Assessing the Unique Healthcare Needs of Refugee and Asylum Seeking Women in Canada

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The undersigned certify that they have read and recommend to the Faculty of Graduate Studies at UPEI and URJC acceptance, a thesis entitled "ASSESSING THE UNIQUE HEALTHCARE NEEDS OF REFUGEE AND ASYLUM SEEKING WOMEN IN CANADA" submitted by Jonna Callbeck in partial fulfilment of the requirements of the degree of MASTER IN GLOBAL AFFAIRS.

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Abstract

Armed conflict, political unrest, and global warming have caused an influx of migration in the 21st century. Migration creates vulnerability as people are separated from their social networks, resources, homes, and culture. Women make up half of the population of displaced person worldwide and are at a heightened risk of experiencing isolation, gender discrimination, physical violence, sexual violence, hunger, and lack of medical care throughout the entirety of the migration process. This paper looks to illuminate the hardships of refugee and asylum seeking women, how these experiences translate into unique healthcare needs, and the barriers that these women face to receive quality and accessible healthcare after arriving in Canada.

Acknowledgments

I would like to give a special acknowledgment and thanks to my supervisor Dr. Colleen MacQuarrie for her insight, support and encouragement throughout this thesis. In addition, I would like to thank my family and friends for their unconditional love and their support for me in my studies. Finally, I would like to acknowledge that the following thesis is about real people and real problems within the world today. When reading, I ask you to remember this. It is my belief that without empathy any change in perspective will be unlikely to follow. As Atticus Finch once said in 'To Kill a Mockingbird,' "*you never really understand a person until you consider things from his point of view, until you climb inside of his skin and walk around in it"* (Lee, 2006, p.36).

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Dedication

This paper is dedicated to the current and future refugee and asylum seeking women of Canada.

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1. INTRODUCTION

Health is an essential part of every human being's quality of life and right that we are all entitled to. Article 25 of United Nations Universal Declaration of Human Rights (1948) states that: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services."(UN General Assembly, 1948). Today, global heath remains a priority for the United Nations (2019) as "good health and well-being" is acknowledged as one of the 17 UN Sustainable Development Goals to be improved by the year 2030. However, war, poverty, famine, persecution and political unrest have generated numerous, toxic implications, particularly on the physical and mental health of the persons immersed in its violence.

These vulnerable people seeking safe haven from their countries of origin are referred to as asylum seekers. They are persons avoiding persecution or harm by residing in an alternative host country while they wait for their "official" refugee status claim to be accepted. Once accepted, asylum seekers are recognized under the 1951 Convention Relating to the Status on Refugees as refugees: persons who are "owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, (are) outside the country of his or her nationality and is unable or, owing to such fear, is unwilling to avail himself or herself of the protection of that country" (Douglas, 2019, p.2).

Today, the United Nations High Commissioner for Refugees (UNHCR) estimates that there is a total of 68.5 million people worldwide that have been forcibly displaced due to conflict. This is the largest number of displaced persons since the time statistics began to be recorded and continues to be an ongoing global issue. Of these displaced persons, 25.4 million are refugees and 3.1 million are considered asylum-seekers (UNHCR, 2019) half of

whom are presumably women (Guruge, Roche & Catallo, 2012). To provide a gender inclusive analysis, it is important to acknowledge, throughout this paper, the terms "woman" and "women" are encompassing of all peoples who personally identify as a woman, a trans woman and those who are gender fluid regardless of biological composition.

Women are especially discriminated against in times of militarization. Isolated from social supports and resources, they are increasingly vulnerable to sex trafficking (UNODC, 2018), rape as a weapon of war, and physical and sexual violence (Grønhaug, 2018). Arcel & Kastrup (2004) state "war kills and creates both acute and long-lasting health problems in men and women indiscriminately but many aspects of war affect the health of women and girls disproportionately through societal changes that subordinate women and under-prioritize their lives and health…" (p. 40). These unique experiences of women create explicit physical and mental health needs compared to their male counterparts upon arrival to countries such as Canada.

Canada has been recognized on the world stage for its acceptance of refugee claims. The UNHCR chief Filipo Grandi commended Canada as a "champion" for its acceptance of refugee claims (Cecco, 2017). Following the crisis in Syria, Canada resettled 40,081 Syrian refugees between November 2015 and January 2017 (Government of Canada, 2017). This year, according to the Canadian Government (2019) Canada aims to quadruple their acceptance of refugees by resettling 29,950 new refugees through various resettlement programs and 19,000 through The Private Sponsorship of Refugees Program. However, as refugees seek asylum in new nations such as Canada, the responsibility of the housing nation becomes an essential player in meeting and accommodating the unique societal health needs of these persons (Bazaid, 2017). Under the Royal College of Physicians and Surgeons of Canada (2010) a societal health need can be described as a requirement "at the individual, family, community and population levels-across the continuum of care-to achieve physical,

cognitive, emotional, social and spiritual wellbeing, taking into account the broad determinants of health" (p. 3).

Although Canada is attempting to establish its commitment to the human rights and health of refugee and asylum seeking women, it is not to say that the nation holds "a gold medal" in regards to women's health. From the time of colonization, the Indigenous peoples of Canada have been marginalised and disrespected for over 300 years (Indigenous and Northern Affairs Canada, 2019). From the exploitation of lands by European settlers, to the assimilation of Indigenous children in residential schools, there has been a sequential display of colonial violence. Today, this violence continues as it is projected that between the years 1980 and 2012 there have been a total of 1,017 Indigenous women victim to homicide and 164 presently considered missing. Within these cases, 225 have gone unsolved. (RCMP, 2014, p.7). Since September, 2016, when the National Inquiry into Murdered and Missing Indigenous Women and Girls began in Canada there has been "at least 140 deaths that were the result of homicides, suspicious deaths and deaths in police custody or while in the care of the child welfare system" (Barrera, 2019, para.4). Human Rights Watch (2017) found that Indigenous women were being subjected to abuse even by the hands of law enforcement. This included episodes of arbitrary arrest, police brutality, humiliating strip searches by male officers, inappropriate sexual conduct, along with degrading comments and or treatment. In regards to the countless women who have gone missing, there appears to be a lack of concern or haste in solving these cases. The RCMP claim that much of it has to do with "lifestyle factors" of the women such as addictions or prior prostitution charges (RCMP, 2014) that somehow deem it acceptable to disregard these crimes as important. However, these crimes are crucially important to acknowledge as it demonstrates an even deeper need to address the human rights and health of women in Canada.

The objective of this thesis is to illuminate the sensitive needs, pertaining to health, that refugee and asylum seeking women in Canada are experiencing. These women, many who have been victims of war, torture, physical and sexual violence, and human rights violations have unique and distinctive needs compared to their male and Canadian counterparts. Past traumatic experiences related to conflict undoubtedly play an imperative role in the prevalence of health, which will be discussed in the following background section. The later section will review previous studies on the particular physical and mental health conditions that these women are experiencing in Canada such as sexual reproductive health issues, PTSD, and depression. Finally, this paper will explore how indirect factors such as language/literacy, culture, employment/finances and government health policies and programs are obstructing refugee and asylum seeking women's access to thorough and equal healthcare. Overall, this paper examines the multiple works and studies of researchers in this area to provide a concise and robust understanding of this international inadequacy while highlighting the areas in need of reform and addressing ways to better improve the lives of refugee and asylum seeking women in the future.

2. BACKGROUND EXPERIENCES OF WOMEN IN CONFLICT

Patriarchy is a prevalent societal system across the globe that is limiting women's power, inclusion and equality in the world. The militarization of societies that radically reinforce traditional gender roles enhance the discrimination of women (Arcel & Kastrup (2004). It is important to first recognize the horrific experiences and indignities that some refugee and asylum-seeking women experience prior to their arrival in Canada. Doing so will cultivate a deeper context and understanding of the current health needs of these vulnerable but strong, resilient survivors. Whether they are forced to flee their country of origin due to war, armed conflict, political turmoil, persecution and or human rights violations (Amnesty International, n.d) these women all have background experience that contributes to their

health. The following section gives a brief overview of an article by Arcel & Kastrup (2004) that debriefs the womanly experience of war in relation to health.

2.1 Access to Food and Healthcare

Women all around the world take on multiple social roles consecutively. However, the responsibilities of these roles that adopt can be amplified as sons, fathers, brothers and husbands are transformed to the role of 'soldier.' Women are rarely accepted into military ranks in many areas of armed conflict and are faced with amplified gender discrimination and isolation. Taking care of a family can be a difficult task for any woman or man, nevertheless in times of war it is increasingly challenging as there is a lack of food, clean water, sanitation and healthcare facilities (Arcel & Kastrup, 2004) & (Human Rights Watch, 2019). The Food and Agriculture Organization (FAO) of the United Nations acknowledges the relationship of violent conflict, food insecurity, health, and well-being. Food insecurity is directly related to poor nutritional status. In turn, the FAO found that poor nutrition commonly causes "chronic malnutrition," and stunted growth in children (Martin-Shields &Stojetz, 2018). Soldiers and military personnel are treated as first class citizens, receiving many benefits and access to limited resources (Arcel & Kastrup, 2004). Food scarcity is a problem that many women face prior to seeking asylum from militarized and war torn states. According to Arcel & Kastrup (2004) malnutrition, anaemia and reproductive health complications are all common health problems among women and children in these areas. Food relief can become hierarchal in that men or "soldiers" can be prioritized over women and generally are granted the right to eat first. An Iraqi Kurdish woman recalled her experience trying to secure food upon arriving in Turkey:

> *It was difficult to get food. All the young men ran fast and got all the food that the Americans were handing out…So we ended up as a family without food. This happened to all the women who fled without their men* [sic].*We were just left out as if we were not there. Three of my grandchildren died in those mountains* (Arcel & Kastrup, 2004, p. 43).

This exclusion makes it difficult for women to meet their own nutritional needs and those of her family. Women spend most of their day trying to find and prepare food in poorly equipped and facilities. Women, who are starving, or who have hungry families may even be forced to exchange sex for food (Grønhaug, 2018). Women who are pregnant also face an additional threat as malnutrition can have a detrimental effect on the outcome of the pregnancy as they lack the nutrients needed for development leading to lower birth rates (Martin-Shields & Stojetz, 2018) .Food is not the only resource received where men and military are prioritized. Health care facilities are scarce, as many have been destroyed, abandoned or unable to supply medication. Treatment and medical attention are once again a privilege of man and warrior (Arcel & Kastrup, 2004). Human Rights Watch (2019) found corresponding situations in Venezuela. There has been an extreme lack in food, available medical services, and care. Families are struggling to meet their basic living needs due to conflict. In 2016, a survey of 200 doctors found "that 76 percent of public hospitals lack the basic medicines that the doctors said should be available in any functional public hospital" (Human Rights Watch, 2019). These shortages in healthcare has led to 21 percent increase in infant mortality from 2015 to 2016 in Venezuela. Additionally, the prevention of HIV is challenging as women lack services for caesarean births and are forced to undergo births through the vaginal canal (Human Rights Watch, 2019). The following sections will review sexual violence and how rape can be used a weapon of war.

2.2 Rape as a Weapon of War

Conflict-related sexual violence is one of the most notable threats to vulnerable women and girls who are trying to escape states of unrest and conflict. Separated from their families and social networks, these single women lack protection and often seek safety where they are most susceptible (Obradovic, 2015). The UNHCR (2016) predicted that 33 percent of women, in their lifetime, are subject to violence and 60 percent "of refugee and migrant

sea arrivals to Europe are women and children, at high risk of sexual exploitation and abuse as they seek safety and shelter" (p. 2). Congested asylum centers, refugee and detention camps, military bases and checkpoints provide inadequate and unsafe sleeping quarters that can contribute to the prevalence of sexual violence. These women can be sexually exploited by other refugees, military, guards, and even UN peacekeepers (Arcel & Kastrup, 2004). Since 2010, there has been an average of 50 annual cases of sexual assault and abuse against UN peacekeepers. (Grady, 2016). It is vital to keep in mind that this number is underreported as many cases of sexual assault go undocumented (Neudorfer, 2015). The UNHCR (2017) on the "Report of the Secretary-General on Conflict-Related Sexual Violence" defines conflict-related sexual violence as:

> *Rape, sexual slavery, forced prostitution, forced pregnancy, forced abortion, enforced sterilization, forced marriage, and any other form of sexual violence of comparable gravity perpetrated against women, men, girls or boys that is directly or indirectly linked to a conflict"* (p. 3).

Although this definition covers a wide verity of human indignities, Arcel & Kastrup, (2004) acknowledge how rape is often used as a weapon of war and women are used as an instrument to conduct violence and inflict harm on the opposing side. Rape is often condoned during armed conflict by the military or political system as a means to: "boost the soldiers' morale; to feed the soldiers' hatred for the enemy; to show their superiority over and victory against the enemy men; or to keep soldiers fighting" (p. 44). Additionally, rape can be used as a mechanism for ethnic cleansing (Grønhaug, 2018.) and genocide, as sexual violence can influence a woman's ability to reproduce (Arcel & Kastrup, 2004). Women and families may refrain from discussing such events, as there can be stigma, humiliation, and social exclusion attached (Neudorfer, 2015). Rape being used as a weapon of war is not only damaging to women but to communities as a whole and the children that are the by-products of such actions. Kyung-Wha Kang, an UN relief official commented, "while entire communities

suffer the impact of armed conflict, women and girls are often the first to lose their rights to education, to political participation and to livelihoods, among other rights being bluntly violated" (Obradovic, 2015, para, 3). Carrying a child to term, giving birth, and raising a child as a product of rape is difficult for these women and creates prolonged suffering long after the rape had occurred. Kristine Grønhaug (2018), member of the Norwegian Refugee Council (NRC), compiled a report on 'Rape as a Weapon of War' that discussed the experiences of women located in Sinjar, Iraq conflict. Many women and girls were raped by Islamic State group members. They were told by the perpetrators that they should be *grateful* to have a child of different ethnic background. Nadia Murad, who was one of the women to experience the horrors of Sinjar was award the Nobel Peace Prize in 2018 for her efforts to end "sexual violence as a weapon of war and armed conflict" (Nobel Prize, 2019). In an interview with Denis Mukwege, Nobel Peace Prize laureate, Murad stated

> I still feel shameful of what has happened to me and many other Yazidi girls. [But] after we were somewhere safe ... we wanted to raise our voices ... If we don't speak up today, tomorrow this will continue" (Al Jazeera News, 2018, para.11).

These experiences of sexual violence due to conflict has both physical and emotional health tolls on women prior to migration. Some of the most common physical health consequences are reports of chronic headache, discomfort in abdomen or chest, and backache. In addition, sexual violence has been associated with damage to "the musculo-skeletal system, structural injuries, functional disturbances and dysfunction of the pelvic joints." Overall, sexual violence has the most drastic effect on women's sexual reproductive health (Arcel & Kastrup, 2004).

Sexual violence does not only have implications for physical health but is closely tied with mental health. Arcel & Kastrup (2004) also identify common mental health problems based on previous literature that are associated with sexual violence in wartime. These include: "anxiety, depression, irritability, emotional instability, cognitive memory and

attention problems, personality changes, behavioural disturbances, neuro-vegetative symptoms such as lack of energy, insomnia, nightmares, and sexual dysfunction" (p.45).

These acts of sexual violence are not limited to areas of conflict but also through the process of migration to safety. Previous United Nations High Commissioner for Refugees, Antonio Gutiérres, commented on the experience that refugee and asylum seeking women in Central America experience when attempting to find sanctuary from countries such as El Salvador, Guatemala, and Honduras. He stated that "for most women, the journey to safety is a journey through hell. After paying exorbitant fees to unscrupulous "coyotes," many women are beaten, raped, and too often killed along the way. This is the untold story of many refugees from Central America" (UNHCR, 2015, p. 2).

2.3: Sexual and Gender Minority Experiences of Conflict

As this paper aims to be inclusive to all women, it is important to discuss the unique physical health need of sexual and gender minority (SGM) women. Myrttinen and Daigle (2017) refer to SGMs as "people whose sexual orientation, gender identity or sexual practices fall outside traditional norms. It may also refer to people who are perceived as such by others, resulting in similar social exclusion and vulnerability" (p.5). This term is flexible and should be used loosely as "traditional norms" vary based on geographical location, culture, and religion. Myrttinen and Daigle (2017) further discuss how people of SGMs are particularly effected by conflict areas, and the challenges that they face. They note that the vulnerability and discrimination of this minority group is enhanced in areas of conflict and people falling under the SGM definition are targeted for violence, including killing and sexual violence. If a woman's sexual orientation is known to be lesbian, bisexual, or trans in some cases for example, they may be subject to "corrective rapes" in that the assailant will attempt to change the victim's sexual orientation through sexual violence. Individuals of the SGM may additionally experience "policing of gender norms; blackmail and extortion; and rejection by

family and other community members" (Myrttinen and Daigle, 2017, p. 17). Overall, it is important to remember that the violence experienced by many members of SGMs is ongoing and does not start or end with the rise of conflict but is merely heighted because of it. The judgement, neglect, violence and abuse can come from conflict actors but also civilians which is why it is a relative health concern for refugee and asylum seeking women in Canada. The bias, discrimination, prejudice, and even violence can continue following migration (Myrttinen and Daigle, 2017).

Although, Canada has demonstrated its commitment to protecting these vulnerable asylum seeking women earlier this year. CBC News (2019) captured the story of Rahaf Mohammed al-Qunun, an 18-year-old woman, left her country of Saudi Arabia to avoid violent family abuse. Arriving in Bangkok, her passport was seized and she was denied entry into the county. However, after using social media to her advantage she was able to gain the attention of the UNHCR and was allowed temporary entry under their protection. She barricaded herself in a hotel room for roughly a week, fearful of being forced to return home by her family and the violent repercussions that would follow. Canada was one of the initial countries that responded hastily to the situation and upon the request of the UNHCR al-Qunnun was granted refugee status and safe transportation to Toronto. Prime Minister Trudeau commented, "Canada has always been unequivocal that we will always stand up for human rights and women's rights around the world" (para. 15). The traumatic experiences that refugee and asylum seeking women face prior to their arrival in Canada are important to identify as it will help provide further context throughout the remainder of the paper.

3. PHYSICAL HEALTH OF REFUGEE WOMEN

The physical health of refugees, particularly refugee and asylum seeking women, is an area of study that lacks depth and knowledge. Much of the research conducted surrounding the psychical health of newcomer women in Canada is strongly focused on sexual reproductive health. As discussed in the previous section, regarding the prevalence of sexual violence and rape as a weapon of war it comes as no surprise that the sexual reproductive health of refugee and asylum seeking women would be the main overlying concern of physical health and well being. Issues such as the utilization and access to information on contraception and the impacts of violence on physical health will be discussed in greater detail in the subsequent segments.

3.1 Sexual Reproductive Health

The discussion of reproductive health can be an uncomfortable and awkward experience. However, it is a major component of women's health that must be communicated to all individuals to support their well being and safety in society. In many cultures, there can be negative socio-cultural stigmas and taboos that are attached to sexual reproductive health that make it an increasingly complex topic to address. For refugee and migrant women these barriers can be increasingly strong due to culture, language, education, and lack of information that ultimately affect their sexual reproductive health. The following section of this paper will cover topics such as the utilization, contraception needs of refugee women, the unique needs of sexual and gender minority, and the impact of violence on physical health.

3.1.1 Utilization

Kiss, Pim, Hemmelgarn and Quan (2013) conducted a study that looked to analyse the healthcare utilization by refugees in Calgary, Alberta. Their sample compared newly resettled refugees, both male and female, who were patients at the Calgary Refugee Health Clinic and non-refugees who were registered at the Alberta Health and Wellness Provincial Healthcare

Insurance Registry. They reviewed the medical records and charts of both groups of patients to derive their data. Their findings concluded that 6 percent of refugees utilized general practitioners than non-refugees, 2 percent more visited the emergency department, and 4 percent more of refugees made trips to the hospital. Additionally, they found that refugee women and young refugees utilized the hospital and emergency room far more than their non-refugee counterparts. The most common differences between non-refugees and refugees were the predominance of refugees that were using medical services for "pregnancy, childbirth and postpartum related conditions" (p.60-61). Although their data was not statistically significant, the information still demonstrates that refugee women are utilizing healthcare services slightly more than their Canadian counter parts. Additionally, Pim, Hemmelgarn and Quan's (2013) findings highlight sexual reproductive health as being a main health concern for these women which resonates with supplementary literature in the area. The following section will analyse sexual reproductive health to a further degree.

3.1.2 Contraception

In the West, one of the main elements of sexual health education is providing information on the importance of contraception. However, the value and use of contraception can vary across cultures. Researchers Marina Aptekman, Meb Rashid, Vanessa Wright, and Sheila Dunn (2014) conducted a quantitative study in downtown Toronto which sought to analyze "what women of reproductive age receiving primary care at a refugee health clinic were using for contraception upon arrival to the clinic" (p.616). Participants consisted of 52 women between 14-59 years of age, which had received care from the Crossroads Clinic in Toronto more than twice, between December 2011 and December 2012. They established their findings through a chart review method to measure the instances in which contraception was being used though clinic visitations and what needs were not being met. Aptekman et al., (2014) used the World Health Organization (2019, Sexual Reproductive Health) definition of

"unmet need" which is "women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child" (para.1). This definition allowed them to quantify their findings. They found 16 of the participants were not using contraception, 12 had an unwanted pregnancy within the last year, and 14 were not using contraception while having no planned intentions of pregnancy (p.616). This study found that condoms were the most popular form of contraception among refuges rather than an oral contraceptive in which none of the participants took. After calculations, Aptekman et al., (2014) found 26.8% of contraceptive needs were unmet under the description of the World Health Organization (2019). Contraception can be as simple as a trip to your local drug store or walk-in clinic but without the proper education and information on available contraceptive practices, it puts refugee woman at a disadvantage and gives these women less control over their bodies and family planning. Overall, this study highlights the importance and need to provide better contraception services to refugee women who may be lacking the education and access to help and information.

3.3 Physical Health and a History of Violence

Guruge et al. (2018) conducted a study on the healthcare need of 58, Syrian refugee women in Toronto. Through a qualitative descriptive interpretive method, using research conversations, they were able to find common themes in regards to these women's health issues. There were common pre-existing medical conditions that many of the women faced prior to arriving in Canada such as asthma, infection, back pain, liver and kidney disease, diabetes, hypertension, reproductive health problems, rheumatoid arthritis, osteoporosis, sleep apnea, thyroid problems, varicose veins and physical disability. Following their arrival in Canada, they found that there were certain collective physical medical conditions that arose, such as abscess, allergies, fainting, flu, fracture, vision problems, loss of appetite,

weight loss and dental problems (p.5). One woman in the study described how she believed that her psychological trauma was related to her physical health. She stated: "

> *When you come (from the war), you are suffering from stress and emotional pressures and it affects you physically, and this is what is happening to me now. I have physical problems that are due to emotional stress and pressures*" (Guruge, et al., 2018, p.4).

This information is also consistent with previous research that Guruge, Catallo, & Roche (2012) published on the "Exploration of the Physical and Mental Health Trends Among Immigrant and Refugee Women in Canada." They conducted a cross-sectional study that consisted of 30 Iranian and 30 Sir Lankan refugee women who had migrated to Toronto in the last 15 years. Through surveys, they aimed to evaluate these women's experiences of violence throughout their migration process, while additionally addressing physical and mental health conditions. They found that both groups of women reported similar physical health issues as those recorded in the more recent Guruge, et al. (2018) study. These physical ailments included: increased headaches, trouble remember things, back pain, colds, flu, and infections. In addition, they found that 30% of the Iranian and 36% of Sir Lankan women had experienced physical violence and 43% of Iranian women and 63% of Sir Lankan women experienced intimate partner violence since the age of 15. However, when analysing occurrences of violence in the last 12 months, 30% of Iranian and 27% of Sir Lankan women reported psychological violence, making it the most pervasive.

It's important to note that these percentages may be underreported as violence can be a difficult subject to discuss particularly with researchers who are strangers. Neither groups of refugee women reported instances of sexual violence, which could be attributed to the stigma, embarrassment and limit of marriage opportunity that is attached to sexual violence (Guruge, Catallo, & Roche, 2012). They did find that one-third of the women were victims to different types and variations of psychological distress and disturbances. These included feelings of detachment, apathy, forgetfulness, feelings of worthlessness, hopelessness, and

tenseness. They had emotional or physical reactions when reminded of the trauma, recurrent nightmares, feelings of fear, worry, and frightfulness, panic attacks, and trouble sleeping. All of these symptoms point towards the possibility of depression and PTSD (American Psychiatric Association, 2019). Surprisingly, they found no statistically significant association between the total scores of violence and the total scores of physical and mental health (Guruge, Catallo, & Roche, 2012). This is not to say that there are no correlations between health and violence as previous studies conducted on non-immigrant populations have found that violence is connected with poor mental and physical health. It is possible that these findings lacked statistical significance due to both variables being relatively high, making a statistically significant positive correlation unlikely. Guruge, Catallo & Roche (2012) advise that due to the multiple physical and mental health issues presented, combined with the prevalence of violence among the entire sample of participants, that healthcare practitioners should inquire on experiences of violence while adopting a "holistic" approach as mental and physical health care can be undoubtedly linked especially in the case of refugee and asylum seeking women (Guruge, Catallo, & Roche, 2012).

4. MENTAL HEALTH OF REFUGEE WOMEN

The physical health of refugee and asylum seeking women is not the only construct of health that needs to be addressed. The World Health Organization (2018) acknowledges that mental health is equally as significant as physical health to a person's happiness and functioning. They define mental health as:

> *A state of well-being in which an individual-realizes his or her own abilities, can cope with the normal stress of life, can work productively and is able to make a contribution to his or her community. Mental health is fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life* (WHO, 2018, p.1).

To provide a well-rounded analysis of health needs it is vital to include in the discussion, the body of mental health, and the mental health disorders that these minority women are increasingly prone to.

4.1 Influencing Factors

Before addressing what mental health complications that refugee and asylum seeking women face, it is first important to identify the influencing factors that may be responsible. Kirmayer, et al (2011) found that times of transition can result in a disruption of this state of emotional well-being. Change in social supports, geographical area, generally manifest into feelings of stress and anxiety for many of us. The threatening feeling of unfamiliarity combined with an indefinite future is understandably conducive to the creation of negative emotions. As refugees flee their homelands to seek safe haven they are subject to numerous unknown, stressful situations. This stress can be prolonged through the acculturation process into a new country as minority groups, such as immigrants, refugees, and asylum seekers are often subject to higher levels of stigmatization and discrimination. Being subject to repeated instances of discrimination and prejudice is correlated to stress and linked to variations in physical and mental health (Whitley JR. & Kite, 2010).

According to Kirmayer, et al (2011) refugees and asylum seekers experience "*changes in personal ties and the reconstruction of social networks, the move from one socio-economic system to another, and the shift from one cultural system to another*" (p.3) which have implications for their mental and physical health. There are three periods of transition that have the potential to influence the mental health of refugees and asylum seekers. The first stage is the pre-migration period which encompasses the traumatic occurrences experienced by the refugee in their homeland prior to the migration process. These experiences of violence, unrest, and persecution are often the reasons why many refugees and asylum seekers leave their countries initially and influence the prevalence of particular

mental health disorders. During the migration process, the route and time spent traveling, living conditions, the uncertainty of the future, exposure to violence, separation from family, and poor nutrition were additional determining factors. Finally, upon arrival, in the post-migration period, the level of uncertainty of refugee status, loss of social status, family, and networks, acculturation, language barriers, discrimination and isolation were indicative to mental health complications. In addition, the economic, occupational, and education status, along with the frequency and severity of traumas were found to be influencing factors of mental health for all refugees in the post-migration setting (Kirmayer, et al., 2011). This is consistent with the information provided by the WHO (2018) in that the social and cultural changes, isolation, exclusion, discrimination and previous human right violations are all contributing factors to poor mental health that many refugees and asylum seeking women experience (WHO, 2018).

4.2 Post-Traumatic Stress Disorder and Depression

As addressed earlier, many refugee and asylum seeking women are exposed to a variety of traumas before their arrival to Canada or new hosts countries. It is estimated that 40 percent of all refugees and immigrants arriving in Canada have experienced a highly traumatic event due to national unrest or war (Pottie, Greenaway, Feightner, et al. 2011). Often it is assumed that the experience of such traumatic events like war, torture, and sexual violence would induce a high pervasiveness of post-traumatic stress disorder (PTSD). The American Psychiatric Association (2019) defines PTSD as: “a psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, rape or other violent personal assault” (para.1). PTSD can cause sadness, fear, nightmares, flashbacks, and emotional detachment. Symptoms include intrusive thoughts such as distressing dreams and flashbacks.

Charlson et al. (2016) conducted a study on the prevalence of PTSD and depression in refugees who had come from areas of conflict. Although this study does not directly pertain to women, it provides insight into these two mental health disorders that both refugee men and refugee and asylum seeking women may be experiencing. Through a systematic review study, they compared rates of PTSD and depression to the Global Burden of Disease Study in 2013 (GBD2013) that "provides the most recent and comprehensive epidemiological profile for a variety of mental disorders" (Charlson, et al., 2016, p.2). They found that major depression or major depressive disorder (MDD) was twice as more prevalent than the GBD2013 study and PTSD was three times higher than that of the GBD2013 in refugees and asylum seekers from areas of conflict (Charlson, et al. 2016).

Continuing with the research of Kirmayer, et al. (2011) they correspondingly established what mental health problems arose in refugees that were faced with traumas during specific phases of migration. They complied and analysed 840 articles "addressing detection, prevention and management of common mental health problems among immigrants and refugees in primary care." Though their research they were able to conclude the following key points surrounding the mental health of immigrants and refugees in Canada. Firstly, Kirmayer, et al. (2011) established that newly arrived immigrants and refugees are less likely than the general Canadian population to suffer from depression and alcoholism. However, as they spend more time in the country the levels being to equalize. Secondly, those who have been exposed to high levels of violence were prone to trauma-related disorders such as PTSD, chronic pain and other somatic syndromes that create emotional distress. This was especially relevant for women. Thirdly, pre-migration experiences, uncertainty during migration, and post-migration resettlement experiences play an important role in the prevalence of mental health problems of refugees and migrants. Fourthly, they highlight the importance of using professional interpreters in the clinical

setting, which will be discussed further in the later section of this paper. Finally, when regarding the mental health of refugee women specifically they coherently found that immigrant women are two to three times more likely to experience post-partum depression than their Canadian counterparts (Kirmayer, et al., 2011).

4.2.1Maternal Depression

Giving birth can be a double edge sword where often the positive is accompanied by the negative. In Canada, it is estimated that 10 to 19 percent of pregnant women and 9 to14 percent of postpartum women experience adverse feelings such as stress, anxiety, and depression. However, refugee, immigrant, and asylum-seeking women are not included within this statistic and experience these effects five times greater than their Canadian counterparts (Ahmed, et al., 2017). Researchers Asma Ahmed, Angela Bowen and Cindy Feng (2017) conducted a qualitative study on the 'Maternal Depression in Syrian Refuge Women Recently Moved to Canada.' They aimed to interpret how 12 Syrian women were feeling towards their new social role as a mother. Although it was a small sample size, they were able to conclude through questionnaires and discussion based focus groups that some the women were exhibiting PTSD, and roughly two-thirds of the participants screened positive for potential depression in the question. However, the measure of depression was not reflected in the focus group, which could be due to the cultural stigma surrounding mental health disorders, the researcher's failure to recognize signs of depression in the focus groups, or, in the case of the questionnaires, the failure to ask enough questions.

5. BARRIERS TO HEALTHCARE

Through the review of the literature and studies provided in the previous section, it becomes clear that refugee and asylum seeking women in Canada suffer from both unique physical and mental health needs. Therefore, the question then becomes: How are refugee and asylum seeking women utilizing health care and what are the barriers that they

face when accessing it?" As anyone can imagine, the transition to a new country can be a stressful experience. New foods, language, culture, and social perceptions can make even the most experienced traveller feel isolated. One can imagine how this feeling of isolation is intensified for refugees and asylum seekers once they have arrived in a new land. Separated from family members, homes, belongings, and customs, they've left behind their once familiar life and arrived in a land where they will face many new barriers every day. The Canadian Paediatrics Association (2019) recognizes that newcomers in Canada face particular barriers when accessing health care. The main limitations they face are language and literacy skills, lack of information and familiarity with the Canadian healthcare system, limited finances, gender, and culture challenges. The following section analyses multiple forms of literature that illuminate the barriers that are faced by refugee and asylum seeking women in Canada.

5.1 Language as a Barrier

Language is a relatively vital component when it comes to communication. Traveling to new area, and lacking knowledge of the common tongue, can be an overwhelming, confusing, and isolating experience. Adding an illness to the equation and attempting to find help can be increasingly difficult. Attempting to explain to someone how you feel in a foreign language is a daunting task that can put the person that is in need at a disadvantage as healthcare practitioners may misinterpret their health problem (Floyd & Sakellarious, 2017). This is the situation that many refugees face in Canada.

Floyd & Sakellarious (2017) conducted a study that assessed the disadvantage of limited literacy as a refugee woman and how that related to their access to receiving healthcare. They stated that "language barriers have been associated with delays in seeking care, reduced compliance, and harmful health outcomes" and "women refugees are more likely to lack English language skills or formal education than their male counterparts" (p. 2).

Their study was based on, government-assisted, refugee women from sub-Saharan Africa who had migrated to British Columbia between 2009 and 2012. Additional criteria were: women who had never attended formal education, could not speak English upon arriving in Canada, and women who were considered to have reading and writing skills below a level 1 according to Canadian Language Benchmarks. They collected data from two semi-structured interviews that sought to address how these women experienced language as a barrier when accessing healthcare. Through data analysis, they were able to establish three main themes such as dependence, isolation, and resourcefulness.

The theme of dependence was drawn from the commonality that many of these women needed others to help them access healthcare as they could not read directions, signs, maps, and appointment slips. Refugee mothers would sometimes rely on their children to help translate or interpret appointments. Many interpreters were non-professionals, which can create ambiguity as the person interpreting, such as a child, might be reluctant or unwilling to discuss certain details such as sexual reproductive health with the health care provider.

Secondly, the theme of "isolation" was related to how their inability to communicate made these women feel secluded when trying to access health care. Floyd & Sakellarious (2017) found that this isolation manifest in three separate ways: Rejection, or being turned down due to the language barrier. An interpreted transcript from one woman's interview describes her first visit to a clinic:

> *She went by herself, there was no way that they can communicate with the doctor, and the specialist called the clinic, and said, "We can't communicate," so there was nothing done at that visit. And she now has to wait 7 months to get a new appointment*" (Floyd & Sakellarious, 2017, p.5).

Interpreters were not always provided and some of the refugee women even experienced racism as a form of rejection.

"Fear" was the second sub-theme of isolation that Floyd & Sakellarious (2017) identified. Women were fearful of navigating, negotiating methods, or getting lost on the way to the hospital or clinic. They also experienced fear when they did not understand the actions and messages of the healthcare practitioners. One woman recalls giving birth and not being able to understand what was happening. Another, recalls the reluctance of a hospital to provide an interpreter for her when her son was undergoing major surgery, she had zero knowledge of her son's condition.

The third subtheme of isolation was the feeling of shame. Shame was internally experienced by these women as they felt poorly towards their own lack of education in a country that 96% of the population has completed primary education (Floyd & Sakellarious, 2017).

Finally, the third main theme of this study was "resourcefulness." Women did not want to feel like a burden to others asking for help all the time due to their language barrier. Some women were able to learn enough English enabling them to read and communicate, while others were able to remember landmarks or memorize bus routes to independently travel to clinics and hospitals (Floyd & Sakellarious, 2017).

This study provides an in-depth analysis of how literacy can manifest as a barrier to accessing healthcare even in a country that requires all provincial healthcare to be available under the Canada Health Act. Floyd & Sakellarious (2017) concluded that "accessible" health care requires the use of professional interpreters and better information on resource provisions by resettlement services to grant refugee women an equal level of healthcare.

5.2 Cultural Barriers

As 2019 has proven with the rise in "pro-life" movements across the United States that sexual reproductive health is an emerging "hot" topic. Today, many women around the world still lack control over their bodies and are faced with numerous obstacles when

accessing safe sexual reproductive health services and information. However, these barriers can be heightened for refugee and asylum seeking women when arriving in new host countries, as there are usually cultural, religious and social disparities between customs and perceptions of sex and reproduction. Silverberg, Harding, Spitzer & Rashid, (2018) state that *"Cultural influences can affect women's access to health care by shaping their perception of symptoms, help-seeking behaviour, decision-making, expectations of the sick role, coping style and communication"* (p. 1347).

The value of femininity and its essence is often determined through socially constructed ideals that are reflected in culture. How a woman perceives her femininity, sex, sexuality and sexual health are all greatly determined by culture and the perceptions of others (Matlin, 2012). As culture varies across the world, refugees who move to a host country, such as Canada, may be faced with more open values surrounding sexuality. Ussher et al. (2017) and by Metusela et al., (2017) both conducted studies in Vancouver, Canada, and Sydney, Australia on the experiences of sexual embodiment by refugee women and analysing how cultural perceptions influenced refugee women's sexual reproductive health.

Both studies were based on qualitative research and produced complimentary results. Through thematic analysis, Metusela et al. (2017) were able to identify three themes: "women's assessments of inadequate knowledge of sexual and reproductive health and preventative screening practices, the barriers to sexual and reproductive health, and negative sexual and reproductive health outcomes" (p.1). Many of the women were under educated on menstruation, contraception, vaccines, screenings, STI transmission, and some saw menopause as an "illness." This is consistent with the findings of Ussher, et al. (2017) as their research stated, "sexual shame is associated with absence of knowledge and communication about sexuality, manifested in secrecy and silence, and has an impact on sexual health and

health seeking behaviour" (p.1915). In both studies, topics such as menarche, menstruation, premarital sex, discussion of sexuality (Metusela et al., 2017), sexually transmitted infections (STIs), HPV, cervical cancer screening, and contraception use were considered shameful, and women reported feeling embarrassed or humiliated (Ussher, et al. (2017). In addition, Ussher et al. (2017) found within their sample that religion and culture projected an "ideal" woman as one that was passive, silent, heterosexual, used sex for reproductive purposes and lacking knowledge about sex and sexual embodiment. This may explain, in part, why women felt as though they could not refuse marital sex or ask their husbands to be tested for STIs (Metusela, et al., 2017).

Together, this research gives a thorough description of why it is that refugee women face barriers in sexual reproductive health and how there is a need for education to abate them. Reproductive health is closely linked to the topic of contraception; more specifically sexual reproductive health is greatly dependant on the education of contraception and access to it. It is a vital player in protecting women from sexually transmitted infections, diseases, and untimely pregnancy.

Another study by Wang, Yung, Shakya, Alamgir & Lofters (2018) reconfirmed various other studies on how the gender of the medical practitioner can be a barrier to accessing healthcare. In this study, Arabic women were reluctant to participate in the breast cancer screening process. This was due to cultural and societal perceptions of gender-appropriate behaviour. An Arabic woman would not be comfortable with a male practitioner giving her a mammogram which makes it difficult to screen women for breast cancer or discuss matters of sexual reproductive health. It highlights a need for more culturally sensitive patient-practitioner relationship.

5.3 Employment/ Financial Barriers

Access to income is a vital component to meeting many basic needs such as good health. The jobs that we qualify for reciprocally determine how much income we will have access to. A survey by Statistic's Canada in 2011 determined that recently immigrated women in Canada between the ages of 25-54 had an employment rate of 57.1% compared to Canadian women of the same age at 79.2% (p.27). They found that immigrant women took a long time integrating into the labour force and face certain challenges such as the incompatibility of credentials. The survey additionally found that 48.6% of migrant women who had secondary degrees or higher were employed in jobs that did not require a degree (p.28) and immigrant women worked full time earned roughly $2,000 less than their Canadian counterparts (p.31). Health and income are directly related according to Mikkonen and Raphael (2010) who published a document outlining the main social determinants of health. They found that "income is perhaps the most important social determinant of health.

The level of income shapes overall living conditions, affects psychological functioning, and influences health-related behaviours such as quality of diet, extent physical activity, tobacco use, and excessive alcohol use" (p.12). Employment is essential to obtaining quality health and Canada recognizes the barriers that minority newcomer women face when attempting to access the labour market. This year the Government of Canada (2019) aims to launch a pilot project to address these barriers such as race and gender-based discrimination, unstable and low-income work, unaffordable childcare, and fragile social supports. Ten services providers across Canada, such as the YMCA of Greater Toronto will receive a portion of $5 million provided by Immigration, Refugees and Citizenship Canada (IRCC) to help newcomer women access better employment. Ahmed Hussen, Minister of Immigration,

Refugees and Citizenship commented on the importance of refugee women seeking employment:

> *Employment is key to the successful integration of newcomers. Having a job isn't just about making an economic contribution to Canada, it's also about providing a sense of dignity and belonging. Visible minority newcomer women can face multiple barriers to employment, including discrimination and lack of affordable childcare* (Government of Canada, 2019, para, 8).

Many refugee and asylum seeking women, who are included under the definition of visible minority newcomer women, have the lowest median annual income sitting at $26,624. Limited employment opportunities, poor financial stability combined with the additional language, gender and cultural barriers newcomer women face create limitations when accessing healthcare, particularly expensive specialist doctors, that the Interim Federal Health Program (IFHP) does not cover (Government of Canada, 2019).

5.4 The Interim Federal Health Program (IFHP)

In 2012, the preceding Prime Minister of Canada, introduced Bill C-31. This bill ultimately reformed the Interim Federal Health Program (IFHP) which was established in 1957 for the purpose of granting basic health insurance to all refugees and asylum seekers. Due to the foundation of Bill C-31 refugees and asylum seekers lacked access to basic healthcare in Canada such as medical and hospital services "unless their illness was a threat to public health" (Antonipillai, et al. 2016, p. 204). In addition, refugees from certain countries would be totally excluded from receiving care and the opportunity to work. Current Prime Minister, Justin Trudeau, amended Bill-31 in 2016 and restored comprehensive or basic provincial health care to refugees and asylum seekers later that year. This is not to say that the effects of Bill C-31 are not still a barrier to refugees. During the four-year period that refugees and asylum seekers were neglected from healthcare, clinics practitioners and hospitals had to turn many of the newcomers away because they had no insurance. This is

still currently happening despite the restoration of insurance. Many places that provide medical care or services are unsure of whether or not newcomers qualify and turn them away due to ignorance or misinformation (Holtzer, et al, 2017; Wright, 2019). This rejection will hopefully be reduced as the release of the 2019 Canadian budget looks promising for refugees and asylum seekers as the refugee health program is receiving $283 million dollars over the next two years to provide adequate care for the increase in refugee claims. This money could be used to fund several of the following recommendations made by researchers in the area of refugee health.

6. RECOMMENDATIONS FOR IMPROVING HEALTHCARE

Following the identification of the physical and mental healthcare needs and challenges that refugee and asylum seeking women face the question then becomes how can Canada make improvements to meet these unique health needs? The following sections combines the research of Vasikevska, Madan, and Simish (2010) with Matlin et al. (2018) to create a compilation of recommendations that directly pertain to improving the quality and access of healthcare to refugees in Canada for the future.

Mental health is on-going and complex; it is not treated by a singular trip to a counsellor or therapist but requires progressive "case-based" therapy. Using a case management approach and listening to the client's needs can be beneficial to improving mental health (Matlin et al., 2018). As a healthcare case is established for a refugee overtime, healthcare practitioners can promote favourable, and unique forms of therapy that may not be offered in their home country. Today, there are various methods of therapy that go beyond basic "talk" based clinical therapy. For example, Ley, Barrio and Koch (2018) found that sport and exercise reduced symptoms of PTSD and contributed to the improvement of war-torn refugees' sense of well-being. In addition, there has been research that has suggested the benefits of horseback riding on PTSD (Johnson, et al. 2018). These are

just two of many unique forms of therapy that are offered in Canada but healthcare practitioners should be flexible in administration, service delivery, and be willing to offer or recommend alternative methods of healing and social supports (Vasikevska, Madan & Simish, 2010, p.24).

Diversity should be respected. Refugees arriving in Canada have varying mental health and health issues based on their country of origin and gender identity. The experiences of refugee and asylum-seeking women from South America may vary compared to those from the Middle-East and Africa which may lead to variations in the prevalence of particular mental health complications and disorders. This requires that healthcare practitioners do not collectively address and treat refugees in the same manner but rather "tailor services to clients' evolving needs" (Vasikevska, Madan & Simish, 2010, p.23).

As discussed earlier the barriers that refugees experience in their new host countries such as language, transportation, and social determinants create difficulties when accessing health care. Both Vasikevska, Madan, and Simish (2010) and Matlin and additional authors (2018) believe that providing an interpreter, and learning about their culture is essential to providing an accurate diagnosis as there can be the cultural and language difference that were addressed above that may hinder the quality provision of both physical and psychological therapy. Vasikevska, Madan & Simish (2010) suggest that serving clients where they settle, or providing an in house service, is one way that could potentially eliminate or at least reduce the transportation and navigation barrier felt by refugees. At the same time, they recommend that refugees would benefit from receiving that in home help from one person, in which they can build a trusting and comfortable relationship. Having services provided by a wide variety of healthcare practitioners can be less efficient to their recovery as it doesn't provide consistent and predictable services (p. 21, 24, 25). Furthermore, Matlin et al. (2018) suggest that social determinants should be considered when identifying the health needs of migrants

and refugees. For example, employment and income is a social determinant of health that was discussed earlier that prevents women from having equal health care when they are faced with limitations in the labour force. Talking these disparities into account is one way Nations can improve health services (Matlin et al., 2018).

As we move into the future, perhaps one of the most important aspects of improving the refugee mental health in Canada the training of forthcoming healthcare practitioners. Vasikevska, Madan and Simish (2010) state that "Ways to do this involve training university students who will become practitioners in the future; collaborating with other human service agencies, and advocating for mainstream health and mental health services to do a better job working with refugees" (p.21). In addition to this training, Matlin et al. (2018) believe that there should be increased or mandatory training for healthcare providers on culture and transitional experiences of refugees and asylum seekers to create a deeper understanding between client and practitioner. Refugee and migrant health should be integrated into health curriculum, adoption of unique training programs, creation of degrees specific to refugee health, cultural competence should be a trained, emphasised skill alike bedside manner (Matlin et al., 2018).

At the national level, states can promote a positive perception of refugees and asylum seekers. As migration continues in the future, Matlin et al. (2018) argue that there is a need to change the way the West perceives migration. Migration and immigration should be considered a normalized component of life in a globalized world. This also includes the shift in adopting the ideology that those seeking asylum bring "significant benefits to the countries that host them, including improved demographics and heightened economic activity and productivity" (p.41). The healthcare system must also undergo modification in that it should be inclusive to refugee and asylum seekers health and based on equality rather than adequacy meeting their health needs. As addressed previously, cultural perceptions can manifest as

barriers to accessing healthcare for migrants, this is equally true for the discernments that Canadians hold towards newcomers. Additionally, adopting an increasingly inclusive national health care policy for all refugees and asylum seekers is one way nations can demonstrate their support and commitment to newcomers. Matlin et al. (2018) suggest that nations ought to develop healthcare policies that address the diverse needs of migrants by work towards better understanding the reasons and effects of migration, adopting an inclusive mind-set in policy formation and increase public awareness on the responsibility of the host country to migrants.

At the global level there needs to be commitment to improve the needs of vulnerable migrants in times of crisis. This includes creating and implementing standardized healthcare and healthcare screening measures, the adoption of an inter-sectoral approach that considers housing, water, sanitation, nutrition, education transportation, and access to culturally appropriate healthcare. Finally, there needs to be better communication between countries in research and education on the topic of migrant health (Matlin et al., 2018).

Finally, and perhaps most importantly, the role of communication is important in any form of public relations. Refugees women are often limited by literacy and language but that does not mean that they should be excluded from the discussion. Matlin et al. (2018) argue that refugees and asylum seekers should be involved in the policy-making around migrant health care as they have experience and expertise that Canadian born policymakers will generally never obtain. Adding migrants, refugees and asylum seekers not only ‘to’ the conversation but ‘in’ the conversation is a step in the right direction.

7. CONCLUSION

Women often face discrimination every day for simply being a woman, however, refugee and asylum seeking women are faced with multiple layers of disadvantage from their

Canadian counterparts. This is particularly true when it comes to accessing healthcare that is responsive to their unique needs.

Past traumas associated with armed conflict, political, and social unrest including the fear of prosecution are undoubtedly connected to both the physical and mental health of arriving newcomers. As we have discussed, women are often neglected from receiving basic needs such as food, clean water and medical care and often treated as second class citizens compared to soldiers in countries of conflict. Women are additionally vulnerable to sexual violence, such as rape as a weapon of war, in their host countries and during the migration process that affect their sense of well-being.

Transition and traumas are highly correlated with health. The three periods of transition such as pre-migration, migration and post-migration all pose a series of potentially stressful situations that can influence the overall health of these women. Many experience chronic pain, headaches, and the flu that can be related to stress and anxiety. Refugees and asylum seekers from areas of conflict experience a greater prevalence of PTSD and depression and newcomer women are five times as likely to develop maternal depression than their Canadian counterparts.

However, the sexual and reproductive health of newcomer women is by far the area of health care that requires the most attention as it is reiterated throughout much of the literature. Women who are victims of sexual violence due to conflict often have physical difficulties with sexual reproductive health such as conception, menstruation, and musculoskeletal pains following the initial trauma. They face many barriers when it comes to sexual reproductive health as it can be a topic that holds cultural and social stigma.

This is not the only barrier that women face, language and literacy levels play an influential role in determining the level of health care they receive. Many feel isolated and rejected when it comes to health care and depend on those who can speak English in their

families to translate and interpret. Health care policy, such as the IFHP, is another barrier that all refugees and asylum seekers face as it can fluctuate in its inclusion level based on the federal government at the time. Newcomer minority women are some of the lowest income earners in Canada. Access to income is an additional social determinant of health employment and finances can prove to be an obstacle to receiving specialized care and services that the IFHP does not cover.

Lastly, it is important to diminish these barriers and create a well-rounded, accessible, and inclusive healthcare system. This can be done through education and training of healthcare practitioners on cultural competency, and creating an understanding of the migration process, risks and experiences that asylum seeker women face prior to arriving in Canada. The health of refugees and asylum seekers should be discussed in the curriculum of medical schools and degrees offered for specialization in the area. In the clinical setting, the use of professional interpreters should be mandatory for clients who lack language and literacy. Clinicians should offer diverse therapy treatments for mental health disorders such as PTSD and be open minded and receptive newcomer patients. Lastly, refugees should be involved in the decision making process, their voices should be heard in policy to provide the best understanding and chance at success.

Overall, the migration of refugees and asylum seekers is a coherent component of Canada's future. As that future nears, it is important that the nation upholds the Immigration and Refugee Protection Act (2001) that works to "promote the successful integration of permanent residents into Canada, while recognizing that integration involves mutual obligations for new immigrants and Canadian society" (p.2). Health is a vital aspect of that integration process and to the quality of life that every human being is entitled to. It is the duty of everyone to encourage an equitable, equal, and just world. A world that aims to provide everyone with the essential needs for success and well-being, while acknowledging

and valuing the unique differences of every person, regardless of where or what sex that individual was born. Women's health is the future's health and it's time that action and consideration be taken locally and globally to improve the health needs of vulnerable refugee and asylum seeking women.

REFERENCES

Ahmed, A., Bowen, A., & Feng, C. X. (2017). Maternal depression in Syrian refugee women recently moved to Canada: A preliminary study. *BMC Pregnancy and Childbirth, (1),* p1-11. https://doi.org/10.1186/s12884-017-1433-2

Al Jazeera News. (2018). The Nobel Interview: Nadia Murad and Denis Mukwege. *Al Jazeera News*. Retrieved from https://www.aljazeera.com/programmes/specialseries/2018/12/nobel-interview-nadia-murad-denis-mukwege-181211082358357.html

American Psychiatric Association. (2019). *What is posttraumatic stress disorder?.* Retrieved from https://www.psychiatry.org/patients-families/ptsd/what-is-ptsd

Amnesty International. (n.d). *Refugees, Asylum-seekers and Mi*grants. Retrieved from https://www.amnesty.org/en/what-we-do/refugees-asylum-seekers-and-migrants/

Antonipillai, V., Baumann, A., Hunter, A., Wahoush, O., & O'Shea, T. (2018). Health inquiry and "restoring fairness" through the Canadian refugee health policy reforms: A literature review. *J Immigrant Minority Health, 20*, 203-213. https://doi.org/10.1007/s10903-016-0486-z

Aptekman, M., Rashid, M., Wright, V., & Dunn, S. (2014). Unmet contraceptive needs among refugees. *Canadian Family Physician Medecin de Famille Canadien, 60*(12), e613-e619. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4264828/

Arcel, L. T., & Kastrup, M. (2004). War, women, and health. *Nordic Journal of Feminist and Gender Research, 12*(1), 40-47. https://doi.org/10.1080/08038740410005758

Bazaid, K. (2017). Syrian refugees in Canada: Clinical experience in mental health care. *European Psychiatry*.

Berrera, J. (2019). MMIW cases continued at same rate even after national inquiry began, data shows. *CBC News*. Retrieved from https://www.cbc.ca/news/indigenous/mmiwg-inquiry-new-cases-statistics- databases-1.5162482

Canadian Paediatric Society. (2019). Barriers and facilitators to health care for newcomers. *Caring for Kids New to Canada*. Retrieved from https://www.kidsnewtocanada.ca/care/barriers#systemic-barrierso

CBC News. (2019). *Canada will grant asylum to Saudi woman fleeing alleged abuse: Trudeau*. Retrieved from https://www.cbc.ca/news/politics/canada-saudi-woman-asylum-alleged-abuse-1.4974344

Cecco, L. (2017). UNHCR chief hails Canada and asks for even greater efforts. *UNHCR*. Retrieved from https://www.unhcr.org/news/latest/2017/11/5a01808e4/unhcr-chief-hails-canada-asks-greater-efforts.html?query=women%20refugees

Charlson, F.J., Flaxman, A., Ferrari, A. J.,Vos, T., Steel, Z., & Whiteford, H.A. (2016). Post-traumatic stress disorder and major depression in conflict-affected populations: An epidemiological model and predictor analysis. *Global Mental Health (Cambridge, England)*, 3, 1-11. https://doi.org/10.1017/gmh.2015.26

Department of Justice Canada. (2001). *Immigration and Refugee Protection Act*. Retrieved from https://www.ifrc.org/docs/idrl/637EN.pdf

Douglas, P., Cetron, M., & Spiegel, P. (2019). Definitions matter: Migrants, immigrants, asylum seekers and refugees. *Journal of Travel Medicine, 26*(2),1-3. https://doi.org/10.1093/jtm/taz005

Floyd, A., & Sakellariou, D. (2017). Healthcare access for refugee women with limited literacy: Layers of disadvantage. *International Journal for Equity in Health, 16*,195, 1-10. https://doi.org/10.1186/s12939-017-0694-8

Government of Canada. (2017). *#Welcomerefugees: Key figures*. Retrieved from https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/welcome-syrian-refugees/key-figures.html#popup2

Government of Canada. (2019). *Canada welcomes more privately sponsored refugees in 2019*. Retrieved from https://www.canada.ca/en/immigration-refugees-citizenship/corporate/mandate/policies-operational-instructions-agreements/timely-protection-privately-sponsored-refugees.html

Government of Canada. (2019). *Supporting visible minority newcomer women in Toronto: Pilot to address multiple barriers to success for women in Canada's job market*. Retrieved from https://www.canada.ca/en/immigration-refugees-citizenship/news/2019/01/supporting-visible-minority-newcomer-women-in-toronto.html

Grady, K. *(2016).* Sex, statistics, peacekeepers and power: UN data on sexual exploitation and abuse and the quest for legal reform. *The Modern Law Review, 79(6).* https://doi.org/10.1111/1468-2230.12225

Grønhaug, K. (n.d.). Rape as a weapon of war, quiet, cheap and scarily efficient. *Norwegian Refugee Council*. Retrieved from https://www.nrc.no/shorthand/stories/rape-as-a-weapon-of-war/index.html

Guruge, S., Roche, B., & Catallo, C. (2012). Violence against women: an exploration of the physical and mental health trends among immigrant and refugee women in Canada. *Nursing Research and Practice*,1-15. https://doi.org/10.1155/2012/434592

Guruge, S., Sidani, S., Illesinghe, V., Younes, R., Bukhari, H., Altenberg, J.,…Fredericks, S. E. (2018). Healthcare needs and health service utilization by Syrian refugee women in Toronto. *Conflict and Health, 12*, 46, 1-9. https://doi.org/10.1186/s13031-018-0181-x

Harper, L. (2006). *To kill a mockingbird*. New York: Harper Perennial Modern Classics.

Holtzer, E., Moore-Dean, A., Srikanthan, A., & Kuluski, K. (2017). Reforming Refugee Healthcare in Canada: Exploring the use of policy tools. *Healthcare*, *12*(4), 46–55. https://doi.org/10.12927/hcpol.2017.25099

Human Rights Watch. (2017). Submission to the Government of Canada on police abuse of Indigenous women in Saskatchewan and failures to protect Indigenous women from violence. Retrieved from https://www.hrw.org/sites/default/files/supporting_resources/canada_saskatchewan_submission_june_2017.pdf

Human Rights Watch. (2019). *Venezuela's humanitarian crisis severe medical and food shortages, inadequate and repressive government response*. Retrieved from https://www.hrw.org/report/2016/10/24/venezuelas-humanitarian-crisis/severe-medical-and-food-shortages-inadequate-and

Indigenous and Northern Affairs Canada. (2019). *Indian Residential Schools*. Retrieved from https://www.aadnc-aandc.gc.ca/eng/1100100015576/1100100015577

Johnson, R. A., Albright, D. L., Marzolf, J. R., Bibbo, J. L., Yaglom, H. D., Crowder, S. M., … Harms, N. (2018). Effects of therapeutic horseback riding on post-traumatic stress disorder in military veterans. *Military Medical Research*, *5*(1), 3. https://doi.org/10.1186/s40779-018-0149-6

Kanagaratnam,P., Pain, C., McKenzie, K., Ratnalingam, N., & Toner, B. (2017). Recommendations for Canadian mental health practitioners working with war-exposed immigrants and refugees. *Canadian Journal of Community Mental Health, 36*(2),107-119. https://doi.org/10.7870/cjcmh-2017-010

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., …Pottie, K. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *CMAJ: Canadian Medical Association Journal, 183*(12), E959-E967. https://doi.org/10.1503/cmaj.090292

Kiss, K., Pim, C., Hemmelgarn, B.R., & Quan, H. (2011). Building knowledge about health services utilization by refugees. *J Immigrant Minority Health, 15*, 57-67. https://doi.org/ 10.1007/s10903-011-9528-8.

Ley, C., Barrio, M.R., & Koch, A. (2018). "In the sport I am here": Therapeutic processes and health effects of sport and exercise on PTSD. *Qualitative Health Research, 2*8(3), p. 491-507. https://doi.org/10.1177/1049732317744533

Pottie, K., Greenaway, C., Feightner, J., Welch, V., Swinkels, H., Rashid, M.,…Tugwell, P. (2011). Evidence-based clinical guidelines for immigrants and refugees. *Canadian Medical Association Journal,183*(12), E824-E925. https://doi.org/10.1503/cmaj.090313

Martin-Shields, C. & Stojetz, W. (2018). *Food security and conflict. Empirical challenges and future opportunities for research and policy making on food security and conflict.* FAO Agricultural Development Economics Working Paper. Retrieved from http://www.fao.org/3/ca1587en/CA1587EN.pdf

Matlin, S. A., Depoux, A. Schütte, S., Flahault, A., & Saso, L. (2018). Migrants' and refugees' health: towards an agenda of solutions. *Public Health Review, 39*(27), 1-55. https://doi.org/10.1186/s40985-018-0104-9

Matlin, M. W. (2012). The psychology of women. Belmont, CA: Wadsworth Cengage Learning.

Mental Health Commission of Canada. (2016). Supporting the mental health of refugees to Canada. Retrieved from https://ontario.cmha.ca/wp-content/files/2016/02/Refugee-Mental-Health-backgrounder.pdf

Merry, L. A., Gagon, A. J., Kalim, N., & Bouris, S. S. (2011). Refugee claimant women and barriers to health and social services post-birth. *Canadian Journal of Public Health, 102*(4), 286-290. Retrieved from https://pdfs.semanticscholar.org/6e8b/24b22ece9575e5bbd1f50888e2ac4bbbf3d2.pdf

Metusela, C., Ussher, J., Prez, J., Hawkey, A., Morrow, M., Narchal, R.,…Monteiro, M. (2017). "In my culture, we don't know anything about that:" Sexual and reproductive health of migrant and refugee women. *International Journal of Behavioural Medicine, 24*(6), 836-845. https://doi.org/10.1007/s12529-017-9662-3

Mikkonen, J., & Raphael, D. (2010). Social determinants of health: The Canadian facts. Toronto: York University School of Health Policy and Management. Retrieved from http://thecanadianfacts.org/the_canadian_facts.pdf

Neudorfer, K*. (2016). Sexual exploitation and abuse in UN peacekeeping: An analysis of risk and prevention factors.* New York City, NY: Lexington Books*.*

Obradovic, M. (2015). Protecting female refugees against sexual and gender-based violence in camps. *United Nations University*. Retrieved from https://unu.edu/publications/articles/protecting-female-refugees-against-sexual-and-gender-based-violence-in-camps.html

Royal Canadian Mounted Police. (2014). *Missing and murdered Aboriginal women: A national operational overview*. Canada. Retrieved from http://www.rcmp-grc.gc.ca/en/missing-and-murdered-aboriginal-women-national-operational-overview

Silverberg, S.L., Harding, L., Spitzer, R.F., & Rashid. (2018). The who, what, why and when of gynaecological referrals for refugee women. *J Immigrant Minority Health, 20*(6), p1347-1354. https://doi-org.proxy.library.upei.ca/10.1007/s10903-018-0733-6

Spitzer, D. L. (2011). *Engendering migrant health: Canadian perspectives*. (Introduction). Toronto: University of Toronto Press, Scholarly Publishing Division. Retrieved from http://eds.b.ebscohost.com.proxy.library.upei.ca/eds/ebookviewer/ebook/bmxlYmtfXzQ2ODk5M19fQU41?sid=d2134dae-ea7e-4db1-a492-b846b547b544@sessionmgr102&vid=4&format=EB

Statistics Canada. (2015). *Women in Canada: A Gender-based Statistical Report.* Statistics Canada Catalogue no. 89-503-X. Ottawa. Retrieved from https://www150.statcan.gc.ca/n1/en/pub/89-503-x/2015001/article/14217-eng.pdf?st=bTwp_DJd

. The Nobel Prize. (2019). Nadia Murad Facts. Retrieved from https://www.nobelprize.org/prizes/peace/2018/murad/facts/

The Royal College of Physicians and Surgeons of Canada. (2012). *Defining societal health needs Royal College definition and guide*, 1-12. Retrieved from http://www.royalcollege.ca/rcsite/documents/health-policy/societal-health-needs-definition-and-guide-e.pdf

United Nations. (2019). *Sustainable Development Goals*. Retrieved from https://www.un.org/sustainabledevelopment/sustainable-development-goals/

United Nations. (1948). *Universal Declaration of Human Rights*. Retrieved from https://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf

United Nations High Commission for Refugees. (2016). *Ending sexual and gender based violence (SGBV)- UNHCR acts*. Retrieved from: https://www.unhcr.ca/news/ending-sgbv/

United Nations High Commissioner for Refugees. (2013). *UNHCR's mental health and psychological support*. Retrieved from https://www.unhcr.org/research/evalreports/51bec3359/unhcrs-mental-health-psychosocial-support-persons-concern.html

United Nations High Commissioner for Refugees. (2015). *Women on the Run: First-hand accounts of refugees fleeing El Salvador, Guatemala, Honduras, and Mexico*. Retrieved from https://www.unhcr.org/publications/operations/5630f24c6/women-run.html?query=women

United Nations High Commission for Refugees. (2017). *Report of the Secretary-General on conflict-related sexual violence*. Retrieved from https://www.un.org/en/events/elimination-of-sexual-violence-in-conflict/pdf/1494280398.pdf

United Nations High Commissioner for Refugees. (2019*). Figures at a Glance*. Retrieved from https://www.unhcr.org/figures-at-a-glance.html

United Nations Office on Drugs and Crime. (2018). *Global Report on Trafficking in Persons in the Context of Armed Conflict*. Retrieved from http://www.unodc.org/documents/data-and-analysis/glotip/2018/GloTIP2018_BOOKLET_2_Conflict.pdf

Ussher, J.M., Perz, J., Metusela, C., Hawkey, A.J., Morrow, M., Narchal, R., & Estoesta, J. (2017). Negotiating discourses of shame, secrecy, and silence: Migrant and refugee women's experiences of sexual embodiment. *Archives of Sexual Behaviour, 46*(7), 1901-1921. https://doi.org/10.1007/s10508-016-0898-9

Wang, A.M.Q., Yung, E.M., Nitti, N., Shakya,Y., Alamgir, A.K.M., & Lofter, A.K. (2019). Breast and colorectal cancer screening barriers among immigrants and refugees: A mixed-methods study at three community health centres in Toronto, Canada. *Journal of Immigrant and Minority Health, 21*, 473-482. https://doi.org/10.1007/s10903-018-0779-5

Whitley JR., B. E., & Kite, M.E. (2010). *The psychology of prejudice and discrimination* (2nd ed.). Belmont, CA: Wadsworth Cengage Learning.

World Health Organization. (2018). *Mental Health: Strengthening our response*, 1-4. Retrieved from https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response.

World Health Organization. (2019). *Sexual Reproductive Health*. Retrieved from https://www.who.int/reproductivehealth/topics/family_planning/unmet_need_fp/en/

Wright, T. (2019, March 27). Feds boost funding for refugee health care, but study says barriers remain. *National Post*. Retrieved from https://nationalpost.com/pmn/news-pmn/canada-news-pmn/feds-boost-funding-for-refugee-health-care-but-study-says-barriers-remain

Wright, T. (2019, June 4). Trudeau pledges more funding for reproductive health services worldwide. *Canadian Broadcasting Company*. Retrieved from https://www.cbc.ca/news/politics/trudeau-pledges-abortion-funding-1.5161891

Vasilevska, B., Madan, A., & Simich, L. (2010). *Refugee Mental Health: Promising Practices and Partnership Building Resources*. Centre for Addiction and Mental Health: Toronto. Retrieved from https://www.porticonetwork.ca/documents/51609/273390/refugee_mental_health_prompractices.pdf/8b5f3b0d-19e0-4816-966b-3bf818eb279a