REFUGEE HEALTH COALITION

REFUGEE HEALTH COMMUNITY ENGAGEMENT PROJECT REPORT

2020

Executive Summary

Health and wellbeing is essential to people's life and depends on access to appropriate healthcare and social supports. Refugees who resettle in Canada have experienced a wide range of pre-migration access to care, from never seeing a physician to paying for private healthcare services in countries along their migration journey.

Limited access to health and social care, combined with the stresses and traumas of fleeing home and living in a refugee camp or temporary housing results in many refugees requiring comprehensive and timely healthcare upon arrival in Canada. Common practice in Canadian cities includes dedicated health services specialized for this population; unfortunately, Edmonton is a major city in Canada without a comprehensive and coordinated service model to address the health and social needs of the refugee population. As a result, many refugees are starting their life in Edmonton with limited and inconsistent access to care which can significantly impact their ability to settle and integrate. A focus on establishing accessible, relevant and meaningful access to care is what the Refugee Health Coalition (RHC) strives to address.

The RHC works closely with the main newcomer-serving agencies in Edmonton whose work is primarily supporting refugees: Catholic Social Services (CSS), the Edmonton Mennonite Centre for Newcomers (EMCN) and the Multicultural Health Brokers (MCHB). We also work closely with AHS, HIV Edmonton, and the University of Alberta. CSS is the primary settlement agency for government assisted refugees, EMCN supports a large proportion of privately sponsored refugees, MCHB provides support for newcomers with complex health and social needs, and HIV Edmonton has a support program specifically for HIV positive newcomers. Many members of the RHC are from these organizations. The design for the engagement project discussed in this report, which was co-led by the RHC and AHS, was established in collaboration with community agencies and the work of the project was carried out by staff in all agencies.

This report provides a comprehensive picture of the lived experiences of access to healthcare for refugees settling in Edmonton. We had conversations with community members who came to Canada as refugees from Bhutan, the Democratic Republic of the Congo, Eritrea and Ethiopia, Myanmar, Somalia, Sudan, Syria and Iraq. These groups represent the primary communities with refugee backgrounds and significant health needs. The report also incorporates the knowledge and expertise of front-line staff, health professionals and key stakeholders.

Through the knowledge gained in this project, along with other research, we have developed seven recommendations to enhance healthcare for refugees in Edmonton. These recommendations are: 1) build the capacity of refugees, 2) find solutions to reduce language barrier, 3) build capacity of healthcare professionals, 4) increase the capacity and number of Community Health Workers (CHW), 5) ensure access and coordination of mental health supports 6) develop a meaningful and culturally relevant model of healthcare, and 7) work towards long-term policy changes. The recommendations are intended to provide a roadmap for Refugee Health Services in Edmonton and area.

Acknowledgements

The Refugee Health Coalition would like to thank all of those who contributed to this project and final report. The RHC thanks Alberta Health Services for the financial support that allowed this project to be completed and the Edmonton Community Foundation for providing financial support. We would also like to thank all of our partner agencies who dedicated significant staff time to consulting, facilitating, interpreting and providing ongoing guidance and feedback.

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Acronyms

AHS	-	Alberta Health Services
CHC	-	Community Health Centre
CSS	-	Catholic Social Services
DRC	-	Democratic Republic of the Congo
EMCN	-	Edmonton Mennonite Centre for Newcomers
GAR	-	Government Assisted Refugee
IFHP	-	Interim Federal Health Program
IFSSA	-	Islamic Family and Social Services Association
IRCC	-	Immigration, Refugees & Citizenship Canada
ISIS or ISIL	-	Islamic State of Iraq and Syria or Islamic State of Iraq and the Levant
LINC	-	Language Instruction for Newcomers to Canada
MCHB	-	Multicultural Health Brokers
PCN	-	Primary Care Network
PSR	-	Privately Sponsored Refugees
PTSD	-	Post-Traumatic Stress Disorder
RHC	-	Refugee Health Coalition
SAH	-	Sponsorship Agreement Holder
TB	-	Tuberculosis
UNHCR	-	United Nations High Commissioner for Refugees
WHO	-	World Health Organization

Glossary of Terms

Cultural brokering

In this report we follow the Multicultural Health Brokers Co-operative (MCHB) definition of cultural brokering "It is the act of linking, bridging and mediating between culturally different individuals or organizations to reduce conflict and catalyze change. Cultural Brokering practice as community health workers". The work of the MCHB is framed within Labonte's 5 spheres of empowerment[1]. In Edmonton there are currently 102 cultural health brokers, serving 2,000 families within 30 ethnocultural communities.

Community Health Worker (CHW)

In this report, we use the Community Health Workers Network of Canada's definition of the CHW model. It is defined as a model that supports both the social and health systems by addressing the social determinants of health and triaging the needs of vulnerable populations to then allow groups to enter the social or health system.

Equity

In this report we follow the WHO definition of equity which is "the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically."[2]

Equality

In this report we follow the definition of equality from the Equality and Human Rights Commission which states that "Equality is about ensuring that every individual has an equal opportunity to make the most of their lives and talents. It is also the belief that no one should have poorer life chances because of the way they were born, where they come from, what they believe, or whether they have a disability."[3] A common way of differentiating equity and equality is that equality is providing all people the same resources whereas equity is providing people the resources they need to have the same opportunities.

Equality

There are no standard, commonly used definitions for health navigators. However, a common component is that health navigators are systems-focused. We have developed a definition based on findings from a scoping review on the role of navigators in primary care: the role of health navigators is to support patients as they access health and social services through "communication, communication with multiple agencies, facilitating access to care, navigating the system and services, or assisting individuals with health insurance."[4]

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[1] Labonte R. (1994). Health promotion and empowerment: reflections on professional practice. Health Education Quarterly, 21(2), 253-268.
[2] World Health Organization. (n.d.). Equity. From Health Systems: https://www.who.int/healthsystems/topics/equity/en/
[3] Equality and Human Rights Commission. (2018, August 02). Understanding equality. From Equality and Human Rights Commission: https://www.equalityhumanrights.com/en/secondary-education-resources/useful-information/understanding-equality
[4] Carter, N., Valaitis, R. K., Lam, A., Feather, J., Nicholl, J., & Cleghorn, L. (2018). Navigation delivery models and roles of navigators in primary care: a scoping literature review. BMC Health Services Research, 18(1), 96. https://doi.org/10.1186/s12913-018-2889-0

Health navigation is a system's based role, intended to reduce barriers patients may face in complex systems. Another feature of health navigators is that they are intended to support any patient with complex needs, not just patients with cultural or language barriers.

Immigrant

The Government of Canada definition of an immigrant is "a person who is or has ever been a landed immigrant/permanent resident. This person has been granted the right to live in Canada permanently by immigration authorities. Some immigrants have resided in Canada for a number of years, while others have arrived recently. Some immigrants are Canadian citizens, while others are not. Most immigrants are born outside Canada, but a small number are born in Canada."[5] However in this report, we use immigrant to refer specifically to people who chose to leave their home country and chose to move to Canada. The distinction of choice is essential when defining refugees and immigrants.

Integration

There is no standard definition of integration either in Canada or as part of the UNHCR. In this report we follow a commonly accepted UNHCR definition, which is: "UNHCR understands integration to be the end product of a dynamic and multifaceted two-way process with three interrelated dimensions: legal, economic and social-cultural. Integration requires efforts by all parties concerned, including preparedness on the part of beneficiaries of international protection to adapt to the host society without having to forego their own cultural identity, and a corresponding readiness on the part of host communities and public institutions to welcome beneficiaries of international protection and to meet the needs of a diverse population."[6]

Newcomer

Statistics Canada defines a newcomer as "Recent immigrants (also known as newcomers) refers to landed immigrants who came to Canada up to five years prior to a given census year."[7] However, for this report, we use the term newcomer to refer to anyone who was not born in Canada and who is a current resident or citizen. The rationale for this is that many people that we interviewed and consulted on this report came to Canada as refugees or immigrants and their lived experience settling is important and essential in their experience.

Participatory Action Research (PAR)

Participatory Action Research in this project follows the definition from Mayan which includes the concept of research where community is "involved in every stage of the research, from

[5] Statistics Canada (2019, January 04). Immigrant status. From Statistics Canada: https://www12.statcan.gc.ca/nhs-enm/2011/ref/dict/pop148-eng.cfm
[6] UNHCR. (2017). Towards Integration: The Syrian Vulnerable Persons Resettlement Scheme in the United Kingdom. https://www.unhcr.org/uk/5a0ae9e84.pdf
[7] Statistics Canada. (2010, February 11). Canada's Ethnocultural Mosaic, 2006 Census: Definitions. From Statistics Canada: https://www12.statcan.gc.ca/census recensement/2006/as-sa/97-562/note-eng.cfm.

identification of the research problem, design of the study, data collection and analysis, and interpretation of the findings through to dissemination of the results".[8] Through PAR refugee communities can actively participate in all stages of research to ensure the project accurately reflects the reality they live in.

Primary care

In this report we follow Alberta Health Services (AHS) definition of primary care, which is: "all the services you receive for your basic, everyday health needs. It is often called the front door to health care - your entry point into the health-care system. It might be a visit to your family doctor, a call to Health Link or an appointment with a therapist. In Alberta, primary care services are provided by both family doctors and Alberta Health Services (AHS). It includes the initial care, treatment and follow-up of various conditions as well as referrals to the rest of the health system when needed. It also encompasses the promotion of wellness, and prevention and management of chronic diseases and injuries."[9]

Primary health care

In this report we follow Health Canada's definition of primary health care which is: "an approach to health and a spectrum of services beyond the traditional health care system. It includes all services that play a part in health, such as income, housing, education, and environment. Primary care is the element within primary health care that focusses on health care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury."[10]

Refugee

In this report we follow the United Nations definition of a refugee, which is "someone who has been forced to flee his or her country because of persecution, war or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group. Most likely, they cannot return home or are afraid to do so. War and ethnic, tribal and religious violence are leading causes of refugees fleeing their countries."[11]

Settlement & Integration

In this report we differentiate between 'settlement' and 'integration', although the terms are often used interchangeably. Settlement refers to the initial stages of adjusting and adapting to a new society, whereas integration is a long-term process. We use the following definition:

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[8] Mayan, M. (2009). Essentials of Qualitative Inquiry. Walnut Creek: Left Coat Press Inc.
[9] Alberta Health Services. (2019). Primary Care. From Alberta Health Services: https://www.albertahealthservices.ca/info/Page4058.aspx
[10] Government of Canada. (2012, August 23). About primary health care. From Government of Canada: https://www.canada.ca/en/health canada/services/primary-health-care/about-primary-health-care.html
[11] UNHRC. (n.d.) What is a Refugee? From USA for UNHCR: https://www.unrefugees.org/refugee-facts/what-is-a-refugee/

"Settlement is a process or a continuum of activities that a new immigrant/refugee goes through upon arrival in a new country. This process includes the following stages:

- Adjustment: acclimatization and getting used to the new culture, language, people and environment or coping with the situation
- Adaptation: learning and managing the situation without a great deal of help
- Integration: actively participating, getting involved and contributing as citizen of a new country.

Integration is defined as the ability to contribute, free of barriers, to every dimension of Canadian [host society] life, that is, economic, social, cultural and political.
The goal of settlement is for every immigrant to have full freedom of choice regarding [their] level of participation in the society. If the immigrant wants to participate actively in the society, there are no systematic barriers preventing [them] from doing."[12]

Service Providers

In this report we define service providers as any individual involved in helping refugees settle in Canada. This definition includes front-line staff such as settlement practitioners, cross-cultural counsellors, mental health therapists, and multicultural health brokers. We also include private sponsors and all healthcare professionals under this umbrella.

Social Determinants of Health

In this report we follow the Canadian Public Health Agency's definition of the social determinants of health (SDH). The SDH are "the social and economic factors that influence people's health. These are apparent in the living and working conditions that people experience every day. The SDH influence health in many positive and negative ways." The commonly accepted list of the SDH are: "Income and Income Distribution; Education; Unemployment and Job Security; Employment and Working Conditions; Early Childhood Development; Food Insecurity; Housing; Social Exclusion; Social Safety Network; Health Services; Aboriginal Status; Gender; Race; Disability; Underemployed",[13] and we also include Immigration Status as a key determinant of health.

[12] Shields, John, Drolet, Julie, and Valenzuela, Karla. (2016). Immigrant Settlement and Integration Services and the Role of Nonprofit Service Providers: A Cross-national Perspective on Trends, Issues and Evidence. Ryerson Centre for Immigration and Settlement.
[13] Canadian Public Health Association. (n.d.). What are the social determinants of health? From Canadian Public Health Association: https://www.cpha.ca/what-are-social-determinants-health

Introduction

Who are we?

The Refugee Health Coalition (RHC) is a collaborative effort of newcomer-serving organizations, healthcare providers, academics and researchers, and community members. The RHC is working to address the unique barriers that refugees face in the healthcare system in Edmonton. In 2018 and 2019 we received financial support from AHS to carry out a needs assessment of refugee health in Edmonton. In early 2019, key stakeholders formed a Steering Committee to plan, organize and oversee the project titled "Refugee Health Community Engagement". Our task was to engage with refugees and refugee health stakeholders (including care providers), as well as to analyze existing research and models, and identify system gaps as they relate to refugee health in the Edmonton context. The Steering Committee members are:

Dr. Vera Caine, Professor in the Faculty of Nursing,
University of Alberta & Co-Chair of the RHC
Astrid Velasquez, Program Manager at CSS &
Co-Chair of the RHC
Rhianna Charchuk, Project Coordinator for the RHC
Dr. Yvonne Chiu, Executive Director of the MCHB
Joud Nour Eddin, Project Assistant for the RHC
Selene Tash, Executive Director of Community
Health Services Edmonton Zone, AHS

Methods

The Steering Committee worked alongside a team of front-line staff from Catholic Social Services (CSS), the Multicultural Health Brokers (MCHB), the Edmonton Mennonite Centre for Newcomers (EMCN), and AHS to develop the process and framework. We would like to acknowledge the following front-line staff and community leaders for their essential roles in this project:
Yesuf Abdela, CSS; Mulki Ali, MHCB; Charles Byusa, CSS; Svjetlana Crkvenjas, AHS; Dawn Estey, AHS; Suzanne Gross, EMCN; Jwamer Jalal, MHCB; Saida Khalif, MHCB; Say Say Lah, MHCB; Muhamad Muslim, MHCB; and Laura Velasquez, CSS.

This core team informed our methods in determining the communities we worked with and they were key to the implementation of the project. Team members also shared their experience as direct service providers to refugees in Edmonton. This project was not a research project; we recognize participants as experts of their own experiences with significant knowledge and insight. We were informed by the theory of human-centered design. The first phase of the project was inspired by the idea of empathy mapping.

This phase was completed between June and September 2019, and included conversations with 10 different communities (n=94), 14 conversations with front-line service providers, private sponsors and healthcare providers (n=58), and 2 key informant interviews. In these conversations we combined the notions of empathy mapping, design and dialogue-based idea development. This allowed participants to share their stories of accessing healthcare in Edmonton and also discuss solutions and thoughts to inform the design of healthcare for refugees in Edmonton and to improve future experiences of refugees. Many participants talked about the concept of wellbeing, of which health and healthcare is only one aspect. These conversations provided a picture of current experiences of refugees and frontline service providers, as well as the gaps in the system and opportunities for change or improvement. They created the foundation for the steering and core committees to brainstorm ideas, discuss promising practices and to design recommendations. The questions that guided these conversations are available in Appendix 1.0.

The second stage, completed between September and October 2019, involved data analysis to identify themes and develop potential solutions. The final step was to present the main findings back to the core team and front-line service providers who had participated in the conversations and who continue to provide front-line service to newcomer communities. This allowed us to verify what we had heard and to receive further detail and feedback. Throughout the project there were ongoing consultations with members of the core team and other front-line staff. We also debriefed with steering committee members after each conversation. These debriefs allowed us to highlight major themes and gather ongoing thoughts and reflections. We shared the main recommendations with the community and received feedback. Through this final step we were able to explore in further detail topics or ideas, and to highlight what the community identified as key and priority. For example, we heard from many front-line staff that they consistently see their clients being discriminated against by healthcare providers. However, we did not hear any of those stories from the community. In this final conversation we were able to explore possible reasons for these two different perceptions. Through this project, we developed a clear and comprehensive understanding of the barriers, gaps and enablers that impact the health and wellbeing of refugees in Edmonton.

Participants

We worked alongside community leaders to identify refugees who would have insight and interest participating in this project. We structured the conversations to join community groups that were already meeting regularly, usually through organization-led support groups. As such, all participants were already connected with at least one community organization. It is important for us to acknowledge that we missed consulting with refugees who are completely unconnected to support systems. However, due to the nature of the conversations and the ethical implications, it was important that participants were supported by community members and organizations' staff. We did not have any set inclusion or exclusion criteria; however, we focused on people who came to Canada as refugees, including government

assisted refugees (GARs), privately sponsored refugees (PSRs) and refugee claimants. The decision to focus on refugees was due to the experiences of members of the Steering Committee and community leaders who felt that this group faces significantly more barriers than immigrants. We recognize there are some immigrants who may be in vulnerable situations and future work should incorporate them.[14]

Background Information

Edmonton is located within Treaty 6 territory, which is the traditional gathering place for many Indigenous peoples.[15] The first European settlers arrived in 1795 and established Fort Edmonton, since then settlers from around the world have made Edmonton their home.[16] Refugees have been arriving in Edmonton for generations as they have fled war, famine and unrest in their home countries. However, the first 'formal' group of refugees that Edmonton welcomed through the United Nations High Commissioner for Refugees (UNHCR) was the Vietnamese Boat People in the late 1970s and 1980s. Many settlement agencies and newcomer-serving organizations that exist today were established to support these refugees.

The majority of settlement services for refugees are funded through the Ministry of Immigration, Refugees and Citizenship Canada (IRCC).[17] IRCC funding focuses on basic needs such as employment, language, and settlement. Other levels of government provide funding to agencies to support the longer-term integration process of refugees in Canada. For example, social integration and community development projects may be funded by provincial ministries or municipal funding bodies.

The refugee settlement system in Canada has three main streams: government assisted, privately sponsored and refugee claimants. GARs and PSRs are permanent residents upon arrival in Canada. GARs receive financial support through the federal government for one year and settlement support from a designated agency in each city that welcomes GARs. In Edmonton, CSS holds the contract to support GARs, an agreement which they have held for 43 years, since 1976.[18] All GARs are welcomed at the airport by CSS staff and are accompanied to CSS temporary housing. CSS staff support GARs with finding permanent housing, completing an English assessment, registering in language classes, registering children in school and all other basic settlement needs (e.g. opening a bank account, registering for Alberta Health coverage etc.). PSRs are welcomed through a variety of private sponsorship groups, including Sponsorship Agreement Holders (SAHs) that have ongoing contracts with the federal government to sponsor refugees. PSRs are not automatically connected to settlement support and often, their sponsors take on multiple roles to help with settlement.

[14] Of note, we did interview one group of immigrant women who moved to Canada either through family or economic streams. This conversation was very different from all other conversations that we had - in the end the only apparent barrier these women faced in the healthcare system was due to language. However, they all had multiple family members to support them who had been in Canada for much longer. After discussing this conversation with the Steering Committee and the core team, we agreed that immigrants have different experiences, and we decided not to use the results from aforementioned interview in the report.
[15] City of Edmonton. (2018) Newcomer's Guide to Edmonton: An introductory guide to help new residents settle in Edmonton.
[16] Edmonton Community Foundation. (2016). Vital Signs: Community foundations taking the pulse of Canadian communities.
[17] Government of Canada. (2019, September 10). Refugees and asylum.
[18] Catholic Social Services. (2019). Immigrant & Refugee Support. From: https://www.cssalberta.ca/newcomer

However, agencies such as the EMCN and the Islamic Family and Social Services Association (IFSSA) have built strong bridges with private sponsors and provide settlement support to PSRs.[19],[20] CSS also has a partnership with the Catholic Archdiocese SAH which sponsors around 200 PSRs a year. Refugee claimants are individuals who enter Canada on their own (e.g. through a visitor permit or work permit) and then claim asylum in the country. Refugee claimants have limited access to services in Canada as they are not eligible for IRCC-funded services until they successfully prove their claim and become permanent residents. Further information on settlement services available in Edmonton can be found by contacting one of the agencies mentioned above.

The different pathways that resettle refugees in Edmonton each entail complexities within the systems of support that refugees can access. Additionally, where refugees come from depends on current global crises and events. Refugees have unique needs and face unique challenges. There is limited research and data around refugee communities specifically in Edmonton. However, in this report we will focus on the wellbeing challenges that refugees face in Edmonton and how we can bridge the gaps in the system to achieve positive outcomes on both the system level and community health level.

[19] Edmonton Mennonite Centre for Newcomers. (2019) Welcome Home. From: https://www.emcn.ab.ca/
[20] IFSSA. (2019). About IFSSA. From: Islamic Family and Social Services Assocation: https://www.ifssa.ca/

Community Snapshots

Refugees who come to Canada represent a diverse group of people; they have come from countries around the world with different histories, stories of conflict and pre-migration experiences. The intention of the community snapshots is to highlight some of this diversity in terms of nationality, culture, religion, pre-migration exposure to conflict, violence, trauma, and other pre-migration experiences. It is essential to understand these factors in order to understand the diversity and complexity of the services required to properly support refugees in Canada. In this section we highlight different communities which represent where the majority of refugees in Edmonton come from.[21]

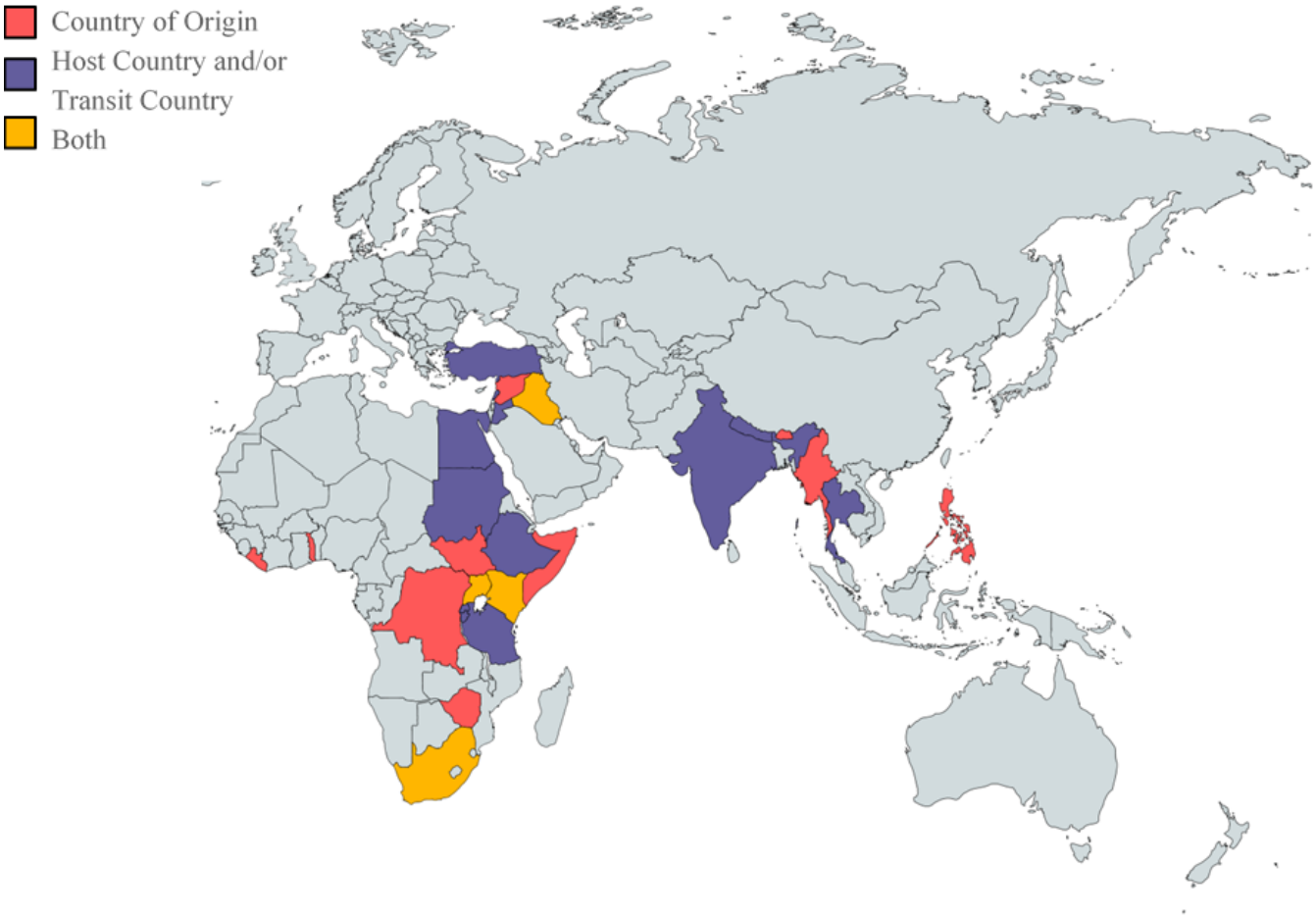


Figure 1: Map Of Home And Host Countries Of Refugees Interviewed For This Project. Host Countries Are Where Refugees Are Granted Asylum And Allowed To Live Temporarily Until They Can Return Home Or Be Resettled. If A Host Country Has Signed On To The Un Refugee Convention Then The Unhcr Can Provide Support For Refugees Within That Country. Host Countries May Also Contribute To Supporting Refugees. Transit Countries Are Where Refugees Transit Through On Their Migration Journey. These Countries Are Usually Bordering The Country Of Origin. Refugees May Stay In The Transit Country Or Continue Moving. Map Provided By Https://Mapchart.Net/World.Html

[21] These background sketches were developed with staff and community members from each of the identified communities.

BHUTAN – LHOTSHAMPA COMMUNITY

Bhutan is a small country in South Asia that borders India and China. In the late 1990s the Bhutanese government implemented "ethnic cleansing" policies targeting the Lhotshampa people - as a result over 100,000 people fled to Nepal and established a refugee camp.[22] The Lhotshampa people originally migrated from Nepal to Bhutan in the 1600s and kept their Nepali language and culture.
Nepal is not a signatory to the United Nations Refugee Convention, therefore when the Bhutanese refugees first arrived they had little support and resources.[23],[24] Although Nepal has still not signed the convention, they collaborate with the UNHCR to support Bhutanese refugees.[25] Save the Children UK established a health clinic in one of the main camps where some of our Bhutanese colleagues in Edmonton used to work as CHWs.

In 2007, the UNHCR began working with resettlement countries to settle the Bhutanese refugees. Canada initially agreed to welcome around 10,000; as of 2017, 6773 Bhutanese refugees have resettled in Canada.[26] There is a community of about 350 people in Edmonton. The United States welcomed the vast majority of the 100,000 Bhutanese refugees who were originally displaced. All Bhutanese refugees were offered resettlement to a third country, however around 10,000 decided to remain in Nepal.[27]

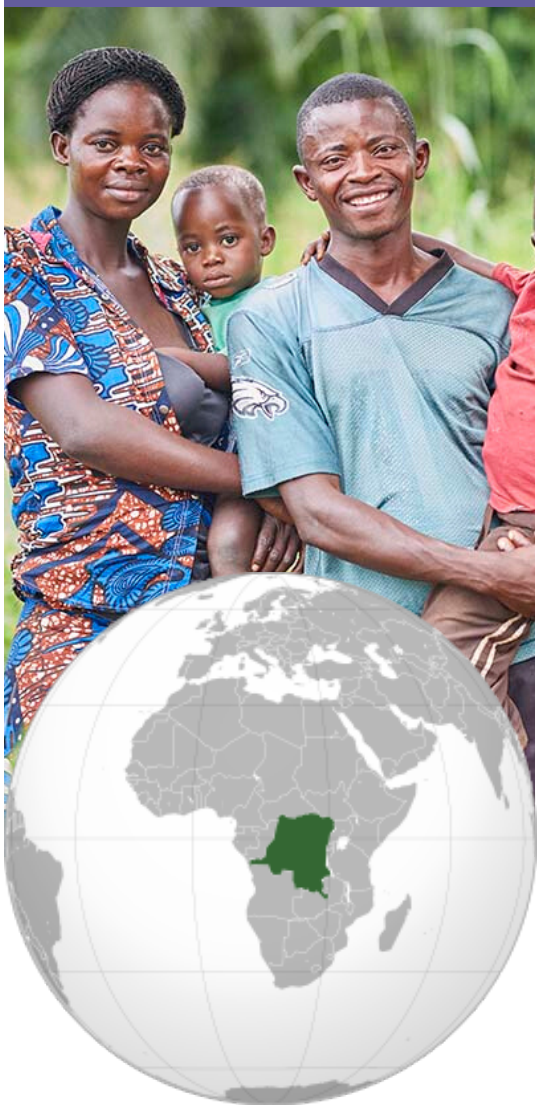
The majority of the Bhutanese community living in Edmonton had limited access to social services pre-migration in Bhutan, and limited access to services in the refugee camps. There are also significant differences in settlement and integration between Bhutanese newcomers who lived in a rural versus urban location in Bhutan prior to displacement - this highlights the fact that pre-migration experiences play a role in settlement and integration post-migration.

[22] Ridderbos, Katinka, Finberg, A., and Finberg, R. (2007, May 16). Last Hope: The Need for Durable Solutions for Bhutanese Refugees in Nepal and India. From Human Rights Watch: https://www.hrw.org/report/2007/05/16/last-hope/need-durable-solutions-bhutanese-refugees-nepal-and-india
[23] UNHCR. (2011). UNHCR Global Appeal 2011 Update: Nepal. UNHCR. From https://www.unhcr.org/uk/4cd96ec19.pdf
[24] Ridderbos, Katinka, Finberg, A., and Finberg, R. (2007, May 16). Last Hope: The Need for Durable Solutions for Bhutanese Refugees in Nepal and India. From Human Rights Watch: https://www.hrw.org/report/2007/05/16/last-hope/need-durable-solutions-bhutanese-refugees-nepal-and-india
[25] Ibid.
[26] Koirala, K. P. (2017, February 06). Where in US, elsewhere Bhutanese refugees from Nepal resettled to. From The Himalayan Times: https://thehimalayantimes.com/nepal/where-in-earth-have-been-bhutanese-refugees-from-nepal-resettled/
[27] Ibid.
Picture from ABC News. (2017). What happens when a country strives for happiness — at any cost?: https://www.abc.net.au/news/2017-06-23/bhutan-strives-for-happiness-but-at-what-cost/8633424

Some of the main concerns among this community include challenges with identity and legal status as they cannot return to Bhutan and many could not stay in Nepal. Furthermore, as there is such a small Bhutanese community in Edmonton there are negative impacts on social integration. This factor, combined with complex health needs and limited access to appropriate healthcare has resulted in many Bhutanese refugees struggling to integrate. Some areas in the United States that resettled larger populations have established Bhutanese cultural organizations and support systems that are not in place in Edmonton. Literacy and low education levels, and concern for the future of their families are the other major factors impacting the Bhutanese community in Edmonton.[28]

[28] Information on this page provided by Govin Timsina, Team Lead at Catholic Social Services, and Shiva Chapagai at Multicultural Health Brokers

DEMOCRATIC REPUBLIC OF THE CONGO (DRC)



The DRC, located in Central Africa, is the second largest country on the continent and the 4th most populous. There are hundreds of ethnic groups in the DRC, and hundreds of different languages.[29] French is the official language, a legacy of the colonial history of the country; however, the DRC also has four national languages: Kituba, Kiswahili, Tshiluba and Lingala.[30] Many Congolese refugees in Canada speak Kinyarwanda and Kiswahili as they are from the Eastern part of the country.

Following a civil war in the 1990s, the DRC experienced decades of ongoing chronic conflict and unrest; now it is one of the poorest countries in the world.[31] Political and economic instability resulted in limited development of infrastructure and social services.[32] The chronic conflict resulted in the displacement of around 4.5 million people within the DRC.[33] There are an additional 536,000 refugees being hosted by the DRC from Burundi, Central African Republic and South Sudan. This displacement is primarily in the eastern part of the country which, coupled with limited access to services and resources, has led to a complex humanitarian emergency. As of August, 2019, there were almost 900,000 refugees from the DRC being hosted in the surrounding African nations, including Uganda, Rwanda, Tanzania and Burundi.[34] The majority of Congolese refugees living in these host countries have been displaced for 20 years or more.

Prior to displacement, many of these people relied on subsistence farming and formal education was limited. The main challenges that refugees from the DRC face in host countries are high rates of infectious diseases, poverty, ongoing violence and unrest, food insecurity, limited social services, limited education, limited employment opportunities, and limited access to healthcare (especially in refugee camps). Although the UNHCR has established services in refugee camps across the region, the high proportion of displaced

[28] Information on this page provided by Govin Timsina, Team Lead at Catholic Social Services, and Shiva Chapagai at Multicultural Health Brokers
[29] Wiese, B. M., Cordell, D. D., Payanzo, N., & Lemarchand, R. (2019, October 04). Democratic Republic of the Congo. From Encyclopaedia Britannica: https://www.britannica.com/place/Democratic-Republic-of-the-Congo/People
[30] CIA. (2019, November 04). AFRICA: CONGO, DEMOCRATIC REPUBLIC OF THE. From The World Factbook: https://www.cia.gov/library/publications/the-world-factbook/geos/cg.html
[31] Ibid
[32] Wiese, B. M., Cordell, D. D., Payanzo, N., & Lemarchand, R. (2019, October 04). Democratic Republic of the Congo. From Encyclopaedia Britannica: https://www.britannica.com/place/Democratic-Republic-of-the-Congo/People
[33] UNHCR. (2019, July). DR Congo Emergency. From UNHCR The UN Refugee Agency: https://www.unhcr.org/dr-congo-emergency.html
[34] UNHCR. (n.d.). Democratic Republic of the Congo. From UNHCR The UN Refugee Agency: https://www.unhcr.org/democratic-republic-of-the-congo.html
Photo from: Catholic Relief Services. (2019). Samuel Phelps. STRUGGLING CONGOLESE EASE STRESS THROUGH FAITHFUL HOUSE: https://www.crs.org/stories/struggling-congolese-ease-stress-through-faithful-house

people, combined with the limited resources of host countries, results in limited services for refugees. Such challenges are reflected in many ways when arriving to Canada. For example, many refugees from the DRC arrive without health records, the prevalence of infectious diseases is high, and many suffer from disabilities - primarily due to lack of proper healthcare during pregnancy. MCHB has noted that around 30% of their Congolese clients have a disability. Additionally, many Congolese refugees have never seen a physician or a nurse.

Some of the primary challenges that Congolese refugees in Edmonton experience are due to challenges learning English. The low level of education pre-migration makes it harder for some people to learn a new language which, in turn, impacts employment and further education. Furthermore, refugees that lived in refugee camps for decades may struggle with many aspects of daily life in Canada. In the camp, the UNHCR organized all food, education and service delivery. Camp inhabitants had no control over many aspects of their life, so when they resettle in Canada, managing these aspects can be a challenge. This is also a challenge among school-aged children as they are not used to the education system and struggle to adjust. Mental health is a major concern in the community as the violent conflict in the region led to high rates of sexual abuse, PTSD and domestic violence. Most, if not all, Congolese refugees have experienced or witnessed violence in their pre-migration journey. Although Congolese refugees have experienced a state of chronic conflict for such a long time that they became "familiar to chaos and struggle", they -in turn- developed strong resilience skills. Regardless, mental health issues within this community are a priority to address and challenging to do in a community which still - to a large degree - stigmatizes mental health.[35]

[35] Information on this page provided by Charles Byusa, Settlement Counsellor at CSS

ERITREA AND ETHIOPIA

Eritrea and Ethiopia are countries in the horn of Africa which share borders with each other. Eritrea and Ethiopia entered into conflict beginning in May 1998 with a dispute over the territory of a border town.[36]The conflict has lasted more than 20 years and cost both countries hundreds of millions of dollars. The conflict has claimed approximately 70,000 lives from both sides, and separated many families who are unable to cross the border, despite being geographically nearby. A peace deal was signed in December 2000, with the disputed territory being awarded to Eritrea, but the result not being accepted by Ethiopia. Eritrea refuses to participate in further negotiations until the treaty is adhered to, and Ethiopia refuses to follow the treaty without further negotiations.[37]

Eritrea maintains a policy of compulsory national service that is designed to last 18 months, but can go on indefinitely. As a result, many young people who do not wish to serve are forced to

[36] Araia, Tesfalem. (2018, May 06). Remembering Eritrea-Ethiopia border war: Africa's unfinished conflict. From BBC News: https://www.bbc.com/news/world-africa-44004212
[37] Ibid.
Photo from: USAID. (2020). Emnet Dereje, Save the Children Ethiopia. U.S. assistance improves health, food security, and education in Ethiopia.: https://www.usaid.gov/ethiopia/our-work

flee; most often to refugee camps in Ethiopia or Sudan, or trying to cross the ocean to Europe. Eritreans make up one of the largest groups attempting to cross into Europe over the ocean, despite the risks and danger.[38]

Besides the cost of the war in terms of logistics, ammunitions, health services, and the substantial economic downturn, there is an enormous displacement and expulsion of thousands of people on both sides. Overall, more than 316,000 people were displaced by the conflict and many of these lost their livelihoods in the process.

Ethiopia also hosts 26 refugee camps, with limited services and opportunities that rely heavily on humanitarian funding. The majority of the refugees are coming from Eritrea, Somalia and South Sudan.[39] UNHCR has identified that many children and women are at risk in the camps for physical and sexual violence as well as early marriage.

Canada has resettled some Eritrean and Ethiopian refugees. According to the CSS database, 1519 Eritrean refugees and 763 Ethiopian refugees were received in Edmonton between 2016 and 2019. These numbers include all categories of refugees; however the majority are privately sponsored. Private sponsorship within the Eritrean community in Edmonton is quite high. Refugees from Eritrea and Ethiopia often arrive in Canada with low levels of health literacy and little experience in interacting with health care professionals. They also often distrust the health care system for fear of what information is transmitted to the government, and the concern that any health conditions would negatively impact their permanent residency status in Canada.[40]

[38] Ibid
[39] UNHCR. (2018, March). Ethiopia. From: UNHCR the UN Refugee Agency: https://www.unhcr.org/ethiopia.html
[40] Information on this page provided by Yesuf Abdela, Special Projects Coordinator at CSS

MYANMAR – KAREN COMMUNITY

Myanmar, formerly called Burma, is a country located in the western portion of Southeast Asia. Myanmar is a very ethnically and linguistically diverse country; the Burmans form the largest ethnic group, and account for more than half of the population. Other major ethnic groups are the Karen, Shan and Han Chinese. [41] The official language is Burmese. However, many of the Karen peoples speak a language called Karen or Kayah. Myanmar has a colonial history, during which English became the official language, but Burmese continued to be used in most settings. The primary religion is Buddhism and other religions, including Islam, Christianity and Hinduism are also present.[42]

[41] Steinberg, David I., and Aung-Thwin, Michael Arthur. (2019, November 01). Myanmar. From Encyclopædia Britannica: https://www.britannica.com/place/Myanmar/
[42] Ibid.
Photo from: Earth Rights International: https://earthrights.org/earthrights-school-visits-indigenous-climate-justice-land-rights-activist-community/

The people in Myanmar primarily live in villages, with the exception of a few large cities. In 2015, 66% of the population in Myanmar lived in rural areas compared to 34% who lived in urban areas.[43] The Karen people live primarily in the plains areas.[44]

The region has been unstable since 1948, when the country gained independence from British India. Since then, the country has experienced several civil wars and military rule. The cultural minority of Karen people have been divided between pro-Burmese factions and those who wished to create an independent state. A cease-fire was drafted in the 1990s, but it broke down shortly after. In 1995, an estimated 20,000 Karen fled to Thailand, and some reports state that over 2,500 villages were destroyed by the Burmese military regime.[45]

With the forced displacement, and the presence of the Burmese military, many refugees share claims of forced labour, confiscated lands and property, torture, sexual violence and other violations of human rights. This has also resulted in poor health, malnutrition, and lack of access to education. Furthermore, due to hydro-electric power and mining development in the Karenni state, there are also forced dislocations due to environmental factors as a result of the land development, flooding and landmine placement.[46] Between 2006 and 2008, the Canadian government resettled around 4000 Karen refugees and they continue to arrive up until 2019.[47] The arrival of Karen refugees in Edmonton presented more complex cases for the sector to support, and as a result new programs and services were developed.

Most Karen refugees had limited exposure to healthcare before arriving in Canada because of a lack of services pre-displacement in Myanmar and also in the Thai refugee camps. Many cultural health brokers and settlement workers noted that there is a high percentage of seniors with complex needs and children with disabilities in the Karen community. The Karen community in Edmonton is also quite small so there are few Karen interpreters available to support people. This community faces a unique language barrier because Karen is not a commonly spoken language.[48]

[43] Ibid.
[44] Ibid.
[45] Minority Rights Group International. (2019). Karenni. From World Directory of Minorities and Indigenous Peoples: https://minorityrights.org/minorities/karenni/
[46] Ibid.
[47] Government of Canada. (2008, June 19). Canada to welcome 1,300 more Karen refugees. From Government of Canada: https://www.canada.ca/en/news/archive/2008/06/canada-welcome-1-300-more-karen-refugees.html
[48] Information on this page provided by Say Say Lah, health broker at MCHB

SOMALIA

Somalia is a country in the horn of Africa, on the east coast of the continent. The Somali people make up the majority of Somalia's population. The primary language spoken in Somalia is Somali, with Arabic as the second official language.[49] The majority of the Somali people are Sunni Muslims.[50]

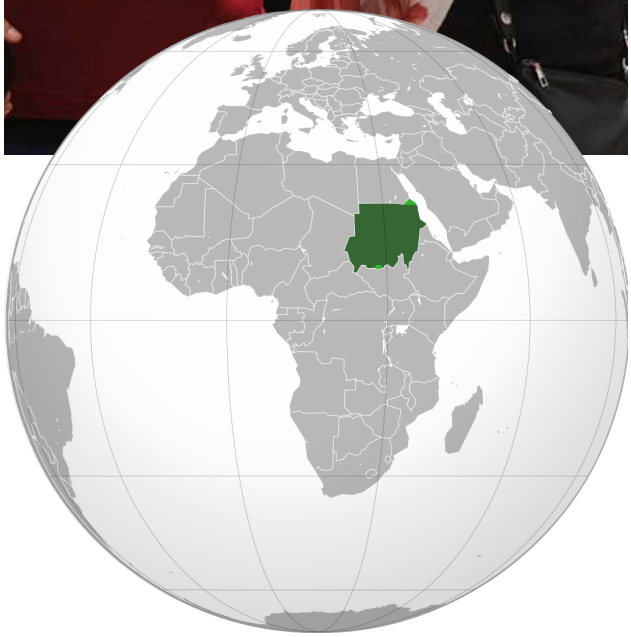
Somalia has been in civil war for decades. It grew out of resistance to the military junta led by Mohamed Siad Barre during the 1980s. By 1988/90, the Somali Armed Forces began engaging various clan-based armed rebel groups. The clan-based armed opposition groups eventually managed to overthrow the Barre government in 1991 but various armed factions followed competing for influence in the power, particularly in the south.[51]

Decades of civil unrest and the lack of a stable centralized government has resulted in a severe humanitarian emergency in Somalia. The country faces drought, unsustainable food prices, ongoing conflict, and chronic under-funding.[52] The WHO has reported that health indicators in Somalia are among the lowest in the world. This is related to a high proportion of the population living in poor conditions including; poor access to water, sanitation and hygiene (WASH), low immunization coverage rates, food insecurity and limited access to health services.[53]

People fled Somalia and travelled through Kenya, Ethiopia, Egypt, and South Africa. Canada has welcomed many Somalian refugees and hosts one of the largest Somali populations. According to the CSS database, 949 Somali refugees were received in Edmonton between 2016 and 2019 which represents 12% of the total clients that CSS received during that time. Many Somali refugees arrive in Canada with complex health needs, serious mental health concerns and exposure to trauma. Common childhood diseases among the Somali population in Edmonton are malaria, TB, meningitis and malnutrition.

[49] Lewis, Ioan M., and Janzen, Jörg H.A. (2019, November 21). Somalia. From Encyclopædia Britannica: https://www.britannica.com/place/Somalia/Civil-war
[50] Ibid.
[51] Ibid.
[52] World Health Organization. (2015). Somalia. From World Health Organization Humanitarian Response Plans: https://www.who.int/hac/donorinfo/somalia.pdf
[53] Ibid.
Photo from: UNHCR Australia. (2015). SOMALIA: A Long Road to Rebuilding Maternal Health: http://mothersmonument.org/2015/03/10/somalia-maternal-health/

SUDAN



Sudan is a country located in northeastern Africa. Islam is the predominant religion and Arabic is the primary language in Sudan. However, Sudan is very diverse in terms of languages, religions, cultures and ethnicities, including Christianity and a variety of African languages and religions. Prior to 2005, Arabic was the nation's sole official language. In the 2005 constitution, Sudan's official languages became Arabic and English.

The country has witnessed a long civil war between the North and the South in addition to the conflict of Darfur. The conflict resulted in the south declaring independence. The south's secession took place on July 9, 2011.[54]
The lack of presidential and government transparency, the ongoing conflict, the worsening economic conditions, including rising inflation and a decline in the value of the Sudanese pound, cuts in fuel and other subsidies, triggered anti-government protests and led many Sudanese to flee from their homes. By the end of 2014 about 650,000 people had sought refuge in Ethiopia, Chad, and Egypt while another 1,873,000 were internally displaced.[55] On April 11, 2019, the president of North Sudan - Al Bashir - was overthrown in a military coup and placed under arrest. Protesters, while happy that Bashir had been removed from office, rejected any plans that included a military-led transition and continued their sit-in, demanding a civilian transitional government. Protesters were finally successful in bringing a new civil government that has a better representation of different groups including marginalized ones and women. In fact, many ministers in the new government are women including the Minister of Foreign

[54] Al-Shahi, Ahmed S., Sabr, Mohy el Din, Collins, Robert O., Spaylding, Jay L., and Sikainga, Ahmad Alawad. (2019, September 13). Sudan. From: Encyclopædia Britannica: https://www.britannica.com/place/Sudan
[55] Ibid.
Photo from: Independent. (2018). Women fueled Sudan's revolution, but then they were pushed aside: https://www.independent.co.uk/news/world/africa/sudan-revolution-women-uprising-democratic-transition-army-bashir-a9038786.html

Affairs, Minister of Social Development and Labour, Minister of Youth and Sports, and Minister of Higher Education.[56]

The effects of the long war and conflict on health, nutrition and population have been significant. Certain problems, in particular malnutrition and tropical diseases, are of a magnitude often reaching crisis proportions.[57] The Canadian government committed to resettle 3,500 refugees from Sudan in the fiscal year ending March, 2017. In Edmonton, 178 refugees from Sudan were received between 2016 and 2019 according to the CSS database. Most refugees come through neighbouring countries of Sudan including Ethiopia, Egypt, and Chad.[58]

[56] Ibid
[57] WorldHealth Organization. (2006). Health System Profile: Sudan. Regional Health Systems Observatory.
[58] Information on this page provided by Radia Fadel at CSS

SYRIA

Syria is a diverse country in terms of culture, ethnicities and spoken languages. Around 46% of the population lives in rural areas while the rest is in urban areas. Services vary between rural and urban. Prior to the civil war which began in 2011, the public healthcare system was well-established in urban areas. Healthcare in rural areas was limited due to resource constraints and minimal health clinics in rural areas. The same case applies to education and many other sectors. The disparities continue to be a huge problem during the refugee crisis. People living in the rural areas are the most impacted by the war.

The Syrian civil war began with peaceful protests in southern cities which were met with violent crackdowns by Syrian security forces. As a result of the government's repression, armed opposition groups started organizing and many Syrian civilians started fleeing their homes.[59] Neighbouring countries (Lebanon, Turkey, Jordan, and Iraq) became destinations for some Syrian refugees while the majority of displaced people remained within the Syrian borders. Fighting has escalated since 2011 with the involvement of terrorist groups such as ISIS and foreign interests such as Russia, Turkey and the United States.

The total number of registered Syrian refugees according to UNHCR is 5,648,395 which is the largest number of refugees since WWII.[60] In 2015, the Canadian government committed to welcoming over 25,000 Syrian refugees in a short period of time. This Syrian initiative saw over 40,000 resettled across Canada by January 2017. Syrian refugees are still arriving and resettling in Canada, in fewer numbers.

[59] Huber, Chris, Reid, Kathryn, and Koenig, Denise C. (2019, October 18). Syrian refugee crisis: Facts, FAQs, and how to help. From World Vision: https://www.worldvision.org/refugees-news-stories/syrian-refugee-crisis-facts
[60] UNHCR. (2019, December 01). Syria Regional Refugee Response. From: Operational Portal: https://data2.unhcr.org/en/situations/syria#_ga=2.31304191.1300211185.1573235488-982553416.1512530260
Photo from: World Vision. (2016). Jon Warren. Syrian refugee children: A story in 23 photos: https://www.worldvision.org/refugees-news-stories/photos-syrian-refugee-children.

Almost all Syrian refugees who resettled in Canada came through a country neighbouring Syria which means that healthcare in these transitioning countries is a large factor of their health status in Canada. The high number of Syrian refugees in countries such as Turkey, Lebanon and Jordan have stretched local resources. Refugees in these host countries face limited access to public healthcare services due to discrimination and limited resources. Syrian refugees in other neighbouring countries experience other challenges of displacement including overcrowding, poor living conditions and sanitation issues.[61]

In Canada, many Syrian refugees arrive without their health records and face multiple challenges navigating the Canadian health system. In addition to this, Syrian refugees have many other challenges related to mental health (especially psychosomatic issues), behavior and learning challenges with their children. As this was an acute crisis, many refugees have limited survival and resilience skills in comparison to countries in chronic crisis where refugee populations are well
established.[62]

[61] Huber, Chris, Reid, Kathryn, and Koenig, Denise C. (2019, October 18). Syrian refugee crisis: Facts, FAQs, and how to help. From World Vision: https://www.worldvision.org/refugees-news-stories/syrian-refugee-crisis-facts
[62] Information on this page provided by Joud Nour Eddin at the Refugee Health Coalition

IRAQ – KURDISH AND ARABIC COMMUNITIES

Iraq is one of the most religiously and ethnically diverse societies in the Middle East. Although Iraq's communities generally coexisted peacefully, fault lines between communities deepened in the 20th century as a succession of authoritarian regimes ruled by exploiting tribal, sectarian, and ethnic divisions. Roughly two-thirds of Iraq's people are Arabs, about one-fourth are Kurds (who mostly live in Iraqi Kurdistan in the northeast), and the remainder consists of small minority groups. Although the proportion of urban dwellers has risen over time, about one-third of Iraqis still live in rural areas. More than two-thirds of Iraq's population in urban dwellings, and almost two-fifths of those are concentrated in the five largest cities.[63]

Prior to the United States invasion of Iraq, the healthcare system was well established and provided free services. Since the overthrow of the government in 2003, the healthcare system has suffered and there are little resources currently available. The system is slowly recovering and now, medical care, though no longer free, is still affordable for most citizens. However, shortages remain, especially of medicine, potable water, and trained medical staff because almost half of all physicians in Iraq left the country after 2003, and most have not returned.[64] Iraq's political, social, and economic instability make it one of the world's most fragile contexts, creating an environment vulnerable to regional unease. The country has a large population of displaced people — 1.6 million — including 250,000 Syrian refugees. About 6.7 million people in Iraq — half of them children — need humanitarian aid.[65]

[63] Chambers, Richard L., Woods, John E., Khadduri, Majid, Kennedy, Hugh, and Blake, Gerald Henry. (2019, December 2). Iraq. From Encyclopaedia Britannica: https://www.britannica.com/place/Iraq

[64] Ibid.

[65] World Vision. (2019, November 2019). Iraq conflict: Facts, FAQs, and how to help. From World Vision: https://www.worldvision.org/refugees-news-stories/iraq-conflict-facts

Photo from: World Vision. (2016). Steve Jeter. Iraq conflict: Facts, FAQs, and how to help: https://www.worldvision.org/refugees-news-stories/iraq-conflict-facts.

Iraq has suffered from decades of conflict with other nations and internal conflict among different ethnic and religious groups. However, ISIL or ISIS the militant group known for its brutality in Syria, moved swiftly to take and hold territory in western and northern Iraq, starting in June 2014. At the peak of hostilities, 6 million people were displaced within the country. About half of them settled in camps for internally displaced people, within host communities, or in mosques and churches in the Kurdish Region of Iraq. Most are now returning to their home communities as the Iraqi government gains control of more territory. [66].

Canada resettled many Iraqi refugees, many of which are Kurdish. There have been 19,427 Iraqis who arrived in Canada between 2009 and 2014. More recently, 247 (3.16% of CSS clients) have been received by CSS in Edmonton from 2016 to 2019.[67],[68]

[66] Ibid.
[67] Issues Surrounding Iraqi Refugees in Canada (n.d.) From A Story Map: https://www.arcgis.com/apps/MapJournal/index.html appid=913b84dc2b1f410d8758b0b4e525cefc
[68] Information on this page provided by Izdhar Gaib at Catholic Social Services.

What did we hear from the community?

Through the summer of 2019, we met with different communities that came to Canada as refugees, to hear their stories, learn what the main challenges are and how we can work together to create solutions. This section provides summaries of those conversations.

Concepts of Health and Wellbeing

We started all conversations with a broad question about health and wellbeing so that we had a better understanding of what this means to each participant. The community leaders who facilitated the conversations spent some time explaining wellbeing in their respective languages. The idea of wellbeing does not necessarily translate directly and often requires complex explanations.

Holistic Concept of Health

Health was described in a holistic sense by all community participants and was closely related to wellbeing. Health was described as being physically healthy and also mentally and emotionally healthy. A strong connection between physical, mental and emotional health was evident. Participants discussed being healthy as having family and loved ones close by, being safe and secure, having access to good food and healthcare. Participants commented that they wanted a physician who would take care of their whole body, including their emotional, spiritual and mental health. Participants who were HIV positive noted that access to medication in Canada has a significant impact on their quality of life. This was due to increased quality of medication, thus reduced side-effects, and easier access to medications. Most conversations included discussion about mental wellbeing and the factors that impact mental health in communities. From these discussions it was also evident that most community participants viewed mental wellbeing from a holistic perspective. They described their wellness as encompassing the physical, emotional, mental, spiritual, relational and material aspects of their lives.

As an example, a group of seniors in the Karen community emphasized farming, gardening, fresh air, and being in the forest as key parts of their health. Health and wellbeing were noted by many people as necessary for a good life. Some other participants also discussed the importance of exercise and being outside.

There was also discussion among many communities about the ability and energy to succeed, to take care of family and others and to achieve goals and aspirations. This included employment and financial stability, which was linked to a sense of purpose. Community support systems were also identified as key for health as they allow people to be connected, share knowledge, support each other and problem solve as communities. There was some discussion of self-care but participants primarily focused on being able to care for family and friends, that is, there was mostly a focus on other-care, which is culturally congruent for the groups in the project.

Negative Impacts on Health

The primary concern that impacts health and wellbeing was described as poverty which was linked to a high cost of living, challenges with underemployment and unemployment, and the need to send money back home to take care of family and loved ones left behind. Participants spoke at length about family separation and how leaving family behind impacted their health and mental health. Some participants spoke of a sense of guilt that they are living in Canada while their family still struggles back home. Many of the youth we spoke with felt responsible for providing for their families. The younger generation generally learn English faster than their parents, which combined with stress about their futures, leads many youth to find employment to support their families and not focus on finishing high school.

Some participants spoke of their fear or mistrust in systems. There were conversations about the fear of sharing mental health concerns with family physicians leading to Children's Services taking their children away. There were also conversations about fear of sharing any health information with the healthcare system leading to the government revoking permanent residency or prevent people from becoming citizens. Some refugees came to Canada when there were health-based restrictions on which refugees were admitted so this fear has continued for years.

A few participants spoke about the trauma from the war or conflict in their home country. We did not specifically ask about this to avoid triggers or re-traumatization. Most conversation about mental health and wellbeing were related to the stress of settling in Canada and the stress of leaving loved ones behind.
The topic of trauma from war or conflict in home countries came up. For example, a number of Syrian women reported the traumatic loss of their husbands during the conflict. Likewise, women from Eritrea and Ethiopia shared they had been exposed to traumatic events, and

Somalian women spoke of the sense of safety they now felt in Canada. Because addressing trauma was not within the skill set of the facilitators, and in order to maintain the safety of participants, we did not explore these topics in detail. Nevertheless, it was clear that the majority of the conversations about the trauma of war and associated mental health impacts related mainly to the stress of leaving loved ones behind and the stressors associated with settling in Canada. It is important to note here that the mental health impacts of war and conflict are influenced by the contexts of migration and resettlement, and that daily stressors (e.g. unemployment, language barriers, isolation) increase vulnerability to stress and decrease coping in refugees (Miller & Rassmussen, 2017)[69]. Also, given that personal violation and losses are associated with higher risk for trauma-related disorders (Kirmayer et al., 2011)[70], ongoing stressors that are out of people's control or that involve repeated exposure to violence (e.g. intimate partner violence, racism) daily stressors, further

[69] Miller, K. E., & Rasmussen, A. (2017). The mental health of civilians displaced by armed conflict: An ecological model of refugee distress. Epidemiology and Psychiatric Sciences, 26(2), 129-138. doi: 10.1017/S2045796016000172
[70] 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), E959E967. doi: http://dx.doi.org/10.1503/cmaj.090292

exacerbate the effects of pre-migration trauma on refugees' mental health. As an example of this, service providers who support LGBTQ+ newcomers in our study emphasized the importance of understanding the mental health impacts of violent systems both in countries of origin and in Canada when serving this population.

What did we learn from this?

The discussion on health and wellbeing made it clear that health is not just medical care or access to health services. Most participants spoke about something non-medical when describing what impacts their health. The stress of settlement is acute among all the communities. Support services for refugees, both provided by government and non-profit organizations, are not addressing the complex and far reaching needs of communities. Poverty, linked to employment, housing, language and cost of living, needs to be further addressed through more holistic care that focuses on wellbeing. In general, we learned that refugees do not experience their settlement needs in isolation - for example, language, employment and housing are linked and services need to be able to address all three.
Of note, the community members we spoke with have a desire to succeed in Canadian society. Many participants spoke about the new opportunities they and their families have in Canada.

Pre-Migration Experiences with Health and Healthcare

Pre-migration experiences are known to have a significant impact on settlement in Canada. We asked community members about their experiences before arriving in Canada so we could get a better sense of their journeys and experiences. We did not ask about the reasons why they left their home country, instead we focused on how long ago they left, their migration path (i.e. which countries they traveled through to come to Canada) and what their experiences were accessing healthcare along the journey.

Healthcare Systems in Home and Host Countries

The Syrian community members we spoke with described a very different experience compared to the other communities. Before the war, the healthcare system in Syria was well established, easy to navigate and provided quality healthcare. The Syrian community members we spoke with commented on how good their health was in Syria due, in part, to easy access to healthcare. Accessing care in the host countries was more challenging. Most host countries had expensive or no healthcare available for Syrian refugees. Participants spoke of many challenges accessing care while living in Jordan, Lebanon and Iraq. This led many to avoid accessing healthcare at all, which resulted in several years with no healthcare which especially impacted children and pregnant women.

Refugees from other countries had very different experiences. Most other countries did not have a well-established healthcare system and access to care in the home country was limited. This was true among refugees from Myanmar, Somalia, the DRC and Eritrea. Participants commented that the healthcare systems in some of the countries in Africa, such as Kenya and Uganda, were 'for the rich'. People without financial resources received poor quality healthcare or no care at all. Furthermore, refugees who are LGBTQ may have faced violence and discrimination in the healthcare system. In some countries where same-sex relationships are still illegal, healthcare can be used to target LGBTQ people. This pre-migration trauma and discrimination has a significant impact on healthcare seeking in Canada.

Healthcare in host countries was partly dependent on aid from UNHCR and from the systems in the host country. For example, refugees living in Egypt or South Africa can access the public healthcare system but they have to pay for it. In the Bhutanese refugee camps in Nepal, international aid organizations established community health centers and trained CHWs. In countries such as Lebanon and Jordan where Syrian refugees fled to, the UN would pay for healthcare services within the local health systems. The UN also set up free clinics in those areas; however long waiting times were a major barrier to care.

Pre-Arrival Health and Well-Being

Through our conversations there was a mix of refugees who said that their health was better before they came to Canada, and others who said their health was worse. Many of the Syrians commented that they were healthy in Syria before the war but not healthy along their migration journey. Other groups of refugees, such as the Congolese, have a culture of only accessing healthcare when there is an emergency. The concept of preventative care is not common. However, the Congolese families commented that their health was poor in their country of origin and during their migration journey. Healthcare in the Congolese refugee camps was very limited.

Several different communities spoke of the natural or traditional healing practices in their cultures. The Bhutanese families primarily relied on traditional healing in Bhutan as the healthcare services were often located in urban settings. They continued this custom in the

refugee camp in Nepal as healthcare services were limited. Interestingly, they commented that once healthcare was established in the refugee camp, the medical staff and traditional healers collaborated in order to provide better care to more of the Bhutanese people. The Karen people also relied on traditional healing practices, both in Myanmar and in the refugee camp in Thailand. The Karen people mentioned that their health was good before they were displaced but access to care in the refugee camp was limited.

What did we learn from this?

It is essential to recognize the pre-migration experiences of refugees in order to understand their situation when they arrive in Canada. People from a culture not accustomed to preventative care require different supports than people from countries where healthcare was easy to access. Furthermore, people from cultures that use traditional healing practices may turn to those methods before seeking care in a Western medical facility. One idea that was exemplified in the Bhutanese refugee camp was traditional healers and medical staff working together, which helped to ensure that people have access to appropriate and respectful care. The common lack of proper healthcare pre-migration also indicates that people need comprehensive health assessments upon arrival. All newcomers to Canada have to complete the Immigrant Medical Exam,[71] however the results from this exam are usually not shared with the refugee and they are not shared with service providers where the refugee is placed for resettlement.

Post-Migration Experiences with Health and the Health-care System

Experiences with the Canadian Healthcare System

Although there are many differences between refugee communities that are settling in Edmonton, some experiences are common. During our conversations we heard positive stories about the Canadian healthcare system. A main positive attribute of the healthcare system that was discussed is that many services are free. As was detailed above, most refugees came from countries with limited access to healthcare and a concept of 'healthcare is for the rich'. Therefore, many refugees expressed gratitude that they do not have to pay out of pocket for most healthcare services in Canada. (Note: There was some discussion about financial challenges relating to healthcare, however this was primarily related to limited dental insurance).

Many participants also spoke of the quality of healthcare in Canada, there were positive perceptions about the high quality of care. Some refugees also had positive experiences with certain healthcare providers. They described these experiences as positive because of the patience and empathy of the providers. Participants also discussed positive experiences at certain healthcare facilities, such as the University of Alberta Hospital. These positive experiences were due to healthcare providers addressing language barriers and working in teams with social workers and other support systems. The conversation with HIV positive refugees also indicated positive experiences. The main concern was around physicians not treating the whole person and a lack of focus on wellbeing. Several participants shared stories of physicians prescribing medication to treat symptoms rather

[71] Government of Canada. (2019, March 12). Medical Exams. From Government of Canada: https://www.canada.ca/en/immigration-refugees citizenship/services/application/medical-police/medical-exams.html

than addressing the underlying concern. Interestingly, some of the participants who had been in Canada for over 10 years noted a significant improvement in how healthcare providers treat people with HIV. Despite people describing positive experiences with the healthcare system, there were many stories of less than ideal experiences within the system. We heard very few stories of healthcare providers using the Language Line interpretive telephone service offered by AHS or facilitating access to interpreters. The majority of people we spoke with were made responsible for finding solutions to the language barriers they encountered. This included calling family and friends who spoke English or connecting with a staff in a community organization. Most people also commented that physicians did not spend enough time with them to hear about their concerns and fully explain what might be going on with their health. Language barriers further complicate this time restriction as interpreted appointments can take much longer.

Another common theme were the many stories of unsafe or inappropriate healthcare especially in maternal health. Many women from the Eritrean and Ethiopian communities shared stories of their physicians pushing them to have abortions. The women's understanding was that their healthcare provider thought they already had too many children. One woman shared a story of an experience when she was pregnant and her physician telling her that her child had a birth defect. She said the doctor showed her pictures of children with birth defects and told her that if she did not have an abortion then her child would look like that. Up until this point in their appointment, the physician had not used an interpreter. However, once the woman started crying the physician decided to use a phone interpreter. In the end, the woman gave birth to a healthy baby. Stories like these were common among the Eritrean and Ethiopian community and have led to an erosion of trust in the healthcare system.

There were also stories among Somali women relating to a fear and mistrust in the healthcare system. Women resisted receiving necessary medical care because they feared if something happened to them, no one would be able to take care of their children. Other women were resistant to sharing their health and mental health concerns for fear that their children would be taken away from them. There were
also comments by many participants about the perception that physicians are focused on making a profit and mistrust in the care they receive based on that idea.

Health and Wellbeing in Canada

Many refugees we spoke with commented that they felt their health was worse in Canada, this was mainly linked to stress and poverty. Refugees acknowledged the challenges with settling in Canada because of loss of family, loss of community, language barriers, poverty, under- or unemployment and challenges navigating the Canadians systems (health, education, housing etc.). Although we did not ask any questions specifically about mental health, many people mentioned concerns about mental health in their community. The conversation with Eritrean and Ethiopian women started with an elder commenting on the

significant mental health struggles their community is facing. She spoke of a high number of suicides the community has experienced in the past six months and how mental health is closely linked to extreme poverty as many men are working 2-3 jobs, sleeping little, sending money to family back home which leads to family conflict.

Although most of the refugees we spoke with are experiencing significant stress and challenges while settling in Canada, the majority also expressed their relief at the safety and security of being in Canada. Most participants were grateful to have been able to move their families to a safe place and for the opportunity to start a new life.

What did we hear from service providers?

Once we began hearing stories from community members, it became clear that we also needed to hear from front-line service providers, mental health providers, healthcare providers and private sponsors (referred to in this section as 'service providers'). The service providers have supported hundreds of refugees from different communities for years; these different perspectives helped us gain a more comprehensive picture of health and healthcare in Edmonton. The service providers offered further insights into the stories we had heard from refugees. These conversations also highlighted which gaps are pressure points in the system that impact many people.

Experience Working with Refugees

We started our conversations with service providers by asking them how they first got involved working with refugees and if they had any formal training in the area. Many service providers in community organizations came to Canada as refugees or immigrants so they had personal experience settling and integrating. Service providers with lived experience spoke of the desire to give back and how their shared experiences allow them to better support newly arrived refugees. This characteristic is common in newcomer-serving organizations as many of the community leaders across different agencies also immigrated to Canada and are now in roles to help the immigrant and specifically, refugee population. We also heard from service providers who were born in Canada. In general, their motivation to work with refugees came from the same desire to give back and support a marginalized population.

Many of these providers had sought out training and education on their own. However, there was consensus that Edmonton has few formal education opportunities to learn how to work with refugees. Furthermore, many service providers commented that this type of work is not something you can learn from a book or by searching the internet. For example, one physician commented, "*it is not something you read in textbooks and search the internet for*". Service providers expressed the need to be integrated in the system and learn through experience. One important characteristic of service providers who provide care to refugees is the ability to be humble. Humility allowed these providers to recognize the limits of their knowledge and learn from refugees and refugee communities.

Strengths in the Current System

Healthcare providers were able to identify some key strengths in the system, the most important of which is the resiliency of the refugees. One healthcare provider discussed how "the biggest strength is that they are resilient...these are people that continue to seek out help, participate in care, and are not dissuaded by the challenges." There were also some positive experiences with the Language Line or other forms of interpretation. Finally, there were positive comments about the insurance coverage through the IFHP. However, most conversations about the strengths led to constructive feedback about what changes are needed to improve health and social care for refugees.

Challenges in the Current System

Language barriers were consistently highlighted as a significant challenge. Participants who work in the community and provide support to refugees had common experiences of being asked by healthcare professionals to interpret in medical appointments. This occurred regardless of the Language Line being available in AHS facilities. These participants also noted that some AHS sites are more likely to find an appropriate interpreter compared to others. For example, there were many positive comments about the Stollery Children's Hospital and the ways they worked with families. At the Stollery Children's Hospital in-person interpreters are provided more frequently. This is an indication of the Stollery's strong commitment to supporting families in their unique healthcare journeys.

Service providers also highlighted that system navigation is a major challenge, even for people who have been in Canada for years. One front-line worker told us a story of a refugee who arrived three years ago and has since had two children in Edmonton. Even with that time and experience giving birth, when she recently was about to deliver her third child she insisted that a health broker accompany her as she was still uncomfortable navigating the system. These challenges are not just related to language but are also linked to culture and generally not understanding how things should work in healthcare.

System navigation is an even greater challenge in the first year after arrival and participants frequently commented that there are not enough supports in place, either within the community or within the healthcare system during this initial settlement period. All the private sponsors we spoke with emphasized this as one of their greatest challenges in supporting refugee families. The sponsors had lived in Edmonton for decades and still struggled to help refugees access healthcare services. For example, in one conversation a sponsor commented that "being able to locate services in one place would be so helpful", instead they spent a significant amount of time "travel[ling] all over the city to reach different services". Another example of challenges of system navigation and culturally appropriate care is the challenge many women experienced with accessing birth control. We heard many stories from front-line staff and physicians that healthcare providers need to broach the topic of birth control carefully and create opportunities for women to ask for birth control without their family knowing. Other service providers are concerned that healthcare providers who are unaware of this dynamic may not be aware of how to have this conversation.

Another challenge identified by service providers and linked to system navigation is the fact that there are not enough advocates within the system. Participants commented that there needs to be more healthcare providers and social workers within the formal healthcare system who can advocate for patients. Front-line staff expressed frustration that they spent so much time arguing with people within the system rather than have those people help advocate for clients. There were some stories of helpful social workers, however these were few. Another component of this is the challenge with front-line workers being able to work in collaboration with the healthcare system. Settlement practitioners, mental health counsellors and health brokers all expressed frustration at the barriers they faced when trying to connect with healthcare providers to provide better care for their clients. Furthermore, once the clients receive healthcare, community agencies are rarely provided with information on how to continue to support them. This often leads to gaps in care and support which is detrimental to many patients and their families.

Another discussion among service providers was about racism and discrimination in the healthcare system. Many service providers from a variety of organizations agreed that they regularly see their clients being discriminated against by a healthcare professional. In our conversations with community there was only one comment about this experience from a conversation with Arabic-speaking men and youth. To explore this topic further we brought it back to many of the front-line staff to hear their thoughts as to why community members did not discuss this challenge. Front-line staff commented that many refugees are accustomed to systems of oppression either in their home country or along their migration journey. They are accustomed to being treated poorly and, therefore are not likely to speak out against it. Furthermore, there is a complicated power dynamic between physicians and patients which exists in the healthcare systems. Front-line staff suggested that many newcomers may just expect to be treated this way and to have no control in the relationship with their care provider.

Service providers also made it clear that the area of refugee health is a unique field, one physician commented that “refugee health needs to be treated as a specialty by itself”. The general consensus amongst service providers was that Edmonton needs more support and emphasis on providing unique health and social care to refugees. It was clear from these conversations that in addition to language barriers and system navigation issues, psychological safety was another important factor and potential barrier in accessing health services for refugees. As a vulnerable population with known premigration experiences of violation and discrimination, this critical need for safety is another unique aspect of refugee health.

Limitations of the engagement process

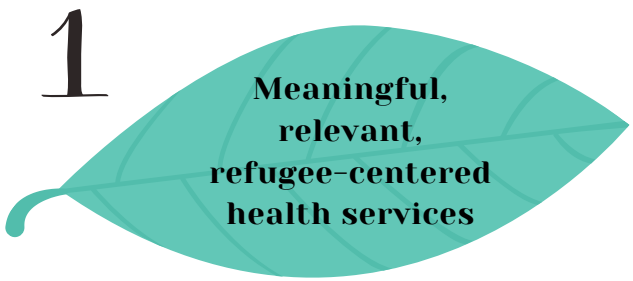
There are many different people and groups involved in the health journey of refugees in Canada. This project aimed to reach as many people and groups as possible but some voices and perspectives are missing. We had limited opportunities to hear from youth and were not able to speak with children. These challenges were related to the ethical considerations of interviewing minors and the need to approach those conversations differently. While we heard from some refugee claimants, we did not reach many of them, as they are not as readily connected to formal refugee services in the city. However, we did capture some stories and ensured that key points from front-line staff who work with claimants were incorporated. A suggestion for the future would be to work with shelters where refugee claimants may be accessing services. Another major limitation is that we primarily heard from refugees who had a connection to a settlement agency or community organization. All conversations were organized by community leaders who worked in one of our partner agencies. We also know from past research that not all newcomers access services, therefore there are many stories from people with limited to no support from newcomer-serving organizations. We would also like to note that although we were able to speak with refugees who have diverse backgrounds and who had been in Canada for a wide range of time, every story is unique. We hope the findings we detailed highlight the complexity and differences in journeys.

There were challenges reaching healthcare providers that are part of the primary care networks (PCNs) in Edmonton. Currently, most GARs are being connected to family physicians in the Edmonton North and Edmonton Oliver PCNs, however we were only able to interview one of these physicians. This was likely due to time constraints and challenges scheduling face to face interviews. A possible alternative for future work would be a different method of data collection, such as a survey, to yield more results.

PRINCIPLES OF REFUGEE CARE

The previously highlighted findings from this project have allowed us to identify specific recommendations and key messages from the conversations.

The key principles of refugee care identified from this project are:



There are significant gaps in healthcare for refugees in Edmonton. We need to work to develop local solutions following best practices of refugee healthcare across Canada and globally. This includes refugee-specific healthcare services that are available immediately upon arrival and designed to meet the needs of each individual.

Access to health services is only a portion of what contributes to health status. As refugees do not experience settlement in silos, those elements that contribute to health such as housing, transportation, education, or poverty must be considered in the whole person. As such, programs and services for refugees need to be able to address and consider all social determinants of health. The social determinants of health include education, employment, social security and housing amongst others.

Throughout our engagement process it became clear that relationships are essential for providing appropriate, relevant and safe care for refugees. Furthermore, building relationships can take a lot of time and effort and the current healthcare system does not easily allow for that type of work. For future solutions and models to be successful, they must focus on person and family centered care and wellbeing, which will ensure that services are timely and culturally sensitive.

This report highlights the diversity between and within refugee populations. Furthermore, the trends in refugee resettlement are constantly changing in response to international tensions. As a result, truly successful solutions need to be flexible to respond to changing pressures. They also need to be owned by the community as community-owned initiatives are inherently more flexible and responsive.

With these principles of refugee care in mind, we have detailed several recommendations that build on the solutions the participants highlighted.

Recommendations & Exploring Solutions

The solutions and recommendations detailed in this section were developed through discussion with community members, front-line service providers, community leaders, key stakeholders and leadership in newcomer-serving agencies.

1.0 Building Capacity of Refugees

Our conversations with different communities highlighted the need for more education to refugees on health, wellbeing and the healthcare system. Settling in Canada is a long process and it can be very challenging for newcomers to learn about all the systems and how to navigate them. Currently CSS provides an 8-week orientation program for all GARs as an introduction to life in Canada. One full day of this program is allocated for health and mental health. However, many people, staff and clients, noted that there needs to be ongoing education provided to newly arrived refugees on the healthcare system and health and well-being. It was suggested that repeating this training 6-8 months after arrival, when people have had a bit more time to adjust would be beneficial. Furthermore, there is no standardized orientation provided to PSRs or refugee claimants. The private sponsors we spoke with all highlighted different challenges with navigating access to care. Orientation and health education should be offered at multiple times in the settlement journey to newcomers who arrived through all refugee categories. Outside of the CSS orientation program, health is a common topic discussed in LINC English classes (Language Instruction for Newcomers to Canada). In fact, one refugee we interviewed stated that most of their knowledge about the healthcare system came from their LINC School. The CSS orientation team often presents on healthcare in LINC classrooms so this initiative should be scaled up.

Some of the topics this education should include are: information about the Canadian healthcare system, rights and obligations of a patient, preventative care and managing chronic diseases. It was clear through conversations with refugees, healthcare providers, service providers and sponsors that the idea of preventative care is not common in many cultures. This impacted refugees' willingness to, for example, to see a family doctor on a regular basis or go to the dentist. Health education could target this gap in knowledge. Furthermore, focusing on building the capacity of refugees to navigate the healthcare system, and advocate for their own health will support the long-term goal of integration.

Who is responsible for this?

Building the capacity of refugees to understand and navigate the healthcare system falls primarily on the newcomer-serving non-profit sector, and collaboration with AHS and other healthcare professionals is necessary. Currently, many newcomer-serving organizations already provide orientation and informational sessions to newcomers, therefore, the framework and foundation already exists. Organizations such as CSS, EMCN and MCHB should work in partnership to develop health-specific curriculum and provide training for refugees at various points in their settlement journey.

Is there progress on this recommendation?

CSS has developed short informational videos over the past year to help newly arrived refugees understand the healthcare system. These resources focus on the first few weeks in Canada. Plans are in place to develop an information session at 8-10 months post-arrival to provide more information about the healthcare system and an opportunity for questions. The MCHB model currently has an emphasis on building capacity of refugees to navigate the system for themselves. What is needed is more CHWs so they can spend more focused time with each family.

2.0 Providing New Solutions for Language Barriers

Language barriers when accessing healthcare services were identified by all participants as one of the key challenges. Refugees, service providers and healthcare providers recognized this as a main barrier with limited solutions currently in place. Currently, AHS contracts a third party company to provide the Language Line (this is an American operation) service, which provides interpretation by professionally trained medical interpreters in 240 languages and is available 24/7. Although this service is provided in all AHS facilities, it was clear from our conversations that the Language Line is not being used sufficiently or appropriately. The use of the language line was introduced in Edmonton several years ago, prior to this time in person translators were utilized through a local Centralized Interpreter Service, which was hosted by the Family Center. The ability to access diverse interpreters was possible through multiple contracts with various community agencies. Unfortunately, this was services was eventually discontinued. To provide safe and high-quality health care, the language barriers and language interpretation issues that currently exist must be addressed.

Because language barriers have such a significant impact on healthcare, the RHC has produced a separate research report on strategies to address language barriers in the healthcare system.[72] This report includes a scoping review of published literature, an environmental scan of models used across Canada and stakeholder interviews with key informants in Edmonton. This review found four key findings to address language barriers: 1) improve culturally competent care of healthcare providers, 2) increase the use of CHWs, 3) increase the use of in-person professionally trained medical interpreters, and 4) increase the number of bilingual, or multilingual healthcare providers. The completed review indicated that there is no one solution or one best practice as language barriers present complex challenges in accessing and receiving health care. As such, the RHC recommends a multi-pronged approach to improve the accessibility of appropriate interpretation services. It is important that AHS make the use of interpretation a required standard of practice in delivering patient and family centered care. Extensive education and training to ensure the effective use of the Language Line and interpretation is also necessary. Physicians who practice in refugee clinics, such as the Mosaic Refugee Health Clinic in Calgary, report that

[72] Fombong, Frankie, Michael, MacNeil, Malowany, Natalie, Sandila, Navjot, Tocher, Paige, and Wilson, Sarah. (2020). Evidence-Based Recommendations to Overcome Language Barriers Experienced by Refugee Populations Accessing Healthcare Services in Edmonton, Alberta. School of Public Health, University of Alberta.

the Language Line can work effectively but the healthcare provider needs to use it appropriately and consistently.
We also recommend that AHS increase the availability of in-person professionally trained medical interpreters in specific contexts. There are circumstances when in-person interpretation is more appropriate, for example when patients have complex health needs. Eventually, health care providers and AHS staff are provided with guidelines and training on how best to involve interpreters.

Who is responsible for this?

An important component of person and family centered care is providing healthcare services in a person's language of choice by using appropriate interpretation supports. AHS needs to continue to work on ways to ensure that language barriers are removed for refugees accessing health services.

Is there progress on this recommendation?

The RHC has raised this concern with various policy and decision makers within AHS.

Summary of Research and Evidence

A comprehensive summary of the review and evidence can be found in the supplemental report highlighted above. It is important that there is an intentional and thoughtful review of what form of interpreting is best for a spectrum of situations in the health care system - this needs to reflect the local context.

3.0 Building Capacity of Currently Practicing Healthcare Providers and Healthcare Students

This project highlighted the fact that there are not enough opportunities for healthcare providers and students to learn about refugees. There are only a few hours in the current medical and nursing school education dedicated to refugee health and there are few placement opportunities in Edmonton. Some of the newcomer-serving agencies provide placement opportunities for nursing students and there are some refugee advocates in the Faculty of Nursing at the University of Alberta who provide learning opportunities. Nationally, there are training opportunities available through different organizations such as the Canadian Collaboration for Immigrant and Refugee Health and the Refugee Mental Health Project through the Centre for Addictions & Mental Health. However, the lack of local resources has led to gaps in healthcare providers' knowledge of how to support and care for refugees. Furthermore, one of the primary challenges we identified was the need for healthcare providers to be empathetic and to understand more about the experiences of refugees. Therefore, one major recommendation is to focus on building the capacity of healthcare students and providers to give them the tools and skills to care for refugees. This recommendation will require multiple activities including, but not limited to working with the

University of Alberta Faculty of Medicine to develop curriculum for medical students, working with the Nursing Faculties to develop curriculum, increase placement opportunities for students, develop workshops and seminars for currently practicing healthcare providers, collaborate with primary care networks to connect with physicians in the community, and create a local hub to gather knowledge and resources around refugee health that can be easily accessed.

Who is responsible for this?

The RHC has done some work in the past to train healthcare students and there are several RHC members eager to be involved in this work. Ultimately, adding to the medical school and nursing curriculum is the responsibility of the respective faculties. The RHC will work closely with the University of Alberta, AHS and other key stakeholders to develop a clear strategy to address this recommendation.

Is there progress on this recommendation?

The RHC has developed a working group of interested members to begin exploring this idea and is planning for education to be a primary activity of the organization moving forward.

Summary of research and evidence

Resources to support healthcare providers working with refugees include interpreters, community resources and agencies, and education on migration health.[73] Integration of interpreters with cross-cultural training can be associated with increased confidence in healthcare providers to administer healthcare to refugees with better success in detecting health issues and increasing client satisfaction.[74] Other supports for healthcare providers include having refugee health information accessible by their professional bodies and associations, online and telehealth tools, formal and informal support groups, and links with community agencies working in refugee health.[75] Hosting student placements within refugee programs will provide students the opportunity to work with community organizations, leaders, and refugees to increase and build upon their knowledge of cultures, communication skills, working with interprofessional teams, and understanding the role of each profession in providing health to a specific population.[76] One example is a curriculum developed for medical residents that focused on refugee health and included: societal, cultural, economic, and human rights profiles of countries; health system policies, resources and statistics; and common manifestations of disease including a focus on tropical and travel health.[77] The key features of this curriculum helped the students in learning by engaging in teaching modules and collaborations with the community.[78]

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[73] Mota, L., Mayhew, M., Grant, K. J., Batista, R., & Pottie, K. (2015). Rejecting and accepting international migrant patients into primary care practices: a mixed method study. International Journal of Migration, Health and Social Care, 11(2), 108-129. doi: 10.1108/ijmhsc-04-2014-0013

[74] Hansen, L., & Huston, P. (2016). Health considerations in the Syrian refugee resettlement process in Canada. Canada Communicable Disease Report = Releve Des Maladies Transmissibles Au Canada, 42(Suppl 2), S3-S7.

[75] Ibid

[76] Margalit, R., Vinson, L., Ngaruiya, C., Gehring, K., Franks, P., Schulte, C., ... Kudlacz, A. M. (2015). Bridge to care for refugee health: Lessons from an interprofessional collaboration in the Midwest. International Public Health Journal, 7(1), 163-171

[77] Asgary, R., Smith, C. L., Sckell, B., & Paccione, G. (2013). Teaching Immigrant and Refugee Health to Residents: Domestic Global Health. Teaching & Learning in Medicine, 25(3), 258-265.

[78] Ibid.

4.0 Increasing Capacity of Community Health Workers

One theme in many conversations was the idea that Edmonton needs more CHWs.[79] Participants who had experience working with a CHW spoke strongly in support of this model of care and commented that Edmonton would benefit from many more CHWs. Many participants who were unaware of the CHW model described the idea as one that would be beneficial. They described the need for a 'health navigator' from the same ethnocultural community of the refugee who could go side-by-side with the refugee through their healthcare journey. In general there are three main roles of a CHW: navigating cultural differences, language interpretation and system navigation, which may include advocacy. The MCHB model incorporates all three roles by hiring staff from the same ethnocultural communities as their clients. MCHB brokers are also trained on the Edmonton healthcare system so they can support clients with navigation. Other newcomer-serving agencies have staff that may fill one or two of these functions. For example, within CSS the Refugee Health Promotion team can act as system navigators and cultural brokers, and, with language interpretation supports, can support clients in all three areas of health brokering. Training should also target staff within the healthcare system whose current role includes system navigation (e.g. social workers) but who may not have knowledge of the cultural and language complexities of supporting newcomers. [1] However, it is the recommendation of this report that agencies invest in new or additional resources that fulfill the CHW role, as this role is key to delivering culturally sensitive services to the refugee population and focus on wellbeing.

Who is responsible for this?

Newcomer-serving agencies who support clients with health needs should explore opportunities to provide training for their staff on health brokering. Government funders should also create opportunities for new positions within agencies so that new CHWs can be hired within the sector and the health system. Partnerships between the newcomer-serving sector and the health system to develop training would also be beneficial.

Is there progress on this recommendation?

In the 2019 Call for Proposals, IRCC included health navigators as a new position for which funding could be received. Some newcomer-serving agencies included these roles in their application for funding that would start in April 2020. Additionally, there is an Ottawa based project intended to provide training to health navigators across Canada. The project leads have presented to the RHC and other agencies in Edmonton and the first course is open in early 2020. Although this project has limited capacity for training there might be opportunities to expand the work locally.

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[79] Definitions of health brokers and health navigators are included in the glossary. The terms are often used interchangeably however, in Edmonton, health brokers provide
support centered around the person, their family and holistic needs. Health brokers are usually from the same cultural and linguistic group as the client in order to support cultural brokering and interpretation as needed. Health navigators are system-focused roles.

Summary of research and evidence

There is a long-standing successful history of involving CHWs in refugee care, led by the MCHB. The work of the MCHB is framed within Labonte's 5 spheres of empowerment [80]. This model supports challenges to attaining health and wellbeing by addressing the social determinants of health and triaging the needs of vulnerable populations to then facilitate entry to the health system.

5.0 Increasing Resources for Mental Health

Mental health came up in numerous conversations by refugees, healthcare providers and service providers. As mentioned previously, we did not specifically ask refugees about mental health. However, some groups raised this issue on their own and many groups discussed mental wellbeing and their challenges fostering this. There was consensus that therapy based on western cultural references does not work for many refugees. The mental health programs at CSS, the EMCN, and the MCHB were highlighted as providing important mental health care. However, most of this care was through one-on-one therapy sessions and participants commented that, for most people, the primary challenge was just getting someone to attend one session. Fortunately, there was lots of discussion around different ways to provide mental health support, many that have had success in the past. These different programs focus on community-based support such as peer leaders and support groups. One example are the men's groups run by multiple agencies that provide an opportunity for newcomer men to gather and share their experiences as they settle in Edmonton. These groups are portrayed as a social event, rather than to focus on mental health. Additionally, mental health professionals are involved with facilitating these groups which allows newcomers to become more familiar with the idea of counselling. It was clear from the conversations that there needs to be more community led initiatives like this one, which build capacity and strength within communities. There also needs to be more resources for these agencies to increase their mental health teams as they often struggle with long wait lists.

Another major challenge in terms of mental health support is the limitations of the mental health resources within the formal health systems. Edmonton has recently launched a new centralized service for all AHS mental health services that includes intake, assessment and referral processes. However, this program is fairly new and has not yet built capacity to work within the context of refugees. There is limited cultural awareness training available for staff and there is limited awareness of the pre-migration trauma of refugees among mental health professionals. Although AHS does provide training to front-line staff in the area of trauma informed care, and many staff do incorporate this into their day to day work, ongoing work is necessary to build this skillset in all healthcare providers in the context of the refugee population in a trauma-informed and holistic manner.

[80] Labonte R. (1994). Health promotion and empowerment: reflections on professional practice. Health Education Quarterly, 21(2), 253-268.

Who is responsible for this?

Newcomer-serving agencies should continue to build on existing programming as community-based programming has been shown to be extremely effective. Furthermore, the RHC alongside the CSS, MCHB and EMCN mental health teams needs to work with AHS to leverage mental health services to better support the refugee population.

Is there progress on this recommendation?

The RHC has already developed a partnership with the AHS Addictions and Mental Health department to start working towards solutions. Through this partnership we hope to learn together on how community based mental health professionals can utilize AHS mental health services more effectively and also how those services could increase their capacity to serve refugees and other newcomers.

6.0 Development of a New Model of Healthcare

Refugee health focused clinics and health centres are a well-established model to provide appropriate care for refugees in Canada. Calgary has the Mosaic Refugee Health Clinic which is a multidisciplinary clinic owned and operated by a Primary Care Network. Mosaic provides culturally appropriate health and social care for refugees. They also have partnerships with local settlement agencies such as the Calgary Catholic Immigration Society and the Centre for Newcomers. Other examples include the Ottawa Newcomer Health Centre, the Sanctuary Refugee Health Centre in Kitchener and the Newcomer Health Clinic in Halifax. Each of these models was developed locally to suit local contexts. By comparison, Edmonton has limited dedicated health services for refugees, and lacks a comprehensive and robust healthcare model for this population. As such it is recommended that community refugee health centre be established in Edmonton to better serve the refugee population.

Two main themes from this project that will inform the development of an Edmonton healthcare model are community-driven and collaborative. The Edmonton newcomer-serving sector is a collaborative environment. Strength comes from community organizations and their commitment to build a new model for refugee health care. Furthermore, many newcomer communities in Edmonton are engaged with community organizations and are eager to be involved in potential solutions. The lived experience of newcomers is essential to guiding a new model of care to ensure it is relevant, safe and appropriate but also sustainable. We propose a refugee specific community health centre (CHC) as a new model of health and social care for refugees in Edmonton. This model will be centrally located in a space that can integrate healthcare professionals, social supports and settlement supports. Central to this model are CHWs. In addition, this model will include multidisciplinary care (physicians, nurses, nurse practitioners, allied health professionals, social workers, settlement counsellors, etc.). The CHC will also incorporate refugee-specific mental health supports which would include trauma-informed, culturally relevant mental health care along with community-driven initiatives.

A centralized CHC would provide a space for continued partnerships between newcomer-serving organizations, the health system, the community and other key stakeholders. Other key sectors that we have not yet formed partnerships with include the school systems and the housing sector. Many of the stories we heard from community involved challenges beyond the health system so it is important to incorporate these opportunities into a CHC.

Who is responsible for this?

As this model is intended to be built on collaboration, it is important that there are several key stakeholders involved. This would include the RHC, CSS, MCHB, EMCN, and AHS. Each of these partners has a unique and specialized perspective and they can each bring their own strengths to a new model of care. Furthermore, CSS, EMCN and MCHB all provide services for marginalized refugees so their partnership is essential.

Is there progress on this recommendation?

The RHC has been exploring different opportunities to develop a new model of care. The first step is for the RHC to focus on formalizing partnerships, identifying possible funding streams and to identify a potential location. The RHC has also begun developing a business proposal for a CHC.

Summary of research and evidence

There are over 30 different refugee health centres and health clinics across Canada that provide specialized healthcare to different groups of refugees. Most of these models provide healthcare to both GARs and PSRs. Some clinics across Canada also integrate immigrants, refugee claimants and undocumented individuals. The health clinics and centres vary in structure from stand-alone clinics to CHCs. Most of the models of care are transitional; the transition period ranges from 6 months to 2 years. However, in some cases clients can access services with no time limit. When clients are ready to be transitioned they are provided with help to find a primary healthcare provider. Staffing for the refugee health models can include CHWs, physicians, nurse practitioners, registered nurses, licensed practical nurses, social workers, counsellors, pharmacists, dieticians, specialists (pediatrician, psychiatrist, infectious disease, obstetrician/gynecologist), medical office assistants, and settlement workers. Interpreter services are available in all models, often both in person and over the phone. The different models also use different types of interpretation services, such as in person interpreters for the initial appointments and then telephone translation services for follow up appointments, other models rely on phone interpretation or in-person interpreters. Funding is often provincial, and in some cases a combination of provincial, federal funding and or grants/private donations. Many of the clinics are teaching sites for health professional students from medicine, nursing, social work, and graduate programs. The extensive work that our colleagues have done across Canada to evaluate different models of care will allow us to learn from promising practices.

The research indicates that a primary health care model for refugee health should focus on primary health care and health promotion strategies that address cultural barriers, access

barriers and the social determinants of health.[81] This model could aid in a better use of resources, providing healthcare in the community where people live and work, organized to the needs of the population, provided by health professionals that have skills in refugee healthcare and encourages teamwork and interdisciplinary collaboration.[82] It can assist in decreasing wait times for the initial health visit, decrease unnecessary use of the emergency room, improve chronic disease management, and ensuring that the right care is delivered by the right provider in the appropriate setting in a timely manner.[83] CHWs who are integrated into refugee health programs support refugees in navigating the systems that related to the social determinants of health.[84] If health navigators were members of the refugee community, they can aid in navigation of services as they have a good understanding of the issues their communities face and can help them in accessing appropriate health and social services. They can also help ensure there is linguistic and culturally appropriate support.[85] Beacon House is a refugee health clinic in Nova Scotia; the primary components of this clinic includes: primary and priority medical care, supportive clinics, transitions capacity building activity, reducing barriers and improving quality of care by providing public health, mental health and language specific services, and developing partnerships with patients, families and communities.[86] Centralized modules can also integrate bilingual staff, transportation to and from appointments, longer clinic hours, and use of gender concordant providers.[87] Interprofessional designs also help facilitate education opportunities for students as students can work with refugee clients, spend time with different professions and work on projects specific to advancing refugee health.[88]

7.0 Long-Term Policy Solutions

In addition to the more immediate solutions detailed above, this project made it clear that there are several systems level challenges that impact health and well-being among refugees in Canada. This section provides context and expands on issues highlighted.

Issues with the Interim Federal Health Program

The IFHP coverage is federally funded health insurance provided to all refugees to Canada for the first year. This insurance ensures that refugees have access to basic healthcare

[81] Batista, R., Pottie, K., Bouchard, L., Ng, E., Tanuseputro, P., & Tugwell, P. (2018). Primary Health Care Models Addressing Health Equity for Immigrants: A Systematic Scoping Review. Journal Of Immigrant And Minority Health, 20(1), 214-230.
[82] Ibid.
[83] Elmore, C. E., Tingen, J. M., Fredgren, K., Dalrymple, S. N., Compton, R. M., Carpenter, E. L., ... Hauck, F. R. (2019). Using an interprofessional team to provide refugee healthcare in an academic medical centre. Family Medicine & Community Health, 7(3), 1-8. https://doi.org/10.1136/fmch-2018-000091
[84] Carter, N., Valaitis, R. K., Lam, A., Feather, J., Nicholl, J., & Cleghorn, L. (2018). Navigation delivery models and roles of navigators in primary care: a scoping literature review. BMC Health Services Research, 18(1), 96. https://doi.org/10.1186/s12913-018-2889-0
[85] Torres, S., Labonté, R., Spitzer, D. L., Andrew, C., & Amaratunga, C. (2014). Improving health equity: the promising role of community health workers in Canada. Healthcare Policy = Politiques De Sante, 10(1), 73-85.
[86] Kohler, G., Holland, T., Sharpe, A., Irwin, M., Sampalli, T., MacDonell, K., ... Ampi Kanakam, R. (2018). The Newcomer Health Clinic in Nova Scotia: A Beacon Clinic to Support the Health Needs of the Refugee Population. International Journal Of Health Policy And Management, 7(12), 1085-1089. https://doi.org/10.15171/ijhpm.2018.54
[87] Joshi, C., Russell, G., I-Hao Cheng, Kay, M., Pottie, K., Alston, M., ... Harris, M. F. (2013). A narrative synthesis of the impact of primary health care delivery models for refugees in resettlement countries on access, quality and coordination. International Journal for Equity in Health, 12(1), 88-101. https://doi.org/10.1186/1475-9276-12-88
[88] Elmore, C. E., Tingen, J. M., Fredgren, K., Dalrymple, S. N., Compton, R. M., Carpenter, E. L., ... Hauck, F. R. (2019). Using an interprofessional team to provide refugee healthcare in an academic medical centre. Family Medicine & Community Health, 7(3), 1-8. https://doi.org/10.1136/fmch-2018-000091

services as well as some supplemental supports (dental, vision and prescriptions). Although this program is comprehensive, the insurance has limitations that were discussed in this project. The primary challenge is the limited dental health coverage, especially for children. Most refugees have not seen a dentist before their arrival in Canada and require extensive dental work.

Limitations in Health Coverage

Through this project we also learned of challenges with health insurance coverage for refugee claimants, undocumented people and even resettled refugees. Refugee claimants should have access to IFHP coverage during their application process as asylum seekers. However, this coverage only lasts 1 year at a time and then they need to reapply. Furthermore, claimants have to use the IFHP for all healthcare needs as they are not covered under the provincial health insurance (e.g. family doctors). Often, claimants face challenges accessing care as family doctors are unfamiliar with the IFHP. Undocumented people do not have access to any health insurance so they have to pay out of pocket for all services. As a result, most undocumented people leave their health concerns until it becomes an emergency. We also heard stories from service providers about resettled refugees who were experiencing barriers with their supplemental health insurance. There is provincial health coverage available for people on income support, however, there are many people who work full-time, who do not receive benefits through work, cannot apply for the provincial benefits and cannot afford private benefits. Some of these challenges may be due to the complicated process to apply for benefits, or they may be due to eligibility requirements. The RHC will explore these barriers in order to develop comprehensive policy recommendations to remove barriers to health insurance for these immigration categories.

AHS Policy on Interpretation

Currently, AHS does not have a policy that requires staff and healthcare providers to use the Language Line when serving clients who do not speak English. There are also limited opportunities for AHS staff to learn about how to use the Language Line effectively. We recommend that AHS prioritize developing and implementing a policy on Language Line use within AHS facilities, provide training on the language line, raise awareness of the availability of interpretation in AHS facilities (e.g. news bulletins, posters etc.).

Who is responsible for this?

The RHC will collaborate with different partners and levels of government to explore how to change these policies and systemic barriers. There is a national network of healthcare providers that work with refugees that have successfully advocated for policy changes in the past. The RHC will work with this network on any national policy discussions, such as the limited dental health coverage within the IFH.

Is there progress on this recommendation?

Policy change will address some of the underlying issues raised in this project, however it is a long-term activity and the RHC has not yet started undertaking action in these areas.

Conclusion

The global refugee crisis is an increasing challenge, which is further complicated by international tensions and the impacts of climate change. Resettlement by a third country, although only accounting for a fraction of the need, provides an opportunity for refugees to start a different life. In 2018, Canada resettled more refugees than any other country. However, refugees have diverse and complex pre-migration experiences and they require the appropriate and relevant supports and services to enable settlement and integration. In particular, the appropriate healthcare services are an essential first step in this process. Through the engagement process the RHC gained invaluable information about the experience of refugees with the health care system and set out to detail solutions for improved health services based on that community input, expert knowledge and research. This report is the compilation of that information with key recommendations that outline solutions to address the gaps in healthcare for refugees in Edmonton and it is intended to serve as a road map to guide the RHC's work over the coming year. Currently, the RHC operates in the space between the community and the systems. The RHC has advocated to different levels of government on behalf of the community, and the RHC has spent significant time with the community to hear and learn from them. We believe this role is essential and needs to continue. As a catalyst the RHC can act as this intermediary body that will work to elevate the voices of newcomers and newcomer-serving organizations.

Appendix 1.0

Key Questions to Start Conversations - Community

1. Initial Introduction Question

o "We are interested in health tied to the healthcare system and wellbeing in a broader sense. In the current Canadian context, we use the term wellness as relating to things beyond health and mental health services."
o What does health and wellbeing mean to you? (*need to keep in mind translation of 'health' into different languages) OR
o What images or thoughts come to mind when you think of health or wellness? (*can use image cards to prompt discussion)

- If you start with a conversation about health and wellness, you can follow this discuss to talk about what the community members need to stay healthy

2. Pre-Migration Question

o What was your health like before you arrived? How did you address or manage your health before you came to Canada? (*probe or follow what the community is saying in this question)

- Please listen for experiences with formal health services, prominent health issues, and holistic or community health supports
- Optional question: How did you receive healthcare before you came to Canada? What was your experience with health and wellness pre-migration?

3. Post-Migration Questions

o "Now we would love to hear about your experience with health, the healthcare system and your general wellbeing since you came to Canada."
o What were your first experiences with healthcare when you first arrived in Canada?

- Please note comments around common/prominent health issues, key services providers and other helpful providers or community members - also note where they first entered the healthcare system (e.g. New Canadians Clinic, East Edmonton, emergency room...?)

o What are your experiences with health and healthcare now in Edmonton?
o Follow-up Questions:

- When you have a health-related issue, where do you go for advice or help? Who helps you find support?
- Where did you go for support?
- What support did you receive?

4. Ideas for the Future: (2 different ways to go here depending on time and where the conversation is at)

- Wrap up questions:
  - Based on your current experiences, what is working very well that you would like more of?
  - What is not working well - do you have ideas for what can improve on this?
  - Who would be the best people to provide you with the healthcare you need, as well as support for your overall wellness (yours and your families)?
    - Gaps in care, barriers to services etc.
- Or, should we continue to discuss what improvements you would suggest to make things better for other patients and families?
- Optional questions:
  - Were there specific things that doctors, nurses or healthcare staff could have done differently to be more helpful to you or your family member?
  - When and where do you want to learn more about health? What do you want to learn more about?
  - What would you have liked to know about your health and healthcare?
  - What are your expectations about healthcare?
  - What would your ideal healthcare provider look like? What is your ideal experience with healthcare
  - What does your ideal healthcare team look like?

Key Questions to Start Conversations -Social Service Providers

1. What is your role within this organization? What populations do you normally work with?
2. How and why did you start working with newcomers?
3. What common health concerns do you see among your clients?
4. What are some practices you use to support their healthcare needs? What kind of gaps do you encounter when trying to serve them?
5. Do you find that the community plays a role in supporting health needs of newcomers?
6. How long do you need to properly assess and support health needs of your clients?
7. What do you find are the strengths and gaps for refugees in our healthcare system?
8. Have you encountered the impact of pre- and post-migration trauma that refugee community members may experience? How do you manage that?
9. What types of resources do you need to provide the appropriate care for community members with a refugee background?
10. What is your ideal model of refugee healthcare?