

Original Research

## User and Provider Perspectives on Improving Mental Healthcare for Syrian Refugee Women in Winnipeg, Manitoba, Canada

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### Abstract

**Introduction:** Refugees have higher risk of developing mental illness like anxiety, depression and Post-Traumatic Stress Disorder as they flee from violence. Women refugees may have unique mental healthcare needs due to their vulnerability to gender-based violence and abuse during flight from war. The research question of this study was what the health system can do better to address the mental healthcare needs of refugee women in Winnipeg.

**Methods:** Semi-structured interviews were conducted with 9 Syrian refugee women and 6 service providers/decision makers. The interviews were analyzed using qualitative inductive analysis and coded for themes based on recurring issues.

**Results:** Limited understanding of mental health and illness among refugees, stigma, and the need for culturally competent care were noted by the service providers. System navigation, language, unemployment and safety of family members left behind in Syria were the main concerns of the refugee women. While there are many programs available for refugee women in Winnipeg, lack of collaboration and coordination among providers was identified.

**Conclusions:** This study recommends that service providers use resources developed by UNHCR and Canadian physicians in providing culturally competent care, decision makers take leadership roles in implementing better collaboration among agencies, employers be open in hiring refugees and everyone in the society ensures that the refugee women feel welcomed and included.

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### Introduction

The number of people being displaced worldwide is currently at a record level. The United Nations Refugee Agency (UNHCR) estimates that 70.8 million people have been forcibly displaced at the end of 2018 as a result of persecution, conflict, violence or human rights violation. [1] This is an increase of 2.3 million people over the previous year and 27.5 million since 2009. Canada has a long history of accepting refugees and is the second largest resettlement country in the world after the United States. [2] Canada has resettled more than 700,000 refugees since 1959 with a record acceptance of 58,437 in 2016. [3]

The mental healthcare of refugees remains a prime challenge as many have fled from war with traumatic experiences. The long-term mental health problems of refugees fleeing from war are not limited to post-traumatic stress disorder (PTSD), but also include prolonged grief, depression, substance-related disorders, explosive anger, and psychotic disorders. [4] Research shows that newly arrived immigrants and refugees underutilize community resources and healthcare services compared to the general population. [5]

Globally, women make up half of displaced migrants due to war and conflict. [6] Physical and mental health disparities that refugee women experience, as compared to men, are often unaddressed during resettlement in host countries. [7] Some refugee women may have been the victim of sexual harassment, domestic violence, rape, forced marriage, or

forced pregnancy and abortion. Gender-specific violence and abuse may have led to mental illness such as depression, anxiety, PTSD, suicide, and psychosis among refugee women. [8-11] Therefore, women may be traumatized and afraid of the uncertainties in settling in a new country and culture. A study by Ahmed and colleagues found that refugee women were nearly five times more likely to develop postpartum depression than Canadian-born women. [12] Settling in a new country can be stressful with limited social networks and no financial capital. Refugee women face more challenges as their family roles begin to change, the traditional support system they had at home becomes non-existent and language, employment barriers, cultural differences become prevalent. [7] Being isolated can have profound consequences on mental wellbeing of refugee women.

The Province of Manitoba has welcomed an average of 1,250 refugees per year between 2006 to 2017. [13,14] The province accepted a record 3,730 refugees in 2016, contributing to a 5-year average of over 1,900 refugees. The 2013 – 2017 data from Immigration, Refugees, and Citizenship Canada shows that Manitoba has accepted the highest number of refugees per capita of any Canadian province or territory. [13] Considering the recent influx of Syrian refugees, it is important to understand how current healthcare services in Winnipeg (the largest City of Manitoba) are meeting the mental health concerns and needs of refugee women. The objective of this study is to examine user and service provider perspectives on improving mental healthcare services for refugee women in Winnipeg, Manitoba. This research brings the voices of refugee women to the attention of policymakers, as to the services available to them, the ways they now access services, and the types of services they need. Results from this study may be used to identify existing gaps in services and inform ongoing development of services and support for refugees.

## Methods

### Design

A qualitative research design was employed to explore what the health system can do to better address the mental health needs of refugee women in Winnipeg. Semi-structured interviews were conducted with Syrian refugee women and service providers/decision makers living/working in Winnipeg. Interviews with refugee women were focused on their lived experiences and service accessibility issues. Interviews with decision makers were focused on policy measures, exploring options for community-based and culturally appropriate healthcare. Qualitative thematic analysis, which is a method for identifying, analyzing, organizing, describing, and reporting themes found within a data set, was best suited for this study. [15,16]

### Sample and Recruitment

Nine Syrian refugee women, five service providers and one decision maker were recruited using a mix of convenience and snowball sampling approach. Among nine refugee women, six were married, two were widowed and one was single. Two participants were Privately Sponsored Refugees (PSRs) and remaining seven were Government Assisted Refugees (GSRs). The education level among the refugee women participants varied. One refugee woman had a bachelor's degree from Syria and was working in a temporary part-time position in Winnipeg. One refugee woman was attending a post-secondary institution. The remaining seven participants had education level in between elementary to Grade 9 and the majority mentioned attending English as an Additional Language (EAL) programs in Winnipeg. One refugee woman was employed, and another woman was engaged in casual work. Most of the participants had to rely on social assistance for living.

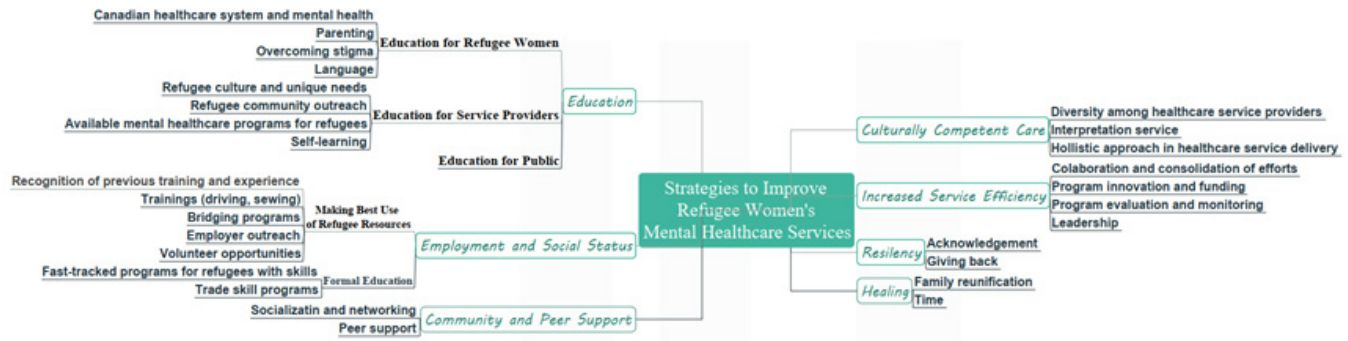
### Data Collection

The refugee women and service providers were offered one-on-one interviews at a time and a place of their convenience. Service providers were given the option to participate in person or via teleconference. Informed consent was obtained before all interviews. All interviews followed a semi-structured format with the aid of an interview guide. The interviews with providers and refugee women were conducted concurrently. Initial analyses and interviews also informed subsequent interviews so that it was possible to build on and further explore emerging themes. All interviews were conducted by the first author between February and April 2019. The interviews ranged in length between 40-90 minutes. All interviews were audio recorded with permission and transcribed verbatim by the first author. Detailed field notes on context and nonverbal cues were taken during the interviews as well. Only two out of nine Syrian refugee women were able to communicate in English. Therefore, two professional interpreters were required for the remaining seven interviews. Both interpreters were women and working at refugee serving organizations but not from Syria. To further add to the trustworthiness of the study, one audio recording was re-interpreted and transcribed by a native Arabic speaker to analyse the interpreter's interpretation of the first author's explanations and questions.

### Analysis

The data were analyzed using qualitative analysis and coded for themes based on recurring issues aided by NVivo 12 qualitative software. The interviews for both refugee women and service providers were analyzed simultaneously. In summary, the analysis process included reading the transcripts over and over to familiarize with the data. Then a list of

primary codes was developed inductively. The codes were further refined, expanded and combined to form overarching themes. While reviewing, defining, and naming themes, sub-themes were assigned within themes where similarities among codes were found. In addition to the analysis software, suggestions from Braun and Clarke, such as visual representations (mind-maps), and other techniques (tables, writing down the codes in a separate piece of paper and sorting the piles of developed themes etc.) were implemented during the analysis. **Figure 1** presents the final Mind-map developed at the completion of analysis. [15]



**Figure 1.** Mind Map of Strategies for Improving Mental Healthcare Services for Refugee Women

### Ethics Approval

This research received approvals from the Health Research Ethics Board at the University of Manitoba, and the Research Access and Approval Committee with the Winnipeg Regional Health Authority (WRHA).

### Results

The interview participants discussed access challenges and strategies for improving mental healthcare services for refugee women in the province. The research findings were categorized in seven themes and described in detail below. Participant quotes were identified by participant number and categorized as refugee woman (RW) and service provider (SP).

#### Education (for Refugee Women)

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

Refugee women lack knowledge about western perspectives of mental health and the Canadian healthcare system in general. Many do not know how to make appointments or obtain a referral to see a specialist, and often end up seeing multiple service providers for the same problem or none. During the interviews the refugee women expressed that they need education and that special programs for women only would be most helpful for them. They showed interest in learning about mental health issues and options to cope with stresses. Presentations on mental health, healthcare services, therapy, counselling, and special programs for women are some options to consider. Distributing leaflets of programs, giving them a phone number to call or a website address will likely be of little help. Considering that many refugee women have limited formal education, going a step further, such as, explaining the facts and services to them in a very simple way or connecting them to those services can help.

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

During the interviews, one refugee woman who is attending a post-secondary institution was able to provide some suggestions around simple ways of explaining things to other refugee women of her community.

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

### *Parenting*

Settlement workers reported refugees' misconceptions around parenting and Child and Family Services (CFS) in Canada and emphasized the need of educating them about rules and regulations. There is a real fear among refugee families, especially the women, that they will lose custody of their children. Specifically, there is fear and confusion surrounding how to discipline children that is causing distress for many refugee women. Participants also voiced concerns about how their children will cope with the new culture while maintaining their own culture.

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

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

### *Overcoming Stigma*

Overcoming stigma is one of the most important strategic areas to improve access to mental healthcare services. Some refugee women also realized the necessity of sharing their mental health issues, stresses, and anxiety concerns with their physician in order to access services. Therefore, it is important to educate refugee women about overcoming stigma and be open about their mental health issues.

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

### *Language*

Nearly every refugee participant reported attending EAL classes to improve their communication skills. Learning English contributed to feelings of freedom and being able to engage in activities outside their home. However, some refugee women mentioned scheduling conflicts with classes being offered only at one specific time, which created challenges for themselves and their husbands in attending the same classes. Offering classes at different times in a day and including childcare facilities while the refugee women attend EAL classes would be beneficial.

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

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

## **Education (for Service providers)**

### *Refugee Culture and Unique Needs*

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

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

### *Refugee Community Outreach*

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

“I think it would be best if the service providers reach out to the community itself and let them teach the service providers what is their community or culture. They (service providers) have to leave their door open because you cannot be the expert on a different community. I can never be an expert on the Syrian community because I’m not Syrian, but I can ask them, and they can teach me. So, that kind of attitude is needed from our service providers. We should not think that they (refugees) just take a service and what we don’t need to know about the culture. I think it’s a necessary process. You have to know the culture before you can provide them culturally sensitive service.” (SP 2)

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

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

### *Knowledge About Other Programs*

It is important that service providers are aware of the programs available for refugee women and where they can access services, not only for their mental health related issues, but also social services. The service providers discussed the need for networking and information sharing among themselves so that they can refer refugee women to the appropriate services. Since many refugee women are unable to communicate in English, navigation is a significant challenge for them. Therefore, service providers can step forward by connecting refugee women to other providers whom they are referring to, instead of just providing a leaflet, a phone number, or an email address.

Partnering with other agencies and organizing combined programs is another potential strategy. The service providers could network and learn about existing services and programs in order to refer refugees.

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

### **Education (for Public)**

Negative attitudes, criminalization, racial slurs or discrimination towards refugee women can have serious consequences on their mental health. Since many of the refugee women, and almost all who were interviewed, are identifiable because of wearing hijab, they may become a target for discrimination. One refugee woman shared her own experience of bullying at school. The service providers recognized the issue of racism and emphasized the importance of public education. Settling in a new country and adapting to a new culture are already challenging for refugee women. The feeling of being unwelcomed, and discriminated against, can be very hurtful for them.

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

### **Employment and Social Status**

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

Unemployment is one of the major sources of stress for the refugee women, and their families, and was mentioned repeatedly during the interviews. Mental wellbeing, the standard of living, or social status all depend on the level of income, to some extent. Almost all of the refugee women interviewed were dependent on social assistance for income. Many considered that the Canadian government has already been generous enough to accept them as refugees in Canada. In addition, receiving social assistance made them feel as though they are a burden to society. The refugee women,

or their husbands, want to work and do not want to be reliant on social assistance programs, but they are unable to do so mainly due to the language barrier and their previous education or training not being recognized in Canada. The refugee women have urged that authorities can do more to identify programs and mechanisms so that they are able to utilize their skills and previous work experience to earn their living.

“Again, my husband, he has the skill (30 years of trades experience from Syria), but he cannot work here with that skill. If the government could make it easier, judged him by his skills, not by education, certificate or language; it would have been easier. We don’t need to depend on welfare, we want to work and earn from our income, from our jobs. We want to do jobs with our skills, we don’t want help from the Government. Only thing the Government need to do is understand us and help us with the procedure.” (RW 3)

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

Service providers suggested some excellent programs during the interviews like driving training, sewing training, volunteer opportunities, employer outreach, or bridging programs. A tailoring or sewing job would not require much language proficiency to start with. Employer outreach, bridging programs, or volunteering are other excellent options, where the refugees are introduced to potential employers after receiving some training from settlement or service providing organizations. The Government could either provide incentives to employers or contribute to the salary for first few months, as the refugees develop job skills and eventually get hired. While it seems that running these programs may be costly for the Government, investing in refugees in such a way is likely more efficient than providing social assistance alone.

#### *Formal Education*

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

There is a misconception among immigrant communities, which came out during the interviews, that only professional jobs such as engineering, medicine, law, accounting etc. are viewed positively. Years of education and training are required for these positions, whereas trade skills education, such as plumbing, electrical, or carpentry, requires fewer school years and have high income potential. These options are not explored in the refugee or immigrant communities, especially by women. Governments, at all levels, could consider incentives for refugees to enroll into these programs, making the admission process more accessible.

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

### **Community and Peer Support**

#### *Socialization and Networking*

Socialization and networking are very important for the mental wellbeing of the refugee women. For many refugee women, loneliness and isolation are a source of stress. Many wanted a place to gather and be able to speak in their own languages so that they can relieve their stresses. Knowing what others are doing to cope with challenges can be a great help, as well as find some comfort in knowing others are experiencing similar struggles. It is also very important for the refugee women to get to know the community outside their own Syrian or refugee community. The service providers discussed logistical requirements in providing refugee women with options for socialization and connecting with new people. The service providers can play an important role here by reaching out to other organizations, community leaders or representatives to arrange events where everyone can participate.

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

### *Peer Support*

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

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

### **Culturally Competent Care**

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

There is a need for privacy. Most refugee women will not talk about physical/sexual abuse (past or present) to, or in front of, a man. While many facilities already offer the privacy that refugee women need, it is also important that service providers understand how to engage in discussions about sensitive subjects like sexual abuse. This will be discussed in more detail in the Diversity Among Healthcare Service Providers section.

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

The service providers discussed ongoing professional development activities. Having knowledge about refugee religion, islamophobia, racial discrimination, and stereotypes will contribute to improved care from service providers. This will also enable them to take on leadership roles in making other service providers aware of the consequences of negative attitudes towards refugees or unconscious biases.

### *Diversity Among Healthcare Service Providers*

The refugee women mentioned their greater comfort in discussing their health problems with a healthcare service provider who speaks the same language. The preference for female physicians has already been mentioned. However, participants also mentioned the lack of Arabic-speaking, female service providers.

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

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

### **Interpretation Service**

The interpreters and cultural brokers can play an important role in minimizing some gaps in communication. This is especially important in the context of mental health given that any diagnosis is based on conversations rather than physical assessments. Interpreters can provide education and cultural training to both clients and healthcare professionals (mental health focused or otherwise) as it relates to treatment of mental illness as well as making the therapy sessions successful. It is also important to make sure that the interpreters are trained well, know what they are doing and can build rapport with clients, as well as understand medical terminology. The service providers reported that attempts to use family, friends, children or virtual interpreters have not been successful, and they discourage using these

options for many reasons, confidentiality being one of them. While discussing the issue of interpretation, the Family Physician who sees many refugee patients repeatedly emphasized the importance of using professional interpreters. If the interpreters are from the same community as the clients are, that also can pose challenges in terms of confidentiality. Therefore, finding a good fit for the role of interpreter or cultural broker can require considerable effort.

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

#### *Holistic Approach in Healthcare Service Delivery*

An holistic approach in healthcare service delivery, aided by longer appointments, that addresses a broader range of socio-economic, ethno-cultural, and integration challenges by the refugee women was recommended by service providers. A specialized mental healthcare clinic for refugees, similar to that of BridgeCare Primary Care Clinic, may be better suited to bringing a multi-disciplinary team together and provide services incorporating a holistic framework. BridgeCare Clinic in Winnipeg provides a single point of access for the initial health assessment and primary care services for newly arrived, government sponsored refugees.

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

### **Increased Service Efficiency**

#### *Collaboration and Consolidation of Efforts*

Almost all service providers interviewed agreed that there are many existing programs providing mental healthcare services, but most of them perform in silos, which has resulted in duplication of efforts and service inefficiency. There have been instances where the refugee women are seeing one counsellor but access the emergency room and then get referred to another counsellor. Afterwards when they come to see a Family Physician, the Physician is not aware of the treatment history unless they investigate further.

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

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

#### *Program Innovation and Funding*

The Canadian Muslim Women’s Institute (CMWI) has started a food bank as an additional service, especially for the refugee women, which is an excellent idea that reaches out to the Syrian and all other refugee women. Stemming from cultural and religious beliefs, Muslim refugee women need to get ‘halal’ food for themselves and their families. They do not know where or how to get ‘halal’ food, and many are unable to read the ingredient lists or labels. At CMWI, refugee women can shop for ‘halal’ food at an affordable price, while also attending awareness sessions and language classes. This is a good example of program innovation.

The program named ‘Cooking and conversation’ has already been discussed. Such program innovation should be encouraged. However, service providers discussed their challenges of being short-staffed, retaining skilled workers, as well as the need for a larger space. Therefore, the continuation of funding to offer programs and additional funding for expansion of effective services are required.

“...getting them ready to be able to work in the Canadian culture and Canadian workplace. And there are pro-



grams that are doing the same thing out there, but I think our clients are very unique in the sense that these are refugees who came here, who don't have the language skills, who have not had the skills to find their job yet. And we need to know the way not just to groom but also do a lot of follow ups and that is lacking. So, we know we need these things, but we cannot do it because we don't have the funding right now." (SP 4)

#### *Program Evaluation and Monitoring*

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

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

#### *Leadership*

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

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

Additional areas identified during the interviews regarding opportunities for leadership improvement include problem recognition, ensuring service efficiency, refugee involvement in decision making, financial support for successful programs, investing in program innovation, and public education.

### **Resiliency**

#### *Acknowledgement*

Many of these refugee women have suffered immensely in their life. They had been through the horror of wars, run for their lives, and lived in refugee camps, yet have shown great resiliency and strength. Many have moved on. While they may have some complaints, especially in regard to service access, they are very grateful that they were given the opportunity to start a new life here, in Canada. They are in safety and a particularly horrific part of their life has come to an end.

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

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

#### *Giving Back*

The participants expressed a strong desire to participate in society and give back to the Canadian Government and the people. They are hopeful and have positive strengths and attitudes.

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

### **Healing**

#### *Family Re-unification*

Many of the refugee women have left their family members behind, which includes immediate family members, children, and partners. They are consistently worried about the safety of their family members. The service providers also believe that family re-unification can facilitate wellness. These refugee women and their families would do well and

contribute more to society if they were together. Since the Canadian Government has already taken a step to welcome these refugee women, an additional step in bringing their spouses or children would benefit all.

“I think their main concern is family back home. If they can re-unite with their family their mental health would be fine. Some of them are trying to go back, find their children and bring them back. For that population, I think Government can support them to bring their loved ones here and they will be much happier. Even the Syrian, they have families or even kids in other countries or in refugee camps. Speeding up the process to bring family members would help with the mental health of the people who are here.” (SP 5)

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

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

### *Time*

Time is probably the best healer. While the refugee women have struggled initially, with time they are doing better and getting used to a new normal. They have been trying hard to leave their sufferings and migration journey behind and move forward. During the interviews all refugee women mentioned that being safe in Canada has been a wonderful experience for them. The refugee women are comparatively young, and their children are learning the English language very well.

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

## **Discussion**

Both service providers and refugee women have provided their perspective on the existing challenges and, in the present study, options or recommendations that can be considered for service improvements. While discussing service improvements, service providers mentioned collaboration among agencies, leadership at all levels, and education for both refugee women and service providers. Refugee women were concerned about their financial struggles and identified employment, or specifically lack thereof, as a critical situation that contributes to their mental wellbeing. Given the importance of learning English, refugee women wanted language programs to be more flexible (in terms of times and locations). This study recommends that service providers use guidelines developed by UNHCR and Canadian physicians in providing culturally competent care to the refugee women, decision makers take leadership roles in implementing better collaboration among agencies, Manitoban employers be open to hiring refugees, and the whole Canadian society is responsible for ensuring that refugees feel welcomed and included.

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

The western healthcare model is a one-way relationship of providing services where the client seeks professional care and often there is no relationship between the client and care provider other than diagnosis and treatment. [17] This approach will not be effective in treating refugees with mental health problems. Studies have suggested that healthcare providers must be mindful of the circumstances around pre- and post-migration. [18-20] After the difficult migration journey and experiencing war violence, refugee families often arrive in host countries to start life once again from nothing. Therefore, they can find themselves at a disadvantaged socio-economic position. Medical practitioners should be mindful of how postmigration disadvantages may increase or exacerbate the risk of mental distress among refugees. [20-21] Service providers must provide enough time to establish a relationship of trust with their refugee clients, be aware of the unique cultural profile of this group, as well as their way of reporting symptoms. [22-25]

According to Huljev & Pandak, “holistic medicine means consideration of the complete person, physically, psychologically, socially, and spiritually, in the management and prevention of disease.” [26] While describing the philosophy behind holistic care, Tjale & Bruce said that “for human beings the whole is greater than the sum of its parts and that mind and spirit affect the body.” [27] The care is based on the idea of holism. Service providers must understand the wide range of factors that put people at risk for mental distress and consider the interaction between the individual, community, societal factors, and their relationship while providing services.

### **Providing Culturally Safe Care**

The need to develop and deliver culturally competent healthcare has been well reported in the literature, but cultur-

al safety is rarely mentioned. Approaches that consider the interaction between the individual, their relationships, community, and societal factors as well as implement new models of collaborative and integrated care should be encouraged. [28-29] Salami and colleagues suggested that investing in culturally competent mental healthcare delivery models can help to address the barriers of distrust and lack of familiarity with mainstream mental healthcare services. [30] They further recommend that services offered to the clients must be flexible, affordable, accessible, and culturally/linguistically appropriate. A study on mental health in Europe's Syrian refugee crisis emphasized that providers need to understand their clients' cultural idioms of distress (i.e., the ways in which distress is verbalised in a specific community) and the explanatory models (i.e., the ways in which people understand and explain their symptoms). [31] These can affect the clients' expectations, coping strategies, ways of explaining an illness, and norms in seeking help. For example, during the interviews one service provider mentioned that most refugee clients do not understand terms like 'mental illness', 'psychiatrists', 'psychologists', 'psychotherapists' or even 'counselling', but they understood the term 'therapy'. It was also easy for providers to refer to this term considering the clients' educational background.

While providing culturally competent care, it is important for the service providers to understand the cultural safety aspect of it, which takes us beyond cultural awareness and recognizes the importance of respecting difference. [32] There is now a growing understanding of the need to move toward culturally safe care, which differs from cultural competency and a focus on the other's culture, to a focus on self-reflection among health practitioners. Relevantly, refugee health literature mostly uses the concept of cultural competency.

In describing cultural competence and cultural safety in nursing education, Hart-Wasekeesikaw et al. state, "cultural safety helps us to understand the limitations of cultural competence, which focuses on the skills, knowledge, and attitudes of the practitioners". [32] Service providers have more responsibilities to ensure that refugee women can feel safe in discussing their mental health challenges without any stigma or feeling of shame. There should not be any judgement about culture, race, or religion in mind as service providers interact with their refugee clients. According to Spence, by understanding the power differentials inherent in healthcare service delivery and readdressing these inequalities through educational processes, cultural safety can be accomplished. [33]

The UNHCR report on 'Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians – A Review for Mental Health and Psychological Support Staff Working with Syrians Affected by Armed Conflict' is an excellent resource that lists common idioms of distress for Syrians. [25] By using this resource, healthcare providers can develop a cross-cultural understanding of Syrian refugees and design relevant training, education, and consultative services. [31] Additional relevant resources, developed by Canadian physicians and researchers, which can aid service providers, include approaches in primary care:

- Common mental health problems in immigrants and refugees: general approach in primary care; [34]
- Evidence-based clinical guidelines for immigrants and refugees; [35]
- Caring for newly arrived Syrian refugee families [36]

### **Improving the Social Determinants of Health**

The effect of poor social determinants of health on access to mental healthcare services by refugees has been extensively discussed in the literature. [37,38,39,30,40,41] Unemployment and income insecurity, limited education and literacy, language and communication challenges, substandard living conditions, struggles with healthy child development, isolation and racial discrimination are all associated with access barriers, and hence contribute to a decline in overall health. During the interviews one refugee woman talked about her husband being unable to find a job with 30 years of experience in trade skills from Syria, which negatively impacts his self-esteem and subsequent mental health. It is unfortunate that a person with such job skills cannot find employment when the country needs more than 167,000 new apprentices in the next 5 years. [42]

Strategies to make the best use of refugee resources, in terms of job skills, would positively contribute to mental wellness, in addition to economic gains. All refugee women who were interviewed expressed a strong desire that they and their family members want to work and contribute to society. They do not want to utilize social assistance. This study suggests that policy makers should explore options such as apprentice opportunities, employment that requires fewer communication skills, employer outreach, credit for previous education and skills, and fast-track or bridging programs. Programs such as these could reach out to potential employers and provide incentives to hire refugees. 'A 10-point multi-stakeholder action plan for employers, refugees, governments and civil society' is an excellent guide, developed by a combined effort of OECD and UNHCR, to hiring refugees so that they can contribute economically and participate more fully in their host societies. [6]

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

The mainstream community will have to play a role in supporting refugee women and their families to better integrate within society. In collaboration with settlement organizations, communities can arrange large gatherings where refugees can participate and get to know others in the community. Attending such events can contribute to refugees feeling welcomed and that they are part of society. Public education and media campaigns on the harmful effect of negative attitudes towards refugees should be developed; for example, campaigns have been developed to address negative stereotypes about Indigenous people in Winnipeg. [43]

Participants discussed their experiences of discrimination and negative attitudes towards refugees. Reinforcement of strict anti-harassment and victimization programs in schools and elimination of racism are recommended. [44-45] Discrimination at doctor's office, as reported in the literature and in the present study, will also need to be addressed. [46] The Provincial Colleges of Medicine and Surgeons will have to take leadership roles by applying strict rules and regulations in such instances. The CMHA has called for new legislation to address stigma and discrimination in the healthcare system, amongst practitioners, as well as at the individual level. [47] The recently published Chief Public Health Officer's Report on the State of Public Health in Canada 2019 has a focus on stigma and discrimination towards persons with health conditions. [48] The report admits that "many forms of stigma that intersect in complex ways, are very much present in our health system, driving those most in need from getting effective care and accessing services". Collectively, these reports and the implementation of their recommendations are important first steps in addressing stigma that refugees, and others, face in the healthcare system.

### **Acculturation**

Understanding the interplay between the long-term psychological consequences of the process of acculturation and mental health is very important. Living an entire life in one culture and then attempting to re-establish lives in a new country where the culture is completely different is very challenging for refugee women. Integration seems to be the best acculturation process where refugees maintain some degree of cultural integrity, while seeking to participate as an integral part of the larger social network at the same time. [49] During the interviews, participants talked about the importance of socialization and networking for the mental wellbeing of refugee women. This needs to happen within their own communities, as they can speak their own language, share experiences and grief, express ideas, as well as with the mainstream communities where they will be able to learn the culture and language. Living in isolation is an obstacle to mental wellbeing.

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

### **Policy Planning and Innovations**

The study findings agree with the works by Levesque et al. and Woodgate et al. that access to care is affected by providers, organizations, institutions, and systems barriers. [50,11] The study also agrees with Woodgate et al. that resource re-adjustment to reduce the systems barriers in the short term with development of policies and programs to eliminate the barriers in the long term could be the right steps for policy makers. [11] Policies pertaining to increasing diversity among healthcare service providers, funding for trained interpreters or cultural brokers, and child support services can also contribute to better mental healthcare for refugee women. The challenges with the mainstream healthcare services includes lengthy wait times and high costs for counselling services, which have all been extensively discussed in the literature and are outside the scope of this discussion. [38,47,39,18,30]

Community-based mental healthcare programs that incorporate a holistic approach by taking the social determinants of health across pre- and post-migration context into consideration have been highly recommended by researchers.

[51,52,30] Integration of community-based mental healthcare programs with other social services may be more effective. [30] The CMHA has reported a chronic underfunding of community-based mental health services and a reliance on intensive, high-cost services like psychiatrists and hospitals. [47] In their report, the association pointed out that while evidence-based healthcare provided by addiction counselors, psychologists, social workers, and specialized peer-support workers is the foundation of the mental health response in other G7 countries, these services are not guaranteed through the public system in Canada. The association had called for a more integrated continuum of care provided through community mental health services that can meet the needs of many people with mental health challenges. Services can include early intervention and prevention, enhanced treatment for those who need it, and longer-term follow-up and supervision for those with severe and persistent illness. Community-based psychiatrists, interdisciplinary family health teams that incorporate psychiatric services, and specialized interdisciplinary teams such as assertive community treatment are some specialized services that can be considered for patients with greater needs, according to CMHA.

The findings of this study strongly agree with CMHA recommendations to increase support for the community-based mental health services. In a joint statement on access to mental healthcare, the Canadian Medical Association and the Canadian Psychiatric Association have advocated for community-based programs to promote and maintain mental health and to facilitate early identification of problems requiring intervention. [53] ‘Community-based protection and mental health and psychosocial support (MHPSS)’ is an excellent resource developed by UNHCR to use as a guide for service providers. [54] Studies have reported the success achieved by case managers and community navigators in the roles of community liaisons. [55,56] Outreach programs for refugees who cannot otherwise reach out to mainstream mental healthcare services due to system complicity and navigation issues have been recommended in this study, as well in other studies. [30]

Researchers have called for modifying the University curriculum in Canada to provide mental health practitioner graduates with much-needed cross-cultural communication skills to work with a culturally diverse population. [57] An example of a program to address curriculum was undertaken at Dalhousie University in Nova Scotia; their medical school developed a community-based service-learning program for medical students. [58] Under this year long “reciprocal mentorship” program, groups of 2-3 medical students are matched with a refugee family with the help of a local resettlement agency. Such initiatives provide benefits to both the students and refugee families. The present study calls for a leadership role in program innovation and design by the Provincial College of Physicians and Surgeons in collaboration with the University of Manitoba, psychiatrists and other health care providers in Manitoba. This group can act as advocates for refugees and advise policy makers and healthcare system developers about the importance of the issue.

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

In conclusion, Canada has a moral obligation to respond to a humanitarian crisis and has already taken some important steps to address the healthcare needs of refugees. Government funded insurance schemes (IFHP) provide refugees basic and extended coverage up to one year. Specialized clinics for refugees have been set up in many Canadian cities, including mental healthcare. These efforts were much appreciated by the refugees as they continue to face initial struggles in navigating the Canadian healthcare system. However, when IFHP support is no longer available after one year, refugee struggles have been reported. According to the Immigration department, most employment obtained by recently arrived Syrian refugees in Canada are typically in the low-paying services and restaurant sectors, or in construction. [58] Therefore, many are struggling to pay for medication or mental healthcare if not covered by the employer insurance.

Maintaining a client-provider trust relationship based on socio-cultural elements is very difficult without funding for interpretation services and trainings for healthcare providers on culturally competent care. With the decline in commodity prices and the economy in a downturn, Canada is facing ongoing challenges in ensuring government and non-governmental funding for services to refugees. Many provinces have seen cuts in healthcare spending and Man-

Manitoba is no different. Most recently, the COVID-19 pandemic has caused even greater damage to the economy and the provincial healthcare systems are stressed to their limits. Nevertheless, from a system perspective, accepting refugees must be simultaneously recognized within healthcare budgets. [5]

Refugee mental healthcare is a complex issue. It is challenging for the provincial healthcare system to address service access and utilization, quality of service, as well as planning and implementing sustainable, comprehensive mental healthcare for refugees. However, refugee women have survived through extremely difficult situations and shown resilience. Participants felt confident that refugees would become accustomed to Canadian culture and the healthcare system in a matter of time. What they need is support at the initial stage, so that any mental health problems get diagnosed and addressed in a timely manner. A welcoming culture in healthcare settings is required to ensure that refugees do not avoid seeking care. Manitoba has a long history of welcoming refugees and is in a good position to support the healthcare needs of this vulnerable group because it has the right people, knowledge, and integrated systems. With committed leadership, some strategic alignment of services, and a few extra resources, Manitoba will be able to provide refugees with appropriate access to healthcare services and supports. Policy makers should consider that allocating financial and human resources to primary and mental healthcare for refugees is not only a humanitarian necessity; it will eventually provide economic benefit in the long-term. Investing in employment for refugees or providing training for employment, when compared to the continued cost of providing social assistance, would likely be less costly in the long term.

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