

**UNDERSTANDING THE NEEDS OF REFUGEE WOMEN IN NAVIGATING
THE CANADIAN HEALTH CARE SYSTEM**

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UNDERSTANDING THE NEEDS OF REFUGEE WOMEN IN NAVIGATING THE
CANADIAN HEALTH CARE SYSTEM

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ABSTRACT

This research explores the health care experiences of refugees settling in Canada. The objective of the study is to understand the health care needs of refugee women and identify strategies that can help improve their understanding, access, navigation and utilization of the Canadian health care system and the services within. An exploratory qualitative research approach informed by the Intersectionality Feminist Framework was employed. Using a purposive sampling technique, data was collected through six focus group discussions and seven in-depth individual interviews from six study locations. The data was analyzed and interpreted using inductive thematic analysis through a social constructivist lens. The findings reveal that the role of gender, educational background, expectations, settlement locations, sociocultural and language differences were significant in the integration of refugee women into the Canadian health care system. Future research or interventions should consider a practical and dynamic approach to ensure a comprehensive understanding of refugee women's health needs and experiences.

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CHAPTER 1. INTRODUCTION

Background of the Study

Migrating from one place to another can change almost every aspect of life. There is a global migration crisis due to conflict, war, and human rights violations that is leaving men, women, and children forcibly displaced (Langlois, Haines, Tomson, & Ghaffar, 2016). These people may be: (a) internally displaced persons (IDPs) who stay in their home country (country of origin); or (b) refugees who cross international borders (Lee, 1996). According to the Refugee Convention of 1951 [Article 1(A) (2)] a *refugee* is a person,

owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it. (Shacknove, 1985, p. 275)

A refugee is a displaced person who fled their country to escape war, conflict, violence (e.g., ethnic, tribal, religious), or natural disasters and moved across national borders. Such persons are unable to return to their country of origin without experiencing harm or persecution (Nyers, 2013). Refugees become asylum seekers until a host country or the United Nations High Commissioner for Refugees (UNHCR) grants them refugee status or they formally make a claim for asylum (UNHCR, 1999). The UNHCR is the lead international agency coordinating the protection of refugees. The UNHCR (2015) stated that about 65.3 million people in the world were forcibly exiled from their home

countries; of this group, 21.3 million were refugees and the others asylum-seekers or IDPs. The migration or asylum process causes significant mental and physical trauma and vulnerability that may have long-lasting consequences to health and well-being (Gonzalez, 2015; Klinik, 2013). Mental and physical health consequences are particularly relevant to women, children, and the elderly. Refugee women often experience reproductive health issues. As refugees settle in a host country, they encounter several challenges (e.g., finances, career, shelter, safety, sense of belonging/acceptance, and overall health). Accessing necessary and appropriate health services is a common challenge for refugees (Corey, 2015). Refugees spend considerable time in refugee camps before settling in a host country and may contract ailments. Limited health care access and barriers to health care utilization are problematic during and after settlement (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009).

Canada is a host country for many refugees originating from Syria, Iraq, Eritrea, Afghanistan, Somalia, Ethiopia, Congo, and Iran thanks to the nations' generosity and equitable refugee policies (Beiser, 2004). Refugees' experiences with the Canadian health care system is an area worthy of inquiry due to the influx of refugees in Canada. Research may improve understanding of the health care needs and experiences of women during early settlement and post-settlement. Such data may inform ways to improve the health care experience for refugees (McKeary & Newbold, 2010).

Problem Statement

Accessing the health care system and available services is a challenge for refugees (Simich, Wu, & Nerad, 2007). Many researchers note difficulties experienced by refugees when accessing, affording, accepting, and utilizing health care services and solutions are understudied - especially among the population of refugee women (Edward & Hines-

Martin, 2015; Simich et al., 2007). Within the first five years of settlement, refugee women must adapt to a new environment, learn a new culture and new language, develop new supports, and in many ways start over. The steep learning curve and the identity of being a refugee can lead to a life with a low social status and limited access to social, cultural, political, and economic benefits, which affect overall health and well-being (Henderson & O'Brien, 2006). Many refugees are unfamiliar with the new health care system and their cultural or religious beliefs may interfere with their uptake of health care services in Canada. Refugee women who experienced violence may come with health issues as they migrate to their host country; feeling isolated from society makes it more difficult to settle in a host country (Allotey, 1999). Another issue is that regulations pertaining to health care insurance eligibility in Canada are not flexible and are difficult to navigate, and many refugees and immigrants are reluctant to share their personal information (Kirmayer et. al., 2010). The label of *refugee* forces such people to reformulate their identity. They lose a sense of belonging and often feel like an outsider in the host country (Burnett, 2013).

Purpose and Significance of the Research

The current study explores the experiences of refugee women when trying to understand, access, navigate, and utilize the health care system in Canada. The purpose of the study is two-fold: (a) to understand the health care needs and challenges these women face as they settle in Canada; and (b) to identify strategies to improve their understanding, access, navigation, and utilization of health services within the health care system in Canada.

The population of interest in this study is refugee women. Women represent roughly half of the 19.6 million global refugees and half of the 244 million migrants

living in other countries (UN Secretary-General, 2016). Many are victims of physical, mental, or emotional abuse, sexual violence, and human trafficking (Keygnaert & Guieu, 2015). They often have complex mental and physical health problems (Keygnaert & Guieu, 2015; United Nations Secretary-General, 2016; United Nations Educational, Scientific and Cultural Organization, 2014). Having the opportunity to speak directly with refugee women in effort to better understand their needs and the barriers to obtaining quality health care services is significant.

The findings will be shared with the refugee population, refugee centres and local leaders, health care providers, and policymakers in hopes to somehow improve the health care experience for refugees.

Research Questions

It takes a coordinated effort by many stakeholders to provide for and manage activities during the settlement phase for refugees (Ministry of Health, 2015). Stakeholders such as local leaders, administrators, health professionals, politicians and the general public need to know how best to educate refugees about life in Canada including the health care services available (Kuile, Rousseau, Munoz, Nadeau, & Ouimet, 2007). The current literature lacks a holistic view of the plight of refugees (Attanayake, 2010; Lim, 2013). Assumptions are sometimes made about refugees' health status, language, cultural sensitivities, and sexuality (Ministry of Health, 2015). It is unknown what refugee women currently understand about the health care system in Canada and the services available to them. This research serves to help us better understand the needs and experiences in regard to their health and well-being. Hence, the research addresses the following questions:

RQ1. *Understanding*: What do refugee women currently know about the Canadian health care system and the health care services available to them? From where and how are they getting their information?

RQ2. *Access*: What supports and/or programs assist refugee women in accessing health care services? How are the women accessing the system?

RQ3. *Navigation*: How do refugee women navigate the Canadian health care system?

RQ4. *Utilization*: How do refugee women utilize the Canadian health care system? What factors influence refugee women's use of and access to health care services in Canada?

RQ5. *Gaps*: What gaps exist between refugee women's expectations and lived experiences of the Canadian health care system?

RQ6. *Goals*: What are the health care goals of refugee women?

RQ7. *Improvements*: What strategies do refugee women believe might improve their health care experience in Canada? What would be a better approach?

Summary

This chapter included a brief background of the study, the problem statement, and gaps in the current literature. The chapter also included descriptions of the purpose and significance of the study and the research questions. In the next chapter, I will present a review of the literature on the plight of refugee women and their health care experiences in Canada.

CHAPTER 2. LITERATURE REVIEW

This chapter is a review of the literature on the health care experiences of refugee women. The chapter begins with a global overview of refugees, refugee trends in Canada, and legislation and policies that guide refugees in Canada with focus on refugee women. The chapter continues with a discussion of the Canadian health care system, the health status of refugees in Canada, and the role of settlement agencies in assisting refugees in acquiring health care services. I also describe the theoretical framework -- the Intersectional Feminist Framework (IFF) as it applies to factors that influence refugee women's experience of health care in Canada.

Global Overview of Refugees

The displacement of people by war or other disasters is a global crisis in terms of its financial, political and health burdens, and is associated with the violation of human rights and security (Bozorgmehr & Razum, 2017; Leppold, Ozaki, Shimada, Morita, & Tanimoto, 2016). The same issues apply to IDPs. Referring to such problems as a *refugee crisis* ignores the needs of victims of forceful displacement; IDPs are often neglected and tend to face greater health risks as they depend on the limited resources available. The 'limited resources available to them' becomes the problem more so than the underlying cause of the displacement (Bozorgmehr & Razum, 2017).

According to the UNHCR (2016a), the number of forcibly displaced people increased from 33.9 million in 1997 to 65.6 million in 2016. Statistics from the UNHCR (2016b) Global Trends Report indicated that 20 new people become displaced every minute, and one in 113 people globally are displaced, refugees, or asylum seekers. Not all displaced individuals gain refugee status. Nearly 10 million displaced people are stateless or seeking asylum from host countries (UNHCR, 2016a). Stateless people experience

discrimination, lack legal identification, and have limited access to basic human needs and rights. If displaced people cross borders and receive refugee status, they may settle in the host country. However, refugee application is a long political and financially influenced process (Gauci, Giuffré, & Tsourdi, 2015).

The UNHCR (2016b) estimated that about 55% of global refugees originate from the Syrian Arab Republic (5.5 million), South Sudan (1.4 million), and Afghanistan (2.5 million). The Central African Republic, Colombia, and Iraq also contribute to the global refugee pool. More than half of these refugees are children under 18 years of age. Developing countries (e.g., Turkey, Pakistan, Lebanon, Iran, Uganda, Ethiopia, Jordan, Congo, and Kenya) have offered to share the responsibilities of hosting some refugees (UNHCR, 2016b). Developed countries also accept refugees, for example the United States (96,900 refugees), Canada (46,700 refugees), and Australia (27,600 refugees) (UNHCR, 2016b). Over the years, Canada has been a major destination for many refugees and their dependents.

Refugee Trends in Canada and the Province of Alberta

Canada is a generous host country for refugees and asylum seekers. There are two major refugee programs available in Canada: (a) the Refugee and Humanitarian Settlement Program, which provides support for people outside of Canada who request protection and settlement into Canada; and (b) the In-Canada Asylum Program for those who claim refugee status within Canada (Citizenship and Immigration Canada [CIC], 2017c; Pressé & Thomson, 2008). The Government of Canada, the UNHCR, and private sponsors support refugees through the Refugee and Humanitarian Settlement Program. These sponsorship agreements secure refugees until they settle in Canada. As refugees

settle, some become community sponsors for other displaced individuals from their community (CIC, 2017c).

The settlement of refugees in Canada, like other countries, is a complex process from their arrival, integration into the new country and their status as they settle. Canada has the highest naturalization rates of any country (Statistics Canada 2013; Migration Policy Institute, 2014; UNHCR, 2016b; Aptekar, 2016). Naturalization is when a non-citizen refugee gets legal citizenship or nationality through local integration (Bloemraad, 2006). Canada's naturalization reports indicated 16,300 refugees in 2016 and 25,900 refugees in 2015 (UNHCR, 2016b) numbers which are increasing and indicate a steady influx of refugees. In 2016, Syria, Eritrea, Iraq, Congo, and Afghanistan were the top five origin countries for refugees in Canada (UNHCR, 2017). Syria had the highest rate with about 33,266 refugees in 2016 (UNHCR, 2017). Canada's Immigration and Refugee Board has recently made significant changes to its policies and program to settle more refugees and provide a safe and quality environment for them.

Data from the National Household Survey of 2011 showed that about 6,775,800 people were foreign-born which represents 20.6% of Canada's population. With the recent surge of Syrian refugees (40,081 as of January 29, 2017), it is important to identify the experiences of newcomers, recognizing the challenges they face in transitioning to a new life in Canada (CIC, 2017b). Many of the recently settled Syrian refugees are adjusting well similar to their proceeding refugee groups, and their integration in the first year is as expected (Drolet & Moorthi, 2018). But all refugees need support and time to become accustomed to their new communities and adapt to a whole new life in Canada.

The province of Alberta is one of the most generous provinces in Canada in terms of hosting refugees; Alberta is the sixth largest and fourth most populous province in

Canada with a population of about 4,067,175 people (Statistics Canada, 2017). According to CIC (2017a), Alberta hosted settlement for 11,745 refugees, of whom 495 are blended sponsorship refugees, 5,220 are government assisted refugees, and 6,030 are privately sponsored. The locations of Calgary, Edmonton, Red Deer, Lethbridge, Medicine Hat, and Brooks are the major settlement centres in the province supported by the Resettlement Assistance Program (RAP).

Legislation and Policies on Refugee Migration to Canada

Several policies regulate the Canadian refugee system (i.e., the Immigration and Refugee Protection Act, the Balanced Refugee Reform Act, the Protecting Canada's Immigration System Act; the Immigration and Refugee Protection Regulations, and Chairperson's Refugee Protection Division Rules) (Immigration and Refugee Board of Canada, 2017). These policies protect both refugees and Canadian citizens. For example, if the refugee applicant has some health issues that pose a threat, danger or risk to public health and safety, the government may reject the application on the basis of the Immigration and Refugee Protection Act (s. 38.1) (Beiser, 2005). Canadian laws protect refugees and provide opportunities for naturalization through Immigration and Naturalization Services. Such programs are available in several Canadian provinces, including the province of Alberta (Broadway, 2007; Yu, Ouellet, & Warmington, 2007).

Since 1950, international lawmakers have paid more attention to the rights of refugee women due to circumstances of female-specific persecution and exile. This has led to the implementation of laws such as the Declaration on the Elimination of Violence Against Women (1993) (Edwards, 2010). Canada was actually the first country in the United Nations (UN) to implement guidelines specific to refugee women (Ruban, 2017); the Declaration on Refugee Protection for Women was adopted by Citizenship and

Immigration Canada (CIC) in 1994. Some of these policies expand on legitimate status and human rights to protect refugees from persecution and discrimination, while others serve to provide a better experience to refugees upon arrival to Canada. The Canadian Collaboration for Immigrant and Refugee Health (CCIRH) has implemented evidence-based guidelines which are tailored towards the unique needs of refugee communities (Chaves, Paxton, & Biggs, 2016; Pottie et al., 2011).

The Experiences of Refugees and Refugee Women in Canada

The experiences of refugees in Canada reflect their expectations of migration, their sociocultural and religious backgrounds, language barriers, trust and mistrust of people and services, lack of knowledge, limited financial prospects, and discrimination (Evans, Caudarella, Ratnapalan, & Chan, 2014; Pollock, Newbold, Lafrenière, & Edge, 2012; Stewart et al., 2015). As stated in Article 25.1 of the Universal Declaration of Human Rights (1948, p. 52) which focuses on the right of every individual to health and well-being,

Everyone has the right to a standard of living adequate for the health and well-being of himself and 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.

The health care needs of refugee women are often unique due to the violence, abuse, and traumatic events they may have experienced. During times of conflict and war, these women are exposed to extreme violence with little access to shelter, food, health care, education, and employment (Block, Riggs, & Haslam, 2013b). This makes integrating into a new environment difficult as there are often trust issues, along with fear

of further violence, abuse, and trauma (Guterres & Spiegel, 2012). Refugee women often have a higher demand for sexual and reproductive health services such as family planning, pregnancy, childbirth, and abortions and the complications involved (Janssens, Bosmans, Leye, & Temmerman, 2006) but when it comes right down to it, what they really need is “the restoration of hope and human dignity” (Pinehas, van Wyk, & Leech, 2016, p. 139).

The experiences of refugee women are quite different from those of male refugees. Most refugee women have experienced sexual violence either by a partner, family member, or stranger resulting in forced prostitution, gender discrimination, or sexually-transmitted illness (Stewart & Gajic-Veljanoski, 2005). They feel vulnerable to similar treatment after migration (Hynes & Cardozo, 2000). Severe mental trauma often goes unattended due to fear of stigmatization and lack of knowledge about the availability of mental health professionals and services. Therefore, in providing support to these people, it is important to go beyond traditional frames of thinking and approaches and rather incorporate *novel* approaches with diverse perspectives in an attempt to better understand their needs and avoid disparities (Schulz & Mullings, 2006). The advanced concepts that are proposed by other authors include frameworks of intersectionality, biological determinism (gender-based), and feminist perspectives (Attanayake, 2010; Schulz & Mullings, 2006). Gabriel, Kaczorowski and Berry (2017) emphasized the need to collect data that will help us to better understand the demographics of refugees, including their current health status and personal goals for their health over a certain period of time after arriving to the host country. Having this information can better help people and organizations (public, private, non-profit) to better serve this vulnerable and marginalized population.

Overview of Canadian Health Care System

Canada's health care system focuses on services that are medically necessary and publicly funded (Watts, 2011). Instead of having a single, national plan, Canada has 13 provincial and territorial plans (CIC, 2016; Watts, 2011). Under this system, all Canadian residents have reasonable access to medically necessary hospital and physician services without paying out-of-pocket. The roles and responsibilities for health care services are shared between provincial and territorial governments and the federal government (Hutchison, Levesque, Strumpf, & Coyle, 2011). Provincial and territorial governments are responsible for the management, organization, and delivery of health care services for residents. The federal government is responsible for: (a) setting and administering national standards for the health care system through the Canada Health Act; (b) providing funding for provincial and territorial health care services; (c) supporting the delivery of health care services to specific groups; and (d) providing other health-related functions (CIC, 2016).

Provincial and territorial health care insurance plans must meet the standards of the Canada Health Act to receive full payment under the Canada Health Transfer (CIC, 2016). These standards reflect five principles: (a) *public administration* (all administration of provincial and territorial health insurance must be done by a public health authority as a non-profit basis); (b) *comprehensiveness* (provincial and territorial health plans must ensure all medically necessary services provided by hospitals, physicians, and dentists be performed in a hospital or health centre); (c) *universality* (province and territory health plans must cover all residents); (d) *portability* (provincial and territorial health plans must cover all residents with limited coverage while travelling outside the country); and (e) *accessibility* (provincial and territorial health plans must

provide all residents equitable access to medically necessary services based on medical need, not the ability to pay) (Health Canada, 2014; Madore, 2005). These principles provide services for all residents; a resident is “a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province” (CIC, 2016. p. 3).

The federal government provides funding for provincial and territorial health care services through the Canada Health Transfer (Canada Health Transfer & Fard, 2009). Provinces and territories receive supplementary federal funding support through other fiscal transfers to provide health care (Marchildon, 2013). Primary health care services are the first-contact for most Canadians under the health care system (CIC, 2016; Hutchison et al., 2011). Primary health care services deliver basic health care and coordinate patients’ health care services for continuity of care; this entails providing high-quality care from diagnosis to recovery to ensure ease of movement across the health care system when more specialized services are necessary.

The Canadian Health Care System: Specific to Refugees

The Canadian health care system serves to address the needs of all residents, but as the country becomes more ethnically diverse and multi-cultural, it also becomes more complex, and the provision of health care services becomes more complex. For refugees, access to certain health care services is limited depending on refugee status. Health care insurance coverage and eligibility for certain services vary from province to province. For example in British Columbia, Manitoba, Ontario, and Quebec, there is a waiting period of one to three months for immigrants or refugees to receive legal entitlement for provincial health care insurance coverage (CIC, 2016). Only refugees who have been approved by

the Immigration and Refugee Board of Canada are eligible to apply for the Interim Federal Health Program (IFHP) and get the provincial coverage.

The IFHP is the primary health coverage/insurance program for refugees; the beneficiaries of this program include settled refugees, refugee claimants waiting for a decision on their application, human trafficking victims, and detainees (Evans et al., 2014). The services provided depend on refugee status (i.e., whether the refugee is sponsored by the government, Joint Assistance Sponsorship Program, private sponsors, or the Blended Visa Office). Usually refugees receive basic health care coverage, supplemental services, and prescription drugs. The basic health care services are only available until a refugee acquires his/her provincial health care coverage. The IFHP provides limited, temporary health care coverage to protected people who are ineligible for provincial or territorial health insurance. It does not cover the cost of health care services or products that a person may claim under a public or private health insurance plan nor does it coordinate benefits with other insurance plans/programs. However, refugees with provincial health insurance can still use IFHP as a supplemental health insurance for emergency care (Elgersma, 2008).

Federal and provincial health funded programs support refugees' access to health care services, but some limitations and delays result due to the documentation the Immigration and Refugee Board requires (CIC, 2011; Elgersma, 2008). Refugees struggle to access necessary information about the health care services available to them. Their willingness to access and use these services is also a barrier. Refugee women tend to be at the highest risk due to the need for immediate gender-specific health services (e.g., reproductive or maternal health services), restrictions due to male dominance, language

barriers, social stigma, and cultural/religious sensitivity (Brown-Bowers, McShane, Wilson-Mitchell, & Gurevich, 2015; Drummond, Mizan, Brocx, & Wright, 2011).

Caulford and Vali (2006) claimed that health care insurance eligibility and entitlement regulations in Canada are not flexible enough and are difficult to navigate, particularly for uninsured and underinsured refugees and immigrants who are reluctant to share information about themselves. Since 2012, the federal government has worked to ensure temporary health care coverage for settled refugees, refugee claimants, rejected refugee claimants, and persons detained under the Immigration and Refugee Protection Act during a period of ineligibility for provincial or territorial health insurance (CIC, 2016). This IFHP program provides limited and temporary coverage of health care benefits but does not address the challenges women experience when trying to understand, access, navigate, and utilize health services.

Health Status of Refugees and Refugee Women in Canada

The health status of refugees influences their settlement (Beiser, 2005). It also influences the success of their refugee application because the Canadian Immigration and Refugee Protection Act (s. 38.1) supports the rejection of refugee applications that pose either a threat to public health and safety or demand extensive health and social services (Beiser, 2005).

Most refugees suffer from post-traumatic stress disorder and other psychological and physical conditions (Craig, Mac Jajua & Warfa, 2009). Women or female refugees (both adult and children) have been shown to be more vulnerable to mental health issues. There are several factors that have been identified as stressors that induce mental health issues in both genders but the more severe impact seems to affect females (Robert & Gilkinson, 2012). This includes having limited supports, being apart from loved ones,

feelings of loneliness, difficulty fitting into Canadian society, language problems, unemployment, financial difficulties, discrimination, gender-based family responsibilities, and health issues (Newbold, 2009; Robert & Gilkinson, 2012). These are stressors that often arise during the pre and/or post-migration periods (Fenta, Hyman, & Noh, 2004). Research conducted in many Canadian provinces confirms the social stigma that surrounds mental health issues, especially for females. Females with mental health issues are often characterized as being 'crazy' or 'weak' and the stigmatization results in people becoming hesitant about seeking care (Kirmayer et al., 2011).

The health care needs of refugees are in many ways much different than those of non-refugees due to illness (e.g., HIV), unfavorable living conditions, environmental conditions (e.g., natural disasters), previous attempts to settle as refugees or asylum seekers, migration patterns, and genetic predispositions in their country of origin. Therefore, it is critical to understand the determinants of refugee health status upon arrival to Canada and to identify preventable and treatable conditions.

Refugees are forced to flee from the country of origin without their valuable items, money, savings, and family members. So, most often they enter Canada with minimal social and financial capital and face unemployment or underemployment (Wilkinson & Garcea, 2017). Even with availability of federal or provincial support, many are not able to afford some of the general services provided in Canada such as dental care, prescription drugs, or laboratory testing. All of these reasons may result in the delay of treatment. Studies suggest that the presence and availability of refugee-dedicated integrated care clinics increases uptake (i.e., the tendency to seek medical care) significantly (McMurray, Breward, Alder, & Arya, 2014). Attention should therefore be given to factors that prevent refugees from seeking medical care. In many cases, health

care providers are simply unaware of the plight of refugees and the reality of their situation. While health care providers may try to deliver fair and equitable care, they may not fully consider nor fully understand the situation facing refugees.

Health Care Delivery for Refugees in Canada and Alberta

The Canada Health Act mandates that all residents receive health care (CIC, 2016; Health Canada, 2014; Madore, 2005). Of the five principles of the Canada Health Act, universality and accessibility are most important to delivering health care services to refugees. Several factors determine the eligibility of a refugee for provincial and federal health care (e.g., age, status of application, type of sponsorship) (Pottie, Dahal, Hanvey, & Marcotte, 2015). Factors that limit refugee access to health care include language barriers, sociocultural and religious barriers, gender issues, discrimination, hesitance to seek help, and lack of knowledge about available health care services (Oda et. al., 2017; Antonipillai, 2015).

Government workers and health care professionals have developed ways to improve the delivery of health care services to refugees. For recent Syrian refugees, supporting information regarding health care access, insurance, and other relevant content appear in Arabic and English on the Alberta Health Services (AHS) website (AHS, 2018). Additionally, AHS provides specific instructions to health care professionals working with Syrian refugees, such as online learning modules on immigrant/refugee health. Both AHS and the Multicultural Mental Health Resource Centre deliver culturally sensitive mental health care for refugees. They provide information on culturally-appropriate mental health services and interventions through local community organizations that advocate for refugees (AHS, 2018).

The province of Alberta supports refugee awareness through entities such as the Centre for Race and Culture and the Multicultural Health Brokers Cooperative. These entities work to improve the awareness of refugees and ensure a sustainable settlement in the province by educating them to overcome barriers to necessary services such as health care (Centre for Race and Culture, 2017). Other initiatives that currently exist include: i) the Alberta Medical Association's 'Emerging Leaders in Health Promotion' grant program, which provides funding to help medical students and resident physicians conceive and implement health promotion projects in support of health advocacy, a program that has relevance to refugees; ii) Calgary Refugee Health's refugee clinics that increase refugee knowledge of health care services via informational packets in 14 languages (Killeen, 2016). In addition, the federal and provincial governments, along with municipalities, have implemented extensive health care delivery programs for refugees. While such programs exist, it remains critical to understand the reasons refugees, especially refugee women, still fail to access and use health care services. Supportive social networks and service provider organizations are essential to ease integration.

The Role of Settlement Agencies in Health Care

Settlement agencies are the main points of contact for most refugees immediately after arrival. The federal and provincial governments try to meet the needs of refugees by funding and providing contracts to non-profit settlement agencies to deliver support programs for refugees (Mukhtar et al., 2016). Settlement agencies assist refugees by offering language programs, employment, community outreach events, and health care information services. Settlement agencies exist in various forms (e.g., faith-based,

multicultural, specialized, mono-ethnic, or community response services) (Wayland, 2007).

Refugee settlement agencies acts as intermediaries between the government, private sponsors, and refugees to promote integration. Social workers and volunteers act as counselors, advocates, and translators (Green, Free, Bhavnani, & Newman, 2005). Private, and community-based agencies work in collaboration with service providers to support refugees as they establish social support networks to help them understand and navigate their new environment. These agencies also assist refugees with transportation to and from appointments, translation services, and activities of daily living (e.g., how to schedule appointments for health care services) (Redwood-Campbell et al., 2008). Settlement agencies are usually funded by the government and/or private sponsors to ensure that refugees have necessary resources and information and that their needs are considered. The data these agencies gather informs policies to benefit refugees.

Refugees have access to several services: immigration services, language assistance, access to community services/resources, and social activities. Settlement agencies deliver services suitable for refugees from diverse cultural and ethnic backgrounds. Despite refugee settlement agencies' commitment to providing effective and continuous assistance to refugees, they experience short-term funding challenges and often go unrecognized for their efforts.

Coping Strategies and Resilience Among Refugees

The literature on refugees has long established the socio-economic, cultural, emotional, and practical challenges that face refugees during the pre- migration, migration and post-migration periods (Joyce, Earnest, De Mori & Silvagni, 2010; Fozdar & Hartley, 2013). In many cases, refugees develop their coping mechanisms (i.e.

resilience) from within and receive support from close relatives and community agencies/ organizations. They rely on their belief systems and engage in social activities to overcome their challenges and other related stressors. Studies shows that the majority of refugee's use coping mechanisms such as religious practices and prayers, maintaining their hope and faith in God or Allah, and through developing social networks (Sabouni, 2019; Jabouin-Monnay, 2016; Schweitzer et al., 2007). Social networks are important for refugees as they help create a sense of belonging, social inclusion, they serve as a resource for information sharing – all which helps to somewhat ease the integration into a new society (Boateng, 2010; Cheung & Philimore, 2017). Refugees often have limited social networks in their early settlement, so they rely on their spouse, children, relatives, friends, volunteers, and social workers, if available.

Resilience is defined as the ability for an individual to recover from difficulties, challenges or adversity and “connotes inner strength, competence, optimism, flexibility and the ability to cope effectively when faced with adversity” (Wagnild & Collins, 2009, p. 1). Despite refugee people facing many challenges and trauma, their strengths and resilience exhibited throughout the settlement process are often neglected or overlooked. It has been identified from the literature that several factors that encourage/ construct or hinder resilience among refugees (Pulvirenti & Mason, 2011; Hutchinson & Dorsett, 2012; Sue & Sue, 2012). Some of the positive factors that positively influence refugee resilience include personal qualities, support, religious and cultural beliefs. Factors that obstruct or impede resilience in refugees include language barriers, discrimination, labelling and fear from previous traumatic experiences (Hutchinson & Dorsett, 2012). Research on resilience centers on the strengths and coping strategies refugees adopt during periods of adversity that effectively helped to maintain their sense of well-being

for survival and success in their new country (Lebens & Lauth, 2016). This mechanism allow refugees to effectively manage their challenges or stressors, thereby minimizing mental health issues (Turner, 2001). Turner (2001) is of the view that resilience comes with certain characteristics such as emotional support, developing and sustaining relationships, having hope, optimism, and a sense of humor, which is necessary to stimulate. However, Khalifeh (2017) argues that resilience among refugee women has positive impacts on individual health and wellbeing as well as for supporting families and community.

Theoretical Perspective: Intersectional Feminist Framework

The underlying theoretical framework of this study is the IFF (see Figure 1). The IFF is well established, especially in research about women, and is applied as a feminist research method. The Canadian Research Institute for the Advancement of Women (CRIAOW, 2006, p. 6) defined the IFF as a system that “aims to understand the circumstances that combine with biased social practices to produce and maintain inequality and exclusion.” The IFF focuses on systems of discrimination and how they reflect social or economic status, race, class, gender, age (reproductive status), ability/disability, sexuality, and location (rural or urban) (Weber & Fore, 2007). The key themes of IFF include: (a) developing strategies for analysis of the complexities of women’s lives; (b) ensuring policy analysis focuses on marginalized women; and (c) considering every aspect of women’s lives when making policy decisions (Hobbs & Rice, 2013). The IFF is a local and global concept that emphasizes how a person’s background, geography, culture, sexuality, and ability intersect to influence interactions of a person or group. Organizations and individuals who actively engage with IFF’s principles help uproot some tensions and challenges by reexamining previously held beliefs. Adoption of

IFF by researchers, policymakers, and activists may generate equitable and broad-based social and economic change (CRIAW, 2006). The IFF may reveal new understandings and strategies for change for refugee women. The reality of women crossing borders is complex and application of IFF provides a broader scope of analysis.

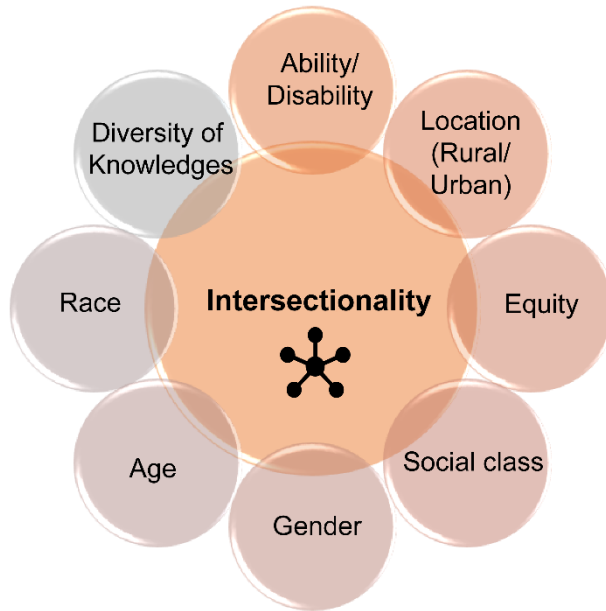


Figure 1. Intersectionality framework and systems of discrimination in Intersectional Feminist Framework (Scambor & Busche, 2009; Weber & Fore, 2007).

Struggles for equality entail many different perspectives. The focus of the IFF is gender but it also addresses racism, sexism, ageism, and discrimination based on language, sexuality, or disability (CRIAW, 2006). Factors that result in inequities during the immigration process include: (a) the demand for highly skilled but lesser paid labor in Canada; (b) policy connections between trade, labor, citizenship, human rights, education, training, social welfare, health, national security, and the military; and (c) historical links between colonialism, nation formation, global economies, and immigration policies (CRIAW, 2006; Hankivsky, 2011).

As women's movements connect on a global scale, researchers generate tools and resources for analysis and to advocate for social change (Alpizar Durán, Payne & Russo, 2007). Organizations working with IFF offer strategies such as "Demarginalizing the Intersection" and "Mapping the Margins" to end vulnerabilities of women of colour, especially immigrants (Carbado, Crenshaw, Mays & Tomlinson, 2013, p. 2). Researchers and feminist activists use the IFF to generate knowledge about marginalized populations of women.

In the present research, the feminist intersectionality paradigm guided the study by promoting in-depth interactions with study participants who are marginalized women to assist me to explore the complexity of their lives, better understand the background and experiences of refugee women accessing, navigating, and utilizing the Canadian health care system within specific social, cultural, political, and economic settings (Attanayake, 2010; Mackenzie & Knipe, 2006; Weber & Fore, 2007). I employed a qualitative research method informed by the IFF to better understand factors that intersect to influence the health status and uptake of health care services among refugee women in Canada.

Summary

Current literature regarding the health of refugees lacks detail on how refugees, especially women, access, navigate, and utilize health care services in Canada. The above general review of the literature highlights gaps in the literature that I view as opportunities for future research. The literature supports the importance of understanding the needs of refugee women, especially in terms of their health and well-being. Navigating a new environment and health care system can be a complex and challenging experience for anyone, but particularly for refugees due to the experience of a profound cultural change, language barriers, limited experience, and a general lack of knowledge

of such a system including the services available to them (Straiton & Myhre, 2017). Policies, along with a person's level of literacy can create barriers to accessing the necessary services that lead to improved health outcomes for these individuals (Hunter & O'Shea, 2017). It is therefore vital to understand the needs and challenges experienced by this group when trying to understand the system and services they need.

CHAPTER 3. RESEARCH DESIGN

This chapter includes a discussion of the methods I used to conduct the study. A qualitative approach was used to gather and analyze data regarding the experiences and needs of refugee women pertaining to health care services in Canada. I also address the data collection and analysis procedures, as well as the trustworthiness of the data and ethical considerations.

Philosophical Stance

Jackson (2013) argued that the philosophical underpinning a study is fundamental to clarifying the research methods, study design, and framework, and influences the quality of the research findings. The philosophical method of inquiry for this research is a social constructivist approach which is used to understand the background and experiences of participants on the phenomenon being studied and how they impact their world (Creswell 2003; Thomas et al., 2014). The application of social constructivism yields in-depth insights into refugee women's social and cultural background and also how their development of knowledge affects their social world (Creswell, 2003; Mackenzie & Knipe, 2006). Social constructivist researchers rely on the beliefs and experiences of participants and analyze how historical and cultural settings influence their way of life by inductively creating patterns of meanings throughout the research process (Creswell, 2003). The ontological assumptions of the constructivist approach reflect the fact that opinions and experiences may reveal several perspectives and cannot be generalized (Mack, 2010). To understand the health care needs and experiences of refugees accessing health care services, I used social interaction to constructively consider collective and individual views and perceptions.

Setting

The setting of this study was southern Alberta. Alberta is the fourth most populous province in Canada with about 4,252,900 people (Statistics-Canada, 2016). Between 2010 and 2014, the number of refugees admitted to Canada was about 49,516, approximately 1% of the population (Hyndman, Payne, & Jiminez, 2017). Refugees account for about 5% of the immigrant population in the province (Alberta Finance and Enterprise, 2009)

The target population of the study was refugee women from six locations in Alberta: the cities of Brooks, Calgary, Medicine Hat, and Lethbridge are urban locations with refugee settlement agencies, adult learning institutions, and community centres that are either government or privately funded. The city of Brooks (population: 14,451 as of 2016) (Statistics Canada, 2017) is a small community that provides settlement programs and services to refugees through settlement agencies and organized adult literacy programs. In the larger cities of Medicine Hat (population: 63,260 as of 2016) (Statistics Canada, 2017) and Lethbridge (population: 99,769 as of 2018) (City of Lethbridge, 2018), the federal government has established two federally funded refugee reception centres. Calgary (population: 1,267,344 as of 2018) (City of Calgary, 2018) is the largest city in Alberta and welcomes thousands of refugees from around the world; there are government and privately funded settlement agencies and a refugee clinic to support refugees. The other two locations involved in this study were the rural communities of Claresholm and High River. In Claresholm (population: 3,780 as of 2016) (Statistics Canada, 2017), refugees receive support from private sponsors (e.g., faith-based organizations, non-profits, businesses, families, friends, and volunteers). The Claresholm Community Centre and the public library are the main sources of information for new refugees. In the community of High River (population: 13,584 as of 2016) (Statistics

Canada, 2017), there is a non-profit immigrant agency that provides settlement and integration assistance. The diversity of the study locations (urban and rural) helped me investigate the health care needs of refugee women in different locations to identify how they familiarize themselves with, access, navigate, and use the health system and services available to them.

The area of Southern Alberta was chosen for the location to conduct the study as it is the area where my academic institution is located and the communities are all within a two-hour drive. The red symbols on the Google map (see Figure 2) identify the six communities that were involved in the study.



Figure 2. The geographical locations of the research study within southern Alberta.

Participants

To explore the health care needs and experiences of refugee women in understanding, accessing, navigating, and utilizing the Canadian health care system and also to identify strategies to improve the resettling experience, the study was structured using two different group of participants: i) refugee women; and; ii) local leaders/ refugee

centre administrators. The refugee women were invited to a focus group interviews, while the administrators engaged in individual interviews.

For the refugee women, the inclusion criteria were as follows: participants had to be English-speaking, between the ages of 18 and 49, had lived in the province for six months to five years, and willing to volunteer time to share their experiences. However, some refugee participants could not speak English fluently so required assistance from an interpreter who translated their local languages (i.e., Syrian Arabic, Somalian Arabic, Burmese, and Spanish) to English. The inclusion criteria for the individual interview participants that they had to be a local leaders /refugee centre administrator who worked in a role that provided support to refugee women upon their arrival to Canada.

A purposive sampling technique with snowball sampling methods was used to recruit participants from the refugee community. This technique is appropriate for selecting specific persons, settings, or events based on their unique information (Holloway, Wheeler & Holloway, 2010). Some researchers refer to this method as selective or subjective sampling as it is dependent on the characteristics of the sample population and the researcher's judgement (Silverman, 2015). Application of a purposive sampling technique helped to identify specific refugee women from a particular setting who had unique and rich information to share (Maxwell, 2005). It also helped me to determine study sites.

Snowball sampling is a nonprobability sampling technique where existing study participants recruit future participants from among their acquaintances. Thus, the sample group is said to grow like a rolling snowball. Snowball sampling was used according to the recommendation of Creswell (2008) who views it a beneficial sampling strategy for researchers who are not entirely familiar with the study population. Through the

application of the snowball sampling methods, the number of refugee participants and the number of focus groups for the study actually increased from twenty-four (24) to thirty-nine (39) refugee women participants and from four (4) to six (6) focus groups respectively.

I employed an exploratory qualitative design to gather the perceptions and experiences of refugee women in understanding, accessing, navigating, and utilizing the Canadian health care system, and the observations of local leaders regarding the women's experiences. Qualitative research is a means of social inquiry that seeks a deeper understanding of how individuals identify and interpret their environment (Atkinson, Coffey, & Delamont, 2001).

Data collection for this study was conducted in two phases (Figure 3 below) as is common for qualitative research studies on health care utilization (Crosby et al., 2009) and refugee health (Gabriel et al., 2017). Phase I involved focus groups, and Phase II involved in-depth individual interviews. The interviews generated rich data and complemented the data collected from the focus groups, which helped me to gain a deeper understanding of the lived experiences and beliefs of refugee women (Gill et al., 2008).

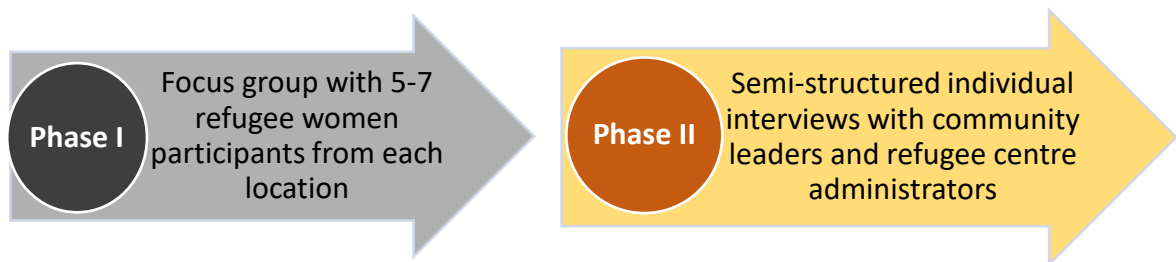


Figure 3. Two-phased data collection method employed in the study.

Phase I (focus groups). The focus groups provided opportunities for the refugee women to exchange information in a safe, comfortable setting and generate insightful data. The purpose was to explore the women’s perceptions of health care and the health care system in Canada. Six focus groups with 39 participants contributed to the study in all locations except Claresholm. As stated by a refugee centre administrator, the refugee women in Claresholm were not willing to participate in the study due to “fear of being sent back to their home country and the discomfort in sharing their previous experiences.”

- **Recruitment.** To recruit women for the focus groups, I sought the assistance of local leaders/administrators at refugee centres, community centres, faith-based organizations, and learning organizations via phone, email, and in-person to inform them about the study and ask for their assistance. I also made use of my social network to connect with some of the refugee women, this helped to build trust and relationships, and encouraged some women to participate in the focus group discussions and feel comfortable sharing their views. After the initial contact and agreement to assist was made, I then provided the potential participant with a Memo to Inform (Appendix A) and a Letter of Ethical Approval (Appendix B). I then had Study Posters (Appendix C) placed on the notice boards in each of the participating organizations to inform potential focus group participants about the study. The posters contained an invitation to participate along with my contact information. Those people interested in participating then contacted the local leader/administrator to inform him/her of their interest. Once enough interest was generated, that local leader/administrator informed me. From there the local leader/administrator and I would work to come up with a mutually agreed upon

date, time and location to conduct the focus group. The local leader/administrator served as an advocate for the women in setting up the focus group.

- **Process.** At the start of each focus group session, I informed all participants of the purpose of the study, and discussed ethical considerations such as maintaining confidentiality, use of the information collected, benefits and risks associated with participating, and the ability to withdraw from the study up to the point of data analysis without explanation or consequence (see Letter of Information, Appendix D). All participants were then asked to sign an Informed Consent Signature form (see Appendix E) and a Confidentiality Agreement (see Appendix F). I provided one-to-one time with each participant as needed to review the Letter of Information and Letter of Informed Consent to ensure they fully understood. An interpreter/translator was available to assist the refugee women with language difficulties throughout data collection.

The Focus Group Guide for refugee women appears in Appendix G. Each focus group session lasted between 45 and 90 minutes and was audio-recorded upon consent of the participants. The focus groups were face-to-face interactions at a mutually agreed upon location, date, and time. After completion of each focus group, participants received a \$15 gift card in appreciation for their participation. There were no withdrawals from participants or observable emotional distress noted during data collection.

Phase II (semi-structured individual interviews). The second phase of data collection involved an interview with a local leader/administrator from each of the participating community organizations involved in Phase I. Seven individual interviews, were conducted, which helped me to understand the situation better in each of the

different communities. Involving these individuals who were already familiar with the study (as they assisted in recruiting participants for the focus groups) helped to ensure some consistency in the information gathered and allowed me an opportunity to clarify questions raised during the Phase I.

- **Recruitment.** After a focus group session was completed, I then contacted the local leader/administrator from that same community, to explain the second phase of the study and ask for his/her participation in an interview. Once the person verbally agreed to participate, I organized a mutually agreed upon date, time and location to conduct the interview. Prior to each interview, participants were emailed a copy of the Memo to Inform (see Appendix A), Letter of Information (see Appendix D), and the Informed Consent Signature Form (see Appendix E).
- **Process.** Between phases, I analyzed the focus group data. Any questions related to data from the refugee women were asked during the individual interview with the local administrators. In addition to those questions, I followed the structure set forth in the Interview Guide (Appendix I) that I developed to ensure some consistency across interviews. Interview participants shared their experiences working with refugee women, and perceived challenges and barriers to accessing health care services, and provided recommendations to improve the health care experience for refugee women. Participants gave their signed consent for the face-to-face interviews to be audio-recorded. The individual interviews lasted between 45 and 60 minutes each.

Interpreters/translators. Interpreters/translators serve as intermediaries to ensure the transfer of information from one language to another (Palmer, 2007). When

recruiting interpreters/translators, it is important to consider their gender, culture, and linguistic backgrounds and those of the participants (Berman & Tyyska, 2011). I employed an interpreter/translator within each community to assist women in transferring information from the local languages to English.

The interpreters/translators were recommended by the local leader/administrator of each participating organization. For the most part, they were from those organizations and familiar with the refugees in the community. After recruiting the interpreters/translators, I provided them with 30 – 60 minutes of training which consisted of an explanation of the study, communication processes between interpreters/translators and the participants, and data management protocols. I discussed ethical obligations with the interpreters/translators to ensure all research information (e.g., participants' identities) would be kept confidential throughout and following the process. All interpreters/translators signed a Confidentiality Agreement (Appendix H). Interpreters/translators were tasked with translating questions and content to participants in a clear voice using precise words without rushing, to ensure understanding. Interpreters/ translators were employed in each study location for all focus group discussions and were selected based on their familiarity with the refugee participants to minimize misinterpretation of information. For instance, most interpreters/translators shared similar cultural experiences and involved in refugee women's daily life experiences like taking them to the clinics, hospitals, and assisting with documentations. In one case, a translator faced difficulty translating the Arabic language as there was a difference between Syrian Arabic and Somalian Arabic; in this case, other participants assisted.

Data Analysis

I applied Braun and Clarke's (2006) thematic analysis procedures and guidelines to analyze the qualitative data. Thematic analysis is a process of encoding and interpreting qualitative data; the researcher reflects, interprets, and compares data to develop theoretical insights (Talbot, 1995). This approach uses six steps to manage and analyze data (Braun & Clarke, 2006; Clarke & Braun, 2013):

- i) *Familiarization with data:* I transcribed all of the focus group and interview data. I engaged with the data by reading the transcripts multiple times and each time wrote notes that included thoughts, ideas, meanings, and interpretations.
- ii) *Generating initial codes:* After familiarizing myself with the data, I identified initial codes using the participants' own words. I then manually generated all codes and themes systematically by comparing the data relevant to each code. Coding is the collecting of relevant phenomena and analyzing those phenomena to find the commonalities, differences, patterns, and structures (Seidel & Kelle, 1995).
- iii) *Searching for themes:* I then analyzed the codes to identify similarities in the data and sorted the relevant coded data into potential themes. A theme is a clear and meaningful pattern in the data that is significant to the research question (Clarke & Braun, 2013). Preliminary themes were broad and more general than later themes.
- iv) *Reviewing themes:* The themes were then reviewed and re-assessed to ensure participants' contributions were well-represented and themes did not overlap. I then confirmed that themes adhered with the coded extracts and the full data

set and re-examined the data to ensure they fit with the themes and compared the relationships among themes.

- v) *Defining and naming themes:* I described each theme, named it, and then clearly defined it to capture the importance of the theme to the study and research questions in a clear, concise, and effective way.
- vi) *Producing the final report:* A report of the final thematic analysis of the data was then produced. This step goes beyond the description of themes and involves analysis of the themes in relation to the research questions (Braun & Clarke, 2006).

Scientific Rigor and Trustworthiness

To ensure the consistency and credibility of the findings, I established scientific rigor and trustworthiness using criteria proposed by Lincoln and Guba (1985). Principles for assessing rigor and trustworthiness in this qualitative study include credibility, transferability, dependability, and conformability.

Credibility. Credibility addresses how congruent the findings are in reality with participants' views and ensures the accuracy and consistency (Pandey & Patnaik, 2014). In this study, credibility was established by being well-informed about the context, community, organizations and people in the study. This process ensured accuracy of the results and representation of the voices of the participants. To ensure participants' views were well presented, each participant was provided time to communicate with me through an interpreter on a one to one basis if needed via email, telephone, or in person. The accuracy of the interview data was confirmed by re-listening to the recordings and comparing them with the transcribed interviews. I engaged in member-checking with study participants with the assistance of the interpreter/translator to avoid

misrepresentation of their responses. All participants approved the data to be included in the analysis without any withdrawals. An encrypted version of the transcribed focus group discussion and individual interviews was provided to participants prior to the data being analyzed.

Transferability. Transferability addresses the degree to which the study findings apply to other individuals, groups, contexts, or settings (Liamputtong, 2009).

Transferability ensures external validity/generalizability of the findings (Shenton, 2004). It is the degree to which the results from qualitative research resonate with other contexts or settings in the general population as it provides rich description of the unique experiences of participants. In this study, I presented detailed descriptions of the data collection methods and the inclusion criteria to promote transferability.

Dependability. Dependability is whether the process of data collection, data analysis, and the study findings are reliable and repeatable over time (Lincoln & Guba, 1985; Morse, 2015). To ensure this consistency, I completed an audit trail of the research which involved reviewing all documents pertinent to the study and maintaining a clear and full account of records during all phases of the research (e.g., problem formulation, selection of participants, maintaining field notes, transcriptions, data analysis, and interpretations).

Confirmability. Confirmability is the last criterion of trustworthiness that a qualitative researcher must establish. It is the attempt of objectivity (Shenton, 2004). Confidence in a study's findings depend on participants words as well as the researcher's biases, interests, and/or preferences (Lincoln & Guba, 1985; Shareia, 2016). In this study, I established confirmability with a process of reflexivity. I recorded and wrote down my thoughts pertaining to topics that were unique and interesting during data collection and

coding. For example, I provided a rationale for merging codes together to generate specific themes and explained what the themes meant. As I interpreted the experiences of my participants, I found myself as an outsider being the researcher, and an insider as an immigrant woman, having had similar experiences finding my way through a new health care system.

Reflexivity is an attitude that a qualitative researcher adopts when collecting and analyzing data. Here, I open-mindedly considered my background and perspective to determine how they influenced the research process (i.e., choosing the topic and methodology, analyzing the data, interpreting results, and presenting conclusions). Being a woman with an immigration background, it was important for me to ensure that I limited outside influences (such as, my personal experiences as an immigrant and woman) as best I could during the interpretation of the data. To achieve this, I made use of a reflexive journal by writing down my experiences, thoughts and actions during the research process to ensure transparency (Ortlipp, 2008). For example, I recall on facing challenges as a new immigrant learning about what to do, whether to treat myself at home, go to the pharmacy or who to contact about my health during my early settlement in Canada.

Ethical Considerations

Ethical approval for this research was obtained from the Human Subject Research Committee (HSRC) at the University of Lethbridge. This committee adheres to the Tri-Council Policy Statement (TCPS 2) for Research Ethics compiled by the Inter-Agency Secretariat on Research Ethics (Canada), the Social Sciences and Humanities Research Council of Canada (SSHRC), the Canadian Institutes of Health Research (CIHR), and the Natural Sciences and Engineering Research Council Canada (NSERC) (2014). The

TCPS 2 lists three core principles that must be following in conducting research: respect for persons, concern for welfare, and justice (CIHR, 2014).

- Respect for persons was addressed by ensuring all refugee participants are adults, able to participate willingly and give consent without coercion. The Letter of Information (Appendix D) and Informed Consent Signature Form (Appendix E) were read and explained to participants individually or given to them to read before they signed it. I also obtained approval to conduct the research with local leaders/administrators.
- Concern for welfare was addressed by informing participants of the potential risks and benefits of participating in the research and their right to withdraw from the study prior to data analysis without consequence. Due to the design of the research, I could not protect participants' identities from others in the focus group; however all participants signed a Confidentiality Agreement (Appendix F). The negotiation of consent with refugee groups is an ethical consideration because they are often reluctant to sign documents or may not fully comprehend the research due to language or education deficiencies (Block, Warr, Gibbs, & Riggs, 2012; Czymoniewicz-Klippel, Brijnath, & Crockett, 2010). In this study, the use of interpreters who refugee participants were familiar with helped with the data collection process. Mackenzie et al. (2007) suggested "iterative models of consent start from the assumption that ethical agreements can best be secured through a process of negotiation, which aims to develop a shared understanding of what is involved at all stages of the research process" (p. 302).

- In addition, all interpreters/translators who were involved in the study also signed a Confidentiality Agreement (see Appendix H) to safeguard information regarding participants' identities.
- Justice was addressed by treating all participants with impartiality, respect, and fairness. I provided detailed information about the study to all participants and ensured they clearly understood the research and process.

Summary

This chapter includes details of the design for conducting the research. This involved a description of the philosophical underpinning of the study, setting, participant recruitment and methods for data collection and analysis that allowed me to acquire an understanding of the needs and experiences of refugee women in understanding, accessing, navigating, and utilizing the Canadian health care system. Ethical considerations and processes to ensure the scientific rigor of study and trustworthiness of the study findings were also discussed. In the next chapter, I will discuss the findings of the study.

CHAPTER 4. FINDINGS

In this chapter, I present the findings of the study of the health care experiences of refugee women after arrival in Canada. I include interpretation of the focus group and individual interview data from refugee women and local leaders/refugee centre administrators. The study findings capture the experiences of refugee women as they settled into Canadian society and engaged with health care services. The views and experiences of local leaders/refugee centre administrators reflect ways they supported refugee women through that process. Further, I include a discussion of the refugee women's experiences, including challenges they encountered and strengths they discovered in finding their way through the system. The chapter concludes with strategies participants suggested may improve the health care experience of refugee women as they settle in Canada.

I begin with a brief description of participants' demographic characteristics followed by their stories, supported by verbatim quotations. I include themes and sub-themes that emerged from both the focus group and interview data. The data revealed an overarching theme, "*Fitting in*", along with three key themes. These themes are aligned with the Intersectional Feminist Framework and speak to: (a) living with loneliness; (b) finding our way; and (c) pathways for improvement.

Demographics Characteristics of Participants

In Phase I of the study, 39 refugee women participated in six focus groups; each focus group was conducted in a different community (e.g. Brooks, Calgary, Claresholm, High River, Lethbridge and Medicine Hat). In Phase II of the study, a total of seven individual interviews were conducted in the same communities with the exception of Claresholm. In Claresholm, none of the potential participants showed up to participate in

the scheduled focus group due to fear of being sent back to their home country and the discomfort in sharing their previous experiences, according to refugee administrator. The interview with the administrator in Claresholm was conducted.

To acquire demographic data, two different questionnaires were used depending on whether participants participated in a focus group or individual interview (see Appendices G and I). Focus group participants were asked to provide information on their gender, age, nationality, education, marital status, occupation, number of dependents, length of stay in Canada, and need for the use of a translator. These data helped determine how social, economic, and cultural factors influenced participants' experience with the Canadian health care system. Table 1 includes demographic information of the focus group participants, whose countries of origin, English language abilities, and time spent in Canada ranged widely.

Six females and one male local leaders/refugee centre administrator participated in the individual interviews (see Table 2). The majority of these participants were born and raised in Canada and had a Bachelor's degree. Most of these participants had been working in their role, supporting refugees, for at least seven years.

Table 1

Demographic Data for Refugee Women

Characteristic		Number	Percentage
Age range (18-49 yrs)	18-25	6	15.38%
	26-33	9	23.08%
	34-41	15	38.46%
	42-49	9	23.08%
Nationality	Algeria	1	2.56%
	Columbia	1	2.56%
	El Salvador	1	2.56%
	Ethiopia	1	2.56%
	Egypt	1	2.56%
	Jordan	2	5.13%
	Libya	2	5.13%
	Mexico	4	10.26%
	Myanmar	5	12.82%
	Somalia	2	5.13%
	Sudan	1	2.56%
	Syria	17	43.59%
	Vietnam	1	2.56%
Education	Bachelors	10	25.64%
	Diploma	4	10.26%
	Secondary	6	15.38%
	Primary	16	41.03%
	None	3	7.69%
Marital Status	Married	30	76.92%
	Single	9	23.08%
Occupation	Professional/ Skilled	4	10.26%
	Unskilled	4	10.26%
	Unemployed	31	79.49%
No. of Dependents	0-2	17	43.59%
	3-5	17	43.59%
	6-8	5	12.82%
Use of translator	Yes	32	82.05%
	No	5	12.82%
	Partial	2	5.13%
Length of stay in Canada (months)	6-12	15	38.46%
	13-36	21	53.85%
	37-60	3	7.69%

Table 2

Demographic Data for Local Leaders/Administrators

Characteristic		Number	Percentage
Gender	Female	6	85.71%
	Male	1	14.29%
Country of Origin	Canada	5	71.42%
	Jordan	1	14.29%
	Myanmar	1	14.29%
Education	Masters	1	14.29%
	Bachelors	4	57.14%
	Diploma	2	28.57%
Occupation	Social Workers/ Directors	4	57.14%
	Sponsors/ Volunteers	3	42.86%
Duration working with Refugees (yrs.)	0-3	3	42.86%
	4-7	3	42.86%
	>8	1	14.29%

Description of Themes

The following section presents the themes and sub-themes that presented from my analysis and interpretation of the data. The themes speak to refugee women's experiences with the Canadian health care system as they settle in Canada.

The overarching theme, "*Fitting in*", captures refugee women's experiences, approaches, and challenges in adapting to a new environment. Three key themes emerged from the analysis of the data: (a) living with loneliness; (b) finding our way; and (c) pathways for improvement. Figure 4 and Table 3 below illustrates the health care experience of refugee women.

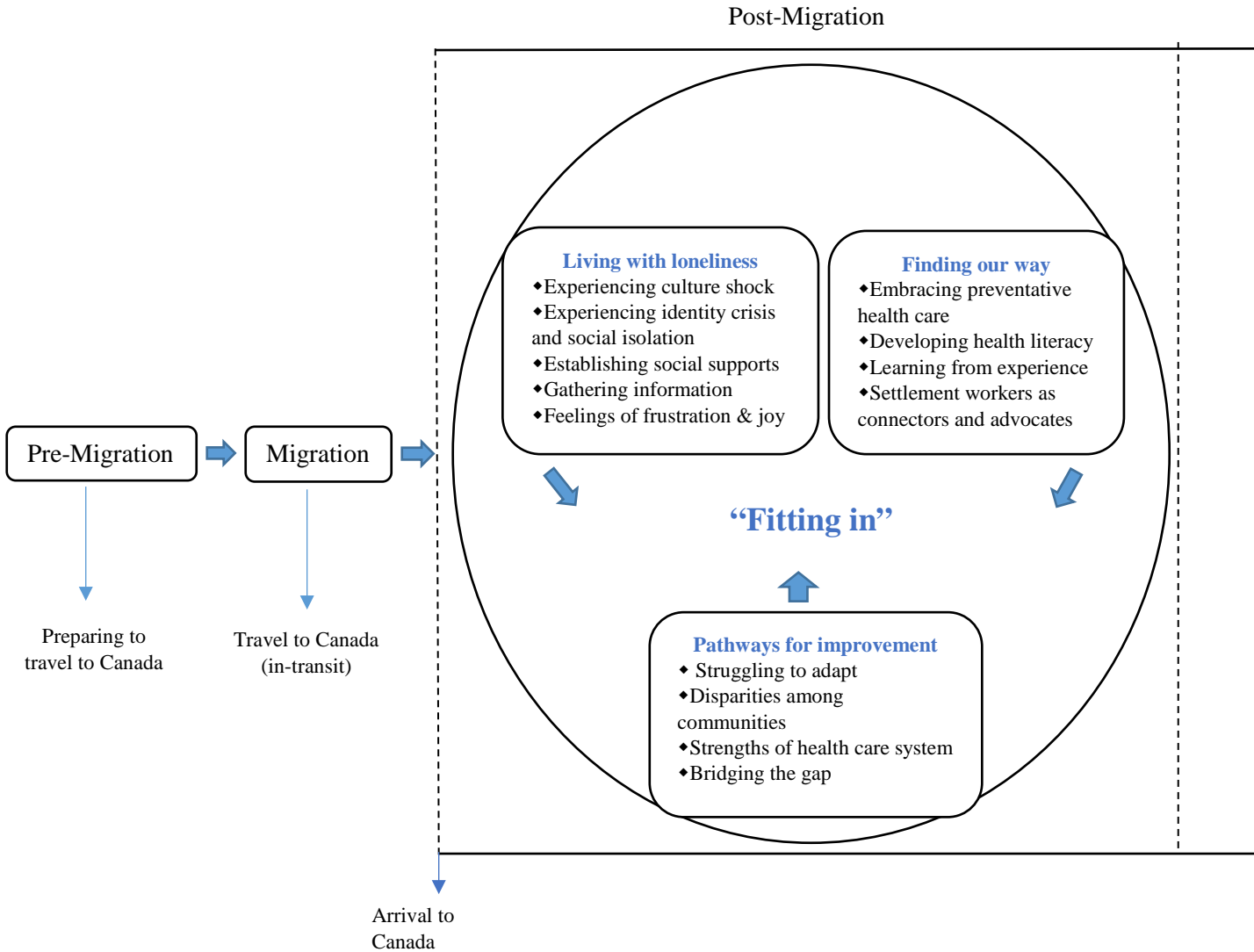


Figure 4: Refugee women’s health care experience in Canada.

Figure 4 presents an illustrated conceptualization of the journey and timeline experienced by refugee women starting with pre-migration, through migration, to post-migration or the period of *trying* to “fit in.” Although the study does not address the pre-migration and migration experiences of refugee women, it clearly influences the post migration experiences. Some refugee women have had very traumatic and long journeys from the home country to get to Canada and that experience can impact how they access, utilize and navigate the Canadian health care system. In the pre-migration phrase,

refugees are preparing to leave their home country due to a natural disaster, conflict, war or even forcibly displaced to the a safe community or country. During this period of migration, refugees are exposed to severe physical and emotional violence and abuse and may have limited or no access to basic needs such as food, shelter, and water as well as health services (Lori & Boyle, 2015; Swinkels et al., 2011; UNHCR, 2015).

Migration is the initial transition or movement of people to seek refuge in a safe area on a temporary basis. As refugee flees their home country trying to survive in a refugee camp, women become more vulnerable and face harsh experiences such as sexual abuse, severe illness, disability or even death (Collyer, Duvell & De Haas, 2012; Martin, 2004). In transit, refugees encounter life-changing experiences in which these women in learn to become resilient and cope with the situations while looking forward, with hope, to a better life. The post-migration phase is the final stage of migration in which refugees settle in a developed host country and are provided with protection and support.

Upon their arrival in the host country, Canada, refugees begin a new life and are introduced to unfamiliar social and cultural structures as they strive for survival and success. Refugees experience this with mixed feelings – it is an opportunity for a better life away however there will be further challenges encountered as the confront cultural and language differences, a loss of identity, and feelings of loneliness as they strive to adjust to the new environment. To “fit in” to the Canadian system, they find a way to establish social supports to learn about their personal health, the health care system and embrace a new lifestyle (which includes preventative health practices). During this period, local leaders/ refugee centre administrators also play a vital role as advocates and connectors in supporting refugee women’s integration either as part of their job or their desire to serve. In quest to bridge the gap between expectations and lived experiences,

refugee women recommended some strategies and also highlighted on the efforts of the Canadian health care system to support them and improve their health experience in Canada.

Table 3

Overarching Theme, Key Themes, and Subthemes of Focus Groups and Interview

Overarching Theme: “Fitting in”			
Key themes	Living with loneliness	Finding our way	Pathways for improvement
Sub-themes	Experiencing culture shock	Embracing a preventative model of health care	Struggling to adapt
	Experiencing identity crisis and social isolation	Developing health literacy	Disparities among communities
	Establishing social supports	Learning from experience	Strengths of the Canadian health care system
	Gathering information	Realizing the importance of settlement workers as connectors and advocates	Bridging the gap
	Feelings of frustration and joy		

Overarching Theme:

Fitting In

The overarching theme of “*Fitting in*” highlights the challenges refugee women face as they settle in Canada and adjust to a way of living, and a new health care system. The early experiences of refugee women and their uncertainties about the future leave them questioning how to adapt to their new country. Navigating a new health care system can be a challenging experience for refugees when they first arrive in a host country

(Morris, Popper, Rodwell, Brodine, & Brouwer, 2009). In this study, participants described how they integrated into the Canadian health care system. Participants described their post-migration experience as “*fitting in*” to a new world. For example, one refugee woman in a focus group stated,

Everything was strange to me in the beginning and I was feeling lost. It was a struggle for me like starting life all over again and in this place, you have to get ahead to fit into the system. (FB)

Among the many experiences participants shared, some challenges involved adapting and integrating into the new environment, difficulty starting over, and problems navigating the health care system. Participants described some success stories, but most faced difficulties integrating into Canadian society. Participants explained difficulties understanding and familiarizing themselves with the health care services available to meet their unique health needs. One refugee woman reflected on her health care experiences in Canada:

The health care system here is very different as compared to back in Syria and it takes sometime to understand. You have to become like them or try fitting in to get the health you need here in Canada. If you get someone, or find out yourself the necessary step to go to doctor or pharmacy. (FL1)

A refugee centre administrator working directly with refugee women shared her views of refugee women’s experiences. She stated, “They [Canadian health care practitioners] listen to the women, they make sure all needs are met and they try their best to understand the values, the beliefs and how we can fit them to the care” (PL2). The local leaders/ refugee centre administrators’ perception of “fitting in” described refugee women embracing Canadian health care practices as they adjust to their new environment. Refugee women shared experiences of their journey integrating into the Canadian health and social system from beginning a new life and feeling lost and alone,

to finding pathways to health, and then assessing their unmet needs and expectations. Most refugee participants expressed their experience as a process of *fitting in* to the Canadian health and social system.

Key Themes

Key theme #1: Living with loneliness. Starting a new life can be daunting for refugees transitioning to their host country. In this study, participants described their initial settlement experience as feeling *lost* and *alone* with little understanding of what to do or where to go. They considered their transition to Canada as the beginning a new life and strove for survival and success in a new country. Loneliness was an enduring experience of refugee women during their early transition. One refugee woman described how she felt during the first stage of settlement in Canada.

We came to this country with nothing. For me, I have no friends or somebody to help so you feel lost. I do not know anybody here and my family are my kids. My kids come home from school and cry and I ask why, she said mum I want to go back home, here different people, different language, she is scared and lonely.
(FB)

Refugee participants were anxious during the first weeks, months, and even years of the unfamiliar situation in Canada and struggled with feelings of hopelessness. They characterized initial contact with Canadian society as becoming aware of the need to adapt to a different way of doing things. The stories of refugee women highlighted different aspects of their post-migration experience including language barriers, cultural sensitivity, building social networks, accessing information and support, and accessing and utilizing health care services.

Experiencing culture shock. Issues of cultural shock were particularly prominent in the focus groups. Cultural shock was described as an unfamiliar experience for

refugees/ newcomers as they are exposed to a new cultural environment or way of life which may lead to feelings of anxiety and loss (Bochner, 2003). Some experiences that caused the shock included new ways of doing things, encounters with new people with different values that participants described as intimidating, and a very different environment from where they grew up. One refugee participant explained, “I felt confused and sad missing home and friends and family. You feel belonging to a group but here you walk alone” (FH).

Adjusting to a new cultural environment can be stressful for refugees. Some refugee participants expressed a sense of anxiety and emotional distress; they felt alone in a new culture. One of the youngest refugee women in the focus group stated, “I was very happy when I first arrived in Canada but not a little long, I realized that everything was different and difficult including the culture and the people” (FCa).

Regarding interacting with new people or joining social activities, refugee participants noted they found it difficult to network in their new surroundings. Some focus group participants mentioned that Canada is a more individualistic society than their collectivist society at home. Some refugee women explained that people in Canada are independent and do not rely on others. In their home country, people are interdependent; they feel connected to each other and act in a group as a community. Participants found the new society and culture frustrating. One refugee participant stated,

I think new people like us also not familiar with things here, I feel worried sometimes and not used to it. Back home we know everyone and neighbors, in my country my house big and everyone comes around but here we don't know anyone, you have to stay inside because of cold and other things. Everyone keep to themselves and it's difficult to make friends and even shy to go for programs. (FB)

Another participant summarized comments of other focus group participants.

It is a whole different perspective. It's not perfect with the social life and health system, it is difficult to navigate for a lot of us obviously, if you have language barrier and cultural difference, yes, it is challenging. I think there has been a real effort for most of us refugees and a lot of them now go for programs and see the same doctor. (FM)

With time, some of the women embraced the Canadian culture or way of life and accessed the services provided to them.

Participants noted significant cultural differences in their understanding of the health care system and their new environment. Refugee women explained that they encountered extensive changes including cultural and socioeconomic challenges as they adjusted to their new life. Most focus group participants were surprised with differences noted in health care practices, especially when booking appointments, seeking care from male doctors, and learning about health care practices in Canada. Most refugee participants shared similar views that the health care services provided in Canada conflicted with their home culture or traditions.

I think the health care that we get is probably better than what we had back in our country just that sometimes we face difficulty with language barrier and cultural change in how the health care is delivered. We need more female doctors as refugee women. For delivering we have male doctors delivering us, and it's very uncomfortable and against our culture. (FL2)

Although refugee participants acknowledged they have advanced health care services here in Canada than what they experienced in their home country, the differences in language and culture posed barriers to interactions with the system.

Participants claimed the Canadian system did not accommodate cultural differences, which presented a challenge for the women. Some refugee participants also noticed that settlement workers and health care professionals who supported them had little knowledge about their needs or any form of cultural sensitivity training. One focus group respondent mentioned,

When you have for example, single women, women who have never had children err mm...they are talking to women who have had seven children and whatever, like it's kind of mmm and I know these women think this is my job and I have to help them [refugee women]. Part of it is the whole cultural difference as well and part of it is the fact that, they do not have kids or any training and don't understand this whole refugee kind of thing. (FL1)

Experiencing identity crisis and social isolation. Many refugee women reported feeling a loss of identity when they first moved to Canada. An identity crisis can occur when a person's sense of identity becomes insecure, typically due to a change in their expected aims or role in society. Fear of the unknown led some refugees to feelings of despair and isolation. They felt excluded from their new world. Taking on a new identity as a refugee causes trauma, stress, and concern about the future. The loss of identity and frustration were evident in a comment made by one refugee woman.

You have been identified as this person first when you left your home country and you have been processed and identified as a refugee here, so through that process sometimes there are expectations that may or may not be completely realistic. (FB)

Interactions with people in the new environment resulted in refugees modifying their values and beliefs and exhibiting a new personality to *fit in* to the new society and system. One refugee woman added, "I need to pause, change, and get a new personality" (FL1). During the settlement process, refugee women witnessed unfamiliar lifestyles and experienced discrimination, isolation, and a loss of identity. Refugee women with identity crises felt isolated and avoided integrating into their new country.

Differences in language can influence participation in social activities, health care access, and the delivery of health care services. When some refugee women talked about identity, they described customs and traditions that influenced what they believe and the ways they act. Some women placed great importance on preserving their past identity, while others placed importance on taking on a new identity. Having a clear identity or

sense of self, and a sense of belonging, can help a person identify more clearly with themselves – with their health care needs and preferences and more confident in accessing health care services.

Some of the refugee women reported that they had no information or support regarding available health care services; others felt they did not deserve it nor could afford it. Some participants expressed a strong sense of isolation and didn't identify as being part of their new society.

Here when we came, I did not know anyone to help me about what to do or where to go when I need to see a doctor or get medicine for my children. And because I am refugee and different from those here, so I keep to myself and prepare some traditional medicine I came with. We did that until we found some church people who were willing to help us. (FM)

Factors such as gender, socio-economic status, lack of appropriate support, sense of belonging, perceived discrimination, and cultural and language barriers can influence a person's utilization of health care services (Beiser, 2005; Kirmayer et al., 2011; Warfa et al., 2006). For example, one woman stated, "For me, I have to go with my husband to the doctor's appointment else my husband won't let me go on my own. My husband sponsored me so I do not know anything" (FH).

Establishing social supports. For refugees, a good social support system can greatly influence their integration into Canadian society. Most refugees depend on support from government, organizations, family, friends, and volunteers to navigate the health and social systems. According to some participants, private sponsors (e.g., religious organizations or spouses) helped them access health care services. Some focus group participants indicated that the women group meetings, workshops and adult literacy classes with settlement agencies enhanced their access to health care services.

In the first month of arrival, Lethbridge Family Services organized meetings after meetings, orientation after orientation and they ask questions. For her [another focus group participant] who is sponsored by the church because it is not easy to get a family doctor, they [church] ask questions like 'is there anyone in your family that require health or if there is anyone with health issues.' (FL1)

Family and friends who have resided in the host country for a longer period of time provided refugee women with basic health information and practical support about how to seek health care services in Canada. A married focus group participant perceived support from her spouse as helpful.

My husband supports me. I did not know anything so it helped. I have some family members here who have been here for about five years. They help me with how to do things here and where to go when I am not feeling well. (FCa)

Participants shared similar responses about social support networks and health care access for refugee women resettling in Alberta. Some local leaders/refugee settlement workers and administrators volunteer or work in organizations that aid refugee women. Many of the participants highlighted that orientation programs about health care in Canada serve to address the health needs of newly arrived refugee women. One administrator stated,

When they come within the first week to about six months or as of now, there are programs or support systems organized for them about health care in Canada. It includes what they can do, and how they can go about their health here. It could be an orientation, event, or something organized by the community or the church. (PL1)

Some participants identified the government as a source of social support that facilitated access to health care services. Local leaders/refugee centre administrators usually referred refugee women to government organizations as a first point of contact to acquire health care coverage and benefits. An administrator noted that government programs ensure that refugees get provincial health support regarding how to navigate the Canadian health system and access appropriate health care services.

I know Alberta Health Services does do a lot of programs and I will send them to the Alberta Health office or tell them where that is. That is the first place I direct them to. The health unit is very good about being open to suggestions, doing tours and talking about women's health, talking about facilities that are available and making sure immunizations are looked after. Those things are helpful. (PH)

Gathering information. Refugee women's access to information about their new environment is vital to helping them integrate and adapt to the new health care system and society. In this study, participants discussed how they gathered information about the health care system. For most refugee women, their social network was the major resource for accessing information about the Canadian health care system and services available to them. Participants socialized in their new community with family and friends or accessed public programs for assistance upon arrival. One refugee participant explained,

When you come here, sometimes the community, family, or friends help you, but if you did not know anyone, you may go to the Association for Children and Families settlement agency or the school here. Yes and we have host friends when we get here, six months they come to visit, some come and volunteer in our home and they also explain how to make appointments to doctor and how to find a family doctor and at the same time when you are sick where to go and all that. (FB)

Participants noted several information sources that contributed to their knowledge about the health care system. Health orientations for refugee women gave them practical experience. Focus group participants shared ways they found information to access and utilize health care services.

Immigration Services help us. They do have health orientation and sponsorship from the church where they give orientation about health here. Through immigration services agency, we take classes to learn about health care here, through Canadian friends and volunteers and also other refugees like socialization. (FL1)

An administrator explained the role of local leaders and refugee settlement workers in providing refugee women with health care information. A representative from

a settlement agency revealed that immigrant services, settlement agencies, and literacy institutions are the primary sources of information and assistance for refugee women.

Initially because so much is done with Lethbridge Family Services so that is where they get their initial information from...yeah a lot of them come into the health classes. Once they have some level of English, they go more in-depth about the services and accessing and that kind of thing; they are learning in their language classes. Family Services provides orientation on a lot of things, but they do it in their first language. So, what we are doing is sort of the same thing, except we are doing it in English. (PL1)

The interview respondents served as translators/interpreters for the refugee women to communicate health care information and assist them in accessing health care services. An interview participant articulated a common experience working with refugee women:

Many of them do not have a level of comfort with computers; they may search for some information to translate and try to equate it to what it will be in their first language. The health care system has some translation services, but you have to book those, so if you know you are going to doctor and you will need that, you need to phone ahead and try to have that set up. If suddenly you are sick, and you have to go to the emergency, you will take somebody with you who can help you at doctor's appointment or with that emergency. Maybe you will call me and say this is what is happening what I should do? There is a broad range of how people cope with those situations in small communities. (PCI)

Feelings of frustration and joy. The feelings of refugee women as they explored their new country varied between frustration and joy. Most participants shared similar experiences of having mixed feelings (i.e., feeling anxious and hopeful at the same time). Some women had high expectations and reservations about the new country, while others were open to any new experience. Some refugee participants felt worried and lost but others had a sense of privilege and the expectation of opportunity in their new country. Most experiences included both excitement and anxiety. "Life is better here but the emotional part is difficult, you pay a high price" (FM). Although the women appreciated their new life, their past experiences of violence and abuse, and current challenges in

adapting to a new environment, caused a lot of mental anguish among many of the refugee women. Most refugee participants felt confused, helpless, and frustrated when faced with unfamiliar social environments or situations. Refugee women participants were fearful about adjusting to the new country.

When we first came, I know some of our people refuse to participate in activities that may even benefit them. It is very much fear of the unknown. They feel vulnerable and about their past experiences...some of us will want to keep to ourselves to avoid bringing up past memories. (FCa)

Upon arrival in Canada, some participants found it difficult to understand and become familiar with the new health system. They never expected to encounter barriers such as lengthy wait times, low income, the high cost of medication, or location and transportation issues. One woman discussed her pre-migration expectations and her actual Canadian experiences.

Before coming to Canada, I was thinking about what is going to be here and having a life I wanted and having all that I wanted. But when I came, it went off the way I did not get any jobs, things are expensive and so much pressure in this system, but I am trying. The distance to the city is what I did not expect. The way I was thinking about the health, before coming to Canada, exactly that happened and more of that I did not think of. (FH)

Some participants reported positive experiences during the initial stage of settlement; they felt welcomed and cared for. Participants' lives improved in different ways and they believed their settlement in Canada gave them an opportunity to start a new life and access needed services. In describing their experiences with the Canadian health care system, a focus group participant said,

The system is very good for us compared to back home. I really like this health care system and especially for somebody that has low-income status. When we came here the first time, we were in low income and needed help and they supported us. Even we can go for regular check up, get to know more about our health, and did not pay a lot. I really like it, for me it is good. (FM)

Some refugee participants emphasized they were happy and satisfied with their health care experiences thus far. They described their experiences as exceeding expectations and reported that the Canadian system fulfilled their needs. Some women did not have any expectations but felt satisfied with the services and felt a sense of belonging.

In this case, I was not really thinking about how the place will be, I needed to just come not expecting anything. Some things are better here than back home; the doctor is good. For low-income people, you get Alberta health benefits. It is for every Canadians including Syrian people or refugees. It is a plus for us and we appreciate what the government is doing for us. (FM)

Other participants had different perspectives, and both positive and negative experiences of Canadian society. One respondent summarized her experiences by saying, “It is mixed feelings from different experiences” (FL2). Some refugee participants reported having mixed feelings of joy, excitement, sadness, and frustration as they left behind the hardships and begin a new life in the host country.

Key theme #2: Finding our way. Upon arrival to Canada, refugee women found ways to meet their needs and understand their new environment. The theme *finding our way* includes learning new processes, embracing new health care options, improving knowledge about health, and identifying who to contact for help and what motivates the women. Refugee women in the focus groups mentioned navigating the Canadian health care system and described it as *necessary* and *eye opening* for them. Their experiences reflected on the process of learning what to do, where to go, and how to get there and how far they have come.

Trying to navigate through a new health care system can be a barrier for refugee women to accessing and utilizing health care services for the first time. Coming from countries with different systems, participants had to find ways to seek health care services

for themselves and their family. Most participants learned to navigate the system through social supports and networks, personal experience, and knowledge they acquired during the settlement process. In this study, it was found that the refugee women gradually learned to navigate their way through the complex system.

Embracing preventative health care. Refugee participants had basic knowledge of the health care system. They defined health through a focus on the physical self and treatment; they had little to no knowledge about preventative care. Initially, refugees were familiar with treatment care but tended to embrace the concept of preventative care with time as they settled in Canada. Some focus group participants commented about their health knowledge. One participant stated, “When I hear about health, what comes to mind is when someone is asking if I am healthy, sick or having any illness in the family” (FB).

As they navigated the Canadian health care system at the initial stage, most women engaged in self-care practices or traditional ways of healing. They had no knowledge of or refused to utilize the available services. Refugee women came to learn about health care in Canada over time from family, friends, settlement workers, and health professionals. Some women were surprised with the follow-up care, immunizations, and health screenings they received as these things were not common in their home country. One woman stated, “One thing that caught my mind is how the family doctor follows up with any test you take...I also like the free immunizations and they try to help you” (FL1). Some participants expressed gratitude about the care they received. One refugee woman stated,

I received three calls from the doctor after my visit to the hospital. The first explained my next appointment date and the next call was about whether the medication works well. I felt glad for medical check-up because it helped me find out about my eye problem early and I was happy to see that. (FL)

This new health practice was surprising for most participants because in their home countries, they waited to become sick before seeking health care (i.e., not used to the preventative model of care). Some participants highlighted that the Canadian health system encouraged healthy eating, physical fitness, mental health, and regular medical check-ups, which helped in attaining early treatment and prevent diseases. One refugee participant explained,

In Canada, you do not eat more fat food, you eat more veggies, fruits, drink more water and exercise that is important to Canadian people. Some people think to be healthy you have to keep healthy, some people do not care they do nothing but it helps my family. Here, they also care about how you feel emotional and the stress as well. (FB)

Participants reported that they learned new steps in health care intervention that helped them to become more proactive regarding their health.

The focus group participants engaged in a shift from use of traditional health practices during settlement to applying newly learned Western health practices. A woman from Syria commented,

Actually, for me, I will not wait for any serious issue but when we came here, we have lots of medicines, Syrian medicines, so we brought with us our medication. Our medications at Syria are bought on the shelf all of it so it is different than here so through our experience we will tell when it is serious to see the family doctor. (FM)

They felt challenged by the Canadian system to adapt to the preventive model of medicine and health practices. A single mother in one of the focus groups said,

I only go to the clinic when I was sick back in Syria. But here, you have so many appointments to check on my body and regular follow up from the doctor before it become any big issue, which is very new to me and help my children. (FL2)

Some participants combined traditional and Western health practices regardless of their length of stay in Canada. A refugee participant mentioned, “I do boil the traditional

medication because my grandmother gave it to my mother and my mother taught me so I do it although I go to doctor. I have to hold on to it and teach my children” (FCa).

At one focus group session, almost all of the participants attested that in Canada they have learned a whole new way of taking care of themselves. This was good news for most of the refugee participants; however, there were some challenges to adopting such changes. Some of the participants were reluctant to engage in preventative health activities due to poor health literacy, cultural practices, and mistrust of the new system. Most of the women were unfamiliar with the Canadian system and found it difficult to shift away from traditional health practices. One woman stated,

They said they do not go right away to see doctor, they are doing their traditional medicine by their own for 2-3 days if it really not help them then they go to see doctor. When I have a headache, I drink hot water or mix some herbs. (FB)

Some of the refugee women reported doubts and mistrust about the health care services. One woman expressed her concern by stating,

I heard the flu shot causes complications on the pregnancy or side effects that is what they are sceptical about. When we first came here, we were told to take for whatever benefits and now we have been here longer, and we hear people’s different views on flu shot. Now we have questions with regard to it. (FL1)

Developing health literacy. As the women settled in Canada, they gradually learned about their personal health care, health needs, and the new health care system. During settlement, some of the women participants attended adult literacy classes to learn how to communicate, and understand basic health information and services. A literacy instructor, one of the local leaders, shared how she supports refugee women through education as they find their way in the community. As study participants developed health literacy, they were able to access health information and services and engage in

preventative health activities. The local leader highlighted the importance of health literacy and the assistance of volunteers and agencies.

I think they want to feel that they belong and to access services whether it is health, job or even communicate, they need to feel comfortable in doing that. The system might be different here to their own country and it is important they understand how it works in Canada. We teach the settlement language program, but it's just teaching different topics related to settlement in Canada and one of those issues is health. So, every class room the teacher at some point will be teaching something related to health and it will be identifying diseases or symptoms, booking appointments and explaining to doctors how you are feeling. Usually we have special section on women's health and so we have a nurse who address female issues. (PL1)

Literacy support helped women participants attain knowledge about health products, health services and understand how to find appropriate care.

Most focus group participants reported a lack of awareness about most health care services during early settlement. They emphasized that in Canada, they learned other aspects of health care (beyond seeing a family physician) that are important in acquiring better health care. As a result of poor health literacy and a lack of education or information, some refugee participants only use health care services during severe illness.

A participant from a focus group shared,

It depends on the situation. If I can avoid going to the health care facility to see the doctor... I try to heal myself - herbal medication - this is my healing pathway, spiritual medicine - the Holy Book. Sometimes I do not use the health services, I think others need it more than me, so I treat myself. (FM)

Most refugee women practice self-care mainly because of their strong traditional beliefs and limited health literacy skills and therefore had challenges making appropriate decisions regarding their health. Medical care was the last resort for most women depending on the severity of the illness. This self-care practices may pose health risks which could lead to life threatening situations. One refugee settlement administrator added,

One thing I would like to add is based on experience like language barrier and the understanding of the health-related problem, so the example is - a refugee claimant in one of our neighbouring communities was having problems with her reproductive system, she did all the testing and the result was negative which she did not really understand. She was still experiencing some problems but thought everything was fine and number of months without re-engaging with the health care system. All of a sudden, she has an emergency and gets diagnoses of terminal cancer. And from there I got involved, the health care system set up translators and lawyers, but it was too late because she was misdiagnosed. Nothing could be done about it, she passed away and her partner left the country. (PH)

There are many barriers (e.g., language differences, misinterpretation of medical information, and lack of understanding about their body) that influence refugee women's health experiences and outcomes.

Learning from experience. Refugee participants struggled to learn a new language and adapt to a new culture. For most refugee women, the early years of arrival included many obstacles and struggles but their experiences improved with time. One refugee woman explained, "It was hard for me at the beginning, but I am learning a lot as things happen. I know after some time things will be easier and I will be able to help others" (FM). Despite the challenges experienced by refugee women, they emphasized on the effort to recover from past harsh experiences and adapt smoothly into the Canadian system. The refugee women used coping strategies and resilience to embrace the new practices as they integrated into their new environment. Some coping strategies included leaning on family and friends for support, relying on their religious beliefs, and participating in social activities. As one Syrian women said "I have seen many troubles before moving here. I have seen many rape, shootings and killings at the war front; I survived many tragedies in refugee camp where I saw a lot of women and children dying because they were too weak and sick. I have learned how to be strong and how to survive and with faith and prayers to God, there is great hope moving me forward."

Refugee women provided insight regarding learning experiences in Canadian society. Learning by themselves and assisting each other were key factors that the women identified as easing their adaptation to the new system. Some of the women learned to integrate by engaging with their children, spouses, and close relatives or friends through social activities. Three women reported that their children or spouses served as translators, which helped them learn faster. They discussed learning about Canadian society from close relatives.

In our early times here, we had to look for someone or our own people who can help with the language and they are not always available. Now our children are in school and my older son is able to translate for us when we see the doctor and I am learning little by little. (FM)

As these women became proficient in the English language, they learned to be independent in the Canadian system. Educational support services for refugees offered information. Adult literacy programs are available for refugees, especially those with sponsors. At the English learning program in the various communities, participants reported discussing several topics including health care in Canada and how to access mainstream services. Describing how she learned, one woman explained,

The volunteers serve as tutors in the beginning whilst we wait to attend the adult learning program. At first, we talk about our goals for the program then discuss all kind of topics and so health care is one of the topics addressed. Some of the course materials include how to make appointments, how to read prescription labels and those kind of things as well as learning about our own bodies and asking personal questions, as we are all women in the class. (FB)

The knowledge participants gained from the literacy institutions or participation in social events transferred to their everyday lives. The experiences of the refugee women participants influenced how they responded to health issues and made health care decisions. Health-seeking behaviours varied across the participants. Some women learned from their personal experiences with the health care system and society, but the majority

seemed to learn from each other. Learning from each other in Canada guided their understanding of health and what to do to access health care services. They mentioned assisting other refugee women by sharing experiences they gained from time spent with their social network. One woman remarked,

We learn those things by experience, for example when I took my son to the hospital, I was talking to one of the sponsor families that brought us here. She said ohh you need to go to the walk-in clinic and they will write a small paper for you so you go to the x-ray centre and they will take an x-ray right away, there is no need to wait. So we get to know through our friends, acquaintances, we know about those things. There is nothing written like you said, no seminars or presentation, all through our own experience. For example, if I have this experience I will tell my other friends about it so they will know about my experience and they will know how to do it later on. (FM)

Local leaders as connectors and advocates. This study revealed the role of local leaders and refugee settlement workers in supporting refugee women's access and use of health care services. Every interview participant (i.e., local leader/administrator) indicated a strong interest in working with refugee women and described how they got involved in their positions. Most individual participants felt satisfied and shared positive experiences of interactions with refugees. The services that local leaders and refugee settlement workers provide reflect their job responsibilities, personal sense of duty, or desire to serve. Some interview participants worked in literacy institutions or agencies that support refugees as they integrate into the Canadian environment; they care for these women. One participant stated,

I have been working with refugees and English language learners for about 15 years. Out of that, I also do language assessment so through that I get a lot of refugee women who are trying to build their life in Canada. As part of the funding from immigrant services, that we receive from the federal government is to work with permanent residents, and refugees. (PCL)

Another interview participant who was also a refugee shared her interest in working with refugee women. She felt a personal sense of duty to support them and help

them feel comfortable as fellow refugees. With the help of local leaders and refugee settlement workers, refugee women are able to access basic health care services and information. One participant explained,

I think for this social worker and I is the same, we came as immigrants to Canada, so the organization helped us a lot while we are here, that's why we want to help another one. When they first came here I was helping and assisting them especially with communication and other things concerning health care. (PH)

This gave some participants the opportunity to become advocates for refugee women and help them in times of need. Most of the interview participants emphasized that they enjoy working with refugee women and considered it a learning experience as they established connections as workers who were also refugees. One individual participant discussed her motivation in assisting refugee women and stated,

I enjoy the work immensely because I do think we would make a difference eerrmm and over the years, you learn more and more about working with women from different countries. When I listen to their stories, it has strong impact on me personally, so I have been looking at how they struggle to find employment, their family, their language and other underlying social standards in their new community. (PL1)

Local leaders and refugee settlement workers identified relationship building and organizing open discussions or workshops for these women as strategies they use to determine health needs. They discussed that some refugee women can comfortably communicate their needs or consult them for information; they build trust and good relationships with them. One participant explained,

It is through relationship building or through inviting them to activities, we have refugee/immigrant women's group that we run a couple of times a year. By inviting them to these meetings and giving them safe spaces, to share and learn from everyone else, that is where we may discover there are further needs and there are extra barriers and then we can help them with that. (PH)

Key theme #3: Pathways for improvement. The theme *pathways for*

improvement reflects the unmet needs of refugee women as they integrate into the

Canadian system and areas to improve for future health care interventions and policies. Beyond the basic needs of protection and settlement, most participants had high expectations for life in Canada. Most participants were confident about having ease of access to health care services and other opportunities that would facilitate their integration in Canada. Some refugee women achieved these expectations. Others had unanticipated realities. Some women had high expectations about Canada which is different from their lived experiences. For instance, some refugee women were convinced by their agents about settling into a new and larger city but they found themselves in a rural community and felt disappointed. Refugee participants admitted receiving support from various sources; yet, they encountered challenges (largely a results of having low health literacy skills, limited social networks, and the presence of language and cultural barriers) to care during settlement. Many refugee women were appreciative of the Canadian health care system's support for the refugee population and described ways the location of health facilities (either urban or rural) influenced their health care experiences. They shared their struggles while integrating into the Canadian system and suggested strategies that could improve future experiences. Some refugee women reported their post-migration experience and identified their expectations about health in Canada.

You had an expectation, you are disappointed for starters and in my mind, you might not access the health care options out here, you might just ignore your health as the other option. (FM)

Struggling to adapt. Refugee women encountered several barriers when trying to navigate the Canadian health care system. Some participants stated that they felt discouraged by the complexity of the Canadian system as they struggled to adapt to the new environment. Numerous participants expressed various challenges (e.g., understanding, access, navigation and utilization of the Canadian health care system).

Language difficulty was a common topic noted in the focus group and interview data; it was a major challenge for refugee women navigating the Canadian system. Participants identified other challenges including long wait times, limited funding, documentation, transportation issues, poor literacy skills, preference for female doctors, and cultural differences.

Refugee women in the five focus groups mentioned that the language barrier affected them in different ways when receiving care. Language affects interactions with the family doctor or specialist, the filling of prescriptions, and seeking help from settlement workers. Most focus group participants shared similar views.

The language is difficult for us in many ways. We have language problems when booking appointments, talking to the doctor about my health issues and even getting medications. I have appointment with specialist at Calgary, I don't know how to get there and what to do. Also, it is very difficult for us to communicate also if you want to communicate with immigration office employees, we need a translator, so we would get the expected help. (FCa)

Local leaders and refugee settlement workers shared similar thoughts about the language barriers that limit access to the health care system. Participants spoke about the challenges of refugee women in communicating their health needs to health professionals or using interpreters to assist them. One participant who sometimes assisted refugee women with translation and interpretation commented,

The main problem is language, let us say whenever they go to hospital or clinic they were told to bring their own interpreters so if they are going to bring their own interpreters this makes talking to the doctor easier. Most of them like I said about 99% of the refugee women do not speak English and then nowadays we are tight like I said. And in this community, we have to work and work we are busy, so we are not able to assist them like when we first got here, so when they are asked to bring interpreters there's no one to help out. (PCa)

Long wait times were major barriers that emerged during the focus group discussions. Some participants expressed concerns about long wait times to access a

family physician or specialist. They experienced delays to access emergency services, walk-in clinics, and diagnostic services. Participants explained that they had to wait for hours, days, months, or even a year to meet with a health professional for urgent health needs. One focus group participant commented,

The waiting time is too long even for emergency cases. The doctor's appointment is takes time and wish we did not have to make appointments. Back home, if you have the money you go right away but here it is free and have to wait for long. (FCa)

Participants explained further that although they were familiar with waiting times back in their home country, they did not anticipate that experience here as they had high expectations about Canada.

During the focus groups, many refugee women indicated their preference for female rather than male physicians. However, there are few female physicians available to provide health care services, especially in rural locations. Some of the focus group participants believed their preference for female physicians may be due to cultural or religious beliefs. One refugee participant stated,

There are issues involved in women not wanting to access a doctor unless it is a female doctor. There used to be huge problems in the past for women not going because it is not female doctors. I think that has been basically taken care of now in some places. So I don't know if there is anything specifically for refugee women or only the general health care services available for everyone. (FL2)

Refugee women participants from diverse countries reported challenges in finding health professionals who genuinely understood their wants and needs (e.g., the preference for female doctors, the need for medical interpreters, or limited rural health specialists). Four of the refugee women made note of the cost of certain health care services (e.g., dental and vision care) and the limitations of financial support for refugees as concerns. They stressed that refugee women with no benefits or funding struggle to pay for health

care expenses such as prescriptions, surgeries, and emergency services. Women in all of the focus groups felt frustrated about the high cost of dental and vision care, but appreciated the services of the general practitioners. One refugee woman expressed her concern and stated,

I like my dentist. I never did oral hygiene or dental back home but if we have problem then we go and see the doctor. Over here, we go every 6 months to check and it feels so good but one thing it is expensive and not everyone can afford. It is difficult to get job in the beginning, as a new person here so you have little money to support the family and health issues. We have to pay for the dental and then eye care. Right now it is on me, I have to pay all, everything. So, I have to pay for checkup and glasses. Eye care is \$90 and dental care is like \$100 or something like that depending on your teeth. (FCa)

Disparities among communities. The health care experiences of refugee women settling in rural and urban locations differed in several ways. Local leaders and refugee centre participants reported that the location of refugee women in the host country profoundly affects their access and utilization of healthcare services. The different responses noted between the rural versus urban refugee women highlighted issues of accessibility, availability and affordability of culturally appropriate health care services and programs. Refugee women's integration into rural or urban host communities has benefits and challenges depending on the location. Participants who settled in smaller rural communities were surprised; they expected to have access to health care without any difficulty or stress. One rural refugee woman stated,

To be honest where we came from and where we are right now there is a big difference, so when are coming from our home country, we expected to be in the big cities where there is everything to live the life we imagined. In the small community like here we are missing a lot. (FH)

Both the rural and urban located refugee women participants received social support from family, friends, agencies, and volunteers.

Refugee participants living in rural areas described having limited health care options and health inequalities based on structural, economic, and sociocultural differences. The determinants of health inequalities identified by participants were related to policies, regulations, legislations and how resources are distributed by the Canadian healthcare system. They noted having access to fewer health professionals, translators/interpreters, and specialized services.

Transportation barriers also made it difficult for rural women to access health care services. Participants living in urban areas had access to various health care services as they adapted to Canadian society. There are more health care facilities and health specialists in the urban cities. Such services are not readily available in rural areas. One refugee participant explained,

If you live in the city you have lots of choices, but you still may need help navigating the health system. If you are really well educated you understand how systems work, you can get through without too much problems but if you are in rural Alberta, it is pretty much “take what you get” unless there are advocates that can help you reach out. They work to provide more in our community or get us to places where there is more availability. (FM)

Some focus group and interview participants described challenges to accessing women’s health needs or reproductive health care services in rural areas, especially family planning, contraception services, prenatal care, complicated surgeries, and deliveries. Many refugees experienced problems accessing women’s health services in rural Alberta.

We have no gynaecologist as such here and in most small communities around. So, if someone is pregnant, and/or had miscarriage, and went through the local hospital and doctors, they will be only basic services provided. When someone is pregnant here, they can go to the local clinics or doctors and if it is not a high-risk pregnancy, the local physician will work with them up to the point of expected delivery, and then they have to go to Calgary, High River or Lethbridge. They do not do deliveries here, so if you are pregnant, you have to prepare on how you will get to the nearby town/city. Sometimes they need Caesarean section, which needs

to be scheduled especially when they are considered high risk and if she is an older mother, and sometimes in the refugee situation, you will be older. They are referred to the high-risk clinics, which are in the city, which is not available here, they are not even High River, in a bigger city and usually Calgary not even Lethbridge. Therefore, pregnancy is a big issue. (PCL)

The lack of adequate transportation in rural areas was an obstacle for some women participants; it limited their ability to build social networks and visit health care facilities. Some refugee women lamented having to seek support from settlement workers or volunteers, the long process of receiving a driver's licence, and spending money to pay for hospital trips. One refugee woman commented,

We did not expect the rural aspect of this community and it's surprising to find out this community is so far away or distant from a big hospital like in Calgary or Lethbridge. There is no bus or taxi and I am not driving unless someone helps me get there. Hmmm, a taxi will cost about \$235 per person to get to the south-west of Calgary that is not affordable to most of us here. (FH)

Most participants expressed that long wait times for appointments and specialized health care services in urban areas discouraged refugee women from accessing regular health care services. This was a worse problem in smaller, rural locations.

I had to wait for eight months to see a specialist. In Brooks, we do not have too many family doctors and anything about specialized care, you go outside Brooks; you go to either Calgary or Medicine Hat. Here, the choices are limited. (FB)

Despite the geographic dispersion of refugee women to rural and urban host communities, most participants in almost all of the study locations shared similar views about the language barriers that limit their access to health services. A refugee centre administrator with long-term experience working with several refugees elaborated:

Language is undoubtedly a challenge in the rural community as well as in the big cities and towns. Language is difficult for these women, and a refugee claimant lost her life to cervical cancer because she could not express herself and did not understand the medical terms. (PCI)

Communication difficulties and adjusting to the Canadian society were difficult experiences for women participants in both rural and urban communities.

Strengths of the Canadian health care system. Despite the barriers refugee encountered, there appeared to be some programs and services that help refugee women overcome challenges to attaining health care. Women in four of the focus groups identified that social support from community members and some health professionals or health centres helped them to understand, access, navigate, and utilize the health care system. Most participants in all of the focus groups revealed that the Canadian system is operating in the best possible way to serve the needs of refugees. Refugee women participants explained that health professionals, sponsor organizations, and community members work together and advocate for refugee women. They help refugee women access health care services. A literacy tutor who also provides settlement services for refugees shared,

I think that Canadian communities are now realizing they have to make changes to help us [refugees] fit in and feel part of this place. So, they are speaking to refugees who can contribute ideas and assist to help other refugees. Some of the doctors ask what they can do to help women who can understand the language. There is a drug store now that's been printing labels out on meds bottles to make it easy for us. So there are programs, workshops and volunteers who are helping to create awareness in the community, I think that's one of the good things that's been happening since I came here. (PL1)

Some of the refugee women praised the Canadian system's support in the form of pamphlets and media. One refugee woman stated,

Always you find someone to help you and answer your questions. Generally speaking, the health care is good. I like the way of promoting health care services through pamphlets and posts and media. Immunizations are available. (FL2)

Another focus group participant emphasized the professional demeanour of health care workers who help refugees' access information and services. Health professionals were

sensitive to their cultural beliefs and valued the need to incorporate their beliefs into the services they provide.

The health care staff treat us good. Doctors take their time examining you. Seeing a doctor is free. Nurses are kind and respectful. They respect cultural differences and values. They ask about preferences or any modification in the care based on values and beliefs. Female doctors are few. (FL2)

Refugee participants shared some positive thoughts about the Canadian health care system. They identified that the Canadian health care system provides the necessary resources and direction for them to gain better access to services and adapt to the new system faster. Refugee women received financial support, specialized health care services, and access to health workshops and adult literacy programs/translation services. One refugee woman participant who has been in Canada for over two years and gained some experience expressed,

I think the health care system tries to overcome the challenges, if they find them struggling with any sort of service they will arrange somebody to come and support. They try their best to identify the best way to provide refugees with the help they need either financial support, specialists, translation services or health programs. (FL1)

Bridging the gap. Participants in all of the focus groups and interviews agreed that understanding, accessing, navigating, and utilizing the Canadian health care system can be difficult for refugee women resettling in Canada. Strategies are necessary to improve refugee health experiences. Both the focus group and interview participants commented that the Canadian health care system improved the health of refugee women, but more effective measures are necessary to help the women better navigate the system with ease.

Participants from five focus groups noted a need for easier access to health care services and shorter wait times, especially for emergency services, doctor's appointments,

and visits to specialists. Long wait times negatively affect the health of refugees by discouraging them from seeking health care services or trusting the system. Several women indicated that short wait times could improve their health and well-being.

Waiting times - that is our concern waiting for a long time for example, I waited for six or seven months to see a specialist for my hearing. In regard to emergency, they should figure out if it's lack of staff or lack of priority, what are they lacking that is it the reason why the emergency system is so slow and why the long wait times before seeing the doctor. They need to figure out what is lacking on their side that the patients are suffering for that. (FL1)

More than half of the refugee women in the focus groups recommended better women's health programs. They expressed a need for health initiatives like workshops to educate refugees about the Canadian health care system and one-to-one discussions to determine their needs. They believed they lacked support because doctors assumed they already had knowledge of such services. One woman summarized the ideas shared by other focus group participants. She stated,

For newcomers, immigration services should hold a meeting like this or even on a bigger scale to have a kind of exact same conversation in regard to what our problems are going, what are the appropriate things to be done or maybe in more of broad scale. Even if these are just individuals or groups come to us and other women to have that meeting to find out more issues to even address larger issues ahead will be a good idea. There should be more programs and orientations to know about the health care system. It will help, because nobody will tell you anything unless you ask. Sometimes people assume you know everything but no you have to ask all the time. (FL1)

Refugee women from four of the focus groups suggested increased financial support to improve their health experience in Canada. More than half of the focus group participants expressed that extended health coverage for dental, vision care, and prescriptions would improve their health. Financial support and health programs are available to new refugee women, but there is a need to increase funding because most

refugee women have low incomes and cannot afford some of the necessary health care services. A refugee participant shared,

Back home, if you have money you go for care, no waiting but there was no money. Looking at the refugee program, we don't pay for our health which is good. I think they should add the extra money we pay for dentists, eye care and some for medicine too. We come from different countries and we work hard, here is not easy for newcomers or immigrants to know everything fast it takes a lot of time. (FCa)

Local leaders and refugee centre administrators shared similar thoughts about extending support to refugee women (e.g., literacy training, social support, and financial resources). The Canadian system does not favour newcomers or refugees with little education as it requires reading, writing, and sometimes the use of technology when accessing health care services, which frustrates most uneducated refugees as they try to integrate into society. A refugee centre administrator suggested some strategies to improve refugee women's health experiences.

I think more extensive coverage, you know one year is not long enough to provide a really good foundation for them like education, availability of language training, longer support systems definitely that's the number one thing I see. So it's those things that makes it easier way to work through the systems whether it is health care, whether it is mental health, whether it is getting a driver's license, whether it is registering your children for school, it's all systems that are set up for very well educated parents to navigate. It does not matter, none of them are set up for people with low literacy or few foundational skills; our systems don't work for them whether you are a refugee or immigrant. (PCI)

Most refugee participants suggested training for community workers and health care providers to help them identify the health needs of refugee women and offer the best possible support. Focus group participants identified that most of the professionals and volunteers had little experience or knowledge of refugee women. One participant summarized the views of refugee women by stating,

They [health professionals and community workers] do not get enough information about refugees, so we will suggest that they should be given more

information or training so they can help us. I think the more the system is open to understanding what we need, we can bring issues to the table including educating the community and health professionals. Because they make decisions on our behalf. It will be good if some training is given. (FCa)

Addressing the challenges of refugee women may improve their health experiences and optimize their health outcomes.

Summary

This chapter included a presentation of the findings as shared by participants from the focus groups and interviews. I discussed the overarching theme and the three key themes, and sub-themes that emerged from the data. I supported these themes with direct quotations from participants who shared their experiences and strategies for improvement of the Canadian health care system.

The overarching theme of '*Fitting in: Refugee women's experience with health care in Canada*' reflected the journey of refugee women as they integrated into the Canadian society and the Canadian health care system. The first key theme, *living with loneliness*, highlighted refugees' early transition in Canada and their initial experiences of culture shock, identity crisis, and building social networks. The second key theme revealed how refugee women *find their way* through the health care system in Canada. The third key theme that emerged was *pathways for improvement*, which included refugee women's expectations of the Canadian health care system, experiences after arrival, and strategies to improve the health care system.

CHAPTER 5. DISCUSSION

In this chapter, I present an interpretation and discussion of the findings in relation to the existing literature. The study results revealed the post-migration health care experiences of refugee women as they strove to settle in Canada. Study findings highlight how refugee women from diverse backgrounds fit into the Canadian system, the struggles they experience in satisfying their unique health needs, and pathways for improving their health experience. This chapter also looks at the findings with respect to the Intersectional Feminist Framework.

Overview of the Inquiry

The purpose of this study was to identify the health needs of refugee women and approaches to improve their health care experience as they settle in Canada. Other authors have reported that understanding the health care needs and experiences of refugees is important to improving their health outcomes (Campbell et. al., 2014). This study focused specifically on refugee women because of the recent influx of refugees into Canada and the increased demand for health care services for these women (Ahmed, Bowen, & Feng, 2017). In this study, refugee women shared their post-migration experience as they navigated their way through the Canadian health care system. The perspectives of local leaders and refugee centre administrators were gathered to assist in understanding their roles and experiences in supporting refugee women. Using the Intersectional Feminist Framework, I examined factors that intersect to shape the women's experiences of health care in Canada.

The data from the six focus groups (refugee women from diverse backgrounds) and seven interviews (local leaders and administrators) were critically analyzed and

transformed into meaningful themes with a focus on refugee women's post-migration health care experience and health needs. The refugee women who participated were from different countries including Myanmar, Somalia, Egypt, Jordan, Libya, Algeria, Columbian, Ethiopian, El Salvador, Mexico, Vietnam, and Sudan with Syrians recording the largest group in this study.

The overarching theme '*Fitting in: Refugee women's experience with health care in Canada*' generated three major key themes (*living with loneliness, finding our way, pathways for improvement*) which represent their collective health care experience. Through participants' stories and interviews, detailed descriptions were provided of their early and ongoing life transition in Canada, the challenges and insights of integrating into Canadian society, and the future directions to assist in meeting their health needs. As refugee participants emerged from countries with different health care systems, their experiences varied as they shared both positive and negative perspectives about the Canadian health care system. In the following sections, I discussed in detail the overarching theme and key themes.

Summary of Themes

Fitting in

I begin by clarifying the concept of '*Fitting in*' in accordance to the views of study participants. The refugee women defined '*Fitting in*' as a challenge of disengaging from one's old ways of doing things and compromising to embrace their new environment for survival. It was evident from the findings of this study that refugee women tend to adjust in order to fit in to the Canadian system. Overall, refugee women participants reported that adjusting to the Canadian society is stressful and adjusting to the health care system in Canada is challenging. Diversity was noted among the refugee

participants in terms of their background, needs, and experiences with the health care system. Similar, however, were their 'collective expectations' relating to health care in Canada. Fang et al (2015) revealed that Somali and Iraqi participants were not familiar with the national health care system in the United Kingdom and had limited knowledge about accessing and utilizing the available health care services, an observation that was similar to mine. Krause et al. (2005) reported that newly admitted immigrant students find it challenging to engage in school activities because they are faced with frustrations and anxiety about fitting into their new spaces. It was also evident in my study and other related studies, including those reported by Burnett and Peel (2001) and Lawrence and Kearns (2005), that refugee women shared diverse needs because they originate from multicultural backgrounds and often lacked understanding of the functions of their new country systems and structures. The current study revealed refugee women in larger and urban locations such as Calgary and Lethbridge have quite different health care experiences than those living in smaller rural locations such as Brooks and Claresholm. The experiences that are similar, however, are the challenges women faced adjusting to their new life in Canada. There was a struggle for most refugee women as they started life all over, learned about the new changes, and found pathways to care.

Living with loneliness

I identified that refugee women settling in Canada tend to live a lonely life because of factors such as social isolation, loss of identity, lack of social networks, language barriers, cultural differences, and inadequate information. Some authors have revealed that loneliness is most prevalent among refugees and immigrants in their early years of settlement in the host country (Yakushko, Watson, & Thompson, 2008).

However, most refugee women participants' experiences of loneliness tend to influence

how they adapt and integrate into Canadian society. In refugee participants' early life transition in Canada, they felt alone and lost as they struggled to fit in their host country. Stewart et al (2010) linked loneliness and social isolation with settlement challenges which influenced how refugees responded to health care services and their health outcomes. Culture plays a significant role in health care provision of migrant and refugee groups due to the social, linguistic and religious variations (Bhugra & Becker, 2005). The findings of the current study revealed many refugee participants face cultural shock and adapt to changes in their early days in Canada. The majority of the refugee participants admitted it has taken longer for them to adapt to Canadian society than expected due to the differences with their home countries which leave them frustrated, anxious, and even confused on how to engage here. For instance, difficulty getting a female doctor, language differences, and different health practices were challenging for them and at times created mistrust which delayed their understanding and access of the Canadian health care system, and this in turn influenced their health seeking behaviours. This is consistent with the findings of Schyve (2007) and Almutairi (2015) who found that cultural and linguistic differences can lead to difficulty in communicating health needs, affecting the quality of care and patient satisfaction.

Gender played a key role in refugee women's approach to health care services and programs. Most refugees come from a patriarchal culture where men make decisions for the spouse and family including health related decisions. It is clear from previous studies that the patriarchal system and men's influence creates a sense of fear in women and restricts them from accessing or using some health care services which may be beneficial to their health (Dudgeon & Inhorn, 2004; Mumtaz, Salway & Waseem, 2003). For example, some refugee participants reported that their husbands do not allow them to take

contraceptives, attend family planning services or be seen by male physicians. Some cultural beliefs also restrict women from seeking health care services from male health care professionals. For instance, a refugee woman going to see a male physician with a male husband and/or a male translator may not be acceptable in some cultures or religions.

In some of the focus group discussions, refugee women identified that most local leaders/ refugee centre administrators or others who assist them have limited knowledge or training about their cultural values/ traditions and expectations. Similar to a study by Herrel et al. (2004) of the maternal experiences of Somali women in the United States, this study confirmed that there is an urgent need for health care professionals and settlement organizations to be culturally aware and sensitive in order to meet these women's needs and help ease their integration.

During the post-migration phase, the refugee participants encountered multiple changes in their personal, social and cultural lives. The women reported having diverse and multiple identities in their new environment which led to different experiences from their previous country of origin and feelings of not belonging in their new country. Segal and Mayadas (2005) confirmed that changes in identity, a lack of belongingness, and experiencing health disparities impact how refugee women approach and use new systems of health care. On several occasions in my study, the mixed identities hindered and or limited the women's understanding, access, utilization, navigation, and utilization of the health care system.

During the migration process, many of the refugee participants tended to lose their social ties and had to establish a new social network in Canada. Building a new social network was a challenging process for many of the women in the early stage of their settlement. Almost all participants spoke about the lack of social support here in Canada,

the reason being the individualistic nature of Canada, in comparison with their home countries which are largely more collectivist in nature. Upon arrival, refugees tend to seek support from both formal and informal sources to facilitate their integration into the new country (Simich, Beiser, Stewart, & Mwakarimba, 2005). In this study, the major sources of social support for refugee women included family, friends, fellow refugees, local leaders, refugee centre administrators, volunteers, religious members and private sponsors who help to facilitate integration into the new society; this helps to shape their experiences. Consistent with research from Simich, Beiser, and Mawani (2003), social support has a significant impact on refugees' adaptation to their new environment, including their health and well-being. The study findings indicate that although the refugee women had limited social supports upon arrival, they relied on their immediate or available social network (such as spouse, relatives, or fellow refugees) for information about their basic health needs. Some interview participants (local leaders/refugee centre administrators) spoke about the orientations, health programs, and meetings that are organized for refugees in their early settlement where they gain information in accessing and navigating their way through the Canadian health care system. Lee, Sulaiman-Hill, and Thompson (2013) suggested there should be consideration of the cultural and language differences when disseminating health information to new refugees as this is crucial for them in understanding and addressing their health needs.

Coupled with the lack of social support, starting a new life after transition created many mixed feelings among refugee women participants. Experiencing feelings of joy and optimism helped them to move forward and rebuild their lives. Some refugee participants experienced feelings of frustration and anxiety for "fear of the unknown." Others had unmet expectations and limited social networks during their early settlement.

This finding corresponds with the existing literature on refugee women's experiences during their early settlement (McMichael & Manderson, 2004; Guruge, Roche, & Catallo, 2012; McKeary & Newbold, 2010). It is evident that the early stage of arrival in Canada is an important and challenging time for refugees as they feel lost and need significant support, direction, and intervention to integrate into a new system and society.

Finding our way

As refugee women try to rebuild their lives, they learn new things, encounter new challenges and develop new coping strategies in managing their day-to-day lives. In the process of settlement, refugee women gradually adjust to new lifestyles and practices in their new community which include acquiring health care services, accommodations, employment, food, clothing, transportation and education. In this study, women had a very basic and superficial understanding of health and viewed it solely in terms of the "physical." This is consistent with the literature that states this basic understanding is usually related to women's level of literacy, beliefs, or experiences (Beiser, 2005; Salman & Resick, 2015; George, Thomson, Chaze, & Guruge, 2015). It was evident most refugee participants were not familiar with the holistic concept of health and had little to no knowledge about the preventative model of healthcare. Being healthy meant seeking treatment or care *only* when faced with some illness or disease. Similar to other studies, refugees often have inadequate knowledge about their personal health and are unfamiliar with the health resources and services available in the host country (Henderson & Kendall, 2011; Carballo & Nerukar, 2001; Resick, 2008).

In regard to changes and transitions, refugee participants identified challenges associated with adapting to Canadian health care practices such as finding a family doctor, scheduling a doctor's appointment, seeking follow up care, mental health services,

proper diet and exercise, prescriptions, immunizations and health screening – things that were not readily available in their home countries. As noted by Morris et al. (2009), settled refugees in the United States were not willing to access preventative health services due to language barriers, cultural beliefs, previous health experiences, and mistrust of western health practices. Refugee participants in this study also reported facing challenges from the onset. Other researchers (Renfrew et al., 2013; Morris et al., 2009; Redwood-Campbell et al., 2008) have identified the slow uptake of health practices by refugees, similar to the finding in this study as the majority of the refugee women reported gradually embracing the concept of preventative healthcare over the course of settlement. This is an important aspect of the refugee women's integration and adapting to the Canadian health care system. Low levels of health literacy are identified as a barrier in adopting quality preventive care by refugees and newcomers (Griswold et al., 2018).

Almost all of the refugee participants experienced challenges understanding their new health care system irrespective of their educational status. Both educated and uneducated women had similar challenges in terms of interacting with their society; this could be related to language and cultural differences. However, those refugee women who were more educated were able to learn faster in comparison to their counterparts who were less formally educated. Prior research has shown that level of education, gender, and refugee status influences how a person will respond to new practice and systems of care (Israelite, Herman, & Alim, 1999; Lebrun, 2012). In this study, most of the refugee women attended (and continue to attend) adult literacy classes or settlement programs to learn the English language and gain practical skills to integrate the system and society. These women depended on social supports like settlement workers, friends, family or translators/interpreters for assistance which is not always readily available.

Additionally, I identified how the misinterpretation of medical information and limited understanding of health and well-being is an ongoing concern for these women. This was realized to be partially a result of the language barrier, which affected their understanding of directives from medical professionals and medical terminology. Due to language and communication barriers, some of the refugee participants delayed getting treatment. This finding adds to the body of literature that speaks to the influence of limited literacy and language barriers on health seeking behaviours (Lebrun 2012; Messias, McDowel, & Estrada, 2009).

In an effort to adapt, it was evident that the refugee women were willing to learn new things and support each other as they tried to integrate into society and the Canadian health care system. Similarly, in a study by Baird (2009), Sudanese refugees described using self-supporting strategies for themselves and other family members as they settled in the United States. Other authors highlight the impact of pre-migration conditions and settling experiences in helping refugees to regain their sense of independence in their host country (Guruge & Khanlou, 2004; Young & Chan, 2015; Berman, Girón & Marroquín, 2006). Despite challenges faced by settled refugee women, some authors (Beiser, 2005; Grove & Zwi, 2006) have revealed that refugee women use coping strategies, resilience, and support systems to overcome the challenges. Similar to my study findings, most of the refugee women use family reunion as a powerful tool in coping with settlement difficulties. This in many ways seem to help alleviate the constant distress linked to their new unexpected situations in their new country. Others were hopeful that with time things would get better amidst their challenges they were experiencing. Refugee centre administrators and local leaders spoke of the important role they play in supporting the health care needs and experiences of refugee women. Whether it was based on a personal

sense of duty or desire to support the refugee women, or was simply part of their job, they all expressed a desire to see the women succeed. Other authors also highlight the importance of settlement workers and/or volunteers in terms of social supports that can improve settlement experience (Makwarimba et al., 2013). In this study, refugee centre administrators and local leaders served as connectors and advocates in helping refugee women understand, access, and navigate the Canadian health care system. The interview participants offered a range of support services which included language services, orientation services, community services as well as general day-to-day guidance. This is consistent with the findings of Bartel (2018) and Grove & Zwi (2006) who noted settlement trajectory factors and how supports offered by different organizations and individuals can influence the experience and well-being of refugees during the settlement period.

Pathways for improvement

This theme highlights key areas identified by study participants that require a focus on future health care interventions, policies, and programs to help ease refugees' assimilation to a different country. It is evident from the focus group discussions that the refugee women were appreciative of the support received from various sources; however, spoke of the difficulty they experienced trying to manage unmet health needs. This is a finding similarly voiced in other studies pertaining to refugee immigrants (Guruge et al., 2018; Ohene-Bekoe, 2017; Woodgate et al., 2017). Findings from the focus groups and interviews identified some of the challenges that present such as long wait times, limited funding, documentation issues, transportation issues, poor literacy skills, language barriers, preference for female health professional and cultural differences. Some refugee women hold the view that it is unacceptable in their culture to seek health care services

from a male doctor or make health decision without approval from their husbands. Men sometimes serve as barriers in women's health services utilization due to cultural and religious beliefs which result in fear and anxiety. For instance, some refugee women in rural areas with limited female doctors tend to practice self-care at home to avoid family conflict or domestic violence which puts them at risk. Some negative cultural beliefs and decision-making power exerted by men has been linked to low use of health care services among women such as family planning, the use of contraceptives, pre-natal and maternity care services (Ganle & Dery, 2015 Hou & Ma, 2011). A study by Salinas (2017) revealed the institutional, social, and cultural barriers to health for Bhutanese refugees settling in the United States. Refugee participants attested to a lack of familiarity with the health care system which influenced their health seeking behaviours; there are studies in the literature that support this finding (Bushra, 2018; Miedema, Hamilton, & Easley, 2008).

In this study, the settlement location (i.e., rural versus urban) had an impact on health care and settlement experiences. Some refugee participants revealed they encountered similar and multiple barriers in their settlement locations, particularly in the rural communities. When comparing the responses of the rural versus urban located refugee women, differences were noted in discussions about accessibility, availability, affordability and culturally appropriate health care services and programs. Some of problems emerged from the expectations of refugee women. The issue of health disparities was deeply expressed by participants in rural communities; this seems to be an area overlooked in the literature. The challenges experienced by the rural participants mostly centred on transportation difficulties, long wait times for medical appointments, limited health resources (as compared to urban participants), and limited female physicians. Gagnon (2002) suggested that the Canadian health care system should

consider the urban-rural health needs and restructure the provision of health services according to the various settlement locations of newcomers and refugees. Likewise, language barriers, lack of health information, and adjusting to Canadian life were found to be common challenges for both refugee women in the rural and urban settings. Despite these concerns, I also found that both rural and urban refugee women participants had some level of social support from immediate family, friends, and agencies, as well as from volunteers. Although there is literature that focuses on rural-urban immigrants and general newcomers' settlement experiences (Bégin-Gillis, 2010; Carter, Morrish, & Amoyaw, 2008), there is no research that speaks to refugees' experiences with the Canadian health care system. It is important for future researchers to extensively examine the disparities and inequalities experienced by refugees settling in urban and rural communities and their impact on the integration process.

Results from this study indicated that some elements of the Canadian health care system facilitated access and utilization of health care services. This corresponds to a study by Czapka and Sagbakken (2016) that highlighted key facilitators of Polish migrants' access and use the Norwegian health care system. Refugee participants in the current study appreciated some of programs and incentives offered to them including the IFHP refugee program, the Alberta Health Benefit program for low-income refugees, the availability of specialized modern health resources, and the translation services which helped them adjust to Canadian society. Refugee participants also added that the demeanour of some health professionals, sponsor organizations, and refugee agencies were friendly, supportive, and provided them with whatever health information or assistance was needed. Although the Canadian health care system and refugee program has responded to some of the health needs of refugees over the years (Romanow 2002;

McKeary & Newbold, 2010), it is important to listen to their views and work towards minimizing the barriers.

Participants from the interview and focus groups suggested strategies to help bridge the gap between health service offerings and health service needs. Recent research has suggested that Canadian service providers and policy makers concerned with the health of immigrants and refugees should focus on addressing the systemic challenges, coordinating information and services, and adopting a comprehensive, long-term perspective on their settlement and integration process (Simich et al., 2005). The findings from this study add to the evidence that it is necessary to create health programs/interventions and consider providing more social opportunities and spaces for refugee women to share their knowledge and gain more information about where, when and how to acquire the necessary health services.

To enhance refugee women's integration in the Canadian health care system, both refugee participants and settlement/local leaders identified areas for consideration: extending health and social support in relation to health insurance/coverage, financial support, literacy training, translation services, and other settlement support. The issue of extending support is also discussed by Lawrence and Kearns (2005, p. 459) as "a necessary prerequisite and commitment" to sustaining the health demands and needs of resettling refugees in a new community. Refugee women recognized the vital role of local leaders, refugee centre administrators, and volunteers in their settlement process and the importance of improving services to help advance the health and social aspect of their lives. Refugee participants described the need to provide cultural sensitivity training for health professionals and community workers to create awareness about the differences in beliefs, language, and values. Several studies indicated that bridging cultural and

bilingual differences is crucial to enhancing communication and interpersonal care and improving the quality of care (Asgary & Segar, 2011; Joshi et al., 2013). There is a need for refugee women to be provided with culturally appropriate health care services which may help ease the transition to their new society. Drawing from the study findings and the literature, it is observed that refugee women's health needs and experiences can be addressed through a more holistic approach. The study findings confirmed that an intersectional approach is necessary to understand the unique health experiences of refugees and interconnected challenges that affect the understanding, access, navigation and utilization of the Canadian health care system by refugee women.

Theoretical Contribution: Intersectional Feminist Framework

To explore factors that intersected and influenced refugee women's understanding, access, navigation and utilization of the Canadian health care system, the IFF was employed. The guiding principles for the IFF are race, age, social class, gender, equity, location (rural/urban), ability/disability, and diversity of knowledge. The findings of this study highlighted education, gender, geographic location, identity, employment, culture, and social marginalization as being factors that influence participants' health needs and experiences of refugee women; as these determinants of health further corresponds with the IFF. Dillaway and Brubaker (2006) argued that the concept of intersectionality is about the unequal distribution of opportunities and standards of living especially among marginalized populations. The study by Dillaway and Brubaker (2006) is consistent with the major findings from this study as most refugee women encountered health and social inequalities, limited access to resources, discrimination, and restrictions from immigration policies, which shaped their health and settlement experience.

Specifically, I found that a woman who settles in a certain location (rural versus urban) and comes from a different background (different country or culture) often comes with lower income status, low educational background, of childbearing age, and from a minority population – these factors influence the settlement experience. The connection between these constructs (namely age, race, gender, social class) was eminent in this study and played a significant role in the lives of these women. According to Crenshaw, (1991) and Seng, Lopez, Sperlich, Hamama, and Reed Meldrum,(2012), the connection and intersecting effect of the above-named constructs can negatively influence marginalized minority groups such as refugees and immigrants, leading to disparities in health outcomes.

Given the context of the study participants, one could argue that their status as refugees and as women could affect their ability to make health care decisions, access/utilize certain health services, or gain employment during their early years after arrival. When this happens, the person becomes dependent on government and non-governmental agencies for support. Their status as refugees further marginalizes them because they are most likely to be denied opportunities that should be available to them (Williams, 2012).

Most of the women in this study found it difficult to find their way in the new system due to the complex institutional structures and a lack of understanding of how these institutions work. For instance, most participants did not understand how walk-in clinics operate or the referral system – largely due to the language barrier and having limited literacy skills. This, in addition to an entirely new culture, had an effect on how well the women integrated into their new society. Some of the women found it very difficult to relate to members of their new communities. It is also possible that other

factors perceived to be racially discriminated influenced their refugee women understanding and experiences of the services provided to them (Guruge & Khanlou, 2004).

Income status seem to play a role in understanding their new environment. Consistent with the literature, I found that a woman from low income class and especially from a minority group has intersections of multiple identities (background, history, and status) which shape their experiences (Sanchez-Hucles & Davis, 2010). Most of the refugee women resorted to self-care practices instead of seeking professional health care services. Self-care practices are also linked to their inability to find employment and being able to afford health care service of their choice.

In the early years after arrival, most of the refugee women confirmed that they faced employment challenges. Most women were jobless, this was identified from a review of the demographic data and seemed to be related to the women being from within a minority population (Colic-Peisker & Tilbury, 2007). Therefore, with respect to these women understanding and experiencing a health care system that is new to them, I highlight the need to assess how the IFF constructs (e.g. age, race, gender, and social class) intersect and influence their experience of health care in Canada.

The intersectional approach was appropriate to use in this study, as it emphasized the social and health disparities that can present, from a feminist perspective, within multiple categories (Hankivsky et al., 2012; Weber & Fore, 2007). The study findings support the use of the Intersectional Feminist approach as it offers dynamic and diverse perspectives and seeks to understand and address social and health inequities.

Summary

In this chapter, I discussed the study findings in relation to relevant literature. Results of the study resonate with previous studies and confirm that refugees are faced with several health and social challenges in understanding, accessing, navigating, and utilizing health care services in Canada. It is clear, however, that research that addresses the specific health needs and experiences of refugee women is required. Importantly, the roles of gender, educational background, and culture were significant in influencing refugee participants finding our way through the Canadian health system.

CHAPTER 6. CONCLUSION

This study highlights several significant factors relevant to the health experience of refugee women during their initial settlement time in Canada. I explored the refugee women's perceptions of health care in Canada to identify their needs during the settlement and integration process. I drew on concepts including understanding/familiarity with, access, navigation, and utilization of the health care services to investigate the challenges these women encounter. The diversity of these women points to the unique experiences and challenges they face in addressing their health needs. The study findings resonate with findings from the literature within the context of the methodological and theoretical approach. In reviewing the literature, a number of authors emphasized the need to pay attention to refugees' health needs and lived experiences as they settle in Canada (Attanayake, 2010; Awuah-Mensah, 2016; Herrel et al., 2004); however literature specific to refugee women is limited. The study findings serve to address a gap in the literature and contribute to knowledge in the area of refugee women's health. The following sections specifically address the research questions posed for this project.

RQ1. *Understanding*: What do refugee women currently know about the Canadian health care system and the health care services available to them?

Participants described their understanding of health, health care in Canada, and the health care system. The responses varied and this may be attributed to different viewpoints, experiences, and beliefs. The descriptions and perspectives of *health* as voiced by the participants were in contrast to having a *holistic* view of health. Their understanding of health largely centred on *physical* health; some related it to their spiritual/cultural beliefs. However, their view of health was limited and partly due to my

inability to speak the languages of participants. . Developing an understanding from the viewpoint of refugees would help to us to understand how they make choices and improve our delivery of care and service to better address their needs.

RQ2. Access: What supports and/or programs assist refugee women in accessing health care services? How are the women accessing the system?

Refugee participants' responses to how they access health care services begins with establishing social supports and gathering information from their network. Despite their early struggles and unfamiliarity with the Canadian system, these women learn to socialize with other refugees, family, and friends, go to public places, and involve themselves in community services offered to help build their knowledge base. The initial transition and experience of loneliness and social isolation makes it difficult for them to identify the supports and programs available to them. Some refugee participants expressed concerns that the available programs are not tailored to meet their health needs in terms of women specific programs, language and cultural differences. Similar to findings by Simich et al. (2005), refugee women's experience with health care was mostly influenced by systemic structures and policies

RQ3. Navigation: How do refugee women navigate the Canadian health care system?

The feeling of *starting over* was challenging for these women, but they gradually learned to embrace new ways of doing things and navigate their way through the Canadian system. This finding aligns with those of Debs-Ivall (2016). The complexity of navigating the health care system was initially frustrating and stressful for most of the women as they experienced culture shock, a loss of identity and had to adjust to language differences, learn a new language, and develop their health literacy skills. During their

encounter with the system, they were introduced to some new health practices (such as the preventative model of medicine, booking appointments, acquiring a family doctor and follow-up care). They experienced mixed feelings including frustration and joy as they had to shift from their traditional way of doing and being.

RQ4. Utilization: How do refugee women use the Canadian health care system?

What factors influence refugee women's use and access of health care services in Canada?

The health seeking behaviours and utilization of health care services varied among participants. Most of the refugee women had a low level of education according to the demographics of the participants which influenced their use of services and affected interaction and communication with others in the communities. For instance, many of the refugee women refused to seek medical attention due to the language barrier, limited literacy skills, and lack of understanding and thus preferred to self-medicate possibly worsening their health conditions (Ying1990: Shaw, Huebner, Armin, Orzech, & Vivian, 2009: Zhang, Gallagher, Ding & Neubeck, 2018). Often, the gender of the care providers contributed to their hesitance to access the system. Their preference for female care providers and the lack thereof affected the amount of utilization.

RQ5. Gaps: What gaps exist between refugee women's expectations and their lived experience of the Canadian health care system?

There is a gap when it comes to the expectations of refugee women and the realities in relation to the health care experience in Canada. Participants stated that before migrating to Canada, their expectations were quite high and different from what many have actually experienced. The largest gaps were identified in the following areas: wait times to see a health care provider, disparities between rural and urban centres in terms of

accessibility of resources, and inadequate or lack of support received by the refugee women in the rural areas compared to the urban.

RQ6. Goals: What are the health care goals of refugee women?

Refugee women emphasized taking care of their physical health. Some mentioned their mental health, while others spoke about improving their health literacy and learning to become more self-reliant. To better meet their health needs, participants strove to develop strategies to locate available resources/support services in their new environment. They developed resilience and coping strategies as they found their way through the Canadian system. Most refugee women were determined to overcome their challenges by participating in adult literacy classes and adapted new women health care practices which includes family planning and use contraceptives. Others resort to family and friends support, prayers, and participating in community programs. Schweitzer, Greenslade, and Kagee (2007) reported similar findings in their study of Sudanese refugees and their experiences during their migration process.

RQ7. Improvements: What strategies do refugee women believe might improve their health care experience in Canada? What would be a better approach?

Given the challenges and goals disclosed by study participants, it is important that strategies be put in place to improve the health care experience for refugee women to help ease the transition to their new country. Developing an educational program such as *'Health Care Basics for Women and their Families'* might help to reduce the lack of information and misunderstandings that refugees have after migration. Such education would serve to broaden their understanding of the health system and health services available to them. There is also the need to improve the actual delivery of health care, taking into consideration refugees cultural backgrounds. Further, services and provide

equal support should be extended to refugee women, no matter where they live - rural or urban. It may be helpful to make cultural sensitivity training mandatory for all people who work with refugees. The more refugee women are understood, the better we can serve them and help to address their needs.

Implications for Practice

My intentions for this study was to improve the health care experience for refugee women and better understand their health needs as they settle in the host country, Canada. The findings of this study take into account their voices and the difficulties they face as they transition and integrate into their new environment. Although the study findings do not reflect every aspect related to their health, there are some important implications that could help improve their experience. By considering the diversity of refugee women's health needs and expectations, their individual needs may be better satisfied and this might help them to feel a greater sense of belonging. It is essential to regularly assess their individual needs, stay informed about how they are doing, and strive to understand the challenges they are encountering as they attempt to understand, access, navigate, and utilize the health care system.

The study revealed that some health care providers, policymakers, and settlement agencies have limited knowledge about the health care needs of refugee women. Private, governmental, and non-governmental organizations and health researchers are encouraged to apply a practical approach to regularly assess the individual health care needs during their settlement period. The findings may serve to inform the Canadian health care system about the changes needed to improve refugee women's health care experience.

In the initial stage of settlement, refugee women have a limited social network and limited supports to help them integrate into Canadian society and the Canadian health care system. Helping them to create a strong and supportive network is crucial to providing them with information and support they need to navigate the Canadian health care system. Organizations involved in refugee settlement should create social activities to bring community members together in support of refugees. Such programs and activities might help non-refugees to better understand and become more aware and accepting of the needs of refugees.

In addition, there should be more collaboration among settlement agencies, health care organizations, and policymakers to develop joint initiatives that work to improve the health outcomes of refugee women. Increasing collaboration and partnerships among rural and urban agencies will help mobilize resources and increase capacity to meet the needs of refugee women.

The study findings also suggest that creating medical outreach programs specific to the needs of refugee women would be valuable. Intensive education sessions that educate refugee women particularly in the areas of nutrition, mental health, and interpretation of medical information will greatly assist refugee women (Brunger, Duke, & Kenny, 2014). Refugees face significant challenges with integration during their early arrival period and this may be related to differences in their social, cultural, religious, economic and political background (Pittaway, Muli, & Shteir, 2009). Further, it is important to intervene earlier with pre-migration orientation and provide refugees with adequate information to prepare them for the transition and ease their initial contact with the health care system in Canada. Mental health programs should be prioritized. This

initiative will help adjust their expectations and better equip refugees with helpful tools, advice, and supports upon their arrival.

Recommendations for Future Research

Further research is needed to improve the post-migration experience of refugee women in relation to their understanding, access, navigation, and utilization of the health care system and health care services in Canada. From the results of this study, the following recommendations are made:

1. Expand studies on impact of pre-migration experiences (assessment) on refugees and host communities. Research in this area may provide refugee centre administrators, health care providers, and other community workers/volunteers with knowledge or information to better understand the needs of refugee women as they settle.
2. Examine the post-migration mental health experience of refugees. When the expectations of refugee women are not met, emotional stress and instability in their early settlement can result. It would be helpful to identify strategies refugees could adopt to help manage this.
3. Investigate the cultural/ traditional concepts of health that influence how refugees approach the health care system. This may help provide culturally appropriate services to the refugee/ newcomer population.
4. Explore the health needs of refugees or newcomer populations in different locations for transferability and comparison. Future research should focus on finding out about the experiences of men, children, and seniors. There is the need to conduct individual interviews of refugee women to help assess the individual needs coming from diverse background and beliefs.

5. Investigate the challenges and experiences of health care providers, settlement agencies, and private sponsors in supporting refugees in accessing the care that they need. Exploring the perspectives of people that support refugees and existing community members is important to understand their views on refugees' health and settlement experience.

Limitations of the Research

Some of the limitations to the research are as follows:

- *Representative sampling limitations:* The representativeness or involvement of a wider population was limited by geography and the availability of willing participants. There was also a lack of diversity in the study participants were largely refugee women. In my study, I encountered a geographical limitation as the study was confined to communities in the southern part of Alberta. Due to the short duration of my study the area of southern Alberta was chosen based on feasibility and convenience. Exploring other provinces would have been significant in identifying how differences in policies, programs and services and how these differences impact refugee women's health experiences.
- *Fear and emotional distress / freedom of speech of some participants:* Some study participants (and potential study participants) voiced signs of fear and hesitation to express their feelings or share their experiences or sensitive information with me during the focus groups. This is largely because of the violence, abuse, and trauma they experienced in the past. Some of these participants also expressed fear to share certain information to persons with power, or a stranger, perhaps due to previous experiences with researchers or authorities who interviewed them

without a positive outcome (Temple & Moran, 2011). Participants who expressed fear and hesitation to share their experiences either did not participate or did show up and were provided with a lot of support and assurance that it would be okay to share information.

- *Language and interpreter/translation barrier:* Because English was not the first language of refugee women, language was a major limitation in this study. Although there was a translator to assist participants, some participants still could not express themselves well. In some instances, the translator did not speak the exact language or dialect of participants, which resulted in participants translating for each other. For example, in one focus group - a participant requested an Arabic translator but the participant spoke Somalian Arabic and the translator Syrian Arabic. Other participants/refugee women did not know enough vocabulary to express their true feelings or describe their full experience.
- *Exploring the perspective of health professionals:* Exploring the perspectives of health professionals in regard to the needs of refugee women in understanding, accessing, navigating, and utilizing health services and the health system in Canada would have been beneficial. The perspectives of health professional were not included in this study; however it would be a valuable population to consider in future research.
- *The need for individual interviews for refugee women:* It would have been useful to conduct individual interviews with some of the refugee women. In a focus group interview, some women may be shy and uncomfortable to speak publicly and share their experience while others may overshadow or take over the

conversation. Some women may feel more comfortable and open up more in a location convenient to contribute to the study due to privacy of an individual interview.

Dissemination of the Findings and Sharing of Knowledge

The findings will be shared with the refugee population, refugee centre staff, and local leaders, healthcare providers, and policymakers in hopes of improving the health care experience for refugees. As knowledge mobilization is a critical aspect of qualitative research, the study findings will be communicated back to the various communities and refugee groups/centres located within Southern Alberta where the study was conducted. I will provide participants with a summary of the findings pamphlet and also share a power point presentation about the study. The information pamphlets/booklets will be presented in different languages specifically in the local languages used in this study. I anticipate presenting the study findings to external stakeholders in the study communities (e.g., municipal council, health care professionals, educators, clergy, and members of the public). The purpose of the presentations is to share the finding of the research, supported by the current literature, as a means to enhance community programs in support of refugees. I will also strive to present findings to health care professionals including physicians and nurses with another version of pamphlet educating them about the needs of refugee women. It would be useful to include health professionals as my target audience to inform them about the changes necessary to improve refugee women's health experience during settlement in Canada.

I would also like to present my work at conferences in Canada such as the Conference of the Canadian Association of Refugees and Forced Migration Studies and the North America Refugee Health Conference at University of Toronto. In 2018, I

presented my preliminary findings at the 2018 Migration, Ethnicity, Race, & Health World Congress. Also, in 2018, an abstract of the study was published in the European Journal of Public Health (Anteh, 2018). I will attempt to publish in other scholarly journals that focus on women's health, such as the Journal of Women's Health Care or the International Studies in Gender, State, and Society. A copy of the thesis will be submitted to the University of Lethbridge Thesis Portal.

Reflection

In carrying out this research, some important findings were realized about myself. I grew up in a society (Ghana) where most women have little influence and control, are lacking knowledge about their health, and have limited access to health care services. My personal experience growing up in Ghana, as well as trying to adjust to a new life here in Canada, has made me empathetic to the plight and needs of refugees. It is for these reasons that I developed an interest in exploring the health needs of vulnerable women. I want to better understand their needs and work to identify strategies to improve their experience with health care and hopefully health in some way.

Coming from a culturally and ethnically diverse society with people from different backgrounds, I realize that I may be bounded by my religious and cultural beliefs and values from my home country. These beliefs and values can either help or hinder communication with participants and interpretation of the study findings; the important thing is to be aware and strive to stay neutral. Before and during the data collection process began, I kept a reflective journal of preconceptions and also some practical guidelines to follow as a means to help minimize any biases that could influence the interpretation of the data. The cross-cultural nature of the study and the use of

translators makes this especially important due to the possibility of interpretation bias that could threaten the accuracy of the data collected.

Also, as an immigrant from Ghana, I've experienced some challenges getting to know about my new environment and integrating and adapting to Canadian society.. My personal experience has helped me to gain a broader view and understanding of refugee women's experience and perspective about health care services.

I view this research as an opportunity to integrate with refugee women and develop my research skills. During this study, I experienced some challenges (e.g., with recruitment, data analysis) which improved my skills and knowledge as a novice researcher. Being the principal researcher, I learned a lot about qualitative research and some of the ethical and sensitive issues that come into play and how to manage them. Gaining access to participants was a bit of a challenge; the local leaders/administrators in each community were crucial in this respect. I also found that willingness to participate was an issue among some of the women – the root of the issue largely being a lack of trust. I think that my gender, cultural background, and immigration status helped many of the women to feel more comfortable sharing their stories with me ... at times I felt like I was one of them. I used my social network to build trust and relationships with these women which helped to create a more welcoming and safe ambiance to share their personal experiences and thoughts. For instance, I was invited to some social events like house parties, adult literacy classes, church programs and women group meetings which was a great opportunity to meet people, learn from them and better appreciate the importance of community inclusion.

Overall, the experience of conducting this research has allowed me to gain many new skills that will better equip me for conducting research in the future. It has also

provided me with insight that will help me to better advocate for refugee women in the future in meeting their health care needs during the settlement period.

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APPENDICES



APPENDIX A: MEMO TO INFORM (ALL PARTICIPANTS) MEMO TO INFORM (LOCAL LEADERS AND/OR ADMINISTRATORS)

Project Title: “Understanding the needs of refugee women in navigating the Canadian health care system”

Dear [Local Leader, Refugee Centre Administrator],

My name is Eunice Anteh and I am a graduate student in the Faculty of Health Sciences at the University of Lethbridge, Alberta. I am doing my master’s degree and am interested in finding out the health care experience of refugee women who are living in Southern Alberta. The purpose of my study is to understand the health care needs of refugee women as they settle in Southern Alberta to help find ways that can improve your *understanding, access, navigation, and use* of health care services.

The reason I am contacting you is because I am looking for refugee centre administrator / local leader to join and I am wondering if you are interested. I am looking to engage refugee centre administrator/ local leader who have lived in the area for about six months to five years and familiar with refugee women and their needs, who works with and supports them in their settlement process. The purpose of the individual interview is to share their experience supporting and working with refugee women in the area, barriers refugee women face in accessing health care services in Canada as well as thoughts to improving the health care experience for refugee women.

The individual interview will take place in an equally agreed upon public location that is safe and suitable for participants. The individual interview will take about 45-90 minutes and in English or any language you can speak. Participation is voluntary; all responses will be kept private and secured in a locked cabinet and/or stored as a password protected file on the password protected computer of the researcher. Your identity will be protected using pseudonyms and not their real names throughout the course of study and dissemination of the findings.

The data to be collected is important as it can help scholars, practitioners, consultants, administrators, policy makers, and other health experts to come up with possible solutions to serve refugee women better in taking care of their health care needs. I will share the study results through Power Point presentations and distribute a summary report of the findings with refugee women and refugee centre administrator/ local leader in the various refugee groups/centres located in those communities.

If you want to join or have any questions about the study, please contact me. You have the right to withdraw from the interview up to the point of data analysis without any penalty. Questions regarding your rights as a participant in this research may be addressed to the Office of Research Ethics, University of Lethbridge (Phone: 403-329-2747 or Email: research.services@uleth.ca).

Thank you for your time and consideration.

Eunice Anteh (Graduate Student)
Faculty of Health Sciences, University of Lethbridge
Email: e.anteh@uleth.ca

Dr. Claudia Steinke (Supervisor)
University of Lethbridge
Email: claudia.steinke@uleth.ca



MEMO TO INFORM (REFUGEE WOMEN)

Project Title: “Understanding the needs of refugee women in navigating the Canadian health care system”

Dear [Potential Participant],

My name is Eunice Anteh and I am a graduate student in the Faculty of Health Sciences at the University of Lethbridge, Alberta. I am doing my master’s degree and am interested in finding out the health care experience of refugee women who are living in Southern Alberta. The reason for this study is to understand the health care needs of refugee women as they settle in Southern Alberta to help find ways to make better what you know, how you get into, find your way through, and use the health care services.

The reason I am inviting you is because I am looking for refugee women to join and I would be glad if you are interested. I am looking to involve refugee women between the ages of 18- 49 years who have lived in the area for about six months to five years. If you decide to join, you will be part of a focus group of about seven women. The focus group is to talk what you think and experiences of health care services among refugee women from different countries.

The reason I am contacting you is because I am looking for refugee women to join and I am wondering if you are interested. I am looking to engage refugee women between the ages of 18-49 years who have lived in the area for about six months to five years. Participation will involve being part of a focus group of about 5-7 women. The purpose of the focus group is to discuss the various ideas and experiences of health care services among refugee women from different countries.

The focus group will take place in an equally agreed upon public location that is safe and suitable for participants. The focus group session will take about 45-90 minutes and in English or any language you can speak. Participation is voluntary; all responses will be kept private within other participants of the focus group interview. All participants will be asked to sign a confidentiality agreement not to tell anyone outside the interview about any person or information shared within the focus group. Participants’ identity will be protected using pseudonyms and not their real names throughout the course of study and dissemination of the study findings. All information shared will be secured in a locked cabinet and/or stored as a password protected file on the password protected computer of the researcher.

The data to be collected is important as it can help scholars, practitioners, consultants, administrators, policy makers, and other health experts to come up with possible solutions to serve refugee women better in taking care of their health care needs. The focus groups are also opportunities for refugee women to share their experiences (good and bad) with Canada’s health care system. I will share the study results through Power Point presentations and distribute a summary report of the findings with the participants and various communities/refugee groups/centres located in those communities.

If you want to join or have any questions about the study, please contact me. You have the right to withdraw from the focus group discussion without any penalty. Questions regarding your rights as a participant in this research may be addressed to the Office of Research Ethics, University of Lethbridge (Phone: 403-329-2747 or Email: research.services@uleth.ca).

Thank you for your time and consideration.

Eunice Anteh (Graduate Student)
Faculty of Health Sciences, University of Lethbridge
Email: e.anteh@uleth.ca

Dr. Claudia Steinke (Supervisor)
University of Lethbridge
Email: claudia.steinke@uleth.ca

APPENDIX B: LETTER OF ETHICAL APPROVAL



Office of Research Ethics
4401 University Drive
Lethbridge, Alberta, Canada
T1K 3M4
Phone: (403) 329-2747
Fax: (403) 382-7185
FWA 00018802 IORG 0006429

Thursday, 10 January 2019

Student Investigator: Eunice Anteh, Faculty of Health Sciences

Faculty Supervisor: Dr. Claudia Steinke, Faculty of Health Sciences

Study Title: Understanding the Needs of Refugee Women in Navigating the Canadian Health care System

Action: Approved

HSRC Protocol Number: 2017-090

Approval Date: January 10, 2019

Term Date: June 30, 2019

Dear Eunice,

Thank you for submitting the renewal report for your protocol titled “Understanding the Needs of Refugee Women in Navigating the Canadian Health care System”. It has been reviewed and approved on behalf of the University of Lethbridge Human Subject Research Committee (HSRC) for the approval period **January 10, 2019 to June 30, 2019**. The HSRC conducts its reviews in accord with University policy and the Tri- Council Policy Statement: Ethical Conduct for Research Involving Humans (2014). Please note that any changes to the protocol or the informed consent must be submitted for review and approval by the HSRC before they are implemented.

We wish you the best with your continuing research.

Sincerely,

Susan Entz, M.Sc., Ethics Officer
Office of Research Ethics
University of Lethbridge
4401 University Drive
Lethbridge, Alberta, Canada
T1K 3M4



“Refugee Women and Health care”



Would you be willing to participate in a focus group interview?

I want to find out how refugee women find their way through the Canadian health care system.

To take part you must be a refugee woman between the ages of 18 – 49 years who have lived in Alberta, Canada for about six months to five years. This interview will take about 45-90 minutes.

Interested in participating? Please contact:

Ms. Eunice Anteh

Email at e.anteh@uleth.ca

Eunice Anteh e.anteh@uleth.ca	Eunice Anteh e.anteh@uleth.ca	Eunice Anteh e.anteh@uleth.ca	Eunice Anteh e.anteh@uleth.ca	Eunice Anteh e.anteh@uleth.ca	Eunice Anteh e.anteh@uleth.ca	Eunice Anteh e.anteh@uleth.ca	Eunice Anteh e.anteh@uleth.ca	Eunice Anteh e.anteh@uleth.ca	Eunice Anteh e.anteh@uleth.ca
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APPENDIX D: LETTER OF INFORMATION (ALL PARTICIPANTS)

Project Title: "Understanding the needs of refugee women in navigating the Canadian health care system"

Dear [Potential Participant],

My name is Eunice Anteh and I am a graduate student in the Faculty of Health Sciences at the University of Lethbridge, Alberta. I am doing my master's degree and I want to find out the health care experience of refugee women who are living in Southern Alberta. The reason for this study is to know the health care you need as you settle in Southern Alberta to find ways that can help to make better what you know, how you get into, find your way through, and use the health care services.

The reason I am inviting you is because I am looking for refugee women to join and I would be glad if you are interested. I am looking to involve refugee women between the ages of 18- 49 years who have lived in the area for about six months to five years. If you decide to join, you will be part of a focus group of about seven women. The focus group is to talk what you think and experiences of health care services among refugee women from different countries.

The focus group will take place at a public/private location that is safe and good for participants. The focus group session will take about 45-90 minutes and in English or any language you can speak. Participation is voluntary; all responses will be kept private within other participants of the focus group interview. All participants will be asked to sign a confidentiality agreement not to tell anyone outside the interview about any person or information shared within the focus group.

The data to be collected is important as it can help scholars, practitioners, consultants, administrators, policy makers, and other health experts to come up with possible solutions to serve refugee women better in taking care of their health care needs. The focus groups are also opportunities for refugee women to share their experiences (good and bad) with Canada's health care system. I will share the study results with the participants and various communities /refugee groups/centres located in those communities.

If you want to join or have any questions about the study, please contact me. If you have any questions about the study, please contact the Office of the Research Services at the University of Lethbridge (research.services@uleth.ca) or (403-329-2431).

Thank you for your time and consideration.

Eunice Anteh (Graduate Student)
Faculty of Health Sciences, University of Lethbridge
Email: e.anteh@uleth.ca

Dr. Claudia Steinke, (Supervisor)
University of Lethbridge
Email: claudia.steinke@uleth.ca



APPENDIX E: INFORMED CONSENT SIGNATURE FORM (ALL PARTICIPANTS)

Project Title: "Understanding the needs of refugee women in navigating the Canadian health care system"

I have read the Letter of Information and fully understand the purpose of this research study and have had the opportunity to ask questions and have those questions answered. I understand that I am free to ask further questions about the study at any time. I understand that I can contact the researcher at any time through the addresses/phone numbers listed below.

a) **Consent to Participate:** I agree to voluntarily participate in this study:

Yes No

b) **Consent to Audio recorded:** I agree to have my responses recorded with an audio recorder during the focus group or interview:

Yes No

c) **Request to Review Transcribed Focus Group or Interview Data:** I wish to review a copy of the transcribed focus group or interview to make any necessary changes to my responses before the final analysis:

Yes No

d) **Request to Receive Results:** Upon completion of the study, I wish to obtain a summary copy of the study findings:

Yes No

My email or mailing address is as follows:

.....

.....
(Signature of Participant)

.....
(Date)

.....
(Signature of Researcher)

.....
(Date)

A copy of this form has been given to you for your records



**APPENDIX F: CONFIDENTIALITY AGREEMENT (REFUGEE
WOMEN)**

*Project Title: "Understanding the needs of refugee women in
navigating the Canadian health care system"*

I read the Letter of Information and fully understand the purpose of this research study. I agree to participate in a focus group interview and I am free to ask further questions about the study at any time. I agree to maintain the confidentiality of information disclosed during the focus group interview. I agree not to disclose any participant's identity or information with anyone other than the researcher.

.....

Print Name

.....

Signature

.....

Date

A copy of this form has been given to you for your records.



APPENDIX G: FOCUS GROUP GUIDE (REFUGEE WOMEN)

Project Title: “Understanding the needs of refugee women in navigating the Canadian health care system”

Date:

Time:

Location:

Participants:

Participants	Country (Origin)	Age	Education	Occupation	Marital Status	No of Children
<i>Participant 1</i>						
<i>Participant 2</i>						
<i>Participant 3</i>						
<i>Participant 4</i>						
<i>Participant 5</i>						
<i>Participant 6</i>						
<i>Participant 7</i>						

Introduction

Hello, my name is Eunice Anteh and I am a graduate student in the Faculty of Health Sciences at the University of Lethbridge, Alberta. I am doing my master’s degree and I want to find out the health care experience of refugee women who are living in Southern Alberta.

Purpose

The reason for the study (and this focus group session) is to know your health care needs as you settle in Southern Alberta to find ways that can help to make better what you know, how you get into, find your way through, and use the health care services. The information collected here is important as it can help scholars, practitioners, consultants, administrators, policy makers, and other health experts to come up with possible solutions to serve refugee women better in taking care of their health care needs. This focus group is also an opportunity for you to share your experiences with Canada’s health care system.

Upon completion of the study, I will share the study results back to you and the various communities/refugee groups/centres. I will do this by way of giving a Power Point presentation in each community and you will be invited to attend along with your supporters and local leaders. Once the study is complete, I also plan to present my work at various conferences such as the North America Refugee Health Conference. I will also share the study results through publications in a scholarly journal such as the International Journal of Migration, Health and Social Care. A copy of my master’s thesis will be available on the University of Lethbridge Thesis Portal to help contribute knowledge to other areas.

Consent Form

Before we start I would like to go through the Letter of Information and Signature Consent Form with you?

[Hand each participant a Letter of Information and Informed Consent Signature Form. Read through these documents with them; ask if they have any questions; do they understand the consent

form; if they are okay with what is written in both documents, then have them to sign off on the consent form which will indicate their agreement to participate in the research.]

Audio-Recorder

As I mentioned earlier, I would like to audio record this focus group with your permission. The reason for recording this is to make sure I write the exact information you share. Does everyone agree to have this focus group session recorded? *[Ensure their consent; if consent provided, have them sign off on the consent form. If one person does not agree then no audio-recording will take place.]*

Review of Transcription

I plan to write out the focus group interview within a two-week period; do you think that you would like to see a copy of the transcribed focus group and to make any changes needed before it is included in the final study? *[If they would like to see a copy of the transcribed focus group, have them check this off on this on the consent form, then you will need to contact them in two weeks to allow them to review the transcription. You will need to specify that they will need to send you any changes within a one-week time.]*

General Questions

Before we start, does anyone have any questions?

If there are no questions, I will now turn on the audio recording device. *[Turn on the recording device.]*

Focus Group Questions

1. Understanding
 - a. Can you tell me what comes to your mind when I say the word “health” and “health care”?
 - b. What do you know about the Canadian Health care System and the health care services available to you?
 - c. How did you find out that information? Where do you get your information from and how (word of mouth, electronic means, library, etc.)?
 - d. How do you currently take care of your health issues while living in Canada?
2. Accessing
 - a. Describe your experience(s) so far with the health care system in Canada?
 - b. What supports and/or programs are in place to help you in getting into health care services?
 - c. How do you access the health care system?
 - d. As a refugee, how have your experiences influenced you getting into health care services in Canada?
 - e. Where do you usually go to get health care (e.g. walk-in clinic, community health centre, hospital)
3. Navigating
 - a. Once you are in the system, how do you find your way through the system? How do you know how to get around in the system ... or where to go next? Who do you contact for help?
4. Utilizing
 - a. Do you know what health care services are available to you? What are they?
 - b. How do you use the health care system and the services available to you?
 - c. What are some of the things that influence you in using health care services here in Canada?

5. Gaps
 - a. What are the differences between your expectations and experiences (what you want versus what is happening) with the health care system in Canada?
 - b. What are some challenges that you face in getting into and using health care services in Canada? What are some of the early challenges that you faced? Do you go through those same challenges now?
 - c. What are the things that have made it easy for you?
6. Goals
 - a. What are your personal targets for your health care?
 - b. What are your personal expectation(s) of the Canadian health care system?
7. Improvements
 - a. What can be done to improve the health care experience for you?
 - b. Can you think of a better approach? What does a better approach look like to you? Or, is there a better way for us to serve you in terms of supporting you with your health needs?
8. Other
 - a. Before we end this focus group, is there anything anyone would like to add ... any other comments?

In Closing

Thank you everyone for joining in this focus group and for sharing your thoughts and experiences with me.

[Turn off recording device.]

APPENDIX H: CONFIDENTIALITY AGREEMENT

(TRANSLATOR/INTERPRETER)



Project Title: "Understanding the needs of refugee women in navigating the Canadian health care system"

I agree to perform any specific research tasks (e.g. transcribing, interpreting, translating, or recording data) and to keep all research information shared with me including participants' identity confidential by not disclosing to anyone other than the researcher. I will keep all information regarding this project in any form (e.g. tapes, transcripts, disks) in my possession secured and return all to the researcher when I have completed all my research tasks. I agree to destroy all information about this project in any form (e.g. tapes, transcripts, disks) at submitting all information to the researcher which cannot be retrieved by anyone including myself.

.....

.....

Print Name

Job Description

.....

.....

Signature

Date

A copy of this form has been given to you for your records

APPENDIX I: INTERVIEW GUIDE (LOCAL LEADERS AND/OR

University of
Lethbridge



ADMINISTRATORS)

Project Title: “Understanding the needs of refugee women in navigating the Canadian health care system”

Date:

Time:

Location:

Participants:

Participants	Country (Origin)	Education	Occupation	Duration of time working with refugee women
Participant 1				
Participant 2				

Introduction

Hello, my name is Eunice Anteh and I am a graduate student in the Faculty of Health Sciences at the University of Lethbridge, Alberta. I am offering a thesis-based master’s degree and am interested in studying the health care experience of refugee women who are living in Southern Alberta.

Purpose

The purpose of my study (and this interview session) is to understand the health care needs of refugee women as they settle in Southern Alberta in hopes of finding ways that can further help to improve their *understanding, access, navigation, and utilization* of health care services. The information collected here is important as it can assist scholars, practitioners, consultants, administrators, policy makers, and other health experts to plan and improve their system or project, in meaningful ways, that can better serve refugee women in addressing their health care needs. This purpose of this interview with a local leader and/or refugee centre administrator (e.g. someone that is familiar with these women and their needs, who works with them, and supports them in their settlement process) is to share your experiences supporting and working with refugee women in your community, and to hopefully provide some information on the difficulty these women face in accessing health care services. I am also interested in hearing your thoughts about what can be done to improve the health care experience for these women.

Upon completion of the study, I will share the study findings back to you, the focus group participants, and the various communities/refugee groups/centres. I will do this by way of giving a research presentation in each community whereby you will be invited to attend along with other local leaders. Once the study is complete, I also plan to present my work at various conferences such as the North America Refugee Health Conference. I will also share the study findings through publication in a scholarly journal such as the International Journal of Migration, Health and Social Care. A copy of my master’s thesis will be published on the University of Lethbridge Thesis Portal to help contribute knowledge to the related fields.

Consent Form

Before we start I would like to go through the Letter of Information and Signature Consent Form with you?

[Hand over a Letter of Information and Informed Consent Signature Form. Read through these documents with him/her; ask if they have any questions; do they understand the consent form; are they okay with things, have them sign off on the consent which will indicate their agreement to participate.]

Audio-Recorder

I would like to audio record this interview upon your permission, to ensure accuracy in the transcription of the data. Do you agree to have this interview recorded? *[Ensure their consent; if consent provided, have them sign off on the consent form. If one person does not agree then no audio-recording will take place.]*

Review of Transcription

I plan to have the interview transcribed within a two-week period; do you want to see a copy of the transcribed interview and make any necessary changes on the transcription before it being included in the final study? *[If he/she would like to see a copy of the transcribed interview, have him/her check this off on this on the consent form, you will then have to contact them in two weeks to allow them to review the transcription. You will need to specify that they will need to send you any changes within a one week period.]*

General Questions

Now before we start, do you have any questions that I could answer at this time?

If there are no further questions, I will now turn on the audio recording device. *[Turn on the recording device.]*

Interview Questions

1. Understanding

- a. Could you please tell me about how you became interested in working with refugee women?
- b. How have you enjoyed your experience working with refugee women?
- c. Could you tell me how you determine the needs of refugee women?
- d. Upon arrival, what do refugee women know about the Canadian Health care System and the health care services available to them? After being in Canada for six months, what do they know about the health care system and services available to them?
- e. How do they get their information? Where are they getting the information from (word of mouth, electronic means, library, etc.)?
- f. How do you currently assist refugee in caring for their health needs?

2. Accessing

- a. What supports and/or programs are in place to assist refugee women in accessing health care services?
- b. Do refugee women consult you for assistance and why? What kinds of assistance do you provide? What kind of health assistance do refugee women seek?
- c. Where do refugee women usually go to get health care (e.g. walk-in clinic, community health centre, hospital)?

3. Navigating

- a. In what way(s) do you assist refugee women to find their way through the system when they arrive in Canada? How do they learn how to find their way through? Who do they contact for assistance?
 - b. How do refugee women find their way around in the health care system? How do they know where to go? Who to contact for help? Next steps?
4. Utilizing
- a. What services are available to refugee women? What services do they usually acquire?
 - b. What factors influence refugee women in using health care services here in Canada?
5. Gaps
- a. What are the gaps existing between expectations and reality (what you expect versus what you have experienced) with the health care system in Canada?
 - b. What are the gaps that exist between the actual health care needs of refugee women and their experiences in meeting those needs?
 - c. What are some of the challenges refugee women face in accessing and using health care when they first came to Canada?
 - d. What are the things that make it easy or difficult for you to support refugee women?
6. Goals
- a. What goals do you have (or set) in supporting refugee women and their health care needs?
 - b. What are your expectations of refugee women in terms of addressing their health care needs?
 - c. What are your expectations of the health care system in terms of assisting refugee women?
7. Improvements
- a. What is your perspective/thought about the Canadian health care system in meeting the needs of refugee women?
 - b. How does the Canadian health care system help refugee women to overcome their challenges and provide the services they need?
 - c. What can be done to improve the health care experience for refugee women? Is there a better way to serve them in terms of the assisting them with their health needs?
8. Other
- a. Before we end this interview, is there anything you would like to add ... any other comments?

In Closing

Thank you for joining this interview. Thank you for your time and for sharing your thoughts and experiences with me.

[Turn off recording device.]