would seem no surprise that there was difficulty in finding out what health services were available to them, understanding what was available, and making full use of these services. In addition to educational limitations, the majority of the refugees in this study were also of lower socioeconomic status, having lost their livelihoods during the wars and conflicts in their home country. The assistance provided by government or other agencies was low enough that many refugees sought additional employment, usually in the kind of service job that made it difficult to get time off work to go to medical appointments. Interference in appointment schedules contributes to poor compliance with sub-specialist referrals, leading to poor health outcomes for refugees. Socioeconomic barriers may reduce the quality of health care service received by these individuals and delaying their early diagnosis and further treatment. Again, the study findings echo those of the other literature in this area.

Cultural and religious barriers. The culture of refugees' countries of origin brings comfort in their new host country during integration (Kirmayer, et al., 2011). Refugees' beliefs, traditions, and life experiences also shape their perception on health care access, which in some cases may interfere with the interactions between health care providers and the refugees, thus potentially reducing the quality of the health care services they receive (Gabriel, Morgan-Jonker, Phung, Barrios, & Kaczorowski, 2011; McKeary & Newbold, 2010). Health care providers are required to be well-informed and educated about factors that affect refugees' interaction with health care providers during service delivery, but respecting cultural belief can create its own barriers. In this study, health care providers revealed how different cultural beliefs and previous health care experiences determine refugees' expectations of Western medical care. Health care providers working with the refugee population were culturally sensitive and informed their patients

of treatment and care options. In my opinion, continuing to do this will improve the communication and interaction between refugees and service providers.

Refugees' cultural and religious beliefs play an integral role in the preferences and choices that influence their health-seeking behaviour. In such instances, refugees may resort to the use of local knowledge in treating health concerns, rather than seeking help from medical clinic or hospital. This may have negative consequences for their health. The literature discusses how refugees from many cultures experience discomfort receiving care from health providers of the opposite sex, (Meyer, Pawlack, & Kliche, 2013) and this was affirmed in the study's results. The women refugees spoke of avoiding seeking primary care if their care providers are male, specifically for screening services. The finding leads to the question whether screening and prevention services are being accessed appropriately. Moreover, the influence of culture on the health of refugees may affect perceptions of health concerns, illness, causes of disease, death, approaches to health promotion, and the types of treatment patients prefer (Burgess, 2004). This study affirmed that the health care expectations of refugees are affected by their religious and cultural beliefs, which may contribute to delayed care and may influence refugees' long-term health.

5.4 Refugees' Perceptions of Discrimination and Racism

At times, refugees report perceived discrimination based on race, gender, and immigration status, which acts as a barrier to access and utilization of health care services. The literature describes immigrant and refugee overall health care status as mixed: sometimes their health is better when they arrive in host nations and deteriorates over time, whereas sometimes the opposite occurs. The first change is what the literature terms as the healthy immigrant effect; most refugees, however, experience the second change toward better health (Fowler, 1998; CIC News, 2013). It

is important to understand the influence that discrimination and racism have on refugees' health, however. Refugees' perception of ethnic and racial discrimination has very harmful health effects, thereby increasing the already complex health concerns experienced by this population during their settlement and integration (Sanmartin & Ross, 2006). Regrettably, this study's results revealed that some of the women refugees perceived some form of discrimination and racism during their access to health care. They perceived they did not receive the same services as Canadian citizens during their visits, based on their race, ethnicity, or culture.

The refugee population in this study has different perceptions of the concept of health and what constitutes an effective and appropriate treatment when ill health is encountered. Some refugees are unfamiliar with their new host country's medical system and practices, which may further influence their understanding of and experiences and familiarity with the health system or service provision. Perhaps because of this, the refugees in the study perceived that there are differences between their treatment and that of other people. Their perception is that the perceived unequal treatment is because of their race and identity as refugees. They would see people moving in and out of consulting rooms while waiting for their turn, but might not know what exactly transpired in those rooms. I would suggest that if refugees have the notion of unequal treatment in their minds, they are deterred from seeking health care services.

Furthermore, frustrated refugees may lack continuity and consistency in health care delivery during their visits at health care facilities, and may lack knowledge about the importance of having regular health care services, which may inform their health-seeking behaviours. Significantly, in this study, it was revealed that most care-seeking is at walk-in clinics. There, the refugees expected to receive some prescribed medication after being assessed by the health service provider, but were often disappointed that they received nothing. In comparing Canadian and

refugee populations, they noted that the health care practices in their home countries differ from those their host countries; of note, they expected to receive something (medication) on every visit to the hospital. In the study, refugees believe that when medications are given for every health concern, they will get well, “they will be happy” (Shelley: refugee) and the health service providers would be doing very well in providing quality health care service. In contrast, the women in the study expressed their dismay that they were not given any medication when they went to the hospital. In situations where refugees’ perceived needs are not met, the level of patronage of health care services when needed will be low, leaving them more vulnerable. It is quite likely refugees will resort to the use of un-prescribed over-the-counter medications.

Further, many refugees, as well as many Canadians, experience long waiting times during health service delivery (Vaughn, Jacquez, & Bakar, 2009). Most of the time, the refugees had to wait a lengthy period before they were attended to, even in an emergency. This may add more frustrations to refugees who may be accustomed to immediate care. Moreover, long wait times discourage refugees from seeking care when they have a health need. While experiences in Canada informed their choices, I sensed that the refugees’ health-seeking behaviours are mostly informed by their experiences in their home country where, in many instances, patients queue at an outpatient department for shorter periods (with no waiting for long hours) and no pre-booked appointments are necessary. The refugees interviewed in this study believed it was not worth waiting long hours to receive health care services. Lengthy waits to receive health care services may deter refugees from seeking health care since they find it unacceptable to wait many hours to receive care. Given the refugees’ backgrounds, a long wait for an appointment could lead to the development of chronic health conditions; this issue should be addressed, for when refugees do not feel they can regularly access health care services, they will be less likely to pursue help when

they experience symptoms or ill health. Not receiving regular health care would mean that there will be a break in their continuity of care, and worsening health conditions or diseases that are treatable when detected and diagnosed early (e.g., diabetes), potentially leading to a longer treatment and recovery period. Such delay can also cause emotional upset, as in the case of one of the women, who mentioned long waiting times for her appointment and expressed her concern over the possibility of something happening to her during that lengthy period. Also, in such situations, refugees may resort to arranging emergency appointments rather than waiting; something that adds further burden to the health care system, as the cost of an emergency room visit is significantly higher than the cost associated with visiting one's GP or a walk-in clinic.

Even with these experiences and perceptions, the healthcare access experienced by refugees in Saskatoon compares favourably to that of refugees in other parts of Canada and the world. In general, Saskatoon-based refugees are not experiencing any major setbacks and, rather, are enjoying quality health care services in the city. However, perception and experiences of racism did exist; and frustrations and misinterpretations of the systems deterred some women from seeking care. These are things that can be addressed and should be noted.

5.5 Refugees' Health Care Delivery Experiences

If I want to compare healthcare in Somalia or Botswana to Canada, then it is like comparing zero to hundred. (Ivy: Refugee)

I don't understand the way things are done here that much, and it's going to take me some time to understand it. (Shelley: Refugee)

During health care delivery, health care providers require refugees to share their health information for quality treatment. This requires refugees' trust and confidence in health care providers, with whom they may not be familiar. As revealed in the study, health service providers often have difficulty in retrieving refugees' current or past medical records; sometimes refugees were thought to be reluctant to share their past medical history. Trust requires time to develop; it is challenging for refugees who encounter so much agony in their pre-migratory stage to share their past, painful stories with unknown people (Canadian Doctors for Refugee Care, 2016; Canadian Council for Refugees, 2013). Again, trust is a big issue, particularly for refugees coming from war-torn areas where trusting others could be dangerous (Canadian Doctors for Refugee Care, 2016; Canadian Council for Refugees, 2013). Ensuring and maintaining trust and confidentiality for a traumatized population is essential in the prevention of re-traumatization (Canadian Doctors for Refugee Care, 2016; Canadian Council for Refugees, 2013). The study did not find, however, a uniform distrust for health care providers among refugees. While some refugees in the study revealed in their stories how uncomfortable they felt around health care providers and resettlement agency representatives, others refer to them as their relations.

Despite the difficulties in delivering health care to the refugee population, health care providers in the study were mostly found to be very dedicated to their duty and professions. Health care providers go to great effort to provide quality and needed health care in those cases where refugees are not entitled to health care services. Some health care providers spend more time with refugees than with other patients in order to provide quality care. Also, during consultation, health care providers try to use the opportunity to educate refugees about the health system, services, where to seek health care, and what services they are entitled to. These are all very important to overcoming barriers within the clinical setting. There is a wider context for care, however.

Although this study was conducted after the cuts to IFHP were restored in 2014, the impact of the reforms was seen to have had some effects on health care access for refugees during the period (Deacon & Sullivan, 2009; Hollifield, Martin, & Orrenius, 2014) before the cuts were restored in 2014. In particular, health professionals and other stakeholders who help refugees noted problems that may not have been visible to the refugees themselves. Although across the country, the 2012 cuts to IFHP raised major concerns of rising vulnerability among this population's health; fortunately, the refugee women in the study in Saskatoon were not so affected by the obstacles instituted during the period of the cuts to the IFHP.

Rather, the complexities that came with the billing system associated with refugee access to health care during the period of the cuts may have decreased refugees' choices in seeking continuous care by increasing confusion of both refugees and health care providers. Thus, I would suggest that issues that arose due to the complicated administrative and complex billing procedures may have prevented refugees who were eligible to access health care from doing so, even if they had a disease of public health concern.

5.6 Summary

With the number of refugees in Canada rapidly increasing, health care access is an important factor in their lives, particularly due to their numerous health concerns, which may impede their access to health care services. These health concerns have often been left untreated, due to the circumstances of their migration, and thus pose a great danger to their lives, undermine their overall health outcomes, and influence their health-seeking behaviour. Despite Canada's role in providing refugees basic health care services, the health disparities of this vulnerable population continue to persist.

This discussion revealed how women refugees in Saskatoon access health care services in their first year of resettlement and illustrated the many similarities with the literature on refugee populations across Canada. Through the examination of multiple intersecting factors, the influences on refugees' access to health care services were brought to the fore. Based on the findings, this research highlights several important factors about refugees' access to health care services. It shows how refugees' unique experiences and life circumstances informed their expression of health needs and the health choices they make, clearly signifying the importance of viewing refugee health care access within the broader context of the social, economic, and political dimensions within which they live.

Refugee health care is characterized by significant barriers and challenges, which increase the suffering and health needs of this already traumatized population. Based on the study's findings, it appears that refugees' access to health care services during their post-resettlement stage is hampered by their lack of knowledge of Canadian health care systems and health services, as well as poor literacy, perceived discrimination, and transportation difficulties. These challenges were recognized by both resettlement agencies and health care providers. There were clear examples from the study, indicating that refugee populations seeking health care are not only confronted with language, interpretation, and communication barriers, but also with different cultural and religious beliefs, discrimination, and racism, all of which create inequalities in the quality of care refugees receive. In the midst of barriers and challenges facing refugee health care access in Saskatoon, health service providers and resettlement agencies have instituted dynamic measures to address these access barriers, with an emphasis on advocating for improved and quality health care delivery services, to support refugee access to health care services.

While refugee women were eligible for limited access to health care through the IFHP, it was evident that the 2012 IFHP cuts created complicated administrative processes and complex billing procedures. The lack of knowledge of the IFHP program on the part of healthcare providers was also confusing which made it difficult for service providers to know which services were accepted under the reforms.

5.7 Conclusion

Access to health care services remains a challenge for refugees during their pre- and post-resettlement process. It is, therefore, important that refugees receive high-quality health care to address their varied health needs and concerns, which developed before their arrival in their host country. Refugees' health status is a reflection not only of their pre-arrival health and health care experiences during their transition, but is also a reflection of their post-arrival status. Despite Canada's promise of universal health care coverage, it was evident that refugees faced challenges regarding access to health care services. The challenges associated with refugees' health care access have a significant impact on the overall health of this population, particularly within their first year of resettlement. Making health care services available does not guarantee refugees will be able to access these services. Despite efforts to the contrary, health care disparities continue to exist for marginalized, vulnerable, and oppressed populations, such as refugees.

In conclusion, ensuring equitable access to health care services for disadvantaged and vulnerable populations presents challenges for Canadian health care providers and resettlement agencies. "Health care access is a key social determinant, and access to it is regarded as a basic human right" (Garcea, 2006; Public Health Agency of Canada, 2007) Access to health care services by refugees is an important area that needs further research. The generation of more evidence is necessary to inform health care provision, policies, and programs aimed at improving

access to quality health services. For refugees to have equitable and quality health care access to services during their pre- and post-resettlement, health care providers and stakeholders need to be culturally and linguistically competent when delivering health care services. In addition to exhibiting cultural sensitivity, they need to be aware of and work to circumvent language barriers when delivering health care services. Also, issues of access, inequalities in the quality of care received, and disparities in refugees' uptake of healthcare services need to be examined and addressed.

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APPENDICES

Appendix A: Collaborators (Resettlement Agencies)

Saskatoon Open Door Society (SOD). The Saskatoon Open Door Society (SOD) is a non-profit organization in Saskatoon. It was established in 1980 to assist in welcoming refugees and immigrants arriving in Saskatoon. The organization is committed to providing information, resources, support, and services related to immigrants and refugees to help them be effectively integrate into the Canadian society as well as involving these communities in the welcoming process, with about immigrants and refugees from 115 different countries under their umbrella. Their organizational vision aims to realize a multicultural aspect of Saskatoon by ensuring that newcomers participate in economic, social, intellectual, and cultural opportunities to have better lives. They believe that a community that is well informed about immigrants and refugees will provide a welcoming environment to opportunities.

International Women of Saskatoon (IWS). International Women of Saskatoon (IWS) is a non-profit organization that is a grassroots, equality-seeking women's organization dedicated to assisting immigrant and refugee women and their families, residing in Saskatoon and area, through free programs and services designed to support their settlement and integration into their community. IWS works both independently and in partnership with other community-based organizations, both immigrant and mainstream serving agencies, as well as private and government organizations. IWS's unique position as the voice of immigrant and refugee women in the Saskatoon community is rooted in the founding principles on which the organization was established namely: equality, empowerment, empathy, equity, diversity, respect, tolerance, and inclusiveness; it has, over the years, continued to define its organization's methods through

program development and delivery strategies to the needs of these immigrants, refugees, and asylum-seekers.

Global Gathering Place (GGP). Global Gathering Place (GGP) is a non-profit organization that provides services for immigrants and refugees in Saskatoon with the main aim of helping newcomers in adapting to new life while in Canada, with services such as support and skills development, acceptance, and settlement advice to these immigrants. Global Gathering Place is assisted by community- and immigrant-serving agencies, Citizen and Immigration Canada, and other private and government funders in Saskatoon. GGP's mission is to engage and support immigrants and refugees to fully integrate and thrive into the Canadian society.

In bridging the gap between immigrants and refugee newcomers, GGP maintains its core values of person-centred support using a holistic approach to finding solutions to meet the needs and preferences of these immigrants and refugees.

Appendix B: Forms related to Ethics Approval

A. Participants' Information and Consent Form (In-Depth Interview)

PROJECT TITLE: Refugee and Asylum-seekers Healthcare Service Cut and the Access to Reproductive Health Services: Case Study of Saskatoon

RESEARCHER: Sylvia Ohene-Bekoe, Department of Community Health and Epidemiology, University of Saskatchewan. Telephone number: 306-203-1226 Email: syo723@mail.usask.ca.

SUPERVISOR: Dr. Lori Hanson, Department of Community Health and Epidemiology, Telephone number: 306-966-7936, Email address: lori.hanson@usask.ca.

Dear Participant,

We are inviting you to take part in a study about the refugees and asylum seekers access to health care. We hope the findings will help develop an understanding into the realities being faced by refugees and asylum seeking women in Saskatoon who may be having issues with access to healthcare as result of the Interim Federal health policy.

Please read the following information carefully and ask any questions that you may have before agreeing to be in the study

WHO ARE THE STUDY PARTICIPANTS?

I will be talking to women refugees and asylum seekers aged 18 and above who have lived in Saskatoon for at least 3 years preceding the study. I will also be talking to representatives from four (4) refugee-based organizations in Saskatoon as well as health professionals working with refugees and asylum seekers in Saskatoon on their knowledge, experiences and perceptions on refugees and asylum seekers and their access to health care.

WHAT DOES THE STUDY INVOLVE?

The study involves in-depth interviews where participants will be asked open-ended questions. I will ask you questions to know about your experiences and perceptions of access to healthcare. All interviews will last 1-2 hours and I will audio-tape recorded with your permission. All interviews will be conducted at suitable locations chosen by the participants. I will inspect the chosen locations for their suitability and convenience. Interview guides will be used to conduct the interviews.

ARE THERE POSSIBLE RISKS AND DISCOMFORTS?

This study does not possess any risk or harm to participants. However, there may be some minimal of risk of discomfort (e.g. anxiety, stress) for participants since the issues reflects on how they access healthcare. However, if a participant experiences or expresses emotional distress due to the interview, she will be referred to a counsellor within the participating refugee-based organizations in Saskatoon, if necessary.

WHAT HAPPENS IF I DECIDE TO WITHDRAW?

Taking part in this research is voluntary. If you take part in this study and later want to leave, you can do so at any time. Please feel free to ask any questions regarding the procedures and goals of the study or your role. However, you may refuse to answer any questions or discuss any topic that you are not comfortable with. You have the right to stop during anytime of the interview if you don't want to continue. However, you can only ask me to remove what you tell me from the study before June 21, 2015.

WILL I BE INFORMED OF THE RESULTS OF THE STUDY?

I will share the results of my findings with participants and the key informants at a location that will be agree upon. I will invite you to come to this gathering in Saskatoon in early fall. During the debriefing session, I with the help of an interpreter (where necessary) will thank all women

refugee and asylum seekers and key informants for supporting my research. I will encourage them to ask any questions they may have or express their concerns about the study findings.

WHAT WILL THE STUDY COST ME?

Refreshments and a \$30 gift card from Superstore will be offered in appreciation of your participation.

WILL MY TAKING PART IN THIS STUDY BE KEPT CONFIDENTIAL?

Although the data from this research project will be used as a requirement for my Master's Thesis, published and presented at conferences, the data will be reported in aggregate form, so that it will not be possible to identify individuals. Moreover, the Consent Forms will be stored separately from the (materials used), so that it will not be possible to associate a name with any given set of responses.

Because the participants for this research project have been selected from a small group of people, all of whom are known to each other, it is possible that you may be identifiable to other people on the basis of what you have said. The gathering should you choose to attend, will also indicate your participation to others.

- Storage of Data:
 - All identifying information (consent form and master list) will be stored separately from interviews. The paper data and audiotapes will be stored in a secured filing cabinet in the Department of Community Health and Epidemiology at University of Saskatchewan and the typed field notes and interview transcripts will be encrypted and stored on my personal computer with a security password. The Principal Investigator will be responsible for the long term storage. Project results and associated material will be safeguarded and securely stored by the faculty

member/researcher at the University for a minimum of five years post publication.

When the data is no longer required, it will then be appropriately destroyed.

WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT THE STUDY?

If you have any questions about this study at any time, you can contact Dr. Lori Hanson, Department of Community Health and Epidemiology; Telephone number: 306-966-7936. Email address: Email address: lori.hanson@usask.ca.

This research project has been approved on ethical grounds by the University of Saskatchewan Research Ethics Board. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office: ethics.office@usask.ca (306) 966-2975. Out of town participants may call toll free (888) 966-2975.

Your signature below indicates that you have read and understand the description provided; you have had an opportunity to ask questions and your questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

_____	_____	_____
Name of Participant	Signature	Date

_____	_____
Researcher's Signature	Date


Option 2-Oral Consent

I read and explained this Consent Form to the participant before receiving the participant's consent, and the participant had knowledge of its contents and appeared to understand it.

_____	_____	_____
Name of Participant	Signature	Date

Thank you very much for your help.

B. Ethics approval Certificate

		UNIVERSITY OF SASKATCHEWAN		Behavioural Research Ethics Certificate of Approval
PRINCIPAL INVESTIGATOR Lori Hanson		DEPARTMENT Community Health and Epidemiology		BEH# 15-131
INSTITUTION(S) WHERE RESEARCH WILL BE CONDUCTED Saskatoon Saskatchewan, Canada				
STUDENT RESEARCHER(S) Sylvia Obene-Bekoe				
FUNDER(S) INTERNALLY FUNDED				
TITLE Refugee and Asylum-seekers Healthcare Service Use and the Access to Reproductive Health Services: Case Study of Saskatoon				
ORIGINAL REVIEW DATE 14-May-2015	APPROVAL ON 04-Jun-2015	APPROVAL OF: APPLICATION FOR BEHAVIOURAL RESEARCH ETHICS REVIEW INVITATION LETTERS TO STUDY PARTICIPANTS (REPRESENTATIVES FROM REFUGEE-BASED ORGANIZATIONS AND HEALTH PROFESSIONALS LETTER OF INVITATION FOR REFUGEES AND ASYLUM SEEKERS PARTICIPANTS INFORMATION AND CONSENT FORM TRANSCRIPT RELEASE FORM INTERVIEW GUIDE ASYLUM SEEKERS INTERVIEW GUIDE HEALTH PROFESSIONALS INTERVIEW GUIDE REFUGEE-BASED ORGANIZATIONS		EXPIRY DATE 03-Jun-2016
Full Board Meeting <input type="checkbox"/>				
Delegated Review <input checked="" type="checkbox"/>				
CERTIFICATION The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.				
Please send all correspondence to:		Research Ethics Office University of Saskatchewan Box 5000 RPO University, 1602-110 Gymnasium Place Saskatoon SK S7N 4J8 Telephone: (306) 966-2975 Fax: (306) 966-2099		

- 2 -
PRINCIPAL INVESTIGATOR
Lori Hansen


DEPARTMENT
Community Health and Epidemiology

Beh #
15-131

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month prior to the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: <http://research.usask.ca/for-researchers/ethics/index.php>


Vivian Ramsden, Chair
University of Saskatchewan
Behavioural Research Ethics Board

Please send all correspondence to:

Ethics Office
University of Saskatchewan
Room 306 Kirk Hall, 117 Science Place
Saskatoon SK, S7N 5C8
Telephone: (306) 966-2064 Fax: (306) 966-2069

Appendix C: Invitation Letters

A. Letter of Invitation for Refugees

Project title: Refugee and Asylum-seekers Healthcare Service Cut and the Access to

Reproductive Health Services: Case Study of Saskatoon

Researcher: Sylvia Ohene-Bekoe, Department of Community Health and Epidemiology,

University of Saskatchewan. Telephone number: 306-966-7946

Supervisor: Dr. Lori Hanson, Department of Community Health and Epidemiology, University of Saskatchewan. Telephone number: 306-966-7936, Email address: lori.hanson@usask.ca

Dear Madam,

I am Sylvia Ohene-Bekoe, a student from University of Saskatchewan. I am pleased to invite you to take part in an interview if you are a female refugee or asylum seeker in Saskatoon and you have lived in Canada for 3 years preceding this study. My masters' research study is entitled "Refugee and Asylum-seekers Healthcare Service Cut and the Access to Reproductive Health Services: Case Study of Saskatoon". Your response is valuable and it will help to reveal how refugees and asylum seekers in Saskatoon access reproductive healthcare services in the middle of the refugee healthcare cut policy. Also, the study will help develop an understanding in the realities being faced by women refugees and asylum seekers women in Saskatoon who may be having issues with access to healthcare as result of the refugee healthcare cut policy.

If you agree to participate, the in-depth interview will be conducted at a suitable location that participants will agree upon. Participants will be allowed to assess the venue for their approval. I am hoping that we will be able to meet for about one to two hours on one occasion to talk about your experiences and knowledge of refugees and asylum seekers access to reproductive health services. Your responses will be put into stories as part of my thesis and

parts of your stories may be presented in publications or at conferences. I would also share the study findings (including your stories) and results with refugees and asylum seeking organizations and as health professionals and health organizations who work with refugees and asylum seekers in Saskatoon.

Before the start of the interview, we will talk about some ways that we can protect your privacy, such as using a false name or changing some of the details of your stories. It is very important that you understand that people who know you or about you may be able to identify you based on what you say. I will always respect your right to choose how your story should be told and will do everything I can to protect your privacy, but I encourage you to carefully think about this before you decide to participate in this study.

I have received approval from University of Saskatchewan in Canada Research Ethics Office at University of Saskatchewan to do this study.

Yours Sincerely

Sylvia Ohene-Bekoe

B. Invitation Letters to Study Participants (Representatives from Resettlement Agencies and Health Service Providers)

Project title: Refugee and Asylum-seekers Healthcare Service Cut and the Access to Reproductive Health Services: Case Study of Saskatoon

Researcher: Sylvia Ohene-Bekoe, Department of Community Health and Epidemiology, University of Saskatchewan. Telephone number: 306-966-7946

Supervisor: Dr. Lori Hanson, Department of Community Health and Epidemiology, Telephone number: 306-966-7936, Email address: lori.hanson@usask.ca

Dear Sir/Madam,

I am Sylvia Ohene-Bekoe, a student from University of Saskatchewan. I am pleased to invite you to take part in a study if you are a representative from a Refugee-Based organization or a Health Care Professional. The title of my study is “Refugee and Asylum-seekers Healthcare Service Cut and the Access to Reproductive Health Services: Case Study of Saskatoon”. Your response is valuable and it will help to reveal how refugees and asylum seekers in Saskatoon access reproductive healthcare services in the middle of this new health and social policy. Also, the study will help develop an understanding in the realities being faced by refugees and asylum seeking women in Saskatoon who may be having issues with access to healthcare as a result of the refugee healthcare cut policy.

I am hoping that we will be able to meet for about one to two hours on one occasion to talk about your experiences and knowledge of refugees and asylum seekers access to reproductive health services. The in-depth interview will be conducted at a suitable location that participants will agree upon. Participants will be allowed to assess the venue for their approval.

The results of this study will be part of my master’s thesis, and may be presented in publications or at conferences. I would also share the study findings with refugee-based organizations as well as health professionals and health organizations who work with refugees and asylum seekers in Saskatoon. Before the start of the interview, we will review a consent form that will provide more information.

I have received approval from the Behavioral Research Ethics Board at University of Saskatchewan to do this study.

Yours Sincerely

Sylvia Ohene-Bekoe

Appendix D: Rules of Engagement

1. Introduction

Hello,

Thank you all so much for coming to join me today. I will appreciate and value your ideas and insight regarding your experiences in this interview is valuable and it will help to reveal how refugees and asylum seekers in Saskatoon access reproductive healthcare services in the middle of this new health and social policy. Also, the study will help develop an understanding in the realities being faced by refugees and asylum seeking women in Saskatoon who may be having issues with access to healthcare as a result of the new health cut policy.

My name is Sylvia Ohene-Bekoe, and I am a student in the University of Saskatchewan – Department of Community Health and Epidemiology and I am carrying out this study as part of my masters thesis. I am working under the supervision of Dr. Lori Hanson who is a professor in Community Health and Epidemiology. As you were already informed earlier in the letter of participation, I will be audiotaping digitally and manually recording our discussion. This is done, so we can remember all of the insightful things that are said here today.

Please do not be nervous and let me assure you that I will do my outmost to safeguard the confidentiality of your comments.

2. Consent Form

You have agreed to voluntarily participate in this interview, please kindly sign and return to me your Consent Form.

3. Rules of Engagement

With that goal in mind, I would like to outline a few “rules” to make sure that today’s discussion is a productive and meaningful one.

- When I ask a question, we will go around in a circle so that everyone has a turn to speak.
- Speakers are not to be interrupted by other participants while speaking.
- When it's your turn to speak, address the question whichever way you like. You don't have to carry forward the same idea as the one presented by a previous speaker.
- Each person talks until they are finished, but try to be respectful of everyone's time.
- You do not have to always comment on every single question. You may choose to pass on a question if you feel one of the other participants has adequately represented your point of view.
- I want to emphasize there are no right and wrong answers. We need to be equally respectful of everyone's ideas and comments even when we may not be in agreement with them.
- I am not here to judge or comment about others; we're just here to listen and share our ideas.
- The comments made in this room by all the participants should be kept in strict confidence.
- I won't be repeating these stories verbatim to anyone. This will never be attributed to you as an individual.
- With that in mind, are there any questions for me?

4. Conclusion

I have to begin to wrap up now.

I know that many of you have to be somewhere else to be very soon.

Know that your comments and ideas today will make a meaningful difference in improving the immigrant women's access to mental health services in SHR in the near future.

If you remember anything later or if you would like to speak with me privately, you are welcome to do so by e-mailing me.

Thank you for your participation, I deeply appreciate and value your time and contributions.

Thanks again and have a great day.

B. Training Manual for Transcriber/Translator

1. Detailed description of study purpose and objectives
2. Emphasized the importance of transcribing interviews verbatim from voice to Somali and then translate them verbatim from the local language to English language
3. Keep all research materials in your possession confidential (audio-recorded interviews, transcripts, emails)
4. Do not discuss the content of audio-taped interviews or transcripts with anyone without my approval
5. Periodically, you, myself will review interview transcripts against audio-tapes to ensure consistency and quality of data
6. At the end of the study you will return to me all audio-recorders with recorded interviews intact. You will delete all email correspondence between you and I that contain information regarding the study
7. At the end of the study you will sign transcript release form from University of Saskatchewan. Please be informed that you will be bound by every word in the transcript release form that you sign

A. Confidentiality Agreement with Translator and Transcriber

This form may be used for individuals hired to conduct specific research tasks, e.g., recording or editing transcribing, interpreting and translating.

Project title -

I, _____, have been hired as an (translator/ transcriber)

I agree to -

1. To respect, protect and maintain the confidentiality of all materials transcribed, interpreted or translated or otherwise processed by me with respect to this research.
2. Keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (tapes, electronic data, transcripts, emails, conversation etc.) with anyone other than the Researcher(s).
3. Keep all research information in any form or format ((tapes, electronic data, transcripts, emails, conversation etc.) secure while it is in my possession.
4. Return all research information in any form or format ((tapes, electronic data, transcripts, emails, conversation etc.) to the Researcher(s) when I have completed the research tasks.
5. After consulting with the Researcher(s), erase or destroy all research information in any form or format regarding this research project that is not returnable to the Researcher(s) (e.g., information stored on computer hard drive).
6. I confirm that I have no right of ownership or of use of any information transcribed, interpreted or handled by me as part of this research.

_____	_____	_____
(Print Name)	(Signature)	(Date)

Researcher: Sylvia Ohene-Bekoe

(Signature)

(Date)

Supervisor: Lori Hanson

(Signature)

(Date)

This research project has been approved for its adherence to ethical guidelines and approved by the University of Saskatchewan Research Ethics Board. For questions regarding your rights as a participant and ethical conduct of research, contact the Research Ethics Office at 306-966-2975 or ethics.office@usask.ca.

B. Transcript Release Form

Project title: Refugee and Asylum-seekers Healthcare Service Cut and the Access to Reproductive Health Services: Case Study of Saskatoon

Researcher: Sylvia Ohene-Bekoe, Graduate student, Department of Community Health and Epidemiology, University of Saskatchewan, Telephone number: 306-979-5904, Email address: syo723@mail.usask.ca.

Supervisor: Dr. Lori Hanson, Department of Community Health and Epidemiology, Telephone number: 306-966-7936, Email address: lori.hanson@usask.ca

-----, waive my right to review the transcript of my personal interview in this study, and have agreed for Sylvia Ohene-Bekoe to use it in accordance with the ethical requirements that apply to his research study. I hereby authorize the release of my interview

transcript to Sylvia Ohene-Bekoe to be used in the manner described in the Consent Form. I have received a copy of this Transcript Release Form for my own records.

Name of Participant

Date

Signature of Participant

Signature of Researcher

Appendix E: Interview Guides

A. Interview Guide for Refugees

Can you tell me a little bit about where you come from? How long have you been in Canada? How long have you been living here in Saskatoon? What was your country of last residence before you came to Canada? Where is your homeland or country? Under what circumstances did you come to Canada? What is your refugee/ asylum seeking status? How old are you now? What is your marital status? Do you have any children living with you at the moment (if any)? Probe: If yes, how many? Who else accompanied you to Canada? Could you tell me about any other relatives/family members living in Canada? What language/s do you speak at home? What is your highest level of education? When you first came to Canada, did any person/organization help you in the settlement process? Probe: Can you tell me more about them?

How is your health? How is the health of your family? Probe: How was your health in your home country, during your journey and when you first came to Canada? Do you find the health care system in Canada to be different from your country or other countries you have lived? Probe: If so, how?

When you first came to Canada, how did you learn about the health care system? Did someone help you with the health care system? Probe: If so, how? How easy or hard was it to get information/help about available health care services? Can you tell me about the first time you went to the doctor here? Probe: What happened? Do you have a family doctor here in Canada?

How do you seek health care services? Where do you usually seek health care services either when you need to or on a regular basis? Where do you usually seek care? (i.e. walk-in clinic, community health centre etc.) How often do you or members of your family see a medical professional? Probe:

Do you have any reproductive health concerns? Probe: If you do, what are the various reproductive health concerns you are facing/ having?

Are you aware of the services available to you? Are you satisfied with the services you receive when you visit the doctor? Do you think that the quality of care you receive is different for other people?

Have you or anyone you know faced any difficulty in accessing health care? Probe: What happened? If so, what barriers do you face in accessing health care services?

What do you think Canadian health system needs to do to help you overcome these challenges and to provide better health care to you? Do you have any suggestions or steps/solutions to improve health care/services for refugees and asylum seekers? Probe: Can you share with us?

B. Interview Guide for Representatives from Resettlement Agencies

Can you tell me about yourself? What is your position and how long have you worked here? Can you tell me a little bit about your organization? What is your role in this organization? Probe: Or what is your work like? Who are the people who seek services here? /What is the profile of people who come here for services? What kind of services do they require? Probe: What kind of services do you provide? How many refugees and asylum seekers do your organization receive in a month? How do you come in contact with refugees/asylum seekers? Are there other agencies or organizations you work with in providing services for refugees/asylum seekers? Probe: If yes, what are they?

As a service provider, what are your thoughts about the overall health of these refugees and asylum seekers? In your opinion, do you think the refugees and asylum seekers that you see are healthy?

What kind of health concerns do refugees and asylum seekers have? Do you see differences in the health of refugees and asylum seekers? Probe: If yes what are they?

Can you tell me about how these women access health care services? (i.e. IFHP etc.)

Probe: Where do you get your information on the cuts to the interim federal health program?

What do you know about the cuts and how do you feel about them? Probe: Is there anything you have noticed or had to deal with vis-à-vis the cuts?

What are the impact of the cuts to the Interim Federal health policy on the services you provide to refugees and asylum seekers? How is it affecting your practice and the service you provide?

What do you think are the key health challenges and needs of refugees and asylum seekers?

What do you think are some of the challenges they face in accessing healthcare? Probe: What are some of the challenges that you face in serving this population?

What are your experiences with the refugees and asylum seekers? In your opinion, do you think Canadian healthcare system has failed to provide quality health care for refugees/asylum seekers?

C. Interview Guide for Health Professionals

Can you tell me about yourself? What is your position and how long have you worked here?

Who are the people who seek services here? /What is the profile of people who come here for services? What kind of services do they require? Probe: What kind of services do you provide?

As a service provider, what are your thoughts about the overall health of these refugees and asylum seekers?

What kinds of health concerns do your refugee and asylum seekers patients have? Probe about reproductive health: What are the various reproductive health concerns you treat refugees and asylum seekers of? On average how many refugees/asylum seekers do you treat in a month?

Probe: How many of the cases you treat are reproductive health issues? Do you see differences in the reproductive health of refugees/asylum seekers and the Canadian women you attend to?

Can you tell me about how these women access to health care services? (i.e. IFHP etc.)

Where do you get your information on the cuts to the interim federal health program?

Probe: What do you know about the cuts and how do you feel about them? Is there anything you have noticed or had to deal with vis-à-vis the cuts?

What are the impact of the cuts to the Interim Federal health policy on the services you provide to refugees and asylum seekers? How is it affecting your practice and the service you provide?

What do you think are the key health challenges and needs of these women?

Probe: What do you think are some of the challenges they face in accessing healthcare? What are some of the challenges that you face in serving this population? What are your experiences with the refugees and asylum seekers?

In your opinion, do you think Canadian healthcare system has failed to provide quality health care for refugees/asylum seekers?